AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Open Board Meeting

Wednesday, 23 September 2020

10:00am

Note:

- **Open Meeting from 10:00am**
- **Public Excluded to follow**

Via Zoom

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Published 18 September 2020

Agenda
Meeting of the Board
23 September 2020

Venue: Via Zoom **Time:** 10.00am

Board Members	**Auckland DHB Executive Leadership**	
Pat Snedden (Board Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Dr Karen Bartholomew	Director, Health Outcomes for ADHB/WDHB
Doug Armstrong	Mel Dooney	Chief People Officer
Michelle Atkinson	Margaret Dotchin	Chief Nursing Officer
Zoe Brownlie	Mark Edwards	Chief Quality, Safety and Risk Officer
Peter Davis	Joanne Gibbs	Director Provider Services
Tama Davis (Board Deputy Chair)	Dame Naida Glavish	Chief Advisor Tikanga and General Manager Māori Health – ADHB/WDHB
Fiona Lai	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Bernie O'Donnell	Meg Poutasi	Chief of Strategy, Participation and Improvement
Michael Quirke	Shayne Tong	Chief Digital Officer
Ian Ward	Sue Waters	Chief Health Professions Officer
	Justine White	Chief Financial Officer
	Dr Margaret Wilsher	Chief Medical Officer
	Auckland DHB Senior Staff	
	Rachel Lorimer	Director Communications
	Auxilia Nyangoni	Deputy Chief Financial Officer
	Marlene Skelton	Corporate Business Manager
	Allan Johns	Director, Facilities & Development
	(Other staff members who attend for a particular item are named at the start of the respective minute)	

Agenda

Please note that agenda times are estimates only

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

10.05am **2.** **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?

10.07am **3.** **CONFIRMATION OF MINUTES OF 12 August 2020**

10.10am **4.** **PRESENTATION**

4.1 Dr Janice Wilson - Health Quality and Safety Commission
(*with Dr Wilson will be Collin Tukuitonga who is a board member and Iwona Stolarek, Executive Lead Quality and Systems*)

10.40am **5.** **ACTION POINTS**

10.50am	**6.**	**EXECUTIVE REPORTS**
	6.1	Chief Executives Report
	6.2	Health and Safety Report
11.10am	**7.**	**PERFORMANCE REPORTS**
	7.1	Financial Performance Report
	7.2	Planning and Funding Outcomes Update
11.30am	**8.**	**COMMITTEE REPORTS - Nil**
	9.	**DECISION REPORTS**
11.30am	9.1	Delegations during COVID-19 Event Response – Updated
	10.	**INFORMATION REPORTS**
11.35am	10.1	System Measures Level Report
11.50am	**11.**	**GENERAL BUSINESS**
11.50am	**12.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Next Meeting:	4 November 2020 at 10.00am A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

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Attendance at Board Meetings

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

2020/2021

Members	26 Feb 20	08 Apr. 20	20 May. 20	18 June 20	8 July 20	12 Aug 20	13 Sept 20	4 Nov 20	16 Dec 20
Pat Snedden (Board Chair)	1	c	1	1	1	1			
Joanne Agnew	1	c	x	1	1	1			
Doug Armstrong	1	c	1	1	1	1			
Michelle Atkinson	1	c	1	1	1	1			
Zoe Brownlie	1	c	1	1	1	1			
Peter Davis	1	c	1	1	1	1			
Tama Davis	1	c	1	1	x	1			
Fiona Lai	1	c	1	1	1	1			
Bernie O'Donnell	1	c	1	1	1	1			
Michael Quirke	1	c	1	1	1	1			
Ian Ward	x	c	1	x	1	1			

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
Pat SNEDDEN	Director and Shareholder – Snedden Publishing & Management Consultants Limited Director and Shareholder – Ayers Contracting Services Limited Director and Shareholder – Data Publishing Limited Trustee - Recovery Solutions Trust Director – Recovery Solutions Services Limited Director – Emerge Aotearoa Limited and Subsidiaries Director – Mind and Body consultants Ltd Director – Mind and Body Learning & Development Ltd Shareholder – Ayers Snedden Consultants Ltd Executive Chair – Manaiakalani Education Trust Director – Te Urungi o Ngati Kuri Ltd Director – Wharekapua Ltd Director – Te Paki Ltd Director – Ngati Kuri Tourism Ltd Director – Waimarama Orchards Ltd Chair – Auckland District Health Board Director – Ports of Auckland Ltd Chair – Counties Manukau Audit, Risk and Finance Committee Member – Health Partners Ltd	08.07.2020
Jo AGNEW	Professional Teaching Fellow – School of Nursing, Auckland University Casual Staff Nurse – Auckland District Health Board Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Shareholder – Karma Management NZ Ltd (non-Director, majority shareholder) Member – New Zealand Nurses Organisation [NZNO] Member – Tertiary Education Union [TEU]	30.07.2019
Michelle ATKINSON	Director – Stripey Limited Trustee - Starship Foundation Contracting in the sector Chargenet, Director & CEO – Partner	21.05.2020
Doug ARMSTRONG	Trustee – Woolf Fisher Trust *(both trusts are solely charitable and own shares in a large number of companies some health related. I have no beneficial or financial interest* Trustee- Sir Woolf Fisher Charitable Trust *(both trusts are solely charitable and own shares in a large number of companies some health related. I have no beneficial or financial interest* Member – Trans-Tasman Occupations Tribunal Daughter – *(daughter practices as a Barrister and may engage in health related work from time to time)* Meta – Moto Consulting Firm – (*friend and former colleague of the principal, Mr Richard Simpson)*	20.08.2020
Zoe BROWNLIE	Director – Belong Director - GenderTick Partner – CAYAD, Auckland Council	20.07.2020
Peter DAVIS	Retirement portfolio – Fisher and Paykel Retirement portfolio – Ryman Healthcare Retirement portfolio – Arvida, Metlifecare, Oceania Healthcare, Summerset, Vital Healthcare Properties	19.11.2019
William (Tama)	Director/Owner – Ahikaroa Enterprises Ltd Whanau Director/Board of Directors – Whai Maia Ngati Whatua Orakei	01.07.2020

DAVIS	Director – Comprehensive Care Limited Board Director – Comprehensive Care PHO Board Board Member – Supporting Families Auckland Board Member – Freemans Bay School Board Member – District Maori Leadership Board Iwi Affiliations – Ngati Whatua, Ngati Haua and Ngati Tuwharetoa	
Fiona LAI	Member – Pharmaceutical Society NZ Casual Pharmacist – Auckland DHB Member – PSA Union Puketapapa Local Board Member – Auckland Council Member – NZ Hospital Pharmacists' Association	26.08.2020
Bernie O'DONNELL	Chairman Manukau Urban Māori Authority(MUMA) Chairman UMA Broadcasting Limited Board Member National Urban Māori Authority (NUMA) Board Member Whānau Ora Commissioning Agency	26.08.2020
Michael QUIRKE	Chief Operating Officer – Mercy Radiology Group Convenor and Chairperson – Child Poverty Action Group Director of Strategic Partnerships for Healthcare Holdings Limited	27.05.2020
Ian WARD	Director – Ward Consulting Services Limited Director – Cavell Corporation Limited Trustee of various family trusts Oceania Healthcare – wife shareholder	21.05.2020

Minutes
Meeting of the Board
12 August 2020

Minutes of the Auckland District Health Board meeting held on Wednesday, 12 August 2020 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 10:30am

Board Members Present	**Auckland DHB Executive Leadership Team Present**	
Pat Snedden (Board Chair)	Ailsa Claire	Chief Executive Officer [arrived during item 5.]
Jo Agnew	Mel Dooney	Chief People Officer
Doug Armstrong	Margaret Dotchin	Chief Nursing Officer
Michelle Atkinson	Mark Edwards	Chief Quality, Safety and Risk Officer
Zoe Brownlie	Joanne Gibbs	Director Provider Services
Peter Davis	Dr Debbie Holdsworth	Director of Funding – Auckland and Waitemata DHB's
Tama Davis		
Fiona Lai	Rosalie Percival	Chief Financial Officer
Bernie O'Donnell	Shayne Tong	Chief Digital Officer [Present for item 9.2 only]
Michael Quirke	Sue Waters	Chief Health Professions Officer
Ian Ward	Dr Margaret Wilsher	Chief Medical Officer
	Auckland DHB Senior Staff Present	
	Hanna Adams	Communications Advisor – Media and External
	Marlene Skelton	Corporate Business Manager
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

[Secretarial Note: The Board took time to listen to the address of the Prime Minister and Director General of Health in relation to matters surrounding the recent potential community transmission of COVID 19 which had placed Auckland back in Alert Level 3 and the remainder of the country in Alert Level 2. The Open Board Meeting commenced at 11.10am.]

1. ATTENDANCE AND APOLOGIES

That the apologies of Executive Leadership Team members Dr Karen Bartholomew, Director, Health Outcomes for Auckland and Waitemata DHBs and Meg Poutasi, Chief of Strategy, Participation and Improvement be received. That the apology of Ailsa Claire for late arrival be received.

2. REGISTER AND CONFLICTS OF INTEREST *(Pages 6-8)*

Bernie O'Donnell advised that his interests should now be recorded as follows:
Chairman Manukau Urban Māori Authority(MUMA)
Chairman UMA Broadcasting Limited
Board Member National Urban Māori Authority (NUMA)
Board Member Whānau Ora Commissioning Agency

Fiona Lai advised that her interests should be amended as follows:
Casual Pharmacist – Auckland DHB

3. CONFIRMATION OF MINUTES 8 JULY 2020 *(Pages 9-24)*

Doug Armstrong asked for an update on action arising from the MRTB visit to the Auckland

DHB and the potential review of their existing mandate.

Sue Waters advised that a meeting had been held on 29 July where concerns were discussed in detail, in particular a possible pathway to registration and what that might look like. A subsequent paper has been provided to the Chief Executive and Chair of the MRTB to put before their Board in August. It essentially proposes an alternative pathway to registration other than on pure qualifications using the full mandate that is gazetted in their scope in so far as it applies to the HBCA, Section 12. It is hoped that they will support the proposal which would result in a pilot at Auckland DHB.

Doug Armstrong commented that a close eye should be kept on this issue so that the MRTB are held to account.

Resolution: Moved Pat Snedden / Seconded Jo Agnew

That the minutes of the Board meeting held on 08 July 2020 be confirmed as a true and accurate record.

Carried

4. ACTION POINTS *(Page 25)*

All actions are covered under existing reports within the agenda.

5. EXECUTIVE REPORTS

5.1 Chief Executive's Report (*Pages 26-36)*

While waiting for the arrival of the Chief Executive, Ailsa Claire the Board Chair, Pat Snedden provided some comment on the recent visit of Minister Hipkins to Auckland DHB.

Minister of Health, the Hon Chris Hipkins and the Director General of Health, Dr Ashley Bloomfield visited Auckland City Hospital on 29 July 2020 to announce funding for the second tranche of Auckland DHB's 10-year programme of critical works to replace and upgrade infrastructure at Auckland City Hospital, Starship Hospital and Greenlane Clinical Centre.

The visit provided an opportunity to discuss Auckland DHBs financial position and the Board Chair advised that he was of the opinion that Minister Hipkins clearly understood the strategy and methodology employed by Auckland DHB to remediate its financial position over the next two years. It appeared that the Ministry of Health is supportive of Auckland DHBs position too. This was a positive and valuable visit.

The Chief Executive, Ailsa Claire advised that up until yesterday the hospital was making good progress on addressing elective surgery. However, recent COVID events may see a change in this situation.

The following was covered during discussion of the report:

- Fiona Lai drew attention to page 30 of the agenda and questioned what patient and clinician feedback had been received around the use of Telehealth; were there drawbacks to its use, what financial considerations should the Board be aware of and had the DNA rate reduced as a result.

Ailsa Claire advised that post COVID the use of Telehealth had dropped but with the current situation it was expected that this use would now increase again. There are no financial savings emanating from use of this tool as it does not reduce time spent on an appointment on the part of the clinician and bookers and schedulers were still required to be part of the process. It is however, a more effective and efficient way for patients to interact with the DHB and does assist with reducing the DNA rate. Clinicians take-up and satisfaction with Telehealth was very much specialty related. There were some specialties where the tool assisted with interaction and engagement such as in mental health. There are other specialities where there is still no substitute for face-to-face interaction.

Resolution:

That the Chief Executives report for 9 June 2020 – 20 July 2020 be received.

Carried

[Secretarial Note: Item 9.2 was brought forward and considered at this point in the agenda.]

5.2 Health and Safety Report *(Pages 37-45)*

In the absence of Mark Edwards, Chief Quality, Safety and Risk Officer, Sue Waters, Chief Health Professions Officer asked that the report be taken as read drawing attention to the lead and lag indicators shown on page 38 and 39 of the agenda.

Induction, which was raised as an issue at the last meeting, had been addressed by processes being put in place in areas where there is not 100% compliance asking for managers to follow up directly to resolve, which should see an improvement in figures.

The lag indicators are much as they were at last reporting date. The lost time injury rate appears to have decreased but this is likely to be normal cause variation.

On page 40 of the agenda further work around workplace violence and aggression and lone workers is outlined.

Page 42 of the agenda has a section on the DHB and HDC making the workplace safer and mention of the supply chain project which is an area of focus with a national approach going forward. Year one results will be reported to the Finance, Risk and Assurance Committee over the next couple of months.

There were no questions.

Resolution:

That the Board receive the Occupational Health and Safety Performance Report for July 2020.

Carried

6. PERFORMANCE REPORTS

6.1 Financial Performance Report *(Pages 46-52)*

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

The underlying result was $5.2M favourable to the planned deficit and there was an extra provision for the Holidays Act of $60.8M and unfunded impacts of COVID 19 of $26.3M.

The Ministry has advised that the latter two be reported separately and the DHBs accountability sits against the underlying result.

The Board Chair, Pat Snedden commented that this was a fairly impressive result given circumstances of the Holidays Act and COVID 19 expenses.

The following was covered during discussion of the report:

- Advice was given that investigations were being carried out to determine whether there was sufficient money available to undertake the PAS project. Ailsa Claire added that there would be if other things were deferred but it had to be accepted that this would be at the expense of clinically critical projects. Rosalie Percival advised that she had had a conversation with Ministry staff about this and they had asked to be provided with information about the opportunity cost trade-offs that would be required. This information would also be provided to the Board.
- Peter Davis asked about the shortfall in funding for hospital services which was currently being offset by the Funding arm. Peter wished to see a list of the programmes that had actually been funded by the Funder Arm so that it was clear what was being foregone in that area. The Board Chair commented that this financial scenario had been run for some years and when the census data issue arose it forced a rethink around the assumption that the local population were being under serviced. Ailsa Claire advised that if the funding reflects the revised population number and the DHB receives the correct pricing for next year then there would be no cross subsidisation. The Provider Arms problem has largely been associated with pricing for regional and tertiary services. If this is remediated then the situation of cross subsidisation no longer exists.
  Rosalie Percival advised by way of example that management had thought that the Boards PHO coverage, based on actual enrolment level and the population figure of last year, was 85%. The movement of 60,000 in the population number makes that coverage more like 95%. All the coverage numbers are currently being recalculated by the Ministry. The scenario is likely to be that when the DHB thought it was underinvesting it actually wasn't. The large gap in pricing of $50M actually netted this situation off.
  The Board Chair, Pat Snedden felt that the Board was now moving to a position where it could genuinely say that the money for the various delivery mechanisms that the Board has out in the community and in the hospital will be in the right place. The only difference at the moment lies in timing of funding where the Board is getting from the Ministry of Health half of the difference in the 2021 year and a

100% of the difference in the following year. After that there would be no excuse for not applying the money in the right areas.

- Doug Armstrong raised the issue of gratuities and long service leave commenting that they were outdated public service relics. The public sector had moved from this and these things should be negotiated out of the Meca. Advice was given that those staff on existing old contracts could not have these removed however; new staff were not offered these benefits.

Resolution:

That the Board receive this Financial Report for the month and full year ended 30 June 2020

Carried

6.2 Planning and Funding Outcomes Update (*Pages 53-72)*

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

The early progress made in the Uri Ririki – Child Health Connection Centre is pleasing. The benefits of joined up data are starting to being seen as well as introduction of NCHIP. There is a sad aspect to this as a result of intensive data quality work we are addressing the issue of the records of a number of deceased children under 6 years (which will include stillbirths) which historically has meant our health system was recalling deceased tamariki. To address this and remove the potential for upsetting families has been important.

It is anticipated that a CPHAC meeting will be held next month allowing more in-depth conversations around the programmes being run by the Panning and Funding team.

The following was covered during discussion of the report:

- Peter Davis commented that a number of Maori over 65 who were not even enrolled with a PHO was surprising. "There was an NHI system and surely there must be a way of utilising that and helping those people enrol". It was advised that while we encourage PHO enrolment and have done work with PHOs to increase this, PHO enrolment is voluntary. Interestingly, geographic mapping had been done in relation to flu vaccination coverage in this group and it appeared un-enrolment was an issue in the wealthier demographic and not in the least deprived areas. The reset of our demographic has shifted what was a very low rate up to 95%.
- Peter Davis also raised the measles immunisation rate where he thought a system was in place that had raised the level into the high 90's and asked what had changed that now affected Maori and Pacific disproportionately. Debbie Holdsworth advised that there were a number of reasons. There is a known 'immunity gap' with New Zealanders born between 1980 and 2005 which results from a number of issues:
    - sub-optimal immunisation from 1990 when this vaccine was introduced - as low as 40-50% for Māori and Pacific
    - vaccine hesitancy from the now discredited link between MMR and autism in

the late 1990's

- a change in the vaccine schedule in 2001 which brought the 11-year old-MMR forward to 4 years - a large number of people are missing a second dose despite a catch-up programme
- the NIR which is end of life, was only introduced in 2005 and coverage prior to this was patchy an unknown and immunisation follow-up process was less robust

Pat Snedden asked what was being done to address these issues and Debbie advised that the Government had undertaken a review and were now funding an MMR campaign which we supported.

- Peter Davis commented that as the immunisation register is old and not particularly fit for purpose it bothered Peter that this was not being addressed and that the situation was deteriorating. Pressure should be placed on the government insisting that these systems be made more robust. Debbie advised both Auckland and Waitematā DHB have repeatedly raised this with the Ministry. As an example, Debbie advised children under six years old are automatically opted on to the NIR and GP practice management systems and have a reminder prompt if they haven't. Adults are not required to opt-on and there is no automatic prompt for anyone over the age of six. There are probably many more people immunised for flu than is shown by the register as it takes three clicks to manually opt them in. More work was required to understand that gap. Auckland and Waitematā DHB have repeatedly raised this with the Ministry as a challenge with accurate coverage.

Resolution:

That the Board note the key activities within the Planning, Funding and Outcomes Unit since the last update provided on 1 July 2020.

Carried

7. COMMITTEE REPORTS - NIL

8. DECISION REPORTS - NIL

9. INFORMATION REPORTS

9.1 2021 Meeting Schedule *(Pages 73-74)*

The Board Chair, Pat Snedden advised that this report provided a draft 2021 meeting schedule.

In consideration of the meeting schedule for the remainder of this year it was anticipated that meetings would once again be stood up in full. However, if recent COVID events continue on it may be necessary to consider having weekly one-hour Full Board meetings via Zoom. Pat did not want to reinstitute the Executive Committee of Board as he did not wish to disenfranchise any Board Member and wanted the process to remain inclusive of all.

This met with the approval of Board Members should the situation warrant it.

Resolution:

That the Board receive the draft schedule of Auckland DHB Board and Committee meetings for 2021.

Carried

9.2 Digital Transformation – Presentation by Shayne Tong

Shayne Tong, Chief Digital Officer tabled a presentation document. (Attachment 9.2.1)

Attention was drawn to the Executive Summary and the five points outlined. Shayne Tong commented that he was proud of the ability of the DHB to now leverage new digital platforms a number of which had been implemented. The strategy of having one monolithic system to manage everything within the organisation was an old way of thinking. The new strategy was to have core systems but then to be able to take the data within those systems and allow cloud-based analytics to occur.

The old back end systems are very old and clunky so new platforms are being leveraged that allow rapid development to deliver value both operationally and clinically.

What we are able to do today that we were not able to do five years ago is to deploy data into the cloud to provide real time information which can be accessed via mobile phone. During COVID it enabled digital workflow to be put in place at the Border, in the managed isolation facilities and around mobile testing. This also has great promise in the clinical areas where a range of work is currently being undertaken with Starship. It provides the ability to take fragmented systems and join them together to provide a new unified workflow for clinicians and patients.

There is a 10-year IT strategic plan to replace old core systems so that models of care can be transformed and also to leverage digital technology and mobility to supplement what already exists.

The plan is made up of four investment portfolios around strengthening the core ITC foundations to move the ITC infrastructure and systems into the modern world. An example being the data centre being moved into the cloud with a partnership with a third-party secure data centre that hosts the hospitals system. As the region collaborates and as the cloud is utilised work has to be done to identify the right people requiring access into the systems as data is pushed out to the consumer. Old core IT systems do not allow this to occur.

There is a need to ensure the right platforms are in place and to rationalise systems to achieve a smaller number that are joined up and integrated for both Auckland DHB and the northern region. An example of this is the PAS.

Interoperability is important along with consistent standards that enable data sharing in a modern and safe way. A key component of that is a robust health information platform. Currently data is derived from multiple systems. Data needs to be safely shared regionally and nationally.

A ten-year ITC strategic plan in the region of $800M of capex has been completed. 50% of that has been secured through northern regional funding through depreciation held by hA and there is local funding required from DHBs. There is still a requirement for new money of around $400M of capital over that 10-year period. $17M has just been secured for Northland DHB to replace their community and mental health system.

The focus is now on determining what the digital health strategy at Auckland DHB is and how it both aligns with the ISSP from an IT perspective and also the Auckland DHB strategy around the outcomes that the Board is trying to achieve for service provision and models of care. Slides 7 and 8 shows what is being attempted.

Board Member Comment

- Bernie O'Donnell commented that he did not see reference to people in the strategic planning for these new digital platforms and as we are aware these new technologies are driven by young people. What he would like to see is a pathway that provides understanding that the platforms and digital infrastructure are led and mentored by young people.
- Tama Davis was advised that the data maturity nationally was very low so there was a need for strong governance and ownership around data and good data sharing principles agreed and in place to allow safe data sharing. A lot of the old systems make it difficult to get access to the data and share it in a common way. It is not consistent; it is proprietary so good data standards are necessary to allow the sharing of it.
- Assurance was asked for around the security of data when transferred from legacy systems and whether capable people were available to lead this. Shayne advised that security was being tightened up across the region with everything managed through security governance processes to alleviate some of the traditional issues associated with data transfer and there were good people experienced in data management and leading data transformation on the team.
  Shayne asked Board Members to remember that transformation was not just about technology it was also about capable people, operating models of service, the data itself and the security of that data.
- Ailsa Claire advised that previously the organisation could not have operated like a young person, digitally literate and able to do things because the basic core technology was not in place. Data could not be shared between platforms. The last two years-worth of work had been focused on enabling this core technology so that the organisation could become more agile and modern. While that core technology is important all the other things that are being done is enabling the services to utilise technology in a smarter way. For example, the Visitors App for COVID and the Telehealth programmes.
- Doug Armstrong commented that he respected Shayne's ability and the obstacles and frustrations that he would be facing. He felt that the DHB was too slow in being able to utilise new technologies and that the Government needed to recognise that this was just as important as facilities upgrades. People's health and lives are at risk by the slow take-up of these technologies.

- Peter Davis commented that a positive argument for funding would be that with digital investment staff productivity was being increased. It must be possible for staff to do a lot more now with a reduction in manual intervention and doubling handling. Data needed to be produced that showed that digitally enabled Boards can run a lot more efficiently.

Resolution:

That the Board receive the Digital Transformation presentation.

Carried

[Secretarial Note: Item 5.2 was considered next.]

10. GENERAL BUSINESS

Presentation to Rosalie Percival, Chief Financial Officer

The Board Chair, Pat Snedden acknowledged Rosalie's service to the Board, commenting that Rosalie was a superb and wonderful contributor to the health sector within New Zealand. The work that had been done for Auckland DHB had been exemplary providing the Board with a sound footing through very agitated financial times and it was done with competence. Rosalie's straightforward honesty and trustworthiness was highly valued. The esteem in which Rosalie was held nationally could be considered a huge personal complement.

One of the things that Pat noted about Rosalie was a very strong moral purpose as she wanted to do things right, do them well and do them so that people benefited from the action taken. Rosalie was definitely a person who understood the nature of service, who put herself directly in the service of others and did so in a way that people felt listened to. Around the country, when there are hard things to be done, research required to manage situations, big questions to be addressed with the Ministry, Rosalie Percival is always one of the people sitting at the table for that national conversation. Rosalie is always to be seen as transparently promoting the good for all rather than indulging in self-promotion which speaks highly of Rosalie's personal integrity. For the Board, in a governance role, to have a trustworthy CFO who is beyond reproach and is prepared to deliver the truth is a very fundamental part of the Board being able to carry out its duties well.

Pat, on behalf of the Board acknowledged their respect and admiration for Rosalie and commented that she would be sorely missed.

Michelle Atkinson acknowledged the skill and leadership displayed by Rosalie but noted that something that was notable to her as a young and inexperienced Board Member was Rosalie's warm and welcoming manner when explaining financial matters and that had meant a lot to her.

Ian Ward noted that he had worked with Rosalie for a number of years and she had always been available, nothing seemed to perturb her, she gets on and gets the job done and provides very professional advice.

Tama Davis thanked Rosalie for her even-handed approach to providing information to Board Members in a very helpful way so that progress could be made. Tama acknowledged the

intention provided through the portfolio of the CFO that supported the equity space by providing financial drivers for equity across the board.

Doug Armstrong commented that he rarely awarded high ratings but Rosalie was fully deserving and he gave her a 10 out of 10. He commended her for her contribution and considered her CEO material and urged her never to sell herself short.

Bernie O'Donnell wished Rosalie all the best with her new role at Capital and Coast DHB.

Rosalie Percival replied thanking the Board Members commenting that it had been a pleasure to work at Auckland DHB and to work with the Board. Rosalie thanked Pat for his leadership. It had been good to work for an organisation that had values that were modelled right from the top starting with the Board and Senior Management through all levels of staff. Rosalie commented that the Board had some exciting times ahead of it particularly in the equity space.

The services that were delivered at Auckland DHB along with the people themselves were amazing. She had learned so much from Ailsa Claire. She was sad to be leaving but it was very much a personal next stage in her life that had simply fallen easily into place.

Rosalie expressed her support for her successor who she considered was "cut from the same cloth".

Ailsa Claire then presented Rosalie, on behalf of the Board, with a bouquet of flowers and a service trophy acknowledging Rosalie's service from July 2012 to August 2020.

11. RESOLUTION TO EXCLUDE THE PUBLIC *(Pages 75-78)*

Resolution: Moved Pat Snedden / Seconded Jo Agnew

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

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. Apologies	N/A	N/A
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.	**Commercial Activities**	That the public conduct of the

Confirmation of Confidential Minutes 8 July 2020	Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	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 Circulated Resolution - Draft Annual Plan 2020/21	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Action Points	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	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 Risk Management Update	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time.	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 Chief Executives Confidential Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 Human Resources	**Commercial Activities** Information contained in this report	That the public conduct of the whole or the relevant part of the

Report	is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time.	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 People Analytics Dashboard	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time.	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 Draft People and Culture Plan 2020-2023	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.1 Finance, Risk & Assurance Committee Minutes – for information	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	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 Draft Northern Region Service Plan 2020/21	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that	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

	information was made public.	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 NZ Health Partnerships Statement of Performance Expectations 2020/21	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.3 Abortion Services	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.4 Integrated Primary Mental Health Initiative	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	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]
9.5 Outcome Data -Verbal	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
10.1 Pacific Services Model	**Commercial Activities** Information contained in this report is related to commercial activities	That the public conduct of the whole or the relevant part of the meeting would be likely to result in

	and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time.	the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11 Information Reports - NIL	**N/A**	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
12.1 2020/21 Auckland DHB Statement of Performance Expectations	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

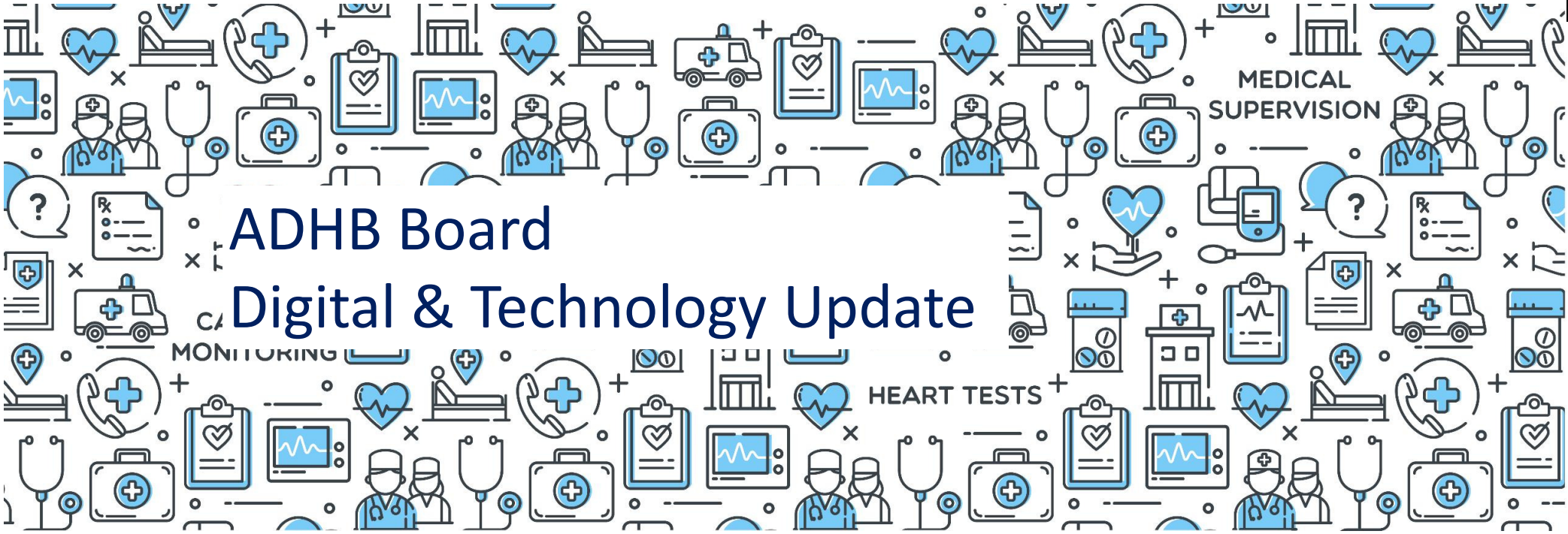
Carried

The meeting closed at 4.15pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 12 August 2020

Chair: _____ Date: _____

Pat Snedden



ADHB Board
Digital & Technology Update

12 August 2020

Shayne Tong – Chief Digital Officer

Executive Summary

1. We have a complex landscape of “traditional” technology capabilities but we are leveraging **new modern digital platforms** to accelerate our digital [systems of engagement] and advanced analytics [systems of intelligence] journey

2. Leveraging these new digital platforms have allowed us to move rapidly to deliver “step change” clincial and operational benefit in **advanced analytics, artificial intelligence, digital automation & workflow and mobility** [e.g. Integrated Operations]

3. These digital platforms also allowed us to be responsive and adaptive to our **COVID-19 and Managed Isolation Quarantine response** and models of care in ADHB, regionally and nationally [e.g. Boarder, CBAC, hospital & mobile testing responses].

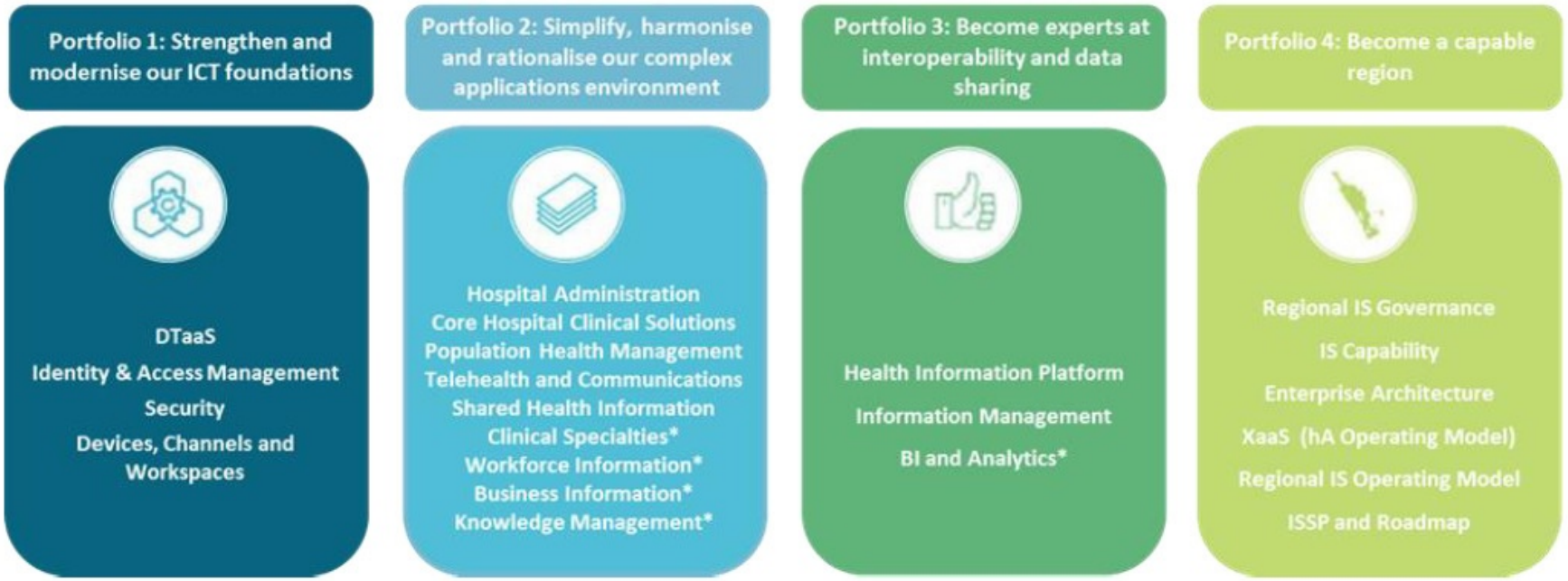
4. We have a **Northern Region DHB 10 year IT strategic plan** that supports our ability to leverage new modern digital platforms while we replace our core hospital systems over the next 10 years that will enable our health services to transform to new models of care [commonly known as two speed IT - digital innovation and transformation]

5. Our highest risk core hospital system [system of record] is our three legacy 20 year old **Patient Administration Systems[PAS]**. We are currently in the process of replacing these legacy PAS systems with a new modern PAS system from Intersystems that supports data and interoperability

Board Update – Key Discussion Points

1. Regional IS Strategic Plan [ISSP]
2. ADHB Digital Strategy
3. ADHB 10 Year Digital Investment Plan [aligned to ISSP]
4. Insights & Intelligence Update
5. Digital Automation & Workflow Update [PaperLite]

Northern Region DHB 10 Year Information Systems Investment Plan [ISSP]



4

Northern Region DHB 10 Year ISSP – Funding Assumptions

The table below shows a summary over the 10 years for the three main funding sources required to enable our northern region health services to transform to new models of care and digital health;

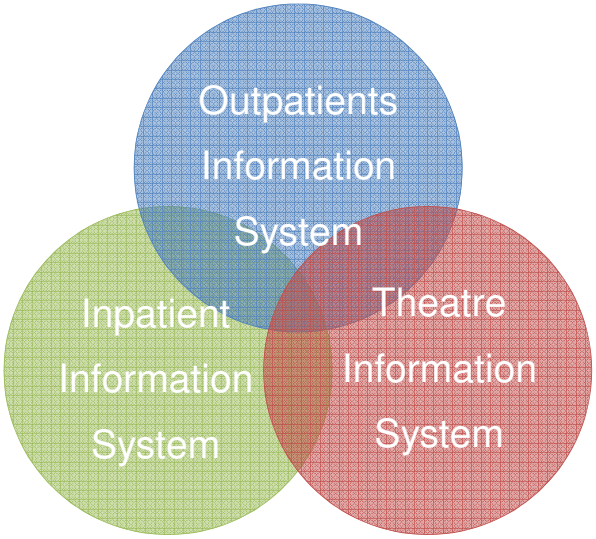
- DHB funding (depreciation)
- Northern region DHB funding (healthAlliance depreciation)
- Government funding [new]

Northern Region: FY19/20 Capital Plan version 2.0

Version 2.0	ACT	1	2	3	4	5	6	7	8	9	10	Total - 10 year	Total - 10 year	Total - 10 year
Amount in $ millions	FY19/20	FY20/21	FY21/22	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	FY 27/28	FY 28/29	FY 29/30	(inc FY19/20) V2.0	(exc FY19/20) V1.0	(exc FY19/20) Variance
Summary:														
1.0 Centrally Funded Capital	36.4	53.2	41.1	44.8	45.1	48.2	49.6	47.7	49.8	50.7	51.6	466.7	450.5	16.2
2.0 Government Funded (CGF) via CIC	0.0	8.0	17.1	2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	27.1	66.1	(39.0)
3.0 DHB Funded														
CMH	*1.5*	*3.8*	*3.8*	*3.8*	*3.8*	*3.8*	*3.8*	*3.8*	*3.8*	*3.8*	*3.8*	*35.6*		
ADHB (inc HARP)	*0.0*	*13.3*	*23.8*	*25.5*	*8.9*	*6.5*	*6.5*	*6.5*	*6.5*	*6.5*	*6.5*	*103.8*		
WDHB	*1.5*	*3.8*	*3.8*	*3.8*	*3.8*	*3.8*	*3.8*	*3.8*	*3.8*	*3.8*	*3.8*	*35.6*		
NDHB	*0.5*	*3.8*	*3.8*	*1.5*	*1.5*	*1.5*	*1.5*	*1.5*	*1.5*	*1.5*	*1.5*	*18.7*		
TOTAL DHB Funded	3.5	24.5	35.2	34.5	18.0	15.6	15.6	15.6	15.6	15.6	15.6	193.6	155.5	38.0
4.0 Others: FPIM Funded by DHB												-	22.0	(22.0)
TOTAL REGIONAL CAPEX	39.9	85.7	93.4	81.4	63.1	63.8	65.2	63.3	65.3	66.2	67.2	687.4	694.2	(6.8)

5

ADHB: Core System Replacement Patient Administration System [PAS]



Current: Auckland DHB 20 Year Old PAS Systems

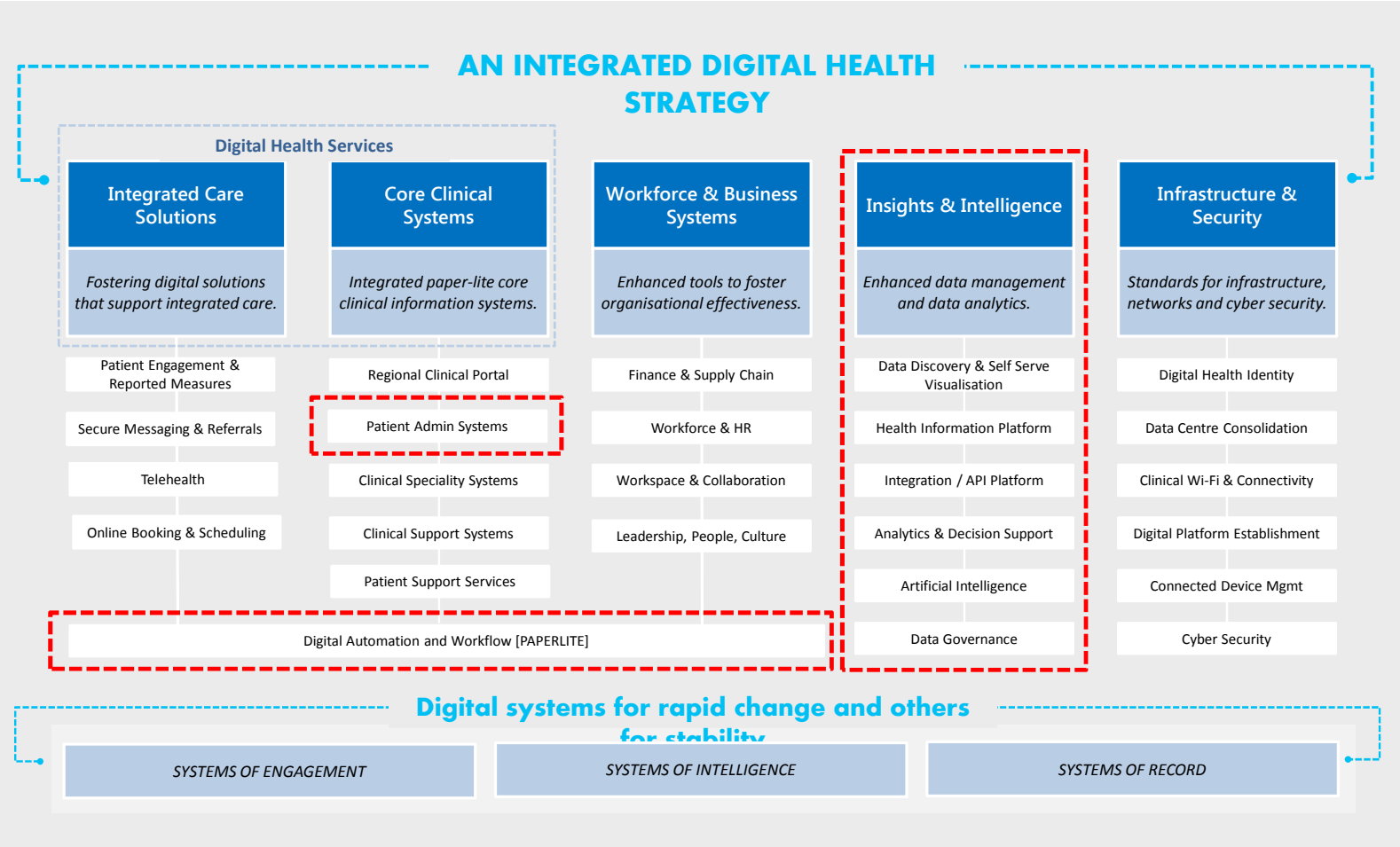
InterSystems

Planned: New modern InterSystems PAS System

6

ADHB Digital Health Strategy

Working draft



Digital Strategy aligned to ADHB Strategy to 2023

Auckland DHB - Strategy to 2023

Opportunities

The health sector is undergoing rapid change

We will stay engaged in COVID-19 response work

Through COVID, we have rapidly developed new ways of working, we've been innovative and have developed new models of care

There are big gains in regional work, in taking a whole system approach and working with our partners

The Wai 2575 Treaty claim, the Health and Disability System review and the general election will generate further changes

To get gains for Māori health, we need our Treaty of Waitangi obligations and Māori health at the forefront and embedded in everything we do

We have the knowledge and expertise and evidence to eliminate inequities in health outcomes

Ongoing changes to our population and migration will put more pressure on our funding

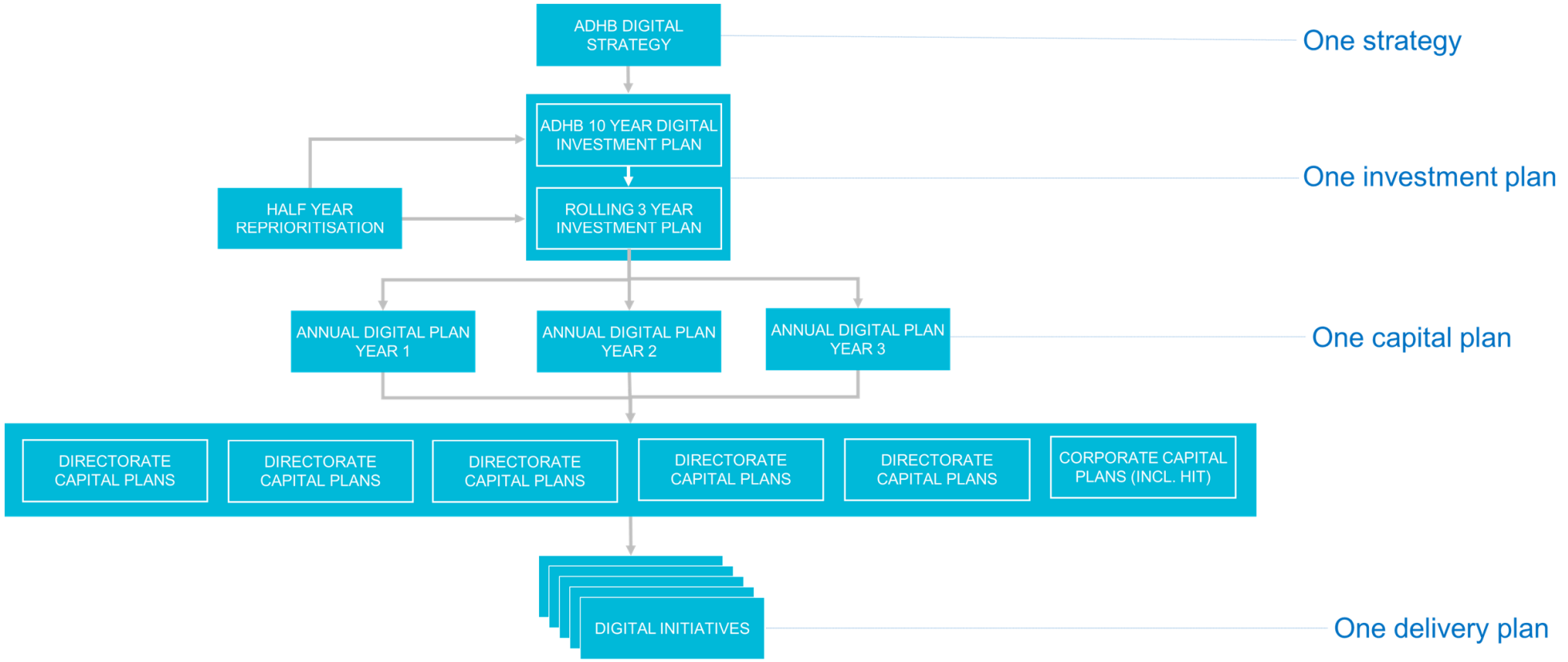
The demand for specialist health care and our equity work will continue to outstrip the funding available

Vision	Healthy communities -- World-class healthcare -- Achieved together Kia kotahi te oranga mo te iti me te rahi o te hāpori				
Purpose	Maximise the health and wellbeing of the 545,640 people who live in our district Commission health and disability services across the whole system from problem prevention to end of life care Provide specialist healthcare services to people who live outside of our district Take a lead role as a training and research facility				
Strategic outcomes	Treaty embedded	Inequity eliminated	Delivering change	Digital leadership enhanced	Resources used to best effect
Focus of activity	Māori health gain front and centre of our work Develop widespread understanding of DHB responsibilities under Te Tiriti o Waitangi Deliver priority initiatives that demonstrate Māori health gain Support Māori led solutions to problems Dismantle institutional racism Become a bicultural organisation Require cultural safety	Embed foundation principles for equity and take action: • protect Māori Indigenous rights • build a common understanding of equity and causes (principles established across ADHB) • Māori-led responses • Pacific-led responses • Strengthening network of primary and community care through the pathway • Allocate resource to get results Commission services that will make the biggest difference	Tackle a tight number of priorities and deliver them Focus on health outcomes rather than outputs Draw from the methodologies that teach us to be fast and flexible e.g. agile, partnerships, digital solutions Manage outcomes by having strong accountability alongside distributed responsibilities Work in ways that enhance the mana of communities, patients and staff Support staff to flex with the many changes and demands required	Build sophisticated use of data, evidence and insight through lived improvements in the priority programmes Improve pathways for patients using digital solutions Create better aligned electronic records Embed telehealth and digital consultations as everyday tools to enhance patient care Implement the Hospital Administration Replacement (HARP) programme on fast track post-Covid	Prioritise projects and deliver them: • planned care (elective surgery) • mental health service development • Public Health • integrated primary and community care • improve hospital efficiency Financial sustainability prioritised review of costing and pricing structures to meet change Work regionally where this creates efficiencies Work with the Ministry to review national pricing

Older version

8

ADHB digital strategic planning and investment plan

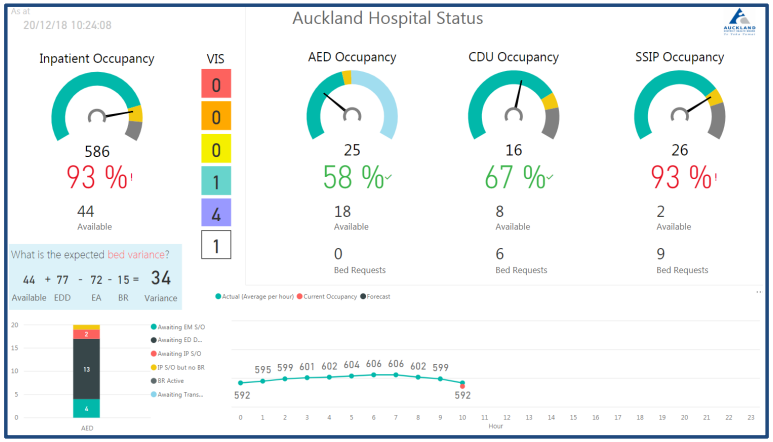


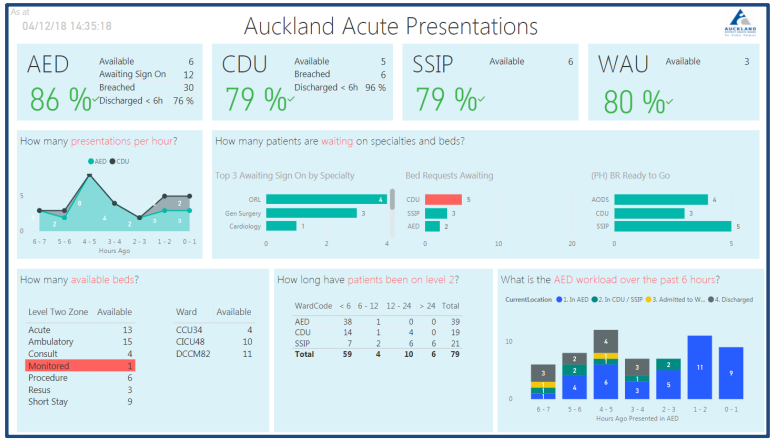
9

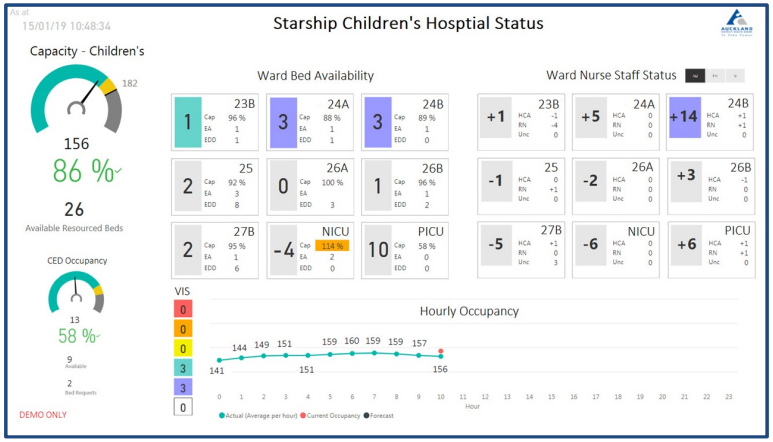
Integrated Operations: Insights & Intelligence

Identifies at a glance what is happening in our local health care system, **provide real-time visibility** and **inform data-led decision making** to improve patient and staff safety and support the key principle of care capacity and demand management (CCDM)

Microsoft Azure





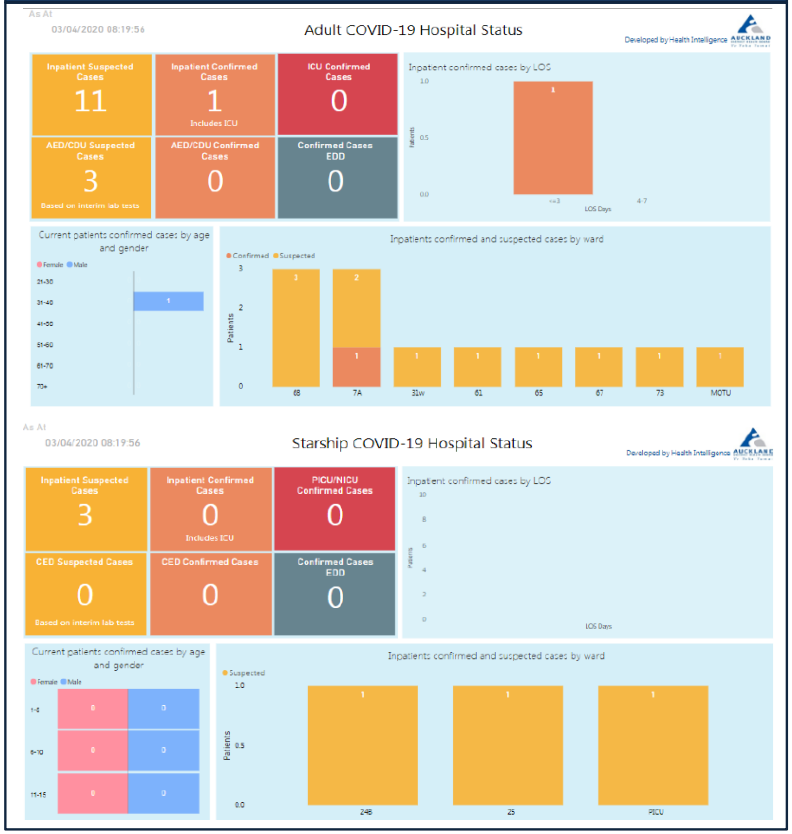


10

COVID-19 Response: Insights & Intelligence

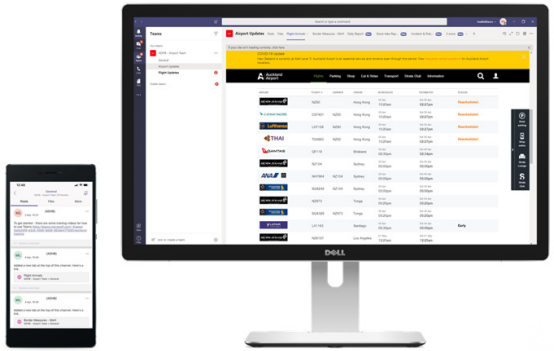
Acute COVID-19 Presentation Dashboard

Adult & Starship COVID-19 Hospital Status

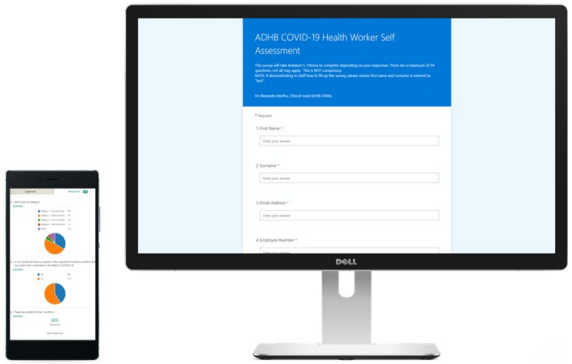


COVID-19 Response: Digital Automation & Workflow

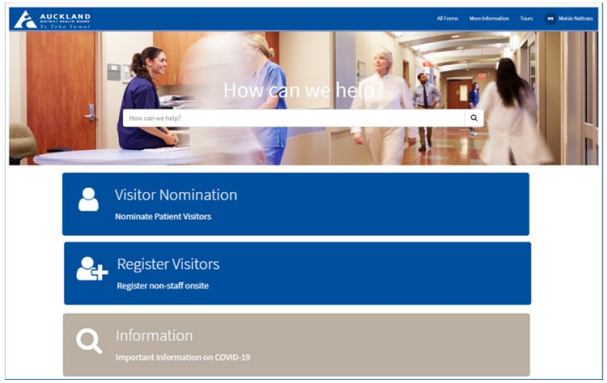
Auckland Airport Boarder COVID Team



ADHB Vulnerable & At Risk Staff Survey



ADHB Hospital Visitor Registration App [Contact Tracing]



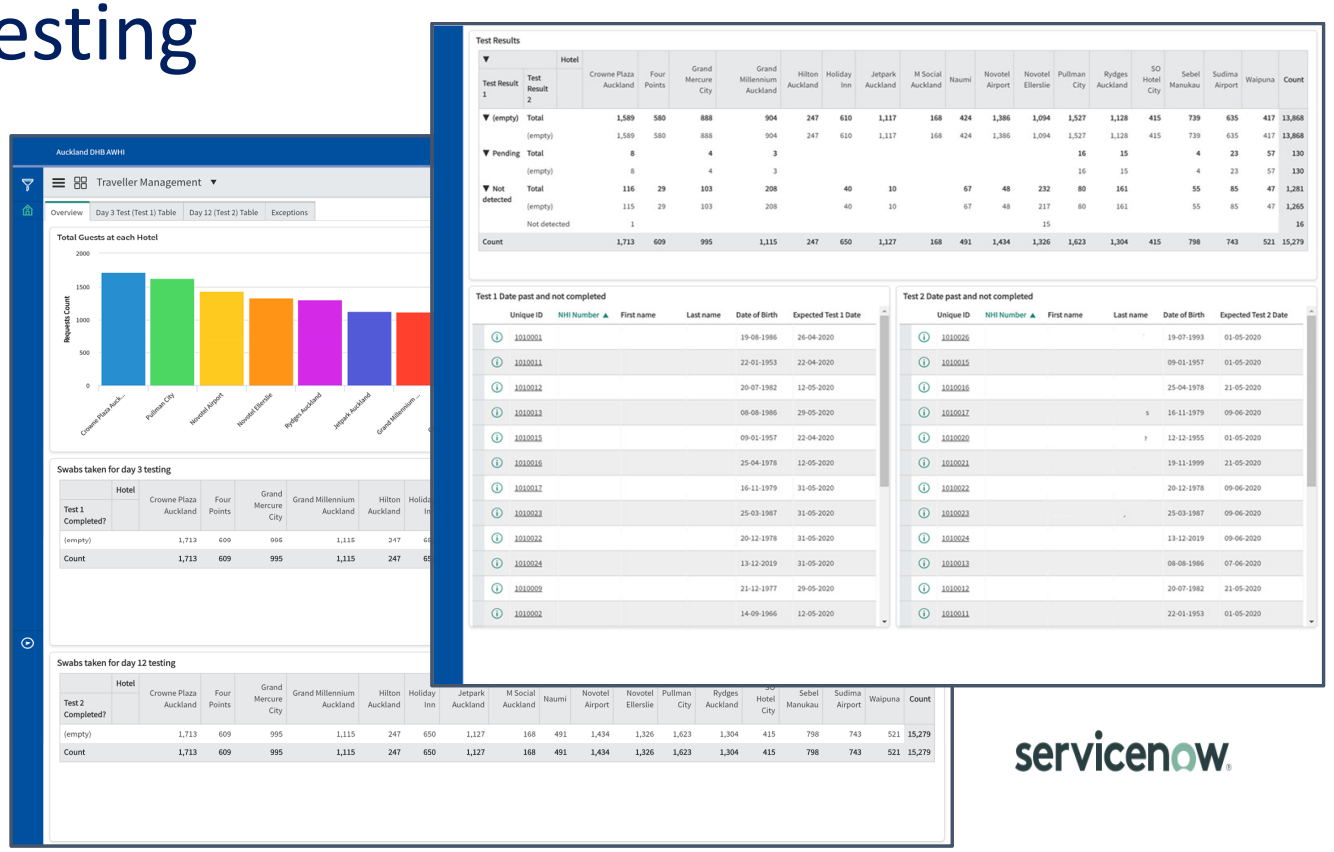
Our digital platforms

Microsoft Azure · aws · servicenow · blueprism

12

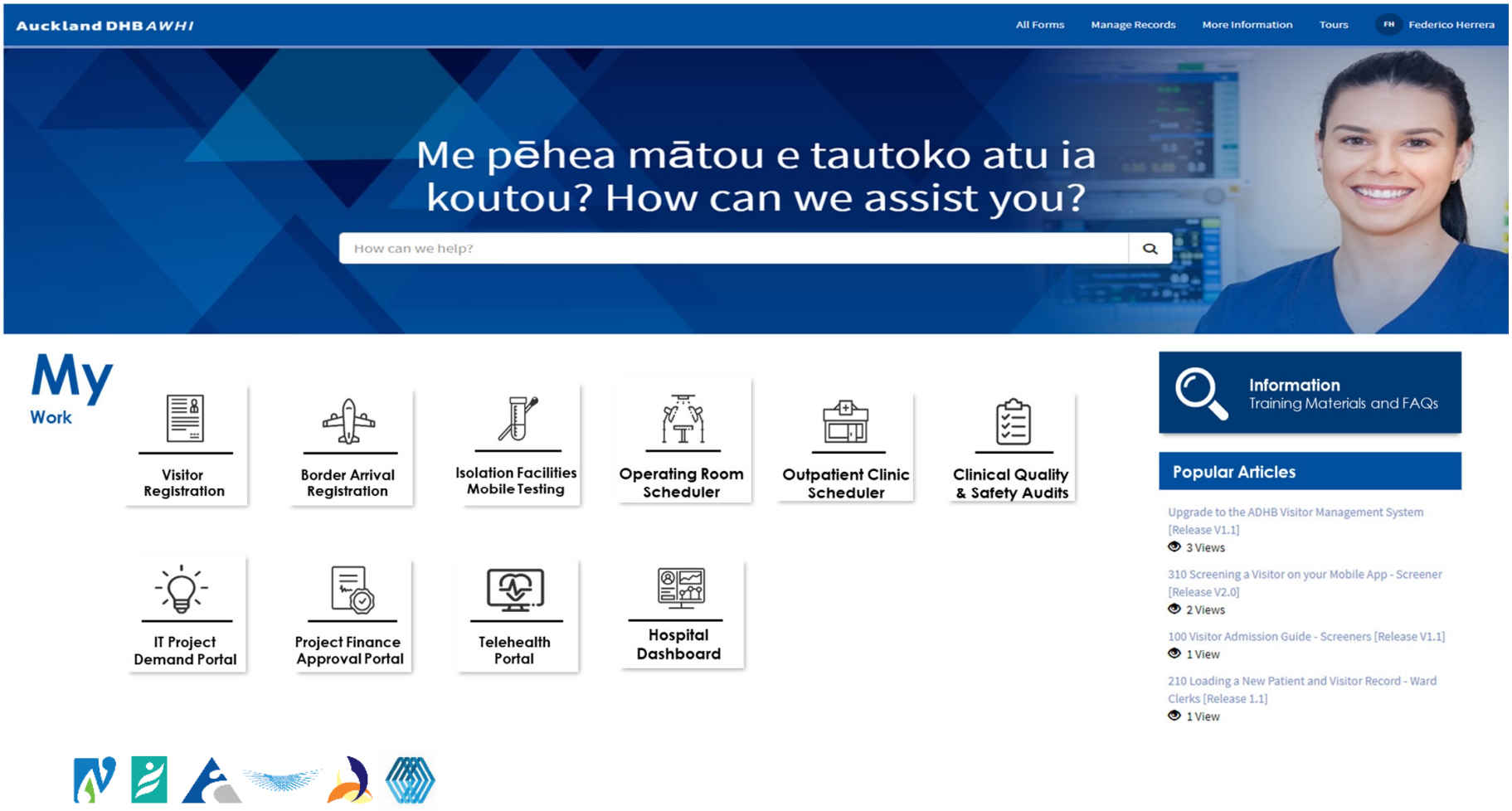
Managed Isolation Quarantine [MIQ] – Mobile Scheduling and Testing

A MIQ testing management solution that digitally manages the **scheduling and testing** of COVID-19 test. The solution acquired data from the **National Contact Tracing System** to determine when tests are required



servicenow

ADHB Digital Automation & Workflow



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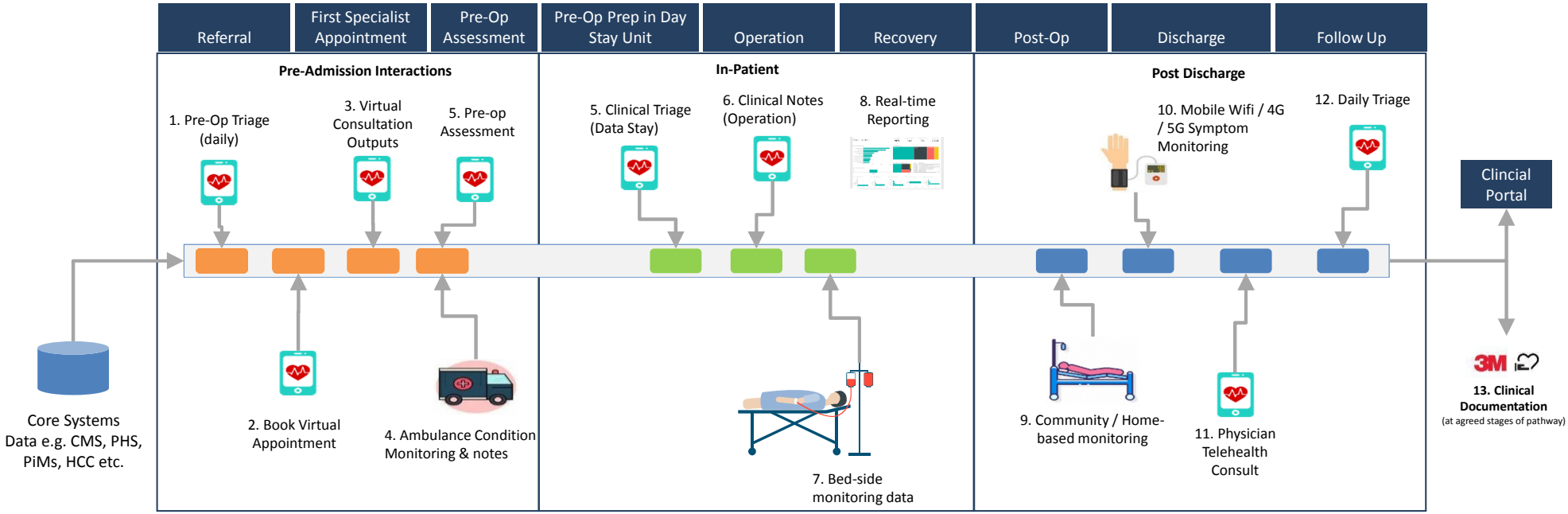
ADHB Digital Automation & Workflow for Clinical Pathways



Action Points from 12 August 2020 Open Board Meeting

5

As at Wednesday, 23 September 2020

Meeting and Item	Detail of Action	Designated to	Action by
	NIL		

Chief Executive's Report

Recommendation

That the Chief Executives report for 21 July 2020 – 31 August 2020 be received.

Prepared by: Ailsa Claire (Chief Executive)

1. Introduction

This report covers the period from 21 July 2020 – 31 August 2020. 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

Shared Goals of Care

Shared Goals of Care is a decision making process shared between the patient and the clinical team. It encourages clinicians to think carefully about a patient's prognosis and likely response to treatment and to determine what treatment options are most important within the context of that person's continuum of care. This could be curative or restorative, symptom-focused, or care at the end of life.

It encourages discussion and decision making while respecting patients' autonomy regarding appropriate treatments of care.

Shared Goals of Care provides the clinical team, and after hours emergency responders, with clarity about appropriate treatment options well in advance of a critical situation arising.

It helps, for example, to identify those who may wish to decline treatments that might otherwise be given by default. It also raises awareness of the importance of discussing with patients, and their whānau, what their real wishes are with regard to medical treatment.

Paul Hooper, Robyn Toomath, Anthony Jordan and Anne O'Callaghan have been instrumental in shaping this and piloting it in General Medicine. We have now extended the use of the Goals of Care form across the adult inpatient services, replacing the historic resusitation status form. We expect to see fewer inappropriate calls to our resus team and to have greater patient and whānau satisfaction with their care and the communication of such.

Auckland DHB top ten carbon reducers of 2020!

Toitū Envirocare recently announced their top carbon reducers of 2020 – and Auckland DHB is proud to say we came second with a reduction of -8,052 tCO^{2e}.

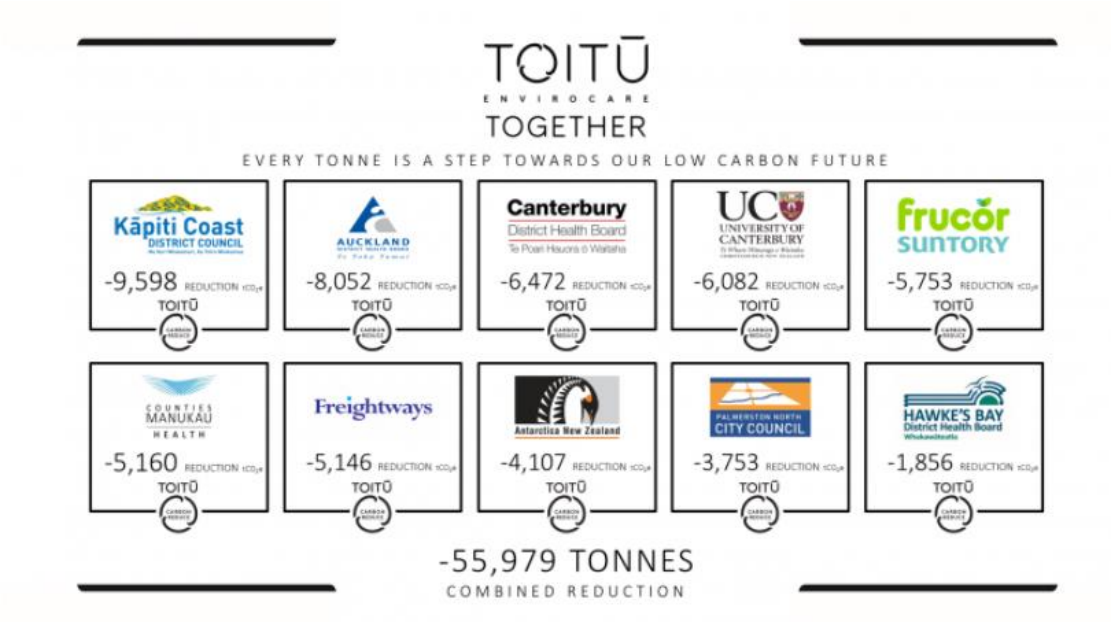
"Auckland District Health Board is proud to be second in Toitū's Top 10 carbon reducers in 2020. We have reduced emissions by 22 per cent over five years. This recognition belongs to our 11,000 Auckland DHB people. I want to acknowledge our Sustainability Manager Manjula Sickler, our network of almost 300 passionate sustainability champions, and our many partners, particularly Ngāti Whātua.

"As a socially responsible organisation, we have been running an active sustainability programme since 2015 at Auckland DHB, which is designed to reduce our impact on the environment, and improve the health and wellbeing of the communities in which we live and work. As part of this, we have committed to a zero-carbon target by 2050.

"Underpinning our sustainability programme is an integrated view of the environment founded on principles of kaitiakitanga and responsible stewardship which align with Te Runanga o Ngāti Whātua.

"We are continually looking at ways in which we can improve and operate as a more sustainable healthcare provider. Current areas of focus include decreasing our electricity and gas usage; applying green building principles to existing and new infrastructure projects; reducing waste that goes to landfill; reducing single use plastics and packaging, and working with key suppliers to drive more repurposing of end-of-life products. "

- Ailsa Claire, Chief Executive Officer.



2. 2 COVID-19 response

The Auckland DHB team quickly stepped up to respond to the latest wave of COVID-19 transmission in the community.

As Auckland moved into alert level 3, visitor and patient screening was quickly put in place. Many staff went back to working from home.

Staff members across the organisation have quickly got used to wearing face coverings in our public spaces, helping to protect colleagues and patients.

Māori and Pacific response

The recent outbreak of COVID-19 (Auckland August Cluster) had a much higher impact on Māori and Pacific communities. The Māori and Pacific response was coordinated at a regional level. Some of the communication activity to connect with our Māori and Pacific Communities include:

- **The Whaanau Guide for COVID-19** – a Facebook livestream that ran for the duration of the first situation was stood-up again for the second outbreak. Platforms for the show include: Northland, Waitematā, Auckland and Counties Manukau DHBs, Māori Television, Māori health providers (Waipareira Trust, Turuki, Papakura Marae, Hāpai Te Hauora, Raukura Hauora o Tainui). The show ends mid-September.

- **Radio (paid) interviews** – Radio Waatea (breakfast show), Iwi radio network, Mai FM, 53i Pacific Radio, Nui FM
- **Social media** – tiles and videos using Māori and Pasifika influencers
- **Language specific** – social and printed media for our Pasifika whānau was language specific
- **Māori Stakeholder Update** – email update to all Māori Stakeholders within the northern region
- **Posters and pamphlets** – in a range of places including supermarkets
- **Networks** – linking into groups distributing food parcels who added printed collateral to the parcels distributed to families.

Deployment of our people

During the recent COVID-19 outbreak, additional Auckland DHB staff, mostly nurses, have been deployed to help with the regional COVID-19 response. This included providing support for contact tracing, testing and the borders. I would like to acknowledge all those who have showed our true value of tūhono by rapidly adapting to new roles.

New digital visitor screening tool

Whilst COVID-19 remains in the community, we are continuing to screen visitors to our sites. This includes those visiting for patient appointments, whānau, support persons and some contractors.

The new digital screening tool provides a code to patient's nominated visitors, and also allows outpatients, support persons and contractors, to pre-register ahead of their visit – speeding up the

screening process when they arrive on site.

Pre-registered visitors are fast tracked through a dedicated 'Pre-registered' screening queue.

Between 12 and 21 August we have used the digital tool to screen 14,264 visitors.

Outpatients are being notified they can pre-register ahead of their visit through patient appointment letters, and inpatients are sent letters asking them to bring details of their nominated visitors.

The tool has also been promoted to our visitors externally across our social channels, website and onsite through posters at our entrances and car parks.

The innovation not only saves time for our visitors, but ensures that information is recorded all at once, as opposed to the original paper forms which required manual recording into our systems after completion.

Social media concept

Our kaimahi Māori have come up with a powerful concept for presenting social distancing messaging through a kaupapa Māori lens.

We are supporting them with developing a short video featuring Auckland DHB kaimahi Māori relating physical distancing to concepts found within haka, ā-ringa, poi, mau rākau as well as popular sports like netball and basketball. The 2-3 minute video will feature 10-15 Auckland DHB performers sharing these concepts and utilising kupu relating to social distancing that have been provided by Te Taura Whiri i te reo Māori.

This is a wonderful opportunity to support our kaimahi Māori and showcase their multitude of talents. We are confident that 'crowd-sourced' content like this will resonate strongly with our network of 11,000+ employees as well as their expansive online networks of whānau and community.

Unwired workforce response

Weekly face to face briefings are being organised for our unwired workers to ensure key messages are making their way to this group. Due to the nature of their roles this group, largely comprising of cleaners, orderlies, security guards and the CSSD team, does not have access to digital channels of communication like email and the intranet. To guide these briefings, the Communications team prepares a one-pager of simple key messages.

Questions are encouraged at the end of each session and responses are woven into the next set of messages.

2. 3 Patients and community

2. 3. 1 Email enquiries

The Communications Team manages a generic communication email box, responding to all emails and connecting people to the correct departments. For this period, 460 emails were received. Of these emails, 51 were not communications-related and where appropriate, were referred to other departments and services at Auckland DHB.

2. 3. 2 Patient experience

Some examples of patient feedback we received this month:

Greenlane Surgical Unit

“The nurse checked very frequently on me whilst I was going in and out of sleep from my general anaesthesia. Even when my eyes where closed she would address me with my name to make sure I was still ok and still waking up. Even when I needed the bathroom, they got me a wheelchair as I was very wobbly on my legs at first but gave me privacy to use the bathroom by myself after asking if I was able to do so. ” – Anon.

Ward 62

“I needed hip replacement surgery. The surgeon was brilliant and explained everything clearly to me. The pre-op medical officer was also really excellent, clarifying the process and

explaining the medical timeline. Walking into the operating theatre was an interesting experience, and all of the OR staff were just fantastic. I have little memory of going from the recovery room to my ward. I was grateful for a single room, as I was concerned how I would cope in a general ward as a transgender person, but I had no difficulties whatsoever. The nursing staff were just wonderful, a fantastic team. The food was fine! And the person taking my orders was just lovely, sparkly person. And thanks to all the other staff who brought me food, cleaned my room and wheeled me about the hospital. ” – Anon.

2. 4 External and internal communications

2. 4. 1 External

Between 21 July and 31 August we received 87 requests for information, interviews or access from media organisations. Requests continued to focus on the COVID-19 response and included enquiries about oncology wait times, IT infrastructure, and a number of enquiries regarding the impact of COVID-19. Around 5 per cent of the enquiries over this period sought the status of patients admitted following incidents such as road traffic accidents.

Auckland DHB responded to 22 Official Information Act requests over this period.

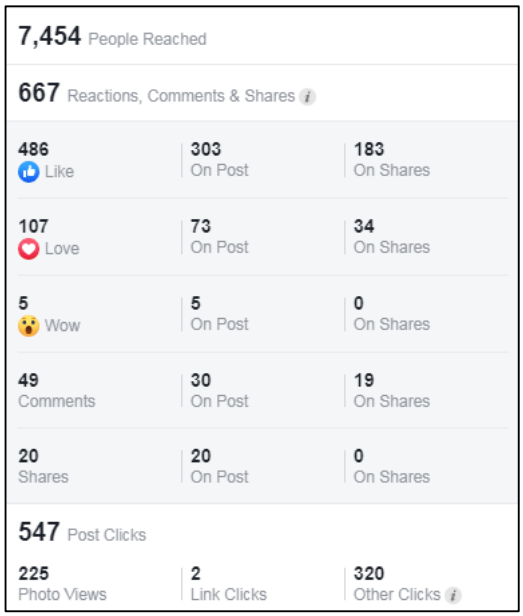
2. 4. 2 Internal

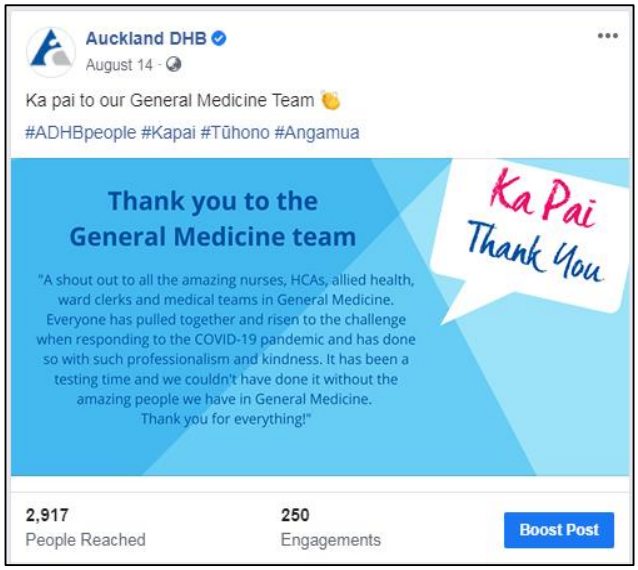
- Six editions of Pitopito Kōrero | Our News, the weekly email newsletter for all employees, were distributed.
- Five editions of the Manager Briefing were published for all people managers.
- Six webinar sessions were held for all employees to provide updates on the organisation and COVID-19 with the opportunity for questions.
- 13 CEO COVID-19 update emails were sent out to all employees.

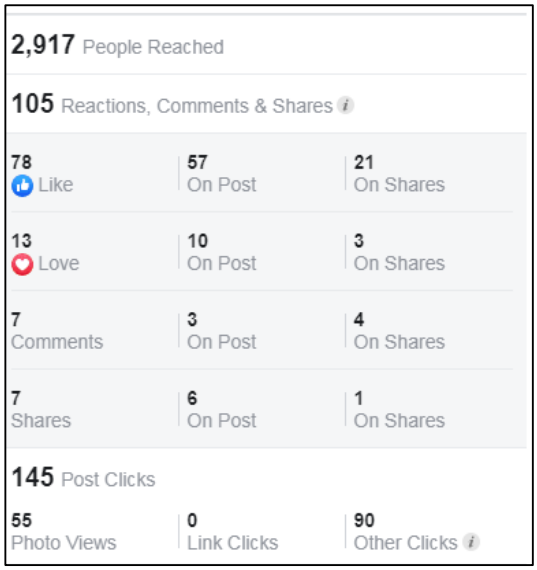
2. 4. 4 Social Media

Top posts and statistics

Facebook







2. 5 Our People

2. 5. 1 Local Heroes

There were 36 people nominated as local heroes in June and July. Congratulations to our June and July Local Heroes. Here are their nominations:

June – Kirk Freeman

Intensive Care Specialist, DCCM

"Kirk took on the role of the clinical lead for the PPE taskforce for the DHB's COVID-19 response. He put a huge amount of effort into researching, sourcing and supplying PPE for staff. Kirk was available to staff and was always polite and pleasant despite the frustrations. He visited the most high-risk areas many times to get an understanding of how they worked, and to supply items they were missing. This work is far outside of the scope of his normal role. "

July - Duncan Bliss

Interim Associate Director, General Surgery

"Duncan's level of communication to the service was outstanding; he included everyone, was clear in his approach and delivery of information and had a calming influence whilst keeping morale up with his positive friendly nature. He is a fantastic leader and this was certainly demonstrated again during COVID-19. I am sure it was especially challenging given the Directorate leadership also changed at this time, yet Duncan never portrayed any difficulty, he led us all with his usual assurance and calm decision making. He is held in very high esteem across the Directorate and this was reinforced during the COVID-19 period. "

July – Leva Hehepoto

Pacific Island Community Health Worker, Starship Community

"Leva is a very important member of our Starship Community team. She has worked at within child health at Auckland DHB for 14 years and the work she does within our community with children and whānau is invaluable. She is a proud Tongan woman who has provided cultural support and advocacy to many families as well as staff. She is a very humble person and her way of engaging with families should be recognised. Her commitment to some very vulnerable families has been really valued by her clients and her contribution to our Starship Community clients is making our local communities a better place. "

2. 5. 2 Ka Pai – Shout Outs

Our team are always aiming high – especially so as we responded to COVID-19. We've created an interactive space on Hippo for staff to say a quick ka pai to a team or colleague for a job well done.

Some of the recent Shout Outs:

Hineroa Hakiaha and Pauline Fakalata

"For sharing their wisdom and how they and their teams are supporting their whānau/aiga and each other to keep well spiritually, to offer comfort, to connect and appreciate in the CE Webinar. You were both an inspiration. Thank you. "

All the amazing Cleaners

"All the cleaners who frequent our department are so hard working and they never make a fuss! It's a tricky time for all of us, but our amazing cleaners do such amazing work whilst still smiling! Thank you very much from everyone in CED. "

2. 5. 3 Celebrating our people

Research into Inequity after first myocardial infarction in Māori and Pacific patients

Dr Corina Grey, Pacific Health Data and Insights lead at Auckland DHB, is co-author of a recently published study on the reasons for differences in survival in people from different ethnic groups experiencing their first heart attack in New Zealand.

Research found that mortality in the first year was nearly three times higher for Pacific and Māori people than European people of similar age and sex.

At least half of these worse outcomes for Māori, and three-quarters for Pacific people, were found to be related to differences in potentially preventable or modifiable clinical factors present at, or prior to, the heart attack.

Global research on Corticosteroid drugs as a treatment for critically ill patients with COVID-19

Auckland City Hospital Intensivist Dr Colin McArthur has worked with a global team of collaborators to confirm corticosteroid drugs as beneficial for the treatment of patients critically ill with Covid-19.

The research into critically ill patients with COVID-19 shows fewer people died and less intensive care support was required when patients received corticosteroids.

Ka pai Dr McArthur and team for truly displaying our Auckland DHB value of Angamua.

New Zealand Hi-Tech Awards 2020

Auckland City Hospital Specialist Anaesthetist Dr Doug Campbell is part of the team recognised in the Best Hi-Tech Solution for the Public Good category at the New Zealand Hi-Tech Awards 2020, for, nzRISK.

nzRISK is an electronic tool designed to provide accurate risk assessments for patients undergoing surgery in New Zealand.

nzRISK will provide improved risk information to New Zealand patients and improve the care of surgical patients.

2. 5. 4 Senior Leadership changes

Haere mai to our new Service and Programme Manager for the Clinical Quality and Safety Service

Congratulations to Katie Quinney who has been seconded to the role of Service and Programme Manager for the Clinical Quality and Safety Service. As a result of the secondment, she will be stepping down from her role as the Nurse Director for Surgical Services for the duration of the secondment.

Katie has significant nursing experience and leadership having previously worked as a Service Manager and Nurse Consultant in the Surgical Directorate.

Katie has always had a passion for high quality patient-centred healthcare and for the wellbeing of her colleagues. In recent times she has managed to highlight her passions, standing strong whilst leading the talented nursing teams in the Directorate. She has also recently provided invaluable support for the Border Team and has made significant contributions to establish the Kaiārahi Nāhi Hautū and Pacific Planned Care Navigation teams.

Farewell to Rosalie Percival, Chief Financial Officer

We were very sad to say goodbye to Rosalie Percival, Chief Financial Officer whose last day was on 20 August.

Rosalie has moved to Wellington to take on the role as CFO for Capital and Coast and Hutt DHBs.

During her 8 years at Auckland DHB has made a significant contribution. She not only was skilled but also carried a large workload including Facilities, Commercial, Legal and EPMO. Regionally she led on Capital Finance, FPIM and was on the Boards of hA NZ (chairing the Audit Committee) and HealthSource.

Welcome to Justine White, Chief Financial Officer

We look forward to welcoming Justine White as our new CFO on 14 September. Justine joins us from Canterbury DHB where she was Executive Director of Finance and Corporate Services. Justine is widely respected across the sector and we consider ourselves very fortunate to be able to attract her to join us. She has significant experience in leading finance and corporate services functions in the health sector, through times of challenge and change.

Justine will retain her role as the National Chair of the CFO group across the 20 DHBs.

3. Performance of the Wider Health System

3. 1 Priority Health Outcomes Summary

	Status	Comment
Acute patient flow (ED 6 hr)		Aug 91%, Target 95%
Improved access to elective surgery (YTD)		91% to plan for the year, Target 100%
Faster cancer treatment		Aug 99%, Target 90%
Better help for smokers to quit: • Hospital patients • PHO enrolled patients • Pregnant women registered with DHB-employed midwife or lead maternity	  	Aug 96%, Target 95% Jun Qtr 87%,Target 90% Jun Qtr 95%,Target 90%
Raising healthy kids		August 100%, Target 95%
Increased immunisation 8 months		Jun Qtr 94%, Target 95%

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

4. Financial Performance

The 2020/21 approved budget is a deficit of $45M. The annual plan has not yet been approved by the Ministry. Financial performance against this plan for the first two months of the year ending 31 August 2020 is a deficit of $15.8M against a budgeted deficit of $2.9M, thus unfavourable by $12.9M. This unfavourable variance is entirely attributed to net Covid impacts and includes a provision for IDFs and Planned Care revenue adverse wash-ups of $7M as volume delivery was impacted by Covid. The consolidated Business as Usual (BAU) operations' result (excluding Covid impacts) is favourable to budget for the year to date by $107K.

At a divisional level, the Provider Arm result ($11.5M unfavourable to budget) and Funder Arm result ($266K) are unfavourable to budget entirely due to Covid impacts and the Governance and Admin Arm result is similar to budget.

Occupational Health and Safety Performance Report

Recommendation

That the Board receives the Occupational Health and Safety Performance Report for September 2020.

Prepared by: Alistair Forde (Director Occupational Health and Safety)
Endorsed by: Mark Edwards (Chief Quality, Safety, and Risk Officer)

Glossary

TRIFR	Total recordable Frequency Rate (# of Lost Time (LTI), Medical Treatment (MTI) and Restricted Work (RWI) Injuries x 1000000/total personnel hours)
LTIFR	Lost Time Injury Frequency Rate (# of Lost Time Injuries x 1000000/total personnel hours)
AIFR	All Injury Frequency Rate (# of All LTI, MTI, RWI & First Aid Injuries x 1000000/total personnel hours)
BBFA	Blood and/or Body Fluid Accident
EY	Ernst and Young Limited
HSR	Health and Safety Representative
HSWA	Health and Safety at Work Act (2015)
LTI	Lost Time Injury (work injury claim)
MFO	Medical Fees Only (work injury claim)
MOS	Management Operating System
PCBU	Person Conducting a Business or Undertaking
PES	Pre-employment Health Screening
SMS	Safety Management System
SPEC	Safe Practice Effective Communication (SPEC)
SPIC	Safe Practice in the Community
YTD	Year to date
A/A	As Above

Board Strategic Alignment

Community, whanau and patient-centred model of care	*Supports Patient Safety, workplace safety, visitor safety, worker health and wellbeing.*
Emphasis and investment on both treatment and keeping people healthy	*This report comments on organisational health information via incidents, worker safety, health monitoring and leave information.*
Service integration and consolidation	*This report details mandatory workplace safety audit results and reports findings and updates to the Finance Risk and Assurance Committee.*
Intelligence and insight	*The report provides information and insight into workplace incidents and what Auckland DHB is doing to respond to these and other workplace risks.*
Consistent evidence-informed decision-making practice	*Demonstrates Integrity associated with meeting ethical and legal obligations.*
Outward focus and flexible, service orientation	*Health, safety and wellbeing risks and programmes are inherently focused on staff, patients, visitors, students and contractors. All strategic and operational work programmes and policy decisions are discussed with relevant services such as site visits and approaches to reduce risks.*
Emphasis on operational and financial sustainability	*Addresses Risk minimisation strategies adopted.*

1. Performance Summary

Lead Indicators

Description	Current Month Actual	Previous Month	3mth Trend	6mth Trend
Leadership Observations	303	156	↑	↑
Leadership Discussions (H&S Rep Meetings, Regional H&S Technical Advisory Group (TAG) ACC/Safe 365	102	196	↓	↑
Training (Inductions/PPE/Patient Handling)	315	125	↑	↑
Audits/Inspections	85	79	↓	↑
N95 Mask Fit Testing	Total 1,467	-	-	-
Vulnerable Staff Self Assessments	Total 188	-	-	-

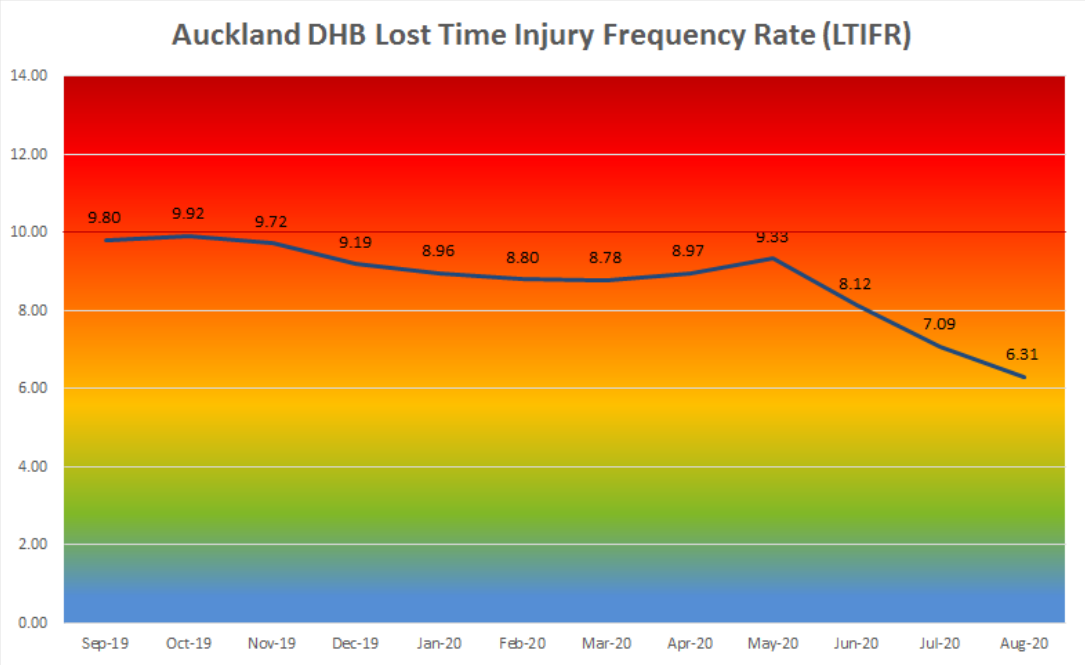
a. In August 2020, we had more than 405 leadership activities across Auckland DHB. Training activities increased despite the resurgence of COVID-19.
b. We have put in place risk mitigation for individual risk assessments of staff who may have additional vulnerability to COVID exposure.
c. A total of 1,974 valid employee self-assessment forms received since 26 March were transferred securely from SharePoint to MedTech32.

d. To date, 34% of staff who sought a COVID risk category during the April 2020 lockdown now have an updated Occupational Health record.
e. The OH&S Advisory Team observed 68 workplaces and made 303 observations. The highest number of significant at-risk observations were around control of key risks and a combination of training, experience and knowledge.
f. The number of Leadership Discussions has decreased from last month. A number of meetings and events were cancelled due to the resurgence of COVID-19.
g. We introduced a monthly directorate reporting template to facilitate collection of key data. We anticipate this to be in use starting in September.

Lag Indicators

Description	Target	Actual	Prev Month	3mth Trend	6mth Trend	12mth Trend
Total Recordable Injury Frequency Rate (TRIFR) (per 1,000,000 hrs)	–	**21.61**	**21.62**	**28.19**	**25.20**	**28.40**
LTI Frequency Rate (LTIFR) (per 1,000,000 hrs)	10.00	**6.31**	**7.09**	**8.12**	**8.80**	**9.80**
All Injury Frequency Rate (AIFR) (per 1,000,000 hrs)	–	**109.00**	**113.62**	**119.60**	**112.70**	**78.41**

a. There were 29 recordable injury ACC claims for August which were mostly ergonomic injuries from general manual handling or patient manual handling, with some BBFA or adverse reactions to Personal Protective Equipment (PPE) and several workplace violence injuries.
b. TRIFR, LTIFR and AIFR last month are lower than they were in the last two months. While this is a good occurrence, we believe this is mainly due to the COVID restrictions in place.



The main type of injury reported relates to manual patient handling.

We have drafted several procedures to address injury prevention and management. These will go through several months of review and implementation before we should see a reduction in injuries. We have also started discussing with each of our Directorate Directors about validating key actions to minimise serious incidents involving Workplace Violence.

2. Risk Analysis

The three key risks with a residual risk rating of High are as follows:

- Contractor Management
- Work Place Violence and Aggression
- Biological Hazards

Safe 365's First Year Assessment of our contractor supply chain, undertaken as part of a 3 DHB project funded by ACC has indicated that overall health and safety maturity within that supply chain is low in a number of key areas. This will be consistent with ACC's expectation and purpose in funding this initiative.

The Executive summary notes that Contractors/Suppliers to the three DHBs had an average maturity rating of 62% which was consistent with the NZ industry-wide benchmark. There was, however, a higher than normal positive bias where some over-rated their maturity which inflated the overall maturity. This may relate to the increased emphasis on Health and Safety compliance by DHBs within procurement.

It is positive that a significant majority of suppliers to the DHBs are open to coordinating and collaborating with the DHBs regarding health and safety matters.

The report also notes that between the DHBs there was inconsistency in respect of identification of overlapping PCBU responsibilities. This is not unexpected, neither is inconsistency in the translation of Health and Safety compliance into supplier procurement and on-going supplier/contractor management processes. While HealthSource has recently introduced Health and Safety compliance as a factor in procurement via standard questions in RFPs, this will not necessarily be occurring nationally.

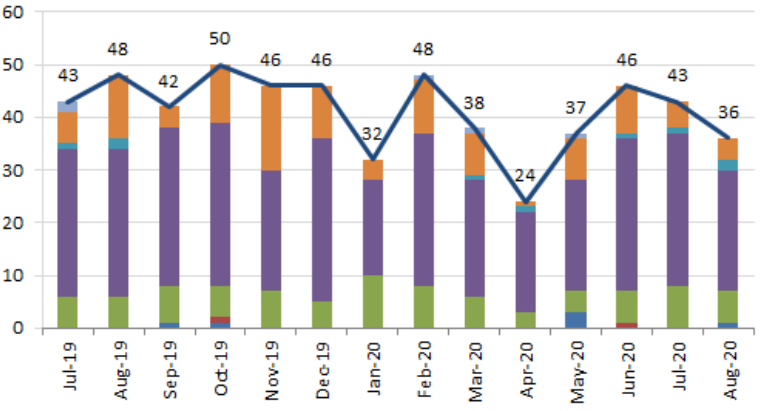
We have increased the Contractor Management risk to High in response to this information.

Following on from the Deep Dive on the Lone Worker and Workplace Violence and Aggression Reviews, the resurgence of COVID-19 in the community has necessitated a shift in focus and review back to Biological Hazards.

We have observed that a majority of the risk controls to manage the spread of COVID-19 are being consistently applied with on-going daily reminders and updates from the Occupational Health and Safety team.

Please refer to Appendix 2 for more information.

Blood and Body Fluids Incidents



	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
Unknown	2	0	0	0	0	0	0	1	1	0	1	0	0	0
Splash	6	12	4	11	16	10	4	10	8	1	8	9	5	4
Scratch	1	2	0	0	0	0	0	0	1	1	0	1	1	2
Puncture by needle	28	28	30	31	23	31	18	29	22	19	21	29	29	23
Laceration by scalpel or other sharp instrument	6	6	7	6	7	5	10	8	6	3	4	6	8	6
Laceration by bone spicule	0	0	0	1	0	0	0	0	0	0	0	1	0	0
Bites	0	0	1	1	0	0	0	0	0	0	3	0	0	1
Total BBFA's	43	48	42	50	46	46	32	48	38	24	37	46	43	36

BBFA's have increased in June back to a level which is consistent with previous months. Assessment has led to a finding that there is a number of inconsistent applications of controls in place across Auckland DHB and that these are not effective in reducing the types of injuries observed.

We have engaged a supplier to provide a needleless technology solution to be trialled throughout the hospital.

Vulnerable Workers and COVID-19

We have put risk mitigation in place for individual workers who may have additional vulnerability to Covid exposure. Workers are provided with a plan that can be implemented through future Covid prevalence changes. Reassessment is required as clinical situations change.

A total of 1,974 valid employee self-assessment forms received since 26 March were transferred securely from SharePoint into the Occupational Health Medtech (PIMS) on 24 July. Over 2,000 telehealth consultations have been performed by Occupational Health on vulnerable workers. Interdisciplinary consultation has occurred with over 12 specialties. Worker health conditions and their COVID risk category are being coded into their individual records.

Through the self-assessment forms we have heard staff express anxiety and distress. By phone we have assessed staff further and referred to appropriate care where necessary. We have advised staff with poorly controlled long-term health conditions of the steps to take for better health outcomes.

Since 12 August, an additional 188 workers have sought a COVID risk category and have been advised by phone and email. Their Occupational Health record is being updated during the risk assessment.

To date there are 266 Category 3 and 27 Category 4 vulnerable workers who need protecting. Managers and HR have been assisted with guidance on specific duties that these workers can and cannot do. As COVID-19 is an example of the risk posed to workers by respiratory droplet infectious diseases, and Category 3 and 4 health conditions are expected to progress, worker health status reviews have been scheduled with view to longer term career planning.

Covid Response –N95 Respiratory Mask testing

The respiratory protection equipment (RPE) deemed necessary to keep a worker safe in their job requires that the worker is provided with a respiratory mask that is appropriate for the purpose and is the correct size and fit. They must also be provided with adequate training and instruction in the use of the RPE. The recognized transmission of COVID 19 between people through close contact and droplets has required a programme of work to provide a large number of staff working in at risk areas with an appropriate N95 mask. This work has been complicated by the interruption to supply chains for two of the most commonly used N95 masks.

A large number of workers have been assessed and fitted into appropriate masks. This has been achieved using Occupational Health Nurse resource, an in-team trainer model and an external provider. A high throughput model staffed by Occupational Health Nurses and in-team trainers will be utilised to assess the remaining workers by the end of September. This model will also accommodate those workers who need to be reassessed and fitted into a newly sourced type of N95 masks due to supply chain interruption.

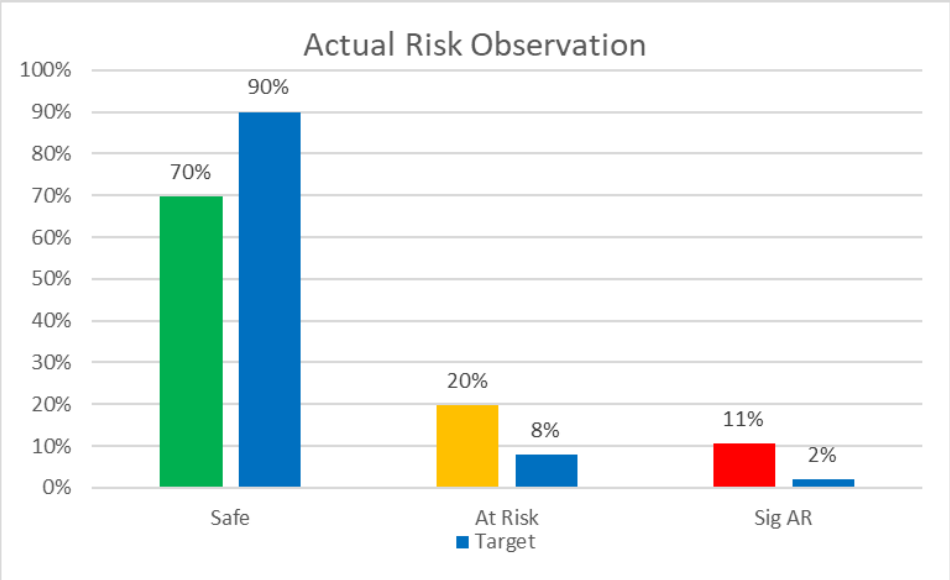
Covid Response – Contact Tracing

Contact tracing Auckland DHB workers when necessary is undertaken by a small team and the ability to rapidly contact trace within the DHB, particularly with a large-scale contact trace remains a key risk that the Board needs to be mindful of. We are working on development of a surge model approach to enable a workforce to be assembled when needed. Occupational Health and Safety completed over 30 assessments of risk to determine whether a contact trace was required in August. 5 formal contact traces were initiated in August involving CDU (Emergency Department), Marino Ward (Older Persons Health), FMU (Psychogeriatrics) and Ward 68 (Respiratory).

Several PPE breaches have resulted in staff requiring Occupational Health managed self-isolation, daily symptom checks and swabs – and follow up from Health and Safety to ensure proper processes were being trained and followed.

Through clear messaging on not coming to work while sick, clear clinical protocols that consider the hierarchy of controls, active management of vulnerable staff, and early and thorough contact tracing, risks to Auckland DHB staff have been minimised. To date, no Auckland DHB staff member has contracted COVID from work tasks.

3. Observations



We completed 68 site visits from which resulted in 303 observations. 211 were assessed as Safe, 60 as At Risk, and 32 as Significant At-Risk. The Significant At-Risk observations included:

- Inconsistent implementation of COVID-19 controls in non-clinical areas;
- Inadequate controls around hazardous substances; and,
- General understanding of applying the correct manual handling techniques

All above observations were communicated to workplace managers to rectify.

4. Information Technology

Initial research has begun to understand the cost of upgrading Medtech 32 to the latest cloud-based version called Medtech Evolution. This will help to inform our decision on replacement versus upgrade and also help to mitigate the risk of the upcoming healthAlliance Windows 10 programme as Medtech 32 is not Windows 10 compliant.

5. DHB/ACC 'Making Health Safer' Supply Chain Project Update

As noted above we received the ACC-funded Safe 365 first year assessment of our contractor supply chain which has indicated that overall health and safety maturity within that supply chain is low in a number of key areas across the 3 DHBs that are participating in the project. This will be consistent with ACC's expectation and purpose in funding this initiative. The implications of the ACC/Safe365 report have been shared across the DHB CEOs nationally and a consistent national approach to improve the issues identified is being formulated. The intent is to continue to work with ACC. Key recommendations from year one are:

1. Refine and implement the proposed DHB contractor management framework which has been drafted from the key learnings in year 1 of this project.

2. Implement the stakeholder management framework developed from key learnings in year 1 of this project to improve stakeholder awareness and criticality of effective overlapping PCBU practices.

3. Undertake a large sample of third-party assessment calibration to understand the extent of positive bias more accurately across the supplier cohort.

4. Undertake deeper research to further understand supplier apathy and positive bias with regard to participating in overlapping PCBU practices with DHB clients with a view to informing interventions that can overcome challenges in this aspect of DHB / supplier relationships.

5. Continue to educate the participating suppliers on the project learnings and support a focus and messaging shift to continual improvement activities in their business, monitored by on-going visibility of Safe365 maturity assessments. Continual improvement data can be mapped against ACC claims data to further understand the relationship between understanding and improving safety maturity and what impact this approach has on harm profiles and claims data.

6. Auckland DHB Health and Safety Governance Committee

The Auckland DHB Health and Safety Committee meet six-weekly. No meeting occurred in August due to the COVID-19 resurgence. Our next meeting is on 11 September 2020.

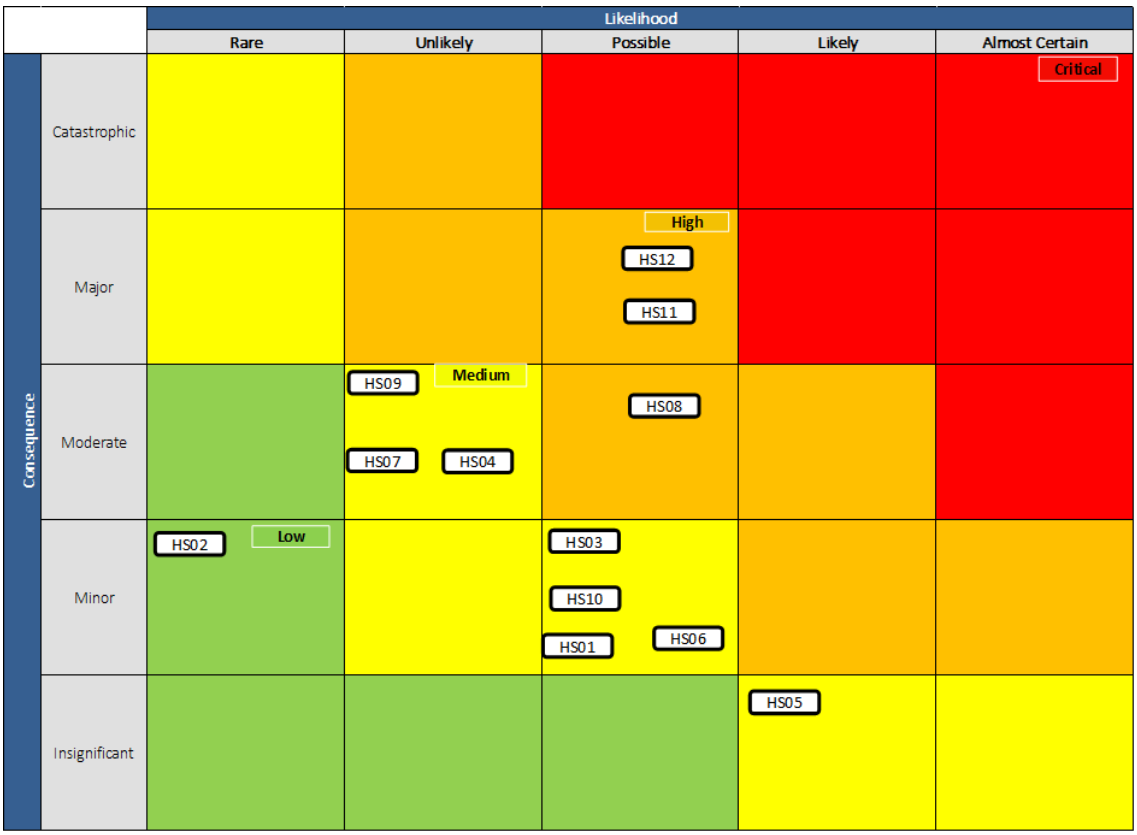
Appendix 1

% Pre-employment screening before start date	TBC
Training	
# local H&S Induction completed (one-month lag)	44
# H&S e-learning completed (excl RMOs & HOS, one-month lag	70
# H&S Representatives Trained	11
# MAPA training completed in high risk WV areas	0
# Contractor inductions completed by Facilities & Development	174
Audits	
# of contractor audits completed	85
% compliance contractor audits	0
# of hazardous substance audits conducted	0
% hazardous substance audits compliant	0

Appendix 2

Health and Safety Risks

The following Heat Map of the key risks identified within Auckland DHB from an Occupational Health and Safety perspective.



Key:

HS01 – Asbestos risk
HS02 – Confined spaces
HS03 – Manual handling
HS04 – Remote and isolated work (lone worker)
HS05 – Vehicles and driving
HS06 – Working at height
HS07 – Hot works
HS08 – Contractor management
HS09 – Fatigue management
HS10 – Hazardous Substances
HS11 – Workplace violence and aggression
HS12 – Biological hazards

Financial Performance Report for the period ending 31 August 2020

Recommendation

That the Board Receives the Financial Report for the two months ending 31 August 2020

Prepared by: Auxilia Nyangoni, Deputy Chief Financial Officer
Endorsed by: Justine White, Chief Financial Officer
Ailsa Claire, Chief Executive Officer
Date: 16 September 2020

1. Executive Summary

The 2019/20 year end audit has progressed well to date and is almost complete. The Draft Financial Statements to be included in the 2019/20 Annual Report were presented to the Finance Risk and Assurance Committee on 2 September 2020. Year end audit processes are still continuing and the audited annual report will be presented to the Board for approval by December 2020. Parliament passed legislation on 5 August 2020 to extend the statutory reporting timeframes by up to 2 months for organisations with 30 June 2020 balance dates that report under Crown Entities Act 2004, Crown Research Institutes Act 1992, Local Government Act 2002, Public Finance Act 1989 and State-Owned Enterprises Act 1986. For DHBs, the extension is up to December 2020 (usually 31 October 2020).

The 2020/21 Annual Plan Financial Budget was approved by the Board in August with a deficit of $45M. The Annual Plan has not yet been approved by the Ministry. Financial performance in this report is based on the approved budget.

For the year to date period ending 31 August 2020, the DHB realised a deficit of $15.8M, which was $12.9M unfavourable to the budgeted deficit of $2.9M. The result by division and showing the Covid impacts is as follows:

Result by Division	**For the two months ending 31 Aug 2020**		
	Actual	**Budget**	**Variance**
Funder	2,671	3,150	479 U
Provider	(18,726)	(6,050)	12,678 U
Governance	262	(5)	268 F
Net Surplus / (Deficit)	**(15,793)**	**(2,905)**	**12,888 U**
COVID-19 Net impact on bottom-line	(12,490)	505	**12,995 U**
BAU Net impact on bottom-line	(3,303)	(3,410)	**107 F**

The $12.9M unfavourable variance, mainly in the Provider Arm and also to a lesser extent the Funder Arm, is entirely due to Covid impacts, as the underlying Business as Usual (BAU) operations' result was overall favourable to budget by $107K as shown above.

Covid impacts include a provision for adverse IDF and Planned Care revenue wash-ups of $7M reflecting significantly reduced volumes during the level 3 Covid lockdown period. The balance of the variance is due to net unfunded Covid costs.

2. Summary Result and Financial Commentary for August 2020

$000s	Month (Aug-2020)			For the two months ending 31 Aug 2020		
	Actual	Budget	Variance	Actual	Budget	Variance
Income						
Government and Crown Agency	145,470	145,435	36 F	294,538	291,269	3,269 F
Non-Government and Crown Agency	8,745	8,543	202 F	16,995	17,293	299 U
Inter- District Flows	56,098	60,598	4,500 U	116,696	121,196	4,500 U
Inter-Provider and Internal Revenue	1,426	1,295	131 F	2,897	2,590	307 F
Total Income	**211,740**	**215,871**	**4,131 U**	**431,126**	**432,349**	**1,223 U**
Expenditure						
Personnel	100,617	95,567	5,050 U	197,850	192,075	5,776 U
Outsourced Personnel	2,551	1,600	950 U	4,805	3,201	1,604 U
Outsourced Clinical Services	3,761	3,601	161 U	7,687	7,188	499 U
Outsourced Other Services	6,857	7,395	538 F	13,796	14,789	994 F
Clinical Supplies	28,305	28,715	410 F	55,415	56,410	995 F
Funder Payments - NGOs and IDF Outflows	63,391	62,490	901 U	128,788	124,980	3,808 U
Infrastructure & Non-Clinical Supplies	19,884	18,298	1,586 U	38,579	36,612	1,968 U
Total Expenditure	**225,366**	**217,666**	**7,700 U**	**446,919**	**435,254**	**11,665 U**
Net Surplus / (Deficit)	**(13,626)**	**(1,795)**	**11,831 U**	**(15,793)**	**(2,905)**	**12,888 U**

Result by Division	Month (Aug-2020)			For the two months ending 31 Aug 2020		
	Actual	Budget	Variance	Actual	Budget	Variance
Funder	1,309	1,575	266 U	2,671	3,150	479 U
Provider	(14,928)	(3,380)	11,547 U	(18,726)	(6,050)	12,678 U
Governance	(8)	10	18 U	262	(5)	268 F
Net Surplus / (Deficit)	**(13,626)**	**(1,795)**	**11,831 U**	**(15,793)**	**(2,905)**	**12,888 U**
COVID-19 Net impact on bottom-line	(10,787)	48	**10,836 U**	(12,490)	505	**12,995 U**
BAU Net impact on bottom-line	(2,839)	(1,843)	**995 U**	(3,303)	(3,410)	**107 F**

Commentary on DHB Consolidated Financial Performance

Result for the Month of August 2020

Major variances to budget on a line by line basis are described below:

Revenue for the month of August 2020 is unfavourable to budget by $4.1M (-1.9%), significant revenue variances include:

- $7M adverse impact from a provision for IDF and Planned Care revenue wash ups due to under delivery of volumes due to Covid.
- $2.5M favourable variance to budget in additional Covid income, mainly additional laboratory income for high volumes of Covid-19 testing
- $0.8M unfavourable Non Resident revenue $0.8M reflecting reduced Pacific contract cases as a result of Covid-19
- $0.7M unfavourable MOH Public Health funding budgeted but not yet received for additional costs relating to Covid-19.
- Retail Pharmacy revenue $0.6M favourable (partly offset by additional cost of goods sold)

Expenditure for the month is unfavourable to budget by $7.7M (-3.5%), with $5.6M of this variance due to unbudgeted costs arising from Covid-19 and the balance in BAU operations. Significant variances include:

- $6M (-6.2%) unfavourable variance in combined Personnel and Outsourced Staff costs, mainly reflecting:
  - Unbudgeted Covid-19 related expenditure of $2.7M
  - Budgeted personnel vacancy and cost per FTE assumptions not achieved $1.6M unfavourable
  - One off backdated costs $0.3M unfavourable
- Clinical Supplies are $0.4M (1.6%) favourable. Laboratory consumable costs are $0.9M unfavourable due to the extremely high volume of Covid-19 tests processed during the month. Excluding these costs, the

underlying Clinical Supplies variance is $1.3M favourable, in line with overall volume performance below contract.

- $1.6M (-8.8%) unfavourable variance in Infrastructure & Non-Clinical supplies, with key variances being:
  - Unbudgeted Covid-19 related expenditure of $0.7M
  - Facilities Costs $0.2M unfavourable, due to higher than anticipated costs in security and repairs and maintenance expenses.
  - Bad and Doubtful Debts $0.4M unfavourable – this varies from month to month and reflects current assessment of outstanding non resident debts
  - Cost of Goods Sold $0.3M unfavourable for retail pharmacy, offset by additional retail revenue for the month.
- $901K unfavourable variance in Funder NGOs expenditure mainly reflecting a $300K unfunded Covid impact and the balance of the variance is due to unbudgeted expenditure for initiatives which is fully offset by additional unbudgeted MoH funding.

Result for the Year To Date

Major variances to budget on a line by line basis are described below:

The $1.2M unfavourable year to date revenue variance includes a net unfavourable Covid impact of $3.2M, with BAU revenue being $1.9M favourable. Significant variances in revenue categories include:

- Provision for planned care and IDF revenue wash-ups of $7.0M adverse, reflecting significantly reduced volumes during the level 3 lockdown period.
- Unbudgeted Covid income $5.6M favourable for community based testing and for laboratories services high volumes.
- Non Resident revenue $1.7M unfavourable, reflecting reduced Pacific contract cases as a result of Covid.
- MoH Public Health funding $1.4M unfavourable, for which MOH funding is still to be confirmed, partly for additional Covid-19 expenditure and partly for business as usual.
- Retail Pharmacy revenue $1.3M favourable (partly offset by additional cost of goods sold)
- $2M additional MoH revenue for funded initiatives introduced after budgets had been set with corresponding expenditure variances.

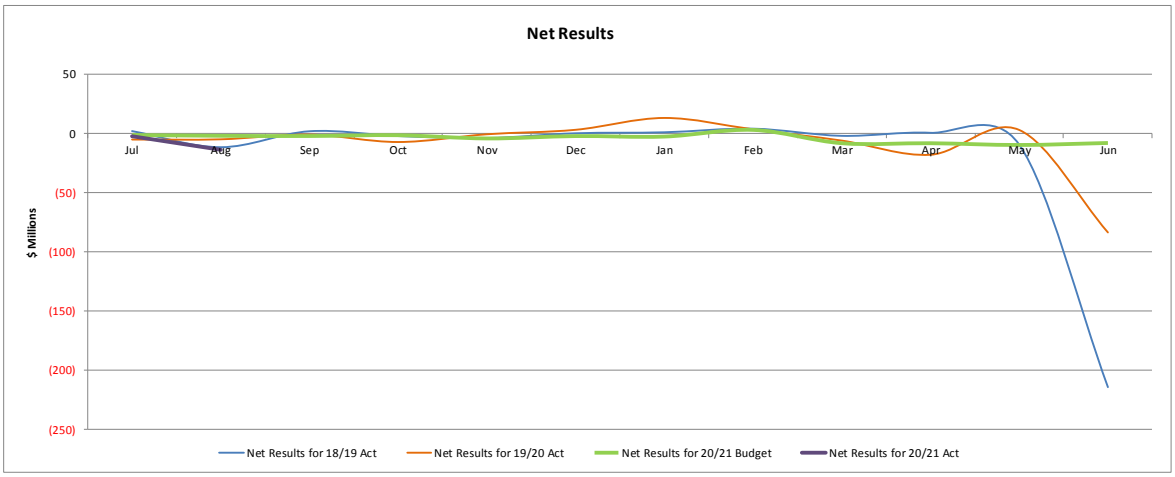
The year to date expenditure variance of $11.7M (-2.7%) includes an overall adverse Covid impact of $9.8M and the balance is due to BAU operations. Significant variances are:

- $7.4M (-3.8%) unfavourable variance in Personnel/Outsourced Personnel costs, driven by the following:
  - Unbudgeted Covid-19 related expenditure of $3.5M
  - Budgeted personnel vacancy and cost per FTE assumptions not achieved $3.0M unfavourable
  - One off backdated costs $0.3M unfavourable

  Year to date average FTEs are 119 above budget, this includes unbudgeted Covid FTEs.
- $1M (1.8%) favourable variance in Clinical Supplies. Covid impact is $1.5M adverse and the BAU position is $2.5M favourable reflecting volumes also under delivered. Main variances are in Laboratory consumable costs which are $1.0M unfavourable due to the extremely high volume of Covid-19 tests processed during the month and with some offsetting revenue.
- $1.6M (-8.8%) unfavourable variance in Infrastructure & Non-Clinical supplies. Covid impact is $1.1M unfavourable and the balance of the variance is in BAU operations. Main variances include:
  - Bad and Doubtful Debts $0.3M unfavourable – this varies from month to month and reflects current assessment of outstanding non resident debts
  - Cost of Goods Sold $0.8M unfavourable for retail pharmacy, offset by additional retail revenue.
- $3M (-3%) unfavourable NGO costs and IDF Outflows. Unfunded Covid impacts are $498K unfavourable and the balance reflects costs for unbudgeted MoH funded initiatives including new Mental Health initiatives relating to the implementation of Integrated Primary Mental Health (with offsetting additional revenue) and higher than budget costs for Pharmaceuticals.

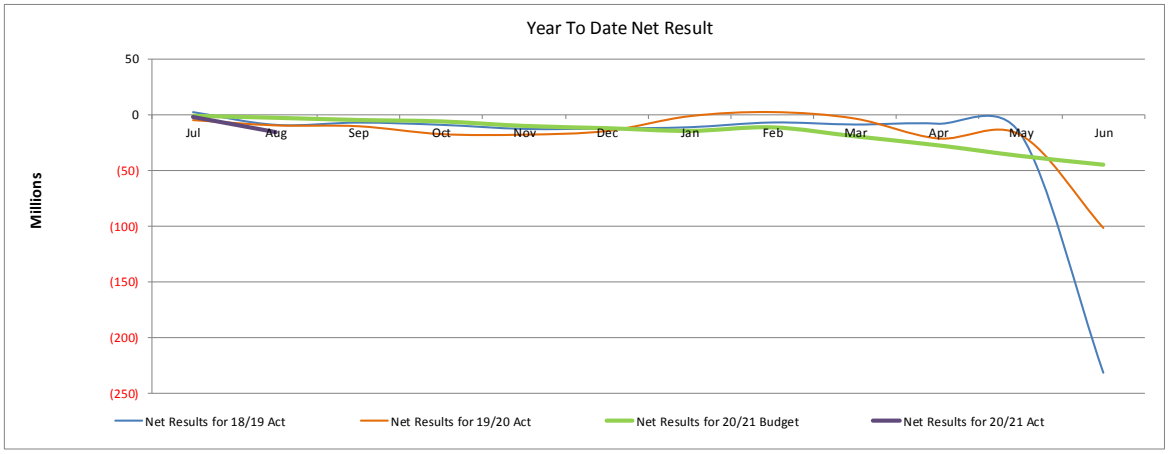
3. Performance Graphs

Figure 1: Consolidated Net Result (By Month)



$ millions	July	August	September	October	November	December	January	February	March	April	May	June	Total
Net Results for 18/19 Act	2.183	(11.446)	2.057	(2.009)	(3.665)	0.324	1.185	4.248	(1.830)	0.728	(9.280)	(214.462)	(231.967)
Net Results for 19/20 Act	(4.968)	(4.764)	(0.776)	(7.055)	(0.494)	3.289	13.310	3.679	(5.846)	(17.834)	3.151	(83.568)	(101.875)
Net Results for 20/21 Budget	(1.110)	(1.795)	(1.975)	(1.290)	(4.026)	(2.028)	(2.449)	3.189	(8.065)	(8.066)	(9.566)	(7.864)	(45.043)
Net Results for 20/21 Act	(2.167)	(13.626)											(15.793)

Figure 2: Consolidated Net Result (Cumulative YTD)



$'millions	July	August	September	October	November	December	January	February	March	April	May	June
Net Results for 18/19 Act	2.183	(9.263)	(7.207)	(9.215)	(12.880)	(12.556)	(11.371)	(7.122)	(8.953)	(8.225)	(17.505)	(231.967)
Net Results for 19/20 Act	(4.968)	(9.732)	(10.509)	(17.564)	(18.057)	(14.768)	(1.458)	2.221	(3.625)	(21.459)	(18.308)	(101.875)
Net Results for 20/21 Budget	(1.110)	(2.905)	(4.880)	(6.169)	(10.195)	(12.224)	(14.672)	(11.483)	(19.548)	(27.614)	(37.179)	(45.043)
Net Results for 20/21 Act	(2.167)	(15.793)										
Variance to Budget 20/21	(1.057)	(12.888)										

4. Financial Position

4.1 Statement of Financial Position as at 31 August 2020

$'000	31-Aug-20			31-Jul-20	Variance	30-Jun-20	Variance
	Actual	Budget	Variance	Actual	Last Month	Actual	Last Year
Public Equity	923,613	934,789	11,176U	920,389	3,224F	919,427	4,186F
Reserves							
Revaluation Reserve	599,151	599,151	0F	599,151	0F	599,151	0F
Accumulated Deficits from Prior Year's	(791,677)	(790,846)	831U	(791,677)	0F	(688,960)	102,718U
Current Surplus/(Deficit)	(15,793)	(2,905)	12,888U	(2,167)	13,626U	(102,718)	86,925F
	(208,319)	(194,600)	13,719U	(194,693)	13,626U	(192,526)	15,793U
Total Equity	**715,294**	**740,189**	**24,895U**	**725,696**	**10,402U**	**726,901**	**11,606U**
Non Current Assets							
Fixed Assets							
Land	347,122	347,122	0F	347,122	0F	347,122	0F
Buildings	618,487	625,291	6,804U	621,330	2,843U	624,109	5,622U
Plant & Equipment	83,471	90,429	6,958U	85,096	1,625U	86,655	3,185U
Work in Progress	83,578	84,724	1,145U	78,994	4,584F	74,518	9,061F
Total PPE	1,132,658	1,147,566	14,908U	1,132,542	115F	1,132,404	254F
Investments							
- Health Alliance	74,268	75,057	789U	74,268	0F	74,268	0F
- Health Source	271	-	271F	271	0F	271	0F
- NZHPL	5,755	5,633	122F	5,755	0F	5,755	0F
- ADHB Term Deposits > 12 months	-	-	0F	-	0F	-	0F
- Other Investments	518	-	518F	518	0F	518	0F
	80,812	80,690	122F	80,812	0F	80,812	0F
Intangible Assets	2,072	4,059	1,987U	2,142	69U	2,216	144U
Trust Funds	16,514	15,970	544F	16,145	369F	15,970	544F
	99,398	100,719	1,321U	99,098	300F	98,998	400F
Total Non Current Assets	**1,232,056**	**1,248,285**	**16,229U**	**1,231,640**	**415F**	**1,231,402**	**654F**
Current Assets							
Cash & Short Term Deposits	146,825	123,466	23,359F	132,757	14,068F	135,902	10,923F
Trust Deposits > 3months	17,892	16,394	1,498F	20,392	2,500U	16,394	1,498F
ADHB Term Deposits > 3 months	15,000	15,000	0F	15,000	0F	15,000	0F
Debtors	26,390	45,325	18,936U	28,051	1,661U	45,325	18,936U
Accrued Income	77,165	53,611	23,554F	77,767	602U	54,556	22,608F
Prepayments	9,166	6,098	3,069F	7,781	1,385F	5,729	3,438F
Inventory	15,755	27,511	11,756U	15,502	253F	27,511	11,756U
Total Current Assets	**308,193**	**287,405**	**20,788F**	**297,250**	**10,943F**	**300,417**	**7,776F**
Current Liabilities							
Borrowing	(1,847)	(1,925)	78F	(1,809)	38U	(1,828)	19U
Trade & Other Creditors, Provisions	(189,019)	(167,528)	21,491U	(181,607)	7,411U	(177,892)	11,127U
Employee Entitlements	(533,745)	(524,748)	8,998U	(519,551)	14,194U	(524,748)	8,998U
Funds Held in Trust	(1,384)	(1,376)	8U	(1,384)	0F	(1,384)	0U
Total Current Liabilities	**(725,995)**	**(695,576)**	**30,419U**	**(704,351)**	**21,643U**	**(705,851)**	**20,144U**
Working Capital	**(417,802)**	**(408,171)**	**9,631U**	**(407,101)**	**10,700U**	**(405,434)**	**12,368U**
Non Current Liabilities							
Borrowings	(10,028)	(10,814)	786F	(9,913)	116U	(10,136)	108F
Employee Entitlements	(88,931)	(89,110)	179F	(88,931)	0F	(88,931)	0F
Total Non Current Liabilities	**(98,960)**	**(99,924)**	**964F**	**(98,844)**	**116U**	**(99,067)**	**108F**
Net Assets	**715,294**	**740,190**	**24,896U**	**725,696**	**10,402U**	**726,901**	**11,606U**

Commentary

The major variances to budget are summarised below:

Property, Plant and Equipment:
The variance reflects capital expenditure tracking below budget as at August 2020. Budgeted capital spend is based on timing of implementation of capital projects as advised by services which may vary due to timing of capital approval, procurement and implementation timeframes.

Cash and Short Term Deposits:
The higher than budgeted balance mainly reflects the impact of the delay in the capital program on cash and timing of receipts and payments. The cash balances include $15M investment matured and not yet reinvested.

Debtors and Accrued Income:
Debtors and Accrued income in total variance is mainly driven by to the timing of billings to and receipts mainly from MOH.

Inventory
The higher inventory budget reflects budgeted PPE stock purchased on behalf of MOH ($12m). As at 30 June 2020, the stock value was reclassified into accrued debtors as this stock was purchased by ADHB on behalf of MOH.

Trade & Other Creditors and Provisions:

Trade & Other Creditors, Provisions:	**$000's**
Trade Creditors (including accruals)	170,524
Income in Advance	18,495
Total	189,019

4.2 Statement of Cash flows as at 31 August 2020

$000's	31-Aug-20			For the two months ending 31 Aug 2020		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Revenue Received	211,579	215,644	4,065U	440,439	431,479	8,960F
Payments						
Personnel	(86,423)	(95,567)	9,144F	(188,853)	(192,662)	3,809F
Suppliers	(48,288)	(51,440)	3,152F	(101,125)	(101,571)	446F
Capital Charge	0	(3,807)	3,807F	-	(7,614)	7,614F
Payments to other DHBs and Providers	(63,391)	(62,490)	901U	(128,788)	(124,980)	3,808U
GST	291	0	291F	(2,899)	0	2,899U
	(197,811)	(213,304)	15,493F	(421,664)	(426,826)	5,162F
Net Operating Cash flows	**13,768**	**2,340**	**11,428F**	**18,775**	**4,653**	**14,122F**
Investing						
Interest Income	213	227	14U	409	454	45U
Sale of Assets	6	0	6F	6	0	6F
Purchase Fixed Assets	(5,777)	(17,690)	11,913F	(10,742)	(33,565)	22,823F
Investments and restricted trust funds	2,500	0	2,500F	(1,500)	0	1,500U
Net Investing Cash flows	**(3,057)**	**(17,463)**	**14,405F**	**(11,826)**	**(33,111)**	**21,285F**
Financing						
Interest paid	(22)	(99)	76F	(127)	(197)	70F
New loans raised	319	1,225	906U	319	1,225	906U
Loans repaid	(165)	(190)	24F	(408)	(369)	39U
Other Equity Movement	3,224	7,660	4,436U	4,186	15,363	11,176U
Net Financing Cash flows	**3,356**	**8,597**	**5,242U**	**3,971**	**16,022**	**12,051U**
Total Net Cash flows	**14,067**	**(6,525)**	**20,592F**	**10,919**	**(12,436)**	**23,355F**
Opening Cash	132,757	129,991	2,766F	135,903	135,902	1F
Total Net Cash flows	14,067	(6,525)	20,592F	10,919	(12,436)	23,355F
Closing Cash	**146,825**	**123,466**	**23,357F**	**146,825**	**123,466**	**23,357F**
ADHB Cash				141,813	117,263	24,550F
A+ Trust Cash				4,665	5,857	1,192U
A+ Trust Deposits - Short Term < 3 months & restricted fund deposits				346	346	0F
				146,825	**123,466**	**23,357F**
ADHB Short Term Investments 3 > 12 months				15,000	15,000	0F
A+ Trust Short Term Investments 3 > 12 months				17,892	16,394	1,498F
ADHB Long Term Investments				-	-	0F
A+ Trust Long Term Investment Portfolio				16,514	15,970	544F
Total Cash & Deposits				**196,231**	**170,830**	**25,399F**

Planning Funding and Outcomes Update

Recommendation

That the Board note the key activities within the Planning, Funding and Outcomes Unit since the last update provided on 12 August 2020.

Prepared by: Wendy Bennett (Manager Planning and Health Intelligence), Joanne Brown (Funding & Development Manager Hospitals), Tim Wood (Funding & Development Manager Primary Care), Kate Sladden (Funding and Development Manager Health of Older People), Ruth Bijl (Funding & Development Manager Women, Children & Youth), Meenal Duggal (Funding & Development Manager, Mental Health and Addiction Services), Shayne Wijohn (Manager Māori Health Gain), Leani Sandford (Portfolio Manager, Pacific Health Gain), Samantha Bennett (Manager Asian, Migrant and Former Refugee Health Gain)
Endorsed by: Dr Debbie Holdsworth (Director Funding), Dr Karen Bartholomew (Director Health Outcomes)

Glossary

ALT	-	Alliance Leadership Teams
ARC	-	Aged Residential Care
ARDS	-	Auckland Regional Dental Service
ARRC	-	Age Related Residential Care
ASH	-	Ambulatory Sensitive Hospitalisations
CALD	-	Culturally and Linguistically Diverse Communities
CBAC	-	Community Based Assessment Centre
CMHC	-	Community Mental Health Centres
CSW	-	Community Support Worker
CVD	-	Cardiovascular disease
CT	-	Computed Tomography
DCNZ		Dental Council of New Zealand
DHB	-	District Health Board
EP	-	Electrophysiology
ESBHS	-	Enhanced School Based Health Services
ESPI	-	Elective Services Performance Indicators
FCT	-	Faster Cancer Treatment
FP	-	Family Planning
GP	-	General Practitioner/General Practice
HCSS	-	Home and Community Support Services
HEEADSSS		Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety
HPV	-	Human Papilloma Virus
IC		Immunisation Coordinators
IDF	-	Inter District Flow
IPC		Infection Prevention and Control
LAS	-	Language Assistance Services
LARC	-	Long Acting Reversible Contraception
MADS	-	Metro Auckland Data Sharing
MHAS		Mental Health and Addiction Service
MMR	-	Mumps, Measles and Rubella
MoH	-	Ministry of Health
MRI	-	Magnetic Resonance Imaging
MSD	-	Ministry of Social Development

NBE		Newborn Enrolment Coordinator
NCHIP	-	National Child Health Information Platform
NCSP	-	National Cervical Screening Programme
NZ	-	New Zealand
NGO	-	Non-Governmental Organisation
NHI	-	National Health Index
NIR	-	National Immunisation Register
NRA	-	Northern Region Alliance
NRHCC	-	Northern Region Health Coordination Centre
OIS	-	Outreach Immunisation Service
PCV	-	Pneumococcal virus
PFO	-	Planning, Funding and Outcomes
PHO	-	Primary Health Organisation
PFO	-	Planning, Funding and Outcomes
POAC	-	Primary Options for Acute Care
PPAL	-	Positive Parenting Active Lifestyle
PPE		Personal Protective Equipment
PRRT	-	Peptide Receptor Radionuclide Therapy
RhF	-	Rheumatic Fever
RFP	-	Request for Proposal
SHH	-	Sexual Health Hub
SMILE	-	Smoke and Alcohol Free, Mental wellbeing Matters, Immunise, Lie on Your Side and Eat Healthily
STI	-	Sexually Transmitted Infections
UR-CHCC		Uri Ririki - Child Health Connection Centre
WCTO	-	Well Child Tamariki Ora

1. Purpose

This report updates the Auckland District Health Board (DHB) on Planning and Funding and Outcomes (PFO) activities and areas of priority, since its last meeting on 12 August 2020.

2. Planning

2.1 2020/21 Annual Plans

The final draft of the 2020/21 Annual Plan was submitted to the Ministry of Health (MoH) on 19 August. However, the MoH has indicated that further discussions need to occur with Auckland DHB before the Plan can be finalised and approved.

As per the modification to the Crown Entities Act (149CA), Auckland DHB's signed 2020/21 Statement of Performance Expectations (SPE), including the financial position at the time, was published to the DHB's website by 15 August 2020 and provided to the MoH. Notice to take up the extension to publish, in line with the modification to the legislation, was published to the DHB's website, as required. This notice must also be included in the DHB's Annual Report. It should be noted that should the Annual Plan require amendments in response to further MoH requirements or feedback, the SPE may need to also be amended and republished. However, Audit NZ will audit against the 15 August position included in the original SPE.

2.2 2019/20 Annual Reports

Due to the Planning team's involvement in the response to the second wave of COVID-19, the development of the draft 2019/20 Annual Report has been delayed. The financial statements were

presented to the 2 September Finance, Risk and Assurance Committee meeting. Parliament passed legislation on 5 August to extend the statutory reporting time frames by up to two months for organisations with 30 June 2020 balance dates that report under the Crown Entities Act 2004 (as well as a range of other Acts). The statutory time frames have been extended to ensure that there is no reduction in the quality of financial and performance reporting because of the impact of COVID-19. The new deadline is 18 December 2020. Therefore, we intend to present the first draft of the 2019/20 Annual Report to the 14 October Finance, Risk and Assurance Committee Meeting, with the final version presented to the 4 November Auckland DHB Board meeting to ensure adherence to the new deadline date.

It should be noted that the Auckland DHB's response to COVID-19 has and will continue to have significant impact on many of the indicators we monitor for annual reporting. This has been discussed with Audit NZ and they have released information regarding the expectations around disclosure of these impacts. This is being considered in the preparation of the draft Annual Report.

3. COVID-19 Response

Many of the Planning Funding and Outcomes team have continued to be seconded to the Northern Region Health Coordination Centre (NRHCC), Auckland Regional Public Health Service (ARPHS) and other areas to help in the second wave response. A particular focus for the teams are the Pacific and Māori response support in contact tracing and welfare with ARPHS and in the testing approaches in the community. As a consequence, much of the 'business as usual' has remained on hold.

4. Primary Care

There is no significant update to primary care this month as primary care team continues to be involved in the Northern Region Health Coordination Centre activities, with a particular focus on community testing.

5. Health of Older People

5.1 Aged Residential Care

Work is near completion for publishing minimum and maximum charges for premium rooms in aged residential care facilities with the intention that this will start in October. The agreement with the ARC sector is that this will be addressed at the same time the 'opt out' clause for premium room charging in the national Aged Related Residential Care (ARRC) Agreement is revised. DHBs need to protect residents who experience hardship and this is why the clause currently exists in the Agreement. However, to avoid misuse of the clause an amendment is being considered that requires a resident and family to demonstrate genuine financial hardship, which requires them to back out of their agreement to pay for a premium room. There will also be a review of the notification timeframes for opting out of this payment.

A support plan is being implemented to ensure ARC facilities:

- maintain their COVID-19 preparedness long term
- have the most up to date COVID-19 information
- have a thorough understanding of how to implement new requirements /changes in processes as the COVID-19 situation evolves.

Regular information exchange sessions are being offered (via zoom) on specific practical COVID-19 topics tailored to the ARC setting. A process has been established to identify when a facility needs an in-depth review of its preparedness assessment e.g. due to a trigger event (change in manager/clinical manager, change in facility design, significant complaint) and/or have not engaged in recent DHB quality of care initiatives.

5.2 Other Health of Older People Services

In response to the COVID-19 outbreak in March there was national agreement that HCSS providers would continue to be funded at historical levels irrespective of the hours delivered to ensure sustainability and stability of the HCSS workforce. When Auckland went back into Alert Level 3 in August, the Metro Auckland DHBs agreed to maintain surety of funding for HCSS providers using the same method until the 4 October. This support ensures providers continue to have surety of funding whilst meeting requirements of changing Alert levels. Surety of funding comes with the requirement that providers continue to pay their workers.

Standardised interRAI assessments are currently used across the country to assess older people requiring support. A COVID-19 version of the interRAI Contract Assessment (COVID CA) with eight COVID-19 related items inserted into the assessment and an interRAI COVID-19 Vulnerability Screener (CVS) have been developed and will become available in New Zealand over the next few months. The COVID CA and the CVS are designed to identify the presence of COVID-19 symptoms, frailty and major comorbidities that increase the mortality risk related to COVID-19 in older people being assessed for support services.

6. Child, Youth and Women's Health – ADHB Funder Update September 2020

6.1 Immunisation

6.1.1 Childhood Immunisation Schedule Vaccinations

There has been a significant primary healthcare disruption due to COVID-19 which will affect immunisation coverage, based on observation of immunisation coverage and anecdotal feedback regarding reluctance to access health services.

Coverage for the total infant population at 8 months is stable at 94%; however Māori coverage has fallen to 80%, whilst Pacific had a small improvement to 93%. There has been a recovery in on-time immunisation, with the 3-month rolling coverage at 6 months being at an ideal 85% (to achieve 95% at 8 months) in the last few weeks, for the first time since late December 2019.

The COVID-19 impact is more likely to be felt in the first quarter of 2020/21. We are monitoring 6 month and 18 month immunisation coverage as a measure of timeliness. The one month rolling average, a more 'real-time' indication (although prone to fluctuation due to population size), has shown a reduction in coverage during earlier lockdown which is now recovering. Tamariki Māori have been most affected by the drop in on-time coverage and we are working with Primary Health Organisations (PHOs) and Well Child Tamariki Ora (WCTO) colleagues on initiatives to catch up these children.

Māori Immunisation Coverage as at	6m	8m	18m	24m
11/05/2020	58 %	81 %	68 %	91 %
08/06/2020 (L1)	57 %	91 %	71 %	91 %
06/07/2020	55 %	76 %	67 %	87 %
03/08/2020	62 %	81 %	77 %	87 %
31/08/2020	67 %	90 %	74 %	84 %

Our primary care colleagues report almost all general practices continued to provide immunisation services during the level 3 lockdown and although anecdotal reports are that there was less reluctance from whānau in accessing primary care during this period, we have noticed an increase in referrals to the Outreach Immunisation Service (OIS). The OIS continued to provide in home immunisation appointments and report that families were more accepting of the service entering their bubble than in previous lockdown. The National Immunisation Register (NIR) team have identified the Māori and Pacific cohort who were due immunisation during lockdown for priority follow up by the NIR team and Outreach Immunisation Service (OIS).

As at 1 July 2020, the Immunisation Schedule has dropped the 3 month Pneumococcal virus (PCV) vaccine (PCV-10) dose (so now only given at 6 weeks and 5 months), high risk PCV schedule remains three doses and other changes are brand only. The change has created problems with the NIR reporting where the second PCV dose is recorded at 3 months instead of 5 months – this will require manual correction from the NIR team to ensure immunisation coverage is not adversely affected.

In October 2020 a 12 month event is being introduced with the first dose of Measles, Mumps and Rubella (MMR) and a PCV vaccine. The 15 month event remains but will be three immunisations (Haemophillus influenzae b, Varicella and the second dose of MMR). The four year event will only be DTap-Polio. Upcoming webinars are planned to ensure primary care and other child health providers are aware of the changes.

The MoH have confirmed that the data warehouse functionality used for reporting will change to a Qlik platform for coverage for this quarter. They have also informed the sector that an “all doses” method will be used instead of a “final dose assumption” – our NIR team will be undertaking regular data cleaning activities to identify missing doses to ensure coverage is accurately reflected by the data. We anticipate that there may be some impact on coverage with this change as a result of children coming from overseas with incomplete records and will continue to work with the sector to follow-up records and include overseas doses on the NIR.

6.1.2 HPV immunisation

The MoH continue to utilise an alternative coverage reporting methodology for the HPV coverage. We have highlighted discrepancies in this to the MoH, however remain concerned that a change to use of the NIR population versus census estimates will grossly under-report immunisation coverage. The NIR population for this age group is not clean data and includes children who have moved to other DHBs or overseas. A significant amount of work goes into following up and data-cleaning the 4-year cohort from changes since the 15-month event, by the age of 14 the NIR clean-up required would be unmanageable. Without an identifiable accumulated dose report for this event, a data clean-up for the population is impossible, especially given there is no ability to accurately confirm children as being overseas, therefore coverage will continue to under represent the hard work of the sector to provide this immunisation.

Comparison against the historical reporting mechanism of the 1A report shows that Auckland DHB has improved 5% (to 86%) and met the 75% target; however Māori coverage has fallen to 67%, whilst Pacific coverage remains stable at 85%. The alternative methodology has total coverage at 65%, with Māori coverage at 67% and Pacific coverage at 64%.

The addition of boys to the programme continues to be positive. School Based Vaccination Service data for 2019 has total boys' coverage at 72% versus 65% for girls. Coverage for Māori boys exceeded girls by 5% (73% and 68% respectively), whilst Pacific boys and girls were both 80% coverage for dose 2.

We continue to work with the school based immunisation programme (SBIP) to maintain high coverage, particularly in light of COVID-19 disrupting the immunisation programme during 2020.

6.1.3 Measles

In February 2020, the MoH announced funding of a national measles campaign, with a focus on 15-29 year olds, particularly Māori and Pacific. Auckland DHB has submitted a plan to the MoH for the allocated funding – the focus is on utilising the relationships with schools through the Enhanced School Based Health Service (as per the successful MMR catch up during the mumps outbreak), tertiary institutes, workplaces (alongside 'flu vaccination in 2021), sexual health clinics, community pharmacies and other community settings such as marae and pacific churches.

The programme will be supported by a communication strategy which will be informed by focus groups with rangatahi Māori and Pacific people aged 15-29. A young Māori researcher has been engaged to assist with this work. We await the national communication suite, however expect that static media, social media (TradeMe), Dating aps, Spotify and radio advertising (Flava and Mai FM, including sponsored messages on their social media) will be used to get messaging to the target communities. We are in the process of recruiting a project manager and nurse lead for this work, as well as engaging with our secondary school nurses for their support of the campaign.

6.2 Uri Ririki – Child Health Connection Centre

The Uri Ririki - Child Health Connection Centre (UR-CHCC) is now established. UR-CHCC comprises teams of administrators tasked with management of the National Immunisation Register (NIR), National Child Health Information Platform (NCHIP) and Noho Āhuru – Healthy Homes (formerly called Kāinga Ora).

During the COVID-19 lockdown Level 3 the teams successfully managed to work from home and subsequently return to the office with very little disruption to service. The national NIR is once again functioning well with the previously reported migration issues generally resolved. The NIR team have had positive feedback from the Immunisation Coordinators (ICs) for their support during the NIR migration challenges in providing data the ICs were unable to generate themselves.

'Axe the Fax' planning is underway and communication has started with PHOs to explore using alternative methods to communicate with the NIR administrators. An initial review found that 70% of practices still use faxes to inform the NIR that children have transferred to another GP or refer children for outreach immunisation services.

Work continues to harness information from NIR and NCHIP to help understand the impact of COVID-19 disruptions on the uptake of childhood immunisations. Additional follow-up is being provided to General Practices (GP) regarding children who were due/overdue immunisation during the lock down periods. Current results suggest that childhood immunisation services adapted well to the changing environment and overall this cohort have maintained good immunisation uptake.

Linkage with the Ministry of Social Development (MSD) continues to evolve, with business processes finding some delay related to COVID-19 prioritisations.

One of the objectives of NCHIP and UR-CHCC is to reduce duplication of effort in the sector and reduce complexity for parents in accessing services. A New-born Enrolment Coordinator (NBE) role has been in place for 3 years in Auckland DHB to connect babies with Well Child Tamariki Ora (WCTO) providers. Feedback has found the effort is well received by Lead Maternity Carers, all WCTO providers as well as the few whānau needing direct contact each month. With NCHIP now in place we have made some early improvements in data flow which has reduced the administrative effort for the NBE midwife coordinator. The time released will be applied to improve regional cohesion and extend the NBE connection service to include Waitemata DHB babies and WCTO providers.

As at 31 August 2020, Auckland DHB received 1,486 referrals to Noho Āhuru – Healthy Homes. This included 5,513 family members getting access to healthier home interventions. Of the referrals received, 504 (34%) were for families with a newborn baby or hapu woman.

6.3 Well Child Tamariki Ora and B4 School Check

All the providers resumed face to face WCTO services under COVID-19 alert level 1 and were focusing on catching up those Tamariki that could have missed core visits during lock down. The change to level 3 and then 2.5 has again disrupted some WCTO services. Most contacts were provided by phone though some high-needs whānau still received face-to-face visits. Phone screening is undertaken before undertaking home visits. Two WCTO Nurses from Ngati Whatua Orakei have completed the Provisional Vaccinator course and can immunise over 3 year olds for MMR and Influenza. Many WCTO nurses have indicated an interest in becoming authorised vaccinators and we will be pursuing suitable options to support this.

6.4 Rheumatic Fever

The MoH has provided some funding for innovative activities in support of managing Rheumatic Fever (RhF). The MoH want to work with the team to implement the following short-term/high impact initiatives in the Auckland and Waitematā DHB regions.

a. Identification of culturally safe ways to increase referrals to the Healthy Homes initiative
b. Piloting of whānau support worker programme
c. Piloting dental health services for adults with Acute Renal Failure / RhF Disease
d. Finalisation, evaluation and release of ‘fight the fever’ mobile app.

The project manager is reviewing opportunities for increasing awareness and using pharmacy as a means to increase access. Focus groups will be run by the young Māori health researcher to inform these approaches. The MoH has agreed that some of the funding will be used to engage a nurse to partner with the social workers in Noho Ahuru, to undertake whānau health and well-being assessment, identify unmet health needs and facilitate whānau engagement with acceptable health services. The service will initially work with whānau referred into the healthy housing initiative with RhF but could be extended to other groups if there was sufficient resourcing. .

6.5 Oral Health

The Auckland Regional Dental Service (ARDS) is the provider of universal oral health services for pre-school and school age children across metropolitan Auckland. There are approximately 280,000 children enrolled with the service. Services are delivered from 83 clinics, which are primarily located in schools. The majority of children are seen while they are at school, without a parent or caregiver present.

The onset of COVID-19 has had a significant and enduring impact on the delivery of the service. With the change in COVID-19 alert levels to Level 3 across Auckland region from 12 August to 30 August 2020, all oral health providers were directed by the MoH and Dental Council of New Zealand (DCNZ) to postpone all routine dental treatment. Therefore, ARDS was only able to provide urgent and emergency dental care to children, once the child’s condition has been assessed by a dental clinician

over the phone. DCNZ had also further advised that if a child's dental condition can be accurately diagnosed and effectively managed without needing to see the child in-person, then that was best.

During Level 3, ARDS had seven essential dental care clinics open across Auckland – Silverdale, Glenfield Intermediate, Henderson Intermediate, Point England, Browns Road Clinic in Manurewa, Buckland Road Clinic in Mangere and Pukekohe Intermediate.

From 31st August to 4th September 2020, ARDS commenced a phased approach to service provision with examinations and treatments limited to non-Aerosol Generating procedures only. This more cautious midway approach was taken between that of Hospital and Specialist Dentistry who continue to operate as at alert level 3 guidelines as advised by ADHB IMT, and that of the DCNZ who currently advise to operate under alert level 2 guidelines. From 7th September, 2020 full service provision will be recommenced. Routine and emergency care for low COVID-19 risk patients is being provided, with the requirement for COVID-19 pre-screening (clinical symptoms and High Index of Suspicion risk) for all patients with enhanced infection prevention and control measures.

During the last alert level 2 and 1, the service experienced significant challenges with transitioning back to the provision of routine care. Specifically:

- The need to maintain physical distancing reduced the number of chairs that could operate in each clinic.
- Some schools were reluctant to have mobile clinics operating on their campus, with many requesting that services did not recommence until alert level one.
- Additional infection prevention and control measures required by the DCNZ impacted on service productivity.
- The DCNZ required all children to be COVID-19 pre-screened prior to their appointment. This had to be completed with a parent or caregiver. This has resulted in children being unable to be seen at school if the service has been unable to make contact with their family/whānau.

Many of these issues have continued into this alert level 2, due to the DCNZ screening requirements in place. The service is continuing to work on maximising the number of children that can be seen whilst adhering with the DCNZ requirements. The requirement to call all families to pre-screen is resource intensive and has an impact on productivity.

ARDS recovery plan has an equity focus to see those children identified in the highest risk categories as per MoH recommendations. The current clinical prioritisation focus is on children with an immediate clinical concern, children who have previously had an examination and are in the process of having their treatment completed, and children who are most overdue their routine examination (check-ups).

6.6 Maternal Oral Health Project - *Hapu Māmā Oranga Niho Ki Tamaki*

Under alert Level 3, only urgent and emergency dental care was provided for hapu māmās who were accepted into the service, once their condition has been assessed by the community dentist over the phone. All wahine whose referrals have been accepted into the service, were contacted and updated about this service delivery during alert Level 3.

The referral criteria for entry in to this service was recently reviewed and extended to also include new mothers with a child aged under 6 months old. ARDS is working closely with the Patient Experience team to seek patient feedback from the hapu māmās who are currently undergoing treatment, to identify any areas of improvement for the service.

6.7 Youth Health

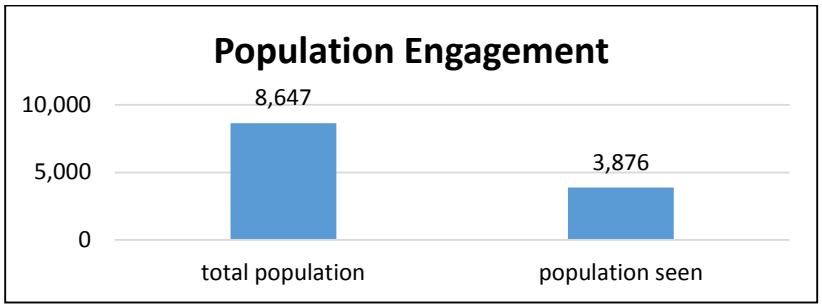
Enhanced School Based Health Services

Young people attending lower decile secondary schools are less likely to access youth appropriate primary and mental health care when they need to. This can result in missed opportunities for preventive health care and poorly managed health conditions. As well as the negative impact on health, it also affects their educational outcomes. The Enhanced School Based Health Services (ESBHS) programme offers youth friendly, confidential, and easy to access health services – the nurse is available at school every day, supported by a visiting general practitioner and clinical psychologist. Services in schools provide an opportunity to increase health literacy and to identify and address unmet health needs for an identified population of young people with higher needs, risk and complexities. About 8,607 secondary school students have improved access to primary healthcare in Auckland DHB through the ESBHS programme.

Some of the key ESBHS activities during the first two school terms (Term 1 and Term 2) in 2020 are included below.

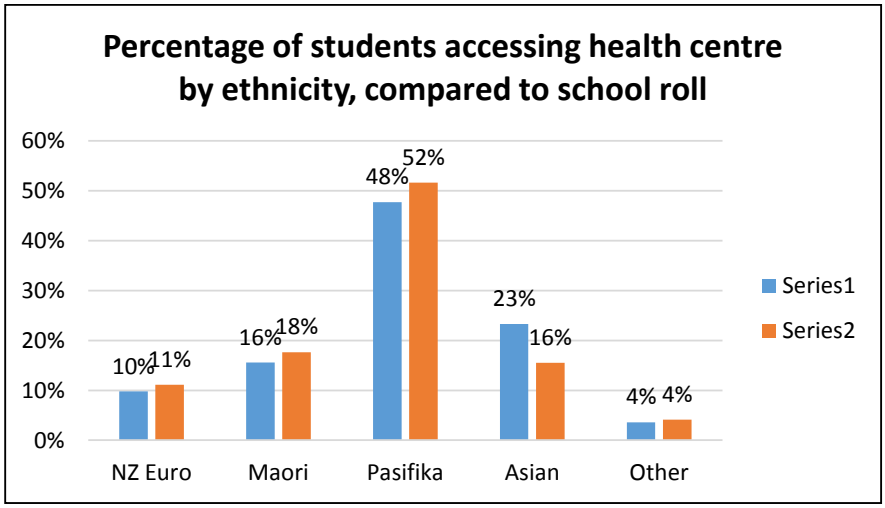
Engagement

Of the ADHB school population, 45% of all students engaged with the health centre during 2020. This is lower than usual.



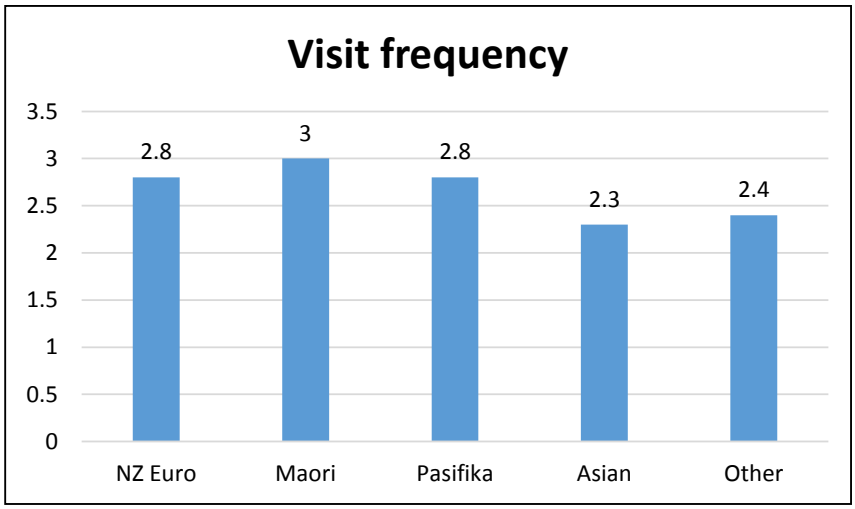
Health Centre Use

The graph below provides a snapshot of ethnicity breakdown and student engagement. The school based services has an emphasis on delivering equitable health services. This is evidenced through the graph below showing 52% of Pasifika and 18% of Māori students accessing the health centre. Asian students have lower access with 16% of the Asian population visiting the health centre.



Series 1: Percentage of school roll, **Series 2:** Percentage of students accessing service

Whilst slightly less likely to present to ESBHS, Māori students are likely to come to the clinic more often; with Māori students visiting on average 3 times this year, to date. European students are likely to visit 2.8 times, Pasifika students 2.8 times and Asian and other ethnicities only 2.3 and 2.4 times respectively. This metric is considered a proxy for acceptability of services. (A student survey is also used to assess the acceptability of services.)



6.8 Contraception

Service agreements are now in place across a network of community locations as well as via ADHB women's health services (including community clinics) and Auckland Regional Sexual Health Clinics. Work is ongoing to facilitate additional community based clinics in few locations that are not well served.

The MoH has commissioned the preparation of National Contraception Guidelines, these have now completed a final round of consultation. Once the guidelines are complete, a training package will be released by Family Planning Association. This training, which has been commissioned by MOH, will provide some free training for health practitioners to access LARCs training. Training has been a gap to date and remains an issue in achieving a robust network of providers who can offer all types of contraceptive options. We are working with Family Planning to confirm the offering for our DHB and prioritise recipients of training as well as work towards a sustainable training programme going forward.

6.9 Fertility

Fertility services are seeing patients as per usual with a process in place to address both delays and disadvantages that may have been experienced due to COVID closures. Demand outstrips capacity in this service and work is ongoing to address this.

6.10 Cervical Screening

The National Screening Unit has recently confirmed that HPV-Self Testing will be included in the HPV primary screening programme for cervical screening when this is implemented. Implementation timeframe is still uncertain and funding for a new NCSP register is a dependency.

A number of guidelines changes have been implemented, some of which came into effect during the April-May lockdown period. We have worked to update the Health Pathways guidance to reflect these and this is now in final approval for updating.

A Cervical Screening update was held on 2nd September. This was the first time we have held such an update virtually, the update was hosted via Zoom, recording was taken to enable us to use the presentations for an e-learning update to be available via Ko Awatea. The update and the e-learning can be accessed for free by primary care practitioners or others interested in cervical screening. Over 50 people attended the virtual update which included an explanation of HPV self testing research, the recent guidelines changes and the evidence supporting them and a number of practice points. Feedback and questions have been very positive.

7. Mental Health and Addictions

7.1 COVID-19 preparedness and planning

During and following the recent return to level 3, work continues with the provider arm and Non-Governmental Organisation (NGO) residential providers to plan for COVID-19 preparedness in the event of an alert or outbreak in a facility. In particular:

- Infection Prevention and Control (IPC) assessments were carried out of all residential NGO providers following the first rahui. A number of follow up actions resulted from those assessments, which were followed up and addressed.
- NGO pandemic plans were reviewed by a contracted Mental Health and Addiction Service (MHAS) expert and feedback provided on customising them to meet the unique challenges posed by COVID-19. Work continues with addressing these with providers and reviewing the adequacy of changes.
- Working with the MHAS provider arm of Auckland DHB to address how the DHB will respond to and assist NGO residential providers in the event of an alert or outbreak.

7.2 Coronial suicide data

Speculation and reporting about suicide data was a concern during the original rahui. On 21 August 2020, the Chief Coroner provided provisional data on suspected suicide deaths for the 19/20 financial year. Of note:

- contrary to speculation the total number of suspected suicide deaths decreased slightly compared to the previous year, for a total of 654.
- the decrease applied to all ethnicity groups, except Asian ethnicities for whom there was an increase compared to the previous year.
- suspected suicide deaths for 15 to 19 and 20 to 24 age groups decreased.

Sadly, in the Auckland DHB area, there was a slight increase in suspected suicide deaths. It is important to note that no conclusions can be drawn from a single data point.

The Director of the Suicide Prevention Office, Carla Na Nagara, commented that she hoped these figures would see an end to harmful speculation on suspected suicide deaths, although the decrease in the past year's numbers should not be used to draw any conclusions about our suicide rate overall which requires an all-of-society effort to be addressed.

8. Māori Health Gain

8.1 Māori health COVID-19 response

The Māori Health Gain Team have supported the Māori Incident Management Team at NRHCC by seconded several teams members to support their response. As a result, the bulk of our work during this reporting period has been centred on responding to COVID-19.

8.2 Māori mobile units

Due to the most recent outbreak, only one of the Māori Mobile Units has operated as intended in the past quarter. The other Units funded to cover Auckland DHB have been diverted to COVID-19 community testing. These, however, will be operational in the next quarter.

Orakei Health Services have successfully operated their Unit in vulnerable communities. In the first four weeks of operation their Unit visited 58 households. All of these households had Māori aged 65 years and over living in them, and some with multiple generations under one roof. The team completed only 3 flu vaccinations, with the others reported having already had a vaccination (the NIR identified all of these whānau as "not being vaccinated") or vaccination was declined. The former point highlighted the known issues with the incompleteness of data for people over 14 years old in the NIR. The Māori Health Gain team are taking this issue up with the appropriate DHB/MoH teams.

The service completed household and individual health needs assessments that span a number of wellbeing domains. They found that some whānau were already engaged in care programmes for various health conditions and support as provided on these as requested. While some had had little to no engagement with health services, and were largely well and coping. The team found that as a result of fear and anxiety about COVID-19 many whānau were relying on their social networks and wider whānau to support them through lock downs with food deliveries, zoom calls, and regular communication. There were however a number of kaumātua who were isolated and anxious. The Mobile team connected all whānau with health and social support services offered by Orakei where this was necessary. Orakei health services are maintaining close contact with whānau who felt isolated to ensure they are connected to care. Finally, the service made a number of referrals to primary care, quit smoking programmes and a single referral was made to the Community Alcohol and Drugs Service. We are currently seeking advice from the MoH who fund this service to determine how best to roll these service out.

8.3 Kaimanaaki services

During the first COVID-19 response in Auckland DHB's catchment area the Kaimanaaki programme funded 11 FTE Kaimanaaki (Non-clinical support workers) for three months via three identified lead proviiders: Orakei Health Services, Kotuku ki te Rangi (a kaupapa Māori mental health provider) and Piritahi Hauora (on Waiheke Island). A total of 16 individuals were provided with employment and training to reach out to whānau safely, and undertake basic welfare assessments to determine their level of need. These 16 individuals reached a total of **937** households, comprising **2,314** individual whānau members, of which **87%** were Māori and **286** were kaumātua. By far, food insecurity was the biggest issue with 9,219 meals delivered to these households, along with 117 hygiene packs that gave whānau the confidence that they were protected, and a total of 153 referrals were made by Kaimanaaki - 44 for GP enrolments, 6 midwife referrals, 38 to quit smoking services and 75 flu vaccinations were completed.

Te Kahu o Taonui, the northern Iwi collective who led the northern Iwi response, has had a similar success, yet their programme is still underway. Their programme, which is funded through several sources as well as health, is designed to get essential resources to isolated communities. Since 1

June, they have delivered over 24,000 food parcels to over 18,000 homes primarily across Northland and to some whānau in metro Auckland. Their funding comprised the following components:

- Funding to set up an Iwi Coordination centre and hub. This centre houses response teams, a call centre, logistics support teams who oversee 4 distribution centres, housing support programmes, data support and analytics, training support and, of course, their leadership team to coordinate this response on behalf of the nine northern iwi groups.
- Over 90 FTE for Iwi Kaimanaaki roles throughout Te Tai Tokerau. To date, they have completed 307 wellness plans with whānau. These roles are still underway.
- A Whānau Support Fund for immediate financial assistance to purchase essential items for vulnerable whānau. So far, 78 whānau have met the vulnerable criteria and have had blankets, food, water for their tanks, fire wood, and heaters purchased for their household.

A final report from Te Kahu o Taonui is expected in November.

8.4 Māori Pipeline Projects

The Māori Health Pipeline of work is currently being reviewed and updated. A summary of recent Māori Health Pipeline activity is below:

- Lung cancer screening – the planned inaugural Māori Consumer Advisory Group (comprised of focus group and survey participants, whānau support and DHB kaumatua) had to be postponed till October due to the second COVID-19 group restrictions. The options for material graphics have been completed by a Māori artist for review by the advisory group. The Cost-Effectiveness equity re-analysis has been accepted for publication in the British Medical Journal Open. Three applications for research funding have been completed and submitted. Planning for the pilot to start in 2021 is now underway. Additional surveys in Northland have also been completed.
- Alternative community cardiac rehabilitation model – work on the business case was on hold during COVID-19.
- Alternative community pulmonary rehabilitation model – the workshop with kapa haka and physiotherapy pulmonary rehab experts to design the intervention was also postponed with COVID-19.
- Northern region breast screening datamatch (‘500 Māori women campaign’) – interim reporting has been completed, due to second wave COVID-19 catch-up further time been allowed for final reporting.
- Māori provider and PHO datamatch – Most of the Auckland DHB and Waitemata DHB providers have contributed data, however the Counties providers have not to date. An interim report to the Māori governance group has been prepared with options for next steps.
- Facilitated PHO enrolment – on hold with COVID-19.
- High grade cervical screening project – on hold as the clinical lead has been supporting the COVID Managed Isolation clinical model. A review has been completed of progress to date and will be presented to the steering group virtually when the clinical lead returns.

9. Pacific Health Gain

9.1 Pacific Regional response to COVID-19

The onset of the August COVID-19 outbreak has had a significant impact on the Pacific health gain team workplan for the month. Once the NRHCC Pacific response team was re-established to lead and contribute towards the pandemic response, the Pacific health gain team has focussed its efforts on this work. The disproportionately high number of Pacific people living in Auckland that tested positive with coronavirus differed from the last COVID -19 outbreak in March which saw fewer positive cases amongst Pacific people compared to non-Pacific populations.

During this outbreak, the Pacific response team has worked in partnership with the ARPHS to support contact tracing and welfare support for Pacific families including those in managed isolation facilities. Furthermore, the Primary care, Pacific response team, Pacific providers, Pacific church and community leaders have worked collaboratively to increase COVID-19 testing amongst Pacific communities. To remove barriers to access, a number of pop up mobile testing units have been set up in a variety of settings. This includes community settings that have a predominantly high Pacific residential population for example Tāmaki, Pacific churches and workplaces that have a significant Pacific workforce. Pacific specific mobile units have also been used to set up pop up clinics.

The change from Alert level 3 to alert level 2.5, has resulted in a lifting of restrictions and a return to work, school and other activities for everyone. This has seen a reduction in the testing volumes, however, a more concerted effort is being made to test at workplaces alongside opportunities to offer testing at Pacific churches, sports clubs, local communities and at home for vulnerable Pacific populations that are unable to access testing.

9.2 Pacific Mobile service

As part of the Northern Pacific regional COVID-19 response to support Pacific peoples and communities, a Pacific mobile service will be available to support vulnerable Pacific populations in Auckland DHB. Agreement has been reached with the Tongan Health Society Inc. to deliver a Pacific mobile service from September to December 2020. The service will provide focused mobile capacity and is able to deliver services at home, in community settings and may also provide surveillance swabbing if requested by the DHB, primary care assessment and care and social service support as is needed.

9.3 Measles Mumps Rubella (MMR) Vaccination plan

The Health Promotion Agency is responsible for developing the MMR national awareness campaign. The organisation is currently working to finalise the concepts that will be used to promote the MMR vaccination uptake. The draft proposal has been reviewed by the MMR steering group and feedback provided.

The Pacific team is supporting the local DHB MMR response. Two Pacific focus groups will be held next month to discuss and inform the content and pitch of the local awareness campaign. A meeting is also planned with Sisters United to consider a variety of approaches that will engage and resonate with Pacific youth and young adults.

10. Asian, Migrant and Former Refugee Health Gain

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

An Asian, new migrant, former refugee and current asylum seeker health plan 2020-2023 has been developed and will be tabled to the joint Auckland and Waitematā Community Public Health Advisory Committee at the next available meeting.

The team has responded to the COVID-19 resurgence by providing Communication and Welfare support to the NRHCC Welfare Team for ethnic communities.

10.2 Increase access and utilisation to Health Services

Indicators:

- Increase by 2% the proportion of Asians who enrol with a Primary Health Organisation (PHO) to meet 88% (Auckland DHB) by 30 June, 2021

The Auckland DHB, Asian PHO enrolment rate for Quarter 3 2020 remains at 86%. There were 856 new enrolees between Quarter 2 and Quarter 3, 2020.

A suite of activities have been rolled out to increase awareness and access to health services including:

- English NZ Health and Disability System video aimed at new migrants, former refugees and international students has been refreshed with subtitles added, https://vimeo.com/158429915
- Mandarin video version in process of being refreshed
- Korean and Arabic language videos are in the process of development.

The team is coordinating the Metro Auckland Interpreting and Translation Service Steering Group to oversee regional planning and coordinate management of the RFP application (Phase 2 of the national Language Assistance Services Programme (LAS)) to bid as a supplier of Face to Face Interpreting services for health and non-health specialities in the metro Auckland region.

10.3 Indicator: Increase opportunities for participation of eligible former refugees enrolled in participating general practices as part of the *'Improving access to general practice services for former refugees and current asylum seekers' agreement'* (formerly known as Former Refugee Primary Care Wrap Around Service funding)

The team will be hosting a Zoom *Former Refugee & Asylum Seeker Health & Wellbeing* Webinar on 8th September on the topic 'Response and reflections of COVID-19 in accessing and utilising primary health services'. Guest speakers from Red Cross and Refugees As Survivors NZ along with Asian, Migrant and Former Refugee Health Gain Manager will be presenting.

The team is assisting Asylum Seeker lawyers in supporting their clients' access support services while their application is accessed.

11. Hospitals

11.1 2020/21 Planned Care Services

11.1.1 Planned Care – annual uplift

The Ministry of Health allocates additional revenue each year for the delivery of planned care services including elective surgical discharges for the Auckland DHB population. There is an expectation that each year there is an increase in the level of access of planned care services provided and this is funded through an additional funding arrangement. We are currently finalising the revenue agreement for the planned care uplift in 2020/21. In order to achieve this revenue and meet the MOH expectations regarding additional discharge volumes, the Auckland DHB provider will need to deliver additional volumes equivalent to $16M revenue. Internal capacity constraints and additional disruption associated with the COVID response puts this revenue at risk.

11.1.2 Planned Care $282.5M COVID 19 Backlog and Waiting List Initiative

In August and September 2020 the Ministry of Health has provided guidance and policy to support the additional $282.5M revenue allocated by Government to support the delivery of additional

services to address waiting lists and reduce backlogs developed during the COVID 19 response. This funding has been allocated over a period of three years and includes revenue for both additional activity and service improvement and capital bids to enable the optimisation of capacity within the system to deliver more planned care services. The activity based funding is allocated to DHBs on a population based funding (PBF) share and the intention is that this revenue is paid in arrears on a quarterly basis. The total additional revenue available to Auckland DHB for additional planned care services is $6.4M. In order for DHBs to achieve 100% of this revenue there is a requirement to establish and achieve improvement plans to reduce waiting times and achieve compliance over time with national waiting time indicators. The Ministry will withhold a portion of this funding if DHBs do not achieve all elements of their improvement plans. Northern region DHBs are in the process of finalising both regional and local plans to access this expenditure and these plans are expected to be agreed with the Ministry of Health by the beginning of October.

11.1.2 Planned Care services - Regional Vulnerable services work plan

A regional work plan has been established and is embedded in the Northern Regional Service Plan to address longstanding vulnerable services. This work is supported by a Regional Service Improvement Steering Group chaired by the Auckland DHB Chief Executive. Key services have been prioritised for regional review including Vascular, Ophthalmology, Oral Health, ORL and Sarcoma services. Progress is being made across all these regional discussions with the intention that regional service arrangements will be reviewed to establish more resilient and sustainable services to support the population of the Northern region. Work to date has seen agreement to prioritise funding, service improvement and capital resources to support improved regional consistency and enable progress towards addressing regional inequalities.

11.2 National Planned Care Performance Indicators

11.2.1 Elective Services Performance Indicators (ESPI) Performance

The ESPI compliance position for all DHBs nationally have deteriorated as expected as a result of COVID 19. In February 2020 3.4% of patients (n = 553) waiting for First Specialist Assessment (ESPI 2) were waiting longer than 120 days and this has deteriorated to 12.2% of patients (n= 1735) in July 2020. In February 2020 9.7% patients (n=598) were waiting longer than 120 days for surgery (ESPI 5) and this has deteriorated to 21.6% patients (n = 1446) in July 2020. As a result of the August COVID outbreak we are expecting some deterioration in these indicators however there has been significant effort across all services to minimise the disruption to planned care services and use of capacity has been optimised for high priority patients.

11.2.2 Colonoscopy national indicators

Auckland DHB has been unable to achieve compliance with national waiting time indicators for symptomatic and surveillance colonoscopy for some time. A plan to outsource additional procedures in April 2020 to address waiting times was disrupted by the COVID response. This outsourcing was initiated in June 2020 and is expected to be complete with a further bolus of outsourcing to be completed as soon as possible to achieve compliance with the national indicators by November 2020 when the Auckland DHB Bowel Screening Pilot is expected to be rolled out.

11.2.3 Radiology national indicators

Auckland DHB compliance with national radiology indicators was impacted by the COVID 19 response. In February 86% patients were receiving outpatient CT scans within 6 weeks and this deteriorated to only 71.8% in May, however performance has since improved to 88% patients receiving CT scans within the recommended waiting time in July. Auckland DHB has struggled to achieve compliance with the MRI waiting time indicator for some time however since June there has been steady improvement in the number of patients receiving MRI within 6 weeks to 69% at the end of July compared with 42% in February 2020.

11.3 National Services

11.3.1 PRRT (Peptide Receptor Radionuclide Therapy)

With the lockdown situation continuing in Melbourne Australia, New Zealand patients have been unable to access PRRT treatment for Neuro Endocrine Tumours since April 2020. Following consultation with a range of stakeholders including the Ministry of Health, Pharmac, Peter Macallum Hospital in Melbourne and Auckland DHB Clinical leaders, an interim service proposal has been established to commence delivering this service at Auckland DHB by the end of September subject to confirmation of funding from the Ministry of Health. This is to be followed by a more substantive business case being developed to establish an enduring national service going forward from Auckland DHB facilities.

Decision

Delegated Authorities During COVID Events

Recommendation:

That the Board:

1. **Approves the following revised delegated authority levels to remain in place during the current COVID event and during any future waves of COVID.**

Proposed DAs for COVID-19 requests only (In $'000s)		Capex Delegations			Opex Delegations	
Role	Name	Current		Proposed	Current	Proposed
		Budgeted	Unbudgeted	All	All	All
CEO	Ailsa Claire	500	300	1,000	3,000	No change
CFO	Justine White	250	150	500	1,000	No change

2. **Approves the delegated authority to the CEO and Board Chair to jointly approve COVID related operational spend required under emergency for a value up to $20M to remain in place during the current COVID event and during any future waves of COVID. Any such approvals will be reported to the next full Board meeting.**
3. **Revokes the authority delegated to the Auckland DHB IMT COVID-19 Controller as this is no longer required.**
4. **Notes that these delegations were previously approved by the Executive Committee of the Board on 1 April 2020 in response to the Wave 1 COVID Event.**

Prepared by: Auxilia Nyangoni, Deputy Chief Financial Officer
Endorsed by: Justine White, Chief Financial Officer and Ailsa Claire, Chief Executive Officer
Date: 16 September 2020

Glossary

ADHB	ADHB - Auckland District Health Board
Capex	Capital Expenditure
CEO	Chief Executive Officer
CMO	Chief Medical Officer
COVID-19	Coronavirus disease 2020
DA	Delegated Authority
ELT	Executive Leadership Team
IMT	Incident Management Team

1. Overview

Ministerial Directions were issued on 17 March 2020, setting out the Government's instruction to direct DHBs to work consistently with the national level Influenza Pandemic Plan and, the National Health Emergency Plans that govern the health system's response to pandemics.

In response to this, the Auckland DHB Board established an Executive Committee of the Board to enable agile, appropriate and efficient decision making for matters that fall outside the Board meeting cycles. On 1 April 2020, the Executive Committee of the Board passed the following resolution, approving revised delegated authority levels for the Auckland DHB IMT COVID-19 Controller, CFO, CEO and joint CEO/Board Chair:

Resolution

6.1 Delegations During COVID-19 Event Response

That the Executive Committee of the Board:

1. Approves the following changes to delegated authority levels to enable appropriate and efficient response and decision making on urgent and unbudgeted COVID-19 events and will stop on advice from the CEO to the Board that these are no longer required

Proposed Das for COVID-19 requests only (In $'000s)		Capex Delegations			Opex Delegations	
Role	Name	Current		Proposed	Current	Proposed
		Budgeted	Unbudgeted	All	All	All
CEO	Ailsa Claire	500	300	1,000	3,000	No change
CFO	Rosalie Percival	250	150	500	1,000	No change
ADHB IMT COVID-19 Controller	Incident Controller	100	50	200	250	No change

2. Delegates Authority to the Board Chair and Chief Executive Officer to jointly approve COVID-19 related operational spend required under emergency for a value up to $20M, with any such approval being reported to the Executive Committee of the Board within 48 hours.
3. The Corporate Business Manager to append a list of any such items approved to each meeting of the Executive Committee of Board so that patterns and trends can be identified.

The CEO has reviewed these delegated authority levels in view of the second wave of COVID and uncertainty regarding potential future COVID waves and, concluded that all other revised delegated authority levels per the resolution copied above need to remain in place, except for the authority delegated to the Auckland DHB IMT COVID-19 Controller which can now be revoked.

The Board is being requested to approve the recommendations noted at the start of this report.

System Level Measures – Quarter 4 Report

Recommendation:

That the Board note the Quarter four[1] results for the fourth SLM Improvement Plan.

Prepared by: Wendy Bennett (Planning & Health Intelligence Manager) and Tim Wood (Acting Director of Funding – Auckland and Waitematā DHBs)
Endorsed by: Dr Debbie Holdsworth (Director of Funding) and Dr Karen Bartholomew (Director Health Outcomes)

Glossary

ACP	-	Advance Care Plan
ALT	-	Alliance Leadership Team
ARPHS	-	Auckland Regional Public Health Service
ASH	-	Ambulatory sensitive hospitalisations
CEO	-	Chief Executive Officer
CVD	-	Cardiovascular disease
DHB	-	District Health Board
ED	-	Emergency Department
HT	-	Health Target
HQSC	-	Health Quality and Safety Commission
PES	-	Patient Experience survey
PHC	-	Primary health care
PHO	-	Primary Health Organisation
POAC	-	Primary Options for Acute Care
SLM	-	System level measure
WCTO	-	Well Child/Tamariki Ora

1. Introduction

The System Level Measures (SLMs) Framework was developed by the Ministry of Health with the aim of improving health outcomes for people by supporting DHBs to work in collaboration with health system partners (primary, community and hospital) using specific quality improvement measures. This provides a framework for continuous quality improvement and system integration.

System Level Measures are set nationally and designed to be outcomes focused, requiring all of the health system to work together to achieve. They are focused primarily on children, youth and those parts of the population who experience poorer health outcomes than others. DHBs are able to choose from a suite of 'contributory' measures or devise their own – which they have identified as having the biggest impact on achievement of each system level measure. These in turn are connected to local clinically led quality improvement activities.

System Level Measures recognises that good health outcomes require health system partners to work together. Therefore the district alliances are responsible for implementing SLMs in their districts.

The Counties Manukau Health and Auckland Waitematā Alliance Leadership Teams (the Alliances) jointly developed the 2019/20 System Level Measures Improvement Plan and are firmly committed to achieving the SLM milestones over the medium to longer term. The focus is on areas where there is the greatest need and, where possible, robust data can be used for quality improvement. Contributory measures were added where data collection processes have been developed in response to identified clinical priorities.

[1] Latest available data currently

The steering group continues to meet in order to further develop key actions (particularly at a local level), monitor data, and guide the on-going development of the SLMs. Steering group membership includes senior clinicians and leaders from the seven PHOs and the three DHBs. The steering group is accountable to the two Alliance Leadership Teams (ALTs) and provides oversight of the overall process. PHO Implementation Groups also meet to support and enable implementation of SLM improvement activities.

This paper provides quarter four results on the current (fourth) improvement plan: 2019/20. The six System Level Measures are:

1. Ambulatory Sensitive Hospitalisation (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
5. Babies living in smoke free households at six weeks
6. Youth are healthy, safe and supported.

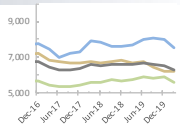
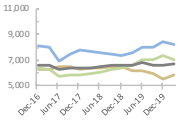
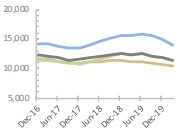
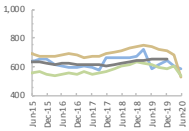
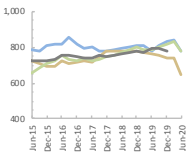
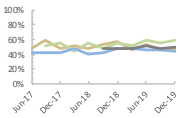
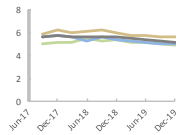
For each SLM, there is an improvement milestone to be achieved in 2019/20. The milestone must be a number that improves performance from the district baseline, reduces variation to achieve equity, or for the developmental SLMs, improves data quality. In 2019/20, the Auckland Metro Region has continued focusing on cross–system activities which have application to multiple milestones. Activities with a prevention focus may show collective impact across the life course over time. It seems pragmatic for each milestone to benefit equally from activities which add value in multiple areas. The work is the foundation for quality improvement activities, and illustrates enabling activities such as building relationships, providing support and education, and creating and maintaining essential data management processes.

This plan reflects a strong commitment to the acceleration of Māori and Pacific health gain and the elimination of inequity for Māori and Pacific peoples. In planning, each contributor has been tasked with considering the role of equity for their particular measures, and providing measures and activities that promote improvement for those with the poorest health outcomes.

This report includes the most up-to-date data available at quarter four for each DHB for both the SLMs and contributory measures. It also outlines progress against the improvement activities identified for each SLM in the SLM Improvement Plan.

Please note that due to COVID-19, some data has been delayed and also activities and actions have had to be paused, which impacts on performance for this time period.

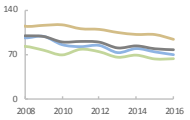
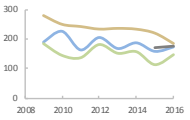
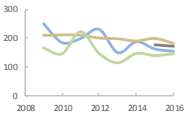
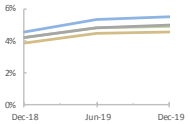
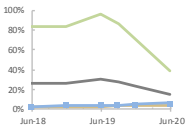
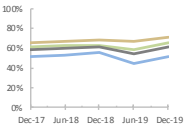
Scorecard – Part 1

		DHB / Region	Target		Performance: Actual	Data Period	Trend
1. Ambulatory Sensitive Hospitalisations: 0-4 Year-Olds							
Measure:	Rate per 100,000 domiciled 0-4 year-olds - Total Population	Auckland	7,381 (max.)		**7,558**	12-monthly	
		Counties Manukau	6,605		**6,223**	to	
Target 2019/20:	3% reduction	Waitemata	5,502		**5,577**	Mar-20	
		Metro Auckland	6,343		**6,302**		
Measure:	Rate per 100,000 domiciled 0-4 year-olds - Maori	Auckland	7,109 (max.)		**8,260**	12-monthly	
		Counties Manukau	6,355		**5,895**	to	
Target 2019/20:	3% reduction	Waitemata	6,181		**7,031**	Mar-20	
		Metro Auckland	6,365		**6,668**		
Measure:	Rate per 100,000 domiciled 0-4 year-olds - Pacific	Auckland	15,184 (max.)		**13,925**	12-monthly	
		Counties Manukau	11,051		**10,395**	to	
Target 2019/20:	3% reduction	Waitemata	12,045		**11,269**	Mar-20	
		Metro Auckland	12,405		**11,328**		
2. Acute Hospital Bed Days							
Measure:	Age-standardised rate per 1,000 domiciled population - Maori	Auckland	648 (max.)		**587**	12-monthly	
		Counties Manukau	717		**525**	to	
Target 2019/20:	3% reduction	Waitemata	616		**540**	Jun-20	
		Metro Auckland	667		**unavail**		
Measure:	Age-standardised rate per 1,000 domiciled population - Pacific	Auckland	780 (max.)		**781**	12-monthly	
		Counties Manukau	755		**648**	to	
Target 2019/20:	3% reduction	Waitemata	774		**774**	Jun-20	
		Metro Auckland	763		**unavail**		
3. Patient Experience of Care							
Measure:	DHB Adult Inpatient Experience Survey: medication side effects question answered "yes completely"	Auckland	55%		**47%**	Quarterly	
		Counties Manukau	53%		**59%**	to	
		Waitemata	49%		**45%**	Dec-19	
Target 2019/20:	5% improvement	Metro Auckland	51%		**49%**		
Target 2019/20:	Primary Care Survey - time to get GP appointment Weighted response: 10 = same	Auckland	6.70		**5.70**	Quarterly	
		Counties Manukau	5.90		**4.90**	to	
		Waitemata	6.00		**5.00**	Dec-19	
Target 2019/20:	10% improvement	Metro Auckland	6.20		**5.20**		

A note about the population:

Stats New Zealand and the Ministry of Health recently released updated population estimates and projections using new methodology (and there are likely to be further updates to these figures). This had a significant impact on the population figures for Auckland DHB, with substantially fewer people living within the DHB boundaries according to these new figures compared with previous estimates and projections. This will in turn have a substantial impact on performance against those measures that use DHB population as denominator. Going forward, there may be marked changes in both current results and trend information. Note: that some of the target data has had to be reworked within this dashboard and therefore, may not match the target presented in the 2019/20 SLM Plan or previous dashboards/reporting.

Scorecard – Part 2

		DHB / Region	Target		Performance: Actual	Data Period	Trend
4. Amenable Mortality							
Measure:	Age-standardised rate per 100,000 domiciled 0-74 year-olds.	Auckland	70.4 (max.)	●	**69.6**	12 monthly	
		Counties Manukau	99.2	●	**93.7**	to	
Target 2019/20:	6% reduction by 2021	Waitemata	62.1	●	**63.3**	Dec-16	
		Metro Auckland	75.4	●	**77.4**		
Measure:	Age-standardised rate per 100,000 domiciled 0-74 year-olds - Maori	Auckland	154.8 (max.)	●	**173.0**	12 monthly	
		Counties Manukau	215.2	●	**184.6**	to	
Target 2019/20:	2% reduction by June 2020	Waitemata	110.8	●	**146.8**	Dec-16	
		Metro Auckland	167.2	●	**175.6**		
Measure:	Age-standardised rate per 100,000 domiciled 0-74 year-olds - Pacific	Auckland	159.3 (max.)	●	**154.9**	12 monthly	
		Counties Manukau	195.2	●	**181.7**	to	
Target 2019/20:	2% reduction by June 2020	Waitemata	136.8	●	**146.4**	Dec-16	
		Metro Auckland	173.5	●	**172.1**		
5. Youth Health							
Measure:	Chlamydia testing coverage for 15-24 year-old males.	Auckland	6%	●	**5.4%**	12 monthly	
		Counties Manukau	6%	●	**4.6%**	to	
Target 2019/20:	6% coverage rate by June 2020	Waitemata	6%	●	**4.9%**	Dec-19	
		Metro Auckland	6%	●	**5.0%**		
Measure:	Alcohol-related ED presentations	Auckland	10% (max.)	●	**4.3%**	12 monthly	
		Counties Manukau	10%	●	**6.5%**	to	
Target 2019/20:	Reduce 'unknown' alcohol related ED presentation status to less than 10%	Waitemata	10%	●	**38.0%**	Jun-20	
		Metro Auckland	10%	●	**15.0%**		
6. Babies Living in Smokefree Households							
Measure:	Proportion of babies living in smokefree homes at 6 weeks postnatal	Auckland	68.1%	●	**71.30%**	12 monthly	
		Counties Manukau	53.9%	●	**51.10%**	to	
Target 2019/20:	2% increase on baseline	Waitemata	63.1%	●	**64.94%**	Dec-19	
		Metro Auckland	61%	●	**61.22%**		

Legend

- ● Target met / on track
- ● Improvement needed
- ● Significant improvement needed
- ● Data or target unavailable

- Metro Auckland Region
- Auckland DHB
- Counties Manukau DHB
- Waitematā DHB

Overall Progress Report

Overarching activities for Q4:

- Implementation of the 2019/20 SLM Improvement Plan is on-going and has become business as usual for many of the stakeholders involved.
- Reporting is released quarterly or more frequently where available to PHOs via Citrix Sharefile or from Healthsafe, which allows safe and secure sharing of confidential information.
- The 2020/21 SLM Improvement Plan has been developed, submitted to the Ministry of Health and approved.

3. System Level Measures Report

Keeping children out of hospital

ASH rates per 100,000 for 0–4 year olds

Improvement Milestone: 3% reduction (on Dec-18 baseline) (by ethnicity) by 30 June 2020

	Milestone Target[2]			**Actual – 12 months to March 2020**		
	Auckland	Counties Manukau	Waitematā	Auckland	Counties Manukau	Waitematā
Total pop.	7,381	6,605	5,672	7,558	6,223	5,577
Māori	7,109	6,355	6,372	8,260	5,895	7,031
Pacific	15,184	11,051	12,417	13,925	10,395	11,269

Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through prevention or therapeutic interventions deliverable in a primary care setting.

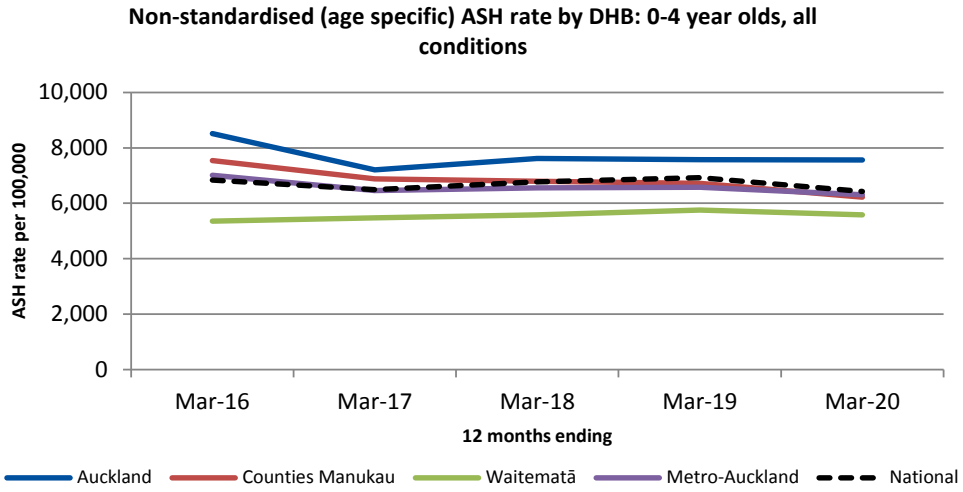
Determining the reasons for high or low ASH rates is complex, as it is in part a whole-of-system measure.

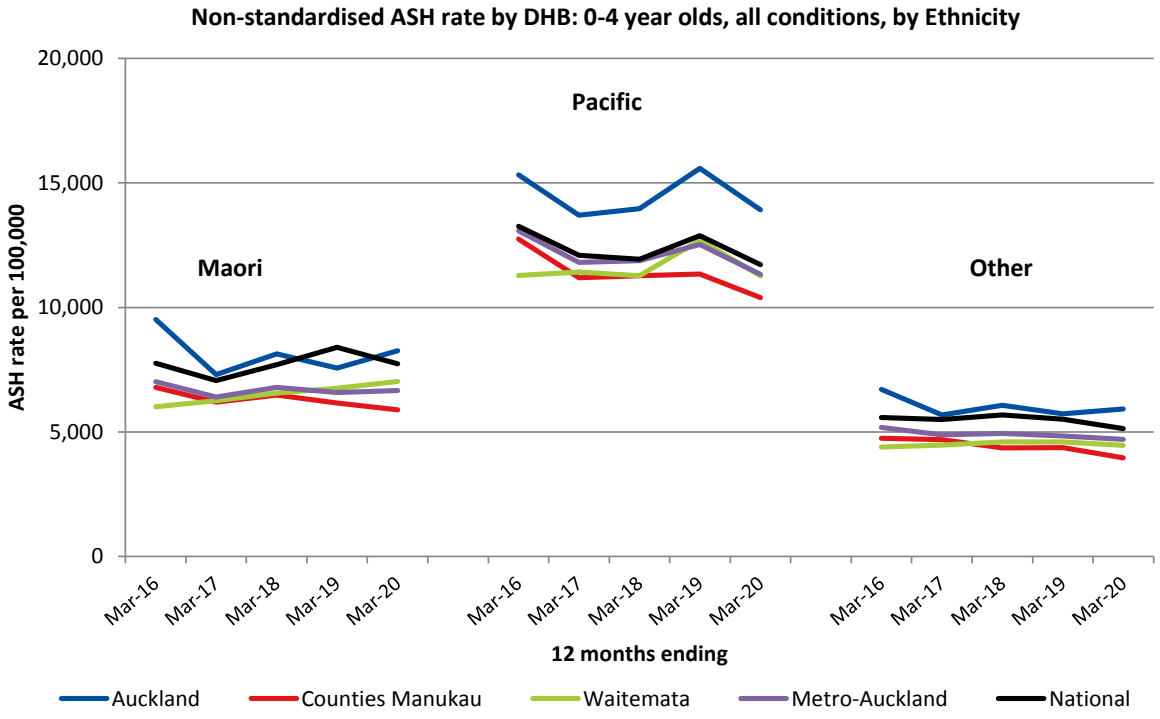
It has been suggested that admission rates can serve as proxy markers for primary care access and quality, with high admission rates indicating difficulty in accessing care in a timely fashion, poor care coordination or care continuity, or structural constraints such as limited supply of primary care workers.

ASH rates are also determined by other factors, such as hospital emergency departments and admission policies, health literacy and strongly, by the overall social determinants of health, particularly housing. This measure can also highlight variation between different population groups that will assist with DHB planning to reduce disparities.

In 2019/20, the overall improvement milestone and the milestone for both Māori and Pacific ASH rates are to achieve a reduction of 3% for 0-4 year olds by June 2020. Ethnic specific targets are important to ensure that interventions reduce, not worsen inequity. Metro Auckland's rate is 6,302 per 100,000 for the 12 months to March 2020 for the total population. This is a 4.5% decrease (improvement) on the results to December 2018 (baseline) of 6,587[2] per 100,000 population. At an ethnic-specific level, the Māori and particularly Pacific rates also improved (by 1.4% and 10.7%) from baseline.

[2] These have been updated, see Note about the population on page 3





The higher (non-standardised) rates for Auckland DHB Pacific children persist, though they are declining compared to the same time last year.

When compared, rates for Pacific are nearly six times that of 'Other' ethnicities across metro-Auckland for dermatitis and eczema, four times the rate for cellulitis and nearly twice the rate for pneumonia. Though numbers are much smaller, Pacific and Māori children are much more likely to be admitted for vaccine preventable MMR (measles, mumps, rubella).

Using health resources effectively

Total acute hospital bed days

Improvement Milestone: 3% reduction (on Dec-18 baseline) for Māori and Pacific population by 30 June 2020 (standardised)

	Milestone Target[2]			**Actual – 12 months to March 2020 (latest available)**		
	Auckland	Counties Manukau	Waitematā	Auckland	Counties Manukau	Waitematā
Māori	647.7	716.7	615.9	606	681	600
Pacific	780.0	754.5	773.9	843	737	829

Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by efficiencies at a facility level, effective management in primary care, better transition between the community and hospital settings, optimal discharge planning, development of community support services and good communication between healthcare providers. Good access to primary and community care and diagnostics services is part of this.

The measure is the rate calculated by dividing acute hospital bed days by the number of people in the New Zealand resident population. The acute hospital bed day's per capita rates will be illustrated using the number of bed days for acute hospital stays per 1000 population domiciled within a DHB with age standardisation.

Certain conditions are more likely to result in unplanned hospitalisation alongside other contributory factors such as the referral process to ED (self, provider variation, ambulance etc.). The social determinants of health are a key driver of acute demand.

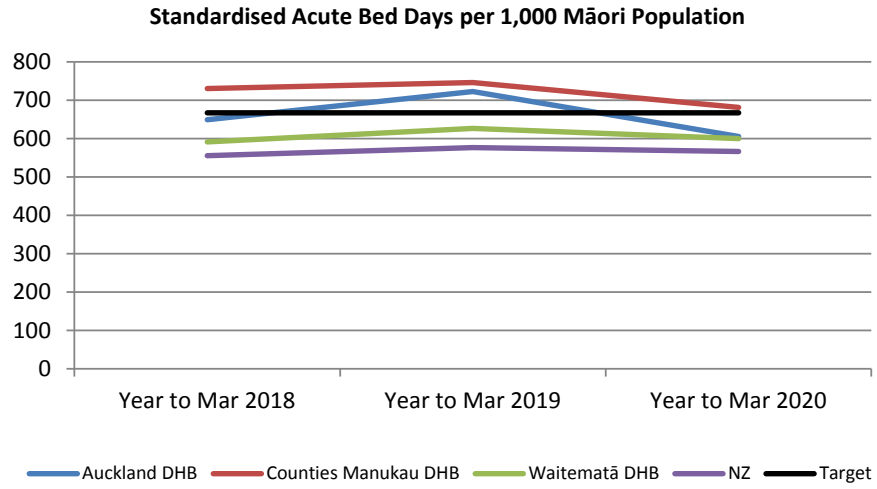
The Auckland Metro age standardised acute bed day rate per thousand population has been re-calculated and targets re-set to reduce the rate by:

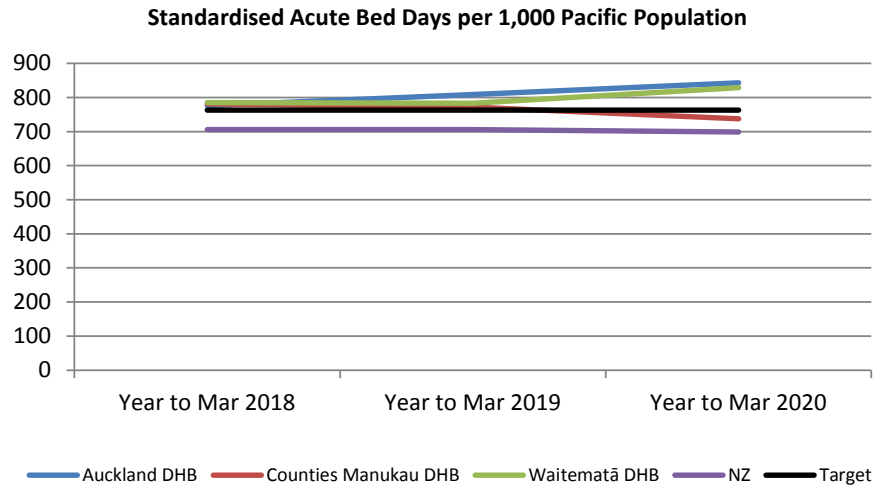
- 3% for the Māori population – target 667.0 standardised acute bed days/1000 by June 2020
- 3% for the Pacific population – target 762.6 standardised acute bed days/1000 by June 2020

It must be noted that the opening of new beds within the region will impact on this indicator.

While overall standardised rates have been generally declining over time, the metro-Auckland ethnic specific rates to March 2020 are mixed. Pacific rates are not meeting target for either Auckland or Waitematā DHBs, rates for Māori are better than target for both these DHBs. For Counties Manukau, performance is the opposite – better for Pacific and worse for Māori.

Note that only three time periods are presented in the trend graphs below, as recalculation of rates has not been done on retrospective datasets prior to this.


Standardised Acute Bed Days per 1,000 Māori Population
800
700
600
500
400
300
200
100
0
Year to Mar 2018
Year to Mar 2019
Year to Mar 2020
Auckland DHB
Counties Manukau DHB
Waitematā DHB
NZ
Target


Standardised Acute Bed Days per 1,000 Pacific Population
900
800
700
600
500
400
300
200
100
0
Year to Mar 2018
Year to Mar 2019
Year to Mar 2020
Auckland DHB
Counties Manukau DHB
Waitematā DHB
NZ
Target

Patient Experience

'Person-centred care' or how people experience health care is a key element of system performance that can be influenced by all parts of the system and the people who provide the care. Integration has not happened until people experience it. The intended outcome for this SLM is improved clinical outcomes for patients in primary and secondary care through enhanced patient safety and experience of care.

Hospital inpatient survey

The nationally applied DHB Adult Inpatient Survey was conducted quarterly from 2014. However, with the move to another reporting provider, the HQSC has taken the opportunity to redevelop both the inpatient and outpatient surveys. Therefore, the survey went into hiatus for most of 2020 and data is only available up until December 2019 (as previously reported). The redeveloped survey was conducted for the first time in August 2020 and results from this are still pending.

The previous Adult Inpatient Experience Survey captured four measured domains - communications, partnership, coordination, and physical and emotional needs. The 2019/20 target was to achieve a 5% improvement on the inpatient survey question: 'Did a member of staff tell you about medication side effects to watch for when you went home?' by 30 June 2020.

Interventions take a multidisciplinary approach, focusing on culturally appropriate patient-centred information, co-design of patient experience initiatives with a focus on Māori and Pacific people, developing an integrated approach to feedback so patient stories can be heard outside of traditional survey collection mechanisms and developing a Māori Patient Experience plan endorsed by the Māori Health Equity Committee.

Learnings are to be shared with primary care through established networks and forums. There is also a focus on improving response rates, especially for Māori and Pacific, and monitoring this through regular reporting.

Auckland DHB established a Patient and Whānau Centred Care Board, with consumers and community partners, to lead and monitor the delivery of the participation and experience work programme.

Improvement milestone: 5% improvement on the inpatient survey question: 'Did a member of staff tell you about medication side effects to watch for when you went home?' by 30 June 2020.

Hospital Inpatient survey – percentage of respondents who answered 'yes, completely', to the inpatient survey question: 'Did a member of staff tell you about medication side effects to watch for when you went home?'

Targets				% of 'yes, completely' result for Q2 2019/20			
ADHB	CMDHB	WDHB	Metro-Auckland	ADHB	CMDHB	WDHB	Metro-Auckland
55.2%	52.5%	47.0%	51.4%	47.4%	58.8%	44.8%	49.4%

With the exception of Counties Manukau DHB, the improvement target was not achieved for this measure in Q2 2019/20. The Metro-Auckland results improved slightly against the 2018 calendar year baseline (49.0%), the Waitematā DHB result did not change from baseline (44.8%), and Auckland DHB's performance is lower than the baseline (52.6%).

Primary health care patient experience survey (PHC PES)

Primary care survey: 10% relative improvement on PES question: 'When you ring to make an appointment how quickly do you usually get to see your current GP?' by 30 June 2020

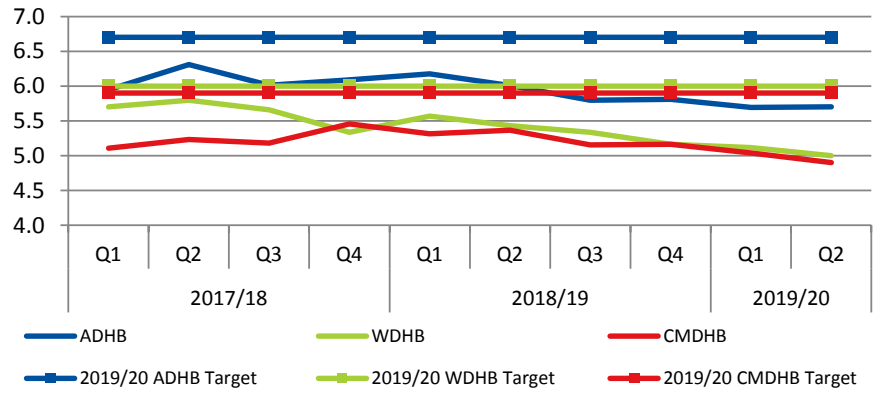
The PHC PES was implemented in practices over the 2017/18 year. Since then, practice participation has steadily increased. The focus this year has been on improving practice response to patient feedback.

Primary health care patient experience survey – percentage of respondents who answered 'same day' or 'next day', to the survey question: 'When you ring to make an appointment how quickly do you usually get to see your current GP?'

Targets (by practice location)				% of 'same day/next day' result for Q2 2019/20			
ADHB	CMDHB	WDHB	Metro-Auckland	ADHB	CMDHB	WDHB	Metro-Auckland
6.7	5.9	6.0	6.2	5.7	4.9	5.0	5.2

None of the three DHBs are meeting target in Q2 2019/20. While Auckland DHB's results are fairly stable, Waitemata and Counties Manukau DHB results are declining.

Percentage of PHC PES respondents who report being able to make an appointment to see their current GP on the same day or the next day (by DHB of practice)



Preventing and detecting disease early

Amenable mortality

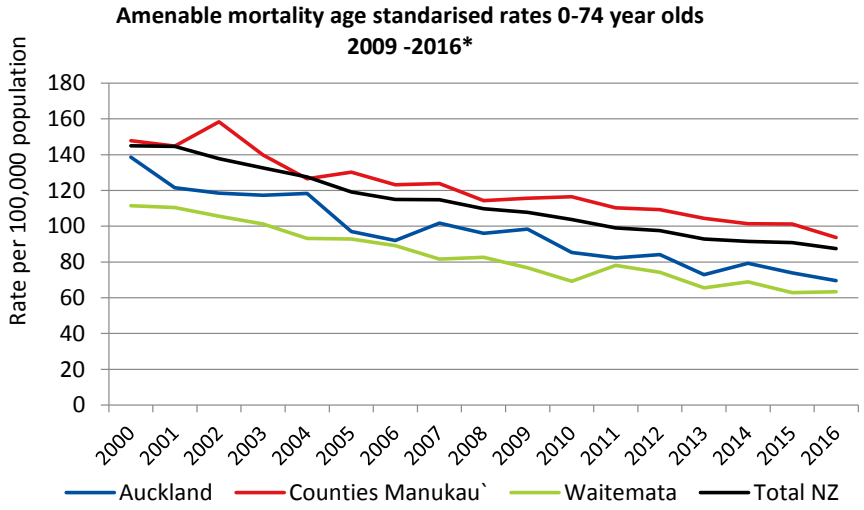
Improvement milestone 6% reduction for each DHB (on 2013 baseline) by 30 June 2021.
2% reduction for Māori and Pacific by 30 June 2020.

Note: no new data is currently available

	Milestone Target			Actual – 2016 deaths (* draft data)		
	Auckland	Counties	Waitematā	Auckland	Counties Manukau	Waitematā
Total Pop	70.4	99.2	62.1	69.6	93.7	63.3
Māori	154.8	215.2	110.8	173.0	184.6	146.8
Pacific	159.3	195.2	136.8	154.9	181.7	146.4

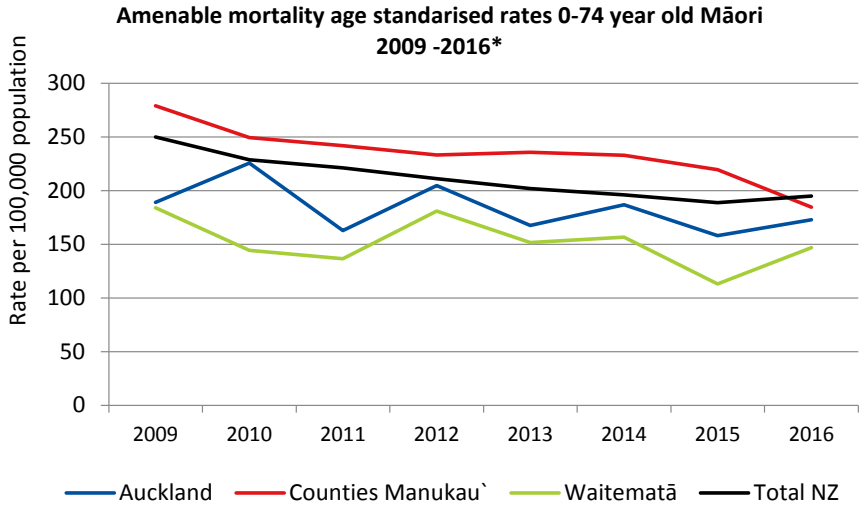
Amenable mortality is defined as premature deaths that could potentially be avoided given effective and timely care. That is, deaths from diseases for which effective health interventions exist that might prevent death before 75 years of age. This indicator considers all deaths for those aged 0-74, in the relevant year

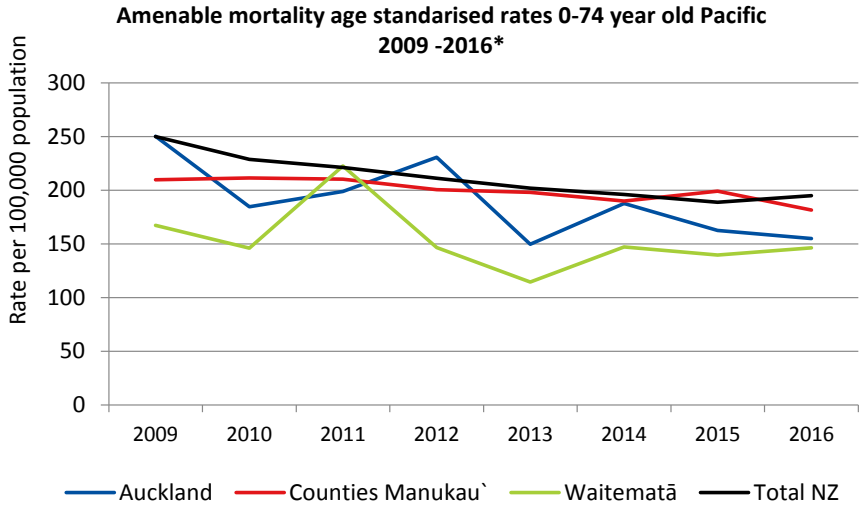
with an underlying cause of death included in the defined list of amenable causes. It takes several years for some coronial cases to return verdicts; therefore results for this indicator are approximately 2-3 years delayed. 2016 mortality coded mortality data has been delayed, so we are unable to provide updated results currently.



Based on trends over time, all three Metro Auckland DHBs show consistently declining rates as illustrated in the graph above, despite some fluctuation. Comparing current (2016) rates with baseline (2015) rates, there is a 2% decline in rates for metro-Auckland, or 1% when comparing the 5 year rates. Given that there will always be some annual fluctuation and that the target extends to 2021, we should be on track to meet the 6% reduction by 2021.

While rates for Māori are also declining, the sharp, consistent decline seen for overall rates is not evident. This is even more so for Pacific rates, however smaller numbers will mean greater year on year variation.




Amenable mortality age standarised rates 0-74 year old Pacific
2009 -2016*
Rate per 100,000 population
300
250
200
150
100
50
0
2009
2010
2011
2012
2013
2014
2015
2016
Auckland
Counties Manukau`
Waitematā
Total NZ

Youth access to and utilisation of youth-appropriate health services

Chlamydia testing coverage in 15-24 year old males

Improvement milestone: increase coverage of chlamydia testing for males to 6% for 15-24 year olds by June 2020.

Results for the 6 month period to December 2019: males only.

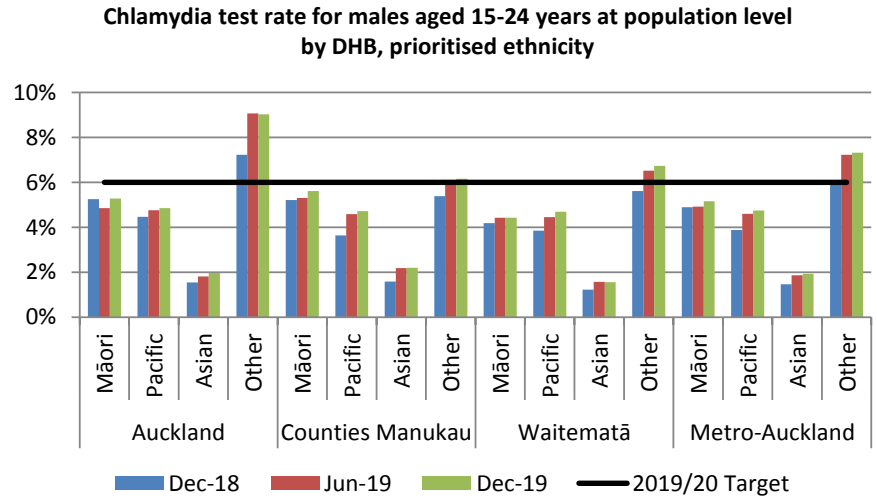
DHB	Ethnicity	No. of males 15-24 years having chlamydia tests	Population	Chlamydia test rate (%)
Auckland	Māori	200	3,790	**5.3%**
	Pacific	249	5,130	**4.9%**
	Asian	280	14,210	**2.0%**
	Other	1,338	14,820	**9.0%**
Counties Manukau	Māori	481	8,570	**5.6%**
	Pacific	569	12,050	**4.7%**
	Asian	264	12,000	**2.2%**
	Other	670	10,870	**6.2%**
Waitematā	Māori	263	5,950	**4.4%**
	Pacific	200	4,270	**4.7%**
	Asian	159	10,270	**1.5%**
	Other	1,432	21,280	**6.7%**
Metro-Auckland	Māori	944	18,310	**5.2%**
	Pacific	1,018	21,450	**4.7%**
	Asian	703	36,480	**1.9%**
	Other	3,440	46,970	**7.3%**

* 6 with unknown gender excluded

Youth have their own specific health needs as they transition from childhood to adulthood. Most youth in New Zealand successfully transition to adulthood but some do not, mainly due to a complex interplay of individual, family and community stressors and circumstances, or risk factors. Research shows that youth whose healthcare needs are unmet can lead to increased risk of poor adult health and overall poor life outcomes.

The focus for 2019/20 has been on sexual and reproductive health – specifically on Chlamydia Screening for 15-24 year old males for whom testing coverage has been very low. Chlamydia is the most commonly reported sexually transmitted infection in Auckland, usually diagnosed in females aged 15-19 years and in males aged 20–24 years. However, in the context of SLMs, chlamydia screening is being used as a proxy for access to sexual health services.

At a population level, screening coverage rates for men have improved when comparing the six months to December 2018 and the six months to June 2019. This will need further monitoring to understand if these rates continue to trend upwards. Overall, the target of 6% coverage for males is not being reached, despite the upward trend.



At a population level, screening coverage rates for men have improved overall, when comparing the six months to December 2019 and the six months to December 2018. However, the rates for Māori, Pacific and Asian males have not increased as markedly as they have for other ethnicities, effectively widening the gap between each of these ethnicities and Other ethnicities screening coverage. The only exception at DHB level is for Counties domiciled Pacific males, where there is a small decrease in gap between Pacific and other ethnicities screening coverage.

Current results – at PHO enrolled population level:

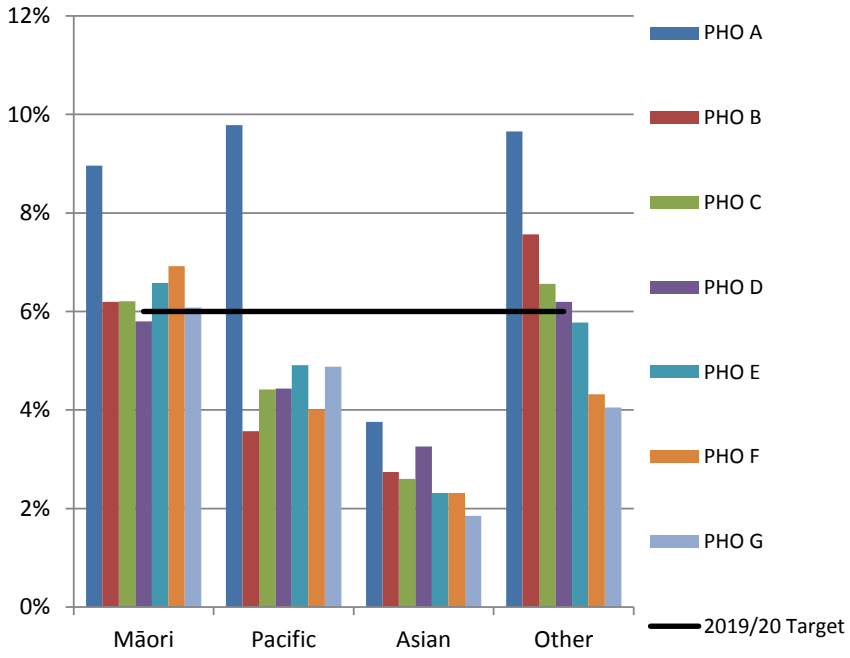
Results at this level are much better and improving over time – the enrolled Māori population appears to have the best overall coverage. The differences between this level and population level coverage rates suggests that there is under-enrolment for this cohort of the population.

Results at December 2019 (target 6%):

PHO	Ethnicity	No. of males 15-24 years having chlamydia tests	Population	Chlamydia test rate (%)
PHO A	Māori	25	279	9.0%
	Pacific	36	368	9.8%
	Asian	41	1,091	3.8%
	Other	122	1,264	9.7%
PHO B	Māori	64	1,033	6.2%
	Pacific	36	1,008	3.6%
	Asian	42	1,533	2.7%
	Other	70	925	7.6%
PHO C	Māori	433	6,977	6.2%
	Pacific	371	8,394	4.4%
	Asian	253	9,719	2.6%
	Other	1,670	25,454	6.6%
PHO D	Māori	78	1,345	5.8%
	Pacific	150	3,381	4.4%
	Asian	52	1,596	3.3%

PHO	Ethnicity	No. of males 15-24 years having chlamydia tests	Population	Chlamydia test rate (%)
	Other	110	1,775	6.2%
PHO E	Māori	103	1,565	6.6%
	Pacific	52	1,059	4.9%
	Asian	57	2,464	2.3%
	Other	533	9,234	5.8%
PHO F	Māori	169	2,442	6.9%
	Pacific	256	6,387	4.0%
	Asian	74	3,196	2.3%
	Other	57	1,320	4.3%
PHO G	Māori	20	329	6.1%
	Pacific	8	164	4.9%
	Asian	27	1,456	1.9%
	Other	133	3,282	4.1%

Chlamydia test rate for males aged 15-24 years at PHO enrolled population level by ethnicity

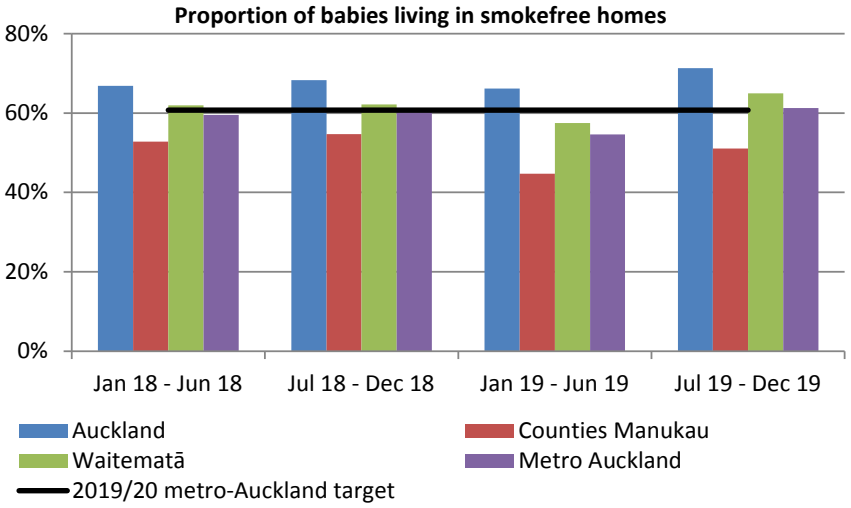


Healthy start

Proportion of babies who live in a smoke-free household at six weeks post-natal

Improvement milestone: Increase the proportion of babies living in smokefree homes by 2% (Jan 18 – Jun 18 baseline)

Reporting period	DHB of domicile			
	Metro-Auckland	Auckland	Counties Manukau	Waitematā
Jan 18 - Jun 18	59.5%	66.8%	52.8%	61.9%
Jul 18 – Dec 18	60.9%	68.3%	54.7%	62.2%
Jan 19 - Jun 19	54.6%	66.2%	44.7%	57.5%
Jul 19 – Dec 19	61.2%	71.3%	51.1%	64.9%
2019/20 Targets	**60.7%**	**68.2%**	**53.9%**	**63.2%**

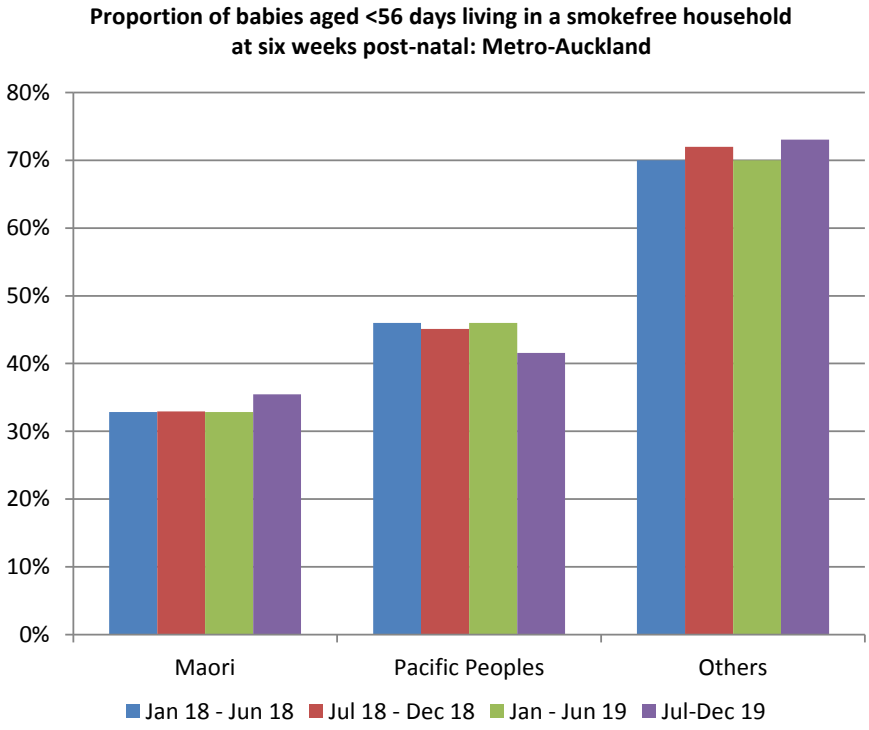


The release of this data from the Ministry of Health has been sporadic and delayed and the methodology for calculating the measure has changed three times. Therefore the data presented uses only the latest methodology. Results show that only Counties Manukau DHB is not reaching the DHB's individual target although performance has improved since the last reporting period.

This measure aims to reduce the rate of infant exposure to cigarette smoke by focusing attention beyond maternal smoking to the home and family/whānau environment. It will also encourage an integrated approach between maternity, community and primary care. It emphasises the need to focus on the collective environment that an infant will be exposed to – from pregnancy to birth and the home environment within which they will initially be raised.

Data is sourced from Well Child Tamariki Ora providers and shows that around 61% of metro-Auckland babies live in a smokefree household at 6 weeks post-partum with a small improvement since the Jan-Jun 2018 reporting period.

The percentage of Māori babies living in smoke free homes is much lower than other ethnicities - 29% in Counties Manukau DHB, 38% in Waitematā DHB and 48% in Auckland DHB. Rates for Pacific are also lower than other ethnicities. This correlates with rates of smoking in pregnancy, and general smoking, in Māori and Pacific populations.


Proportion of babies aged <56 days living in a smokefree household at six weeks post-natal: Metro-Auckland
80%
70%
60%
50%
40%
30%
20%
10%
0%
Maori
Pacific Peoples
Others
Jan 18 - Jun 18
Jul 18 - Dec 18
Jan - Jun 19
Jul-Dec 19

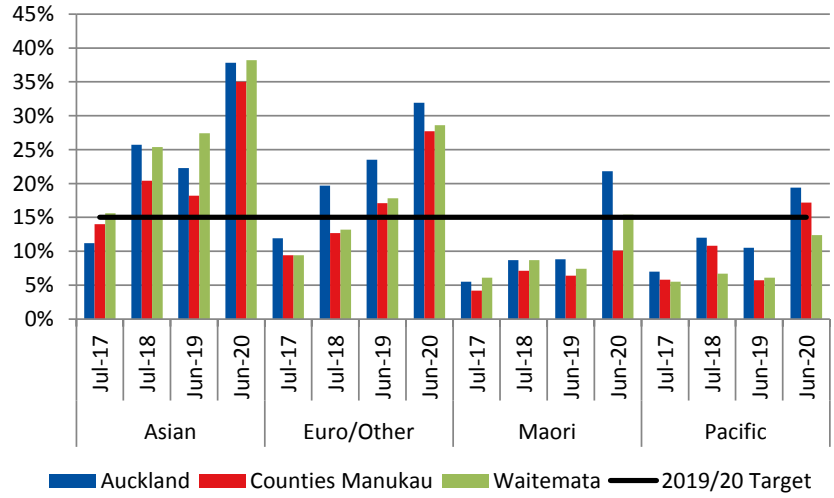
4. Improvement Activities and Contributory Measures

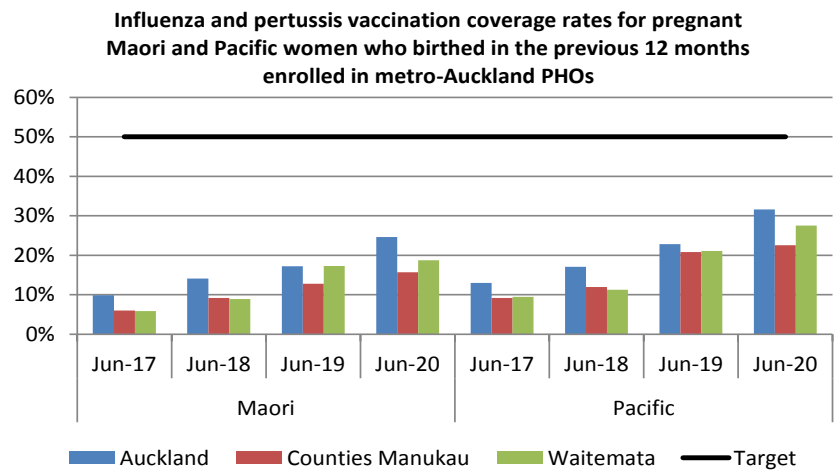
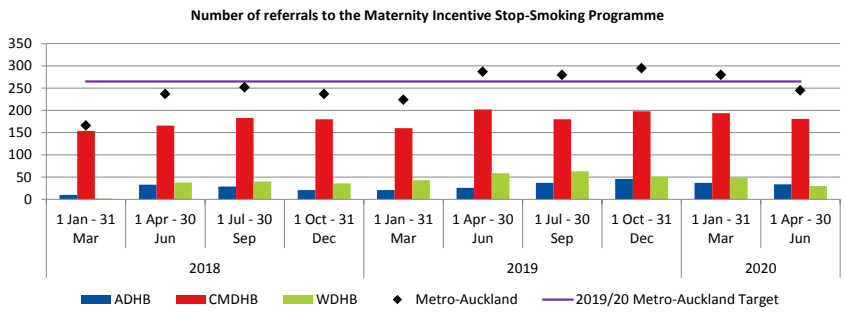
Improvement activities create change and contribute towards improved outcomes in the various SLM milestones. These activities are measured locally by contributory measures which support a continued focus in each area. Activities support the improvement of the system as a whole. For 2019/20, Auckland Metro region focused on choosing activities which relate to multiple milestones where possible for best collective impact.

Respiratory Admissions in 0-4 year olds

SLM Milestones impacted: Ambulatory Sensitive Hospitalisation (ASH) Rates per 100,000 for 0 – 4 Year Olds
Amenable mortality
Babies in Smoke free Homes
Acute hospital bed days

Respiratory conditions are the largest contributor to ASH rates in Metro Auckland. Pertussis (whooping cough) and influenza are potentially very serious conditions in infants and young children, and can lead to further respiratory complications; both of these are vaccine preventable. Social factors like housing and smoking also contribute to poor respiratory health. We are working to increase referrals to healthy housing programmes and help more pregnant women quit smoking. eReferrals for smoking and healthy housing went live in early 2019, supporting a reduction in ASH admissions. We are working with healthAlliance to develop a process for matching e-referral data to PHO registers with a view to driving increased referrals from practices.

Indicator	Target	Results
Influenza vaccination rates for eligible Māori and Pacific children	15%	***Flu vaccination rates at July 2017, July 2018, June 2019 and June 2020 for children hospitalised with a respiratory condition***  **Commentary** • Overall coverage has increased from 7.4% in July 2017 to 22.8% in June 2020. Coverage rates have consistently increased since monitoring and improvement activities began. • Auckland DHB domiciled children have the highest coverage at 27.5% • While a coverage rate of nearly 23% has been achieved for the total population, rates for Māori and Pacific children continue to be much lower, though these are also increasing and for the first year, the 15% target has been exceeded for both Māori and Pacific children in Auckland DHB • Four of the seven PHOs have surpassed the 15% target for their eligible Māori children, and all but one have surpassed this target for their Pacific children. Implementation of the special immunisation programme had wide support by PHOs, although national supply chain logistics challenges related to influenza vaccine may have adversely affected these results. The data matching process conducted by DHBs produced valuable lists for action supported by PHOs. Concerns about COVID-19 in the community and coordinated efforts to vaccinate vulnerable populations as part of winter planning likely impacted the increase in uptake in quarter 4. Further integration of processes in practice PMS and workflow will likely see greater gains. Vaccination rates should continue to improve – particularly for Māori and Pacific children – with integration into wider systems such as inpatient services – where the first vaccination is given in hospital, socialisation of the importance of flu vaccination for children can occur alongside more effective use of discharge summaries.

Indicator	Target	Results
Increase influenza and pertussis vaccine coverage rates for pregnant Māori and Pacific women	50%	 **Commentary** Combined antenatal influenza and pertussis vaccination rates have improved markedly since June 2017. Results for Māori have more than doubled for both Counties Manukau and Auckland DHBs and more than trebled for Waitematā DHB. Improvements for Pacific are also obvious. Despite this, coverage for both Māori and Pacific pregnant women is still well below the target of 50% and below that of 'Other' ethnicities. Antenatal pertussis vaccination rates for Māori and Pacific were below 10% for all the metro-Auckland DHBs in 2016 and are now over 27% for Māori and over 37% for Pacific. Across 2018 and 2019 there has been a significant uplift across multiple ethnicities. To June 2020, the highest vaccination coverage rates (12 month period) are seen among women domiciled in Auckland DHB (61.5%), followed by Waitematā DHB (54.4%) and Counties Manukau DHB (42.2%). By ethnicity, Auckland and Waitemata DHBs have the best results for Māori at 37.5% and 31.6% respectively, with Counties Manukau at 22.3%.
Increase referrals to maternal incentives smoking cessation programmes, for pregnant women	ADHB = 27 WDHB = 58 CMH = 180 = 265 per quarter	 **Commentary** Overall performance for the region met the 2019/20 target, with all but Waitematā DHB meeting quarterly targets., Referral numbers have continued to grow - overall a 48% increase since March 2018. Note that the differences in referral numbers between DHBs reflects the size of the programme operating at each DHB – the Counties programme being much larger than the others. A system whereby pregnant women are required to opt out of referral to smoking cessation was successfully trialled in one DHB and has been adopted by the other two and is being considered by PHOs. Implementation has been incomplete and will be further supported over the next year. Better integration with Maternity Services is also needed.

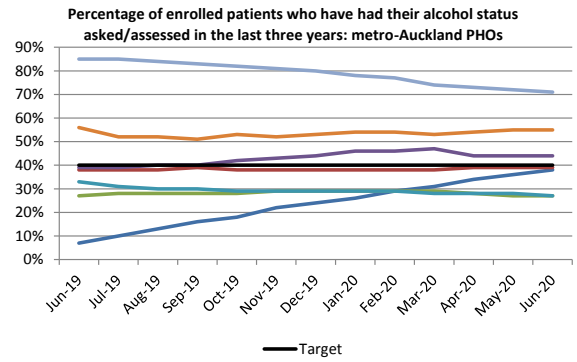
Alcohol Harm Reduction

SLM Milestones impacted: ***Youth access to and utilisation of youth-appropriate health services***
Acute bed days
Amenable mortality

Identifying and monitoring alcohol-related ED presentations will enable better understanding of alcohol harm and the populations and communities most affected. From July 2017, a mandatory data item was added to the National Non-admitted Patient Collection. In some DHBs, full implementation and reporting to the Ministry has taken some time to implement. The mandatory question is "Is alcohol associated with this event?" Possible answers are: yes, no, unknown and secondary (e.g. passenger in car driven by drunk driver, or victim of violence where alcohol is involved). It should be noted that the response recorded may be a subjective assessment by healthcare staff and not confirmed by alcohol testing. Data quality has been a significant issue, particularly for Waitematā DHB, with missing data in some areas. However, quality improvement work undertaken during 2018/19 resulted in the question becoming mandatory, achieving some improvement; however work is on-going.

Alcohol ABC in primary care has been rolled out in some areas, led by a Counties Manukau programme. A SLM Implementation group specifically for Alcohol ABC has been established and will consider the resource required to offer practice support and quality improvement. The 2020/21 SLM Plan has included Alcohol ABC within the Counties Manukau catchment, and these will be evaluated and lessons shared.

Indicator	Target	Results	Commentary
Percentage of ED presentations where alcohol involved	Baseline	Data quality at Waitematā DHB remains insufficient to be able to baseline metro-Auckland results correctly.	Data capture is now mandatory at Waitematā DHB resulting in improved quality for 2019/20 reporting, but still with some issues to resolve.
Reduce 'unknown' alcohol related ED presentation status	<10%	Results (latest available) to March 2020 (DHB of service): Auckland DHB = 4.1% Counties Manukau DHB = 5.6% Waitematā = 55.2%	See above.

Indicator	Target	Results	Commentary
Percentage of the enrolled population aged over 14 years with alcohol status documented *Note: PHOs de-identified*	40%		The data is only available from practices with Medtech PMS and represents 73% of the enrolled population aged over 14 years. Currently three of the seven PHOs are meeting or exceeding the target of 40%, with another two very close. We are working with PMS vendors to reduce the amount of missing data. A quality improvement approach across all DHBs is in development, but has been delayed due to the increased requirements in the sector for COVID-19 response.

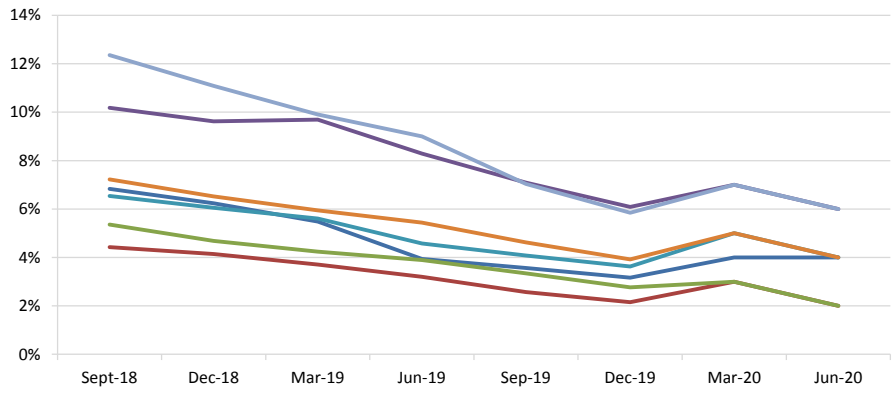
Smoking Cessation

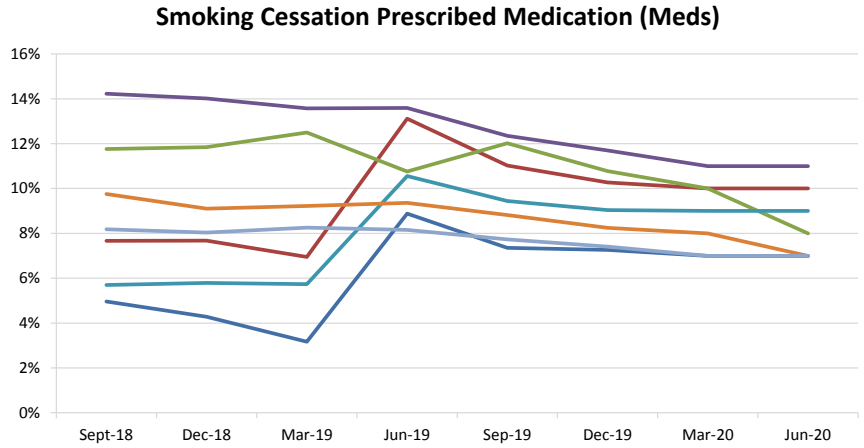
SLM Milestones impacted: ***Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds***
Acute bed days
Amenable mortality
Babies in smoke free homes

Tobacco smoking is a major public health problem in New Zealand. In addition to causing around 5,000 deaths each year, it is the leading cause of disparity, contributing to significant socioeconomic and ethnic inequalities in health. In 2011, the Government set a goal of reducing smoking prevalence and tobacco availability to minimal levels, essentially making New Zealand a smoke-free nation by 2025. Using the 2018 usually resident population, 13% of New Zealanders smoked tobacco every day. That rate was even higher among Māori (28%) and Pacific people (21%), although reduced since 2013. Differences continue to be evident in the prevalence of smoking between the three ethnicity groupings of European/Other, Māori and Pacific.

Indicator	Target	Commentary
Rate of referral to smoking cessation providers by PHO *Note: PHOs de-identified*	N/A – new indicator developed	Referral rates have previously been measured using Read codes in the practice PMS. This has been found to be inaccurate – thus performance cannot be measured against the target set. A new definition has been developed for an alternative performance indicator that measures referrals received by Ready Steady Quit and CMH Living Smoke free.

Smoking Cessation Referrals to Ready Steady Quit and Living Smokefree services



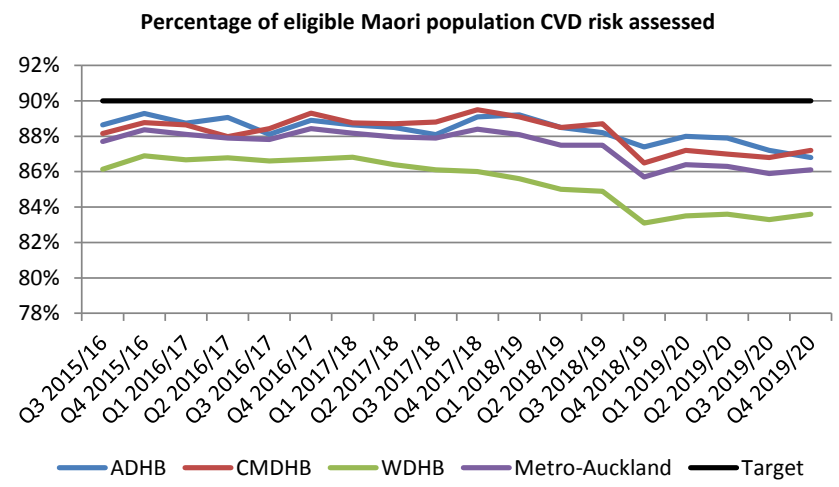
Indicator	Target	Commentary
Rate of prescribing of smoking cessation medications by PHO *Note: PHOs de-identified*	N/A – new indicator developed	Measuring prescribing rates using Read codes under reports primary care prescribing. Again, performance cannot be measured against the target set and a new definition has been developed for an alternative performance indicator that measures prescriptions supplied, sourced from PHOs' PMS systems. 

Cardiovascular Disease (CVD) Risk Assessment and Management

SLM Milestones impacted: ***Acute bed days***
Amenable mortality

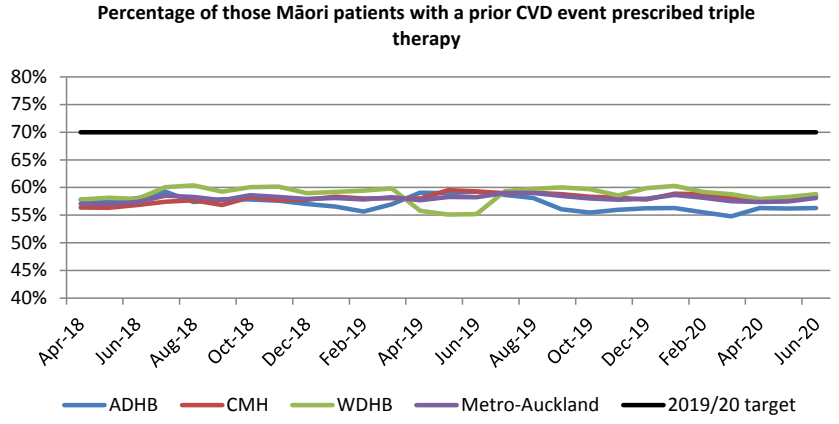
CVD is a major cause of premature death in New Zealand and contributes substantially to the escalating costs of healthcare. Modification of risk factors, through lifestyle and pharmaceutical interventions, has been shown to significantly reduce mortality and morbidity in people with diagnosed and undiagnosed CVD. Patients with established CVD (and those assessed to be at high CVD risk) are at very high risk of coronary, cerebral and peripheral vascular events and death, and should be the top priority for prevention efforts in clinical practice.

The burden of CVD falls disproportionately on Māori and Pacific populations, and there are well-documented inequities in CVD mortality, case fatality and incidence. Reducing these inequities is a high priority and can be achieved through increased use of evidence-based medical management of high-risk patients.

<table>
<tr><th>Indicator</th><th>Target</th><th>Results</th></tr>
<tr><td>CVD Risk Assessment rates for Māori</td><td>90%</td><td> 

Commentary
The introduction of the new CVDRA algorithms following the 2018 consensus statement has likely contributed to lower CVDRA rates. The process for risk assessment was less clear. The number of people eligible for risk assessment was increased. Considerable work has been done by PHOs to implement the new risk assessment algorithms.

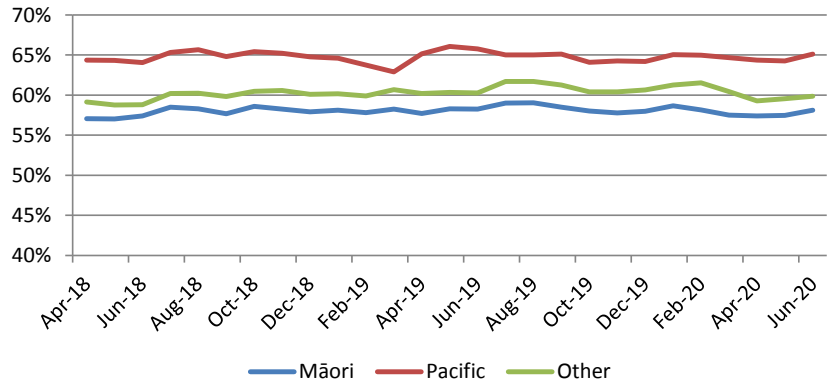
Results show performance is declining over time, particularly for Waitematā DHB, although this seems to have levelled off over the past financial year.

Various strategies have been tried by PHOs to engage with young Māori men to measure cardiovascular risk. Considerable resource has been required with minimal results, primary car enrolment and engagement is low for this age cohort. Many of these men do not engage with primary care. PHO led initiatives at work places and at social events have encountered barriers including:
• Difficulty in obtaining blood results
• No clear criteria for referral and follow-up for patients at different levels of clinical acuity
• Lack of processes resulting in poor flow of data between systems including practice management systems, Testsafe and risk assessment tools
• Patients being enrolled in different PHOs
• Cost of running initiatives
Extensive discussions on approaches and results have been had at both Implementation and Steering Group level with the resulting view that a nationally driven health promotion approach is more likely to result in success.</td></tr>
<tr><td>Increase prescribed triple therapy for those Māori with a prior CVD event.</td><td>70%</td><td> 
</td></tr>
</table>

10.1

<table>
<tr><th>Indicator</th><th>Target</th><th>Results</th></tr>
<tr><td></td><td></td><td>
Commentary
Note: there were some data quality issues between April-June 2019 which accounts for the dip in performance at this time

Results remain relatively static over time for Māori and remain lower than for other ethnic groups. All DHBs are below the 70% target, for all ethnicities.

Percentage of enrolled metro-Auckland patients with a prior CVD event prescribed triple therapy


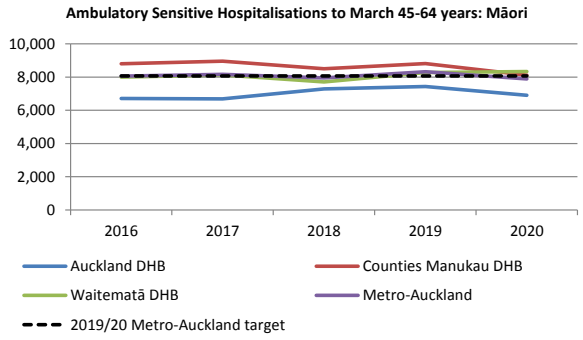
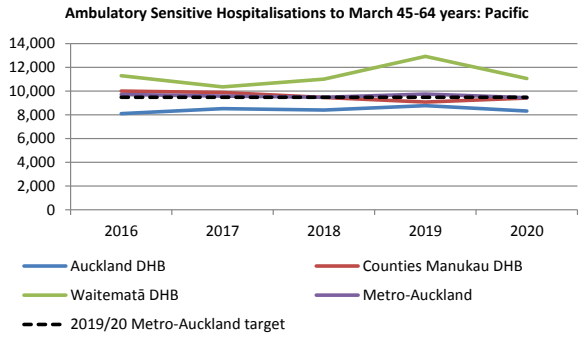
See commentary above.
</td></tr>
<tr><td>Influenza vaccination rate for patients with a prior CVD event under 65 years of age</td><td>35%</td><td>
<table>
<tr><th></th><th>CY 2018</th><th>CY 2019</th></tr>
<tr><td>Auckland</td><td>31.6%</td><td>27.1%</td></tr>
<tr><td>Counties Manukau</td><td>30.4%</td><td>31.1%</td></tr>
<tr><td>Waitematā</td><td>25.6%</td><td>31.8%</td></tr>
</table>
<table>
<tr><th>Metro Auckland</th><th></th><th></th></tr>
<tr><th></th><th>CY 2018</th><th>CY 2019</th></tr>
<tr><td>Māori</td><td>28.9%</td><td>25.5%</td></tr>
<tr><td>Pacific</td><td>38.7%</td><td>34.4%</td></tr>
<tr><td>Asian</td><td>32.7%</td><td>30.8%</td></tr>
<tr><td>European/Other</td><td>23.7%</td><td>26.3%</td></tr>
</table>
Waitemata DHB's coverage shows the greatest improvement overall when comparing the two time periods available, as well as significant improvement by ethnicity – results for Māori have increased by 5.7% and for Pacific by 3.5% (absolute). In contrast, Auckland DHB's results have deteriorated across all ethnic groups, but particularly for Māori and Pacific. Māori and Pacific rates for Counties Manukau DHB have also decreased, but not as significantly. However, Pacific rates are closest to (or surpassing) target across all three DHBs.

Influenza coverage calculation issues, impacting Auckland DHB particularly, have been outlined in the Funder Update to Board previously. A key challenge with this indicator is the under recording of vaccinations in the NIR. Vaccinations delivered at work places are not recorded in either the NIR or the practice PMS. This makes setting recalls in primary care an inefficient process.
</td></tr>
</table>

Complex Conditions

SLM Milestones impacted: ***Acute bed days***
Amenable mortality

Improving chronic condition hospital admission rates for adults requires improved integration of services and a 'whole of system' approach that engages patients and their families, as well as community and hospital based services. A number of activities have been shown to be effective in reducing avoidable hospitalisations for chronic conditions, including system or institution-wide programmes to improve access to health services, comprehensive disease management programmes which are patient-focused and involve multidisciplinary teams, education and self-management programmes in association with disease management programmes and disease-specific management programmes for long-term conditions.

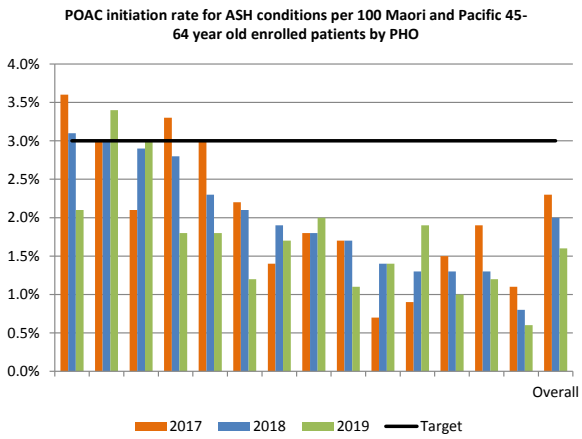
Indicator[3]	Target[2]	Results	Commentary
Reduction in the overall ASH rate for Māori adults aged 45-64 years old.	8,073 per 100,000 (2% reduction) (Baseline = 8,238 per 100,000 at December 2018)		Coding of ASH in primary care has improved over time, with the development of a more robust definition. We are monitoring utilisation of Primary Options for Acute Care (POAC) for ASH related conditions for Māori and Pacific patients aged 45 – 64 years. Data sharing between primary and secondary care to improve coding for ASH conditions contributing to acute hospital bed days has been agreed under the Metro Auckland Data Sharing Framework. Data has been supplied from the Ministry of Health. Processes for improving coding are in development. Improved coding of long term conditions in primary care will support targeting appropriate cohorts with QI activity.
Reduction in the overall ASH rate for Pacific adults aged 45-64 years old.	9,474 per 100,000 (2% reduction) (Baseline = 9,667 per 100,000 at December 2018)		

[3] Note: rates are standardised

Primary Options for Acute Care

SLM Milestones impacted: ***Acute bed days***
Amenable mortality

Primary Options for Acute Care (POAC) provides healthcare professionals with access to investigations, care or treatment for their patient, when the patient can be safely managed in the community. Access to existing community infrastructure and resources is utilised to provide services that prevent an acute hospital attendance or shortens hospital stay for patients who do attend or are admitted. The aim of POAC is to deliver timely, flexible and coordinated care, meeting the healthcare needs of individual patients in a community setting. We aim to have more individuals being treated (where appropriate) through the POAC pathway, thus preventing unnecessary and costly acute hospital admission.

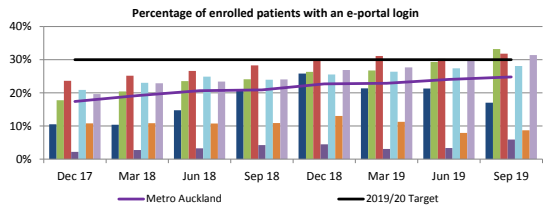
Indicator	Target	Results	Commentary
Increased POAC initiation rate for 45-64 year old Māori and Pacific people with ASH conditions	3 per 100 (3%) per PHO	 **Variation by PHO (split by DHB location) across the metro-Auckland region (PHOs not identified)**	Initiation rates vary by geographic location, even where the PHO is the same. Overall, rates have declined between reporting periods. Regular POAC data has not been available until recently and there have been various data quality issues to resolve. NHI level data is available to PHOs. *See commentary above.*

Patient Experience

E-portals

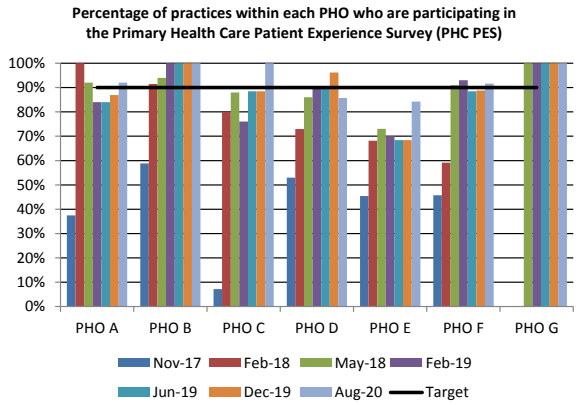
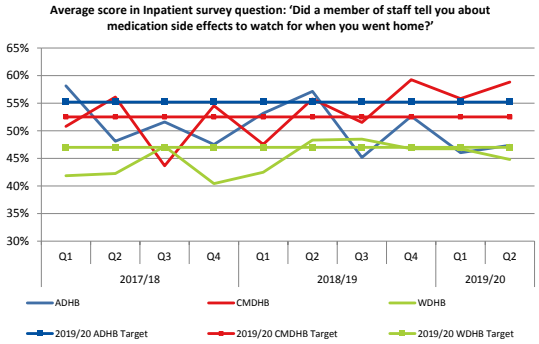
SLM Milestones impacted: ***Patient experience of care***

E-portals are a single gateway for patients to gain access to their general practice information which can include: booking appointments, ordering repeat prescriptions, checking lab results, and viewing clinical notes/records. More general practices are offering patient portals and there is scope within primary health care for them to positively impact on patient experience. This can be enabled through alternative access point/navigation for the patient, enabling coordinated self-managed care provision; maintaining and providing online communication; and partnering with the patient to work collaboratively online (lab results, appointment bookings, care monitoring-physical needs).

Indicator	Target	Results	Commentary
Percentage of each PHO's enrolled population with login access to a portal	30%	 **Variation by PHO across the metro-Auckland region and change over time (PHOs not identified)**	Note: data for the last two quarters has been delayed, due to COVID response work. Previous data showed the target was achieved in three of the seven PHOs, but not for the Metro Auckland enrolled population. One PHO that did not achieve the target is actively piloting a new portal system.

Patient Experience Surveys in Primary and Secondary Care

'Person centred care' or how people experience health care is a key element of system performance that can be influenced by all parts of the system and the people who provide the care. Integration has not happened until people experience it. The intended outcome for this SLM is improved clinical outcomes for patients in primary and secondary care through improved patient safety and experience of care.

Indicator	Target	Results	Commentary
Maintain or increase practice participation in the PHC PES (as at February 2019)	February 2019 baseline = 90%		The majority of PHOs are meeting or nearly meeting the target to maintain baseline participation rates.
Average score in Inpatient survey question: 'Did a member of staff tell you about medication side effects to watch for when you went home?'. Target 5% improvement.	5% improvement Targets: ADHB: 55.2% CMDHB: 52.5% WDHB: 47.0% (Metro-Auckland target = 51.4%)	 **Q2 2019/20 Metro-Auckland result = 49.4%**	Note: no new data available. Survey has been redeveloped and ceased during the second half of 2019/20. New survey implemented from August 2020. As at December 2019, only Counties Manukau DHB was surpassing target, although Waitemata was tracking closely. Auckland DHB had not met target for the previous 12 months.

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. Apologies	N/A	N/A
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. Confirmation of Confidential Minutes 12 August 2020	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	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 Circulated Resolution - Circulated Resolution - Health System Catalogue Business Case	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	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 - NIL	**N/A**	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4.1 Greenlane Clinical	**Commercial Activities** Information contained in this report is	That the public conduct of the whole or the relevant part of the meeting would

Centre Car Park Update	related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	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 Risk Management Update	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time.	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 Chief Executives Confidential Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 Human Resources Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time	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 Second Draft: Pūmanawa Tāngata - A plan for Strengthening our Organisational Culture and Building our People Capability 2020-2023	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report	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]

	and would prejudice or disadvantage if made public at this time	
8.1 Finance, Risk & Assurance Committee Minutes – for information	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	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 Capex Variation Approvals for: Facilities Infrastructure Remediation Programme (FIRP) Tranche 1, FIRP Tranche 2 Central Plant and Tunnel Main Contractor Procurement Strategy Amendment and Starship Hospital (SSH) Outpatient Refurbishment Stage 2	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time.	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 Facilities Infrastructure Remediation Programme – Tranche 3 Summary Assessment of Risks	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.3 Hospital Administration Replacement Project(HARP) - Single Stage Business Case	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Obligation of Confidence** Information which is subject to an obligation of confidence is enclosed in the report.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.4 Business Case for Additional Cath Lab Capacity	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	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

	Prevent Improper Gain Information contained in this report could be used for improper gain or advantage if it is made public at this time.	1982 [NZPH&D Act 2000]
9.5 Regional Joint Audit Committee	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
10.0 Discussion Reports - Nil	**N/A**	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11.1 healthAlliance Key Highlights Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
12.0 General Business	**N/A**	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]