AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Open Board Meeting

Wednesday, 07 September 2016

10:00am

Note:

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

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

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Published 01 September 2016

Agenda
Meeting of the Board
07 September 2016

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

Time: 10:00am

Board Members	**Auckland DHB Executive Leadership**	
Dr Lester Levy (Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Fiona Barrington	Change Director
Peter Aitken	Simon Bowen	Director of Health Outcomes – AHB/WDHB
Doug Armstrong	Margaret Dotchin	Chief Nursing Officer
Judith Bassett	Joanne Gibbs	Director Provider Services
Dr Chris Chambers	Naida Glavish	Chief Advisor Tikanga and General Manager Māori Health – ADHB/WDHB
Dr Lee Mathias (Deputy Chair)	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Robyn Northey	Fiona Michel	Chief of People and Capability
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	
	Elizabeth Jeffs	Group HR Director
	Bruce Levi	General Manager Pacific Health
	Auxilia Nyangoni	Deputy Chief Financial Officer
	Marlene Skelton	Corporate Business Manager
	Suzanne Stephenson	Acting Director Communications
	(Other staff members who attend for a particular item are named at the start of the respective minute)	

Apologies Members:

Apologies Staff:

Karakia

Agenda

Please note that agenda times are estimates only

10.00am **1.** **ATTENDANCE AND APOLOGIES**

2. **RESOLUTION TO EXCLUDE THE PUBLIC**

12.45pm **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?

	4.	**CONFIRMATION OF MINUTES 3 AUGUST 2016**
12.50pm	**5.**	**HEALTH AND SAFETY REPORT**
	5.1	The Next Steps – From Safety to Health and Safety – A verbal presentation by Ailsa Claire
1.10pm	**6.**	**ACTION POINTS 3 AUGUST 2016**
1.15pm	**7.**	**CHIEF EXECUTIVE'S REPORT**
	7.1	Chief Executive's Report
1.25pm	**8.**	**COMMITTEE REPORTS**
		Audit and Finance Committee
	8.1	Sub-Committee Recommendations Arising from Risk Management Discussion
1.30pm	**9.**	**PERFORMANCE REPORTS**
	9.1	Financial Performance Report
	9.2	Funder Performance Report
1.50pm	**10.**	**DECISION REPORTS**
	10.1	Safe Staffing and Healthy workplaces Unit Care Capacity Demand Management Programme
	11.	**DISCUSSION PAPERS - NIL**
2.00pm	**12.**	**GENERAL BUSINESS**

Next Meeting:	Wednesday 26 October 2016 at 9:45am A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

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Attendance at Board Meetings

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

Resolution to exclude the public from the meeting

Recommendation

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

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

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

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

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

Register of Interests – Board

Member	Interest	Latest Disclosure
Lester LEVY	Chairman - Waitemata District Health Board (includes Trustee Well Foundation - ex-officio member as Waitemata DHB Chairman) Chairman - Auckland Transport Chairman – Health Research Council Independent Chairman - Tonkin and Taylor Ltd (non-shareholder) Professor (Adjunct) of Leadership - University of Auckland Business School Head of the New Zealand Leadership Institute – University of Auckland Lead Reviewer – State Services Commission, Performance Improvement Framework Director and sole shareholder – Brilliant Solutions Ltd (private company) Director and shareholder – Mentum Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as a shareholder) Director and shareholder – LLC Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as shareholder) Trustee – Levy Family Trust Trustee – Brilliant Street Trust	09.02.2016
Jo AGNEW	Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Professional Teaching Fellow – School of Nursing, Auckland University Appointed Trustee – Starship Foundation Casual Staff Nurse – Auckland District Health Board	15.07.2015
Peter AITKEN	Pharmacy Locum - Pharmacist Shareholder/ Director, Consultant - Pharmacy Care Systems Ltd Shareholder/ Director - Pharmacy New Lynn Medical Centre Shareholder/Director – New Lynn 7 Day Pharmacy Shareholder/Director – Belmont Pharmacy 2007 Ltd Shareholder/Director – TAMNZ Limited Shareholder/Director – Bee Beautiful Limited	07.10.2015
Doug ARMSTRONG	Shareholder - Fisher and Paykel Healthcare Shareholder - Ryman Healthcare Shareholder – Orion Healthcare (no beneficial interest held) 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 Acting Chair - Health Innovation Hub Director - Health Alliance Limited Director/shareholder - Pictor Limited Director - Lee Mathias Limited Director - John Seabrook Holdings Limited Trustee - Lee Mathias Family Trust Trustee - Awamoana Family Trust Trustee - Mathias Martin Family Trust Director – New Zealand Health Partnerships	11.05.2016
Robyn NORTHEY	Trustee - A+ Charitable Trust Shareholder of Fisher & Paykel Healthcare Husband – shareholder of Fisher & Paykel Healthcare Husband – shareholder of Fletcher Building Husband – Chair, Problem Gambling Foundation	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	Deputy Chair - NZ Blood Service Director and Shareholder – C4 Consulting Ltd Shareholder – Vector Group Shareholder / Director - Eltham Investments Limited Shareholder / Director - Cavell Corporation Limited Shareholder / Director - Ward Consulting Services Limited Trustee - LP Leasing Limited Trustee - Chris C Lynch Limited Son – Oceania Healthcare	18.07.2016

Minutes
Meeting of the Board
03 August 2016

Minutes of the Auckland District Health Board meeting held on Wednesday, 03 August 2016 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 9:45am.

Board Members Present	**Auckland DHB Executive Leadership Team Present**	
Dr Lester Levy (Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Simon Bowen	Director of Health Outcomes – AHB/WDHB
Peter Aitken	Joanne Gibbs	Director Provider Services
Doug Armstrong	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Judith Bassett	Dr Andrew Old	Chief of Strategy, Participation and Improvement
Dr Chris Chambers		
Dr Lee Mathias (Deputy Chair)	Rosalie Percival	Chief Financial Officer (Left after item 8.1)
Robyn Northey	Linda Wakeling	Chief of Intelligence and Informatics
Morris Pita	Sue Waters	Chief Health Professions Officer
Gwen Tepania-Palmer	Dr Margaret Wilsher	Chief Medical Officer
Ian Ward		
	Auckland DHB Senior Staff Present	
	Brigita Krismayanti	Corporate Committee Administrator
	Marlene Skelton	Corporate Business Manager
	Suzanne Stephenson	Acting Director Communications
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

1. ATTENDANCE AND APOLOGIES

That the apologies of Senior Managers, Margaret Dotchin, Chief Nursing Office and Fiona Michel, Chief of People and Capability be received.

2. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution: Moved Lee Mathias / Seconded Ian Ward

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:

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	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage,	That the public conduct of the whole or the relevant part of the

22 June 2016	commercial activities [Official Information Act 1982 s9(2)(i)]	meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
1.1 Board circulated Resolution – Auckland DHB Long Term Investment Plans	**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 the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Action Points 22 June 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 Northern Electronic Health Record (NEHR) Programme - 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]
4.1 Health and Safety Report	**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 in the disclosure of information

	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)]	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 and Safety Policy	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Protect Health or Safety** The disclosure of information would not be in the public interest because of the greater need to protect the health or safety of the public [Official Information Act 1982 s9(2)(c)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4.3 Presentation – Taking Health and Safety to the Next Step	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Protect Health or Safety** The disclosure of information would not be in the public interest because of the greater need to protect the health or safety of the public [Official Information Act 1982 s9(2)(c)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Tamaki Regeneration Programme: Next Steps	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 Risk Management Discussion Document	**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,	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

	without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.2 Business Case – Cardiovascular Directorate – CIU Room One X-Ray Replacement	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.4 Substitution – Fraser McDonald Unit Sluice Room	**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 Occupation Licence Agreements – Retail Outlets at Auckland City Hospital and Greenlane Clinical Centre	**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]
6.6 Update – Progress on Implementation of new After-Hours Arrangements	**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]

6.7 Integrated Pharmacist Services in the Community – Implementing a New Approach	**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]
6.8 Auckland DHB Blood Services Work Area Technology Upgrade	**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]
6.9 Business Case Auckland City Hospital Support Building – Upgrade Service Lifts	**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]
6.10 Request for Funds to Complete Emergency Department Design	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 Strategy 2020 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)]	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 programme Management: Implementing the Organisational 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 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 Auckland DHB Research 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 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 Auckland Healthy Food and Drink Policy	**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 Draft Terms of Reference for an External Review of Orthopaedics	**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]
7.6 Shareholder Approval Request – NZ Health	**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 in

Partnerships	Information Act 1982 s9(2)(i)]	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 External Bodies Findings Report	**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)] **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)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.2 Minutes – Auckland DHB and Waitemata DHB Collaboration Committee Meeting	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

3. CONFLICTS OF INTEREST

There were none.

4. CONFIRMATION OF MINUTES 22 June 2016 (Pages 14-26)

Resolution: Moved Jo Agnew / Seconded Ian Ward

That the minutes of the Board meeting held on 22 June 2016 be confirmed as a true and accurate record.

Carried

5. ACTION POINTS 22 JUNE 2016 (Page 27)

There were no current action points to report on.

[Secretarial Note: Item 8.1 was considered next]

6. CHIEF EXECUTIVE'S REPORT (Pages 28-37)

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

- The Health Minister Hon Dr Jonathan Coleman had visited Auckland DHB on Tuesday 26 July; meeting with Ailsa, heads and staff of the Adult and Children's emergency department, Transplant ward, PC3 Lab, as well as students from the Design Lab.
- The Head of State of Samoa, Tui Atua Tupua Tamasese Efi, opened Pasifika week on 11 July and visited Auckland City Hospital as part of ARPHS' Talanoa.
- The Board had achieved the national health targets with the exception of the increased immunisation 8 month target. Ailsa drew attention to the year on year comparison with other Auckland region DHBs on page 33 of the agenda.
- From 4 July, we now offer an ESD service to support appropriate patients to leave hospital sooner and return home for treatment before the end of their expected length of stay.
- ACC Minister Hon Nikki Kaye and Minister for Senior Citizens, Hon Maggie Barry, visited Auckland City Hospital in July and announced the Government invest $30.5 million over the next four years in supporting better outcomes for older people at-risk of a fall or injury.
- The new all-age (adult) stroke rehabilitation service was launched in early July. The service is based within Auckland City Hospital's Rangitoto Ward as part of Reablement Services.
- A fully integrated Eating Disorder Services hub now establishes a centre of excellence supporting eating disorder services in the Midland, Metro-Auckland and Northern regions. Services formerly known as "Thrive" and "REDS" will be collectively known as Tupu Ora.
- Prescribing the most appropriate antibiotic treatment for patients has been made

easier at Auckland City Hospital with the development of a mobile application and is the focus of an Auckland DHB and HRC funded research project.

Matters covered in discussion and in response to questions included:

- Lester Levy commented that it was good to see the progress that all three metropolitan District Health Boards had made in meeting the national health targets.
- Morris Pita acknowledged all the good work of the staff at the service level as highlighted through the reported local hero awards.

That the Chief Executives report be received.

Carried

7. COMMITTEE REPORTS

7.1 Collection of Data for Patients with Disabilities (Page38)

Resolution: Moved Ian Ward / Seconded Gwen Tepania-Palmer

That the Board:

1. **Receives the Collection of Data for Patients with Disabilities report.**

2. **Notes that the Auckland Metro DiSAC groups:**
   - **2.1. Actively engage with the disability data and evidence working group**
   - **2.2. Seek to understand how the need for better disability population data will be reflected in the review of the disability strategy.**

3. **Notes that that the Auckland Metro DiSAC groups recommend to their Boards that:**
   - **3.1. The same method of data collection be employed across the three regional DHBs**
   - **3.2. They investigate processes for the collection of the identified data about staff with disabilities.**
   - **3.3. A small working party be established representing the three DHBs to establish guidelines relating to the collection of data to support the DHBs to be good employers of people with disabilities.**

Carried

8. PERFORMANCE REPORTS

8.1 Financial Performance Report (Pages 39-46)

Rosalie Percival, Chief Financial Officer asked that the report be taken as read, highlighting that June had been an extremely busy month and detailing the year end position as follows:

The DHB financial result for June 2016 was a surplus of $15K which was favourable to budget by $216K. The full year preliminary and unaudited result is a surplus of $2.9M. This was favourable to budget by $504K. Overall, Funder arm and Governance results were favourable by $21M and this fully offset the unfavourable variance in the Provider arm of $20.5M.

Full year expenditure is unfavourable to budget by $16.3M. Significant variances include unfavourable personnel of $8.2M, outsourced personnel of $8.6M; clinical supplies of $6.2M; infrastructure and non-clinical supplies of $4M; outsourced clinical services $1.9M and capital charge of $1.9M; offset by favourable Funder payments to NGOs of $14.7M.

The full year financial plan of $2.4M surplus has been achieved as at 30 June 2016.

Matters covered in discussion and in response to questions included:

- Lee Mathias referred to page 42 of the agenda and the reported key unfavourable variance in Cancer and Blood Services related to additional costs for treatment previously funded under a research trial and asked what happened to patients when drugs were withdrawn and patients are still part of a trial. Margaret Wilsher advised that if it is perceived to be to the benefit of the patient then the product is continued to be offered. It is unethical in New Zealand to withdraw a trial treatment.
- Rosalie Percival drew attention to the full revaluation of land completed at 30 June 2015 which had resulted in an increase in the revaluation reserve of $31.8M, increasing the year end Equity position. The land value increased further from Jun 2015 to June 2016 by $37M and this has been included in the summarised accounts. An analysis of the improvements impact (which is also an increase in valuation) is underway and will be included in the Audited result.
  Lester Levy asked what would happen to the balance sheet if a drastic recalibration of the housing market were to occur. Rosalie Percival advised that the Board would receive a capital adjustment so the effect would be minimal.
- Rosalie Percival advised that the Board had received a provisional B Investor Confidence Rating. Treasury had been complimentary of the process undertaken and were happy that the District Health Board understood the requirements. It was unlikely that the final rating would change from a B. It was pleasing to see that all the metropolitan District Health Boards had received B ratings which put them in a very good regional position going forward.

That the Board receives this Financial Report for June 2016.

Carried

[Secretarial Note: Item 6 was considered next.]

8.2 Funder Performance Report (Pages 47-65)

Debbie Holdsworth, Director Funding asked that the report be taken as read, highlighting:

- The Auckland DHB provider reported the FCT 62 day indicator result for May had fallen to 55%. This related to data processing and timeliness of service provision impacted by SMO availability across a range of specialities particularly Dermatology and Gynaecology. A recent review of breach records enabled targeted efforts to improve performance with the 62 day indicator now as of 12 July 2016 at 76.4%. The service is working to implement mandatory delay code reporting including patient choice and increasing focus on the 31 day target to improve overall pathway performance.
- Auckland DHB did not achieve the Immunisation Health Target of 95% of 8 month old infants fully immunised in Q4 2015/16. Auckland DHB achieved 93%. The key issue is the increasing decline rate which has been experienced nationally and thought to be directly related to a very successful anti-vaccination campaign. We anticipate this to get worse as Food babe, a celebrity with significant internet influence, is now pregnant and likely to take an anti-immunisation stance on the basis of being anti-chemicals. The Funder is currently looking at innovative ways in which to promote positive messages around immunisation.
- We were pleased to have achieved the smoking target noting that only four District Health Boards had achieved this.
- Early results for the obesity target suggest a solid start towards the target with Auckland performing considerably above the national average of 21%. In Auckland DHB, 38% of eligible children referred have been acknowledged by General Practice providers.
- Despite a number of interventions being implemented, Rheumatic Fever rates across Auckland DHB are not yet achieving the MoH target. While we are tracking better for Māori; Pacific rates continue to be a concern. The Hype event was very positively received.

Matters covered in discussion and in response to questions included:

- Lester Levy commented that both the financial performance and Funder reports were well written and had the right level of detail for the Board.
- Lester Levy supported a different approach be taken with anti-vaccination groups and to ensure we moved away from a technical approach to promoting messages Perhaps it was time to use social media to take advantage of the powerful peer to peer transmission of messages. It was obvious that something different needed to be tried. Lee Mathias noted that the Ministry were now only funding health promotion of specific campaigns and had stopped funding generic immunisation health promotion.
- Chris Chamber asked whether regional services were working closely with urology services and was advised that Counties Manukau DHB had developed a strategy to

bring in-house urology services it was outsourcing. Jo Gibbs was in dialogue with Counties about this strategy.

That the Funder Performance report be received.

Carried

9. DECISION REPORTS

9.1 Directorships – healthAlliance (Page 66)

Lester Levy advised that Anthony Norman had resigned as a Director of hANZ and FPSC as of 1 July 2016, and Northland DHB have proposed that Meng Cheong, Northland DHB CFO be appointed as a Director of both these companies. Northland DHB is suggesting Meng Cheong should join the Boards until such time as a newly constituted Northland DHB Board reviews the position.
Waitemata DHB has proposed that Russell Jones become a director of hANZ in the place of Andrew Brant, CMO at Waitemata DHB.
Lester Levy considered that these appointments would bring new and good expertise to both Boards.

Resolution: Moved Ian Ward / Seconded Peter Aitken

That the Board:

1. **Note that Waitemata DHB wishes to appoint Russell Jones to become a director of healthAlliance NZ Ltd (hANZ) and healthAlliance (FPSC) Limited (FPSC) in the place of Andrew Brant, Chief Medical Officer - WDHB.**
2. **Note that Northland DHB has proposed that Meng Cheong, CFO - NDHB be appointed as a Director of (hANZ) and (FPSC), to replace Anthony Norman.**
3. **Note that the Constitution of hANZ and the Shareholders' Agreement provides that all shareholders jointly appoint directors. Auckland DHB is a shareholder in hANZ.**
4. **Resolve that Russell Jones and Meng Cheong be appointed as Directors of hANZ and FPSC and that the Chief Executive be delegated authority to execute all related documentation.**
5. **Resolve that the Constitution of hANZ and the Shareholders' Agreement be modified to allow each shareholder to appoint a director and that the Chief Executive be delegated authority to execute all related documentation to affect this change.**

Carried

10. DISCUSSION PAPERS - NIL

11. GENERAL BUSINESS

There was none.

The meeting closed at 1.45pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 03 August 2016

Chair: _____ Date: _____

Lester Levy

Action Points from 3 August 2016 Open Board Meeting

As at Wednesday, 03 August 2016

6

Meeting and Item	Detail of Action	Designated to	Action by
	NIL		

Chief Executive's Report

Recommendation

That the report be received.

Prepared by: Ailsa Claire (Chief Executive)

Glossary

1. Introduction

This report covers the period from 18 July to 12 August, 2016. It includes an update on the management of the wider health system and is a summary of progress against the Board's priorities to confirm that matters are being appropriately addressed.

2. Events and News

2.1 Notable visits and programmes

2.1.1. Upcoming visits

MP for Tamaki and Chair of the Health Select Committee, Mr Simon O'Connor, is expected to visit Auckland DHB later in August. He will meet with the Auckland DHB Chair and myself, as well as heads and staff of the Adult and Children's emergency department and students from the Design Lab involved in the acute flow work.

2.1.2 National CDEM Exercise Programme

Exercise Tangaroa is a Tier 4 exercise which will take place over 3 days (31 Aug, 14 Sep & 28 Sep) - the first full exercise held under the Interagency National Exercise Programme. This will be based on a regional source tsunami scenario and will test the region's preparations for, response to, and recovery from, a national tsunami impact.

2.2 DHB Elections

Nominations closed for District Health Board Elections 2016 noon Friday 12 August. Refer to http://www.adhb.health.nz/about-us/adhb-election-2016/ for nominated candidates.

2.3 Patient and Community

Communications manages a generic communication email box, responding to all emails and connecting people to the correct departments. For this period, 93 emails were received with approximately 25 referred to other departments and services at Auckland DHB.

2.4 External and Internal Communications

2.4.1 External

Auckland DHB made no proactive statements during this period.

We received 50 requests for information, interviews or for access from media organisations between 18 July and 12 August. Media queries included requests for information about the Regional Eating Disorder Service; costs of bariatric beds; for interview with Dr Ed Gane regarding hepatitis c treatments and an interview with Dr Richard Sullivan regarding melanoma treatments.

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

The DHB responded to 10 Official Information Act requests over this period.

At the request of Tauranga lung transplant patient Nikki Reynolds-Wilson, Auckland DHB enabled her three hours of admission and pre-operative procedures (and a post-op interview) to be filmed for *Attitude* which screens on TV One at 8.30am on Sunday mornings. Together with her sister Kristie Purdon, they are known as the 'cystic sisters' and will continue telling their inspirational story of positivity in the face of cystic fibrosis. They are both charitably active in their community and vow to continue their '65 acts-of-kindness' social activity post-transplant. They raise awareness of their condition inspired by the way young children say cystic fibrosis - 65 roses.

Nikki Reynolds-Wilson on one of her good deeds.
Photo/Supplied

2.4.2 Internal

- Two CE blog posts were published. In the first I talked about *our Amazing People* and a summary of the 2015/16 year and the second I talked about *hidden sugar in food and my sugar free journey*.
- The August/September edition of Nova was printed and distributed around the organisation.
- 19 news updates were published on the DHB intranet.
- Five eNova (weekly electronic newsletters) were published.
- Three '*In the know*' sessions took place on 5 August. These are for all managers across the organisation.
- A refresh of the DHB intranet (internal resource) is taking place and is due to go live in September. The new intranet will provide a much better managed approach to information with a more powerful search function.

2.4.3 Events and Campaigns

Sustainability forum

To continue on our sustainability journey we have reached out to connect with the wider community and organisations to share their insights at a series of Sustainability Forums. In July, Ann Stephens, CE, Enviro-Mark Solutions joined us to share their story and ideas. The next forum takes place on 26 August when Lesley Stone, Sustainability Manager at the University of Auckland shares the challenges of sustainability in a large organisation.

Partnership with Energy Efficiency and Conservation Authority

The Energy Efficiency and Conservation Authority (EECA) promotes energy efficiency, energy conservation, and renewable energy. Auckland District Health Board are partnering with them in a three year programme to implement energy efficiency measures at Auckland DHB sites. The DHB uses energy equivalent to 14,500 NZ houses. We predict we can make energy cost savings of almost $400,000 and reduce our carbon footprint by about 900 tonnes of Carbon Dioxide, the equivalent of taking 300 cars off the road.

Chief Executive of EECA, Mike Underhill (photographed right with Ailsa) announcing our partnership with EECA

Energy Efficiency and Conservation Authority
Te Tari Tiaki Pūngao

Certificate of achievement for PVC Recycling

In August we received a certificate of recognition for our work recycling PVC intravenous bags, oxygen masks and oxygen tubes. David Waddell General Manager, Baxter NZ (one of our suppliers of medical plastics) congratulated us on working with them to recycle more than 535kgs of PVC which has in turn been made into 170 playground mats.

Right to left: Shankara Amurthalingam, Operations Manager; Ailsa Claire, David Waddell GM Baxter NZ; Prue Sinclair, Sustainability Project Manager.

Health Excellence Grand Round

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

The first of these new Grand Rounds took place on 2 August. Winners from last year's Health Excellence Awards spoke at the event: Helen Evans winner of the Community Health and Wellbeing Award and Natasha Caldwell part of the winning team for Process and Systems Improvement. There was also an opportunity for attendees to get some application tips for this year's Health Excellence Award from Dr Andrew Old one of the Health Excellence Awards judges.

2.4.4 Social Media

Facebook likes: 3,958
Twitter followers: 2,516
LinkedIn followers: 5,065
Instagram followers: 107

Most popular posts:

Our people

- #patientexperience letters
- Local Heroes
- Auditions for staff review
- Call for submissions – Health Excellence Awards
- Ward 78 achieving Releasing time to Care Modules

Public health alert or education

- Measles
- Healthcare 1, 2, 3 where to go

Campaigns

- #missingtype NZ Blood campaign
- World Breast Feeding Week
- Drier Safer Homes
- Look Up community event
- Stroke and heart health awareness campaigns

Recruitment

- Weekly round-up of new job postings
- LabPlus Careers Day

Featured example:

To support NZ Blood seeking 10,000 first-time donors, it asked places of high interest to remove the letters A and O (two of the most common blood groups) to create awareness.

We created 'mock-ups' of our signage and logo and shared this across our digital platforms.

2.4.5 Our People

Staff musical performance

Auditions for the staff musical performance, *The Committed* took place on 4 August. The cast made up of the talented Auckland DHB team is almost complete. The show will take place on 12 and 13 December.

Local Heroes

There were 13 people nominated for during July for local hero. Congratulations to our August Local Hero: Lee Fogarty, Charge Nurse, Outpatients at Greenlane Clinical Centre

Lee was nominated for the high values she sets for herself, her team and everyone involved in patient care. Lee goes the extra mile to ensure patients receive quality care, clinical documents contain accurate information and fulfil requirements for scanning, so that money can be spent where needed.

The staff member nominating Lee said, "*Recently, on my way to meet Lee, a Scan Centre staff handed me a pile of appointment letters sent for scanning to patient records - instead of being mailed out. I took it along to to my meeting with Lee to ask who I should contact.*

Lee took the letters from me and said that if patients do not receive them it results in patients not attending appointments. This is terrible for patients in desperate need of care. Lee went the extra mile to consult with all involved and put a plan in place to prevent the same issue happening again.

Lee, thank you for being a walking example of the our values: Respect, Welcome, Together and Aim High. You see the entire picture and know the value of each staff member."

Long Service Awards

Plans are underway to recognise approx. 140 people across the organisation in three sessions on Monday 10 October for 20, 30 and 40 years' service.

3. Performance of the Wider Health System

3.1 National Health Targets Performance Summary

	Status	Comment
Acute patient flow (ED 6 hr)		Jul 96%, Target 95%
Improved access to elective surgery *		91.5% to plan for the year
Faster cancer treatment		Jun 76%, Target 85%
Better help for smokers to quit: • PHO enrolled patients • Pregnant women registered with DHB-employed midwife or lead maternity	 	 Jun Qtr 92%, Target 90% Jun Qtr 100%, Target 90%
Raising healthy kids		Jul 52%, Target 95%
Increased immunisation 8 months		Jun Qtr 94%, Target 95%

* 16/17 discharge phasing is still under review

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

3.1.2 National Health Targets – YOY comparison Auckland region DHBs

*Denotes anomaly on MoH website – all DHBs were entered at 100	Auckland Region	2014/15				2015/16			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
 95% of patients will be admitted, discharged, or transferred from an emergency department within six hours.	**Auckland DHB**	**93**	**94**	**95**	**95**	**93**	**95**	**95**	**95**
	Waitemata DHB	95	97	95	96	93	95	96	95
	Counties Manukau	95	96	96	97	95	95	96	96
	All DHBs	93	94	95	95	92	94	94	94
 The volume of elective surgery will be increased by an average of 4000 discharges per year.	**Auckland DHB**	**100**	**100**	**97**	**100**	**93**	**98**	**98**	**101**
	Waitemata DHB	109	109	107	104	101	101	102	106
	Counties Manukau	111	112	108	108	99	103	105	109
	All DHBs	105	107	107	107	104	105	106	108
 85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks by July 2016, increasing to 90% by June 2017.	**Auckland DHB**	*****	**50**	**59**	**60**	**66**	**70**	**75**	**77**
	Waitemata DHB	*	66	70	77	74	68	70	75
	Counties Manukau	*	52	59	63	70	72	70	74
	All DHBs	*	66	67	68	69	75	75	74
 95% of 8-months-olds will have their primary course of immunisation (6 weeks, 3 months and 5 months immunisation events) on time.	**Auckland DHB**	**96**	**94**	**94**	**94**	**95**	**94**	**94**	**94**
	Waitemata DHB	92	94	92	93	93	95	93	92
	Counties Manukau	94	94	93	95	95	95	94	95
	All DHBs	92	94	93	93	93	94	93	93
 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months. 95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking. 90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.	**Auckland DHB**	**P 100**	**P 98**	**P 96**	**P 97**	**85**	**86**	**88**	**91**
		H 96	**H 96**	**H 96**	**H 95**				
	Waitemata DHB	P 99	P 100	P 99	P 94	85	88	90	91
		H 97	H 98	H 98	H 98				
	Counties Manukau	P 98	P 96	P 95	P 96	87	88	89	92
		H 96	H 95	H 95	H 95				
	All DHBs	P 88	P 89	P 89	P 90	83	85	86	88
		H 95	H 95	H 96	H 96				
 90% of the eligible population will have had their cardiovascular risk assessed in the last 5 years.	**Auckland DHB**	**92**	**92**	**92**	**92**	**92**	**92**	**92**	**92**
	Waitemata DHB	90	90	91	90	91	90	91	91
	Counties Manukau	91	91	91	92	92	92	92	92
	All DHBS	**86**	**87**	**88**	**89**	**90**	**90**	**90**	**91**

3.2 Financial Performance

The financial performance for the first month of the 2016/17 financial year (July) was a surplus of $3.5M which was favourable to budget by $77K. Within this result, the Provider Arm was unfavourable to budget by $3.7M, mainly due to electives volume funding not recognised as volumes are under contracted levels. This adverse position is fully offset by favourable performance to budget in the Funder and Governance Arms. The full year plan signed off by the Board is for a surplus of $4.5M that will be achieved through additional funding advised by the Ministry of Health. Underlying that plan are savings in excess of $37M. Subsequent to Board approval of the plan, further changes have been made primarily in relation to electives volumes. We are currently in discussions with the Ministry to finalise the additional electives volumes for the year and other matters. Any changes to the full year financial plan will be advised to the Board via the Audit & Finance Committee.

The 2015/16 financial audit is progressing with no major issues identified so far. The preliminary result previously advised to the Board remains at a surplus of $2.9M, against a planned surplus of $2.4M. The full Annual report including the Annual Accounts will be presented to the Board for approval in October.

3.3 Data Quality Measures

We have been advised by the Ministry of Health of an outstanding achievement in data quality. On a quarterly basis DHB performance is assessed by the Ministry against the following data quality measures:

Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections		
Focus area 1 - Improving the quality of identity data within the National Health Index		
Measure No	**Measure Description**	**Target**
1	New NHI registration in error (duplication)	<4%
2	Recording of non-specific ethnicity in new NHI registration	<2%
3	Update of specific ethnicity value in existing NHI record with a non-specific value	<2%
Focus Area 2 - Improving the quality of data submitted to National Collections		
Measure No	**Measure Description**	**Target**
1	National Booking Reporting System has accurate dates and links to the National Non-admitted Patient (NNPAC) and National Minimum Data Set (NMDS)	>97%
2	National Collections File load Success	>98%
3	Standard versus edited diagnosis code descriptors in the NMDS	≥75%
4	Timeliness of NNPAC data	>95%

In response to the Auckland DHB Q4 results, we have received the following feedback from the Ministry.

"Auckland DHB's commitment to data quality is particularly evident in the continued favourable ratings across:

- Measure 1: National Booking Reporting System collection has accurate dates and links to National Non-admitted Patient and National Minimum Data Set
- Measure 3: Standard versus edited diagnosis code descriptors in the National Minimum Dataset (NMDS)
- Measure 4: National Non-admitted Patient Timeliness.

These measures are consistently rated as Achieved or higher. Auckland DHB has been given an overall rating of Outstanding for 2015/16.

4.0 Clinical Governance

4.1 Development and recognition

4.1.1. In memory Professor Derek North

The University of Auckland Faculty of Medical and Health Sciences Dean, John Fraser, advised that the third Dean of the Faculty (1989-92), Professor Derek North has passed away. Emeritus Professor Ian Simpson will be providing a formal obituary for Professor North to be presented at University Senate.

Professor North is remembered as a kind, warm and gentle man supportive of many in their careers and four of his five daughters followed him into the medical profession. In an excerpt from the 1904-2004 New Zealand Rhodes Scholars' *A Civilising Mission*, he described his work establishing Auckland's Medical School as the "highlight of my career." http://www.otago.ac.nz/library/exhibitions/rhodes_scholars/pdf/rhodes.pdf

Professor North's career is also chronicled in Dr Thomas Miller, David Richmond and Judy Murphy's book, *In the Beginning: A history of the Medical Unit at Auckland Hospital and the formative years of the Department of Medicine, The University of Auckland.* https://researchspace.auckland.ac.nz/handle/2292/27450

4.1.2 Honorary Associate Professor announced

Congratulations to Dr Colin McArthur, a senior intensivist in the Department of Critical Care Medicine at Auckland City Hospital who was recently made an Honorary Associate Professor in The University of Auckland School of Medicine's Department of Anaesthesiology.

Dr McArthur is a graduate of this Faculty and a dual qualified medical specialist (anaesthesia and intensive care) and it was his excellent research record for a busy clinician that prompted the department to nominate him. He has 85 publications in peer-reviewed journals, including 10 in the New England Journal of Medicine and several in other prestigious journals including JAMA, BMJ, and Lancet. Although these publications are often of collaborative multi-centre trials with large teams of investigators, Dr McArthur is often on the writing committee and this represents an extremely impressive record of collaborative research.

Dr McArthur is a long-term member of the Auckland District Health Board Research Review Committee and is the Chairman of that committee.

4.1.3 Pharmacy Awards 2016

Congratulations to our teams who won two of the 2016 Pharmacy Awards on 6 September:

- ProPharma Technician Superstar Award
  Dianne Gulliver, Radhika Devi, Yuki Tsukiyama, Sian Dawson and Kim Brackley won for their work involving Ward-based Pharmacy Technicians who oversee medication supply on wards 63, 65, 71 and 73. These technicians have been shown to facilitate more timely medication supply and release additional nursing time for direct patient care.

- Aspen Pharmacare and Pamol Self-care Award
  The Clinical Pharmacy Team lead by Amy Chan, Natasha Pool, Sarah Wang, Ricky Wan, Ziyen Lam, Kiri Aikman and Joe Monkhouse also won an award for "PLAN" – a clinical pharmacy initiative to promote health literacy and support patients to better understand their medicines.

4.1.4 Health Excellence Award applications now open

Applications for the 2016 Health Excellence Awards close on 5 September. The Awards are an opportunity to celebrate some of the great achievements taking place in research, clinical care and wellbeing. Winners will be announced at the 2016 Health Excellence Awards evening on 1 December at Auckland Museum.

4.1.5 HiNZ 2016 Clinicians' Challenge

The Clinicians' Challenge is a joint initiative from the Ministry of Health and Health Informatics New Zealand (HiNZ). The challenge is funded by the Ministry of Health and supported by HiNZ to encourage innovative ideas using information and technology to improve health care.

The deadline is midnight Monday 12 September. The four selected finalists will be required to give a 5-minute presentation to the judges during the HiNZ Conference at SKYCITY Auckland on Wednesday 2 November 2016.

5.0 Funding

5.1 Applications open

5.1.1. A+ Trust Research Grants

Applications are open for the next A+ Trust research funding round based on scientific merit, feasibility, ability to deliver and opportunities to develop the capacity of new researchers/practitioners in clinical research. Two types of funding are available; Small Project Grant (maximum of $15K) or project grant (maximum of $50K). Applications close 2pm Thu 1 September.

5.1.2 Harkness Fellowship applications

Mid-career professionals (government policymakers, academic researchers, clinical leaders, hospital managers, and journalists) have until 6 September to apply for up to 12 months in the US as a Harkness Fellow in Health Care Policy and Practice. Fellows work with leading US experts to study health care delivery reforms and critical issues on the health policy agenda in both the US and their home countries. Applications close Tue 6 September.

5.1.3 Cancer Society 2017 Grant Round

The Society will consider proposals from prominent and well-published researchers aimed at preventing, detecting and treating cancer more effectively. The Society will also consider applications for training scholarships to allow students to undertake advanced research in the field of cancer, leading to a Doctorate in Philosophy from a New Zealand University. Applications close 5pm 30 September 2016.

5.1.4 Starship Foundation funding

The Foundation's application process has been updated and funding for projects under $2,000 is now open year round. Applications for projects $2,000 and over close on 30 September 2016. Funding for training and conferences is available quarterly, whilst research funding applications close 12 September 2016.

5.2 Funding received

5.2.1 Multi-disciplinary Operating Rooms Simulation (MORSim)

Associate Professor Jennifer Weller, Professor Alan Merry and Professor Ian Civil have secured ACC funding for this surgical team training programme which will be offered to all DHBs in New Zealand through the University of Auckland. This exciting and world leading patient safety initiative will establish sustainable simulation programmes in all DHBs. MORSim aims to reduce avoidable patient harm by improving teamwork, communication and information-sharing. The programme, led by Jennifer, Alan and Ian, will include simulation resources, instructor training and on-going support. MORSim is endorsed by the Health Quality and Safety Commission and will be implemented in Auckland DHB in 2017. For more information on MORSim see www.morsim.ac.nz

Circulated Resolution – Audit and Finance Committee

Sub-Committee Recommendation Arising from a Risk Management Discussion

Recommendation: Moved Ian Ward/Seconded Norman Wong

That the Audit and Finance Committee recommend that the Board:

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

Prepared by: Marlene Skelton (Corporate Business Manager)

1. Background

This matter was discussed by the Audit and Finance Committee at their meeting held on 17 August 2016 and was item 11.6 on that agenda (see page 255).

At the meeting, Ian Ward advised that the report in the agenda had been withdrawn. This had occurred because comment and dialogue with committee members and staff had revealed additional matters to be taken into consideration. A revised report was tabled and members were encouraged to read this and provide comment. This comment was collated to form a new report for Circulated Resolution to Audit and Finance Committee members so that a recommendation could be made to Board.

The attached report and appendices have been endorsed by both Ian Ward and Norman Wong.

The committee considered the attached reports via circulated resolution on Wednesday, 24 August 2016 and recommends to the Board as set out above.

Sub-Committee Recommendation Arising from Risk Management Discussion

[Second Revision of report tabled at Audit and Finance Committee meeting on 17 August 2016]

Recommendations

1. **That the "Sub-Committee Recommendation Arising from Risk Management Discussion" paper be received by the Audit and Finance Committee.**
2. **That the Audit and Finance Committee recommend that the Board:**
   - **2.1 Approve the renaming of the current Audit and Finance Committee to be the Finance, Risk and Assurance Committee**
   - **2.2 Approve the amended Terms of Reference for the renamed Finance, Risk and Assurance Committee**
   - **2.3 Approve the proposed Terms of Reference for the Facilities and Capital Sub Committee**
   - **2.4 Approve the proposed Terms of Reference for the Finance and Reporting Sub Committee**
   - **2.5 Approve the proposed Terms of Reference for the Health and Safety Sub Committee**
   - **2.6 Delegate authority to the Board Chair and Chair of the Audit and Finance Committee to appoint the Members and the Chair of the Sub-Committees.**
   - **2.7 Approve the proposed changes outlined in section 5 of the report to the delegation of authority scheme.**

Prepared by: Marlene Skelton (Corporate Business Manager) for
Sue Waters (Chief Health Professions Officer)
Endorsed by: Ian Ward, Chair of Audit and Finance Committee

1. Introduction and Background

At the Audit and Finance Committee on 13 July 2016, discussion was held regarding the range of options for strengthening risk management arrangements at Auckland DHB. These options included recommendations from management for a review of the committee structure to ensure an enhanced focus on risk management, health and safety and major capital business cases.

As a result of this discussion, the following recommendations were endorsed by the Audit and Finance Committee and forwarded to the Board**:**

i. A review of the purpose and scope of the Audit and Finance Committee to become the Finance, Risk and Assurance Committee,
ii. The development of two sub-committees reporting to the Finance, Risk and Assurance Committee to deal with Facilities and Capital Business Cases, Risk Management and Health and Safety.

At their meeting on 3 August 2016, the Board supported these recommendations and agreed that the new committee structure be reviewed in six months to establish its effectiveness.

This paper has been prepared in response to these Auckland DHB Board and Audit and Finance Committee resolutions. In particular, approval is requested for:

- Revised assurance and risk management duties for the newly named Finance, Risk and Assurance Committee.
- The Terms of Reference for the Facilities and Capital Sub-Committee
- The Terms of Reference for the Finance and Reporting Sub-Committee
- The Terms of Reference for the Health and Safety Sub Committee
- The change in the delegation of authority scheme, as necessitated by the Terms of Reference for the Facilities and Capital and Health and Safety Sub-Committees

2. Introduction and Background

The parent committee is to be renamed the Finance, Risk and Assurance Committee in order to reflect the prime responsibility of managing risk across the organisation.

Three Sub-Committees are proposed to sit under the Finance, Risk and Assurance Committee. These are:

1. Financial Reporting Sub-Committee
2. Facilities and Capital Sub-Committee
3. Health and Safety Sub-Committee.

This paper focuses on the initial implementation of all three Sub-Committees as the Board has identified particular risk around significant investment in renewals of clinical equipment and facilities plant and equipment to maintain services and investment in assets to accommodate population growth along with health and safety issues.

It is expected that establishing the sub-committees in a phased approach will provide the opportunity to test and refine the revised committee structure and to confirm whether the risk management and assurance processes require further amendment. This phased approach also aligns with the Board's request for a review in six-month's time.

Revised terms of reference are required for the Finance, Risk and Assurance Committee and all three of its sub-committees.

Standing Order 1.9.3 states that "Any committee may delegate any of the functions duties or powers of the committee to any subcommittee appointed by the committee under subsection 1.9.1(2) with the prior written approval of the DHB. (Clause 40(1) Schedule 3).

In order for the Audit and Finance Committee to set up these sub–committees it must first amend its own terms of reference in order to confer the correct functions, duties and powers accorded it by the Board.

3. Finance, Risk and Assurance Committee - Terms of Reference

A proposed Terms of Reference for the newly renamed Finance, Risk and Assurance Committee is provided in Appendix 1 for review and approval. These terms of reference provide for a change in name and a clarification around functions and duties related to risk and health and safety.

4. Sub-Committee - Terms of Reference

A proposed Terms of Reference for each of the Sub-Committees is provided in Appendix 2, 3 and 4 for review and approval. These terms of reference provide a detailed outline of the role, function and membership of each sub-committee.

The Sub-Committees are overseen by and report to the Finance, Risk and Assurance Committee.

Standing Order 1.10.1 (2) allows the Finance, Risk and Assurance Committee to appoint membership of the sub-committees reporting to it.

"Unless directed otherwise by the District Health Board, a committee may at any time and from time to time appoint or discharge any member of a subcommittee appointed by the committee."

It should also be noted that the Board Chair is an ex offio member of any Committee of the Board. Standing Order 1.10.1 (8)

"The Chairperson of the DHB shall be, at the Chairpersons' option, an ex-officio member of any committee."

Standing order 2.8.1 (3) determines the quorum of any meeting of the District Health Board.

"The quorum at any meeting of the District Health Board
or a Statutory Committee shall consist of half the members (including vacancies) if the number of members is even, and a majority if the number is odd."

It should be noted that the membership of these Sub-Committees allows for co-opting of non-voting members as and when required.

As a key principle and to ensure consistency with other committees, the Chair of the Finance, Risk and Assurance Committee will be a member of each of these sub-committee and any other sub-committees of the Finance, Risk and Assurance Committee.

5. Proposed Changes to Delegated Authorities

In addition to the changes in committee structure through the establishment of these sub-committees, the following amendments to the delegation of authority scheme are required:

- The Facilities and Capital Sub-Committee will undertake comprehensive review of business cases for capital projects and make recommendations to the Finance, Risk and Assurance Committee for approval.

- Following receipt of recommendations from the Facilities and Capital Sub-Committee, the Finance, Risk and Assurance Committee will receive, consider recommendations and approve business cases - provided they are on the Annual Capital Plan – by exercising the requisite delegated authority from the Board.

- The Board will retain authority for approving the Annual Capital Plan for each year and any amendments to the Plan.

- The Facilities and Capital Sub-Committee will have the ability to approve capital expenditure proposals presented by management to the value of two million dollars.

- The Audit and Finance Committee at its meeting held on 17 August determined that a "capital carve out pool" be set up to deal with critical health and safety issues and risk and that management of this be delegated to the Health and Safety Sub-Committee.

Appendix 1

AUCKLAND DISTRICT HEALTH BOARD

Terms of Reference
Finance, Risk and Assurance Committee

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1. Establishment

The Finance, Risk and Assurance Committee is established by the Board ("Board") of the Auckland District Health Board ("Auckland DHB") under clause 38 of Schedule 3 of the New Zealand Public Health and Disability Act 2000 ("Act"). The Board may amend the terms of reference for the Committee from time to time.

2. Functions of Committee

The function of the Finance, Risk and Assurance Committee is to receive and consider all financial matter and audit and risk material from the Board, Management, internal and external audit, and duly recommend to the Board the appropriate action required.

The Finance, Risk and Assurance Committee should receive periodic briefings (operational as well as financial) on the various operational units of the Auckland District Health Board. Management must inform the Finance, Risk and Assurance Committee of relevant issues at an early stage and provide briefings on key operational and financial matters. The focus of the Committee is on the total **risk,** financial and contractual aspects of Auckland DHB.

Material referred to the Committee should include:

- **All Risk Reporting**
- **Regional Internal Audit**
- **External Audit**
- **All Consumable & Capital Projects Requiring Board Approval**
- **All Financial Reporting including Treasury Activities and Accounting Policies**
- **Contract Schedules**
- **Legal Reporting**

All Risk Reporting

- Ensure all risks in the District Health Board are reported to the Committee and the Board
- Review and evaluate all risks reported by management as they pertain to the District Health Board
- Confirm recommended actions where necessary to reduce/eliminate identified risks

Regional Internal Audit

- Endorse the appointment/dismissal of the regional internal auditor.
- Review the charter for regional internal audit.
- Review and confirm the regional internal audit plans as they pertain to Auckland DHB.
- Instruct the regional internal audit on areas to be reported on.
- Review internal audit reports and confirm the recommended action.
- Consider and review with the regional internal auditor:

    (a) the adequacy of the Auckland DHB's internal controls inclusive of computerised information system controls and security and fraud management.

    (b) any related significant findings and recommendations together with Management's responses.

External Audit

- Review/discuss the external audit plan with the auditors.
- Review external audit reports and confirm the recommended action.
- Consider and review with the external auditor:

    (a) the adequacy of the ADHB's internal controls inclusive of computerised information system controls and security and fraud management.

    (b) any related significant findings and recommendations together with Management's responses.

- Review and recommending the audit fee to the Board.
- Recommend appointment of the External Auditor to the Board.

All Financial Reporting including Treasury Activities and Accounting Policies

- Review at least the half yearly results and annual financial statements and any other statutory financial reports and recommend acceptance or otherwise by the Board.

- It is important that as part of this review the Audit and Finance Committee specifically considers any significant Management estimates and understands the reasons underlying the estimates.

- Review and recommend to the Board on accounting policies and procedures recommended by Management including:

    - depreciation rates;

    - provisions;

    - income recognition;

    - asset valuations; and

    - treasury.

- Review the monthly financial performance reports including treasury activities supported by Executive Management explanations and provide guidance to the full Board on any material issues arising.

All Consumable and Capital Projects Requiring Board Approval

Review submissions made by Management to the Board. The Finance, Risk and Assurance Committee may either support recommendations made by Management and forward to the full Board for consideration or will guide Management in any further work or actions required. The Finance, Risk and Assurance Committee will review the Procurement Policies and make recommendations to Management on any changes to those Policies.

3. Relationship with Board and Management

(a) The Committee is established by and accountable to the Board. The Committee's role is advisory only, unless specifically delegated by the Board from time to time in accordance with clause 39(4) of Schedule 3 of the Act.

(b) The Committee shall receive all material and information for its review or consideration through the Chief Executive or the Regional Internal Auditor.

4. Membership

(a) The Committee shall comprise a minimum of three Board members and a maximum of six members appointed by the Board and in addition, external members may be appointed.

(b) The Board will endeavour to appoint, as members of the Committee, persons including external persons, who together will provide a balance of skills, experience, diversity including commercial and clinical and knowledge to enable the Committee to carry out its functions.

(c) The Board will resolve to appoint persons to be members of the Committee including the Chair of the Board and one of their number, other than the Chair of the Board, to be chairperson.

(d) A quorum will consist of not less than half the number of Committee members.

(e) In terms of Standing Order 1.9.3 the Committee may delegate any of the powers and functions to a sub-committee appointed by the Committee.

5. Meeting Procedure

(a) The Committee shall meet at least once per quarter and more frequently if required. Meetings shall be conducted in accordance with the Standing Orders of the Auckland DHB.

(b) The Chief Executive, Chief Medical Officer, Chief Planning and Funding Officer, Chief Financial Officer and the Regional Internal Auditor are not members of the Committee. However, it is likely that frequent submissions will be received from them and their corresponding attendance at Finance, Risk and Assurance Committee meetings will be required. The Committee may invite other Auckland DHB officers and employees to attend as required.

(c) Other Board members may be requested by the Chairperson of the Committee to attend meetings of the Finance, Risk and Assurance Committee from time to time. Other Board members have the right to receive all Finance, Risk and Assurance Committee papers and to attend any meeting of the Finance, Risk and Assurance Committee.

(d) Internal and external auditors of the Auckland District Health Board have the right of direct and unrestricted access to the Finance, Risk and Assurance Committee and Chair of the Board and both parties should be advised that the Committee expect to be advised of any areas requiring their special attention.

Appendix 2

AUCKLAND DISTRICT HEALTH BOARD

Terms of Reference

Facilities and Capital Sub-Committee

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1. Definitions

In this document:

1.1 "Board" means the Board of Directors of the Auckland District Health Board;

1.2 "Auckland DHB" means Auckland District Health Board;

1.3 "Sub-Committee" refers to the Facilities and Capital Sub-Committee;

1.4 "Member" refers to any person elected or appointed to the District Health Board or appointed to any committee of the District Health Board;

1.5 "CFO" refers to the Chief Financial Officer of the Auckland District Health Board.

2. Establishment

Auckland DHB has identified the need for:

a. Significant investment in renewals of clinical equipment, facilities, plant and equipment to maintain services.

b. Investment in assets to accommodate population growth.

In light of this, the Facilities and Capital Sub-Committee is established to ensure detailed reviews of proposed capital investment projects, and the associated risk, and to make recommendations to the Finance, Risk and Assurance Committee.

This Sub-Committee reports directly to the Finance, Risk and Assurance Committee and is not a statutory committee of the Auckland District Health Board.

The Finance, Risk and Assurance Committee may amend the terms of reference for the Sub-Committee from time to time and recommend these proposed amendments to the Board.

3. Functions of Sub-Committee

The Facilities and Capital Sub-Committee is overseen by and reports to the Finance, Risk and Assurance Committee. More specifically the areas that the Sub-Committee will report on are:

- Provide assurance to the Finance, Risk and Assurance Committee that the capital plan is fully aligned to the Auckland DHB Strategic Plan and expenditure items are prioritised accordingly.
- Detailed review of the capital plan and prioritisation framework.
- Risk associated with proposed capital investment in renewals of clinical equipment, facilities, plant and equipment to maintain services.
- Appropriate sources of capital to support proposed capital investment projects [with the exception of capital IT projects].
- A thorough critique of the viability and robustness of capital projects and their implications on the District Health Board including any commercial impacts.

Responsibilities

To carry out its functions, the Sub-Committee will review and advise the Finance, Risk and Assurance Committee on:

- Capital projects, and the associated risks, following comprehensive review by the Sub-Committee.
- Identified sources of funding to support capital projects
- Approval of capital expenditure proposals presented by management to the value of two million dollars.

The Sub-Committee will review in detail all major capital planning documents and any other related papers.

4. Relationship with Board, Management and the Finance, Risk and Assurance Committee

(a) The Sub-Committee's role is advisory only to the Finance, Risk and Assurance Committee.

(b) The Sub-Committee shall receive all material and information for its review or consideration through the CFO of Auckland DHB.

(c) The Sub-Committee shall provide advice and direction to management and report to the Finance, Risk and Assurance Committee on advice provided and actions requested.

5. Membership

(a) The Sub-Committee shall comprise a maximum of five members including three members appointed from the Finance, Risk and Assurance Committee of the Board and two external members with relevant expertise.

(b) The Chair of the Finance, Risk and Assurance Committee will be one of the three members appointed from the Finance, Risk and Assurance Committee.

(c) Where appropriate, the Sub-Committee will be able to co-opt further people to attend meetings by agreement of the members. (These co-opted members hold no voting rights.)

(d) The Sub-Committee and the Finance, Risk and Assurance Committee will endeavour to appoint, as members of the Sub-Committee, persons who together will provide a balance of skills, experience, diversity and knowledge to enable the Sub-Committee to carry out its functions.

(e) Fees will be paid for attendance in accordance with the State Services Commission Fees Framework.

6. Role of Sub-Committee Chair

(a) To oversee the effective functioning of the Sub-Committee and to demonstrate leadership and awareness in ensuring the Sub-Committee's work is a representation of best risk management practices.

7. Meeting Procedure

(a) The quorum for meetings of the Sub-Committee is a majority of the members, two of whom must be members of the Finance, Risk and Assurance Committee.

(b) In the absence of the sub-Committee Chair from any meeting of the Sub-Committee the remaining members may choose a chair from among them and proceed with the meeting, provided that the quorum is met.

(c) Favour reaching a consensus by having open and complete discussions.

(d) All decisions of the Sub-Committee shall be decided by a majority vote.

(e) The Sub-Committee shall keep minutes of its meetings that record all actions and decisions taken by the Sub-Committee and these minutes shall be submitted to the Finance, Risk and Assurance Committee as soon as is reasonably possible thereafter.

(f) Auckland DHB will provide support services required by the Sub-Committee.

(g) The Sub-Committee shall meet as frequently as it determines necessary.

(h) An annual calendar of the meetings shall be established at the beginning of each year in collaboration with the CE and CFO and the Chair of the Finance, Risk and Assurance Committee.

(i) Minutes of the meeting must be available at the following Finance, Risk and Assurance Committee. The Sub-Committee Chair will be expected to report.

Appendix 3

AUCKLAND DISTRICT HEALTH BOARD

Terms of Reference

Financial Reporting Sub-Committee

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1. Definitions

In this document:

1.1 "Board" means the Board of Directors of the Auckland District Health Board;

1.2 "Auckland DHB" means Auckland District Health Board;

1.3 "Sub-Committee" refers to the Financial Reporting Sub-Committee;

1.4 "Member" refers to any person elected or appointed to the District Health Board or appointed to any committee of the District Health Board;

1.5 "CFO" refers to the Chief Financial Officer of the Auckland District Health Board.

2. Establishment

Auckland DHB has identified the need to:

(a) Review the half yearly results and annual financial statements and any other statutory financial reports and recommend acceptance or otherwise by the Finance, Risk and Assurance Committee and the Board.

(b) Review and recommend to the Finance, Risk and Assurance Committee and the Board on accounting policies and procedures recommended by Management.

(c) Review submissions made by Management to the Finance, Risk and Assurance Committee and the Board.

In light of this, the Financial Reporting Sub-Committee is established to ensure that detailed reviews of half yearly results and annual financial statements and any other statutory financial reports is undertaken and to review accounting policies and procedures and submissions made by management and to make recommendations to the Finance, Risk and Assurance Committee.

This Sub-Committee reports directly to the Finance, Risk and Assurance Committee and is not a statutory committee of the Auckland District Health Board.

The Finance, Risk and Assurance Committee may amend the terms of reference for the Sub-Committee from time to time and recommend these proposed amendments to the Board.

3. Functions of Sub-Committee

The Financial Reporting Sub-Committee is overseen by and reports to the Finance, Risk and Assurance Committee. More specifically the areas that the Sub-Committee will report on are:

- Progress update reports on year-end audit
- Management progress and update on the auditor's recommendations
- Draft and final Annual Account reports prior to Board approval
- Treasury related decisions, i.e. Interest rate profiling, term deposits and investments
- All financial related policies
- Draft financial budgets and key assumptions
- Investor Confidence Rating progress reports including asset management, Long term Investment Plan (LTIP) and project management framework.

Responsibilities

To carry out its functions, the Sub-Committee will review and advise the Finance, Risk and Assurance Committee on:

- Finance and Treasury related matters, following comprehensive review by the Sub-Committee.
- Policy to support finance and treasury related process.

The Sub-Committee will review in detail all major financial planning documents and any other related papers.

4. Relationship with Board, Management and the Finance, Risk and Assurance Committee

(a) The Sub-Committee's role is advisory only to the Finance, Risk and Assurance Committee.

(b) The Sub-Committee shall receive all material and information for its review or consideration through the CFO of Auckland DHB.

(c) The Sub-Committee shall provide advice and direction to management and report to the Finance, Risk and Assurance Committee on advice provided and actions requested.

5. Membership

(a) The Sub-Committee shall comprise a maximum of three members appointed from the Finance, Risk and Assurance Committee of the Board.

(b) The Chair of the Finance, Risk and Assurance Committee will be one of the three members appointed from the Finance, Risk and Assurance Committee.

(c) Where appropriate, the Sub-Committee will be able to co-opt further people to attend meetings by agreement of the members. (These co-opted members hold no voting rights.)

(d) The Sub-Committee and the Finance, Risk and Assurance Committee will endeavour to appoint, as members of the Sub-Committee, persons who together will provide a balance of skills, experience, diversity and knowledge to enable the Sub-Committee to carry out its functions.

(e) Fees will be paid for attendance in accordance with the State Services Commission Fees Framework.

6. Role of Sub-Committee Chair

(a) To oversee the effective functioning of the Sub-Committee and to demonstrate leadership and awareness in ensuring the Sub-Committee's work is a representation of best financial management practices.

7. Meeting Procedure

(a) The quorum for meetings of the Sub-Committee is a majority of the members.

(b) In the absence of the sub-Committee Chair from any meeting of the Sub-Committee the remaining members may choose a chair from among them and proceed with the meeting, provided that the quorum is met.

(c) Favour reaching a consensus by having open and complete discussions.

(d) All decisions of the Sub-Committee shall be decided by a majority vote.

(e) The Sub-Committee shall keep minutes of its meetings that record all actions and decisions taken by the Sub-Committee and these minutes shall be submitted to the Finance, Risk and Assurance Committee as soon as is reasonably possible thereafter.

(f) Auckland DHB will provide support services required by the Sub-Committee.

(g) The Sub-Committee shall meet as frequently as it determines necessary.

(h) An annual calendar of the meetings shall be established at the beginning of each year in collaboration with the CE and CFO and the Chair of the Finance, Risk and Assurance Committee.

(i) Minutes of the meeting must be available at the following Finance, Risk and Assurance Committee. The Sub-Committee Chair will be expected to report.

Appendix 4

AUCKLAND DISTRICT HEALTH BOARD

Terms of Reference

Health and Safety Sub-Committee

---

1. Definitions

In this document:

1.1 "Board" means the Board of Directors of the Auckland District Health Board;

1.2 "Auckland DHB" means Auckland District Health Board;

1.3 "Sub-Committee" refers to the Health and Safety Sub-Committee;

1.4 "Member" refers to any person elected or appointed to the District Health Board or appointed to any committee of the District Health Board;

1.5 "CHPO" refers to the Chief Health Professionals Officer of the Auckland District Health Board.

2. Establishment

Auckland DHB has identified the need for:

(a) A safe environment for everyone.

(b) A culture of excellence in health and safety performance.

(c) Management of a capital carve out pool to deal with critical health and safety issues and risk.

In light of this, the Health and Safety Sub-Committee is established to ensure that a detailed review of the health and safety system occurs at prescribed intervals and to make recommendations to the Finance, Risk and Assurance Committee should changes be required.

This Sub-Committee reports directly to the Finance, Risk and Assurance Committee and is not a statutory committee of the Auckland District Health Board.

The Finance, Risk and Assurance Committee may amend the terms of reference for the Sub-Committee from time to time and recommend these proposed amendments to the Board.

3. Functions of Sub-Committee

The Health and Safety Sub-Committee is overseen by and reports to the Finance, Risk and Assurance Committee. More specifically the areas that the Sub-Committee will report on are:

- Providing assurance to the Finance, Risk and Assurance Committee that the Auckland DHB complies with all relevant acts, regulations, codes of practice, safe work instruments, industry standards and district health board policy.
- Providing assurance to the Finance, Risk and Assurance Committee that the Health and Safety Strategic Plan, the prioritisation framework and the initiatives are fully aligned to other Auckland DHB strategic plans.
- Monitoring and reviewing the Health and Safety Strategic Plan for the control of health and safety risks throughout the organisation.
- Monitoring the adequacy of the organisation's processes and systems deployed for the purpose of reporting and recording of actual or potential incidents and breaches, subsequent investigations, and remedial actions or control measures.
- Recommendations Finance, Risk and Assurance Committee for expenditure from a capital carve out pool to deal with critical health and safety issues and risk.
- Reviewing organisation wide Auckland DHB health and safety reports and to monitor the organisation's overall performance against prescribed targets.
- Reviewing results of annual assessments/audits of the organisations health and safety risk profile and compliance or control processes.
- Provide feedback and sign off for Organisation Health and Safety policy reviews

Responsibilities

To carry out its functions, the Sub-Committee will review and advise the Finance, Risk and Assurance Committee on:

- Health and safety related matters, following comprehensive review by the Sub-Committee.
- Changes to any relevant legislation that affects the organisations ability to meet its health and safety obligations under the act.
- Policy to support health and safety related process.

The Sub-Committee will review in detail all major health and safety documents and any other related papers.

4. Relationship with Board, Management and the Finance, Risk and Assurance Committee

(a) The Sub-Committee's role is advisory only to the Finance, Risk and Assurance Committee.

(b) The Sub-Committee shall receive all material and information for its review or consideration through the CHPO of Auckland DHB.

(c) The Sub-Committee shall provide advice and direction to management and report to the Finance, Risk and Assurance Committee on advice provided and actions requested.

5. Membership

(a) The Sub-Committee shall comprise a maximum of three members appointed from the Finance, Risk and Assurance Committee of the Board.

(b) The Chair of the Finance, Risk and Assurance Committee will be one of the three members appointed from the Finance, Risk and Assurance Committee.

(c) Where appropriate, the Sub-Committee will be able to co-opt further people to attend meetings by agreement of the members. (These co-opted members hold no voting rights.)

(d) The Sub-Committee and the Finance, Risk and Assurance Committee will endeavour to appoint, as members of the Sub-Committee, persons who together will provide a balance of skills, experience, diversity and knowledge to enable the Sub-Committee to carry out its functions.

(e) Fees will be paid for attendance in accordance with the State Services Commission Fees Framework.

6. Role of Sub-Committee Chair

(a) To oversee the effective functioning of the Sub-Committee and to demonstrate leadership and awareness in ensuring the Sub-Committee's work is a representation of best practices.

7. Meeting Procedure

(a) The quorum for meetings of the Sub-Committee is a majority of the members.

(b) In the absence of the sub-Committee Chair from any meeting of the Sub-Committee the remaining members may choose a chair from among them and proceed with the meeting, provided that the quorum is met.

(c) Favour reaching a consensus by having open and complete discussions.

(d) All decisions of the Sub-Committee shall be decided by a majority vote.

(e) The Sub-Committee shall keep minutes of its meetings that record all actions and decisions taken by the Sub-Committee and these minutes shall be submitted to the Finance, Risk and Assurance Committee as soon as is reasonably possible thereafter.

(f) Auckland DHB will provide adequate resources required by the Sub-Committee.

(g) The Sub-Committee shall meet as frequently as it determines necessary.

(h) An annual calendar of the meetings shall be established at the beginning of each year in collaboration with the CE and CFO and the Chair of the Finance, Risk and Assurance Committee.

(i) Minutes of the meeting must be available at the following Finance, Risk and Assurance Committee. The Sub-Committee Chair will be expected to report.

Financial Performance Report

Recommendation

That the Board receives this Financial Report for July 2016

Prepared by: Rosalie Percival, Chief Financial Officer

1. Executive Summary

The financial performance for the full 2015/16 year was overall favourable to plan by $505K, with a surplus of $2.9M achieved compared to the budgeted surplus of $2.4M. The external audit of the financial accounts is nearly complete and we do not expect the result to change. The final audited result for the year will be reflected in the 2015/16 Annual Report to be approved by the full Board on 26 October 2016.

Overall, for the first month of the 2016/17 year the DHB has performed on budget, with the result for the month of July-16 favourable to budget by $76K. Revenue is unfavourable by $4.3M, offset by favourable expenditure of $4.4M. Funder and Governance Arms fully offset the unfavourable variance in the Provider Arm. Key variances are explained in this report. Detailed financial reporting on the Provider Arm is provided to the Hospital Advisory Committee, with financial performance described at service group level.

Auckland District Health Board
Summary Results: Month of July 2016

$000s	Month (July-16)			YTD (1 month ending 31 July-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Income						
MOH Sourced - PBFF	98,859	98,860	2 U	98,859	98,860	2 U
MoH Contracts - Devolved	7,737	9,239	1,503 U	7,737	9,239	1,503 U
	106,595	108,100	1,504 U	106,595	108,100	1,504 U
MoH Contracts - Non-Devolved	4,746	4,855	109 U	4,746	4,855	109 U
IDF Inflows	51,570	52,772	1,201 U	51,570	52,772	1,201 U
Other Government (Non-MoH, Non-OtherDHBs)	2,892	3,241	349 U	2,892	3,241	349 U
Patient and Consumer sourced	985	1,558	573 U	985	1,558	573 U
Inter-DHB & Internal Revenue	1,054	1,390	336 U	1,054	1,390	336 U
Other Income	4,565	4,223	342 F	4,565	4,223	342 F
Donation Income	291	606	315 U	291	606	315 U
Financial Income	367	610	244 U	367	610	244 U
Total Income	**173,066**	**177,356**	**4,291 U**	**173,066**	**177,356**	**4,291 U**
Expenditure						
Personnel	70,320	71,141	821 F	70,320	71,141	821 F
Outsourced Personnel	2,224	1,143	1,081 U	2,224	1,143	1,081 U
Outsourced Clinical Services	1,670	2,306	636 F	1,670	2,306	636 F
Outsourced Other Services (incl. hA/funder Costs)	4,917	5,041	124 F	4,917	5,041	124 F
Clinical Supplies	21,622	20,945	676 U	21,622	20,945	676 U
Funder Payments - NGOs	43,705	47,642	3,937 F	43,705	47,642	3,937 F
Funder Payments - IDF Outflows	9,567	9,567	0 F	9,567	9,567	0 F
Infrastructure & Non-Clinical Supplies	11,146	11,566	420 F	11,146	11,566	420 F
Finance Costs	1,052	1,052	1 U	1,052	1,052	1 U
Capital Charge	3,381	3,568	187 F	3,381	3,568	187 F
Total Expenditure	**169,604**	**173,971**	**4,367 F**	**169,604**	**173,971**	**4,367 F**
Net Surplus / (Deficit)	**3,462**	**3,385**	**76 F**	**3,462**	**3,385**	**76 F**

2. Result by Arm

Result by Division	Month (July-16)			YTD (1 month ending 31 July-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Funder	3,982	375	3,607 F	3,982	375	3,607 F
Provider	(720)	3,010	3,730 U	(720)	3,010	3,730 U
Governance	200	0	200 F	200	0	200 F
Net Surplus / (Deficit)	**3,462**	**3,385**	**76 F**	**3,462**	**3,385**	**76 F**

The $3.6M favourable Funder Arm result for the month and $200K favourable Governance Arm result fully offset the unfavourable Provider Arm result.

- The Funder result reflects lower expenditure and phasing for demand type services, offset by adverse net IDF inflows and an unearned revenue provision for MoH Contracts – Devolved.
- The Provider Arm result for the month is $3.7M unfavourable. This result is revenue driven, reflecting the under delivery to contract for ADHB population elective volumes and IDFs, both of which are subject to wash-up. Expenditure is close to budget.

3. Financial Commentary for July 2016

Month Result

Major Variances to budget on a line by line basis are described below.
Revenue for the month was unfavourable to budget by $4.3M with key variances as follows:

a) MoH Contracts – Devolved unfavourable variance of $1.5M (16.3%) is mainly due to the creation of a $1.2M provision for unearned revenue. This relates to the under delivery against budget of additional elective revenue. There is also an adverse variance of $0.3M resulting from lower than budgeted revenue for NGO funded initiatives. These adverse revenue variances are all offset by related/equivalent favourable expenditure variances and have a nil impact on the Funder core result.

b) IDF Inflows unfavourable variance of $1.2M (2.3%) is due to the creation of a $1.2M provision for unearned Inter District Flow (IDF) revenue. This relates to the under delivery against budget of mostly acute IDF revenue. This adverse revenue variance is offset by related/equivalent favourable expenditure variances and has a nil impact on the Funder core result.

c) Non Residents $0.5M, reflecting particularly low volumes for the month - volumes vary from month to month, with the full year budget still expected to be achieved.

Expenditure was lower than budget for the month by $4.4M with key variances as follows:

a) Personnel/Outsourced Personnel costs $260K (0.4%) unfavourable reflecting total FTE 72 (0.8%) above budget for the month. The additional FTE is primarily junior doctors and reflects a spike in reported Registrar FTE following rotation, expected to reduce next month.

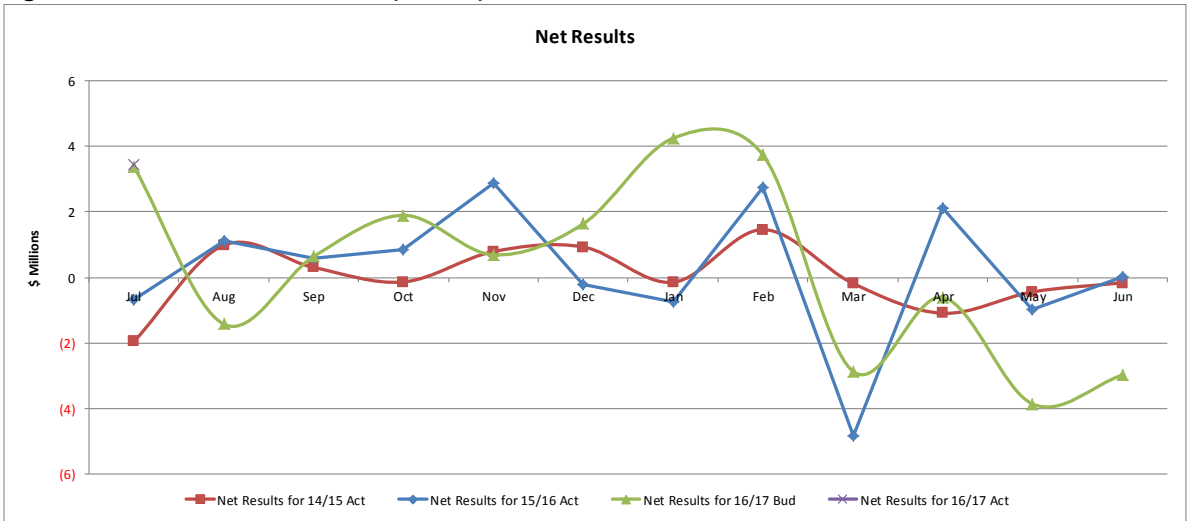
b) Clinical Supplies $0.7M (3.2%) unfavourable, comprising two key variances – depreciation $0.3M unfavourable due to timing of capitalisation of projects (expected to be on budget for the full year) and higher than normal blood product costs for the month $0.2M unfavourable – these costs vary from month to month and aren't necessarily reflective of overall reported volumes.

c) Funder payments – NGOs favourable variance of $3.9M (8.3%) against budget is mostly reflective of all the major NGO service categories but more especially Community Pharmacy and Age Related Residential Care. The favourable Community Pharmacy variance includes phasing related

upsides derived from the new PHARMAC drug investment initiative as well as upsides relating to PHARMAC budget anomalies which we are in the process of investigating. The favourable Aged Residential Care variance is mostly within Private Hospitals and also includes an upside related to phasing. There are various favourable variances related to funded initiatives expenditure which are offset by equivalent adverse revenue variance and have a nil net impact on the core result.

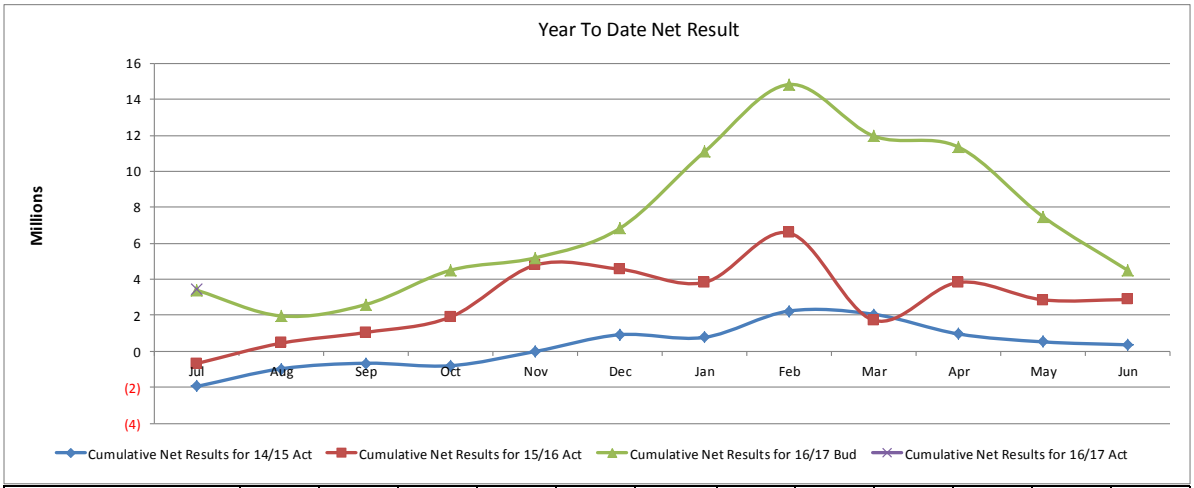
4. Performance Graphs

Figure 1: Consolidated Net Result (Month)



$ millions	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Total
Net Result for 14/15 Act	(1,957)	984	306	(137)	790	931	(147)	1,462	(179)	(1,093)	(441)	(164)	355
Net Result for 15/16 Act	(683)	1,133	595	859	2,881	(227)	(734)	2,747	(4,850)	2,101	(967)	15	2,871
Net Result for 16/17 Bud	3.385	(1.426)	0.641	1.898	0.692	1.639	4.254	3.739	(2.863)	(0.611)	(3.865)	(2.980)	4.504
Net Result for 16/17 Act	3.462												3.462

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 Results for 14/15 Act	(1.957)	(0.973)	(0.668)	(0.804)	(0.014)	0.916	0.770	2.232	2.053	0.960	0.519	0.355
Cumulative Net Results for 15/16 Act	(0.683)	0.450	1.045	1.904	4.785	4.557	3.824	6.571	1.721	3.822	2.855	2.871
Cumulative Net Results for 16/17 Bud	3.385	1.959	2.600	4.499	5.191	6.829	11.083	14.822	11.959	11.349	7.484	4.504
Cumulative Net Results for 16/17 Act	3.462											
Variance to Budget for 2016/17	0.076											

5. Efficiencies / Savings

The total savings target for 2016/17 is $37.2M, with $32.5M to be generated within the Provider Arm and $4.8M within Funding and Planning. Savings achieved in previous years across both Provider Arm and Funder are in excess of $211M as follows: $21.8M in 2015/16; $49.55M in 2014/15; $74.4M in 2013/14 and $66.7M in 2012/13.

For the first month of July, $1.7M savings were reported against the budget of $3.1M, resulting in an unfavourable variance of $1.4M. The savings of $1.7M is attributed to the Funder and Provider arm initiatives including Outpatients, ACC Levy, Labs, FTE review. The Provider savings of $1.3M includes offsets of $368k which are reported in personnel and other areas and have been applied to mitigate some of the unfavourable variances for those initiatives not yet commenced. The unfavourable position is mainly attributed to Provider arm initiatives that are in start-up mode and therefore too early into implementation side to report savings. In addition, these key actions cover a range of provider arm directorates/services and therefore their approach during start-up and/or implementation phases are expected to vary.

6. Financial Position

Statement of Financial Position as at 31 July 2016

$'000	31-Jul-16			30-Jun-16	Variance	30-Jun-16	Variance
	Actual	Budget	Variance	Actual	Last Month	Actual	Last Year
Public Equity	576,798	576,798	0F	576,798	0F	576,798	0U
Reserves	-	-	0F	-	0F	-	0F
Revaluation Reserve	508,998	438,457	70,541F	501,626	7,372F	501,626	7,372F
Cashflow-hedge Reserve	(3,696)	(3,696)	0F	(3,742)	46F	(3,742)	46F
Accumulated Deficits from Prior Year's	(461,173)	(461,173)	0F	(464,047)	2,874F	(464,047)	2,874F
Current Surplus/(Deficit)	3,462	3,386	76F	2,873	589F	2,873	589F
	47,591	(23,026)	70,617F	36,710	10,881F	36,710	10,881F
Total Equity	**624,389**	**553,772**	**70,617F**	**613,508**	**10,881F**	**613,508**	**10,881F**
Non Current Assets							
Fixed Assets							
Land	282,803	249,006	33,797F	282,517	286F	282,517	286F
Buildings	623,802	588,331	35,471F	618,915	4,887F	618,915	4,887F
Plant & Equipment	83,862	86,685	2,823U	85,564	1,703U	85,564	1,703U
Work in Progress	47,004	46,986	18F	45,236	1,768F	45,236	1,768F
	1,037,471	971,008	66,463F	1,032,232	5,238F	1,032,233	5,238F
Derivative Financial Instruments	-	-	0F	-	0F	-	0F
Investments	-						
- Health Alliance	53,103	53,103	0F	53,103	0F	53,103	0F
- HBL	12,420	12,420	0U	12,420	0F	12,420	0F
- ADHB Term Deposits > 12 months	5,000	5,000	0F	5,000	0F	5,000	0F
- Other Investments	503	503	0F	503	0F	503	0F
	71,026	71,026	0F	71,026	0F	71,026	0F
Intangible Assets	704	823	119U	762	58U	762	58U
Trust Funds	14,873	14,494	379F	14,495	379F	14,495	378F
	86,603	86,343	260F	86,283	320F	86,283	320F
Total Non Current Assets	**1,124,074**	**1,057,351**	**66,723F**	**1,118,515**	**5,559F**	**1,118,515**	**5,559F**
Current Assets							
Cash & Short Term Deposits	41,146	39,725	1,420F	34,461	6,685F	34,461	6,685F
Trust Deposits > 3months	10,000	11,500	1,500U	11,500	1,500U	11,500	1,500U
ADHB Term Deposits > 3 months	15,000	15,000	0F	15,000	0F	15,000	0F
Debtors	30,497	29,872	626F	29,869	628F	29,869	628F
Accrued Income	35,540	32,179	3,361F	32,179	3,361F	32,179	3,361F
Prepayments	3,969	1,679	2,290F	1,679	2,290F	1,679	2,290F
Inventory	14,139	14,239	100U	14,239	100U	14,239	100U
Total Current Assets	**150,291**	**144,194**	**6,097F**	**138,927**	**11,364F**	**138,928**	**11,363F**
Current Liabilities							
Borrowing	(429)	(429)	0U	(429)	0F	(429)	0F
Trade & Other Creditors, Provisions	(143,239)	(136,882)	6,357U	(133,316)	9,923U	(133,316)	9,923U
Employee Benefits	(162,347)	(166,505)	4,158F	(166,232)	3,884F	(166,232)	3,884F
Funds Held in Trust	(1,242)	(1,239)	3U	(1,239)	2U	(1,239)	2U
Total Current Liabilities	**(307,258)**	**(305,055)**	**2,203U**	**(301,217)**	**6,041U**	**(301,217)**	**6,041U**
Working Capital	**(156,967)**	**(160,861)**	**3,894F**	**(162,289)**	**5,322F**	**(162,289)**	**5,322F**
Non Current Liabilities							
Borrowings	(305,065)	(305,065)	0U	(305,065)	0F	(305,065)	0F
Employee Entitlements	(37,653)	(37,653)	0F	(37,653)	0F	(37,653)	0F
Total Non Current Liabilities	**(342,718)**	**(342,718)**	**0U**	**(342,718)**	**0F**	**(342,718)**	**0F**
Net Assets	**624,389**	**553,772**	**70,617F**	**613,508**	**10,881F**	**613,508**	**10,881F**

Comments

- The full revaluation of Land and Buildings was completed at 30 June 2016 and resulted in an increase in revaluation reserve and land value of $70.5M (Land valuation increase of $33.8M and Buildings, fitout and infrastructure valuation increase of $36.7M).

Statement of Cash flows (Month and YTD July 2016)

$000's	Month (July-16)			YTD (1 month ending 31 July-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Cash Received	175,149	176,746	1,597U	175,149	176,746	1,597U
Payments						
Personnel	(74,204)	(70,869)	3,335U	(74,204)	(70,869)	3,335U
Suppliers	(41,024)	(38,096)	2,928U	(41,024)	(38,096)	2,928U
Capital Charge	0	0	0F	0	0	0F
Funder payments	(53,272)	(57,209)	3,937F	(53,272)	(57,209)	3,937F
GST	934	0	934F	934	0	934F
	(167,565)	**(166,174)**	1,391U	**(167,565)**	**(166,174)**	1,391U
Net Operating Cash flows	**7,585**	**10,572**	**2,987U**	**7,585**	**10,572**	**2,987U**
Investing						
Interest Income	367	610	244U	367	610	243U
Sale of Assets	(0)	0	0U	(0)	0	0U
Purchase Fixed Assets	(2,765)	(5,906)	3,141F	(2,765)	(5,906)	3,141F
Investments and restricted trust funds	1,500	0	1,500F	1,500	0	1,500F
Net Investing Cash flows	**(898)**	**(5,296)**	**4,397F**	**(898)**	**(5,296)**	**4,398F**
Financing						
Other Equity Movement	0	3	3U	0	3	3U
Interest paid	0	(13)	13F	0	(13)	13F
Net Financing Cashflows	**0**	**(10)**	**10F**	**0**	**(10)**	**10F**
Total Net Cash flows	**6,686**	**5,266**	**1,419F**	**6,686**	**5,266**	**1,420F**
Opening Cash	34,461	34,461	1F	34,461	34,461	0U
Total Net Cash flows	6,686	5,266	1,419F	6,686	5,266	1,420F
Closing Cash	**41,147**	**39,727**	**1,420F**	**41,147**	**39,727**	**1,420F**

ADHB Cash	37,399	**37,192**	207F
A+ Trust Cash	2,189	**479**	1,710F
A+ Trust Deposits - Short Term < 3 months & restricted fund deposits	1,559	**2,056**	497U
	41,147	**39,727**	**1,420F**
ADHB - Short Term > 3 months	15,000	**15,000**	0F
A+ Trust Deposits - Short Term > 3 months	10,000	**11,500**	**1,500U**
ADHB Deposits - Long Term	5,000	**5,000**	0F
A+ Trust Deposits - Long Term	14,873	**14,494**	379F
Total Cash & Deposits	**86,020**	**85,721**	**299F**

Funder Update

Recommendation

That the report be received.

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

Glossary

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

Summary

This report updates the Auckland District Health Board (DHB) Board on planning and funding activities and areas of priority, since its last meeting on 03 August 2016.

1. Planning

1.1 Annual Plans

Both draft 2 Auckland and Waitemata DHBs' Annual Plans are currently being revised in line with amended electives advice and will be resubmitted once finalised to the Ministry of Health for Ministerial sign off.

1.2 Annual Reports

Draft 1 of both Auckland and Waitemata DHBs' 2015/16 Annual Reports has been completed – awaiting audit feedback on the Statement of Service Performance. Both will be updated as per feedback received.

2. Hospitals

2.1 Cancer target

The ADHB provider has reported the FCT 62 day indicator result at 18 August as 77.8%. This is a continued improvement, and the provider is on track to achieve the 85% target by the end of September.

2.2 Auckland DHB 2015/16 Surgical Health Target

The MOH has confirmed the DHB achieved the Health Target for 2015/16. The following table provides a summary of the year end position for the Surgical Health target based on the final position at 2 August. The table provides a breakdown of the different elements of the health target including the surgical elective theatre events versus other activity included in the health target count.

2015/16 ADHB Surgical Health Target – Final*

Surgical Health Target	**Plan**	**Actuals**	**Variance**	**%**
Surgical PUC - Arranged	1379	1498	119	108.63%
Non-Surgical PUC - Elective	618	603	-15	97.57%
Non-Surgical PUC - Arranged	332	241	-91	72.60%
Surgical PUC - Elective	14371	14476	105	100.73%
Surgical Health Target	**16700**	**16818**	**118**	**100.70%**

Surgical PUC Elective – Discharges				
ADHB Provider - Surgical Elective Theatre events	11763	11036	-727	93.8%
ADHB Provider - Skin Lesions	1029	1125	96	109.33%
ADHB Provider - Avastins (Intraocular injections)	726	1588	862	218.43%
IDF Out (Other DHBs)	853	727	-126	85.22%
Total - Surgical PUC Elective Discharges	**14371**	**14476**	**105**	**100.73%**

* MOH reported actual as at 2nd August 2016

The breakdown of the surgical elective purchase units shows reduced elective surgical discharges against plan offset against an increase in non-theatre events. In the current year 16/17, the Ministry have set an expectation of limiting the non-theatre events to a maximum percentage of the overall electives discharge volume. In 15/16 these were 18.7% of the overall target and will need to reduce to under 16% for the current year.

2.3 2015/16 IDF arrangements

The year wash up position has been finalised. The shortfall in the Midland DHB IDF funding arrangements for Eating Disorder services in 15/16 (and 16/17) remains unresolved and ADHB is waiting for feedback from the Northern region Lead CEO for Mental Health, Dr Dale Bramley after preliminary discussions with the Midland lead CEO.

2.4 2016/17 IDF arrangements

An application for an additional IDF supplementary co-payment for Clot Retrieval (Thrombectomy) services provided by ADHB has been submitted to National Casemix group and National General Managers Planning & Funding. If this application is successful this will result in increased revenue to cover current costs of providing this service. A proposal for the investment in additional sustainable workforce infrastructure in the Clot Retrieval service is in the final stages of development. Work is underway to quantify the unfunded costs of delivery of Gynaecology Oncology services for the

Northern and Midland region populations with the intention of developing a proposal for consideration of additional funding by the stakeholder DHBs.

The joint funder (ADHB/WDHB) has entered into an agreement to fund additional resource to support the implementation of the Ophthalmology service improvement plan and a WDHB funder proposal has been developed to fund actual services delivered aligned with progress of the service improvement plan.

The funder has implemented changes to the funding arrangements for Cancer services at ADHB for the Northern region DHBs as a result of the expected increase in volumes and costs associated with the introduction of new melanoma treatments. This funding is associated with an automatic wash up arrangement and close monitoring of the actual volumes will be needed to manage any revenue risk should volumes not occur as planned.

2.5 2016/17 ADHB funder/ADHB provider arrangements

The 2016/17 Surgical Health target discharge plan has been reduced following discussions with the Ministry of Health about local workforce constraints and provider capacity limitations specifically in Orthopaedic services. A revised plan has been submitted to the Ministry on 26 August resulting in a reduction of 364 Adult Orthopaedic discharges for the ADHB population. The provider phasing of the revised Surgical Health Target plan will be confirmed in time for the August financial reporting period.

As a result of insufficient internal surgical capacity in the 1st quarter, the funder has outsourced 100 cataract procedures to a private supplier, with 2nd quarter outsourcing volumes expected to be confirmed within the next week.

2.6 Tertiary services review

The service specific analysis for all Starship clinical services is complete and the final Child Health report has been finalised. The ADHB CFO has requested feedback from a senior MOH analyst in relation to the draft financial analysis.

2.7 Policy Priority areas

Colonoscopy Indicators

The waiting time indicators for June (MoH data) continued to improve for all 3 areas, with routine colonoscopy increasing from 67.3% to 74.1% with the target of 65% within 42 days. For urgent colonoscopy the result for the 75% indicator within 14 days was 94%. For surveillance colonoscopy the result for the 65% indicator within 84 days was also achieved at 89.7%. This reflects the targeted efforts applied to improve performance across all the indicators. The provider is on track to to meet the new indicators in 2016/17.

Radiology Indicators

June performance against the outpatient radiology indicators improved for both the CT and MRI indicators, with the CT indicator achieved at 95% (93% in May – target 85%) and the MRI indicator at 76% (from 64% last month). The July results show CT was maintained at 95% and MRI remained at 76% against the new 2016/17 targets of 95% for both CT and MRI. The waiting times for children continue to be worse than for adults and improvement is slow as a result of insufficient anaesthetic resources to support the paediatric service. The outpatient ultrasound indicator performance has also improved from 81% reported last month to 84%, against the DHB target of 95%.

Waiting Time Targets – ESPI compliance

At the end of July, ADHB was non-compliant (red) for ESPI 5 (booked for surgery) waiting time targets. Internal capacity limitations remain in Adult Orthopaedics, including spinal services, and Paediatric (general) Surgery and other paediatric surgical sub specialties. While the paediatric

surgical services' position is expected to improve from August, the provider is expected to be non-compliant in ESPI 5 from July to December as a result of insufficient Adult Orthopaedic service capacity. The DHB will incur financial penalties from January 2017 unless other strategies are implemented to improve ESPI compliance.

Bone Marrow Waiting Times
At the time of this report there was one patient waiting longer than the clinically recommended 6 weeks maximum waiting time guideline.

2.8 National services
Additional funding in 2016/17 to further increase capacity in Paediatric Cardiac and Adult Congenital services and Heart and Lung Transplant services is available to the DHB upon the recruitment and appointment of new staff. The DHB will not receive the funding unless we are able to demonstrate the new provider capacity is in place.

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

2.9 Regional Service Review Programme
Preliminary work is underway to establish the scope of a review of Head and Neck services with an emphasis on ensuring the relevant pathways are in place to support timely access to Head and Neck Tumour services. There is no other new activity to report.

3. Primary Care

3.1 Health Targets
Better Help for Smokers to Quit
Auckland DHB has successfully achieved the primary care 'Better Help for Smokers to Quit' health target in Q4. Based on the results released by the MoH, only five DHBs across the country achieved the target and this result ranks Auckland DHB as the third highest performing DHB. A key factor in achieving the target has been the engagement of leadership of the PHOs who have all had a strong focus on achieving the target and have tasked dedicated project teams to ensure that people who smoke receive advice and help to stop smoking. Auckland PHO, Alliance Health Plus (AH+), National Hauora Coalition (NHC) and ProCare have all exceeded the target.

The DHBs is also working with PHOs towards improving the recording and reporting of ethnicity based data. We envisage this data to be available to the DHBs in Q1 2016/2017.

More Heart and Diabetes Checks
Based on the preliminary results from the MoH, Auckland DHB has met the 'More Heart and Diabetes Checks' health target in Q4, (92.6% against target of 90%) and ranks first in the country.

All PHOs within Auckland DHB have reached the 90% target. In Auckland DHB, 89.5% of the eligible Maori population and 92% of the eligible Pacific population have had a 'More Heart and Diabetes Check' in the last five years. From 1 July 2016 'More Heart and Diabetes Checks' is no longer a national health target. PHOs will continue to offer More Heart and Diabetes Checks to the eligible population and overall incorporate this activity as business as usual.

3.2 Auckland Waitemata Alliance
The Auckland Waitemata Alliance is a key forum for the DHBs and PHOs to discuss significant issues, agree common work programmes and investment decisions. The Alliance has membership of the

two DHBs, our two Treaty partners (Ngati Whatua and Waipareira) and of six PHOs (Alliance Health+, Auckland, National Hauora Coalition, ProCare, Total Healthcare, Waitemata). It is noted that while Total Healthcare is not a PHO that formally operates in either DHB boundary they have been invited to participate considering their primary care coverage of high needs communities.

To date the Alliance has agreed to joint PHO/DHB funding of the clinical pathways work programme. Further we have a joint approach and work programme for improving diabetes care under at Diabetes Service Level Alliance (DSLA) which is updated below.

The Alliance also oversees the work programme of the Metro Clinical Governance Forum (MACGF), the System Level Measures work, Tamaki mental health initiative and various service level Alliances including; Pregnancy and First Year of Life, Rural, Youth, and After Hours. Further it has oversight of the Metro Auckland Data Sharing work programme.

Until now overview of the flexible funding pool has not been part of the Alliance focus. However, recently it was agree to enter in to a process to improve transparency of flexible funding pool allocations.

3.3 Diabetes Service Level Alliance Update

The Waitemata Auckland District Alliance Leadership Team (ALT) identified Diabetes as a key area of focus. It therefore commissioned the DSLA to develop, oversee and advise the ALT on an appropriate work programme and investment decisions required to achieve the agreed outcomes for people living with type 2 diabetes (particularly Maori, Pacific and Quintile 5 population groups).

The vision of the DSLA is that people living with diabetes are enabled to be leading partners in their own care within systems that ensure they can manage their condition effectively with appropriate support from proactive care teams. Late last year the DSLA developed a Work Programme which was endorsed by the ALT. The DSLA Work Programme has the following components:

- *Workstream 1: Systems Redesign*
  To create a 'system' that is patient-centred, better integrated, accountable, and maximises outcomes
- *Workstream 2: Optimising Clinical Management including Care Planning*
  To implement a range of strategies targeted at improving medical management of diabetes in general practice.
- *Workstream 3: Self-Management Support including Diabetes Self-Management Education*
  To review the effectiveness of the current models as well as identify, and explore and address the current barriers to access
- *Workstream 4: Workforce Development*
  To adopt a systems approach to get the right people, in the right jobs, with the right skills, at the right time to improve the health and wellbeing of people with diabetes.
- *Workstream 5: Mana Tu*
  To explore the opportunities around the Mana Tu approach (addressing social determinants) to Diabetes as proposed by NHC.

It is of note that the Systems Redesign is considered as the overarching workstream. However, for the ease of planning and assigning responsibilities the Work Programme has been structured under the five workstreams.

3.3.1 Workstream 1 - Systems Redesign

Codesign Procurement - Expected commencement: September 2016.
The aim of the codesign work is to capture the 'lived' experiences of patients, carers, families and staff to inform future service planning. An open and contestable procurement process using a

'Request for Quotes' (RFQ) approach was undertaken to identify a suitably qualified Design Expert to successfully lead and coordinate the DSLA Codesign process. Contract negotiation with the successful supplier is in progress.

Review of Retinal Screening Services - Expected completion: October 2016.
The purpose of this review is to take stock of the existing retinal screening services across both DHBs and make recommendations to inform future service planning and delivery such that a high quality, equitable, efficient, effective, sustainable and patient centred screening programme is delivered to all people with diabetes.

Review of Diabetic Podiatry Services - Expected completion: October 2016.
The purpose of the review is to assess the current podiatry services and make recommendations for changes that could improve the quality of experience and health outcomes for people with diabetes who have, or are at risk of developing active diabetes-related foot disease.

3.3.2 Workstream 2 - Clinical Optimisation Workstream including Care Planning

This workstream's priority is to implement the five regionally agreed and ALT approved diabetes/cardiovascular disease (CVD) indicators across both DHBs.

The group is currently reviewing the PHO level reports submitted to the Metro Auckland Clinical Governance Forum and the regional reports generated by the Northern Region Alliance (NRA). These reports do not provide patient identifiable data, however having access to PHO and practice-level information could be a powerful tool to drive improvement in clinical outcomes in general practice. They also provide better visibility around the variation that exists between practices and PHOs and could be the basis for collaborative learning. The PHO practice support teams will use these reports as a benchmarking and monitoring tool. Expected completion: March 2017.

The group's scope of work extends beyond the reporting and includes the development and implementation of a range of strategies to optimise clinical management of diabetes in general practice.

3.3.3 Workstream 3 - Self-Management Support including Diabetes Self-Management Education (DSME)

This workstream is reviewing the effectiveness of the current models of care as well as identifying, exploring and addressing the current barriers to access. The group is also exploring potential technology based solutions. Expected completion: March 2017

3.3.4 Workstream 4 - Workforce Development

This workstream envisions an integrated workforce for diabetes across the two DHBs. The initial focus is on workforce development for practice nurses and GPs. In the next phase this will extend to allied health and unregulated workforce. The group is finalising a stocktake of diabetes education that is currently available for practice nurses and GPs. The development of a workforce capability plan is underway. Expected completion: October 2016.

3.3.5 Workstream 5 - Mana Tu

This workstream has been set up to develop a business case to seek approval from the Alliance Leadership Team to prototype a rapid deployment model called 'Mana Tu' as proposed by National Hauora Coalition PHO. The model would address the wider social determinants of diabetes-related outcomes and is based on a similar approach used in the PHO's Mana Kidz Programme for rheumatic fever. It is envisaged that Whanau Support Workers - Kaimanāki would work with individuals, whanau, practices and services for better outcomes. The mandate for this workstream has been extended to people with pre-diabetes.

The working group has commenced work on developing the business case to be presented to the Alliance Leadership Team in November 2016 for approval to proceed to prototyping. If approved, the model would be deployed across a limited number of NHC practices. Formal evaluation will be undertaken. Expected Completion: November 2016.

3.4 Systems Level Measures Framework

As previously reported, in March 2016, the Minister of Health announced the move from the IPIF to System Level Measures (SLMs). The SLMs are intended to provide a system-wide view of performance It is the Minister's expectation for DHBs to work jointly in alliances to agree a set of contributory measures and to develop and implement.

The four new SLMs implemented from 1 July 2016 are:

1. Ambulatory Sensitive Hospital Admissions (ASH) rates per 100,000 for 0-4 year olds
2. Acute hospital bed days per capita
3. Patient Experience of Care
4. Amenable mortality rates

The following two SLMs will be developed during 2016/17. Implementation is planned for 2017/18:

5. Number of babies who live in a smoke free household at six weeks post natal
6. Youth access to and utilisation of youth appropriate services.

The Metro Auckland DHBs and PHOs have established an overarching SLM Steering Group to guide the implementation of the SLMs across Auckland. In addition, four working groups have also been established to develop the indicators and interventions that will eventually make up the Improvement Plans that will be approved by the Counties Manukau Health District Alliance and the Auckland and Waitemata Alliance.

A more detailed progress report regarding the SLM Framework will be provided at a subsequent committee meeting.

3.5 The Metro Auckland DHBs Community Pharmacy Waste Management Service

3.5.1 Background

Historically, community pharmacies were paid a monthly fee to support the on-going management and disposal of pharmaceutical and sharps waste received from consumers. This arrangement was considered costly and ineffective as each pharmacy had to commission an individualised waste management supplier which resulted in a patchy and inconsistent service for our population. A study by Braund et al. (2009)[1] showed that in New Zealand approximately 70% of respondents disposed of unwanted medicinal waste into the domestic waste system (via the toilet or sink) or through the general household waste collections which end up in a landfill. These disposal methods have detrimental impacts on our environment and allow for pharmaceutical residues to build up in our waterways. Inappropriate disposal of unused/expired medicines and sharps are also related to unintentional harm and needle-stick injuries that may transmit diseases.

3.5.2 New Service Model

The three Metro Auckland DHBs (Auckland, Counties Manukau and Waitemata DHBs) have implemented a regional medicinal waste collection and disposal service for all community pharmacies starting from 1st February 2016. The service was developed to mitigate the risks

[1]Rhiannon Braund, Barrie M. Peake, Lucy Shieffelbien, Disposal practices for unused medications in New Zealand, Environment International, Volume 35, Issue 6, August 2009, Pages 952-955, http://dx.doi.org/10.1016/j.envint.2009.04.003

identified above and to ensure the safe disposal of unused/expired medicines and sharps wastes. A procurement process was completed to find a single provider and International Waste Limited was awarded the contract.

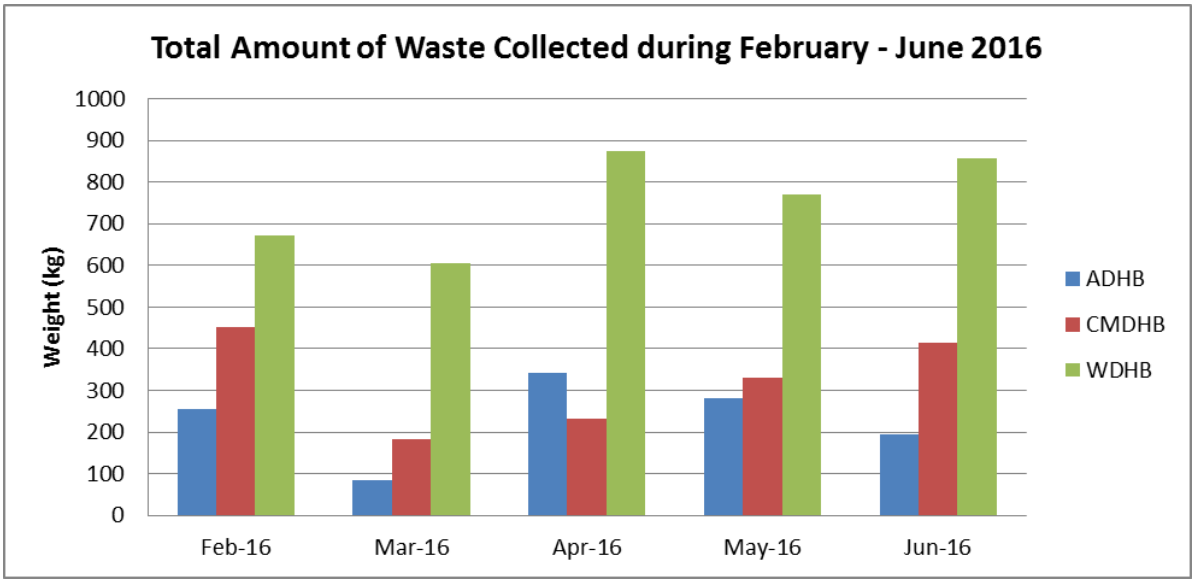
This fully funded service includes the distribution and collection of waste disposal bins to approximately 360 community pharmacies in the Metro Auckland region. It also includes the proper disposal of three distinct types of medicinal waste:

- **Pharmaceutical** - non-controlled, unutilised and expired pharmaceutical products (e.g. tablets and capsules)
- **Sharps** - medical 'sharps' (e.g. used needles and syringes)
- **Cytotoxic pharmaceutical** - non-controlled, unutilised and expired cytotoxic pharmaceutical products (e.g. tablets and capsules) and cytotoxic containers (i.e. containers that have been used to carry cytotoxic medicines).

As a part of this service, community pharmacies receive three types of waste bins to meet the requirements of the specific types of waste. This service is free to all consumers, and they can drop off any expired or unused medicines at any community pharmacy for disposal. It is important to note the waste management service excludes both collection and disposal of controlled pharmaceutical products as current legislation prevents the off-site disposal of Class B controlled drugs.

Since the launch of this service (1st February 2016 to 30th June 2016), Auckland, Counties Manukau and Waitemata DHBs have collected approximately 1,155 kg, 1,609 kg and 3,776 kg of waste respectively (Figure 1). Overall, about 80% of the total waste collected can be attributed to consumers disposing of sharps or needles. Discussions with Diabetes NZ (Auckland Branch) occurred during the development of the service and messaging was communicated through their regular newsletters to inform consumers about bringing all sharps waste back to their local pharmacy. This is the reason for sharps being such a high proportion of all waste collected.

Figure 1: Metro Auckland DHBs - Total weight (kg) of waste collected at community pharmacies during February and June 2016



The current waste disposal volumes are well below the projected volumes as the proposed patient education campaign has not yet commenced. The campaign was delayed to give pharmacists time to become familiar with the new service. Therefore, the lack of community awareness about the service is likely to have resulted in the variability in utilisation (Figure 1).

3.5.3 Patient Education Campaign

The Metro Auckland DHBs are in the process of developing a regional patient education campaign to raise awareness about the safe and proper disposal of medicinal waste. Another aspect of this campaign will also ensure that all health professionals provide consistent messaging to consumers, and refer consumers to community pharmacies for medicinal waste disposal. As a part of this campaign, the Metro Auckland DHBs are considering the running of a D.U.M.P. (Dispose of Unused Medicines Properly) campaign encouraging the public to bring their expired medication from their homes to the pharmacy. Auckland City Council has agreed to support the D.U.M.P. campaign by providing assistance to market the campaign. Further consideration of the logistics and costs of such a campaign are being given.

Overall, this service has received positive responses from both the pharmacy sector and other organisations, such as Auckland City Council.

3.6 Metro Auckland Collaborative for Training Primary Care Nurses in Mental Health and Addictions

Metro Auckland DHBs and PHOs have formed a Collaborative to provide a regional mental health and addictions credentialing programme for primary health care nurses based on Te Ao Māramatanga New Zealand College of Mental Health Nurses (NZCMHN), Primary Care Nursing Mental Health and Addiction Credentialing Framework. A Collaborative approach has been undertaken to:

- Directly respond to the Government's priority agenda of integration and mental health needs of our communities
- Foster positive cross-working and joint-working approaches to provide one programme of learning to the primary health care nursing workforce
- Endeavour to provide a service delivery model which can be sustained over the next 2-5 years as an example of innovative integration to both serve community need and support workforce gaps.

An initial 'pilot' credentialing programme for primary health care nurses has been completed with 27 practice nurses graduating in late February 2016. The programme has been independently evaluated to assess the programme of learning, the model of service delivery and future programme sustainability. The key findings of the draft evaluation have been distributed amongst stakeholders. These findings demonstrate that the credentialing process was found to be very valuable by participants, and stakeholders rated the programme's relevance, efficiency of implementation, effectiveness, and value for money as very good to excellent.

Auckland, Counties Manukau and Waitemata DHBs have agreed to fund the programme for 2016/17, with up to 60 Practice Nurses to be enrolled in the mental health and addictions credentialing programme. Waitemata DHB has agreed to lead this initiative which started on 1st July 2016.

3.7 Tāmaki Mental Health and Wellbeing Initiative

The Tāmaki Mental Health and Wellbeing initiative primary care/NGO integration pilot began in September 2015. This pilot, which links three NGOs with two GP practices, has led to significant learning and further Tāmaki practices requesting to join the trial.

Discussions are progressing on the expansion of the primary care/NGO integration within Tāmaki and into other Auckland DHB localities. During Q2 of 2016 a further six to eight General Practices and up to three NGOs were included in this initiative. By June 2017, the initiative is seeking to have over 10% of Auckland DHB practices involved.

4. Health of Older People

4.1 Home and Community Support Services (HCSS)

Part B of the Inbetween Travel Settlement Agreement focuses on achieving a regularised HCSS workforce, which incorporates guaranteed support worker hours, staff training and safe staffing ratios. Auckland DHB and Taranaki DHB have been identified as the sites for the regularised workforce pilot. A Working Group with representatives from the Unions, Providers, MoH and the two DHBs has been set up to progress these pilots. Currently weekly meetings are being held and the plan is to implement virtual pilots in October, which will inform a budget bid the Ministry is preparing for funding starting 1 July 2017.

4.2 Aged Residential Care (ARC)

The annual review of the Aged Residential Care Agreements for 2017/18 is starting earlier than in previous years. DHBs are required to identify issues they wish to have considered and submit these through their regional HOP Forum by 30 September 2016.

4.3 Falls Prevention

Work is progressing according to plan on the Falls Prevention Programme under the guidance of the joint Auckland DHB, Waitemata DHB and ACC Community Falls Prevention Steering Group. The Programme aims to reduce injury falls and fragility fractures in people aged 65 years and over living in Auckland DHB, specifically to reduce hospitalisations and ACC injury claims.

The programme will deliver across four key areas:

- extending the Fracture Liaison Service
- establishing an in-home strength and balance exercise programme for highest risk people, including traditional delivery and a trial using HCSS providers
- facilitating further development of community group strength and balance sessions (this component will be led by ACC)
- developing a clinical pathway.

4.4 Health of Older People Strategy

The draft Health of Older People Strategy has been released this month for consultation, which closes on 7 September.

5. Women, Children & Youth

5.1 Immunisation Health Target

Our coverage for Q4 2015/16 for all infants fully immunised at 8 months of age was 94%, against the 95% target. This included 89% Maori, 97% Pacific, 97% Asian and 85% Other.

Achieving the target for all ethnicities is an on-going challenge. Recent work is focusing on promoting early immunisation particularly in the antenatal period. The Child, Women and Youth Funder is also working with the Maori Health Gain Team to develop an Action Plan to reduce the equity gap for tamariki Maori. The out-reach immunisation service has revised their processes and introduced an additional early referral point for babies overdue their 3 month immunisation.

5.2 Rheumatic Fever and Housing

The Funder is in discussion with the Ministry regarding a contract for an expanded Healthy Housing Initiative. The value of this contract is around $450k pa. Development work on the expanded Healthy Housing Initiative continues. We are working in partnership with Auckland Council who has been facilitating co-design work and on-going conversations with community housing organisations

regarding how we can work together. Within the DHB we are exploring current processes for accessing housing support for families and looking at how these can be enhanced.

5.3 Childhood Obesity

Good progress is being made against the new childhood obesity health target 'raising healthy kids'. The target is expected to be met by December 2017. At this stage we are sitting around 60% and making gains of around 2 percentage points each week. Our current focus is on developing primary care's understanding and capability to support children referred for weight management under the Raising Healthy Kids criteria. Each PHO has identified a Health Target Champion who will lead the work within their PHO. The dietetics department is rolling out a one-to-one training programme with general practices. This includes a newly developed resource to promote healthy eating and activity appropriate for pre-school aged children.

5.4 Transgender

A clinical leader has been appointed to support the development of a programme of work regarding delivering transgender health services. A contract has been entered into with CMDHB to provide services for ADHB transgender youth as no specialist services were available for this vulnerable group of young people.

5.5 Women

Auckland DHB Pregnancy and Parenting programme has developed strategies to engage priority women through maternity clinics, inpatient wards and home visiting. Work is continuing with community groups and key stakeholders to develop these strategies further, with a focus on Maori, Pacific and teen women and their whanau.

The Funder has commissioned Synergia to undertake an evaluation of the pregnancy and parenting service. The evaluation is due to begin.

6 Mental Health and Addictions

6.1 Look-Up 2016 Exploring Wellbeing around Alcohol and Other Drugs

Look Up 2016 with its focus on Youth wellbeing around Alcohol and Other Drugs (AOD) was held on Thursday 11 August 2016. It was well attended by 110 young people who came with their teachers (17) from a wide range of Auckland schools. In addition there were 53 professionals and 50 Service Providers and Volunteers with over 230 people attending the event.

This event was designed by young people for young people. The key focus was a series of workshops designed to be reflective and explore some of the challenges young people face with wellbeing around AOD. They covered five themes from "Brave Conversations" with Altered High and Odyssey House, "Know Better do Better" with Auckland Sexual Health and St John Youth, "Balance and Connect" with Toi Ora Live Art Trust and Youthline Auckland and finally "Making a difference" with a Youth Panel of young leaders and CAYAD (Community Action Youth and Drugs Auckland City Council). In addition 12 NGO and Community Providers provided an interactive stand delivering key messages around wellbeing. One example was being able to experience the impact of drinking on walking and skate board skills in a safe environment by wearing "alcohol impairment simulation goggles".

A Providers Forum was held at the end to reflect on the day's events and to ask "what and how would we do things differently?" This included two further presentations with Kate Duder of CAYAD presenting the results of the "*Knowing Someone Cares: research of young people's experience with AOD" (Auckland Council, May, 2016)*. This report is based on the insight into the experiences of young people at greater risk from alcohol and other drug related harms in West Auckland. The key

research learning was that it is not enough for young people to just have someone who cared, they needed to know someone cared about them. The second presentation was an extension of Kate's work with Jane Strange presenting co-design model of service development where service users and their whanau are in the design centre with cross-sector collaboration approaches to create radical, system level solutions to seemingly intractable social and economic problems. The provider forum was lively and broad ranging with suggestions to how planning approaches need to be different for this sector. It highlighted the necessity of strengthening the youth voice in health planning and funding processes.

The day was a considered a success with the support of the Providers, Volunteers, Youth Action Team and the Look Up Steering Group with their collective commitment to make a difference to young people through a public health promotion event. On the day, there was a palpable feeling of community, enthusiasm and engagement in the event with young people from about 12 different schools mixing together. One school's feedback summed up the event: "Thank you for today. Our students came away very inspired and encouraged. They came away with lots of information and great ideas for their future. We appreciate all that you do for our students and young people in general."

6.2 Substance Addiction Compulsory Assessment and Treatment (SACAT) Legislation

As previously reported to the Board in March 2016, the Substance Addiction (Compulsory Assessment and Treatment) Bill (SACAT Bill) to be implemented in 2016/17 has potentially significant impacts on the Alcohol and other drugs (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. There is a risk the devolved funds will be insufficient to establish new treatment services of this nature.

The Northern Region DHBs have initiated work to review and develop the service delivery model of withdrawal management services across the care continuum. The assessment and treatment of individuals under the proposed legislation needs to be seen within a wide context of services for people with alcohol and drug issues, and not in isolation of other services. The project has wide ranging deliverables within short time frame with an interim report completed by end of November 2016 to address the following:

- 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 any new services or service changes required
- estimate the impact which the new Act will have on residential service delivery, including competencies of the work force, and consideration of how residential treatment services will manage a potential influx of patients requiring cognitive assessment subsequent to alcohol related brain injury and/or traumatic brain injury and/or mental health diagnosis
- the process of certification of facilities and Accredited Clinician role under the new proposed Act.

6.3 Primary Mental Health Innovation and Initiatives

Primary Mental Health Innovation and Initiative (PMHII) services are required to support the continuation of mental health and alcohol and other drug (AOD) responses in primary care settings for people who have high prevalence conditions: mild to moderate anxiety, depression, alcohol and drug issues or co-existing conditions and medically unexplained symptoms. The key aims of the services are to increase access to psychological therapies, other psychosocial interventions and packages of care for target client groups. Primary care has a key role in driving better health outcomes for New Zealanders. PMHI services were introduced over 10 years ago, and the services have not been formally reviewed since this time with increasing demands placed upon the service providers.

The Funder has initiated a joint project for both Auckland and Waitemata DHBs, in collaboration with current primary care service providers, to review current services. This is to focus future planning efforts on developing a consistent service delivery model that:

- is aligned to new initiatives and the direction of national policy
- is aligned to each DHBs strategic directions and local priorities
- meets the requirements of the PMHII service specifications and
- demonstrates health gains and outcomes for investment.

7. Maori Health Gain

7.1 Auckland and Waitemata District Health Board joint DNA Strategy

The Māori Health Gain Team led the development of the Auckland and Waitemata District Health Board joint DNA Strategy. The Strategy was developed at the request of Auckland District Health Board (DHB) and Waitemata DHB Board Committee members. The Strategy provides an evidence-based strategic framework and a roadmap of activities to reduce inequalities in clinic Did Not Attend (DNA) rates. The Strategy has been endorsed by the Māori Health Gain Advisory Committee and the Auckland and Waitemata DHB Hospital Advisory Committees. The Māori Health Gain Team will support the Provider Arm of Auckland and Waitemata DHBs to implement the recommendations and monitor performance.

7.2 Māori Health Plan

We have received informal sign-off from the Ministry of Health for the Māori Health Plans for both Auckland and Waitemata DHBs. We are waiting for official confirmation via letters which we are expecting shortly.

8. Pacific Health Gain

8.1 Renewing Pacific Health Action Plan (PHAP)

Consultation with the community regarding PHAP has been completed. Six meetings were held. The online version of the consultation is open till 31st August. Meantime consultation with organisations and other government agencies is underway. Meetings have been held with senior management team of Alliance Health Plus, Procare's Pacific Advisory Group, Ministry of Social Development, Ministry of Pacific People's, Auckland Council's Pacific Advisory Panel, Waitakere Healthy Families, LeVa (Pacific workforce development NGO), Commission for Financial Capability and the Catholic Social Services. Meetings will also be held with the Early Childhood Education part of the Ministry of Education, Housing NZ, Tamaki Regeneration Co. and the Mental Health Foundation. The consultation will be completed by 31st August.

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

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

The parenting education and *Living Without Violence* programmes are being offered to churches / groups.

The Ministry of Social Development (MSD) is currently providing family violence intervention training for Samoan practitioners and community leaders. The HVAZ/Enua Ola programme manager is participating in this training. We will continue to work with MSD to align the programme that we are providing with that which MSD is delivering.

8.3 PHAP Priority 2 –Pacific People are smoke-free

West Fono Health Trust (the Fono) is the new Pacific provider of quit smoke services along with Procare. We have contracted with the Fono to undertake focus group meetings with Tongan men as to more effective ways of engaging them in quit smoke services, as the group with the highest smoke rates in the Pacific population. Similar work will be done with Cook Is women and Samoan people.

8.4 Priority 3 – Pacific people are active and eat healthy

Work towards the 4th Aiga Challenge is currently being done.

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

The *Fanau Ola* Integrated Services contract with AH+ has been renewed till 31st December 2016 with the same service specifications including price/volume schedule. The data that AH+ has collected in the past 12 months is not robust enough to base a review of the price/volume schedule on. We agreed that AH+ will continue to work on cleaning/confirming data from its providers in the current quarter, and on the basis of this, we may be able to review the price/volume schedule.

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

The Pacific GM for Hospital Services reports on this priority.

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

Discussion was held by the PHAP working group as to whether this priority should remain in the new Pacific Plan. One view was put forward, that because this is an area that the DHB Pacific Team can do very little about, that it should not be part of the new Plan. The other view put forward was that if housing is not part of the new Plan, that that can be interpreted as housing not being considered as important. It was agreed to retain this in the new proposed Plan and to seek the community's views through consultation.

Initial result of the community consultation is that housing is considered a very high priority. This is no surprise, but the challenge remains as to what the DHBs can realistically do about this issue. This will be further discussed with the PHAP Working Group.

9. Asian, Migrant and Refugee Health Gain

Key projects driving efforts towards the goal of increasing health gain in targeted Asian, migrant and/or refugee populations where health inequalities impact on their health status in the Auckland DHB are:

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

The Final draft of the Asian International Benchmarking Report has now been completed and is currently going through internal review processes before final sign off. It will be presented at the next CPHAC meeting (12/10/16).

9.2 Increase access and utilisation to health services

Indicator: Increase by 2% the proportion of Asians who enrol with a Primary Health Organisation (PHO) to meet 76% (ADHB) by 30 June, 2017

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

The multilingual 'Healthcare- where should you go?' campaign was aimed at promoting culturally appropriate messaging about enrolling with a family doctor and the benefits of it to students and new migrants living in the Auckland city centre and inner city fringe suburbs. The campaign ran for 8 weeks and ended 31 August and was delivered in English, Simplified Chinese, Hindi and Korean. Evaluation on the effectiveness of the campaign will be undertaken to guide planning of a broader campaign roll-out to new migrants and students across the Auckland DHB as phase 2 in Q3 2016-17.

9.3 Indicator: 80% of eligible Asian women have completed a cervical smear by 2020 (current rates 63.0% (ADHB) as at March, 2016)

The intention of the Healthcare- where should you go?' targeted Auckland DHB campaign is to direct new migrant women to general practice to enrol with, and visit their usual family doctor. A benefit of doing so is to increase opportunities to complete a cervical smear for those who have not been screened in the last 5 years or never screened.

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

The Refugee Primary Care Wrap Around Service Agreements with PHOs have been reviewed for the 2016-17 financial year. Professional development opportunities for primary health and the frontline workforce to upskill them on the soft skills and cultural competencies required to support refugee families at the practice level include:

- a refugee health network forum to primary health professionals was delivered on 'refugee youth mental health' on 24 August. The final forum for 2016 will be 'former refugee child mental health' on 9 Nov.
- receptionists cross-cultural training to frontline primary health staff is planned for 19 Oct

Safe Staffing and Healthy Workplaces Unit Care Capacity Demand Management Programme

Recommendation

That the Auckland District Health Board:

1. **Approves the Auckland DHB Chief Executive Officer to sign the Safe Staffing Healthy Workplace DHB Care Capacity Demand Management Programme Letter of Agreement on behalf of Auckland District Health Board**

Prepared by: Margaret Dotchin (Chief Nursing Officer)
Endorsed by: Ailsa Claire (Chief Executive Officer
Endorsed by: Executive Leadership Team

Glossary

CCDM	Care Capacity Demand Management

1. Executive Summary

This paper provides an update on a proposed Letter of Agreement between Auckland DHB, the national Safe Staffing Healthy Workplaces Unit (SSHW Unit) and the relevant unions (New Zealand Nurses Organisation and the Public Service Association) to support delivery of the Care Capacity Demand Management programme within Auckland DHB inpatient services.

The Care Capacity Demand Management (CCDM) programme is designed to balance the requirement for DHBs to deliver quality patient outcomes in a quality work environment in a way that makes efficient use of health resources. CCDM is an approach to ensure patient care demand is matched accurately and effectively with the resources required.

The programme has been delivered in the majority of DHBs within New Zealand utilising a partnership model with health unions and the Safe Staffing Healthy Workplaces Unit. This partnership model provides a mechanism for the DHB, unions and the SSHW Unit to work collaboratively to deliver and embed the programme and to share relevant data and information and is underpinned by the Healthy Workplaces Agreement (New Zealand Nurses Organisation / District Health Boards Nursing and Midwifery Multi –Employer Collective Agreement (Appendix 1b).

It is recommended that the ADHB Board approves the Auckland DHB Chief Executive to sign the DHB Care Capacity Demand Management Programme Letter of Agreement (attached in the resource centre).

2. Background: Care Capacity Demand Management

Care Capacity Demand Management (CCDM) is an organisational approach to ensuring that the demand for patient care is matched accurately and effectively with the resources required (staff, knowledge, equipment, facilities). The focus of the CCDM programme is to support DHBs to achieve the appropriate balance, improve the quality of care for patients, enhance the working environment for staff and increase organisational efficiency.

The CCDM programme has three main elements:

1. An evidence-based method for setting the base nursing staffing model in wards (numbers, skill mix and schedule) utilising validated patient acuity data
2. Developing and supporting a system of multiple response strategies (variance response management) within DHBs to manage short and mid-term variance, meet demand and maintain quality and safety.
3. Developing technical and social processes around a core set of data that is meaningful to ensure real time feedback and monitoring of the demand/capacity match over time at ward level, directorate and executive levels.

Implementation at Auckland DHB

It is expected that a well-executed programme will facilitate Auckland DHB efforts to lead change, achieve expected outcomes and realise a number of benefits as outlined in the proposed Letter of Agreement:

- Increased ability for Auckland DHB to identify and use existing data, as well as identify and develop new sources to augment its current activity associated with CCDM.
- Commitment and participation by representatives of the participating health unions in the collaborative agenda with Auckland DHB
- Achievement of a more complete organisational picture of capacity and demand.
- Advancement of the use of forecasting windows for predicting variance in demand and acting on identified mismatches between capacity and demand.
- Accuracy of budget setting and improved adherence to budgets.
- Reduction in avoidable variance between demand and capacity.
- Ensuring Auckland DHB staff numbers more closely match workload activity, and skill mix is closely matched to acuity ensuring that care capacity meets demand more consistently.
- Variance response management will be embedded and improved.
- Greater flexibility in dynamically matching capacity to demand

3. Letter of Agreement

The proposed Letter of Agreement recognises the existing partnership between the Safe Staffing and Healthy Workplaces unit and the unions that supports the delivery of the CCDM programme within other DHBs. The underpinning rationale for this collaborative approach is the fact that the CCDM programme requires a high level of information and data sharing in order for the partners to make joint decisions.

The Letter of Agreement will commit the requisite resources (data, information, personnel, guidelines and tools) to the programme as well as establishing an executive council to oversee and monitor implementation.

The Auckland DHB CCDM Executive Council will comprise key Auckland DHB personnel (including executives, professional leaders), union representatives and other stakeholders.

The purpose of the group to support the implementation of the CCDM Programme and to make on-going decisions and recommendations to Auckland DHB about improving organisational systems and processes to support safe staffing and healthy workplaces.

4. Risk assessment

The Letter of Agreement clearly outlines the commitment of the parties as well as details of the resources that each individual party will provide.

It does not appear that the proposed relationship will place an undue burden on Auckland DHB. It is anticipated that the established mechanisms will strengthen the ability of Auckland DHB to accurately forecast, plan establish and reduce known or predictable variance between demand and care capacity.

The statement of commitment ensures the CCDM programme enhances and improves current systems and processes in the interests of:

1. assuring patient safety and satisfaction
2. supporting staff health and wellbeing; and
3. maximising organisational efficiency and effectiveness through best use of available health resources.

Current members of the Auckland DHB Executive CCDM Council have undertaken work with the Safe Staffing Healthy Workplace Unit, NZNO and PSA to prepare for and understand the value of working in a partnership model to implement this programme. The successful outcome of this way of working is that all parties can actively engage in robust, solutions-focused discussion without compromising relationships and are able to sustain this long-term in their role as leaders of the CCDM initiative.

5. Conclusion

Safe Staffing Healthy Workplaces Unit in partnership with the DHBs, NZNO and PSA have developed this programme to implement the recommendations of the Safe Staffing Healthy Workplaces Committee of Inquiry Report 2006.

Care Capacity Demand Management (CCDM) is an organisational approach to ensuring that the demand for patient care is matched accurately and effectively with the resources required.

The DHB Care Capacity Demand Programme Letter of Agreement clearly documents the commitments of all parties to successfully implement the programme within Auckland DHB.

DHB CARE CAPACITY DEMAND MANAGEMENT PROGRAMME

LETTER OF AGREEMENT

AUCKLAND DHB

INTRODUCTION

DHBs and other sector groups often work closely together to further the collective needs and initiatives of all parties. This letter of agreement (LOA) recognises the close and collaborative nature of the engagement among the parties in circumstances where they consider it unnecessary to engage in a full commercial-style contract for service delivery, given that there is already shared endeavour and a relationship of trust between the parties. On the other hand, this LOA recognises the need to record and document what services are to be delivered, in what manner, and by when.

The purpose of this LOA is to describe the relationship among the Safe Staffing Health Workplaces Unit (SSHW Unit), Auckland DHB and the union parties, and to set out the parties' commitments to activities and outcomes.

TERM

The term of this LOA is set out in Schedule A (the Term).

NATURE OF RELATIONSHIP BETWEEN PARTIES

For the purposes of this LOA, each party is an independent organisation and this LOA does not create any employment relationship, joint venture, agency, trust or partnership between or among any of the parties.

BACKGROUND TO CCDM PROGRAMME

The SSHW Unit was set up at the request of the 20 DHBs and the New Zealand Nurses Organisation (NZNO) to support the implementation of the recommendations of the 2006 Committee of Inquiry report (the COI Report). Latterly, the PSA and SFWU became involved and a structured programme resulted, and is now being implemented in the majority of DHBs. The Care Capacity Demand Management (CCDM) Programme is established within a DHB using the parties preferred industrial partnership model.

CCDM addresses key elements of the safe staffing healthy workplaces agenda and balances the requirement to deliver quality patient outcomes in quality work environments in ways that make efficient use of the health resources.

The CCDM Programme is underpinned by a partnership approach involving health unions in a collaborative model of participation. To operate successfully, the CCDM Programme requires a high level of information and data sharing so that the parties can make joint decisions.

PURPOSE OF CCDM PROGRAMME

The purpose of the CCDM Programme is to enable the DHB to:

1. Develop a seamless coordinated and effective system of care capacity/demand matching.
2. Utilise a whole of organisation approach that supports interconnection between the social and technical elements.
3. Implement recognised best practice tools and guidelines for DHBS to achieve Care Capacity Demand Management.
4. Implement recognised best practice tools to maximise the effectiveness of the environment of care.
5. Support the parties' commitment under the Health Sector Relationship Agreement (HSRA) and relevant clauses in collective employment agreements.

COMMITMENTS OF PARTIES TO LOA

AUCKLAND DHB WILL:

1. Appoint the DHB CEO as overall sponsor of the CCDM Programme within the DHB for the Term.
2. Establish within the DHB a permanent CCDM Central Council (the Council) in accordance with the clause below, with appropriate terms of reference, comprising key DHB personnel (including key executives, professional leaders and union representatives), and stakeholders.
3. Achieve the agreed programme milestones, timeframes and outcomes by assigning specific responsibilities to the full time CCDM/Trendcare Co-ordinators, as set out in the agreed CCDM Council workplan.
4. Establish standing groups at appropriate points during the Term to support specific activities as defined by the Council in relation to the programme of activity set out in Schedule A.
5. Collaborate with participating unions to ensure delegates are released from the workplace in order to participate in the CCDM Programme's activity.
6. Share the DHB's experiences and learning with other interested DHBs, for example by hosting site visits and sharing the resources it has developed.
7. Participate in on-going collaborative evaluation and research associated with the CCDM.
8. Adhere to the data collection and sharing principles set out in this LOA and share information freely with participating unions and the SSHW Unit for the benefit of the CCDM Programme.
9. Steadily progress development of a whole of organisation approach towards CCDM using strategies that will include (but are not limited to):
    a. Identifying DHB strengths and opportunities for improvement.

b. Planning, prioritising and implementing activity to improve capability.

c. Providing regular reports as requested to the SSHW Unit Governance Group on the DHB's progress with the CCDM Programme.

d. Establishing and refining the DHB's data set to support the CCDM Programme.

e. Forecasting and setting the DHB's staffing base using the tools and processes provided.

f. Implementation and development of Variance Response Management.

g. Ensuring maximum utilisation of a validated patient acuity system.

h. Establishing permanent structures within the DHB to support the CCDM Programme.

THE SSHW UNIT WILL:

1. Provide appropriate SSHW Unit resource to support the parties as set out in Schedule A.
2. Work collaboratively with the DHB and the union parties on the programme of activity as set out in Schedule A aimed at further embedding CCDM within the DHB.
3. Keep information pertaining to the DHB, its operations or personnel strictly confidential, unless the SSHW Unit has the prior agreement of the DHB.
4. Support and promote the strategies, guidelines and tools that result from the CCDM Programme and this LOA to the health sector as a whole.
5. Participate in on-going collaborative evaluation and research associated with CCDM.
6. Provide information and support to assist the DHB in developing a whole of organisation approach towards CCDM.

THE PARTICIPATING UNIONS WILL EACH INDIVIDUALLY:

1. Ensure that their local union staff are provided with appropriate time and support to enable them to participate in the implementation of the programme of activity set out in Schedule A.
2. Work collaboratively with the DHB to ensure that delegates are able to be released to participate in implementation of the programme of activity set out in Schedule A.
3. Provide a visible presence in wards and services that are actively implementing the CCDM Programme.
4. Champion and support the CCDM Programme.
5. Participate in training and development activity associated with the implementation of the CCDM Programme.

6. Take responsibility for communicating relevant information internally with their delegates and members, and nationally within their organisation.

7. Participate in evaluation and research activity associated with the CCDM Programme.

8. Adhere to the data collection and sharing principles set out in this LOA and observe good faith principles in dealing with sensitive information that is shared with them through participation in the CCDM programme.

CCDM COUNCIL AND LOCAL COUNCIL

When a DHB enters the CCDM Programme, a central CCDM Council comprising of DHB and union participants will be established. This group may be known within the DHB as the CCDM Council or by another name. Whatever name is given to the group, it is referred to as the CCDM Council for the purposes of this LOA.

The purpose of the CCDM Council is to support the implementation of the CCDM Programme and to make on-going decisions and recommendations to the DHB about improving organisational design to support safe staffing and healthy workplaces.

Membership of the Council comprises DHB personnel (including key executives, professional leaders and union representatives), and other stakeholders.

As each ward or service takes part in the CCDM Programme across the DHB and considers staffing redesign, a local council (known as the Local Council for the purposes of this LOA) that mirrors the CCDM Council is set up. The purpose of the Local Council is to collect relevant data to show whether the CCDM Programme's processes are working well, to make local changes and to recommend changes to the CCDM Council that are outside of the scope of the Local Council.

Following the implementation of the CCDM Programme within the DHB, both the CCDM Council and each Local Council will become permanent forums within the DHB, supporting on-going decision making and service design or redesign.

DATA COLLECTION AND SHARING

Good quality data is the foundation of CCDM. The goal is that information is generated on the day and over time that demonstrates whether things are going well or whether change is required. There are four main areas where information will be collected for the CCDM Programme:

1. The Discovery Phase. This happens at the beginning of the CCDM Programme and involves an online staff survey, interviews with key staff and consideration of documents associated with the DHBs performance, strategy and goals. A report is generated for the CCDM Council.

2. Wards and services across the DHB are systematically engaged in data collection processes and analysis that results in a report being generated by the DHB, with support and oversight provided by the SSHW Unit, for the CCDM Council and Local Council. The purpose of the report is to propose a revised staffing model, if appropriate, and any recommended changes to the work environment.

3. A centralised operations centre is generally established within the DHB that aims to show the capacity to demand match in the moment. Data is taken from the inpatient management system, the rostering and HR system and is generated directly by staff within the services using a scoring tool to

show capacity/demand match/mismatch. This data is made available to the CCDM Council, to the Local Council, and to staff at appropriate levels of the DHB to aid decision making.

4. The SSHW Unit undertakes research and evaluation of the CCDM Programme within the DHB. This can involve assessing qualitative and quantitative data. Identifiable patient information would not normally form part of the SSHW Unit's data presentation. In the event that it does, it will be de-identified in the process. Staff data can come to SSHW in an identifiable form, and will be de-identified in the process.

WORKING RELATIONSHIP

Primary liaison among the SSHW Unit, the DHB and union parties will be provided by an assigned SSHW Unit Programme Consultant who will work collaboratively with the CCDM / Trendcare Programme Co-ordinator, and CCDM Council.

Functional engagement within the DHB will take place as agreed between the CCDM Council and the SSHW Unit, and will be based on the programme of activity set out in an agreed workplan approved by the ADHB CCDM Executive Council and SSHW governance Group. Progress towards achievement of this workplan will be reported to the ADHB Board.

The SSHW Unit will focus on supporting the parties to develop and maintain robust and accurate data in relation to capacity and demand matching, the quality of the work environment and the quality of patient services.

The CCDM Programme will assist the DHB to develop internal CCDM capacity and continue to work towards successful DHB implementation of the SSHW COI Report's recommendations. Ideally this work will be facilitated via already established local collaborative partnerships (joint forums) and in particular through bipartite make-up of the governance arrangements.

EXPECTED OUTCOMES

FOR AUCKLAND DHB AND UNION PARTIES

The parties intend that during the Term the DHB will benefit from significant progress in the following areas:

1. The ability to identify and use existing data, as well as identify and develop new sources to augment its current activity associated with CCDM.

2. Commitment and participation by representatives of the participating health unions in the collaborative agenda.

3. Achieve a more complete organisational picture of capacity and demand.

4. Advance the use of forecasting windows for predicting variance in demand and acting on identified mismatches between capacity and demand.

5. Accuracy of budget setting and improved adherence to budgets.

6. Reduction in avoidable variance between demand and capacity.

7. Ensuring staff numbers more closely match workload activity, and skill mix is closely matched to acuity ensuring that care capacity meets demand more consistently.

8. Variance response management will be embedded and improved.

9. Greater flexibility in dynamically matching capacity to demand

FOR THE SSHW UNIT

The SSHW Unit will have the opportunity to further test, evaluate and refine CCDM strategies, tools and resources for general DHB implementation.

FOR THE HEALTH SECTOR

Tested and validated tools will be available for application to all DHBs.

STATEMENT OF COMMITMENT

We the undersigned commit to provide the resources required to implement the CCDM Programme as set out in this agreed LOA and workplan approved by the ADHB CCDM Executive Council and SSHW governance Group. Progress towards achievement of this workplan will be reported to the ADHB Board.

We are committed to and will give a high priority to this initiative and in enhancing and improving current systems and processes in the interest of:

1. assuring patient safety and satisfaction;

2. supporting staff health and well-being; and

3. maximising organisational efficiency and effectiveness through best use of available health resources.

We commit to the relationship and activities described in this LOA.

We will commit the resources of our organisation and will use a whole of organisation approach to support the desired outcomes and support our commitments under the Healthy Workplaces Agreement and HSRA.

Where the parties agree that the outcomes of the CCDM Programme demonstrate a mismatch between demand and capacity (over or under supply), we commit to working together towards implementing an appropriate response and acknowledge that the status quo will not be the favoured option.

Management of change processes that are due to this programme will be consistent with relevant collective agreements.

This LOA may be terminated on notice by any Party, and may be revised or modified with the written agreement of all Parties.

Ailsa Claire
Chief Executive SIGNATURE ----------
On behalf of
ADHB DATE ----------

Memo Musa

Chief Executive SIGNATURE ----------
On behalf of
New Zealand Nurses Organisation (NZNO) DATE

Warrick Jones
Assistant National Secretary SIGNATURE ----------
On behalf of
Public Service Association (PSA) DATE

Hilary Graham-Smith
Co-Chair SIGNATURE ----------
On behalf of
Safe Staffing Healthy Workplaces Governance Group Unit DATE

SCHEDULE A: CCDM PROGRAMME OF ACTIVITY

STAGE OF IMPLEMENTATION

Auckland DHB (ADHB) in partnership with their participating CCDM health unions began programme implementation in April 2015.

TERM OF LETTER OF AGREEMENT

The term of this letter of agreement is for three years from July 2015- June 2018.

The DHB and health unions will provide an annual CCDM Programme plan that outlines the major expected programme milestones and timelines for the next 12 months (plan as outlined under 'major milestones and timeline's in Appendix A in this LOA) as well as an outline of intended activity for the following two years of the three year term.

FOCUS OF ACTIVITY FOR FIRST TWELVE MONTHS TO JUNE 2016

TrendCare implementation across ADHB inpatient services as per ADHB implementation plan

Establishment of ADHB CCDM Council and core data set

Discovery in Reablement inpatient services (including survey of all staff, individual and group interviews)

Trendcare audit of Reablement inpatient services (5 wards)

Establishment of Reablement local CCDM council

Staffing methodology across Reablement inpatient services (5 wards) – July 2016 – December 2016,

Variance Response Management – ward level

Escalation planning at service and hospital level

Establish core data set for Reablement

CCDM EXECUTIVE COUNCIL

MEMBERS AS FOLLOWS:

Chief Nursing Officer (Chair)
Chief Executive
HR Change Director
Work stream Leaders (Directorate implementation, Core Data Set, FTE Calculation, VRM, Communications)
Chief Health Professions Officer
Director Patient Management Services
Director Provider Services
CCDM/Trendcare Coordinator(s)
NZNO Professional Nurse Adviser
NZNO Organiser

NZNO CarePoint Campaign Implementation Coordinator
PSA Organiser(2)

Programme Consultant SSHW Unit (ex officio)

PA Chief Nursing Officer (minute taker)

CCDM PROGRAMME COORDINATION

The accountability and responsibility for CCDM programme delivery at ADHB sits with the CCDM Council.

The DHB will assign specific responsibilities to the full time appointed dedicated CCDM/ Trendcare Programme Co-ordinator(s) for roles within the programme based on best skill match, the CCDM Council agreed workplan to achieve the agreed milestones, timeframes and outcomes.

This will vary from time to time based on the workplan and will be agreed by the Director of Patient Management Services and the SSHW Programme Consultant.

These roles also have accountability for the deployment of Trendcare across inpatient areas which is a key enabler to CCDM implementation.

The SSHW Programme Consultant, Director Patient Management Services and will meet / teleconference regularly with the CCDM / Trendcare Programme Co-ordinators to maintain oversight of the work, allocation of responsibilities within the workplan and ensure reporting requirements are met (including monthly reporting requirements).

A review of effectiveness of programme co-ordination will occur in six months to ensure goals of clarity of oversight, clear allocation of responsibilities and integration across the programme are being achieved.

Responsibilities of CCDM / Trendcare Programme Co-ordinator are outlined in the Position Description and include provision of:

- Operational and facilitation support for the implementation of the CCDM Programme within the DHB as detailed in the ADHB Annual CCDM Programme Plan and as outlined in Appendix A of this document
- Support the improvement and functionality of the foundational elements of the DHBs CCDM Programme:
    - effective partnership
    - effective communication
    - and high quality data

SSHW UNIT REPRESENTATIVE

The following resource will be allocated to the CCDM Programme:

0.5 FTE Programme Consultant

MAJOR MILESTONES/ TIMELINE AND RESOURCES REQUIRED

This is an overview of the programme activity for the next 12 months. Please see the detailed programme plan for progress and status of implementation.

Key Programme Milestones and Timelines	Key Resource Required	J	A	S	O	N	D	J	F	M	A	M	J
ADHB High level Discovery	SSHW Unit												
Communication Workshop	Council Members, SSHW Unit, CCDM Site Coordinator												
Partnership Workshop	Council Members, SSHW Unit, external facilitator, CCDM Site Coordinator												
Council Education re programme detail	SSHW Unit, Council members												
Directorate Discovery Reablement inpatient services	SSHW Unit, CCDM Site Coordinator, Directorate personnel, Union Organisers/delegates												
Trendcare audit (5 Reablement inpatient wards) June 2016													
Core Data Set Establish Core Data Set indicators, tolerances and dashboard for reporting to Council	Council Members, SSHW Unit, CCDM Site Coordinator												
Variance Response Management Align Integrated Operations Centre development and CCDM programme plan	Patient Flow Coordinator, IOC Steering Group, ???, Union Rep, SSHW Unit, CCDM Council, CCDM Site Coordinator												
Variance Response Management Develop Standard Operating Responses/Escalation plans across ward/directorate/hospital	Nurse Unit Managers , Service Clinical Directors , Operations Managers Performance Improvement ??, Duty Managers, CNMs, Union Rep, CCDM Coordinator												
Establish Local Data Councils in areas with TrendCare and RTC	CCDM Coordinator, SSHW Unit, CNM's, Union delegates												
Develop Variance Indicators to display real time capacity													

Key

10.1

	completed		Planned

<u>Outline of Intended activity for June 2016-June 2018 towards CCDM BAU</u> (see appendix B of this document for further explanation):

- Staffing Methodology
- Variance Response Management
- Core Data Set
- Discovery process by Directorate

KEY DELIVERABLES AND TIMELINE

DHB's deliverables:

Refer to table above. Specific and detailed activity and timelines are outlined fully in the ADHB Annual CCDM Programme Plan. Progress against this agreed plan is reported using the SSHW Unit Monthly Programme Progress reporting template to the ADHB CCDM Council and the SSHW Unit.

SSHW Unit's deliverables:

Support the site to establish functional and effective:

- Tools for staffing methodology (Work Analysis and FTE calculation)
- Local Data Councils after Work Analysis
- Organisational core data set including minimum safe six indicators
- VRM tools and process templates

Union parties' deliverables:

Provide support to ensure union staff are able attend Council meetings and contribute effectively to the agreed planed ADHB CCDM programme activity. On-going support for union delegates to attend local council meetings and contribute effectively to the agreed planed ADHB CCDM programme activity. Continue to ensure that each ward has effective and active Union delegate representation to support CCDM activity and goals.

SPECIFIC RESOURCE COMMITMENTS

DHB - The DHB will assign responsibility for tasks to dedicated CCDM / Trendcare Programme Co-ordinator(s) for roles within the programme based on best skill match, the CCDM Council agreed workplan to achieve the agreed milestones, timeframes and outcomes.

This will vary from time to time based on the workplan and will be agreed by the Director of Patient Management Services and the SSHW Programme Consultant.

These roles also have accountability for the deployment of Trendcare across inpatient areas which is a key enabler to CCDM implementation.

Performance Improvement specialist time to support Integrated Operations, Variance Response and escalation processes

Data Analyst time sufficient to support the completion of Staffing Methodology and Core Data Set development requirements

Commitment of the CCDM Council Members to attend regular meetings relating to CCDM programme governance and act as organisational champions to the Programme, the goals and the agreed Programme activity

Commitment of the DHB to assign appropriate resources to the programme to enable the required work to be completed as per the agreed site implementation plan

Release of union delegates or nominated members working on behalf of health unions to participate in CCDM Programme activities in paid work time

SSHW –-0.5 FTE Programme Consultant until the end of the term of this agreement

Union parties – Provide support to ensure agreed staff are able to attend Council meetings and contribute effectively to the agreed planned ADHB CCDM programme activity. Provide on-going support and CCDM education to union delegates on site to ensure their increased understanding of CCDM and its goals. Encourage and support delegates to be actively involved in their Local Data Councils and contribute effectively to the agreed planed ADHB CCDM programme activity

REPORTING AND MONITORING

- The SSHW Programme Consultant, Director Patient Management Services and Nurse Director will meet / teleconference regularly with the CCDM / Trendcare Programme Co-ordinators to maintain oversight of the work, allocation of responsibilities within the workplan and ensure reporting requirements are met (including monthly reporting requirements).
- Monthly progress reports will be provided by the CCDM / Trendcare Programme Co-ordinators .to the CCDM Council, Director of Patient Management Services, Nurse Director and the SSHW Unit Programme Consultant against the detailed ADHB annual CCDM programme Plan. These are to be provided using the agreed CCDM Council Monthly Reporting Template. This report should be provided by the second Friday of each month
- DHB CCDM Site Coordinator will participate in the SSHW CCDM Site Coordinators Teleconference hosted by the SSHW Unit fortnightly
- SSHW Unit Director to provide DHB with a Programme Assessment Report against CCDM Business as Usual document (see Schedule B) annually for the term of this agreement term (i.e. July 2016, 2017, 2018)

OTHER

SCHEDULE B: CCDM AS BUSINESS AS USUAL

The following information provides the vision for 'business as usual' (BAU) in relation to the implementation of CCDM. The elements of the programme are described in the table in terms of what BAU should look like for each principle/ intervention and then at the Executive, Operational and Clinical levels of the organisation.

Intervention	Business as usual (BAU)
Partnership	A functional and collaborative partnership has been developed that is actively engaged in leadership of CCDM as BAU
Permanent governance of capacity and demand performance	An understanding of requirement for permanent governance has been reached and suitable existing structures identified
Organisation wide engagement with validated acuity based demand	All finance and business managers are in agreement that validated acuity adds critical accuracy to evidence based staffing models.
Staffing Methodology Work Analysis	Where Staffing Methodology Work Analysis has been utilised the process has been completed using action plans and post intervention evaluation
Staffing Methodology FTE Calculation)	Staffing Methodology FTE Calculation) has been completed for all wards and units Is being used as the basis of annual staffing budgeting
Core data set	The DHB has an agreed set of markers analysed on a monthly basis from the floor to the board
Local councils	Each service has a Local Data Council (or KHWD group or Quality group) that reviews the Staffing Methodology reports and action plans for each service as well as the overall performance of the service using the core data set and VRM data on a monthly basis. This group is empowered to redesign services locally and evaluate their impact (local adaptive governance, Zoli 2012)
Effective variance management	A variety of strategies are being used to effectively manage short notice and mid term variance. There is minimal unmet demand or underutilised capacity
Forecasting sufficiently well to reduce both positive and negative variance	Accurate decisions can be made regarding the management of capacity In response to predicted fluctuations in demand

BAU FOR THE EXECUTIVE & SERVICE LEVEL TEAM

Organisational demand – capacity performance is being managed dynamically at all levels of the organisation. The CEO and executive team know where to go to at any given moment to see how the organisation is performing on a shift by shift, day by day basis, as well as monthly and annually. There are no surprises. The reporting system alerts risk and harm in real time and the organisation is able to activate multiple mitigation strategies as counter measures.

Performance against patient care, staff wellbeing and financial boundaries are all within agreed tolerances. The activity and overt messages of the organisation prioritise performance against these boundaries in equal measure. The culture of the organisation supports innovation at all levels and a 'speak up' mentality associated with self monitoring of performance.

BAU FOR THE OPERATIONS LEVEL

Organisational demand and capacity performance is managed dynamically on a day by day basis according to accurately predicted and well resourced planning. This plan is based on highly credible data generated at multiple levels of the organisation.

There is consistent and present engagement from the multi-disciplinary team at all operations daily, fortnightly and forecasting meetings.

The Operations teams have a suite of strategies to support dynamic responsiveness to meet demand. As well as organisationally agreed strategies to manage risk for patients, staff and the organisation when demand cannot be met. Operational management of demand and capacity are reviewed and redesigned in a structured way to ensure continuous improvement cycles.

BAU FOR CLINICAL STAFF

The ultimate acid test of the success of the programme is when nurses and midwives can claim that the workload is manageable, the standard of care is very good or excellent and the work effort required to keep it there is reasonable. They report that there are enough staff with the right skills available when required to meet the needs of patients on most if not every shift. The work environment and work set up supports staff to be successful in their role. Care is complete. Outcomes for patients, staff and the ward are acceptable to all.

REFERENCES

Zoli, A & Healy, A.M (2012) Resilience: why things bounce back. Headline Publishing Group, London.