AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Open Board Meeting

Wednesday, 04 November 2020

10:00am

Note:

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

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

Healthy communities | World-class healthcare | Achieved together
Kia kotahi te oranga mo te iti me te rahi o te hāpori

Published 30 October 2020

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

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

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

Well Being to All.

Agenda
Meeting of the Board
4 November 2020

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

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	
	Marlene Skelton	Corporate Business Manager
	(Other staff members who attend for a particular item are named at the start of the respective minute)	

Karakia

Agenda

Please note that agenda times are estimates only

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

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?

10.05am **3.** **CONFIRMATION OF MINUTES 23 September 2020**

10.07am **4.** **ACTION POINTS**

4.1 Patients effectively connecting with the hospital system.

10.20am **5.** **EXECUTIVE REPORTS**

5.1 Chief Executives Report

5.2 Health and Safety Report

	5.3	Auckland DHB Pūmanawa Tāngata Update November 2020
	5.4	Auckland DHB People Dashboard – Quarter 1 2020/21
11.00am	**6.**	**PERFORMANCE REPORTS**
	6.1	Financial Performance Report
	6.2	Planning and Funding Outcomes Update
11.30am	**7.**	**COMMITTEE REPORTS**
	7.1	Hospital Advisory Committee
	8.	**DECISION REPORTS**
	8.1	Te Toku Tumai – Auckland DHB Strategy 2020-2023
11.35am	**9.**	**INFORMATION REPORTS**
	9.1	Statement of Performance Expectations (SPE) Performance Report: Quarter Four 2019/20
	9.2	Northern Region Service Annual Plan 2020/21
	9.3	Maternity Services Data Update
	10.	**GENERAL BUSINESS**
12.15pm	**11.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Next Meeting:	16 December 2020 at 10.00am A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

Healthy communities \| World-class healthcare \| Achieved together

Kia kotahi te oranga mo te iti me te rahi o te hāpori

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	23 Sept 20	4 Nov 20	16 Dec 20
Pat Snedden (Board Chair)	1	c	1	1	1	1	1		
Joanne Agnew	1	c	x	1	1	1	1		
Doug Armstrong	1	c	1	1	1	1	1		
Michelle Atkinson	1	c	1	1	1	1	1		
Zoe Brownlie	1	c	1	1	1	1	1		
Peter Davis	1	c	1	1	1	1	1		
Tama Davis	1	c	1	1	x	1	1		
Fiona Lai	1	c	1	1	1	1	1		
Bernie O'Donnell	1	c	1	1	1	1	1		
Michael Quirke	1	c	1	1	1	1	1		
Ian Ward	x	c	1	x	1	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 Partner – CAYAD, Auckland Council Board Member – Waitakere Health and Education Trust	07.10.2020
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
23 September 2020

Minutes of the Auckland District Health Board meeting held on Wednesday 23 September 2020 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 10am

Board Members Present	**Auckland DHB Executive Leadership Team Present**	
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	Debbie Holdsworth	Director of Funding – ADHB/WDHB
Fiona Lai	Meg Poutasi	Chief of Strategy, Participation and Improvement
Bernie O'Donnell	Shayne Tong	Chief Digital Officer
Michael Quirke	Sue Waters	Chief Health Professions Officer
Ian Ward	Justine White	Chief Financial Officer
	Dr Margaret Wilsher	Chief Medical Officer
	Auckland DHB Senior Staff Present	
	Allan Johns	Director Facilities and Development
	Auxilia Nyangoni	Deputy Chief Financial Officer
	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)	

ADDITIONAL LATE ITEM FOR CONFIDENTIAL BOARD

Te Toka Tumai – ADHB Strategy 2020-2023

Resolution: Moved Pat Snedden / Seconded Tama Davis

1. **That the Board allow consideration of the report Te Toka Tumai – ADHB Strategy 2020-2023 as a late item under Standing Order 3.2.9 (5) for the reason that the report was due to be considered at this meeting but did not make it onto the agenda as there was a requirement to consolidate and check information before presenting. Consideration is required to allow the Board to provide direction to management to allow continuation of work in finalising the Strategy.**

2. **That the report Te Toka Tumai – ADHB Strategy 2020-2023 be considered in confidential section because it carries an Obligation of Confidence. Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report. The report suggests structural change that will require consultation and is therefore confidential in the interim.**

Carried

1. ATTENDANCE AND APOLOGIES

There were no apologies to record.

2. REGISTER AND CONFLICTS OF INTEREST

Zoe Brownlie asked that the following changes be made:

Remove 'GenderTick Director'

Add 'Waitakere Health and Education Trust Board Member'.

There were no conflicts of interest with any items on the open board agenda.

3. CONFIRMATION OF MINUTES 12 AUGUST 2020 *(Pages 8-36)*

Resolution: Moved Jo Agnew / Seconded Tama Davis

That the minutes of the Board meeting held on 12 August 2020 be confirmed as a true and accurate record.

Carried

4. PRESENTATION

4.1 Health Quality and Safety Commission – Presentation

Dr Janice Wilson, Chief Executive, Collin Tukuitonga (HQSC Board Member) and Iwona Stolarek, Executive Lead Quality and Systems attended the meeting to make a presentation. [Attachment 4.1]

Board Member Discussion

Peter Davis asked whether the Commission was planning to bring Aged Residential Care facilities into its purview in light of COVID 19 having revealed some quality issues within these facilities.

He also asked how the Commission chose its areas of focus. Presumably the Commission wished to bring to the attention of DHBs areas that would have a high pay off which the DHBs could concentrate on and make a real difference to the safety of patients. Typically patients suffering an adverse event are in hospitals for twice the normal length of time compared to patients who are not.

Dr Janice Wilson drew attention to slide 6 saying there was a programme that included Aged Residential Care facilities. Work had been done building relationships with a strong focus around infection prevention control particularly during COVID. Guidance had been produced for the ARPHS sector on IPC issues.

Work has also been done with HealthSearch and the Ministry to try to understand the main issues they are seeing within Aged Residential Care facilities. The areas of medication safety care and pressure injuries are areas of interest. Work is being done with all partners and the Ministry to

bring all that intelligence together.

The Commission when choosing its areas of focus was conscious of the need to understand its partners individual context and issues and that there may be local projects already underway or things that the Commission did not really understand that would explain why a marker might be skewed for a quarter. This is where a partnership is required so both entities work together to determine what support is required and what the Commission might offer that is of value to its partner.

The intelligence that the Commission can offer is a national collective view that allows DHBs to connect over common issues.

Peter Davis was advised that the Commission had its own quality safety markers and its own adverse event reporting. This data would be part of the new dashboard reporting.

Doug Armstrong asked whether the Heather Simpson report had looked at the role that the Health Quality and Safety Commission played within the health sector and if there was any determination from them. Dr Janice Wilson advised that the report had quoted some of the Commissions publications, particularly around equity. It is the Commissions understanding that it was intended that the Commission continue to have a role. In most health jurisdictions around the world there is a separate agency of some form focusing on quality and safety. This is not to be confused with the performance role of either the Ministry or like agencies. This is why the Commission exists as a separate agency to be closer to the sector to be a helping hand to Boards and staff in undertaking the tasks required around quality and safety.

The Board Chair, Pat Snedden commented that when the Commission was set up it was to provide this degree of separation. The ability to be a "critical friend" has always been one of its major advantages. The fact that the Commission sits outside the performance strictures imposed by the Ministry on Boards enables the Commission to provide expertise and help organisations address issues. The Commission has a wider strategic role which has been beneficial. The national serious events reporting had enabled health agencies to determine how they are keeping people safe in hospitals.

Collin Tukuitonga (HQSC Board Member) agreed that it was useful to have an agency like the Commission that was somewhat removed from day-to-day decision making and resource allocation to be able to keep an eye on issues of health, quality and safety. Collin welcomed the focus that he Commission brought to the issue of equity. The system was a good one for most people but not everyone and there were improvements to be made.

Peter Davis asked whether there were reports that come from the Mortality Review Committee that addressed issues in system terms rather than narrow clinical terms. He was advised that there was an agreed approach for measurement across New Zealand. There are committees that are focused on systems change for example the Child Youth and Mortality Committee and increasingly other committees are expanding their view.

Michael Quirke asked whether the new quarterly reports were designed for management or were also available to Boards and was advised that they would be provided to both the Chief Executive and Board Chairs. There would be a focus on highlighting data from any deep dives that had been undertaken within an organisation with an opportunity for the organisations to respond to that data

and comment.

That Board Chair, Pat Snedden thanked Dr Janice Wilson, Chief Executive, Collin Tukuitonga (HQSC Board Member) and Iwona Stolarek, Executive Lead Quality and Systems for attending the meeting and for the splendid work being done by the Commission along with the important support offered to the health system.

5. ACTION POINTS *(Page 37)*

There were none to consider.

6. EXECUTIVE REPORTS

6.1 CHIEF EXECUTIVE'S REPORT *(Pages 38-51)*

Ailsa Claire, Chief Executive asked that the report be taken as read, advising as follows:

Shared Goals of Care

Margaret Wilsher advised that the Shared Goals of Care programme had been successfully rolled out for the last three weeks across the Adult Hospital. It had been successfully trialled in general medicine. The multi disciplinary team appreciates having a more comprehensive approach to determining what the goals of care actually were as opposed to relying on a simple resuscitation form. It does mean that more active and proactive conversations must be had with patients and whanau, but that is a good thing.

Auckland DHB Top Ten Carbon Reducers of 2020

This was a good piece of work undertaken by Rosalie Percival and Manjula Sickler who championed it through the organisation. The acknowledgement was well deserved.

COVID 19 Response

There has been a wide range of work occur across the organisation particularly in the way the organisation interacted with Maori and Pacific.

During this period there was a significant redeployment of Auckland DHB staff, particularly nurses. There was a larger redeployment than that made by other metropolitan DHBs and this has had an impact on electives services. There is still a significant number of staff on redeployed to ARPHS.

New Digital Visitor Screening Tool

Shayne Tong advised that a digital visitor screening tool had been created automating what was a paper based manual activity. This allows visitors to pre-register and scan which assist with flow and queue management. That data is important for contact tracing and this tool allows a digital file to be sent straight to the ARPHs contact tracing team.

Board members were advised that the reception of the tool had been positive as it allowed public to undertake the screening themselves and to quickly get where they needed to go.

It was also advised that the tool was scalable allowing other regional DHBs to utilise it. Northland had done so.

Social Media

Ailsa Claire encouraged Board members to look at some of the videos that had been produced. The aim was to assure the public that the Hospital was safe place and their safe care was important.

Local Hero Awards

Ailsa Claire drew attention to page 46 of the agenda and the award given to Duncan Bliss.

Ka Pai - Shout Out

This is an interactive workspace where anyone can post an acknowledgement of a job well done.

Ailsa Claire drew attention to page 47 of the agenda and the acknowledgement given to the cleaners. During COVID 19 a lot more cleaning has had to be undertaken in areas where there was potential for infection to enter the hospital.

Assurance was given that the cleaning staff had been given training and the right equipment to safely undertake their tasks.

Senior Leadership Changes

Noting in particular the farewell to Rosalie Percival, Chief Financial Officer and the welcome to Justine White to that role.

Performance of the Wider Health System

It was pleasing to be able to maintain the cancer target which is a significant undertaking during COVID 19.

There is a new calculation which will affect the target "PHO enrolled population" as a result of a change to the population denominator. It is anticipated that as a result of this change that in future months Auckland DHB will meet this target.

It is good to see the target relating to pregnant women registered with a DHB employed midwife or LMC has been exceeded.

Immunisation targets are being maintained as well.

Financial Performance

With the removal of COVID 19 related cost the Board is running just under budget.

The following was covered during discussion of the report:

- Zoe Brownlie extended a warm welcome from the Board to the new Chief Financial Officer, Justine White.
- Peter Davis drew attention to page 42 of the agenda and a reference to appointment letters, asking whether email or text was used to advise patients of appointments. On page 43 of the agenda there was also a reference to "unwired workforce" and he asked whether they should not be issued with pagers querying what might be the best technical solutions to employ given that not everyone has the same access to modern technology.
  Jo Gibbs advised that a text service was offered where people had a mobile phone. Patients

themselves when registered were asked what their preferred method of communication was.

Doug Armstrong added that at the last meeting he had asked how much was being spent on postage. In his opinion a lot of communication was still being conducted by post when email and text was the modern way of conducting business and offered cost savings.

A person's email address travelled with them where ever they went making them contactable all the time.

Ailsa Claire advised that when patients entered the hospital they were asked how they wished to be contacted and whether they were prepared to share their email address and mobile phone number. That was a choice made by the patient. There are also problems email and mobile communication with inaccurate email addresses being provided and with the different mobile platforms ability to interact with hospital systems.

Action

The patients the hospital communicates with should be able to effectively connect with the hospital system.

A short briefing document be provided to the next meeting outlining

- **How often appointment letters/emails went astray/could not be sent**
- **How the new system being invested in would resolve these communication issues**
- **Cost of postage associated with patient communication.**

Resolution:

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

Carried

6.2 Health and Safety Report *(Pages 52-61)*

Mark Edwards, Chief Quality, Safety and Risk Officer asked that the report be taken as read, advising that the report highlights the volume of work undertaken by the Occupational Health Team during COVID particularly during the second outbreak.

The following was covered during discussion of the report:

Mark Edwards advised the Board Chair, Pat Snedden that the Health and Safety area was still a relatively new one to Mark and that he acknowledged that there could be aspects where he 'did not know what he did not know' yet and that kept him vigilant. He was heartened by the fact that there was a relatively comprehensive and well developed risk matrix. However, the organisation was still learning how to use that effectively; interpreting the analysis of risk and relating that to exactly what had happened on the ground was key. Ensuring that the organisation is not reporting for the sake of reporting and that there was an understanding of how people were performing their jobs and managing risk related to health and safety in the workplace was important.

Peter Davis drew attention to page 54 of the agenda commenting that figures had been presented per million hours making it difficult to comprehend or grasp that as a proportion of a million. When studied the rate appears to be a fraction at 0.1%. Was there any way a lay person could get a clear

sense of how important the figures were in terms of potential risk. Peter was advised that this is reported as per industry standard. The biggest lost time injury is with manual handling. Reporting that in a comprehensive and understandable way is a focus over the next months.

Peter Davis also drew attention to page 57 where it had been reported that no Auckland DHB staff member had been infected with COVID as a result of attending work at the hospital and was assured that this was correct and was a result of the work actively done to protect the organisation.

Michael Quirke drew attention to page 56 of the agenda and mention of blood and body fluids, in particular the summary sentence below the graph which mentions inconsistencies in controls. What are those inconsistencies and how serious are they? Mark Edwards advised that the highest rate of incidents sits with needle punctures. There are controls that should be followed with sharps use which are not being inconsistently followed. There is also currently an inconsistent approach across the organisation in relation to needle technology being used.

Ian Ward drew attention to page 55 and contractor management risk which appeared to be high. Mark Edwards advised that this was due to work being done with ACC via the Safe 365 project which had highlighted risks in a way that hadn't previously been visible. On that basis the risk has been moved to high noting that two more years of that project have yet to run which should reduce that risk over that period. Ailsa Claire advised that there had been a reinterpretation relating to contractors with overlapping duties. WorkSafe has provided a reinterpretation which is not consistent with previous legal advice. Nationally legal advice is being sought to determine whether the WorkSafe interpretation is correct.

Fiona Lai drew attention to page 58 noting that over 300 observations had been undertaken asking if there were any surprises revealed by these observations which should be drawn to the Boards attention. Mark Edwards responded that those of most concern were around COVID 19 related risk and manual handling procedures. These results are considered at the time of the incident and then feedback is shared at local and directorate level.

Zoe Brownlie was advised that training around workplace violence and aggression had been halted during COVID 19 as face-to face training had not been possible due to physical distancing issues. The awareness element of the training had been continued via an online course. Full training will be resumed as soon as possible.

Resolution:

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

Carried

7. PERFORMANCE REPORTS

7.1 Financial Performance Report (*Pages 62-68)*

The Board Chair, Pat Snedden welcomed Justine White to her first Board meeting commenting that she had joined the Auckland DHB with high recommendations and the Board was very pleased to have her join the Executive Management Team.

Justine advised that she had been at Canterbury and West Coast DHBs for 8 years and prior to that

in banking and finance so had had a career in finance.

Justine White, Chief Financial Officer asked that the report be taken as read, advising as follows:

The year end audit process had revealed no issues to report and the process is on track to meet the new statutory reporting timeframe of 18 December 2020.

The Board is working to a deficit budget of $45M for 2020-2021 although the Annual Plan has yet to be signed off.

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.

There are other significant variances which are due to vacancy levels , accrued annual leave and some outsourced personnel costs

Clinical Supplies are $0.4M (1.6%) slightly favourable.

In terms of overall risk this can be seen in the pressure on variance, budgeted FTE and vacancy levels that are inherent in the unfavourable budget of $45M. A close eye will need to be kept on these areas.

The other risk area is around IDF, planned care and associated revenue.

The following was covered during discussion of the report:

Michael Quirke commented that putting COVID cost aside and making the assumption that it will be covered, the two month year to date $3M unfavourable figure against personnel cost was the next concerning cost. Although an eye will be kept on it this is not a situation that can be left to grow. Ailsa Claire advised that this cost related to the vacancy factor and accrued annual leave. In normal circumstances there was a vacancy factor covering the gap between a staff member leaving and a successful recruitment which had an assumption factor of $10M built in for the organisation. The current position is that staff were not leaving and that cost has had to be spread across all directorate budgets. While the accrued annual leave position has eased there is still the backlog to be addressed.
Michael Quirke asked what mitigations had been put in place to address the situation and was advised that there were attempts to create other saving opportunities. All cost would be looked at as there are no areas of obvious savings left to draw from. This situation is likely to continue until such time as there is significant movement of staff again.

Peter Davis asked whether the staff ratios negotiated with the Unions were done so on the understanding that a certain number of posts would remain unfilled or were they set on the assumption that all posts would be filled as they were at present. It could be argued that the organisation did not have to work to those ratios if all posts are filled at present. Jo Gibbs advised

that there is not a vacancy factor on the whole in the nursing establishment similar to that existing in other staff establishments. For example Junior Doctors have been over recruited to ensure that expensive agency locums did not have to be employed. When those Junior Doctors do not leave that causes issues. Historically they would have gone overseas to gain further experience, COVID is preventing this.

The Board Chair, Pat Snedden suggested that a closer look at this issue was required. There are competing issues to be considered such as the Board wishing to meet the Crown requirement to CCDM and it was now known that staff are cautious about taking leave because they cannot go overseas creating an accrued annual leave situation along with a nil vacancy factor. There will also be the responsibility to take on the allocated number of Junior Doctors and graduate nurses in coming months. The situation is sufficiently complicated that it needs a closer look.

Jo Agnew was advised that the organisation was currently employing to a vacancy if there was one to employ to. Margaret Dotchin advised that a cohort of nurses had been taken on in September, around 75% of what would normally be taken on. The biggest cohort of new graduate nurses is taken on in February. Currently work was being done to look at what vacant positions could be held or forecast to accommodate that intake or one of the CCDM positions. Auckland DHB is likely to only take 50% of the February new graduate nurse intake.

The Board Chair, Pat Snedden was advised that a number of nurses are currently deployed to ARPHS undertaking contact tracing with some in the managed isolation facilities. Regional conversations were underway to look at the creation of further flexibility by deploying more nurses into the managed isolation or quarantine facilities and backfilling their positions with new graduates. This would enable the organisation to place these new graduates and also gain a cost benefit because they would be employed at a lesser salary than a fully experienced nurse.

Doug Armstrong supported Michael Quirke's comments adding that productivity and efficiencies needed to be considered too. Staffing costs needed to be closely studied to determine whether the new modes of care, ie the Telehealth approach was actually going to result in savings.

Doug wanted any closer look to cover these issues too however, the Board Chair, Pat Snedden felt that the situation around employment relations meeting budget requirements and options available for achieving that needed to be understood first.

Action

That a short paper be presented to the next Board looking at accrued annual leave and vacancy factors taking into account there are competing issues to be considered such as the Board wishing to meet the Crown requirement to CCDM and it was now known that staff are cautious about taking leave because they cannot go overseas creating an accrued annual leave situation along with a nil vacancy factor. There will also be the responsibility to take on the allocated number of Junior Doctors and graduate nurses in coming months.

Resolution:

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

Carried

7.2 Planning and Funding Outcomes Update (*Pages 69-85)*

Debbie Holdsworth, Director of Funding – Auckland and Waitemata DHBs asked that the report be taken as read, advising that COVID had had a disproportionate impact on the teams workload in this reporting period.

There were three main areas of impact, staff that have been seconded into the COVID response, the reduction of service during COVID particularly in Oral Health which has been severely impacted and lastly the confidence of the population in seeking out and using community services.

Teams affected were the Primary Health Care team involved with community testing, the Planning and Intelligence team but with a disproportionate impact on Maori and Pacific communities, these teams who have been involved in community outreach activities.

Pipeline Work

Karen Bartholomew provided comment around the following:

Maori Health Pipeline

There is currently a review of the Maori pipeline for the Iwi Partnership Board looking at what is in the pipeline at the moment, the status and progress made, what has been learned when undertaking the work, what the future might look like and where the gaps and opportunities are.

Lung Cancer Screening

All the foundational preparation work has been able to be completed despite COVID. The Consumer Advisory Group has been established and materials and pathways developed. In addition surveys have been completed within Northland DHB which will be compared with the Auckland surveys and will be useful in designing the next stage. Planning is well under way to get screening started early next year.

Breast Screening Project

With the success of the programme an additional data match has been undertaken. Patients who are not enrolled in Primary Care, potentially the highest risk group, have been the subject of this second data match. As breast screening restarts and when rebooking people this has allowed a focus to support Maori enrolment and screening.

Maori Provider PHO Data Match

There have been some challenges obtaining the data during COVID as obviously the Maori providers have been heavily involved in the COVID response as well. Data was obtained from two thirds of the providers and that report is going to the Maori data Oversight Group this week. It does show that there is a sufficient quantum of people engaged with Maori Providers that aren't enrolled with primary care for progressing the next phase of the work to be undertaken. Work will be done with the Oversight Group about how to take this forward with Maori Providers, including designing what an intervention might look like.

Pacific AAA Screening

Despite the COVID delays the Tongan pilot is nearly completed. A proposal is being developed to extend it to other pacific groups as it has been very successful.

The outcome from the Maori AAA programme was very successful and the Iwi Partnership Board was looking in particular, extending that into Northland. There were a number of large and small AAA's found for Maori during the programme. The uptake of the programme was very good.

The following was covered during discussion of the report:

Bernie O'Donnell asked for an explanation of what the Iwi Partnership Board was and what they did. Karen advised that it involved Iwi across Auckland, Waitemata and Northland and with DHB Chairs looking at how a co-governance relationship can be moved forward.

Bernie O'Donnell was advised that the Whanau Ora Commissioning Agency was not engaged with the Iwi Partnership Board at this point, other than being a recipient of funding. The Commissioning Agency itself did not have a direct relationship but could do so in the future.

Bernie O'Donnell commented that there were times when the models of engagement needed to be updated. There were other groups that had been established, like Whanau Ora, to be part of the Hauora matrix that is being developed to ensure that services reached and covered all Maori and Pacifika. Bernie believed that this was another conversation that was required moving forward to determine what Mana Motuhaki looked like in a contemporary world.

The Board Chair, Pat Snedden believed that the Iwi Partnership Board would be open to that conversation.

Peter Davis was advised that residents in Aged Residential Care Facilities have lower rates of hospitalisation than those living in own homes and ARC therefore reduces demand on the hospital system. The national certification process for aged care facilities does include feedback obtained from residents and their whanau as well as feedback from staff as to satisfaction with care provided.

Peter Davis was assured that the Lung Cancer Screening programme did have a Control Group.

Fiona Lai drew attention to page 72 of the agenda and the childhood immunisation vaccination schedule and reported data pertaining to tamariki Maori. Fiona commented that timings of vaccination is crucial, particularly that second dose and it was good to see that home visits were being undertaken to ensure vaccination took place. She asked that when these visits occurred during lockdown whether staff observed any evidence of family violence. This question could not be answered at the time and Debbie Holdsworth undertook to follow-up.

Fiona Lai drew attention to page 77 of the agenda focusing on the youth health and high school based service noting that Asian students had a lower rate of access to the health centre and asked why that might be. Debbie Holdsworth advised that these services are designed to reach those students that otherwise do not access primary care services through other means. The service is aimed at Maori and Pacific students to improve access, so it is expected that the proportion of Asian students is lower than this at 16 %.

Fiona Lai drew attention to the graph at the bottom of page 77 and whether there was a correlation to household income. Ailsa Claire commented that it could be looked at. Debbie Holdsworth advised that the high school based service is only provided in low decile 1-4 schools so it would reflect socio economic factors. It has now been extended to reach into decile 5 schools in addition

to decile 1- 4.

The Board Chair, Pat Snedden commented that generally in the health market place that there are significant socio economic and ethnicity issues for people getting access to healthcare and people's degree of comfort and experience in getting access to healthcare is very significantly different. The data collected doesn't provide that picture for the Asian population.

Debbie Holdsworth advised that the high school based service is only provided in low decile 1-4 schools so it would reflect socio economic factors. It has now been extended to reach into decile 5 schools.

Fiona Lai asked whether sexual health education was provided in these schools and was there any partnership with other agencies to provide this information to youth. Debbie Holdsworth advised that the predominant service provided by the Enhanced School Based Service was provided directly to students rather than generic public health education. They use the HEEADSSS assessment to identify unmet need. Zoe Brownlie added that she was aware that the Auckland Sexual Health Service did provide education to 25 lower decile schools around Auckland.

Debbie Holdsworth was later in the conversation able to advise that a HEEADSSS assessment involved having a bio-psychosocial Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety (HEEADSSS) assessment to identify unmet health needs. Debbie drew member's attention to item 6.2 of the 12 August Open Board agenda which provided a summary on the Enhanced School Based Health Service and how it operated.

Tama Davis asked how Counties Manukau DHB was included in the mix with the Iwi Partnership Board. It was his observation that there appeared to be a regional commitment and locality delivery issue around service. Karen Bartholomew commented that providing clarity around the extent of this was a contributing factor to undertaking the review of the Maori Health Pipeline. The Iwi Partnership Board had indicated that they wished Northland to be covered. Currently the work covers Auckland and Waitemata together or separately and Counties Manukau in some of the programmes, Northland is included in one project. The review will highlight locations where work is being undertaken and test what extension or locality based view is required going forward

Resolution:

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

Carried

8. COMMITTEE REPORTS - NIL

9. DECISION REPORTS

9.1 Delegations during COVID-19 Event Response – Updated *(Pages 86-87)*

Ailsa Claire, Chief Executive asked that the report be taken as read advising that this was a procedural matter.

Resolution: Moved Pat Snedden / Seconded Jo Agnew

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 Delegati	
Role	Name	Current		Proposed	Current	Pro
		Budgeted	Unbudgeted	All	All	
CEO	Ailsa Claire	500	300	1,000	3,000	No
CFO	Justine White	250	150	500	1,000	No

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.**

Carried

10. INFORMATION REPORTS

10.1 System Measures Level Report *(Pages 88-117)*

Dr Karen Bartholomew, Director, Health Outcomes for Auckland and Waitemata DHBs asked that the report be taken as read, advising as follows:

This report is provided six monthly and is a monitoring report that was developed for the Alliance Leadership Team – the primary care DHB partnership that oversees the programme and receives this information. The intention of the Ministry of Health is to embed a quality improvement approach and integrate across sectors. The nature of the indicators is meant to drive that approach. It is not intended to be used for performance but more for how quality improvement works and it can be got to work in Primary Care. The programme itself is maturing and plans are being extended and refined rather than substantially changed.

There is a lot of data in the report. Each of the six lead indicators have an implementation group underneath them and those implementation groups get comparative data; comparative from both PHOs and practises across metro Auckland. They also get drill down data to patient level so that they get a good look at outliers and comparisons.

In terms of the Q4 report, to note that the SLM programme has lost its programme manager, and in general progress has been slowed due to primary care responses in COVID. There are also substantial data delays from the Ministry of Health who supply the main reporting. The recent population data changes have substantially affected the indicators and the Ministry hasn't actually

managed to supply all of the different indicators where they have had retrospective impact. Some of the trend data isn't very accurate and this has to be born in mind.

Despite these challenges the new SLM plan has been completed and approved by the Ministry of Health. The refinements include a delivery frame around collective impact and a more explicit life-course approach. There is some refocusing around adult ASH conditions, looking in particular at complex conditions, ie cardiovascular disease management, using POAC more efficiently, adding alcohol in as an indicator and there is work around falls prevention and frail elderly. In relation to child ASH healthy housing referrals has been added as a key determinant.

Despite recent challenges there have been positive results with the respiratory contributory measure around influenza vaccination. For Maori and Pacific groups the target of 15% was met for the first time after four years of tracking that result. Karen drew attention to antenatal vaccination for Maori women in particular, is substantially higher than it has been previously. While neither indicator is what is required yet they are showing substantial tracking progress.

The following was covered during discussion of the report:

The Board Chair, Pat Snedden asked whether the in the report it had been annotated where the data was subject to review and was advised that the Ministry sets the six top level indicators so there is input with those in terms of what they are or the data availability. The contributing measures are controlled by the Alliance and many of them are data quality improvement work with Primary Care. Areas where there are questions about data quality or completeness, for example smoking cessation pharmaceutical supply are noted throughout the report.

Peter Davis asked if there was any way in which feedback could be provided on the impact of ASH actions in Primary Care. 30% of under fives being admitted for conditions that could be treated in Primary Care is a major issue. It would be good to know what actions are being undertaken by the PHOs to address this to prevent a young person getting to the stage of hospitalisation.

On page 94 where it mentions efficient use of hospital services and there is a total plus Maori and Pacific should you not have elderly or people over 70 to denote people who have more complex conditions and/or more frail health issues which require longer term hospitalisation and whether that would be a good indicator too. It would be reassuring to look at this over time.

Karen Bartholomew commented that the aim in the way the system level measures were constructed along with the contributory measures was that the areas of focus are to have measurable indicators associated with them. ASH is the headline but the key activities underneath to address the key drivers of ASH are what are tracked and measured to assess improvement and reveal variations, for example the vaccination progress just mentioned. She noted that a deep dive into ASH was proposed for CPHAC to look at this in more detail.

The Board Chair, Pat Snedden commented that in the conceiving of the strategic approach being taken to addressing of the issues of the people in our area this close relationship with Primary Care in planning and collectively addressing issues is actually bread and butter activity that this kind of detail is not always very visible to Board members, so it is very positive to see.

Resolution:

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

Carried

11. GENERAL BUSINESS - NIL

12. RESOLUTION TO EXCLUDE THE PUBLIC *(Pages 118-212)*

Resolution: Moved Pat Snedden / Seconded Michelle Atkinson

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.	**N/A**	That the public conduct of the

Action Points - NIL		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 Centre Car Park 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.	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 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	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]

	report and would prejudice or disadvantage if made public at this time	
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 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 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. **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]
9.5 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]

The meeting closed at 4.00pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 23 September 2020

Chair: _____ Date: _____

Pat Snedden

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

Kupu Taurangi Hauora o Aotearoa

Introduction to the Health Quality & Safety Commission

23rd September 2020

Dr Janice Wilson & Dr Iwona Stolarek

Dr Collin Tukuitonga – Board Member

Mō mātou | About us

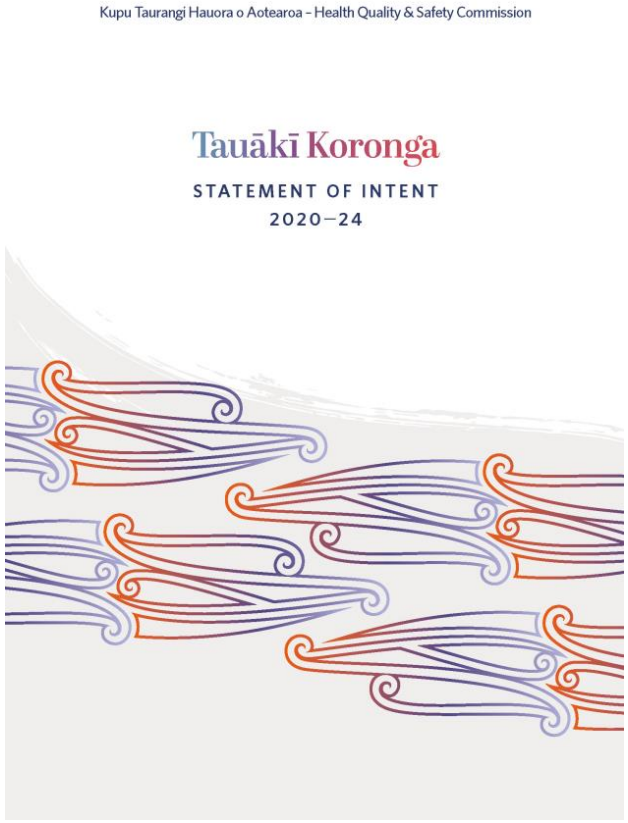
- Provide advice to the Minister of Health to drive improvement
- Lead and coordinate improvements in safety and quality in health
- Report publicly on the state of safety and quality
- Identify data sets and key indicators to inform improvements
- Disseminate knowledge on and advocate for safety and quality

Quality and safety improvements mean fewer people harmed, lives saved, and financial savings

Formed November 2011 as a Crown Entity

Ā mātau kaupapa rautaki matua
Our strategic priorities

- Improving experience for consumer and whānau
- Embedding and enacting Te Tiriti o Waitangi, supporting mana motuhake
- Achieving health equity
- Strengthening systems for quality services



Hōtaka akoranga | Our programmes

Health Quality Intelligence:

Quality Alerts

interactive dashboard

atlas of healthcare variation

patient experience surveys

quality and safety markers

A Window on Quality

Health System indicators (with MOH)

Quality Systems:

Quality improvement programmes aimed at reducing harm

Building capability in patient safety and quality improvement science.

Learning from adverse events.

Effective Board governance for quality

Hōtaka akoranga / Our programmes cont.

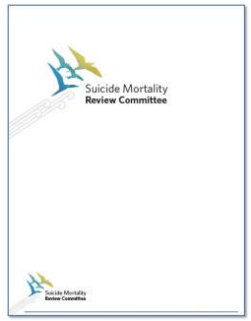
Quality Improvement Programmes

- infection prevention and control
- deteriorating patient
- primary care
- aged residential care
- advance care planning
- “Choosing Wisely”
- mental health and addiction quality improvement
- major trauma

- Consumer/whānau engagement
- Te Ao Māori approaches to quality improvement
- Equity - Pacific
  - People with disabilities

Mortality review committees

- Child and Youth
- Perioperative
- Family Violence
- Perinatal and Maternal
- Suicide



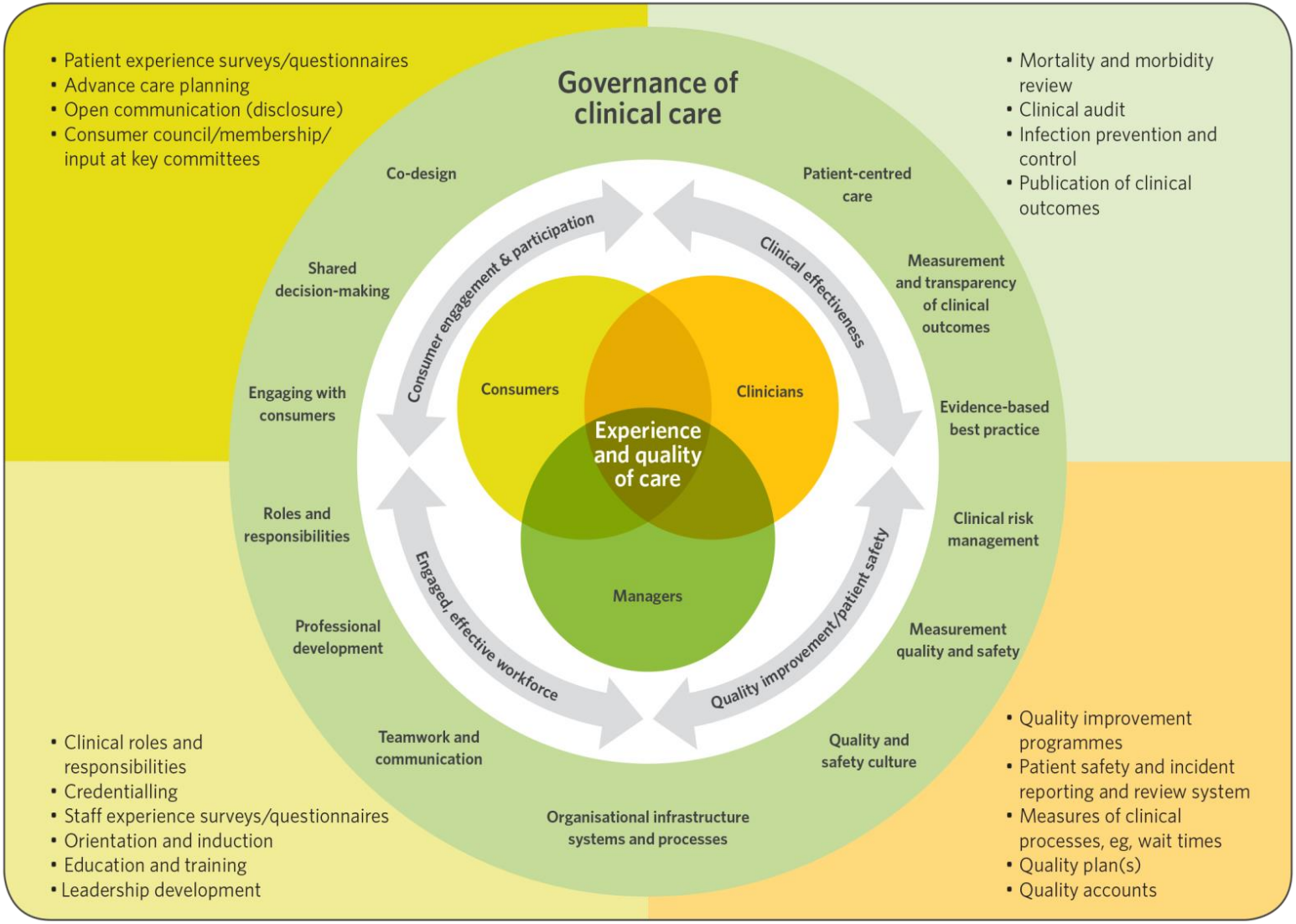
Quality improvement approaches

- Co-design with consumers and whānau.
- ‘Science of Improvement’ – capture practical knowledge and learn from planned changes of results at the ‘front line’. “Model for Improvement”, “Lean, six sigma” approaches and other models.
- Developing a kaupapa Māori approach in partnership with Māori.
- Working collaboratively and in partnership with providers, consumers, other agencies

‘All improvement is change, but not all change is improvement.’

Deming

Clinical governance framework



Strengthening the system

- Focus is more towards a system that is proactive- anticipates, learns, responds and monitors
- Design for success and understand work as is done
- Understand problems as simple, complicated or complex and apply the appropriate response
- Organisational overview and clinical governance framework

Complex domain

Nudge the system, watch its responses, be ready to respond

Complicated domain

Close the gap between current results and the outcomes you want

The Quality Alert System

1) Equity
(all with click-through links)

- Māori health equity dashboard
- Equity views dashboard
- Atlases
- Update on new data

2) HQSC hard data
(all with click-through links)

- Rest of dashboard
- Atlases
- Patient Experience Survey
- Quality and Safety Markers

3) Mortality & Complication
(all with click-through links)

- Comparative analyses of mortality
- Comparative analyses of PSIs, PQIs and QSM outcomes (+ others)
- Analyses of SAEs
- Comparative analyses need building/automating. Mortality analyses needs development. Complications in place

4) Covid-19 specific
(all with click-through links)

- Based on observed versus expected activity we can look at what "backlogs" may exist, who was affected, what specific (down to DRG level) activity did not take place, and is this likely to be illness avoided or presentation delayed

5) Soft Intelligence

- Monthly harvesting from HQSC senior managers and HQI

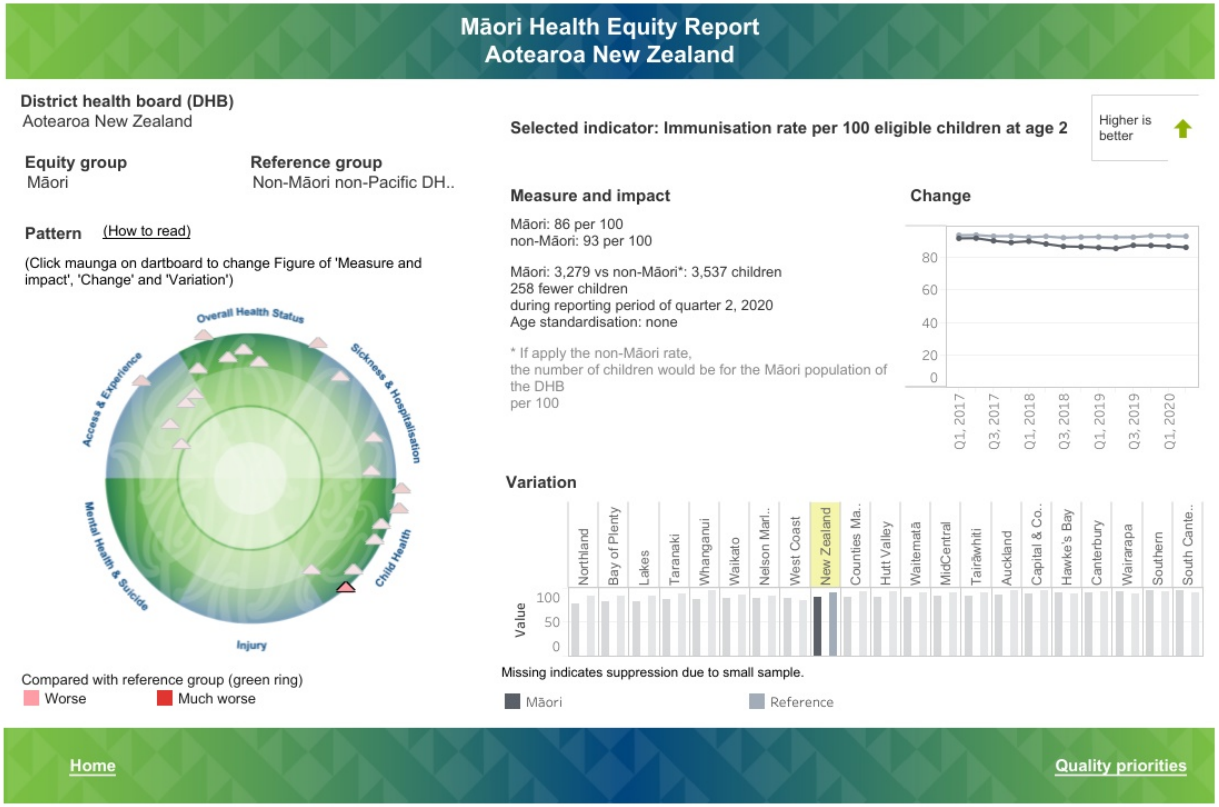
Method to be developed

6) Workforce
(all with click-through links)

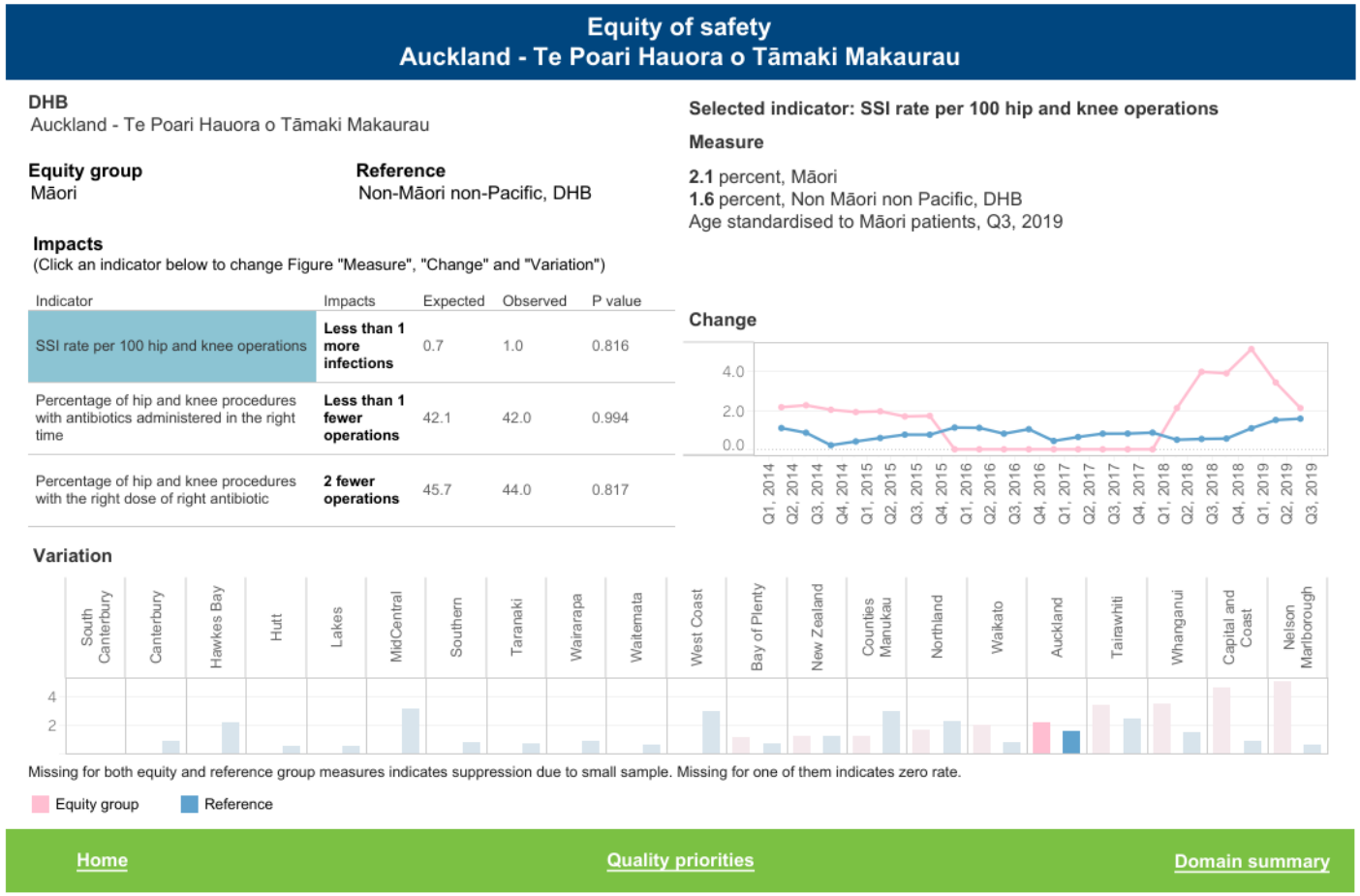
In development and agreement with TAS

Module 1 – Health Equity

- All measures show access, outcomes and experience for Māori are worsening. Childhood immunisation appears to show widening inequality



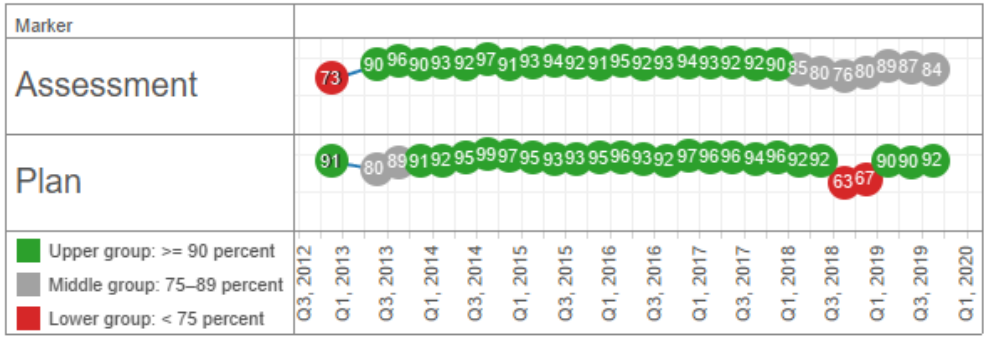
5 quarters of higher hip and knee SSI rates for Māori after a long period of no infections – may be an early warning of an issue



Module 2 – Quality and Safety measures from existing sources

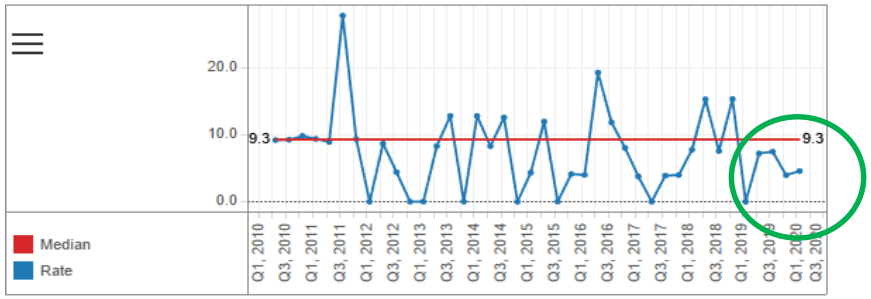
- Falls risk assessments fallen markedly since 2018
  8 consecutive quarters below 90 per cent

Percentage of older patients assessed for the risk of falling and with individualised care plan



- However in-hospital falls with fractured neck of femur trending positively

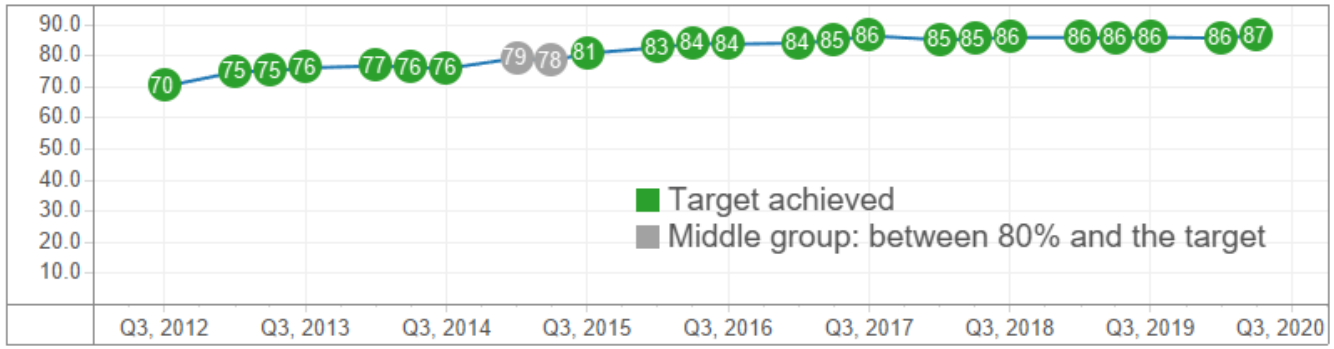
Run chart: Number of in hospital falls causing fracture neck of femur per month



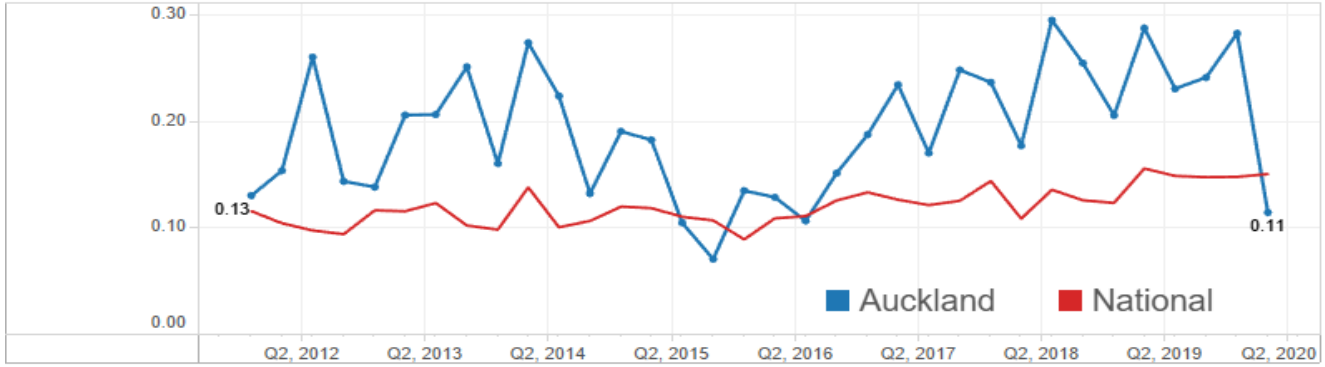
Hand hygiene and SAB rate

SAB infection consistently higher than national rate and rising since early 2017 despite high compliance with hand hygiene

Percentage of opportunities for hand hygiene taken

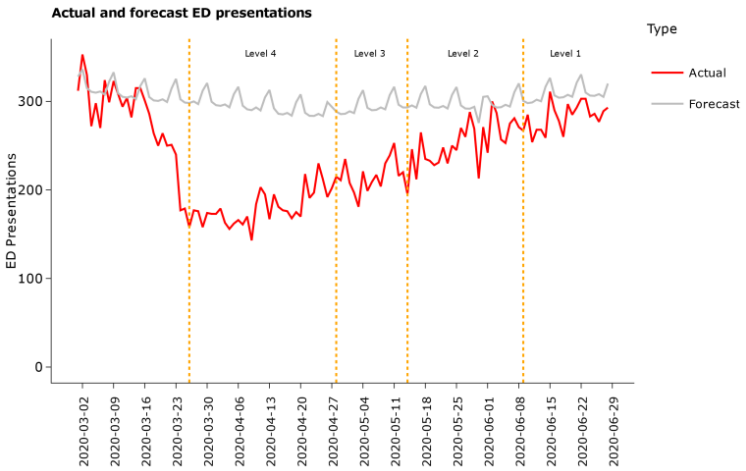


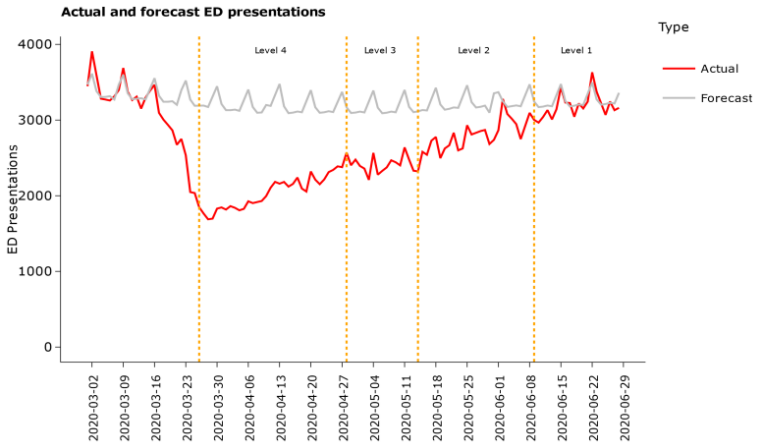
Line chart: *staphylococcus aureus* bacteremia rate per 1000 bed days



The final month is not reported due to data completeness issues.

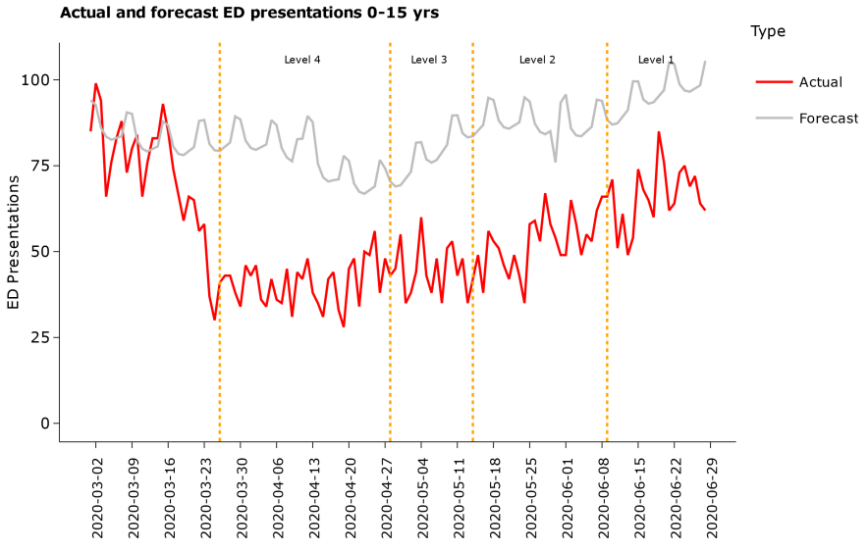
Module 4 - Emergency department presentations

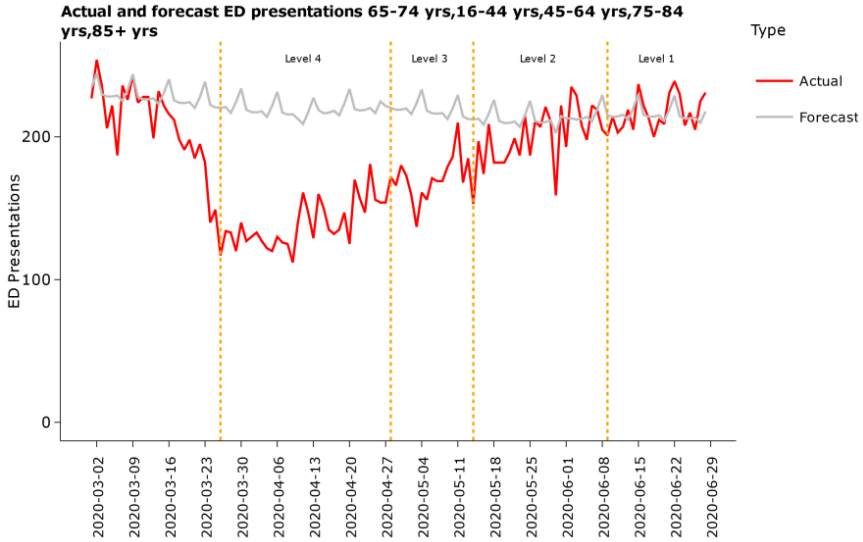




Patterns in Auckland (Left) are pretty similar to the country as a whole (Right), but Auckland doesn't quite return to historic trend by June

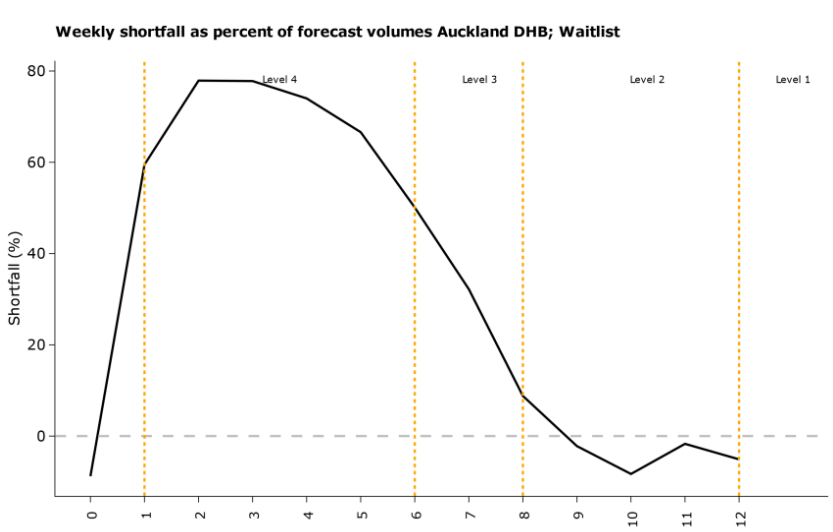
Emergency department presentations

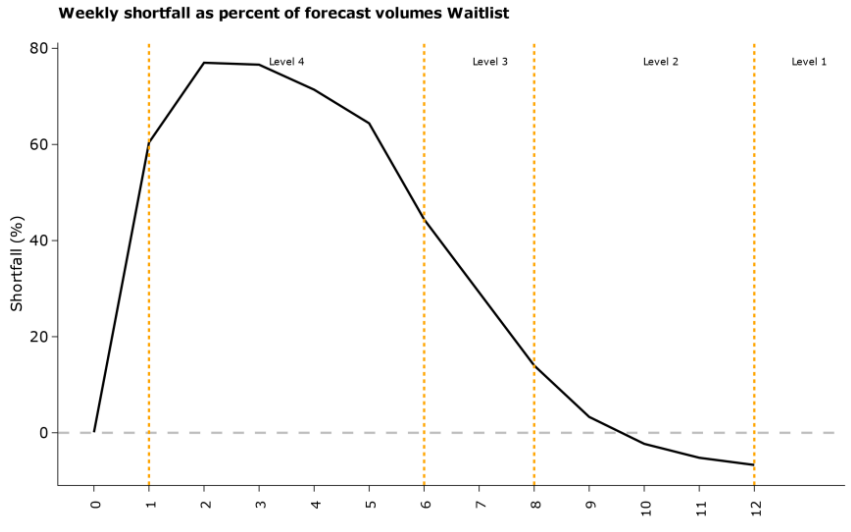




The reduction is more pronounced in children – but partly that is because ED presentations in children have historically increased more rapidly in winter months

Waiting list admissions

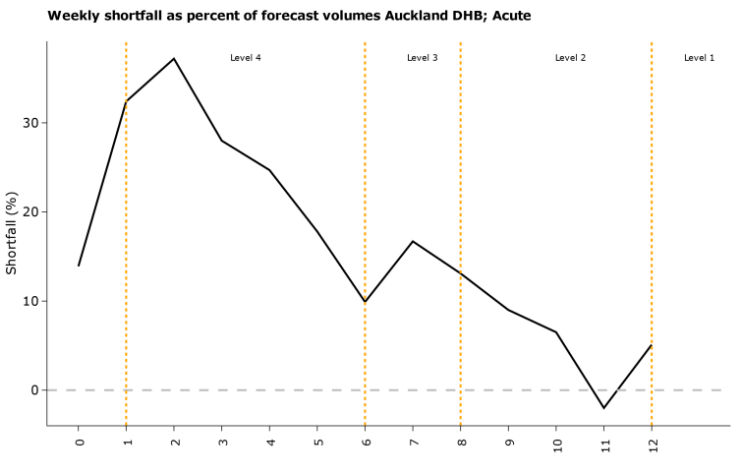


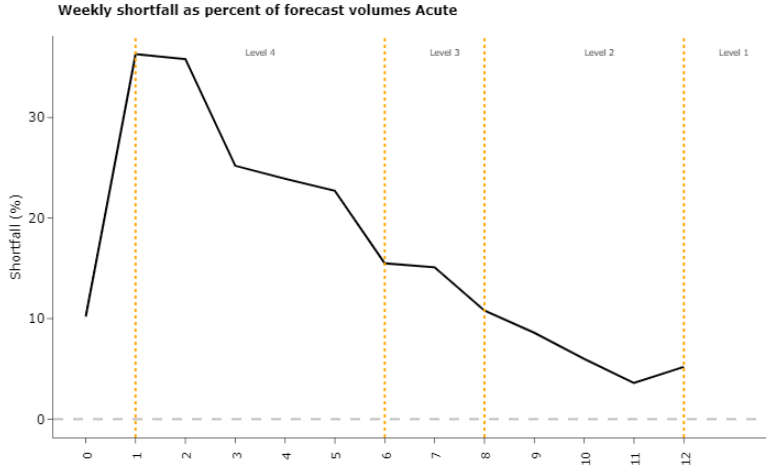


Reduction in Waiting list activity is almost identical in Auckland (Left) as the country as whole

But it amounts to over 2,000 admissions – over 30% of expected activity in Q2

Acute admissions

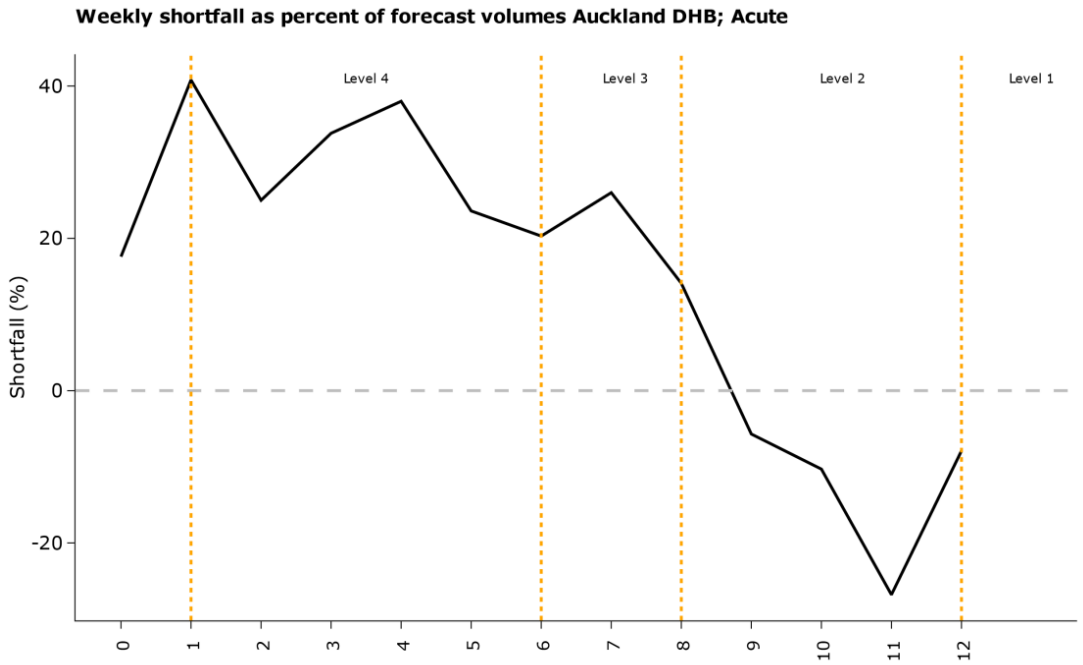




The pattern of reduction in acute admissions is broadly similar (though cumulatively slightly smaller) in Auckland (L) to the country as a whole (R)

Acute admissions

- However for other DRGs – such as cardiac shown here, the reduction may point to delayed presentation which may continue forwards (there were still around 150 fewer admissions than historic trends by the end of June)

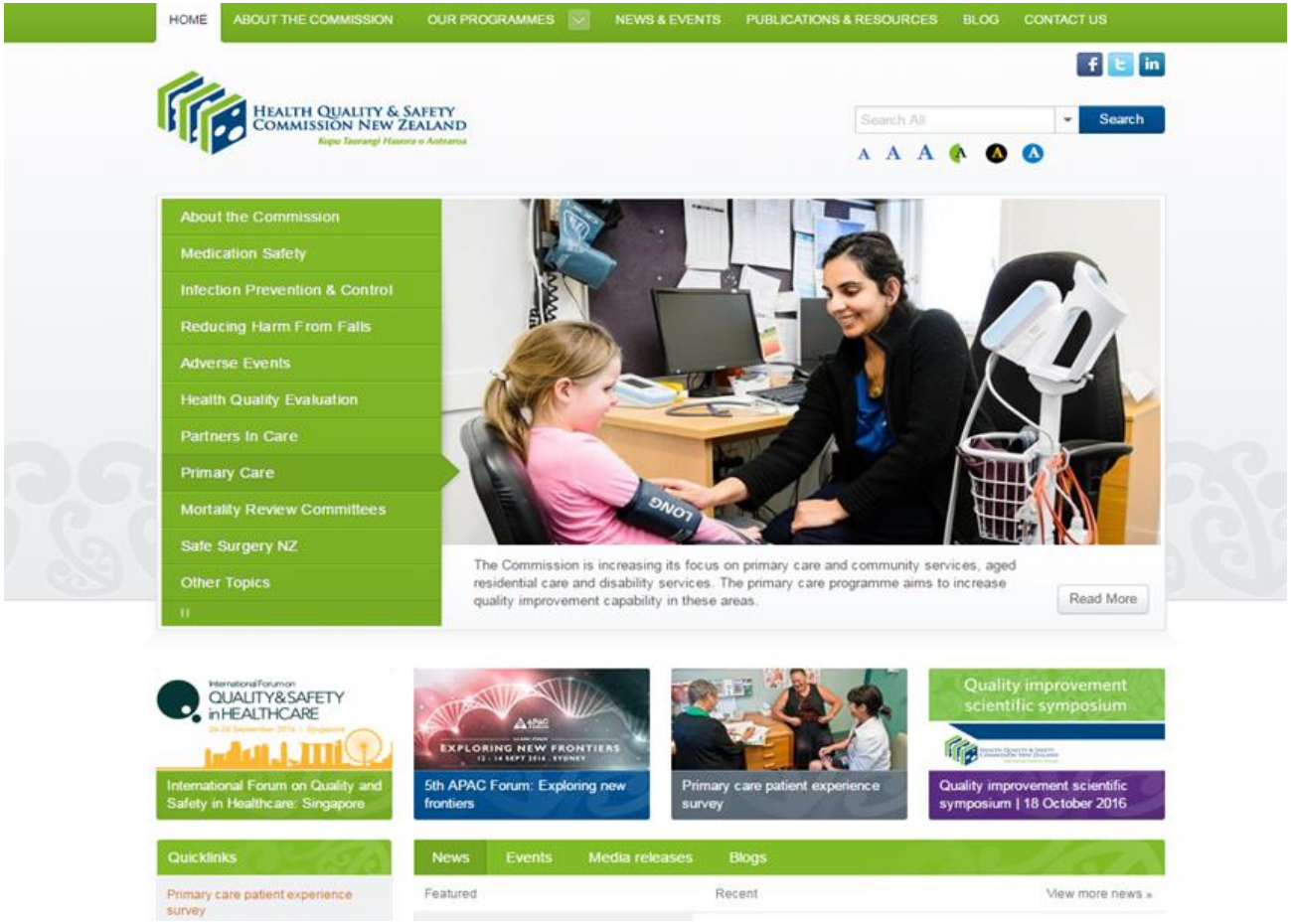


Things boards should know

What are the keys things a Board should know about safety and quality?

Five Key Questions to ask:

1. **How safe are you?**
2. **How good are you?**
3. **How do you measure quality and Safety?**
4. **Are you improving year by year?**
5. **How do you compare with the best?**



- Our website: www.hqsc.govt.nz
- Register for our newsletter and fortnightly email updates
- Contact us: info@hqsc.govt.nz

Action Points from 23 September 2020 Open Board Meeting

As at Wednesday, 23 September 2020

Meeting and Item	Detail of Action	Designated to	Action by
23 Sept 2020 Item 6.1	**Patients effectively connecting with the hospital system.** The patients the hospital communicates with should be able to effectively connect with the hospital system. A short briefing document be provided to the next meeting outlining: How often appointment letters/emails went astray/could not be sent How the new system being invested in would resolve these communication issues Cost of postage associated with patient communication.	Jo Gibbs	See Item 4.1
23 Sept 2020 Item 7.1	**Personnel Costs Including Annual Leave Accruals** That a short paper be presented to the next Board looking at accrued annual leave and vacancy factors.	Mel Dooney Justine White	Transferred to Confidential Board Agenda C4.1

Patients Effectively Connecting with the Hospital System

Recommendation

That the Board:

1. **Receives the Patients Effectively Connecting report**
2. **Notes that this is in response to an Action Point from 23 September 2020 Board Meeting - Item 6.1**

Prepared by: Sarah Danko (Operational Manager – Patient Services Centre)
Endorsed by: Ian Costello (Director, Clinical Support)
Endorsed by Executive Leadership Team: Jo Gibbs (Director of Provider Service)

1. Executive Summary

Over the last 5 years, initiatives have been undertaken to improve outpatient appointment communication to our patients. This includes outsourcing the appointment reminder service and introducing a technical solution to manage the dispatch of our appointment letters
The purpose of this update is to provide the Board with assurance that the project has been successful both financially and from a quality perspective.

2. Introduction/Background

Appointment Text Reminders:
In August 2016, a contract was signed with Dialhog to commence provision of an automated appointment reminder text service. Previously, appointment reminders were manually sent by a team of Patient Liaison Administrators (3.5fte cost approx. $150,000 per year). The process was time consuming and reliant on human intervention – this was an issue during times of absence. The team worked from a daily report provided by Health Alliance. The report needed to be cleansed and checked before being processed. Often the report provided contact corrupt data which delayed the process. As more and more patients recorded their mobile numbers, the workload increased and this became more difficult to manage.
Dialhog already had a contract to provide the reminder service for many of the Northern Region DHBs (including Waitemata and Counties Manukau DHBs).

Appointment Letters:
In June 2017 a business case was approved to introduce a technical solution for the management of clinical correspondence, specifically for outpatient appointment letters. This was following a number of instances where clinics were experiencing high DNAs and it was found that letters were not reaching our patients despite being sent 4 weeks ahead of the appointment date. An end to end forensic review of the letters process found there were up to 12 points of failure and there was no way to provide the organisation with any assurance that letters were being dispatched.

3. The Solutions

Texts and Dialhog
Up until around 5 years ago, texts were sent just to patients who had appointments made in main outpatient scheduling system (PHS). Over the years this has expanded to appointments made in scheduling System for Diabetes and Sexual Health (HCC). More recently, a trial has been rolled out to text patients about their upcoming surgical admission at 21 days ahead, 7 days (to remind about medications) and 1 day (to prompt fasting arrangements). The text service is also used in Child Health for the Patient Focused Booking project to

remind families to call in to make appointments.
During COVID the organisation turned to the text service to prompt patients about visitor screening, mask wearing, distancing, delays to entry, wait in car (to enable distancing) and 24hr ahead screening of patients prior to arrival for appointments and surgery. We are also able to include links to our visitor registration app. We also introduced a "text back" process, where patients were able to respond positively or otherwise to questions about their COVID symptoms.
Routinely, we send over 90,000 texts per month. During COVID, this escalated to over 300,000 per month
The cost per text is 0.11c.

Letters and Pitney Bowes

A number of solutions were considered as part of the business case which included outsourcing the whole mail processing to a third party eg NZ Post. However, the costs were prohibitive and would have escalated as more services were introduced. Pitney Bowes offered the ability to keep control of the process in-house and enable digital solutions that would reduce costs (switching to email). The system is set up to run out of the Greenlane mailroom. A second machine (printer and inserter) has now been set up in the ACH mailroom which acts as Disaster Recovery (DR) for Greenlane but its primary function is to dispatch results for LabPlus.
Simply, the system reads specific fields on the letter template and, working on rules, pulls in additional documents relating to the appointment (site map, brochures or information leaflets). The system will also check which language the patient speaks (first) and pulls down the appropriate Your Rights brochure.
Emails are only sent to patients who have gone through the email verification process and have agreed to receive correspondence from us electronically so that we are confident that we have the correct email address.
Some patients do not opt into the email system which we accept, however, the Pitney Bowes system is able to provide us with assurance that the letter has been printed, put into an envelope and inevitably put into the mailing bag (this is all done automatically). Unfortunately it cannot tell us whether the mailman has delivered.
The table below shows the full year effect savings made during 2019/20.

	2019-20 Budget	On-charge to Eye Clinic	Pitney Bowes	Stationery & Supplies	Postage, Courier & Freight	Printing & Forms	Variance
July	44,171	(10,706)	19,082	4,677	28,075	3,833	5,137F
August	44,171	(10,706)	1,300	6,268	23,350	1,639	22,320F
September	44,171	(10,706)	1,300	3,194	31,797	2,824	21,689F
October	44,171	(10,706)	19,082	9,017	25,035	3,834	3,836F
November	44,171	(10,706)	7,227	31,939	24,521	3,365	6,248U
December	44,171	(10,706)	7,227	2,967	25,553	2,044	23,013F
January	44,171	(10,706)	7,228	2,503	23,349	2,400	25,324F
February	44,171	(10,706)	7,227	9,082	25,787	1,986	16,722F
March	44,171	(10,706)	7,227	2,579	33,565	4,671	12,762F
April	44,171	(10,706)	7,228	578	5,128	870	47,001F
May	44,171	(10,706)	7,227	6,292	9,397	1,436	36,452F
June	44,171	(10,706)	7,227	1,010	29,962	837	21,768F
Full Year	**530,052**	**(128,472)**	**98,582**	**80,106**	**285,519**	**29,739**	**229,776F**

Routinely approximately 60% of appointment letters (where they are managed through the Pitney Bowes solution) are sent via email.

4. Equity

In the 3 months July 2020 to September 2020 the email verification outcomes are as follows:

Ethnicity	# PHS Apts	% Verified email addresses
Maori	18913	55%
Other	140261	69%
Pacific Islander	29860	45%

5. Conclusion

The appointment letter solution is not rolled out to all services. There is opportunity to onboard the rest of the organisation in order to ensure more efficient use of the system and email.
There is more work to be done in collecting email addresses and encouraging our patients to go through the verification process.

Chief Executive's Report

TE TOKA TUMAI
Auckland DHB

5.1

Recommendation

That the Chief Executives report for 1 September 2020 – 12 October 2020 be received.

Prepared by: Ailsa Claire (Chief Executive)

1. Introduction

This report covers the period from 1 September 2020 – 12 October 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

Tō mask e kare

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

The short video – Tō mask e kare - features Auckland DHB kaimahi Māori relating physical distancing to concepts found within haka, ā-ringa, poi and mau rākau.

This was a wonderful opportunity to support our kaimahi Māori and showcase their multitude of talents. This 'crowd-sourced' content is resonating strongly with our employees, whānau and community.

Te Wiki o Te Reo Māori 2020

This year we celebrated Te Wiki o Te Reo Māori with daily te reo quizzes and postcards with kupu (words) and rerenga kōrero (phrases) that may be useful around the hospital.

We incorporated karakia and waiata into the week.

We filmed our kaumatua and kaimahi for a video montage of showcasing their favourite kupu.

The overall aim of the week is to increase awareness of Te Reo so we all feel more confident using it on a daily basis.

Kia Ora tō Wāhi Mahi – building a healthy workplace together

Earlier this year, as part of Hauora sessions, more than 1000 of DHB staff shared their aspirations for wellbeing at Auckland DHB.

This feedback together with best practice frameworks has identified **six action areas** to help build a healthy workplace.

- Improving Connections
- Empowering Leaders
- Comfortable Workplaces
- Enhance Ways of Working
- Giving Staff a Voice
- Living Our Values.

Some of the first actions we have taken include:

- **Supporting our leaders' capability** to nurture their own wellbeing and the wellbeing of their team. Our Leader's Check-ins and the Kāhui Oranga 'Leading for wellbeing' webinar series have provided opportunities for this.

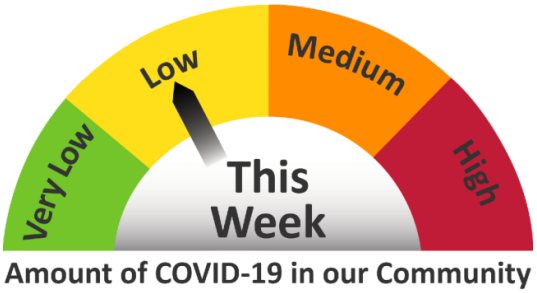
- **The Employee Support Centre** has been put in place to support our DHB whānau who are financially impacted by COVID-19. It also is a place where our people can access opportunities and connections to improve their future.

2. 2 COVID-19 response

As at 23 October our **COVID-19 barometer is at 'low amount of COVID in the community'**. This was changed as new community cases were identified in Auckland.

The barometer and our escalation plan to COVID is reviewed weekly.

A COVID-19 Response Team remains in place so we are able to respond to any changes in our community.



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, 348 emails were received. Of these emails, 37 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:

Urology

"The treatment preparation was supportive and considerate. The clinical explanations were given with patience and attentiveness. The treatment was effective and efficiently delivered." – Anon.

Ward 42

"The staff of Ward 42 and HDU, I think Ward 48 was exceptional and I would like to acknowledge that their skills and care pulled me though to allow this to be the best experience I have had in a hospital as a patient. The fear has dissipated and I am grateful for their skill and standard of care I received. Wonderful teams of people not omitting the surgical staff and the wonderful anaesthetist." – Anon.

2. 4 External and internal communications

2. 4. 1 External

Between 1 September and 12 October we received 85 requests for information, interviews or access from media organisations. This included requests to interview clinicians on COVID-19 treatments, for information on colonoscopy wait times and the National Bowel Screening Programme, and for access to film with Te Manawa o Hine, our Māori Midwifery team. Around 12 per cent of the enquiries over this period sought the status of patients admitted following incidents such as road traffic accidents.

During this period, the Northern Region Health Coordination Centre managed and responded to requests for information about the COVID-19 regional response to the August cluster and the impact on DHB services.

Auckland DHB responded to 25 Official Information Act requests over this period.

2. 4. 2 Internal

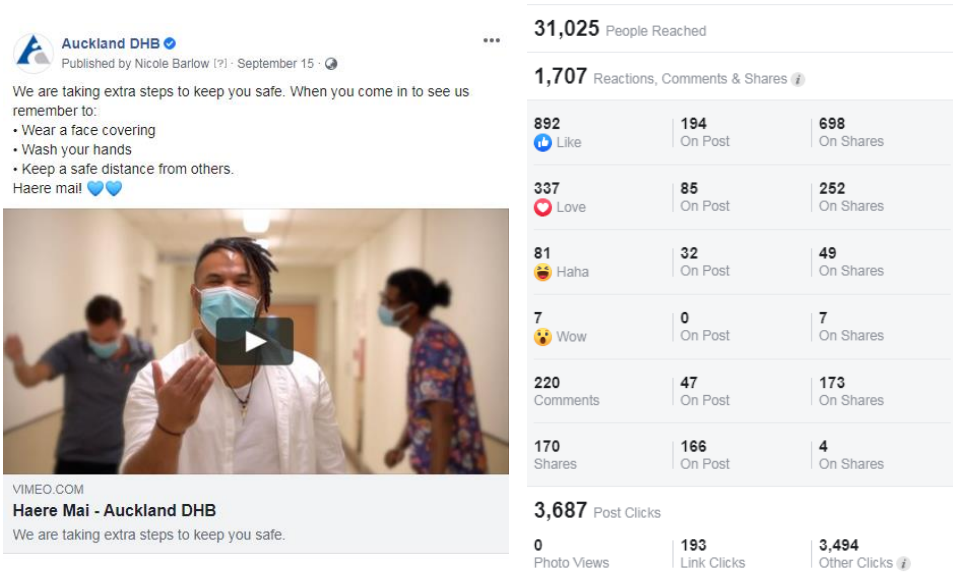
- Six editions of Pitopito Kōrero | Our News, the weekly email newsletter for all employees, were distributed.

- Six editions of the Manager Briefing were published for all people managers.
- Two webinar sessions were held for all employees to provide updates on the organisation and COVID-19 with the opportunity for questions.
- One CEO update email was sent out to all employees.
- The Spring edition of Te Whetu Mārama was published – this featured a thank you and reflection of our response to COVID-19

2. 4. 3 Social Media

Top posts and statistics

Facebook



2. 5 Our People

2. 5. 1 Local Heroes

There were 14 people nominated as local heroes in August. Congratulations to our August local hero, Tamsin Miles – Social Worker, Clinical Support Services. Here is Tamsin's nomination:

Tamsin Miles with her local hero trophy

"Tamsin works tirelessly behind the scenes to coordinate complex birth plans for pregnant women – many of whom are living without secure accommodation while they navigate challenging life circumstances.

Tamsin is the ultimate team player consistently striving to improve the services she is a part of. She is exceptionally diligent and kind in her approach to her work. Due to the nature of her role – she is unlikely to be thanked directly by those who she works so tirelessly for – as they will never know what their experience would have been if she hadn't advocated for opportunities, resources and a timely, supportive plan to be in place wherever possible.

In so many ways Tamsin is a local hero – her generosity and manaaki as a colleague, her high level of professionalism and embodiment of angamua, her capacity to coordinate and effectively team together with multiple parties, and her welcoming open door to anyone who seeks her assistance."

2. 5. 3 Celebrating our people

Congratulations to Dr Angela Beaton and Dr Alison Leversha who won Health Research Council grants.

Dr Angela Beaton, Auckland DHB Charitable Trust

Activating communities to improve outcomes for wāhine Māori

12 months, $30,000.00

Persistent inequities in health outcomes for wāhine Māori speak to the limited ability of national initiatives to drive health equity. The lack of sustainable change points to a systemic problem that requires analysis of implementation pathways that is reflective of community and cultural engagement. Historically, interventions have been developed outside of target communities. This project will focus on relationship development and priority setting, to establish a strong foundation to partner appropriately with wāhine Māori in the implementation of new innovations within Māori communities. We will utilise evidence, culturally-appropriate tools and a systems approach that starts with activating communities to influence what is happening in the broader health system; establish a clear connection to a health care need substantiated by meaningful end-user engagement and health service leadership in the identification of this need; and ensure community partnership is achieved in the formulation of the intervention and a subsequent implementation research project.

Dr Alison Leversha, Auckland DHB Charitable Trust

Reducing inequities in Well Child Tamariki Ora developmental surveillance

36 months, $1,350,785.50

Inequities in learning, development and health are evident when children start school. These trajectories track into adulthood with consequent poorer educational, health and social outcomes. Māori and Pacific and children from disadvantaged communities are disproportionately affected. These outcomes are unjust and costly for society. The universal free Well-Child-Tamariki-Ora Programme (WCTO) is designed to identify developmental concerns so early intervention can maximise outcomes. Emerging evidence suggests the mandated developmental surveillance tool, the Parental-Evaluation-of-Developmental-Status (PEDS), is not performing as it should, potentially increasing inequities. Of concern, the PEDS has not been standardised nor validated in NZ. This research explores parental understanding of child development and how it is assessed, and examines the validity of the PEDS for NZ populations and therefore its appropriateness. Findings will have a direct impact on the redesign and future delivery of the WCTO programme to ensure it reduces inequities and achieves better outcomes for all tamariki.

2. 5. 4 Senior Leadership changes

Haere mai to our new Director of Emergency Management and Strategic Planning

Congratulations to Vicki Nuttall who has been appointed to the role of Director of Emergency Management and Strategic Planning. Vicki will be responsible for leading the Emergency Management and Strategic Planning team in developing organisational resilience plans to anticipate, prepare for, and respond to significant incidents and events.

Vicki has extensive senior experience in crisis management, enterprise risk management and business continuity management across multiple high-risk sectors including the public sector in New Zealand and off-shore. Vicki's qualifications include a Master's of Science (Management), Sloan Fellowship from the London Business School with her thesis on crisis management. In addition, Vicki is a Chartered Accountant through the New Zealand Institute of Chartered Accountants and holds a Bachelor of Management Studies from Waikato University.

Haere mai to our new General Manager, Quality, Safety and Risk

Jennie Montague joined the Quality, Safety and Risk team as General Manager. This position will be a fixed-term role for 6 months.

Jennie has been in continuous employment as a General Manager for several years at Auckland DHB and is familiar with the Quality, Safety and Risk team, having commenced programme work in Occupational Health earlier in the year before being seconded back to NRHCC to manage the airport team at the border as part of the COVID-19 response. Since her work at the border finished Jennie has been involved in pay equity negotiations on behalf of all the DHBs.

In addition to supporting the Quality, Safety and Risk teams, Jennie will assume co-leadership of the Kia Ora to Mahi Wahi initiative and will also assist with some of our COVID-ready programme work.

We are fortunate to secure Jennie's skills as we continue to develop and evolve our portfolio of services.

3. Performance of the Wider Health System

3. 1 Priority Health Outcomes Summary

	Status	Comment
Acute patient flow (ED 6 hr)		Sep 92%, Target 95%
Improved access to elective surgery (YTD)		94% to plan for the year, Target 100%
Faster cancer treatment		Sep 98%, Target 90%
Better help for smokers to quit: • Hospital patients • PHO enrolled patients • Pregnant women registered with DHB-employed midwife or lead maternity	  	Sep 95%, Target 95% Jun Qtr 87%,Target 90% Jun Qtr 95%,Target 90%
Raising healthy kids		September 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 quarter ending 30 September 2020 is a deficit of $22M against a budgeted deficit of $4.9M, thus unfavourable by $17M. This unfavourable variance is entirely attributed to net COVID impacts and includes a provision for IDFs and Planned Care revenue adverse wash-ups of $11M 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 $168K.

At a divisional level, the Provider Arm result is $18.3M unfavourable to budget (mainly due to unfunded COVID impacts) and is partially offset by favourable results in the Funder Arm ($459K favourable) and Governance and Admin Arm (515K favourable).

Health and Safety Performance Report

Reason	*Explanation*
Confidence	*Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report [Official Information Act 1982 s9(2)(ba)]*
Prejudice to Health or Safety	*Information about measures protecting the health and safety of members of the public is enclosed in this report, and those measures would be prejudiced by publication at this time [Official Information Act 1982 s9(2)(c)]*

Recommendation

That the Board receives the Occupational Health and Safety Performance Report for October 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

1.1 Lead Indicators

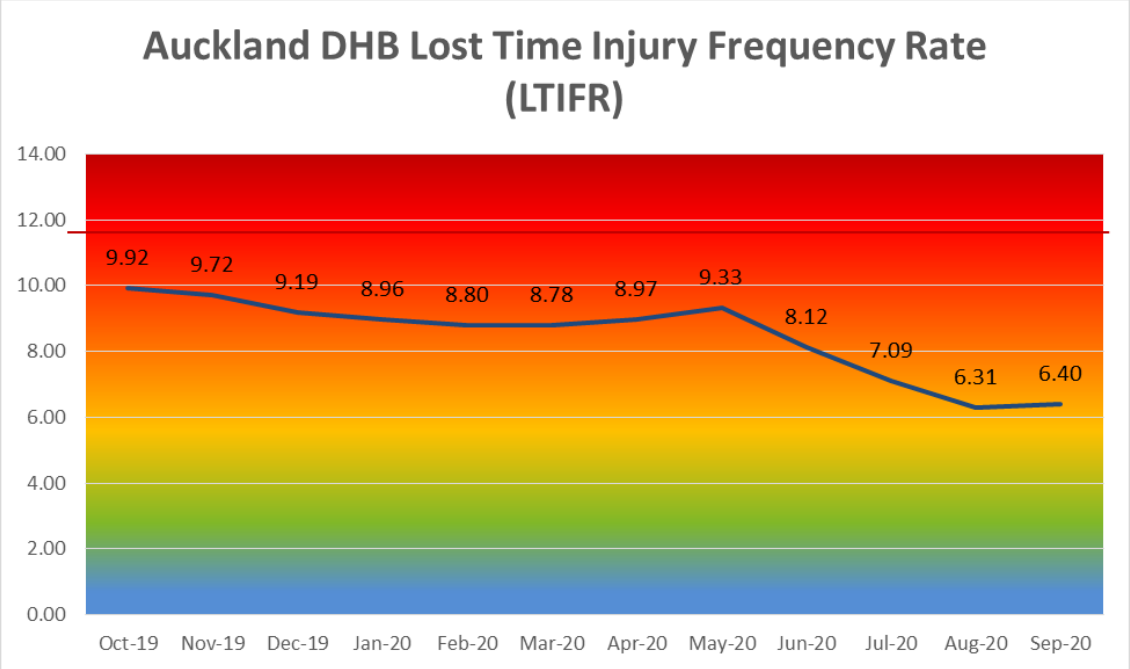
Description	Current Month Actual	Previous Month	3mth Trend	6mth Trend
Leadership Observations	192	303	↑	↑
Leadership Discussions (H&S Rep Meetings, Regional H&S Technical Advisory Group (TAG) ACC/Safe 365	146	102	↓	↑
Training (Inductions/PPE/Patient Handling)	126	315	↑	↑
Audits/Inspections	93	85	↑	↑
N95 Mask Fit Testing	1,825	1,467	-	-
Vulnerable Staff Self Assessments	131	188	-	-
Vaccinations	100	111		

- September 2020 saw a decrease in our leadership activities across Auckland DHB to 338 as our staff operated at an enhanced version of COVID-19 Alert Level 2.

1.2 Lag Indicators

Description	Target	Actual	Prev Month	3mth Trend	6mth Trend	12mth Trend
Total Recordable Injury Frequency Rate (TRIFR)(per 1,000,000 hrs)	-	23.07	21.61	21.62	26.22	28.40
LTI Frequency Rate (LTIFR)(per 1,000,000 hrs)	10.00	6.40	6.31	7.09	8.97	9.92
All Injury Frequency Rate (AIFR)(per 1,000,000 hrs)	-	106.33	109.00	113.62	122.11	90.61

a. All three injury lag indicators have reduced slightly over a 6-month period.
b. Focusing our Health and Safety leadership visibility through education, guidance and assurance type activities from our H&S Advisors is starting to impact positively on reducing our injury risk.
c. We would like to embed this visible leadership approach to health and safety across our people leaders in ADHB.
d. There were 43 recordable injuries in September, comprising of BBFAs, allergic reactions to personal protective equipment (PPE) or hand sanitisers, and ergonomic injuries.



a) The Lost Time Injury Frequency Rate is still trending downwards over the last few months.

b) Our Leadership Observations and Discussions are reducing the risk of potential incidents occurring. We will be introducing the Observation process in the New Year to widen the positive impact of this type of leadership approach.

c) Datix shows 14 out of 19 LTIs reported to have occurred in September involved ergonomic injuries.

d) The incident management process is currently being reviewed to enable the collection of more useful information in a timely manner. This will involve:

- simplifying the reporting process
- fit for purpose software
- updating our incident management process to reflect best practice

2. Risk Analysis

The three key risks with a residual risk rating of high (Appendix 1) are as follows:

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

Based on the last Board Report in August the steering group have submitted a Business Case for Year 2 funding for the "Making Health Safer" project to ACC. It builds on the positive momentum of this project by using Year 1 data and insights to engage, enable and empower the supply chain cohort and participating DHB's in improving safety maturity. In support of this project Auckland DHB will focus one of its internal Health & Safety priorities over the next 12 months on increasing its Contract and Contractor Management Occupational Health & Safety maturity.

Reported Workplace Violence incidents are at a similar level to the previous month even though we have asked our relevant Directorates to focus on more practical preventative solutions to reduce these types of occurrences. We noted that the new Workplace Violence Advisor started last month to continue on the MAPA training program, and further learning options are being explored. Considering the importance and effect of this work we will not reduce this risk effectively in the coming months without increasing our face to face training resource to work through the quota of approximately 4,000 relevant frontline staff members every 2 years.

Statistics gathered relating to the number of encounters Occupational Health doctors had with staff resulting from COVID-19 indicate a significant increase in the number of contacts and consultations. This substantiates the value of Occupational Health and Safety services having had additional resource approved by the ADHB COVID IMT during the COVID-19 resurgence.

We have identified 3,050 of staff needing to be fitted to an N95 respirator of which a total of 1,825 have an up-to-date objective fit test in a respirator with a secure supply chain.

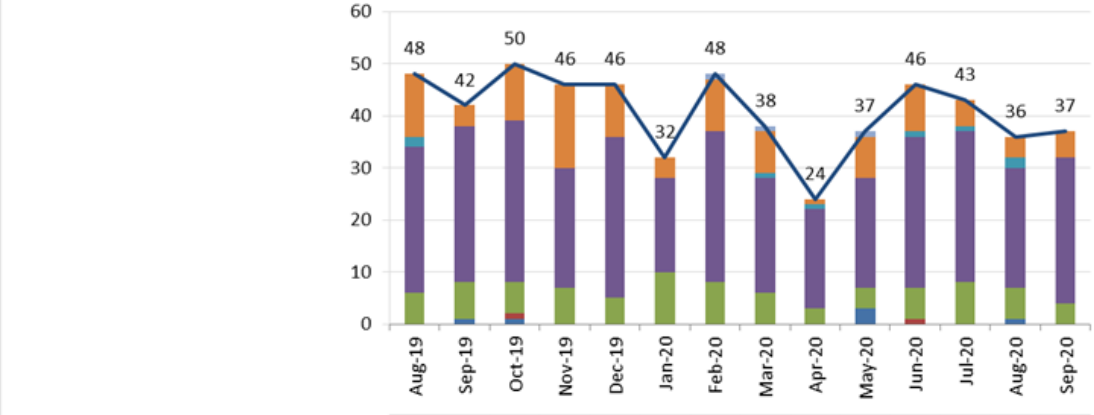
2.1 National Health and Safety Forum

The National H&S Manager Forum submitted a paper to the Chief Executive's Forum seeking funding to develop programmes of work and resources to help standardise a common approach to managing Health & Safety across the DHBs. This was endorsed at the CE Forum.

The National Health & Safety Forum has agreed to focus on a sector-wide approach toward Workplace Violence, Contractor Management and Occupational Health over the next 6 months

It was agreed the ADHB will help spearhead this initiative to provide a template for other DHBs to follow over the next few years.

2.2 Blood and Body Fluids Incidents



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

a) A total of 37 blood and body fluid incidents were reported in September, including 28 involving needle stick injuries.

b) Since January 2018, blood and body fluid incidents have averaged 41 per month. This is equivalent to one to two of our people experiencing this type of incident per day.

c) The work and stakeholder engagement activities relating to reviewing the viability of adopting needless technology across ADHB that was placed on hold during COVID-19 resurgence will be resumed in Alert Level 1.

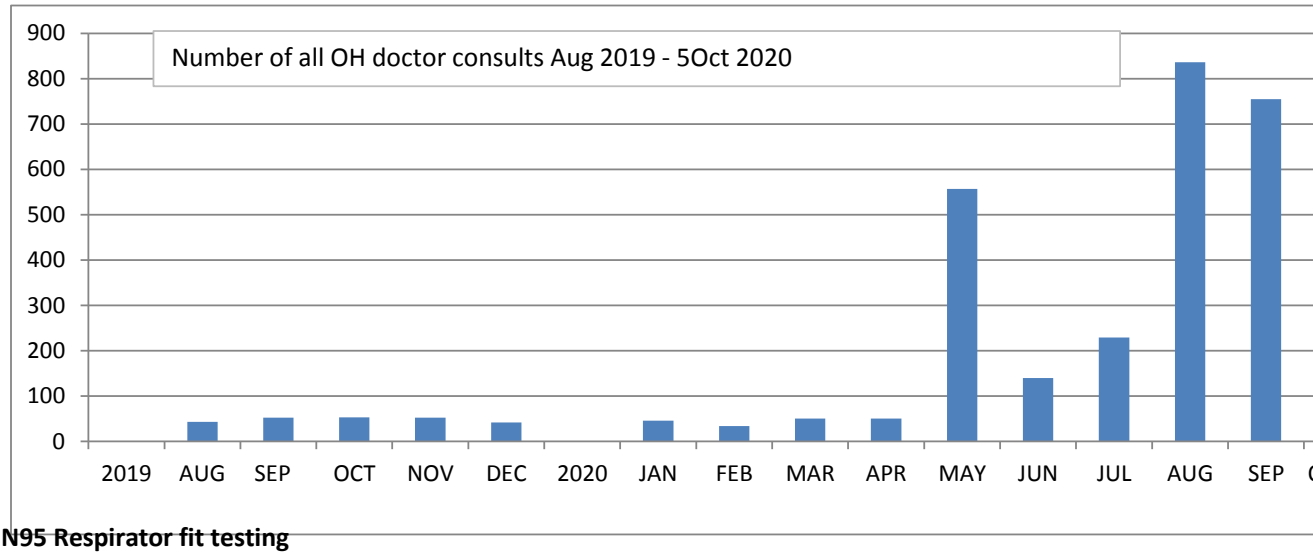
2.3 COVID-19 Response

Vulnerable Staff and COVID-19

To date we have received 2,354 employee Self-Assessment Forms (SAF) of which 5% are duplicates. We have reviewed 2,129 staff (a small number of these more than once over time due to a change in their health status). The previously missing SAFs were located and are being assessed.

A large part of this second small surge of COVID-19 related work has involved updating staff records with the health information that they disclosed to us earlier in the year.

Statistics gathered relating to the number of encounters with staff resulting from COVID-19 indicate a significant increase in the number of contacts and consultations (refer to below graph). This substantiates the value of Occupational Health and Safety services having had additional resource approved by the ADHB COVID IMT during the COVID-19 resurgence.



N95 Respirator fit testing

To date 3,050 staff have been identified as needing to be fitted to an N95 respirator.

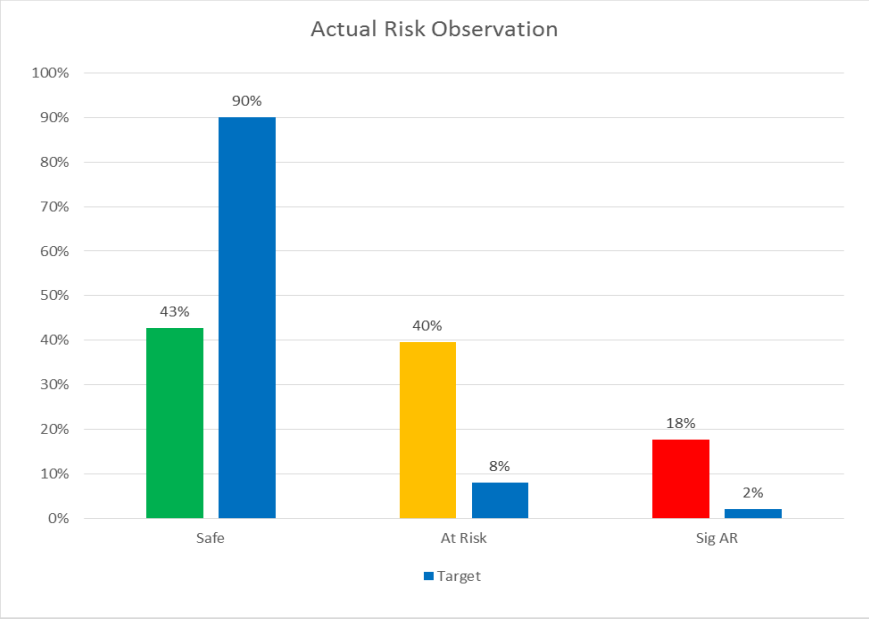
As of 30 September 2020, a total of 1,825 have an up-to-date objective fit test in a mask with a secure supply chain. This represents 59.8% of the staff identified by Auckland DHB who may be required to wear an N95 respirator.

A centralised fit-testing program and in-team trainer model has the capacity to fit test the majority of remaining staff over the next four weeks. In addition, the total number of staff who have been identified as requiring fit testing will be re-validated.

Contact Tracing

There were nil contact traces initiated (contact traces are required for Chicken Pox, COVID19, Measles Mumps, Pertussis, Tuberculosis).

3. Observations



We completed 29 site visits from which we made 192 informal observations. Of those observations, 82 were assessed as Safe, 76 as At-Risk, and 34 as Significant At-Risk. The Significant At-Risk observations included:

- Inadequate hazardous substances controls restricting unauthorised persons
- Inadequate supply of equipment for managing hazardous substances
- Contractors not adhering to ADHB policies and procedures
- Inconsistent understanding controlling/preventing biological hazards in sluice rooms

All above observations were communicated to workplace managers to rectify.

4. Information Technology

There have been delays in our ability to assess total costs in order to make a recommendation on upgrade versus a new system for the Occupational Health patient management system (Medtech32) to mitigate its Windows 10 upgrade risk. The 10 month delay to the Windows 10 programme allows more time to evaluate options and look at longer term solutions. We are actively engaged with HIT to assess options and costs and we are reviewing the regional options to see if there are any synergies.

To support Contact Tracing we are implementing the Waitemata DHB contact trace solution as an interim measure until the National Contact Trace System (NCTS) solution is enhanced for DHB needs.

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

The implications of the ACC/Safe365 report for contractors to the 3 DHBs involved in the project have been shared across the DHB CEOs nationally. This has resulted in strong support from the remaining 17 DHB's to participate in this ongoing programme of work. As part of this approach representatives from Auckland DHB and ACC will meet and discuss possible other funding initiatives for this project. A key driver for that conversation is reducing contractor/supplier injury rates as well meeting and clarifying our (3 DHBs) PCBU overlapping duties for both funded and non-funded contractor/suppliers.

6. Auckland DHB Health and Safety Governance Committee

The Auckland DHB Health and Safety Governance Committee meets six-weekly. The last meeting was on Friday 9 October 2020.

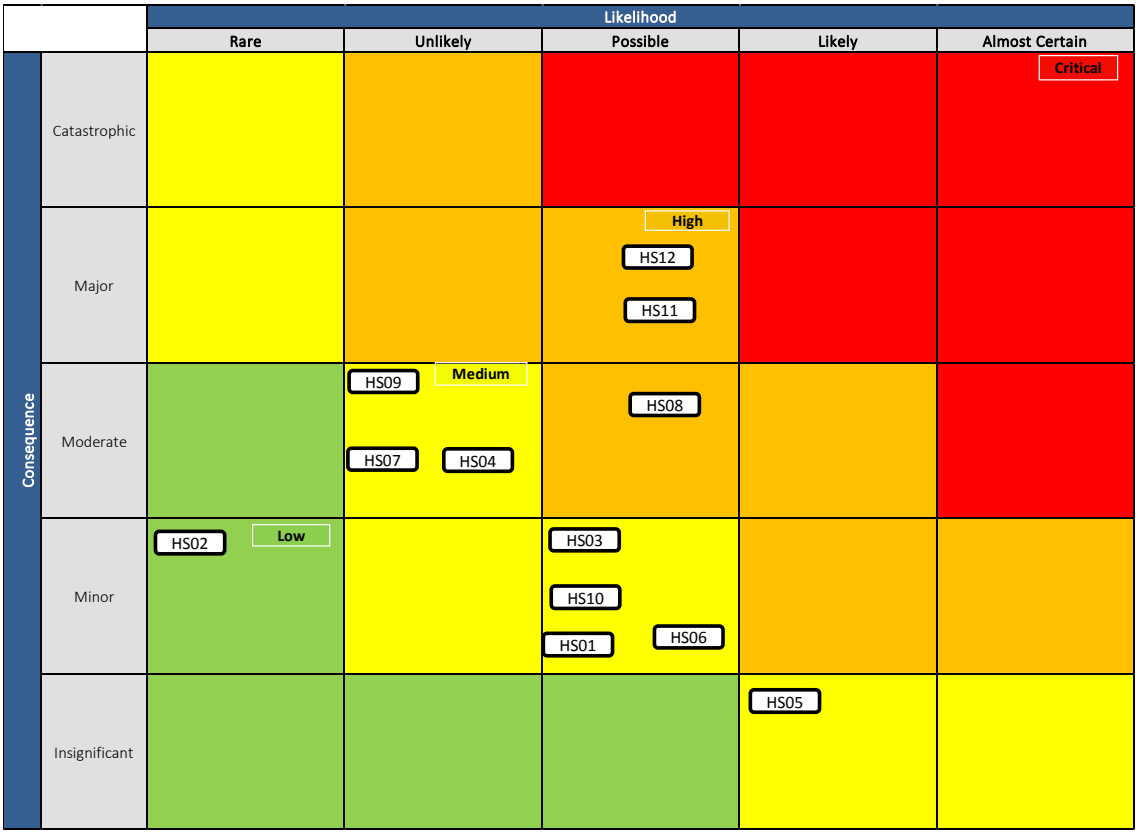
The previous minutes were accepted by the H&S Governance Committee. Key discussion points were as follows:

- The September Board Report
- H&S Representative Role Description and updated H&S Representative Procedure
- H&S Representatives proposed allocation of time to complete their Representative tasks
- Vulnerable staff in relation to COVID and how that impacts work they can do.
- Facilities asked to explain the H&S criteria for allocation of any funds.

Appendix 1

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

Auckland DHB Pūmanawa Tāngata Update November 2020

Recommendation:

That the Board receives the Auckland DHB Pūmanawa Tāngata Update for November 2020.

Prepared by: Mel Dooney (Chief People Officer)
Endorsed by: Ailsa Claire (Chief Executive Officer)

Kuputaka: Glossary

Acronym/term	Definition
Kaimahi	Workforce
Kia Ora tō Wāhi Mahi	Be well at Auckland DHB

1. Haere mai | Introduction

Following the Auckland DHB Board endorsement of the new Pūmanawa Tāngata plan 2020-2023 at the September Board meeting activity has begun to communicate and socialise the content of the plan, and to develop detailed initiative level plans in support of the implementation of the key activities.

This update outlines the activity to date for each Key Result Areas. From Quarter 2 2020/2021, a return to the A3 status update report for the 6 KRA areas will be provided on-going.

2. Current State

The following table provides a short summary of the key activity undertaken in each Key result area of Pūmanawa Tāngata plan 2020-2023 and an indication of next steps. We have also identified where this activity has a commitment made via our Auckland DHB Annual Plan.

Key Result Area	Current Quarter	Next Quarter	Measurement / Links to Annual Plan
KRA1: Continue to strengthen our organisational culture and values	• Pūmanawa Tāngata plan 2020-2023 communications plan in development • Review of Employee engagement activity • Rainbow Workforce action plan developed • Accessibility Workforce action plan developed	• Development of Employee Engagement plan for 20-23 • Rainbow workforce stakeholder engagement and research to begin • Accessibility recruitment workforce data – system to be developed	Employee Engagement and Accessibility Action plan targets are included in the Annual Plan
KRA2: Uphold Te Tiriti o Waitangi as our framework to eliminate racism, build culturally safe practice and achieve health equity	• Bicultural Work group established utilising kāupapa Maori apporach • ELT Steering Group established • Stakeholder engagement and planning underway	• Stakeholder engagement October • Synthesis and action planning November • ELT review December	Linked to Annual plan and Māori Health Action plan targets
KRA3: Grow and develop ngā Kaimahi Māori	• Stakeholder engagement (Phase one) completed. • Summary to People and Culture Sub-committee October 2020	• Meeting with directorate leadership groups to build activity into their local People Plan's	National Workforce Targets via Tumu Whakarae Talent identification targets in Annual plan
KRA4: Implement 'Kia Ora tō Wāhi Mahi' - The Healthy Workplace Plan for Te Toka Tumai	• Hauora insights and communication plan launched across organisation. • Stakeholder engagement completed • Steering group established - including union representation • Four priority work streams identified	• Four priority work streams and work groups set up • High level action plans developed by end of calendar year 2020. • ADHB To Thrive Career Fair in planning for 3rd December (in	2 initiatives to be implemented (Annual Plan)

	• Employee Centre physical location secured	person and virtual fair)	
Key Result Area	**Current Quarter**	**Next Quarter**	**Measurement / Links to Annual Plan**
KRA5: Build pipelines, attract and retain the talent we need to deliver a workforce that is fit for the future	Talent Acquisition • Stakeholder engagement completed • 20-23 Plan presented to People & Culture Sub-Committee in October. • 20/21 initiative planning completed Talent Management – Plan for 20-21 activities under development.	Key projects in implementation phase: - Candidate feedback system - Hiring Manager feedback system - Recruitment Function review Complete Talent Management Planning for priority groups.	
Make it easier to work here - improving the manager and employee experience of people processes	• Leader Leave Manager upgrade complete • Dimensions Project commenced • Workforce Central mitigation in place • Board People Dashboard reporting complete • Directorate level people plan reporting / metrics under development	• Holidays Act rectification to commence • Directorate level people plan reporting /metrics finalised • Reporting on mandatory training obligations • Identification of manager top 5 pain points	

Auckland DHB People Dashboard – Quarter 1 2020/21

Recommendation

That the Board receives the Q1 Auckland DHB People Dashboard – Quarter 1 2020/21

That the Board receives the Deep Dive into the Talent Acquisition Metrics

Prepared by: Sarah McLeod (Director Recruitment & OD)
Endorsed by: Mel Dooney (Chief People Officer)

For information.

The Auckland People dashboard has been prepared for the first quarter.

At the last Board meeting, in order to facilitate deeper engagement with the refreshed People dashboard, a request was made to choose an area of the metrics to deep dive into.

This Talent Acquisition deep dive will provide the Auckland DHB Board with a current state reflection of the performance of the Talent Acquisition function against the goals of the new Talent Acquisition strategy. This work aligns to KRA 5: '*Build pipelines, attract and retain the talent we need to deliver a workforce that is fit for the future'* within Pūmanawa Tāngata.

Quarterly ADHB People Analytics Dashboard - F21 Q1: 30 September 2020

Pūmanawa Tāngata Plan 2020-2023

Strengthening Culture & Building Capability

KRA1: Continue to strengthen our organisational Culture & Values

KRA2: Uphold Te Tiriti o Waitangi as our framework to eliminate racism, build culturally safe practice and achieve health equity

KRA3: Grow and develop ngā Kaimahi Māori

KRA4: Implement 'Kia Ora tō Wāhi Mahi' - The Healthy Workplace Plan for Te Toka Tumai

KRA5: Build pipelines, attract and retain the talent we need to deliver a workforce that is fit for the future

KRA6: Make it easier to work here - improving the manager and employee experience of people processes

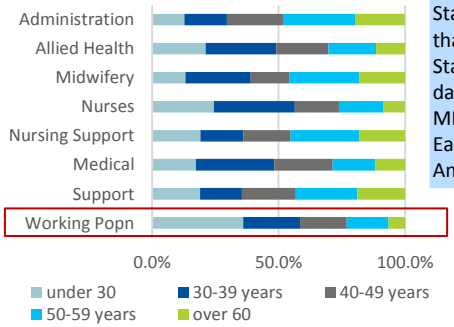
What does our workforce look like?

- As at end September 2020, there are 11,410 employees at Auckland DHB, excluding staff on extended leave.
- As at end of September the FTE based on paid hours was 164 over budget relative to budget but 122 are directly Covid related / attributed.

Budget vs Actual FTE

YTD Sept - Paid FTE	
19/20 Actual	9,560
20/21 Budget	9,784
20/21 Actual	9,948
Variance to Budget	(164) U
Covid Related FTE	122

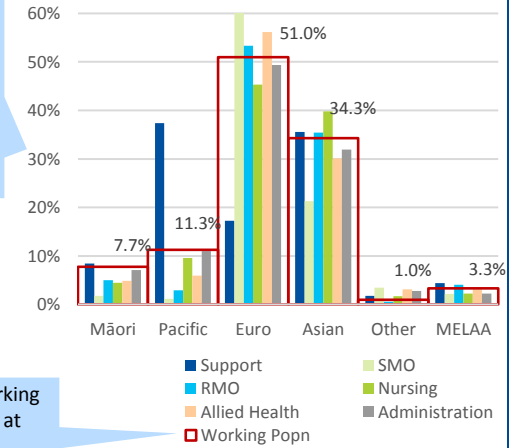
Age by Profession



Auckland DHB has an older working population than the Auckland working population (fewer employees under the age of 30 and significantly more employees over the age of 60).

Grouped as per StatsNZ guidelines. Staff can be more than one ethnicity. Staff with no ethnic data are excluded. MELAA is Middle Eastern, Latin American, or African.

Ethnicity by Profession



Auckland Working Population as at 2018 Census

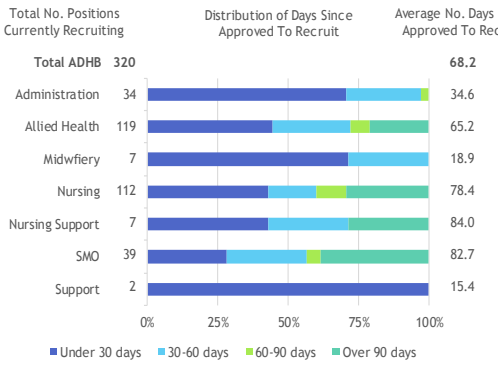
*MELAA = Middle Eastern, Latin American or African

Where are we experiencing change?

Over the last quarter there has been some success in filling Acute Mental Health nurse vacancies. These have been sourced through a number of mechanisms which include employee referrals, social media and immigration Skill finder services. Employment branding workshops with an equity lens are underway for this directorate. We still view these roles to be hard to find and are working on developing a pipeline of potential recruits, despite lower turnover.

The number of SMO vacancies has also reduced – we view this as likely due to COVID related impacts. There has also been some specific long standing SMO vacancies (Psychiatrists, Paediatric Cardiac Surgeon, Palliative Care Physician among others)

Positions Currently in Recruitment



Sourcing of Successful Hires

Source of Hire	Admin	Allied	Midwif.	Nsg Support	Nursing	SMO	Support
Referral	33%	45%	46%	18%	27%	56%	48%
Our Web Site	36%	35%	38%	35%	37%	31%	20%
Job Board	21%	14%	0%	35%	11%	3%	24%
Other	3%	3%	0%	12%	21%	5%	4%
Social Network	6%	1%	8%	0%	1%	0%	4%
Agency	1%	1%	0%	0%	2%	0%	0%
Careers Fair	0%	0%	8%	0%	2%	0%	0%
Prof. Associations	0%	1%	0%	0%	0%	3%	0%
Direct Mail	1%	0%	0%	0%	1%	2%	0%

Hard to Fill Roles

SERVICE	Role and Mitigation
Cardiovascular	•Electrophysiologist *Sourcing on linkedIn, twitter*
Child Health	• Whanau Liaison • Paediatric medical SMO's • HCA - weekend role
Clinical Support	• Physiotherapist • Pharmacist (Senior Roles)
Mental Health	• Mental Health Nurses
Surgical	• SCD Liver Transplant Service. • Oral Maxiofacial Surgeon Oncology and Oral Medicine Specilist. *Advertising on role specific job boards overseas*
Women's Health	• Midwives. *Sourcing on social media (fb. Linkedin) and agency.*

Welcome Haere Mai | Respect Manaaki | Together Tūhono | Aim High Angamua

Quarterly ADHB People Analytics Dashboard - F21 Q1: 30 September 2020

Pūmanawa Tāngata Plan 2020-2023

Strengthening Culture & Building Capability

KRA1: Continue to strengthen our organisational Culture & Values

KRA 2: Uphold Te Tiriti o Waitangi as our framework to eliminate racism, build culturally safe practice and achieve health equity

KRA3: Grow and develop ngā Kaimahi Māori

KRA4: Implement 'Kia Ora tō Wāhi Mahi' - The Healthy Workplace Plan for Te Toka Tumai

KRA5: Build pipelines, attract and retain the talent we need to deliver a workforce that is fit for the future

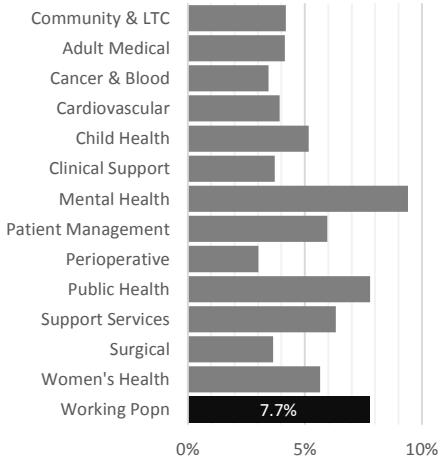
KRA6: Make it easier to work here - improving the manager and employee experience of people processes

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

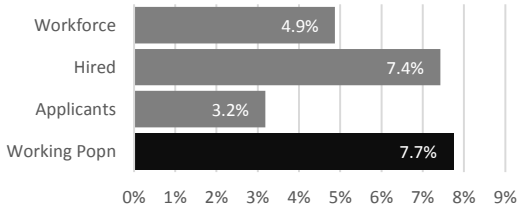
Māori in the workforce

- Over the last quarter a significant amount of engagement has occurred with our Kaimahi Māori to understand their current experience and aspirations for working at Te Toka Tumai. These engagements have resulted in a forward focus for KRA3: on three areas:
  - Increasing the number of Māori workforce within Auckland DHB, and utilising key Kaimahi Māori to support this goal.
  - Growth in Māori representation in leadership roles at all levels of the organisation
  - Integration of Māutauranga Māori in all facets of the organisation.
- Turnover of our Māori Workforce is still high however the work in Pūmanwa Tāngata - the ADHB People strategy is aimed at reducing this.

Māori Representation by Directorate

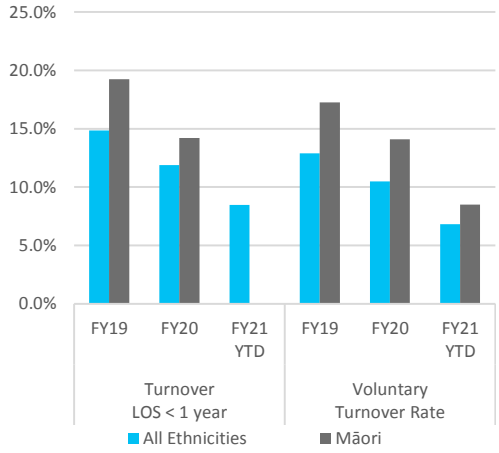


Progression of Māori Applicants Through Recruitment



Year	Percent of Shortlisted Applicants to Interview		Hired : Unsuccessful Applicants Ratio	
	Māori	All Staff	Māori	All Staff
FY21 YTD	57%	39%	1 : 3.2	1 : 8.2
FY 20	54%	35%	1 : 4.0	1 : 7.2
FY 19	46%	33%	1 : 4.6	1 : 7.8

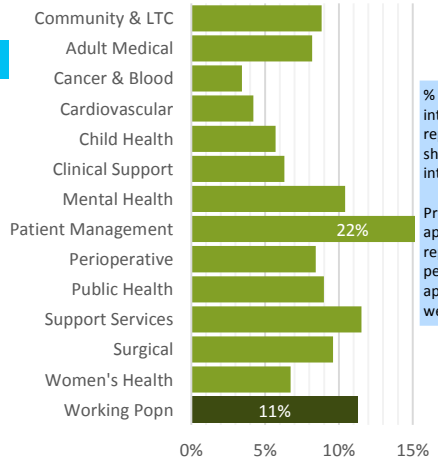
Voluntary Turnover Rate



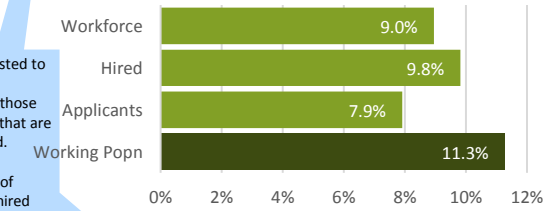
Pacific in the workforce

- Progression of our Pacific applicants though the selection process is maintaining at similar levels to last quarter.
- Turnover for our Pacific Workforce remains lower than for other ethnicities, but of concern is turnover within a year of employment, which signals a mismatch between what people were expecting the work or workplace to be, and the reality of their experience. Work needs to be undertaken to understand this in more detail.

Pacific Representation by Directorate



Progression of Pacific Applicants Through Recruitment

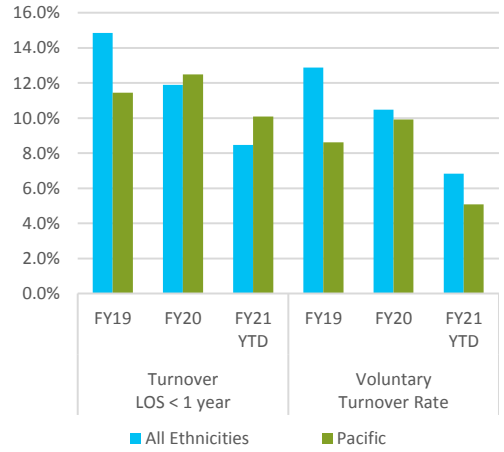


% of shortlisted to interview represents those shortlisted that are interviewed.

Proportion of applicants hired represents the percentage of total applicants who were hired.

	Percent of Shortlisted Applicants to Interview		Hired : Unsuccessful Applicants Ratio	
	Pacific	All Staff	Pacific	All Staff
FY21 YTD	42%	39%	1 : 7.0	1 : 8.2
FY 20	43%	35%	1 : 5.6	1 : 7.2
FY 19	35%	33%	1 : 6.4	1 : 7.8

Voluntary Turnover Rate



Welcome Haere Mai | Respect Manaaki | Together Tūhono | Aim High Angamua

Quarterly ADHB People Analytics Dashboard - F21 Q1: 30 September 2020

Pūmanawa Tāngata Plan 2020-2023

Strengthening Culture & Building Capability

KRA1: Continue to strengthen our organisational Culture & Values

KRA2: Uphold Te Tiriti o Waitangi as our framework to eliminate racism, build culturally safe practice and achieve health equity

KRA3: Grow and develop ngā Kaimahi Māori

KRA4: Implement 'Kia Ora tō Wāhi Mahi' - The Healthy Workplace Plan for Te Toka Tumai

KRA5: Build pipelines, attract and retain the talent we need to deliver a workforce that is fit for the future

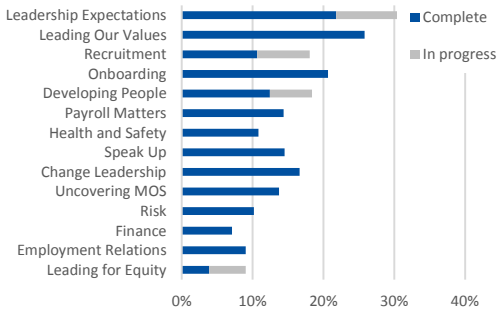
KRA6: Make it easier to work here - improving the manager and employee experience of people processes

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Strengthen Culture & Build Capability

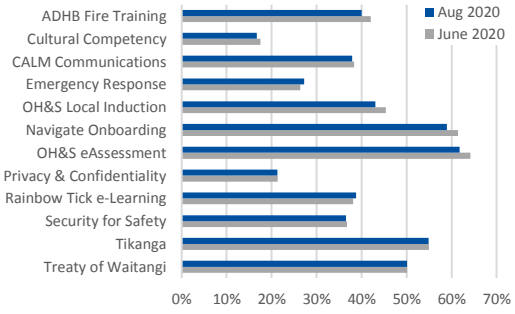
- During the lockdown periods our Management Development Programme (MDP) has transformed to online modules and 'zoom' sessions have replaced face to face sessions. This has resulted in increased participation across the modules.
- 2 further online modules are due for release in the next quarter and 3 face to face (zoom) modules will also be implemented.
- A mandatory training project is just getting underway which will focus on Mandatory training compliance and reporting.
- Annual Leave Management: Directorates are requiring employees with excess leave to have a leave plan put in place. There is also a specific focus for those employees who have taken less than 10 days per annum to have further leave for rest and wellbeing.
- Performance & Development Conversations being tracked in Kiosk continue to be challenging, in particular for areas where staff don't have computers.

Management Development Programme



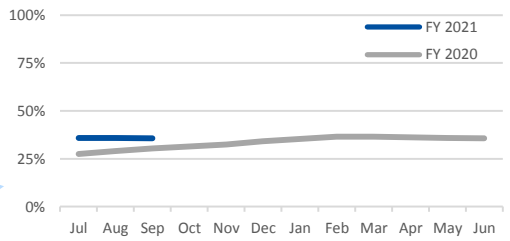
The MDP module completed above are against people managers only.

Mandatory Training



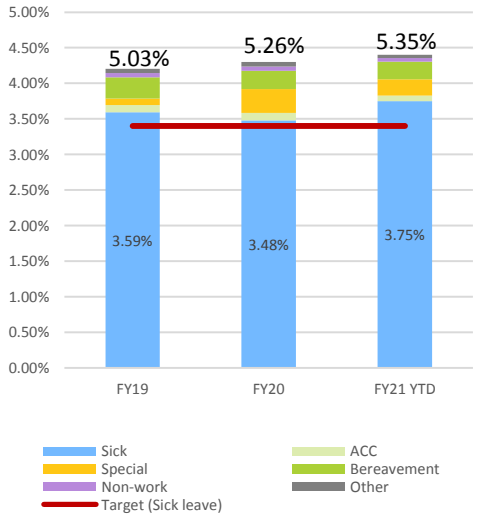
49% of staff took more than their entitled annual leave during FY 2019-2020.

Performance & Development Conversations

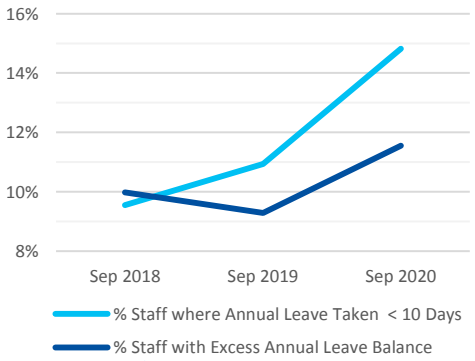


This graph indicates the completion of our requirement to document performance conversations in kiosk. We are aware more performance conversations have taken place but have not been updated in Kiosk.

Unplanned Leave / Absenteeism

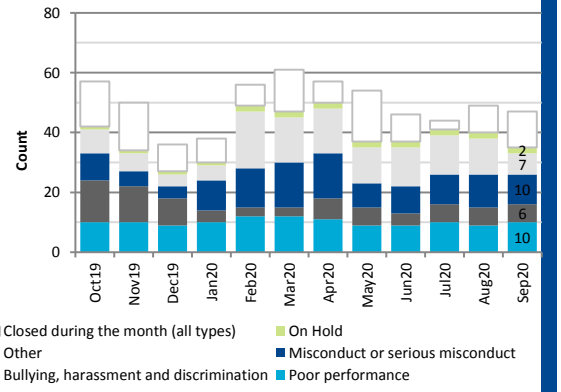


Annual Leave



This represents the percentage of staff that had taken less than 10 days leave (prorated) during the 12 month period. It only includes staff that were paid a min 0.8 FTE. *(Excludes Time In Lieu leave taken)*

Employee Relations Cases



Welcome Haere Mai | Respect Manaaki | Together Tūhono | Aim High Angamua

Talent Acquisition Objective: Build Te Toka Tumai employment brand through multi channel approach

What are we trying to achieve:

- Consistent & attractive brand/EVP overall
- Be attractive to priority groups & provide equitable process for all audiences
- Use effective multiple channels for both sourcing & brand/EVP marketing

How are we performing?

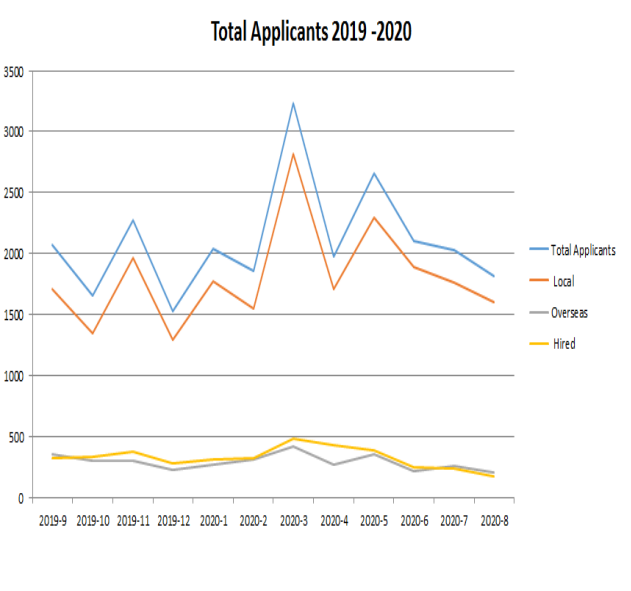
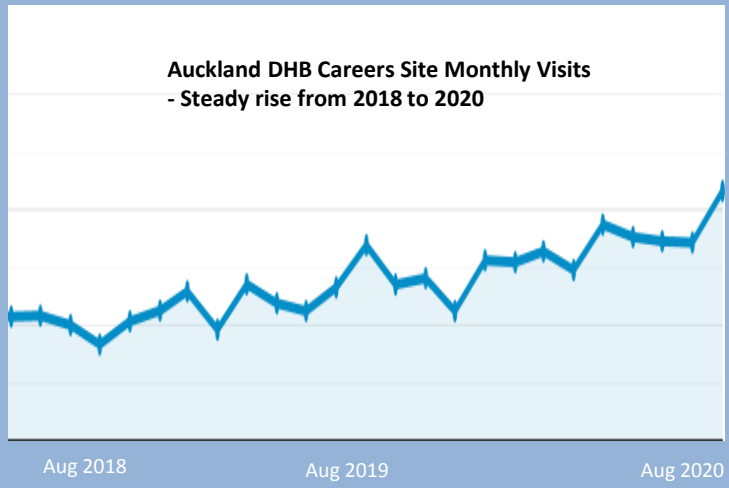
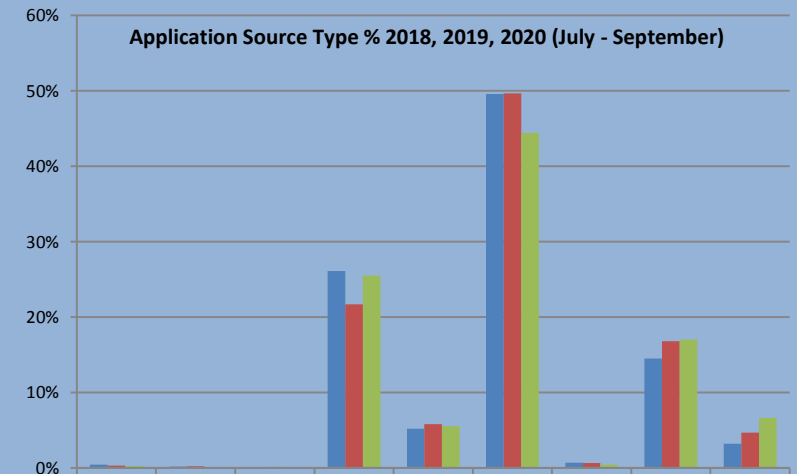


Figure 2

Figure 1





	Agency	Career Fair	Direct Mail	Job Board	Other	Our Web Site	Professional Associations	Referral	Social Network
2018	0.4%	0.2%	0.0%	26.1%	5.2%	49.6%	0.7%	14.5%	3.2%
2019	0.3%	0.2%	0.1%	21.7%	5.8%	49.7%	0.7%	16.8%	4.7%
2020	0.3%	0.1%	0.1%	25.5%	5.5%	44.4%	0.4%	17.0%	6.6%

Figure 3

- Brand & EVP review research underway across multiple stakeholder audiences to inform clearer & consistent positioning for DHB & Directorates /professions
- There has been a steady rise in interest in our website due both to on-going Improvements in our marketing plus the recent COVID lift (see Fig 1)
- Fig 2 shows impact of lift in applications from additional COVID specific positions plus general lift in applications. – reflects interest in COVID roles & perhaps DHB as "safe" employer/job security
- Source of application data (Fig 3) reflects change in candidate channel preference e.g. increased engagement through social networks/media such as Linked In, Facebook advertising & Facebook groups plus more active candidates through job boards

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

5.4

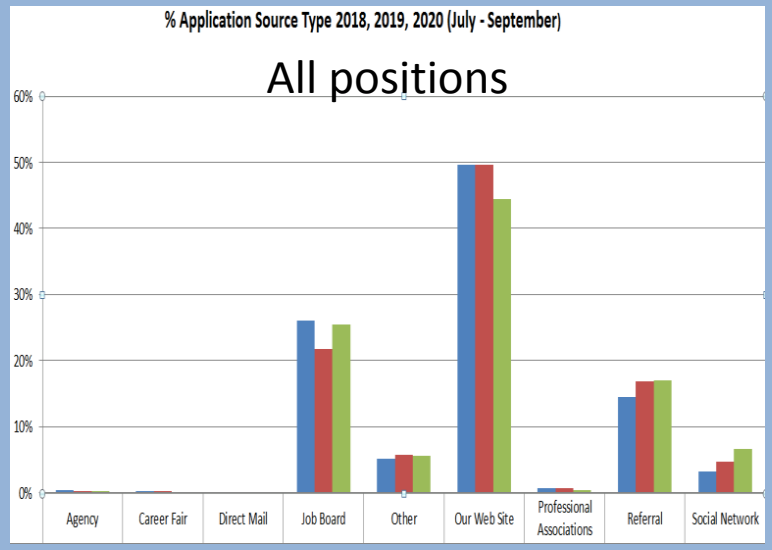
Talent Acquisition Objective: Ensure a fit for purpose model – stratified approaches to meet sourcing demands of different professions / roles

What are we trying to achieve:

- Varied approaches based on role type, business need & client group i.e. not one size fits all
- Use of different & effective sourcing channels
- Model that delivers effective outcomes & continual improvement
- Model supports greater "up stream" involvement in supply chain e.g. tertiary & other training
- Recruitment plans for each Directorate that reflect forecasted workforce needs

How are we performing?

Figure 1



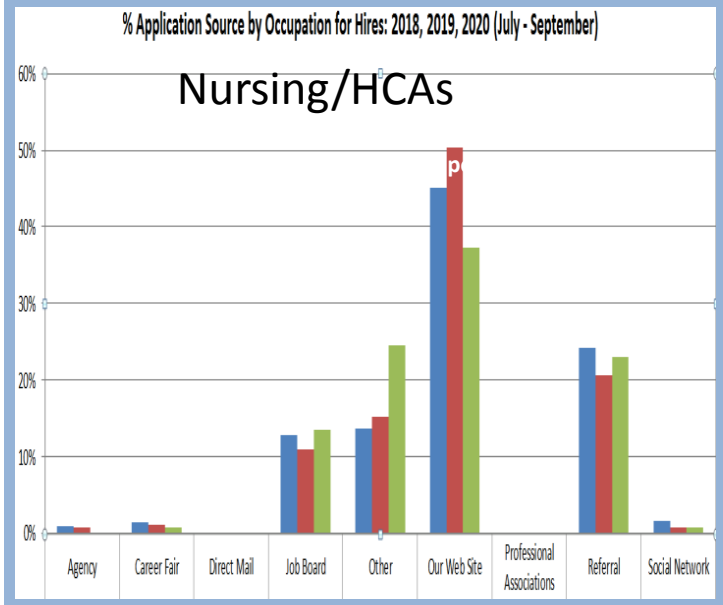


Figure 2

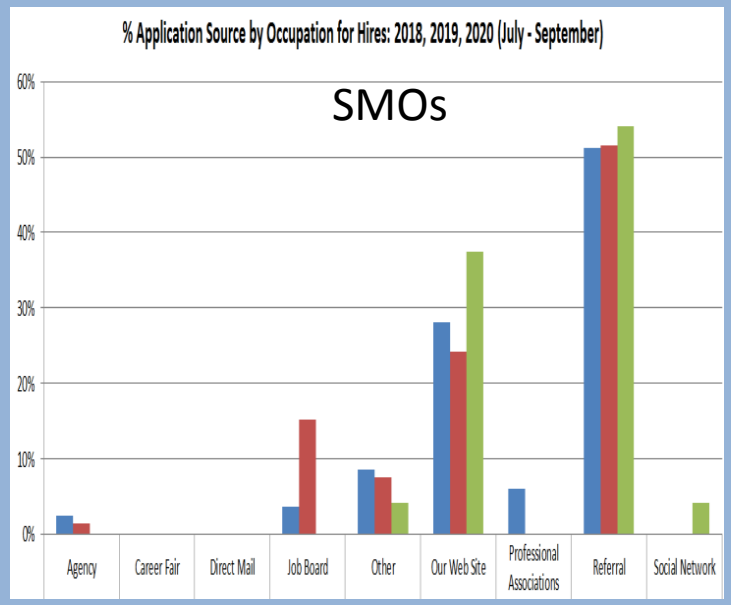


Figure 3

- Data shows emerging change in sourcing channels.
- Figures 2 & 3 show different sourcing approaches are varyingly effective for different professions.
- Talent Acquisition Plan 2020-23 is addressing future state model building on recent insights – including how model supports Te Ao Māori & broader channel strategy
- Fig 4 on next slide shows steady decline in TTH & responses to COVID surge in wave 1 – this indicates improvement in team capability

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Talent Acquisition Objective: Ensure a fit for purpose model – stratified approaches to meet sourcing demands of different positions.

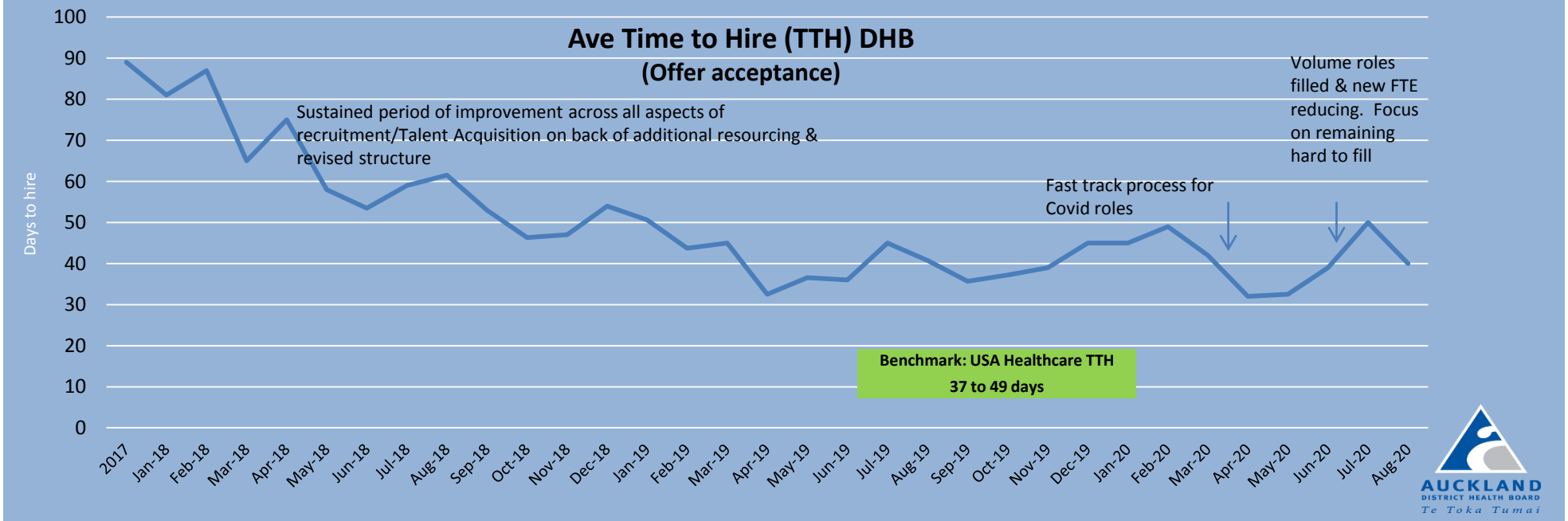
What are we trying to achieve:

- Varied approaches based on role type, business need & client group i.e. not one size fits all
- Use of different & effective sourcing channels
- Model that delivers effective outcomes & continual improvement
- Evolve model to support greater "up stream" involvement in pipeline
- Recruitment plans for each Directorate that reflect forecasted workforce needs

- Fig 4 shows steady decline in TTH & response to Covid surge. Provides solid foundation for further capability development & operational improvement to support 2020/21 plan achievement
- Senior Hiring Directors receive a higher level of recruiter support throughout the process recognising this client group as an "time poor". This again shows differing approaches being developed for differing needs (one size does not fit all)

How are we performing?

Figure 4



Talent Acquisition Objective: Ensure we attract/recruit workforce that reflects the communities we serve

What are we trying to achieve:

- Bespoke attraction/recruitment pathways for all priority groups
- Prioritisation process continues to improve hire rate outcomes
- We attract more Māori & Pacific applicants
- Remove real & perceived barriers to drive equity for all groups
- Support on-going initiatives at service/HR level that retain priority employees

How are we performing?

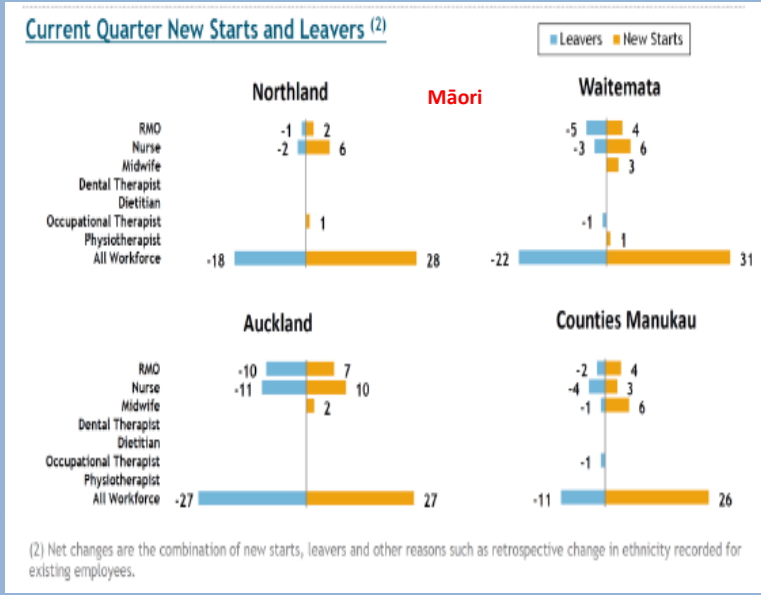
Figure 2

Year	Percent of Shortlisted Applicants to Interview		Hired : Unsuccessful Applicants Ratio	
	Māori	All Staff	Māori	All Staff
FY21 YTD	57%	39%	1 : 3.2	1 : 8.2
FY 20	54%	35%	1 : 4.0	1 : 7.2
FY 19	46%	33%	1 : 4.6	1 : 7.8

	Percent of Shortlisted Applicants to Interview		Hired : Unsuccessful Applicants Ratio	
	Pacific	All Staff	Pacific	All Staff
FY21 YTD	42%	39%	1 : 7.0	1 : 8.2
FY 20	43%	35%	1 : 5.6	1 : 7.2
FY 19	35%	33%	1 : 6.4	1 : 7.8

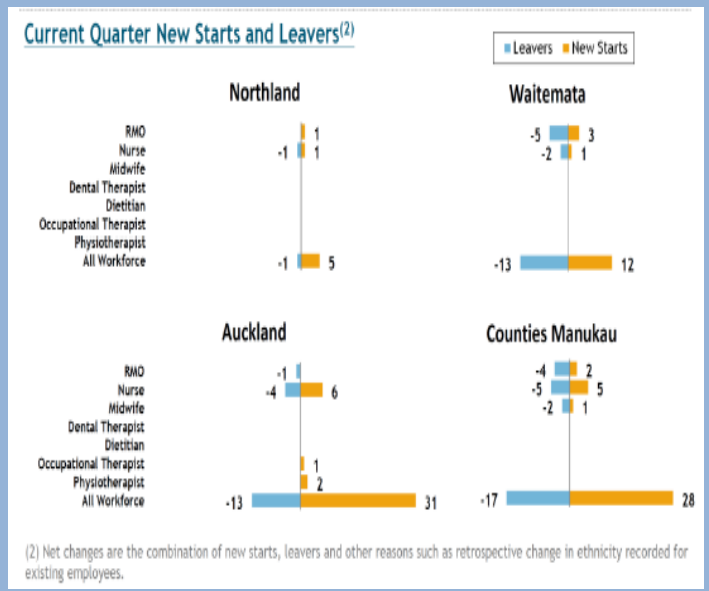
Māori

Figure 1



Pacific

Figure 3



- Prioritisation of Māori & Pacific through recruitment process is yielding positive results (Fig 2). Significantly higher % chance of hire for Māori versus others. Targeted support program for priority groups being trialled to further improve application to hire conversion rate
- Fig 1 compares DHBs hires & leavers rates for Māori by broad profession. Hire rates are similar but ADHB leavers rate is concerning.
- Research planned to inform improved attraction/application rates – strong link to DHB brand reputation driven by actual employee experience. People Plan identifies required work streams.
- Fig 3 shows ADHB hire and retention rates for Māori & Pacific for Q1, 2020/21
- Circa 10 access needs candidates supported during 2020 YTD but improved tracking/reporting process required.

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

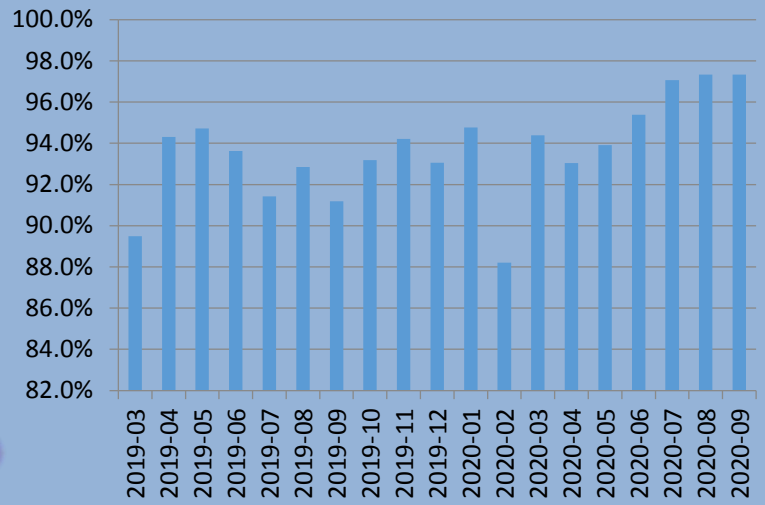
Talent Acquisition Objective: Manaaki our candidates from attraction to belonging

What are we trying to achieve:

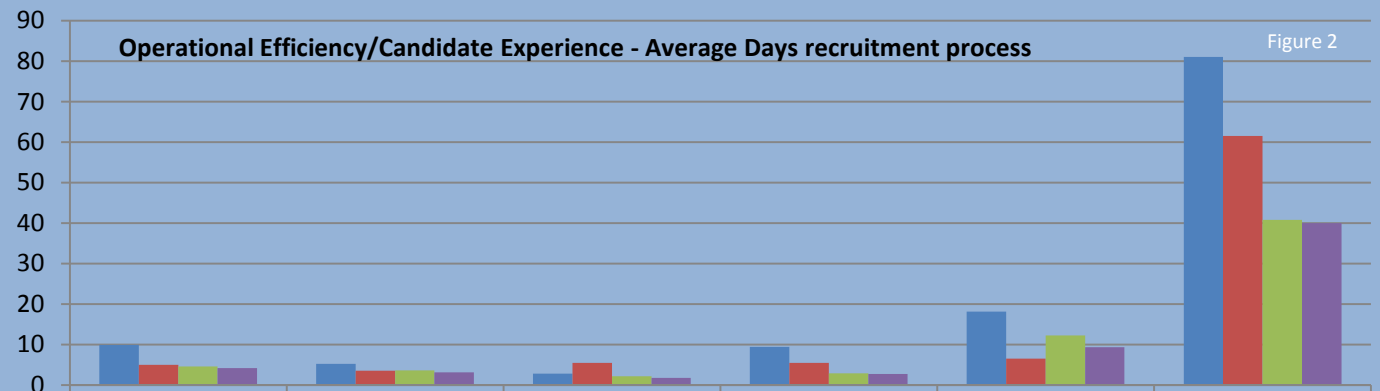
- Provide positive experience ensuring new staff start with high engagement
- Positive brand reputation via new hires network communication
- Identify opportunities for on-going improvement in end to end processes – up to 90 day post start
- Ensure bespoke processes for priority groups & application of Te Ao Māori principles & concepts

How are we performing?

Offer Acceptance % 2019 - 2020 Figure 1



Operational Efficiency/Candidate Experience - Average Days recruitment process Figure 2



	Days Application to Review by Hiring Manager	Days Offer approval through approval process	Days Offer Approved to Offer to Candidate	Days Offer made to offer accept	Days Acceptance to hire	Overall ATR approved to offer acceptance
Aug-17	9.94	5.27	2.79	9.39	18.1	81
Aug-18	4.98	3.54	5.44	5.46	6.53	61.5
Aug-19	4.59	3.58	2.15	2.89	12.22	40.76
Aug-20	4.2	3.17	1.73	2.77	9.35	40

- Core gap in our insights. Only have anecdotal feedback on the experience of our candidates. In depth research is in planning covering process and broader engagement related measures – includes first 90 days in new role
- Research will cover focus on priority groups
- We do know process times have improved significantly delivering easier/faster experience & the anecdotal feedback has been positive from hired candidates
- High recent offer acceptance rate a reflection of Covid & also focused 1:1 care from recruiters for especially international applicants during difficult COVID times
- Step change in process stage improvement since 2017 – intro Taleo on-boarding module
- Supporting hiring managers to deliver positive experience key aspect of strategy

Talent Acquisition Objective: Support Hiring Manager to be Kaitiaki of recruitment & selection process

What are we trying to achieve:

- A positive recruitment experience for hiring managers
- Ensuring hiring manager capability to deliver a positive & engaging experience for their candidates
- Ensure hiring managers are supported in selection of priority workforce candidates
- Supply relevant reporting to managers

How are we performing?

Figure 1

Year	Percent of Shortlisted Applicants to Interview		Hired : Unsuccessful Applicants Ratio	
	Māori	All Staff	Māori	All Staff
FY21 YTD	57%	39%	1 : 3.2	1 : 8.2
FY 20	54%	35%	1 : 4.0	1 : 7.2
FY 19	46%	33%	1 : 4.6	1 : 7.8

	Percent of Shortlisted Applicants to Interview		Hired : Unsuccessful Applicants Ratio	
	Pacific	All Staff	Pacific	All Staff
FY21 YTD	42%	39%	1 : 7.0	1 : 8.2
FY 20	43%	35%	1 : 5.6	1 : 7.2
FY 19	35%	33%	1 : 6.4	1 : 7.8

Manager Completion of Recruitment MDP Module

Count of emp_number_main	Column Labels				
Row Labels	Complete	In progress	Not enrolled	Not yet started	Grand Total
Adult Community & LTC	20	6	9	3	38
Adult Medical Services	2	6	24	8	40
Cancer & Blood Services	4	4	9	13	30
Cardiovascular Services	2	1	16	5	24
Child Health	2	3	47	14	66
Clinical Support	13	4	31	23	71
Mental Health & Addictions	4	10	14	10	38
Patient Management Services	1	1	18	7	27
Perioperative Services	1	3	28	10	42
Public Health	2	1	14	6	23
Support Services	8	2	99	31	140
Surgical Services	4	6	25	17	52
Women's Health	1		25	3	29
Grand Total	**64**	**47**	**359**	**150**	**620**

- Research underway to update hiring manager experience insights from previous 2017 focus group insights
- Fig 1 shows improved support by managers for consideration & hiring of priority candidates. Candidate assessment & experience processes at interview stages not well defined or measured & key area for new plan
- Increased business partnering & support by recruiters part of model review
- Fig 2 shows manager completion of training & embedding of practices remains an improvement opportunity
- Executive/Senior level hiring managers supported with enhanced service level from recruiters

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Financial Performance Report for the period ending 30 September 2020

Recommendation

That the Board receives this Financial Report for the three months ending 30 September 2020

Prepared by: Auxilia Nyangoni, Deputy Chief Financial Officer
Endorsed by: Justine White, Chief Financial Officer
Date: 29 October 2020

1. Executive Summary

The 2019/20 year end audit of the Annual Report is almost complete and an audit opinion on this will be provided by Audit NZ in November 2020. The final 2019/20 Annual Report will be circulated to the Board in December, however due to statutory deadlines, it is proposed that the Annual Report will be authorised by the Chair and Deputy Chair on the approval recommendation of FRAC.

The 2020/21 Annual Plan Financial Budget was approved by the Board in August with a deficit of $45M, which is still subject to approval by the Minister of Health. Financial performance in this report is based on that approved budget.

For the year to date period ending 30 September 2020, the DHB realised a deficit of $22M, which was $17M unfavourable to the budgeted deficit of $5M. The result by division and showing the Covid impacts is as follows:

Result by Division	**For the three months ending 30 Sept 2020**		
	Actual	**Budget**	**Variance**
Funder	5,184	4,725	459 F
Provider	(27,838)	(9,541)	18,298 U
Governance	452	(63)	515 F
Net Surplus / (Deficit)	**(22,202)**	**(4,880)**	**17,322 U**
COVID-19 Net impact on bottom-line	(16,940)	550	**17,490 U**
BAU Net impact on bottom-line	(5,262)	(5,430)	**168 F**

The $17M unfavourable variance is driven by the Provider Arm which is mainly due to Covid impacts, as the underlying Business as Usual (BAU) operations' result was overall favourable to budget by $168K as shown above.

Covid impacts include a provision for adverse IDF and Planned Care revenue wash-ups of $11M reflecting lower than planned volumes delivered 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 September 2020

$000s	Month (Sept-2020)			For the three months ending 30 Sept 2020			Full Year (2020/21)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Income									
Government and Crown Agency	155,391	145,346	10,045 F	449,929	436,615	13,314 F	1,750,905	1,742,995	7,910F
Non-Government and Crown Agency	7,977	9,467	1,489 U	24,972	26,760	1,788 U	103,872	105,660	1,788U
Inter- District Flows	57,114	60,598	3,484 U	173,810	181,794	7,984 U	719,176	727,176	8,000U
Inter-Provider and Internal Revenue	1,707	1,565	142 F	4,605	4,155	449 F	18,242	18,242	0
Total Income	**222,190**	**216,976**	**5,214 F**	**653,316**	**649,325**	**3,991 F**	**2,592,195**	**2,594,073**	**1,878U**
Expenditure									
Personnel	97,280	96,395	885 U	295,131	288,470	6,661 U	1,189,394	1,184,076	5,318U
Outsourced Personnel	3,313	1,613	1,700 U	8,118	4,814	3,305 U	22,559	19,254	3,305U
Outsourced Clinical Services	4,432	3,568	864 U	12,118	10,756	1,363 U	46,281	45,976	305U
Outsourced Other Services	7,290	7,395	105 F	21,086	22,184	1,099 F	83,124	88,737	5,613F
Clinical Supplies	28,504	28,100	405 U	83,919	84,510	590 F	327,913	326,698	1,215U
Funder Payments - NGOs and IDF Outflows	67,941	62,490	5,451 U	196,729	187,470	9,259 U	758,655	749,879	8,776U
Infrastructure & Non-Clinical Supplies	19,838	19,390	449 U	58,417	56,002	2,416 U	226,253	224,496	1,757U
Total Expenditure	**228,599**	**218,951**	**9,648 U**	**675,518**	**654,205**	**21,314 U**	**2,654,178**	**2,639,116**	15,062U
Net Surplus / (Deficit)	**(6,409)**	**(1,975)**	**4,434 U**	**(22,202)**	**(4,880)**	**17,322 U**	**(61,983)**	**(45,043)**	**16,940 U**

Result by Division	Month (Sept-2020)			For the three months ending 30 Sept 2020			Full Year (2020/21)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funder	2,513	1,575	938 F	5,184	4,725	459 F	19,359	18,900	459 F
Provider	(9,112)	(3,492)	5,620 U	(27,838)	(9,541)	18,298 U	(81,796)	(63,882)	17,914 U
Governance	189	(58)	247 F	452	(63)	515 F	454	(61)	515 F
Net Surplus / (Deficit)	**(6,409)**	**(1,975)**	**4,434 U**	**(22,202)**	**(4,880)**	**17,322 U**	**(61,983)**	**(45,043)**	**16,940 U**
COVID-19 Net impact on bottom-line	(4,450)	45	**4,495 U**	(16,940)	550	**17,490 U**	**(16,940)**	0	**16,940 U**
BAU Net impact on bottom-line	(1,959)	(2,020)	**61 F**	(5,262)	(5,430)	**168 F**	**(45,043)**	(45,043)	**0 F**

Commentary on DHB Consolidated Financial Performance

Result for the Month of September 2020

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

Revenue for the month of September 2020 is favourable to budget by $5.2M (2.4%), of which $4.9M relates to Covid and the balance relates to BAU operations. Significant revenue variances include:

- $10M (6.9%) favourable Government and Crown Agency revenue, mostly related to additional Covid revenue realised ($9M favourable) and the balance reflects favourable Ministry of Health (MoH) devolved contract revenue in BAU operations.
- $1.5M (-15.7%) unfavourable Non-Government and Crown Agency, mainly reflecting $0.7M adverse non-resident income driven by a reduction in Pacific contract cases as a result of Covid and the balance is mostly additional revenue assumed from budget initiatives not realised.
- $3.5M (5.7%) unfavourable Inter-District Flows reflects an increase in the provision for adverse revenue wash-up due to volume under-delivery for the month compared to the plan.

Expenditure for the month is unfavourable to budget by $9.6M (-4.4%), with $9.4M of this variance due to unbudgeted costs arising from Covid and the balance in BAU operations. Significant variances include:

- $2.6M (-2.6%) unfavourable variance in combined Personnel and Outsourced Staff costs with all of this variance due to unbudgeted Covid related expenditure.
- $5.5M (-8.7%) unfavourable variance in Funder NGOs expenditure is mainly driven by unbudgeted Covid costs which are offset by additional Covid funding from MoH.

Result for the Year To Date

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

Revenue for the year to date to September 2020 is favourable to budget by $4M (0.6%), with $1.6M of the favourable variance relating to Covid and $2.3M relating to BAU operations. Significant revenue variances include:

- $13M (3%) favourable Government and Crown Agency revenue. This includes additional revenue realised for Covid for community testing and for the increase in Laboratory services favourable to plan by $12M. The balance reflects favourable revenue in BAU operations mainly MoH devolved contract revenue.
- $1.8M (-6.7%) unfavourable Non-Government and Crown Agency, mainly reflecting:
    - $2.4M unfavourable Non-Resident revenue due to reduced Pacific contract cases as a result of Covid.
    - $1.9M unfavourable Other Income reflecting additional revenue assumed for budget initiatives not realised.
    - These were offset by $1.7M favourable Retail Pharmacy revenue and Research Income $0.8M favourable (with corresponding costs of goods sold and research costs respectively).
- $8M (-4.4%) unfavourable Inter-District Flows, mainly from revenue wash-up provisions for under delivery of inpatient services.

The year to date expenditure variance of $21M (-3.3%) includes an overall adverse Covid impact of $19.2M and the balance is due to BAU operations. Significant variances are:

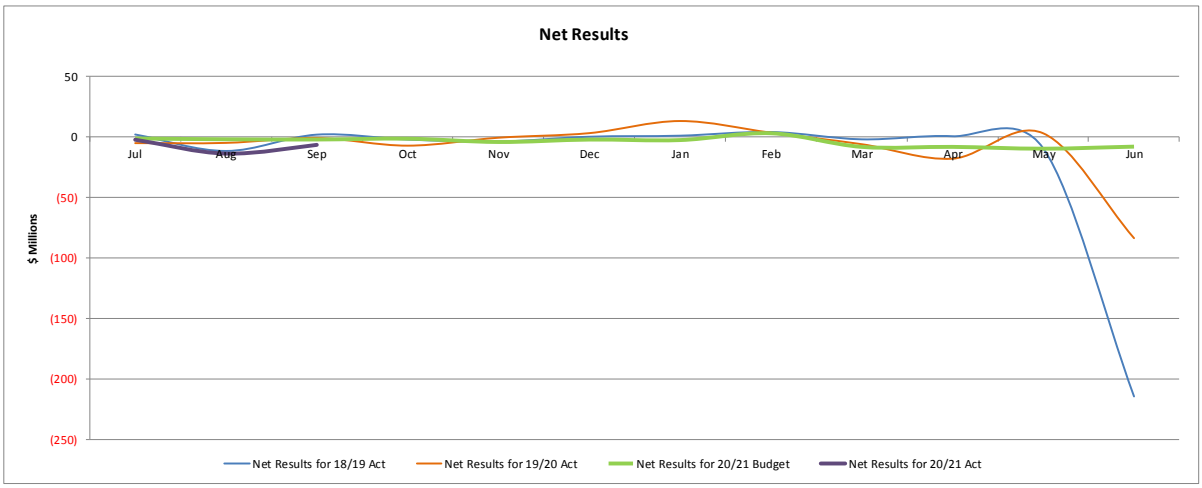
- $10M (-3.4%) unfavourable variance in Personnel/Outsourced Personnel costs, driven by the following:
    - Unbudgeted Covid related expenditure of $6.9M.
    - Budget Personnel vacancy and cost per FTE assumptions not fully achieved $3.1M unfavourable
- $1.4M (-12.7%) unfavourable in Outsourced Clinical Services, with the key variances as follows:
    - Unbudgeted Covid related expenditure of $0.3M (for laboratory sendaway tests).
    - Diagnostic genetics $0.2M unfavourable due to delay in repatriation of tests previously not done in house – this variance will reduce once repatriation is complete.
    - Planned outsourcing for colonoscopy has been completed earlier than budget phasing resulting in a $0.4M unfavourable variance which will correct during the year.
    - Additional MRI outsourcing $0.3M unfavourable for which additional one off MOH funding has been received in September.
- $9.3M (-4.9%) unfavourable variance in Funder NGOs expenditure & IDF outflows, noting that this is fully offset by additional Funder income and is bottom-line neutral. Key Funder variances include:
    - Unbudgeted Covid cost impact of $8.5M, offset by additional Covid revenue.
    - Mental Health unfavourable variance of $1.5M relating to the implementation of Integrated Primary Mental Health initiative which is offset against an equivalent favourable revenue variance.
    - Personal Health expenditure unfavourable variance of $1.7M driven by quarterly IDF wash-ups accounted for as advised by the Ministry to be settled in October-2020 and Pharmaceuticals unfavourable variance driven by a higher than usual prior year cost that exceeded the related year end accrual.
    - Health of Older People is $1M favourable reflecting normally expected variations in business as usual factors across Funder NGO services.
    - IDF Outflow variance is $1.4M favourable mostly due to favourable quarterly Primary Health Organisation wash-ups and agency adjustment.
- $2.4M (-4.3%) unfavourable variance in Infrastructure & Non Clinical Supplies costs mainly due to:
    - Unbudgeted Covid related expenditure of $2.3M
    - Cost of Goods Sold $1.4M unfavourable for retail pharmacy, offset by additional retail revenue.
    - Other Operating Expenses such as Professional Fees and Training $1.0M favourable.

Year End Forecast Result

The high level forecast year end result is a deficit of $61M against the full year planned deficit of $45M, this excludes any further Holidays Act remediation provision. The $16M forecast variance to the budget is primarily due to the year to date adverse impact of Covid. No assumptions have been made yet regarding potential future Covid outbreaks and the financial impacts of these. Additionally, there are likely to be further impacts in regard to the Holidays Act liability which is as yet unknown, and subject to expert estimation. At this stage, at the Ministry's request we have signalled a potential additional $40M of liability. A detailed forecast will be developed from the year to date result to December.

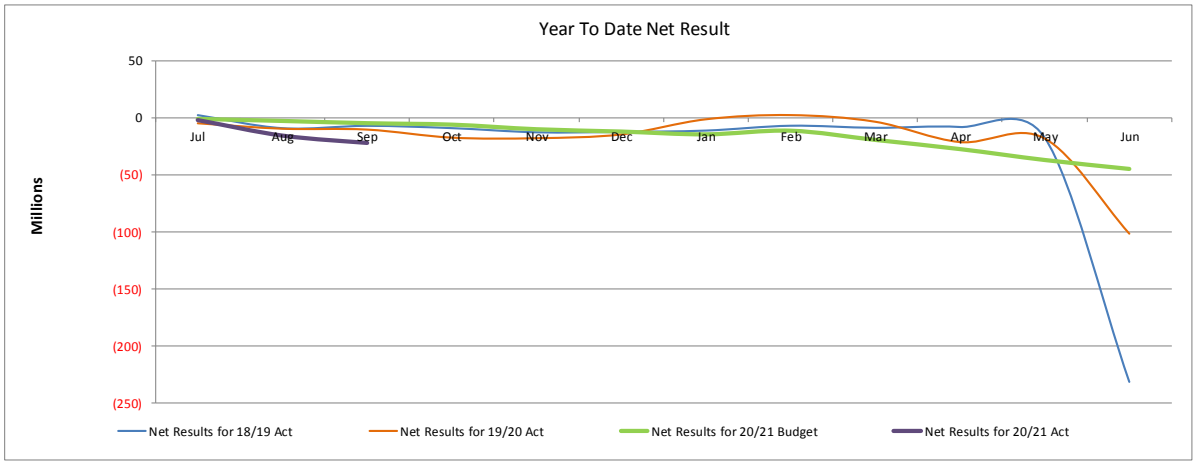
3. Performance Graphs

Figure 1: Consolidated Net Result (By Month)



$ millions	July	August	Spetember	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)	(6.409)										(22.202)

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)	(12.223)	(14.672)	(11.483)	(19.548)	(27.614)	(37.179)	(45.043)
Net Results for 20/21 Act	(2.167)	(15.793)	(22.202)									
Variance to Budget 20/21	(1.057)	(12.888)	(17.322)									

4. Financial Position

4.1 Statement of Financial Position as at 30 September 2020

$'000	30-Sep-20			31-Aug-20	Variance	30-Jun-20	Variance
	Actual	Budget	Variance	Actual	Last Month	Actual	Last Year
Public Equity	928,574	941,875	13,302U	923,613	4,961F	919,427	9,147F
Reserves							
Revaluation Reserve	599,151	599,151	0F	599,151	0F	599,151	0F
Accumulated Deficits from Prior Year's	(792,779)	(790,846)	1,933U	(791,677)	1,102U	(688,960)	103,819U
Current Surplus/(Deficit)	(22,201)	(4,880)	17,322U	(15,793)	6,409U	(102,718)	80,516F
	(215,829)	(196,575)	19,254U	(208,319)	7,510U	(192,526)	23,303U
Total Equity	**712,745**	**745,301**	**32,556U**	**715,294**	**2,549U**	**726,901**	**14,156U**
Non Current Assets							
Fixed Assets							
Land	347,122	347,122	0F	347,122	0F	347,122	0F
Buildings	616,262	626,157	9,895U	618,487	2,225U	624,109	7,847U
Plant & Equipment	84,007	91,553	7,546U	83,471	536F	86,655	2,649U
Work in Progress	87,482	97,201	9,719U	83,578	3,904F	74,518	12,965F
Total PPE	1,134,873	1,162,033	27,160U	1,132,658	2,215F	1,132,404	2,469F
Investments							
- Health Alliance	74,268	75,057	789U	74,268	0F	74,268	0F
- Health Source	271	-	271F	271	0F	271	0F
- NZHPL	6,846	5,572	1,274F	5,755	1,091F	5,755	1,091F
- Other Investments	518	-	518F	518	0F	518	0F
	81,903	80,629	1,274F	80,812	1,091F	80,812	1,091F
Intangible Assets	2,237	5,053	2,816U	2,072	165F	2,216	21F
Trust Funds	16,386	15,970	416F	16,514	128U	15,970	416F
	100,526	101,652	1,126U	99,398	1,128F	98,998	1,528F
Total Non Current Assets	**1,235,399**	**1,263,685**	**28,286U**	**1,232,056**	**3,343F**	**1,231,402**	**3,997F**
Current Assets							
Cash & Short Term Deposits	151,504	114,579	36,924F	146,825	4,679F	135,902	15,602F
Trust Deposits > 3months	15,892	16,394	502U	17,892	2,000U	16,394	502U
ADHB Term Deposits > 3 months	5,000	15,000	10,000U	15,000	10,000U	15,000	10,000U
Debtors	28,663	45,325	16,663U	26,390	2,273F	45,325	16,663U
Accrued Income	89,912	53,611	36,300F	77,165	12,747F	54,556	35,355F
Prepayments	9,447	6,282	3,164F	9,166	280F	5,729	3,718F
Inventory	15,449	27,511	12,062U	15,755	306U	27,511	12,062U
Total Current Assets	**315,866**	**278,703**	**37,162F**	**308,193**	**7,673F**	**300,417**	**15,448F**
Current Liabilities							
Borrowing	(1,985)	(1,925)	60U	(1,847)	138U	(1,828)	157U
Trade & Other Creditors, Provisions	(210,089)	(167,327)	42,763U	(189,019)	21,070U	(177,892)	32,197U
Employee Entitlements	(525,058)	(524,748)	310U	(533,745)	8,687F	(524,748)	310U
Funds Held in Trust	(1,384)	(1,376)	8U	(1,384)	0U	(1,384)	0U
Total Current Liabilities	**(738,516)**	**(695,375)**	**43,141U**	**(725,995)**	**12,520U**	**(705,851)**	**32,665U**
Working Capital	**(422,650)**	**(416,672)**	**5,978U**	**(417,802)**	**4,847U**	**(405,434)**	**17,216U**
Non Current Liabilities							
Borrowings	(11,072)	(12,610)	1,538F	(10,028)	1,044U	(10,136)	936U
Employee Entitlements	(88,931)	(89,102)	171F	(88,931)	0F	(88,931)	0F
Total Non Current Liabilities	**(100,003)**	**(101,712)**	**1,708F**	**(98,960)**	**1,044U**	**(99,067)**	**936U**
Net Assets	**712,745**	**745,301**	**32,556U**	**715,294**	**2,549U**	**726,901**	**14,156U**

Commentary

The major variances to budget are summarised below:

Property, Plant and Equipment:
The variance reflects capital expenditure tracking below budget as at September 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 $25M 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)	187,309
Income in Advance	22,780
Total	210,089

4.2 Statement of Cash flows as at 30 September 2020

$000's	30-Sep-20			For the three months ending 30 Sept 2020		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Revenue Received	211,358	216,749	5,391U	651,798	648,228	3,570F
Payments						
Personnel	(105,968)	(96,395)	9,573U	(294,820)	(289,057)	5,764U
Suppliers	(44,500)	(51,415)	6,915F	(145,626)	(152,985)	7,359F
Capital Charge	0	(3,807)	3,807F	-	(11,422)	11,422F
Payments to other DHBs and Providers	(67,941)	(62,490)	5,451U	(196,729)	(187,470)	9,259U
GST	792	0	792F	(2,107)	0	2,107U
	(217,617)	(214,107)	3,509U	(639,282)	(640,933)	1,651F
Net Operating Cash flows	**(6,258)**	**2,642**	**8,900U**	**12,516**	**7,295**	**5,221F**
Investing						
Interest Income	221	227	6U	630	681	51U
Sale of Assets	(0)	0	0U	6	0	6F
Purchase Fixed Assets	(7,647)	(20,530)	12,884F	(18,387)	(54,095)	35,708F
Investments and restricted trust funds	12,238	0	12,238F	10,738	0	10,738F
Net Investing Cash flows	**4,812**	**(20,303)**	**25,116F**	**(7,013)**	**(53,414)**	**46,401F**
Financing						
Interest paid	(17)	(99)	81F	(144)	(296)	152F
New loans raised	1,226	1,986	760U	1,545	3,212	1,666U
Loans repaid	(45)	(199)	154F	(452)	(567)	115F
Other Equity Movement	4,961	7,086	2,125U	9,147	22,449	13,302U
Net Financing Cash flows	**6,125**	**8,775**	**2,650U**	**10,096**	**24,797**	**14,701U**
Total Net Cash flows	**4,679**	**(8,886)**	**13,565F**	**15,599**	**(21,322)**	**36,921F**
Opening Cash	146,824	123,466	23,358F	135,903	135,902	1F
Total Net Cash flows	4,679	(8,886)	13,565F	15,599	(21,322)	36,921F
Closing Cash	**151,504**	**114,580**	**36,924F**	**151,504**	**114,580**	**36,924F**
ADHB Cash				144,737	108,377	36,361F
A+ Trust Cash				6,420	5,857	563F
A+ Trust Deposits - Short Term < 3 months & restricted fund deposits				346	346	0F
				151,504	**114,580**	**36,924F**
ADHB Short Term Investments 3 > 12 months				5,000	15,000	10,000U
A+ Trust Short Term Investments 3 > 12 months				15,892	16,394	502U
A+ Trust Long Term Investment Portfolio				16,386	15,970	416F
Total Cash & Deposits				**188,781**	**161,944**	**26,838F**

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 23 September 2020.

Prepared by: Wendy Bennett (Manager Planning and Health Intelligence), Joanne Brown (Funding & Development Manager Hospitals), Jean McQueen (Nurse Director 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), Faimafili Tupu (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

ACC		Accident Compensation Corporation
ACM		Auckland City Mission
ALT	-	Alliance Leadership Teams
ARC	-	Aged Residential Care
ARDS	-	Auckland Regional Dental Service
ARRC	-	Age Related Residential Care
ASH	-	Ambulatory Sensitive Hospitalisations
B4SC		B4 School Check
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
CTC		Community Testing Centre
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
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
MHUD		Ministry of Urban Development
MIQ		Managed Isolation and Quarantine
MMR	-	Mumps, Measles and Rubella

MoH	-	Ministry of Health
MRI	-	Magnetic Resonance Imaging
MSD	-	Ministry of Social Development
NAHH		Noho Āhuru – Healthy Homes
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
NWoO		Ngati Whatua o Orakei
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
SPPGG		Suicide Prevention and Postvention Governance Group
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 18 August 2020. To date, no further feedback has been received. However, the MoH have indicated that they do not have a final estimate for when the plan will be approved and that the Ministry is still in discussion with the DHB.

As per the modification to the Crown Entities Act (149CA), Waitematā DHB published a final, signed 2020/21 Statement of Performance Expectations (including the financial position at that time) to the DHB's website on 14 August 2020 (final due date was 15 August). Notice to take up this extension, in line with the modification to the legislation, was also published to the DHB's website, and will also be published in the 2019/20 Annual Report, as required.

2.2 2019/20 Annual Reports

The 2019/20 audit continues and we have been working with the auditors to complete requirements. As per our prior agreement with Audit New Zealand, the MoH and the Chair, the Annual Report will be a 'scaled-down' version, due to COVID-19 response activities which have impacted on service delivery. Many indicators have also been impacted – to ensure this is transparent, performance for the first three quarters of the year is presented separately for many indicators alongside quarter four performance. As per Audit NZ recommendations, we are including a whole section on the COVID response work and impacts, including:

- Participation in the regional response to the COVID-19 pandemic through the Northern Region Health Coordination Centre (NRHCC), which included:
    - COVID testing strategy and model of delivery
    - responsibility for the entire health component of the Managed Isolation and Quarantine (MIQ) system in the Northern Region and the development of robust procedures to ensure the safety of workers, their families and our communities
    - contingency planning for future outbreaks in Aged Residential Care (ARC) facilities
    - Support for our employee's health, safety and wellbeing
    - social welfare and cultural support services
- New services that were developed as part of the response work

The recently updated population estimates (from StatsNZ and the MoH) have also impacted some indicators and some targets have needed to be revised.

3. Primary Care

The PFO Primary Care team continue to have staff working within both the DHB and the NRHCC on the regional COVID-19 response.

Semi-permanent capacity for fixed site Community Testing Centres (CTCs) and mobile testing units was established prior to the August COVID-19 outbreak. This was designed to supplement the COVID-19 testing that is routinely available through general practices and urgent care clinics. In response to the surge outbreak, an additional 18 short term CTCs were established across metro Auckland, and over 70 'pop-up' clinics (ie operated one to three days duration) in a range of locations chosen for easy access.

Since the August COVID-19 outbreak (between 12 August 2020 and 8 October 2020), CTCs and mobile clinics have completed 160,000 swabs, while another 97,000 swabs were taken through general practice and urgent care clinics across metropolitan Auckland. The volume of tests completed since the August outbreak (between 12 August 2020 and 8 October 2020) accounts for around 50% of the total swabs taken since March this year.

4.1 Mobile Outreach Health clinics

During COVID-19 Alert Level 4, approximately 500 rough sleepers were accommodated in motel units ("managed accommodation") across metropolitan Auckland. Auckland and Waitematā DHBs successfully implemented mobile Outreach Health clinics to provide health services to those living in managed accommodation from 1 July 2020 to 30 September 2020. The services supported people not enrolled with a primary care provider and have untreated or unmet health need. 41% of these people are Māori and 15% are Pacific.

In Auckland DHB, the Auckland City Mission's mobile Outreach Health clinic is nurse-led and has access to general practitioners or nurse practitioners and social workers. Services include comprehensive health assessments, triaging, limited range of treatments and supply of medicines, screening/prevention activities and COVID-19 testing if required. The service is being extended for a further six months to 31 March 2021 to continue providing services to people in managed accommodation.

4. Health of Older People

4.1 Aged Residential Care

It is over five months since ARC facilities were assessed by the DHB on their COVID-19 preparedness. It is now important that facilities maintain their vigilance even when the risk of community transmission is thought to be low. To this end, a five week programme has been developed focusing on key areas of COVID-19 preparedness for ARC; the sessions are facilitated through Zoom. Each week the same session is offered over a range of days and times (six sessions per week) providing options for ARC facilities to attend. The sessions provide a forum for information sharing, discussion and questions, and with a view to ensuring facilities feel supported.

The five week programme covers the following topics:

- COVID-19 preparedness – roles and responsibilities
- Preventing introduction of infection into an ARC facility
- Preventing transmission of infection within an ARC facility
- Care Planning
- Business continuity.

As the programme is focused on maintaining COVID-19 preparedness long term in ARC facilities the topics and frequency of sessions may change over time. A Steering Group across metro Auckland Planning and Funding teams has been set up to oversee the programme.

4.2 Other Health of Older People Services

The national framework and service specification for Home and Community Support Services (HCSS) have been published. The national approach is a restorative HCSS model using a casemix methodology to group people with similar levels of assessed needs together. This is the model already in place at Auckland DHB so any changes will not be significant. However, the casemix funding methodology is still to be confirmed so there could be a different funding approach; currently the Auckland DHB model uses a fixed daily rate for each casemix category.

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

5.1 Immunisation

5.1.1 Childhood Immunisation Schedule Vaccinations

Provisional data for quarter 1 2020/21 indicates that Auckland DHB has achieved the 95% target for the MoH's Immunisation focus area. However, ADHB will likely only be said to have achieved partial attainment of the target by the MoH due to the equity gap for tamariki Māori – with provisional coverage at 85%. While the gap is unacceptable, Māori coverage of 85% is an improvement on Q4 2019/20 (83%) and from our last Funder report (80%). There has also been an improvement for Pacific children, with a provisional 95%, an improvement from 92% last quarter.

As previously indicated, COVID-19 will have an impact on immunisation coverage, particularly in the first two quarters of this financial year. The PFO continues to monitor the impact on "on-time" immunisation. In our last Funder report, 6-month coverage had improved to 85% which is the minimum required for achieving 95% by 8 months. However, the most recent lockdown has seen on-time coverage reduce again to 83%, with the more "real-time" one-month rolling coverage dropping below 80% (although this is prone to fluctuation due to small numbers).

Tamariki Māori continue to be the 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. We are also in discussions with the Māori Health Gains team on opportunities for the Māori Mobile health units to support childhood immunisations. Referrals to the Outreach Immunisation Service have also increased following the lock-down with around 1,300 active referrals currently sitting with the service.

Māori Immunisation Coverage (1 month rolling) 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 %
28/09/2020	61 %	90 %	62 %	80 %

From 1 October 2020 a new 12-month immunisation event was introduced, for 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 years of age event will only be DTap-Polio. Auckland PHO led a PHO-DHB-IMAC webinar about the changes which was well received. The changes have been signalled to primary care through Medinz.

5.1.2 Measles

In February 2020, the MoH announced funding for a national measles campaign, with a focus on 15-30 year olds, particularly Māori and Pacific. The primary strategies for ADHB and WDHB are increasing awareness of the need to be immunised and increasing access to the vaccine. The plan includes 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 and Family Planning clinics, community pharmacies and other community settings such as marae and Pacific churches.

The Ministry has confirmed the visual concept of the national communications suite for this programme, as below.

The PFO is developing a targeted communication strategy for the resource suite and expect it will include static media, social media (TradeMe), dating apps, Spotify and radio advertising (Flava and Mai FM, including sponsored messages on their social media). The strategy will be informed by focus

groups with rangatahi Māori and Pacific people aged 15-30, supported by the Māori Health Gains and Pacific Health Gains teams.

5.2 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 (NAHH) (formerly called Kāinga Ora).

NCHIP enables the identification of children who have missed out on universal services, and work with child health providers to engage or re-engage with families. An equity focused methodology is applied by the coordination centre starting with babies in the first 3 months of life. A total of 72 babies previously missing from the NIR were identified via NCHIP and linked in with GPs or outreach for immunisation follow up in Q4 2020. Pathways-to-care scoping work has started with WCTO providers, lead maternity carers and the newborn enrolment coordinator. NCHIP data is now actively being used to investigate which babies are missing their first WCTO core check (4-6 weeks). Following a data quality check, priority is given to Māori, Pacific or Q5 babies for direct whānau contact to link them with an appropriate WCTO provider of their choice.

As at 30 September 2020, Auckland DHB received 1,512 referrals to NAHH. This included 5,689 family members getting access to healthier home interventions. Of the referrals received, 518 (34%) were for families with a newborn baby or hapu woman.

Referrals to the service did not slow as significantly over the second level 3 COVID lockdown and impact on assessment timeframes was limited. Funding for a summer student has been secured from A+ trust which will support the completion of audit activities for the service. The protocol for these is being more fully developed but will help identify opportunities to strengthen on-referral and support in a number of domains.

5.3 Well Child Tamariki Ora and B4 School Check

All providers resumed face to face WCTO services under COVID-19 alert level 1 and were focusing on catching up tamariki who missed core visits during lock down. The change to level 3 and then 2.5 in Auckland has again disrupted some 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. The Ministry advice was to prioritise core checks for those with high needs and the youngest babies.

Recent data shows that providers have managed to catch up those tamariki that had missed their core checks during the lock downs. In quarter one (July – September) of 2019 the ADHB WCTO services delivered a total of 2,112 core checks compared to 2,589 for quarter one of 2020.

WCTO Core checks Q1 2019 and Q1 2020

	Asian	European	Māori	Pacific	Other	Unknown	Total
Q1 2019	212	341	646	843	63	7	2,112
Q1 2020	286	413	913	838	105	34	2,589

COVID alert levels have also impacted B4 School Check (B4SC) services. Unlike the WCTO checks for younger babies, a valid B4SC check requires all components to be completed, only some of which can be undertaken virtually (ie the B4SC wellbeing assessment and health education, developmental screening and the child health questionnaire). Priority for virtual B4SC was given to tamariki who are close to their 5th birthday, Māori, Pacific and Q5. In person contacts for B4SC (Oral health assessment (Lift the Lip) and growth assessment were arranged to resume during alert level 1 and 2. The table

below shows that the target was not achieved for Q1 2020. All providers have been asked to develop appropriate catch-up plans as the alert levels allow.

B4SC Comparison Auckland DHB Q1 2019 and Q1 2020

Percentage of eligible population checked (target = 22.5% in Q1)	High deprivation	Māori coverage	Pacific coverage	Overall coverage
Q1 2019	22.0	26.1	20.8	22.5
Q1 2020	16.2	13.1	13.5	13.4

5.4 Rheumatic Fever

Work has commenced on the short-term/high impact initiatives in the Auckland and Waitematā DHB regions in support of managing Rheumatic Fever (RhF):

- Identification of culturally safe ways to increase referrals to the Healthy Homes initiative. A closed RFQ will be run shortly to recruit a kaupapa Māori researcher and Pacific researcher to use guidance from families to develop resources.
- Piloting of whānau support worker programme. The model of care is in development.
- Piloting dental health services for adults with Acute RhF / Rheumatic Heart Disease. Early costings are being developed for hospital based clinics and community based clinics.
- Finalisation, evaluation and release of 'fight the fever' mobile app. The app has been launched and young people on monthly bicillin injections are now being recruited to the evaluation.

The project manager is reviewing opportunities for increasing awareness, which may include schools and pharmacy settings. Work is underway to establish a nursing service which will partner with the social workers in NAHH, to undertake whānau health and well-being assessment, identify unmet health needs and facilitate whānau engagement with acceptable health services. A service specification is in development.

5.5 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 services. A fuller paper and discussion on the impact has been developed for the Community and Public Health Advisory Committee (CPHAC) meeting in November.

During COVID-19 alert levels 4 and 3, 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 had been assessed by a dental clinician over the phone. Of note schools were also closed during both lockdown periods.

Timeliness (Arrears)

Well over half the children engaged in the service are now overdue dental services. The table below outlines the percentage of children for whom their dental check is overdue (in arrears) by ethnicity and DHB of domicile as of 31 August 2020.

DHB	Māori	Pacific	Asian	Other	Total
Auckland	59%	61%	54%	54%	56%
Counties Manukau	64%	65%	58%	59%	62%
Waitematā	60%	62%	57%	57%	58%
Not yet allocated*	69%	69%	62%	57%	62%
ARDS Total	**62%**	**64%**	**57%**	**57%**	**59%**

*There are about 7,000 children who do not have a DHB of domicile recorded and ARDS is manually reviewing their records to ensure they have an allocated DHB of domicile by end of 2020.

The current level of arrears has been significantly impacted by the COVID-19 lockdown periods. With the move to Alert Level 2.5 and 2 the service has recommenced the provision of routine appointments, however there are on-going DCNZ requirements that continue impacting service productivity and access (pre-screening of all children prior to their appointment). Given these requirements are on-going, it is anticipated that arrears will further deteriorate over the coming months.

Children under 2 years of age

Only 13%of children aged under 2 years have been seen by ARDS. The table below shows the percentage of children, by ethnicity, who are under 2 years and have attended an appointment with the service.

DHB	Māori	Pacific	Asian	Other	Total
Auckland	13%	14%	17%	18%	17%
Counties Manukau	7%	9%	14%	12%	11%
Waitematā	10%	8%	13%	13%	12%
Not yet allocated	7%	14%	29%	23%	20%
ARDS Total	9%	10%	14%	14%	13%

The majority of enrolled children who are under 2 years have not been seen by the service. However, there has been an increase of 2% of children 'seen' over the past month. This is due to the implementation of the Telehealth Oral Health Promotion Pēpi programme, a new initiative where a therapist telephones whānau and offers a virtual appointment. During the appointment the therapist introduces the service, ensures that the child's correct contact details are recorded, delivers key oral health messages and talks with whānau about any concerns they may have about their child's teeth.

The provision of telehealth was prioritised during August (while clinics were closed) and the service delivered approximately 2,000 appointments. The service found it more challenging to contact Māori and Pacific whānau. Strategies to address this are currently being explored, using the Centralised Booking Team to ensure an equitable access for these pēpi.

School Year 8 children

Only a quarter of Year 8 children have been seen during 2020. The table below details the percentage of school year 8 students, by ethnicity, seen by the service as at 31 August 2020.

DHB	Māori	Pacific	Asian	Other	Total
Auckland	25%	28%	27%	22%	25%
Counties Manukau	24%	26%	29%	29%	27%
Waitematā	21%	21%	22%	20%	21%
Not yet allocated	30%	26%	37%	17%	25%
ARDS Total	**23%**	**26%**	**26%**	**23%**	**24%**

The plan to examine all school year 8 students by mid-2020 has been significantly impacted by COVID-19. At present, given the level of disruption across the service and the current number of children overdue their appointment, prioritisation is based on clinical need rather than age alone. Given this, discussions are underway between ARDS and the Auckland, Waitematā and Counties Manukau funders to identify alternative service provision options for these children who will be leaving ARDS at the end of this calendar year.

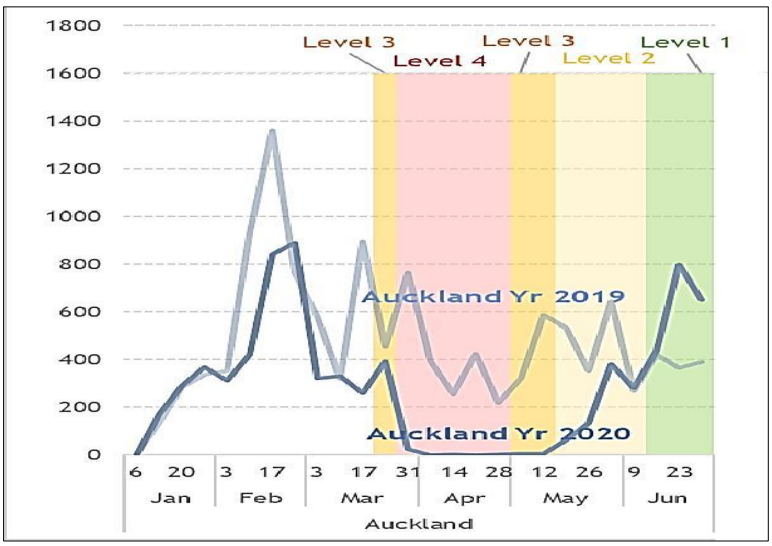
5.5.1 Adolescent Oral Health

Oral Health Services for Adolescents are provided by private oral health providers (dentists) that have a contract, known as the Combined Dental Agreement (CDA), with DHBs. There are 321 dental providers across three metro Auckland DHBs - ADHB 104, CMH 92 and WDHB 125.

The onset of COVID-19 has also had a significant and enduring impact on the delivery of adolescent oral health service. During COVID-19 alert levels 4 and 3, all oral health providers were directed by the MoH and DCNZ to postpone all routine dental treatment. Dental providers were only able to provide urgent and emergency dental care to all age groups including adolescents.

Between January and June 2020, based on MoH interim claims data for DHB of contract, about 4,855 adolescents have accessed funded dental care in Auckland DHB. This is around 20% of the adolescent population eligible for funded dental care in Auckland. As some dental claims are made a few months after completion of treatment, the number of adolescents utilising the service may increase slightly. Based on current claims data, the projected utilisation for adolescents' dental service for 2020 is expected to be somewhere between 40 to 50%. The yearly utilisation target set by MoH for adolescents oral health service is 85%.

The below graph shows weekly claims volume for ADHB: Jan-Jun 2019 vs. Jan-Jun 2020.



5.5.2 Maternal Oral Health Project - Hapu Māmā Oranga Niho Ki Tamaki

Seven additional referrals were accepted into the service in September 2020, bringing the total number of wahine whose referrals have been accepted to 82. Of these, 6% have completed their episode of care, 59% are currently undergoing their episode of care, and 35% have not yet been examined. 54% are Pacific, 40% are Māori, 4% are New Zealand European, 1% are Asian and 1% are Other.

In consultation with the *Hapu Māmā Oranga Niho Ki Tāmaki* Steering Group and Clinical Governance Group, the eligibility criteria for the service has been extended to increase the number of referrals. This was because health professionals who refer wahine into this service were confident all wahine who met the original criteria had been offered the opportunity to be referred. The additional suburbs are Mt Wellington and St Johns, adding to the existing locations in Point England, Panmure and Glen Innes. Wahine with pēpi aged under 6 months old can now be referred, in addition to wahine who are more than 12 weeks pregnant.

5.6 Youth Health

Enhanced School Based Health Services

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. About 8,607 secondary school students have improved access to primary healthcare in Auckland DHB through the ESBHS programme.

Many common mental health problems, such as depression, anxiety and substance abuse that emerge during young people's years at secondary school can have life-long consequences. The Auckland DHB enhanced school based health services help address some of these issues through the visiting clinical psychologists services. The visiting school based psychologists are registered clinical psychologists who specialise in child and family, and youth mental health.

Being available onsite reduces barriers to access resulting in high engagement of Pacific and Māori students. The service also reports a very low DNA rate (5%).

5.7 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. Uptake of the service in primary care and NGO services shows a marked improvement in the last quarter.

The MoH has commissioned the preparation of National Contraception Guidelines, these have now been shared to professional colleges for endorsement. 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 Long Acting Reversible Contraceptives (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.

5.8 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. Catch up in response to the immediate delays and cancellations associated with the COVID level 4 disruption have been completed. Demand outstrips capacity in this service and work is ongoing to address this.

5.9 Cervical Screening

Cervical Screening coverage for ADHB remains significantly below the coverage target 80%, with total coverage of 60%. The coverage rate is more concerning for Māori at 50.5%. We are still waiting for the Ministry to update coverage bases on our revised population forecast which will see this figure improve however; there will remain the equity gap. Cervical Screening coverage has been declining over the past 3 years nationally and locally. The recent COVID restrictions had a significant impact on

completion of cervical screens which are largely provided in primary care. Of greatest concern however are the women who have never been screened, or have not been screened for 5 years or more. The National Screening Unit are moving toward implementation of the HPV Primary Screening Programme, which offers some significant advantages for improving equity and coverage. One of these is the implementation of HPV self testing which the NSU have recently confirmed will be included in the HPV Primary Screening Programme. An implementation timeline remains unclear however it is now assumed that the previously published 2021 implementation date is not achievable. Funding for a new NCSP register is a dependency.

There remains significant interest in HPV self-testing to address the ongoing inequity in both cervical screening coverage and cervical cancer outcomes. Several research proposals are in development nationally which consider aspects of HPV self-testing implementation in anticipation of informing the national programme in due course.

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 going live in October.

6. Mental Health and Addictions

6.1 Suicide Prevention

The Suicide Prevention and Postvention Action Plan 2020/2023 has been reviewed and the Plan has been agreed by the Suicide Prevention and Postvention Governance Group (SPPGG). The Plan will be discussed in detail at the CPHAC meeting early next year.

In late August, the chief coroner Judge Deborah Marshall released the annual provisional suicide data, which show the provisional suicide rate is at its lowest in 3 years. In the year to 30 June 2020, 654 people died by suicide, compared to 685 the year before – a decrease of 31 deaths, and a drop in the suicide rate from 13.93 deaths per 100,000 to 13.01 nationally. There was a slight increase in deaths by suicide for Auckland DHB from 54 in the previous financial year (2018/19) to 58 for 2019/20 financial year, but 15 less suspected suicides from 2017/18 financial year.

As part of the national Suicide Prevention Action Plan 2019-2024, the MoH have funded a role for a Whānau Support Coordinator for those bereaved by suicide for an 18 month period. The purpose of the role is to facilitate recovery / healing for whānau and prevent adverse health outcomes for those bereaved by suicide. The appointment for this position has been completed and there are plans underway to develop support services for whānau bereaved by suicide once the staff member has started their employment.

6.2 Te Whare Hinatore

Te Whare Hinatore (previously named Manaaki Wāhine) is a trauma-informed, kaupapa Māori service consisting of 15 self-contained studios for women who are homeless or rough sleeping or who otherwise would be if they were not in inpatient mental health services. This service is operated by Auckland City Mission (ACM) and was designed collaboratively by the Ministry of Urban Development (MHUD), Ministry of Social Development (MSD), the Accident Compensation Corporation (ACC) and Auckland and Waitematā District Health Boards. The service was officially opened by the Prime Minister on 13 February 2020 at the launch of the National Homelessness Action Plan and initially commenced as a transitional housing service, while funding was identified for the therapeutic component. In 2019 Planning and Funding on behalf of the ACM, submitted a

Proceeds of Crime application to fund the therapeutic component of the service. This application was successful and a total of $1,784,000 has been approved over three-years.

The service provides trauma informed individual and group counselling services and access to a psycho-educational day programme, in parallel with transitional accommodation for up to 60 women per annum. The target is aspirational and has been adversely affected by COVID and the difficulties accessing appropriate permanent accommodation. Designed to build protective factors, reduce risk taking and moderate the impacts of trauma/complex trauma and its symptoms (alcohol and other drug problems; risk taking behaviour, self-harm and such); the day programme will encourage engagement in meaningful activities, (including but not limited to waiata, kapa haka, carving, weaving) and building vocational, employment support and life skills. Importantly, the service provides access to primary care to address outstanding chronic health conditions including cardio vascular disease, diabetes, reproductive and sexual health, alongside access to alcohol and other drug services. This service supports women to find, and transition safely and well into permanent sustainable accommodation. Pathways, protocols and relationships between inpatient mental health services, the NASC and the service are currently being drafted.

7. Māori Health Gain

7.1 Māori health COVID-19 response

The Māori Health Gain Team has supported the Māori Response to COVID-19 Programme (the Programme). This Programme is broken down into five key areas that cover immediate responses to longer term system redesign. The five *pou* are:

1. Leadership and oversight
2. Engagement and communication
3. Māori health services (existing and redeployment)
4. Protecting Māori whānau and communities (testing strategy)
5. Welfare and wellbeing (welfare response and Pae Ora public health response)

Overall, the Māori health response focused on three key programmes of work. The first was communication and engagement, centring on social media engagement through DHB sites and was mirrored on our partners' sites. The Whānau Guide to COVID-19, a show hosted by Māori, asking questions of health experts posted on DHB and Māori TV Facebook pages, received over 25,000 unique views this time around. This ensured whānau had access to up to date information about COVID-19 and the local/regional health system response.

Second, the Māori team focused on implementing a COVID-19 testing response that ensured Māori had access to testing sites. This included the CTC at Whānau House and a number of Māori-led mobile testing stations set up around metro-Auckland where coverage was low. The use of Māori-led mobile units also ensured that targeted sub cluster testing was able to be carried out as required.

The final programme of work consisted of welfare support for whānau who were self-isolating in their homes as close or casual contacts. The Auckland Regional Public Health Service (ARPHS) teams identified whānau needs through their regular contact with them. These needs were referred into the Māori team and care was coordinated from that point. This included access to food parcels while whānau were confined to their homes, or care for their pets, for example, when they were moved into managed facilities. Partnerships with whānau ora providers and other community providers were vital for this programme of work.

A permanent Māori team within the NRHCC is being established, as well as a Māori public health team (Pae Ora Team) within ARPHS. Both of these teams will support preparedness planning for the Māori health sector and lead future Māori health responses to COVID-19 outbreaks.

7.2 Māori mobile units

Since July Ngati Whatua o Orakei (NWoO) have been delivering care to whānau in high needs communities in ADHB through the Māori mobile service. This service initially focused on 'flu vaccinations for eligible Māori in homes as well as offering additional complimentary care while in homes through nurses, social workers and mental health clinicians.

Throughout levels 3 and 2.5 the service was hindered slightly, with whānau reluctant to have clinicians come into their homes. However, overall it has been very well received, 44 Kaumatua/Kuia took part in a satisfaction survey on NWoO's unit, with 86% of these rating the service as excellent and asking them to return. The service has provided the opportunity for whānau to re-engage with mental health and GP services, ensure kaumatua and kuia remained connected with their whānau and strengthen relationships between the community and Māori health providers'.

A paper is being supported through the NRHCC for executives to maintain these mobile units between community outbreaks of COVID-19 to ensure a trained workforce is available when required. Between outbreaks, these teams will support recovery efforts to clear backlogs of patients needing, for example, child immunisations that drop significantly during lock downs.

7.3 Kaimanaaki services

In the midst of our region's COVID-19 response, the NRHCC supported the implementation of Ngā Kaimanaaki services across the Northern Region. In phase 1 of this programme, lead providers in ADHB (Orakei Health Services, Ngāti Whātua, and Piritahi Hauora) were identified to support whānau in Auckland DHBs' catchment area. In phase 2, we supported the northern iwi collective, Te Kahu o Taonui, to roll out the Kaimanaaki programme amongst their providers and services.

In the first wave of the outbreak, Māori community responses were successful in reaching vulnerable whānau across metro Auckland and Northland. Te Kahu o Taonui, the northern iwi collective who led the northern iwi response, has had similar success in engaging high numbers of whānau. 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 27,919 food parcels and hygiene packs to over 25,553 homes primarily across Northland and to some whānau in metro Auckland.

Multiple referrals were made to health and social support services across Northland and Auckland. The Kaimanaaki were non-clinical roles, and comprised largely whānau members from within high needs communities. With the support of clinical leaders from iwi health providers, they carried out brief wellbeing assessments in their own communities. Any immediate wellbeing needs were addressed through the programme (including access to food, water and items for their home), while escalation policies allowed for longer term needs to be referred on to the appropriate healthcare or social support provider.

7.4 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 inaugural Consumer Advisory Group met in mid-October, comprised of participants from the earlier focus groups and surveys, their whānau, and DHB

kaumatua. The group has agreed to walk alongside the project team to develop the programme to ensure benefit for Māori, initially focusing on the communications materials and invitation pathways. A communication approach is underdevelopment. A readiness assessment process with hospital services is being established to map potential impacts on the range of hospital services and to develop the processes models of care to support screening. A screening pilot is planned to begin early in 2021. Further funding grants are under development.

- Alternative community cardiac rehabilitation model – work on the business case remains on hold as staff were deployed in the COVID-19 response.
- Alternative community pulmonary rehabilitation model – on hold over COVID-19, work is underway to establish a group with kapa haka and pulmonary rehab expertise in anticipation of the restarting of the programme.
- Northern region breast screening datamatch ('500 Māori women campaign') – this project is now complete and the results are being developed into a report.
- Māori provider and PHO datamatch – due to COVID-19 not all providers were able to contribute data. Counties Manukau DHB providers did not contribute any data. For those providers who did contribute there was sufficient evidence of whānau engaged with a Maori provider but not enrolled in a PHO to warrant proceeding to Phase 2. The Steering Group recommended re-offering to those ADHB and WDHB providers with missing data to see whether a complete dataset could be confirmed, and to take the findings to the Māori provider forum to discuss the next steps.
- Facilitated PHO enrolment – on hold with the second COVID-19 outbreak.
- High grade cervical screening project – a progress report has been developed and will be presented to the steering group with a proposal to change the direction of the project to incorporate it into a larger HPV self-testing proposal.

8. Pacific Health Gain

8.1 Pacific Regional response to COVID-19

The Pacific team has continued to work collaboratively with Primary care, Pacific providers, Pacific church and community leaders to increase COVID-19 testing amongst Pacific communities. Considerable work and effort has been invested in setting up a number of pop up mobile testing units across many Auckland communities. The change from Alert level 2.5 to level 2 has resulted in a reduction in the number of people seeking a COVID-19 tests, however, ensuring Pacific communities continue to have opportunities to access testing has remained and the team has continued to ensure mobiles are available in the community.

Work is underway to plan for possible future outbreaks in collaboration with various NRHCC teams.

8.2 Pacific Mobile service

The Pacific Mobile service provided by the Tongan Health Society Inc. started 8 September 2020. Flyers to communities and churches, and ringing families have been the form of promoting the service during alert level 2.5. The model is effective in capturing those who have not kept up with their regular medications, blood tests, immunisation for different age groups. The service highlights barriers and challenges in reaching families, and also opportunities to see the reality of each family situation that allows the team to provide appropriate services and progress referrals accordingly. An average of 4-5 families is visited per day.

8.3 Measles Mumps Rubella (MMR) Vaccination plan

Plan is underway for Pacific focus groups to be held in the next 2 weeks. Two pacific focus groups will be conducted, one for age group 18-24 years and for age group 25-30 years. Work is now underway with Sister's United who are happy to partner, support and champion the messages of the MMR Campaign to the target audience with particular focus on Māori and Pacific 15-30 years.

9. Asian, Migrant and Former Refugee Health Gain

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

The Asian, new migrant, former refugee and current asylum seeker health plan 2020-2023 will be presented to the ADHB CPHAC Committee on 18 November.

The Asian, new migrant and former refugee health gain team have contributed significant resource to provide culturally appropriate support in the COVID-19 Outbreak#2 response for the Botany Cluster and South Asian welfare cases on behalf of the NRHCC, as well as Communications to CALD communities.

9.2 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%.

The Asian, new migrant and former refugee health gain team is coordinating the Metro Auckland Interpreting and Translation Service Steering Group. This group oversees 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.

9.3 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)

A *Former Refugee & Asylum Seeker Health & Wellbeing* Zoom webinar ran on 8 September with over 30 people virtually attending on the topic 'Response and reflections of COVID-19 in accessing and utilising primary health services'.

An interim UNHCR Emergency Cases - Metro Auckland Community General Practice Model has been developed (in the absence of a primary care service at Mangere Refugee Resettlement Centre) in partnership with MBIE's Refugee Health Liaison Team and MoH. The intention is to support the emergency case families access the DHBs' *Improving access to general practice services for former refugees and current asylum seekers' agreement'* funding to support their primary care needs. It has been agreed that these some individuals from these families will be accessing immediate Auckland DHB Starship medical care upon arrival into Auckland in late October.

10. Hospitals

10.1 2020/21 Planned Care Services

10.1.1 Planned Care

As part of the Ministry of Health requirement to increase access to planned care services each year, Auckland DHB provider needs to deliver 12,626 elective surgical discharges in 2020/21. For the period to end of September 2020, Auckland DHB has completed 91% of planned elective surgical discharges, with a shortfall of 303 discharges. This is influenced by internal capacity constraints and reduced activity in August and September with 72% and 94% of planned discharges being completed in each of those months. There has been increased activity in October but the impact of the lower level of services being delivered has put at risk approximately $4m of additional revenue from the Ministry of Health. The provider is putting in place a range of measures to increase internal production to address shortfalls in capacity going forward including extending hours of operating in some elective operating rooms and resourcing additional acute operating room capacity on weekends to reduce the need to cancel elective surgery to meet acute demand.

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

The Ministry of Health has allocated additional funding of $6.4M to Auckland DHB to enable increased planned care delivery across a range of services to support clearing waiting list backlogs. Auckland DHB has prioritised this additional funding to the delivery of more colonoscopy procedures, increased outpatient Ophthalmology specialist assessments and follow-ups, additional MRI and CT scans and increased spinal Orthopaedic surgery. The Ministry of Health has yet to approve this plan.

In addition to the additional activity based funding, further funding has been made available nationally to support improvement within DHBs to optimise use of system capacity in support of planned care. The Northern region submitted a consolidated regional bid for the funding available, within which regional and local service improvement projects were identified reflecting priority areas of focus, aligned to both the Three Year Planned Care Plan and the Northern region Regional Service Plan 2020/21. The Ministry of Health has been delayed in providing a response but this is due within coming days.

Capital funding of $50M has been made available nationally for DHBs to support optimising capacity across the system to improve access to planned care. The Northern region submitted proposals to the Ministry of Health in mid September with an expectation that funding allocations would be confirmed early November. DHBs have been advised in recent days that there is a new requirement to resubmit business cases and this means delays to approvals for capital funding will impact on forecast trajectories for some elements of planned care recovery. It is as yet unclear as to the revised timeframe for this process and decisions to be complete.

10.1.2 Planned Care services - Regional Vulnerable services workplan

The regional Vulnerable services workplan was developed following the first COVID wave to support the prioritisation of actions to address sustainability issues in a number of identified services including Vascular, Ophthalmology, Oral Health, ORL and Sarcoma services. This work has been supported by a different regional planning approach with an identified Executive operational or clinical lead, support from the Auckland/Waitematā DHB funder and the Northern Region Alliance (NRA) and leadership and oversight provided by the Auckland DHB Chief Executive and a Regional Planned Care Service Improvement Steering Group. Progress is being made across all identified services with early direction establishing improved regional service integration and coordination, increased regional cooperation in the employment and deployment of specialist workforce across

the region, consolidation of regional waiting lists to support more equitable care and increased local service delivery.

10.2 National Planned Care Performance Indicators

10.2.1 Elective Services Performance Indicators (ESPI) Performance

The ESPI compliance position for all DHBs deteriorated as a result of the March COVID-19 outbreak. In spite of the subsequent community outbreak in Auckland during August resulting in some reduced delivery of planned care services, there has been incremental progress in the Auckland DHB ESPI performance. ESPI 2 improved to 7.6% patients waiting longer than 120 days in August compared with 12.2% in July. Similarly, ESPI 5 performance has improved to 15.5% of patients waiting longer than 120 days for treatment compared with 21.6% in July.

Both the additional activity based funding and the service improvement funding is expected to support further improvement in ESPI performance.

10.2.2 Colonoscopy national indicators

Auckland DHB has been unable to achieve compliance with national waiting time indicators for symptomatic and surveillance colonoscopy for some time. Additional funding and resources have been prioritised to complete additional volumes to improve waiting time performance within the next three months ahead of the planned Bowel Screening roll out for the Auckland DHB population. There has been some improvement in the waiting time indicators in the month of September helped by increased use of private capacity on a short-term basis. Both the urgent and surveillance waiting time indicators were achieved however the waiting time for priority 2 symptomatic patients remains below the expected 70% delivery within six weeks with performance at 44.8%.

10.2.3 Radiology national indicators

As a result of the March COVID-19 outbreak, capacity for delivering Radiology services was affected which impacted waiting time performance for access to CT and MRI. Auckland DHB has managed to maintain relatively stable levels of access to CT with 82.5% patients receiving their scan within six weeks in August (against a target of 95%). Access to MRI has been challenging for some time however, there has been steady improvement in performance over recent months and by end of August with 71% of patients receiving their scan within six weeks. Further improvement and full compliance by the end of 2020/21 is expected with the prioritisation of additional waiting list funding from the Ministry of Health.

10.3 National Services

10.3.1 PRRT (Peptide Receptor Radionuclide Therapy)

The Ministry of Health has now confirmed funding support for ADHB to provide an interim service for PRRT treatment for neuro endocrine tumours. The first patients have been successfully treated at ADHB. The more substantive business case is being developed to establish an enduring national service going forward from Auckland DHB facilities.

There have been a number of changes of personnel within the Ministry of Health and this has delayed decision making on a number of national service arrangements delivered by Auckland DHB. This has been raised with the Ministry and we are waiting for definitive advice regarding an agreed approach to enabling progress.

Hospital Advisory Committee Meeting 7 October 2020 – Draft Unconfirmed Minutes

Prepared by: Marlene Skelton, Corporate Business Manager

Recommendation

That the unconfirmed minutes from the Hospital Advisory Committee meeting held on 7 October 2020 be received.

Minutes
Hospital Advisory Committee – Provider Equity Meeting
07 October 2020

Minutes of the Confidential Hospital Advisory Committee – Provider Equity meeting held on Wednesday, 07 October 2020 via Zoom at 8.30am

Committee Members Present	**Auckland DHB Executive Leadership Team Present**	
William (Tama) Davis (Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew (Deputy Chair)	Mel Dooney	Chief People Officer
Doug Armstrong	Dr Mark Edwards	Chief Quality, Safety and Risk Officer
Michelle Atkinson	Joanne Gibbs	Director Provider Services
Zoe Brownlie	Justine White	Chief Financial Officer
Peter Davis	Sue Waters	Chief Health Professions Officer
Fiona Lai	Dr Margaret Wilsher	Chief Medical Officer
Michael Quirke	Margaret Dotchin	Chief Nursing Officer
	Dame Naida Glavish	Chief Advisor Tikanga – ADHB/WDHB
	Auckland DHB Senior Staff Present	
	Jo Brown	Funding and Development Manager Hospitals
	Nigel Chee	Interim General Manager Maori Health
	Marlene Skelton	Corporate Business Manager
	Kay Sevillano	EA to Board Chair and Governance Administration
	(Other staff members who attend for a particular item are named at the start of the minute for that item.)	

Karakia

The Committee Chair, Tama Davis led the Committee in a karakia.

1. ATTENDANCE AND APOLOGIES

That the apology of Committee member Bernie O'Donnell be received.

The Following apologies were received from members of the Executive Leadership team: Meg Poutasi, Chief of Strategy, Shayne Tong, Chief of Informatics, Dr Debbie Holdsworth, Director of Funding Auckland and Waitemata DHBs, Karen Bartholomew, Director of Health Outcomes Auckland and Waitemata DHBs.

2. REGISTER AND CONFLICTS OF INTEREST

There were no updates to the register of Interests required.
There were no conflicts of interest with any item on the open agenda.

3. CONFIRMATION OF MINUTES 18 March 2020 (Pages 1-7)

Resolution: Moved Jo Agnew / Seconded Fiona Lai

That the minutes of the Hospital Advisory Committee for 18th March 2020 be received.

Carried

4. ACTION POINTS

There were no action points to review.

5. PERFORMANCE REPORTS

5.1 Provider Arm Operational Update (Pages 20-24)

Joanne Gibbs, Director Provider Services asked that the report be taken as read, highlighting as follows:

The initial Exceptions Report has since been reframed to strengthen linkages to the DHBs obligations under Te Tiriti o Waitangi and Equity.

All ten clinical directorates made a commitment last year to contribute to equity work. It is proposed that Directors from Cancer and Blood, Surgery and perioperative will attend. All Directorates will attend committee meetings twice a year to discuss equity work, and provide high-level review of performance, risks and issues. Direction on this proposal is sought from the Committee.

Hineroa Hakiaha and Tracy Silva-Garay were appointed as Partnership Leaders for the Mental Health and Addictions Directorate. Dr George Laking, was appointed Chair, of the rōpū Cancer and Blood Directorate (Pou Ārahi) which also includes new appointments to the Kaumātua for Cancer and Blood Services.

To address inequities in access to surgery, Kaiārahi Nāhi led by Dawson Ward was established to assist Māori patients, and the Pacific Planned Care Navigation team led by Pauline Fakalata to assist Pacific patients.

The Provider Incident Management Team has been stood down to Response Team status due to low incidence of COVID in the community and the move of Auckland to Alert Level 1. From 8 October, the visitor screening process will cease, moving back to the normal visitor policy. Planned Care work will transition back to normal but this will be a gradual process over the next couple of months as staffing returns to business-as-usual from supporting the managed isolation facilities, CBACs and ARPHS.
Emergency Department and General Medicine activity has increased in the last couple of weeks, as is the case across the Northern Region and the country. The reason for this is uncertain. There are no increases in respiratory diseases (e.g. flu, pneumonia) reported but there are a number of frailty presentations and some of the increase could be attributed to

catch-up work post lock down.

The following points were covered in the discussion:

Michael Quirke thanked Jo Gibbs for the report and commented that with the new appointments made it appears that the Board is forging ahead into the territory it said it would and work on equity is moving forward. Michael asked whether these new appointees were in a position to comment on their roles so far and whether there had been any surprises. Jo Gibbs advised that these were exciting appointments but it was early days for these staff. Data is just beginning to be looked at through more critical eyes and this is exposing some of the differences that exist. Data for vulnerable and planned care services show that Māori and Pacific patients are waiting longer for surgery compared to other patients. The appointees are in the early stages of working through the complexities around this, and the work that needs to be done going forward.

Heather Came-Friar asked whether data on ethnic breakdown could be shared, with Ailsa Claire confirming that it is provided when available.

Fiona Lai commented that it was exciting to see the progress made she was impressed and was looking forward to further outcomes.

Michelle Atkinson agreed with points made by Michael Quirke in relation to reporting action in addition to the actual strategy.

Resolution: Moved Tama Davis / Seconded Jo Agnew

That the Hospital Advisory Committee receives the Providers Arm Operational Exceptions Report for October 2020.

Carried

5.2 Financial Update (Pages 25-34)

Justine White, Chief Financial Officer asked that the report be taken as read highlighting as follows:

The results for August 2020 YTD were unfavourable by $10.5M or $12.4M YTD. This needs to be considered with some Covid-19 costs excluded which drops the result for August to $1M unfavourable and $180K unfavourable YTD.

$10.5M is COVID-related cost which can be broken down to $7M relating to IDF and the planned revenue provision for that revenue not being received. The other large component; $136M relates to FTE of which $66M is COVID-related and the remaining amount attributable to annual leave and some assumptions made within the budget around the use of annual leave being similar to previous years. What is being seen is that annual leave has been deferred which pushes FTE up and increases cost in comparison to budget. This is a risk that is being closely monitored, as it will also be impacted by planned care catch-up work.

There are some increases in clinical supplies that have been offset by revenue in labs and

pharmacy.

The following points were covered in the discussion:

Peter Davis commented that he would like management to extrapolate out how the Board was tracking in terms of meeting the budget agreed with central government. A clear trajectory along with assumptions was needed. Justine agreed with Peter and confirmed that going forward, the financial report would include a forecast column, in addition to the current monthly, actual, and YTD figures to make tracking against final budget more easily visible.

Peter Davis queried whether judgement on WIES was made independently of budgetary considerations. Further, he asked how decisions were made in relation to staff determining whether to encourage more day stays and reduce WIES where it is not necessary.
Ailsa Claire explained that increases in relation to WIES were a result of the increased number of complexities in patients. WIES was a reflection of the acuity of the patient and the work undertaken based on a nationally determined model which cannot be manipulated. There is a high correlation between income and WIES, and what Auckland DHB gets paid. For tertiary and national services, WIES cost is not met by the price that Auckland DHB is actually paid for WIES. To be efficient, Auckland DHB has targets and processes in place to increase day stay surgery and attempting to move people down the complexity level where possible. This is a whole programme of work that that can be discussed.
Ailsa Claire explained that there is no financial incentive for the Auckland DHB to keep people in hospitals longer because WEIS assumes an average length of stay and going beyond that, payment is not forthcoming. The average length of stay across all specialties has gone down. The EY report highlighted specialty services where they felt the length of stay could be reduced and pre COVID these services were targeted. Accuracy of coding is improving however you cannot over-code as the data used is based on a patient's case notes.
Peter Davis was satisfied that the system had measures in place to make the process efficient.

Doug Armstrong commented that he looked to the CEO and/or the CFO to provide a "best guess" as to how financial performance was tracking to end of year. He was concerned about the DHB meeting its electives target, and was aware that in the past the Auckland DHB could be penalised by the Ministry of Health (MoH) for not meeting them. He asked whether a spreadsheet could be provided defining electives by category, looking at total numbers, which included a breakdown of in-house services and the balance that is being contracted out and the associated cost related to contracting out along with any penalties. Ailsa said that information could be provided but would involve a large amount of data given the various services, categories and issues involved.

If the outcome being sought was where the Board was in terms of planned delivery, then that data was already available in reports. Ailsa Claire queried whether Doug's objective was to be able to compare outsourcing vs in-house delivery price. Doug's concern was whether it would be more cost effective to maximise in-house services. Ailsa Claire explained that the

Funding and Planning department takes the funding available for the Auckland population and places contracts in a number of places (e.g. this can include everything from primary care to colonoscopy in the private sector) and it's a mixture of determination of what should be provided by Provider Arm, and what is provided from elsewhere. Outsourcing is not necessarily the correct term to use. Rather, contracts are being placed with other providers and other DHBs and vice versa.

Doug Armstrong commented that he was attempting to gain an understanding of in-house capacity versus that which existed outside the hospital. Ailsa Claire advised that if it was information around capacity constraints that was required then that could be reported on, Auckland DHB had significant capacity restraints.

Peter Davis commented that while not against outsourcing he did have a concern that monopolies could be created outside if public hospitals were not competitive in providing services. The DHB needed to keep it contestable for as many services as possible. Ailsa Claire explained that contracts are made with both the private sector and other DHBs and as providers they deliver services at or below national price which is the benchmark when agreeing to cost of services.

Doug Armstrong sought to clarify the rules around financial penalties for quotas not being met. Jo explained that in the past, penalties were issued to DHBs who did not meet targets, but this system is no longer in place in favour of scheduled payment mechanisms which are graded to Auckland DHB's service delivery. For instance, planned care recovery funding this year will be paid in portions dependent on delivery.

Zoe Brownlie agreed that a forecast going forward would be helpful. She queried how COVID-related costs were being reported. Justine White explained that all DHBs are regularly reporting to the MoH on COVID-related expenses and discussions on how these expenses are to be funded are taking place. It is to be determined what will be given in cash vs what will be a tolerated variance from budget. The decision from last week's Cabinet discussion is yet to be communicated. In addition to reporting COVID expenses, ADHB will also present the organisation's expectations in terms of necessary expenditure to be funded by the MoH in order to continue operating effectively.

Michael Quirke asked whether peripheral costs that have arisen as a result of COVID (e.g. FTE, turnover, annual leave) are being considered in the budget. Justine white explained that all DHBs are required to adhere to what the MoH deems as COVID-related expenses and they are very prescriptive in what they consider a direct cost. As an example staff costs for COVID response work are considered a COVID expense but annual leave and turnover as a result of the pandemic are not able to be included as COVID-related costs.

Michael Quirke asked about FTE trends in relation to vacancy turnover after the first lockdown. From a risk perspective, he asked whether the Auckland DHB was analysing whether these trends were domestic or international movement. If the trends were international, then the Auckland DHB would expect to have the same challenges over the

next 9 months that would need to be managed. Justine White agreed that these risks (e.g. annual leave, vacancies) need to be included in forecast budgeting. Justine is working with Mel Dooney to better understand these risks and is looking at ways to manage them.

Resolution: Moved Tama Davis / Seconded Jo Agnew

That the Hospital Advisory Committee accepts the Financial Update for October 2020.

Carried

5.3 Care Navigators Progress Update

Dawson Ward, Kaiārahi Nāhi rōpū lead provided the following progress update:

The Kaiārahi Nāhi rōpū consists of 9 Māori nurses, working with Dawson facilitating patient surgeries for those who have been on the waitlist for 120 days. They also assist patients with systemic issues who face challenges within their whanau group.

Navigators provide patients with self-determination on how they want their treatment to be carried out.

Navigators spend a considerable amount of time on relationship building with patients and their family. The average contact time spent with patients is 710 minutes (range), 102 minutes (mean), 45 minutes (median).

Most contacts by iwi are Nga Puhi because Ngāti Whātua Ōrakei have their own medical insurance and go through NIB to access planned care.

Ophthalmology and Orthopaedics have dedicated navigators working in their directorates. Since working with navigators, Orthopaedics has brought down their patient waiting time to 30 days. Anyone waiting more than 30 days has been contacted, including patients added to the waitlist after coming off the suspended list. Other services (General Surgery, Cardiology, Urology, Neurosurgery and Gynaecology), have different navigators running systems together. Work with Paediatrics has only just started and context around how support can be provided is still to be determined.

Whanaungatanga is an important principle in practice used by navigators because Māori understand relationship building very well. Manaakitanga is another principle used by navigators as it seeks to respect everyone's mana and is vital when building relationships. Kotahitanga is working in unity with patients and whānau to achieve positive outcomes. In practice, these principles enable patients to self-determine how to go about their healthcare (e.g. deciding on whether to have surgery or not). The patient-centered approach enables patients to decide when they no longer need support.

One of the main issues identified is poor communication. Often when patients move between DHBs, the home domicile DHB lose contact with patients, leaving them uncertain of what happens next in terms of their healthcare. There are long gaps in between when communicating with patients.

Bookers and navigators also have issues in communicating with each other as they often are unable to see what the other is working on and this becomes a problem when working on

the same case.

The Implementation Project team do mail-outs, however some people receive their mail, others receive it a week later, or not at all. This results in patients not showing up for scheduled appointments/surgery. Communication via mobile phone is also confusing for those with no mobile phones or those who cannot afford one, or have no interest in purchasing a modern phone.

The patient journey of Master M was used as an example of a complex case. The work of the navigators has seen significant change in making health services more accessible to patients. Dawson has a number of meetings with the different services. These directorates are interested in facilitating change in their respective areas by applying an equity lens on the way they work with patients.

There are many patients (just like Master M) with complex cases requiring support. It is crucial that directorates and navigators work together to come up with a patient plan that is sustainable and resilient.

Comments from the Committee were as follows:

It is apparent that the work undertaken by Kaiārahi Nāhi rōpū is not just that of a navigator but also that of advocator.

Patients being transferred and referred from one waiting list to another is not just specific to Māori but a problem with the overall system. It was requested that a proposal be submitted to improve the hospital system for all people.

Pauline Fakalata, Pacific Planned Care Navigation team lead provided a progress update:

The Pacific Planned Care Navigation team was established in June 2020 with 6 clinical nurse specialists, focused on Adult Health elective surgery. In August, during the second lockdown, 3 clinical nurse specialists were assigned to Starship. The purpose was to improve equity for planned care for Pacifika by reducing waiting time, deferrals and to improve overall outcomes.

The navigator team has made 30 escalations where navigators needed to liaise with directorates, clinicians, surgeons, clinical nurse specialists and managers, to find solutions to progress cases. Seventeen of these are acute cases and these patients have clinically deteriorated because of the wait and have ended up in ED. Twenty-five patients deteriorated where quality of life was affected because of the wait.

Contacts by ethnicity are Samoan 47%, Tongan 18%, and the rest are Cook Island and other Pacifica ethnicities.

A navigator's role includes calling patients who are on the waiting list, engaging with them to find out what barriers they face, and understand any other issues making it difficult for them to get surgery. The navigator then meets with the applicable services to find solutions to fast track surgeries.

Patients generally find it difficult to deal with the hospital system. Engagement and

communication with patients' needs to improve. The numerous letters sent to patients are usually received late or not received at all. The letters also use medical jargon which patients do not understand.

There is need for professional interpreters. It is not always dependable or helpful for family members to act as interpreter. Interpreters play an integral role to help with cultural awareness. They are also able to communicate efficiently with patients to speed up the process.

Booking of appointments should be patient-focused and not based on what suits the hospital. This will ensure that patients are available and will turn up for their appointment.

Clinical eligibility is also a barrier to accessing surgery. A number of Pacific patients with diabetes have blood sugar levels that are not within acceptable levels to progress to surgery. Navigators have to work with services and clinical staff in order to progress these cases.

Pauline presented two patient examples as illustrations of the work of the navigators and issues being experienced by patients. The following points were covered in the discussion:

Michelle Atkinson commended the work being undertaken and thanked the ELT for the support provided to navigators.

Michael Quirke asked whether there was opportunity for other support to be made available to clinical nurse specialists acting as navigators. Pauline Fakalata agreed that a multi-disciplinary approach was the best way going forward and there is need for social work services, psychologists, and community workers as most cases are complex. From a Māori perspective, Dawson Ward said that there are 10 clinical nurse specialists of Māori decent with the majority being Ngā Puhi. An understanding of Māori culture is important and a multi-disciplinary approach is needed. Māori social workers with connections with Māori health providers exist in the community and the Auckland DHB needs to link up with them and communicate with various rōpū and iwi.

Fiona Lai commended the project and the hard work put into the programme. She asked whether identified opportunities can be considered right at the beginning of the patient's journey to improve services at the outset. Dawson Ward deferred to Meg Poutasi and Rawiri Jansen to answer this. Fiona Lai also suggested that the patient journeys be shared at other committee meetings to create a sense of cultural sensitivity. Dawson Ward advised that he has already been invited to join a number of committees to bring these stories to life within the different specialties.

Resolution: Moved Jo Agnew / Seconded Zoe Brownlie

That the Hospital Advisory Committee:

1. **Receives the Care Navigator Progress Update for October 2020.**
2. **Notes the first 3 months of the Care Navigators team's progress within Planned Care.**
3. **Notes insights into approach, challenges and success for Kaiārahi Nāhi rōpū and Pacific Care Navigation team**

Carried

5.4 Patient and Whānau Voice

Vanessa Duthie, Māori Patient and Whānau Experience Lead, Jane Drumm, Patient and Whānau Centered Care Council Advisor, and James Hita, Patient and Whānau Centered Care Council Advisor, introduced themselves to the committee and provided a progress update on Patient and Whānau Voice.

The paper provided to the committee outlined the functions and work plan of the Patient and Whānau Centered Care Council (PWCCC).

Hospital Advisory Committee meetings will now include a section for PWCC to provide input into the agenda and the committee's plans going forward. Council members will attend Hospital Advisory Committee meetings and Jane Drumm will be present as an advisor.

As per the presentation submitted to the committee, James explained the meaning and essence of 'patient whānau centered'. He also discussed the council's terms of reference (vision, scope, purpose and goals), the work programme, projects/workshops, Te Wharenui, and aims going forward. He then asked that the Committee to champion the Council's work across the Auckland DHB.

The following points were covered in the discussion:

Zoe Brownlie asked for concrete examples that have influenced changes within the Auckland DHB since the establishment of the Council. Jane Drumm explained that there are five consumer council members giving feedback (co-design) to the Heart project. This involvement provides a consumer lens where opportunities for patient whanau interface exist. The Council is also involved in the new survey process by providing the required patient lens. A network meeting was held on 7 October 2020, which was organised by a newly formed national group of consumer chairs from across the country.

James Hita spoke at the Health Excellence Awards, sharing his story and involvement in PWCCC, which has led to conversations to facilitate more work for the Council.

An integral part of the Council's communications strategy is to reach out and engage with consumers to provide continual updates on how changes have, and are being made across the Auckland DHB. Engagement with committee members is also important as the Committee is the best advocate for change and promoting strategy.

Jo Agnew queried whether the Council, as the 'voice of the people', could be involved in DISAC. James Hita said that the Council is currently having conversations with different areas in the organisation as they hope to have representation and involvement across the Auckland DHB.

Michelle Atkinson said she supported the Council and acknowledged the skilful and diverse membership of the group. She reiterated that Council's engagement with ELT is vital going forward and that despite budget constraints, it is important to remember that decisions made at the committee have an impact on the lives of people.

Resolution: Moved Michelle Atkinson / Seconded Zoe Brownlie

That the Hospital Advisory Committee receives the Patient and Whanau Voice report and presentation

Carried

The meeting closed at 11:05 am.

Signed as a true and correct record of the Open Hospital Advisory Committee meeting held on Wednesday, 07 October 2020.

Chair: _____ Date: _____

Tama Davis

Te Toku Tumai – Auckland DHB Strategy 2020-2023

Recommendation:

That the Board endorse the strategic priorities and organisational pillars supporting the Te Toku Tumai – Auckland DHB Strategy 2020-2023.

Prepared by: Meg Poutasi, Chief of Strategy
Endorsed by: Ailsa Claire, Chief Executive

1. Introduction/Background

The Board first considered Te Toku Tumai – Auckland DHB Strategy 2020-2023 at its meeting on 23 September 2020.

The Board agreed that at its meeting of 7 November 2020 it would give further consideration to the pillars supporting the strategy. These pillars would become the core of the strategy that would be used throughout the health system.

It was agreed that following the adoption of the pillars management would develop and refine strategic programmes of work for presentation back to future Board meetings.

2. Conclusion

That the strategic priorities and organisational pillars supporting the Te Toku Tumai – Auckland DHB Strategy 2020-2023 be endorsed by the Auckland District Health Board.

Attachment 8.1.1
"Te Toku Tumai – Auckland DHB Strategy 2020-2023".

Our Strategic Priorities

Te Tiriti o Waitangi in action

Support a tangata whenua/ mana whenua led change to deliver mana motuhake and Māori self-determination in the design, delivery and monitoring of health care.

Develop transformation processes with a long-term view, to give effect to the Treaty principles of: partnership; active protection; equity and options.

Develop a whenua ki te whenua, life course approach, to redesign work.

Support the expression of hauora Māori models of care.

Eliminate inequity

Embed principles of equity and take action:

- Protect Māori Indigenous rights
- Build a common understanding of equity and causes
- Support Māori-led responses
- Support Pasifika -led responses
- Strengthen network of primary and community care
- Dismantle policies and drivers that cause inequity

Digital transformation

Insights and Intelligence - enhance data management and data analytics

Digital Health Services:

- Integrate care solutions – digital solutions that support integrated care
- Core clinical systems – integrated paper-lite core clinical information systems

Workforce and Business systems – enhance tools to foster organisational effectiveness

People, patients and whānau at the centre

Invest in a greater range of supports that 'stand beside' patients and whānau, and actively support self-directed care.

Connections and partnerships exist with communities, to achieve shared health service planning and delivery, focussed on areas and groups with the highest need (our localities approach).

Improve experience by partnering with people and service users in the design, in the delivery and evaluation of services (co-design).

Resilient services

Deliver safe and flexible health care with our population in the Covid-19 pandemic response.

Deliver sustainable benefits from the agile and rapid adaption programmes across the provider, focussing on step-change.

Implement agreed continuous improvement initiatives.

Deliver regional approaches in planned care, including changes to vulnerable services and gains in the equity pathways.

Deliver large scale capital investments on time and budget.

Our Organisational Pillars

People and Culture value

Strengthening our culture and building our capability.

Quality, Safety, and Risk (QSR)

Supporting excellent patient and staff outcomes through:

- System reliability and a proactive approach to reducing risk
- Integrating QSR, so it becomes a core part of everyone's role
- Moving from data to intelligence to inform insights, learning and action
- Providing leadership and oversight

Commissioning services for our populations' needs

Planning, developing, sourcing and monitoring service delivery systems to achieve the best outcomes for our population.

Our Purpose

Support our population to be well and healthy

Manage within our means

Put hauora for patients and their whānau at the heart of our transformation work

Commission health and disability services across the whole system mai te whenua ki te whenua/ mō te katoa

Provide specialist healthcare services to patients and whānau from the Northern Region, across districts, and New Zealand

Our Vision

Kia kotahi te oranga mo te iti me te rahi o te hāpori

Healthy communities,
World-class healthcare,
Achieved together

Te Toka Tumai
Auckland District Health Board

Strategy to 2023

Statement of Performance Expectations (SPE) Performance Report: Quarter Four 2019/20

Recommendation:

That the Statement of Performance Expectations (SPE) Performance Report: Quarter Four 2019/20 report be received.

Prepared by: Lily Yang (Reporting Analyst – Auckland and Waitematā DHBs)
Endorsed by: Karen Bartholomew (Director of Health Outcomes, Auckland and Waitematā DHBs), Wendy Bennett (Planning and Health Intelligence Manager, Auckland and Waitematā DHBs) and the Senior Leadership Team

Glossary

CEO	Chief Executive Officer
CVD	Cardiovascular disease
HQSC	Health Quality and Safety Commission New Zealand
NOF	Neck of femur
POAC	Primary Options for Acute Care
SLM	System level measure
SPE	Statement of Performance Expectations

Introduction

This is a regular six monthly report of the indicators in the Statement of Performance Expectations (SPE), a key component (Appendix B) of the Annual Plan. SPE measures represent the outputs or activities we deliver to meet our Annual Plan goals and objectives, and provide a reasonable representation of the vast scope of business-as-usual services we provide. These performance measures help to assess the quantity, quality, coverage and timeliness of service delivery. Actual performance against these measures is published in our Annual Report and audited by Audit NZ.

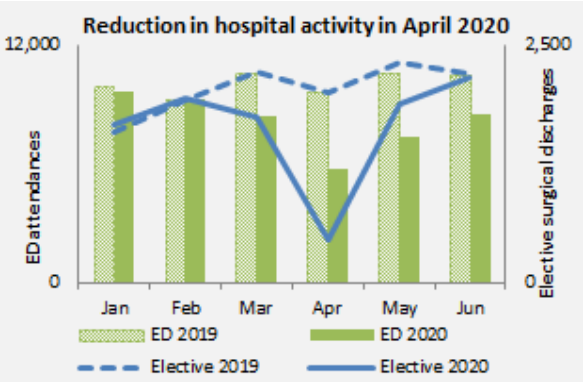
The measures in this report reflect those in the 2019/20 Annual Plan. A focus on equity is reflected in the extended number of measures monitored by ethnicity. This report excludes indicators that measure volumes without a specified target or those for which data is available only annually.

Impacts of COVID on performance
The performance achieved in Q4 was generally good, given that multiple services, both hospital and community, were affected by COVID-19. The reduction in clinical activity as a result of restrictions under the Alert Level 3 and 4 lockdown period (late March to mid-May 2020), and the re-purposing of staff and facilities for COVID-19 functions, was immediate and dramatic. In both hospital settings and in primary care, significantly less care was able to be provided than expected under normal circumstances.

Members of the public generally stayed away from health care facilities, with general practices, urgent care centres and Auckland City Hospital and Starship Children's Hospital emergency

departments reporting very low attendance. Routine elective care was delayed. As a consequence, in-patient admissions were very low in comparison to the same period in previous years.
The majority of routine elective surgeries were delayed during the lockdown period, with less than one quarter of the expected number of elective surgical procedures carried out in our hospitals in April.

Emergency department volumes decreased by 40% in April 2020, compared with April 2019, and acute inpatient volumes were reduced by a quarter. Auckland DHB bed occupancy declined from 86% in March 2020 to 61% in April 2020.



Elective surgery and emergency department attendances were significantly reduced during the lockdown period.

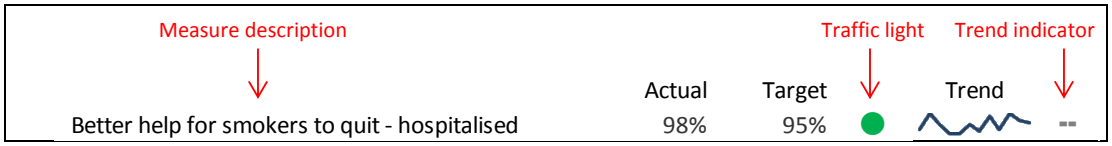
Outpatient activity was less affected as we moved rapidly to offer telephone and video consultations. Auckland DHB delivered three quarters of medical outpatient consultations via telehealth during Alert Level 4.

During the August resurgence we quickly transitioned again to virtual appointments, where appropriate. Auckland DHB is now working to support increased telehealth in the longer term by developing more electronic tools to assist with the delivery of virtual and paperless clinics.
As the majority of the disruption occurred in April and May 2020, our quarter four results are the most affected. In some cases this has been a negative impact and in others a positive one. Some examples: the significant reduction in people attending the Emergency Department (ED) had a positive effect on our ability to ensure that all ED patients are discharged admitted or transferred within six hours of arrival. However, because of the need to reduce or cease some services over this time, waiting times increased for some diagnostic testing eg. colonoscopies and CT/MRI scans.

HOW TO INTERPRET THE SCORECARDS

Traffic lights

For each measure, the traffic light indicates whether the actual performance is on target for the reporting period (or previous reporting period, if displayed in ***grey bold italic*** font).



The traffic light colours align with Annual Plan criteria (with the HQSC exceptions, listed below):

Traffic light	Annual Plan criteria: relative variance actual vs. target	Interpretation
●	On target or better	Achieved
●	0.1–5% away from target	Substantially achieved but off target
●	5.1–10% away from target and improvement from previous reporting period	Not achieved but progress made
●	>10% away from target or 5.1–10% away from target and no improvement from previous reporting period	Not achieved and no progress made

HQSC criteria are applied wherever possible (these measures are labelled with '*'):

Traffic light	HQSC criteria: thresholds are set by HQSC		Interpretation
●	Upper better	Varies with each indicator	Achieved
●	Middle group	Varies with each indicator	Not achieved but near target
●	Lower group	Varies with each indicator	Not achieved

Trend lines and trend indicators

A trend line and a trend indicator are displayed for each measure. Trend lines represent the available data for the latest 12-month period. All trend lines use auto-adjusted scales, and small variations may appear to be large.

YTD measures (e.g. Green Prescriptions, B4 School Checks) are cumulative and their trend lines will always show an increase that resets with each new financial year; the line direction may not reflect positive performance. To assess the performance trend, use the trend indicator as described below.

Trend indicator	Rules	Interpretation
▲	**Current > previous** quarter (or reporting period) **performance**	Improvement
▼	**Current < previous** quarter (or reporting period) **performance**	Decline
--	**Current = previous** quarter (or reporting period) **performance**	Maintained

By default, the performance criteria is the actual: target ratio. However, in some exceptions (e.g. when target is 0 and when performance can be negative), the performance reflects the actual.

Scorecard-specific notes are provided beneath each scorecard.

SPE scorecards: Quarter four 2019/20

Metro Auckland DHBs priority health outcomes and other key indicators scorecard

Quarter 4, 2019/20

	Auckland DHB			Waitematā DHB			Counties Manukau DHB		
Priority health outcomes	Actual	Target	Trend	Actual	Target	Trend	Actual	Target	Trend
Shorter stays in EDs	94%	95%		96%	95%		93%	95%	
Planned Care Interventions (YTD)	91%	100%		100%	100%		104%	100%	
Faster Cancer Treatment - within 62 days	97%	90%		85%	90%		86%	90%	
Increased immunisation at age 8 months	94%	95%		92%	95%		91%	95%	
- Māori	83%	95%		84%	95%		82%	95%	
- Pacific	92%	95%		87%	95%		91%	95%	
Better help for smokers - Primary Care	87%	90%		79%	90%		88%	90%	
Better help for smokers - Maternity	95%	90%		98%	90%		92%	90%	
Raising Healthy Kids	100%	95%		100%	95%		100%	95%	
Key indicators									
a. Breast screening coverage	67%	70%		65%	70%		68%	70%	
b. Cervical screening coverage	*61%*	*80%*		*69%*	*80%*		*65%*	*80%*	
c. Preschoolers enrolled in DHB oral health	108%	95%		97%	95%		89%	95%	
- Māori	79%	95%		73%	95%		73%	95%	
- Pacific	149%	95%		96%	95%		92%	95%	
- Asian	91%	95%		91%	95%		85%	95%	
Urgent diagnostic colonoscopy in 14 days	98%	90%		100%	90%		100%	90%	
b. Opportunities for hand hygiene taken*	*86%*	*80%*		*90%*	*80%*		*85%*	*80%*	
d. Hip/knee procedures given ABx in time*	*96%*	*100%*		*100%*	*100%*		*96%*	*100%*	
b. 0-19 yo Mental Health waiting ≤3 weeks	*68%*	*80%*		*68%*	*80%*		*72%*	*80%*	
b. 0-19 yo Mental Health waiting ≤8 weeks	*81%*	*95%*		*92%*	*95%*		*88%*	*95%*	
b. 0-19 yo Addictions waiting ≤3 weeks	*99%*	*80%*		*86%*	*80%*		*99%*	*80%*	
b. 0-19 yo Addictions waiting ≤8 weeks	*100%*	*95%*		*98%*	*95%*		*99%*	*95%*	

Traffic light criteria

- Achieved; target met
- Substantially achieved; 0.1–5% from target
- Not achieved but progress made, or 5.1–10% from target
- Not achieved and no progress made, or >10% from target

*** HQSC criteria**

- Upper group
- Middle group
- Lower group

Scorecared notes

a. Q4 result; uses the 2019 population projection as the denominator
b. Q3 2019/20 result
c. >100% results are due to mismatch of population projection and ARDS database ethnicity categorisations
d. Q1 2019/20 result
e. Q2 2019/20 result
f. Metro Auckland DHBs result
1. Most **Actuals** and **Targets** are reported for the timeframe listed at the top
2. ***Grey bold italics*** indicate data from previous time frame as noted (e.g. a., b.)
3. **The trend lines** scale is auto-adjusted, small variations may appear large

Auckland DHB Statement of Performance Expectations scorecard

Quarter 4, 2019/20

Focus on priority populations	Actual	Target	Trend
Health promotion			
% of total clients engaged with GRx (YTD) - Māori	13%	11%	
% of total clients engaged with GRx (YTD) - Pacific	22%	17%	
% of total clients engaged with GRx (YTD) - South Asian	15%	18%	
Immunisation			
Pertussis vaccination in pregnancy	62%	50%	
- Māori	38%	50%	
- Pacific	44%	50%	
- Asian	73%	50%	
Flu vaccine in 0-4 yo hospitalised for respiratory illness	28%	15%	
- Māori	22%	15%	
- Pacific	19%	15%	
Increased immunisation at age 5 years	91%	95%	
- Māori	86%	95%	
- Pacific	89%	95%	
- Asian	94%	95%	
Primary health care			
Primary Care enrolment rate - Māori	82%	90%	
Eligible patients without HbA1c in last 15 mo	11%	≤12%	
- Māori	16%	≤12%	
- Pacific	12%	≤12%	
Eligible patients with HbA1c ≤64 mmol/mol in last 15 mo	61%	65%	
- Māori	49%	65%	
- Pacific	49%	65%	
Māori with prior CVD prescribed triple therapy	56%	62%	
Pacific with prior CVD prescribed triple therapy	65%	67%	
b. ASH rate per 100,000 in 45-64 year olds	*3640*	*<3480*	
b. - Māori	*6907*	*<6981*	
b. - Pacific	*8311*	*<8679*	
Mean decayed, missing, filled teeth (DMFT) at Year 8	0.62	<0.65	
- Māori	0.76	<0.65	
- Pacific	0.93	<0.65	
- Asian	0.51	<0.65	
Children caries free at age 5 years	54%	61%	
- Māori	42%	61%	
- Pacific	30%	61%	
- Asian	51%	61%	
Mental health			
b. Mental health service access (age 0-19 years)	*3.2%*	*3.4%*	
b. - Māori	*6.1%*	*6.2%*	
b. Mental health service access (age 20-64 years)	*3.5%*	*3.7%*	
b. - Māori	*10.8%*	*10.2%*	
b. Mental health service access (age 65+ years)	*2.9%*	*3.2%*	
b. - Māori	*3.7%*	*3.5%*	

Traffic light criteria

- Achieved; target met
- Substantially achieved; 0.1–5% from target
- Not achieved but progress made, or 5.1–10% from target
- Not achieved and no progress made, or >10% from target

Scorecard notes

a. Q4 result; uses the 2019 population projection as the denominator
b. Q3 2019/20 result
c. >100% results are due to mismatch of population projection and ARDS database ethnicity categorisations
d. Q1 2019/20 result
e. Q2 2019/20 result
f. Metro Auckland DHBs result
1. Most **Actuals** and **Targets** are reported for the timeframe listed at the top
2. *Grey bold italics* indicate data from previous time frame as noted (e.g. a., b.)
3. **The trend lines** scale is auto-adjusted, small variations may appear large

Auckland DHB Statement of Performance Expectations scorecard

Quarter 4, 2019/20

Output Class 1: Prevention Services	Actual	Target		Trend	
Health promotion					
Pregnant smokers referred to incentives programme (YTD)	154	110	●		▼
Number of clients engaged with Green Prescriptions (YTD)	3,623	4,500	●		▼
Population-based screening					
B4 School Checks completed (YTD)	65%	90%	●		▼
Newborns offered and hearing screened w/in 1 month	89%	90%	●		▼
Auckland Regional Public Health Service					
f. Tobacco retailer compliance checks conducted (YTD)	184	300	●		▲
f. Positive pulmonary TB cases contacted in 3 days	100%	98%	●		▲
f. By-protocol initial contact for high risk enteric disease	100%	95%	●		▲
Output Class 2: Early Detection and Management					
Primary health care					
e. POAC referrals (YTD)	*3,456*	*6,036*	●		▲
e. Primary care survey - appointment timeliness question	*5.7*	*6.7*	●		--
Output Class 3: Intensive Assessment and Treatment					
Acute services					
ED admissions w/ 'unknown' flag if alcohol related (10-24 y)	4.3%	<6.2%	●		▼
b. Eligible stroke patients thrombolysed	*14%*	*10%*	●		▲
ACS patients with coronary angiography in 3 days	85%	70%	●		▼
Elective (inpatient/outpatient)					
Non-urgent diagnostic colonoscopy in 42 days	27%	70%	●		▼
Patients waiting >4 months for FSA (ESPI 2)^	15.5%	<0%	●		▲
CTs completed in 6 weeks	93%	95%	●		▲
MRIs completed in 6 weeks	61%	90%	●		▲
Quality and patient safety (HQSC)					
Staph bacteraemia rate per 1,000 inpatient bed days	0.22	≤0.25	●		▲
e. Older patients assessed for the risk of falling	*84%*	*90%*	●		▼
e. Older falls risk patients with an individualised care plan*	*92%*	*90%*	●		▲
#NOF from falls per 100,000 admissions (rolling 12 m)	5.9	≤8.4	●		▼
d. Hip/knee procedures given antibiotic in correct dose*	*97%*	*95%*	●		
b. Surgical site infections per 100 hip and knee operations	*0.09*	*<0.93*	●		▲
e. Inpatient survey - medication side effects question	*47%*	*55%*	●		▲
Output Class 4: Rehabilitation and Support Services					
Home-based support					
b. HBSS clients with clinical interRAI and care plan	*96%*	*95%*	●		--
Palliative care					
Referrals that wait >48 hours for a hospice bed	0%	<4%	●		--

Traffic light criteria

- ● Achieved; target met
- ● Substantially achieved; 0.1–5% from target
- ● Not achieved but progress made, or 5.1–10% from target
- ● Not achieved and no progress made, or >10% from target

^ ESPI 2 only (MoH)

- ● 0
- ● >0% and <0.4%; *n* = 1-10
- ● ≥0.4%; *n* ≥11

*** HQSC criteria**

- ● Upper group
- ● Middle group
- ● Lower group

Scorecard notes

a. Q4 result; uses the 2019 population projection as the denominator
b. Q3 2019/20 result
c. >100% results are due to mismatch of population projection and ARDS database ethnicity categorisations
d. Q1 2019/20 result
e. Q2 2019/20 result
f. Metro Auckland DHBs result

1. Most **Actuals** and **Targets** are reported for the timeframe listed at the top
2. *Grey bold italics* indicate data from previous time frame as noted (e.g. a., b.)
3. **The trend lines** scale is auto-adjusted, small variations may appear large

PRIORITY HEALTH OUTCOMES
SCORECARD VARIANCE REPORT

Indicator	On target	Variance commentary
1. Shorter stays in EDs	✓	
2. Planned Care Interventions	✖	*Prior to COVID-19, we were on track to deliver more Planned Care Interventions than the previous year. Service improvement activities will continue and are expected to increased discharges in the coming year; this will improve performance and assist with delivery of recovery plans.*
3. Faster Cancer Treatment – within 62 days	✓	
4. Increased immunisation at age 8 months	✓	
- Māori	✖	*There was a significant primary healthcare disruption due to COVID-19, which will affect immunisation coverage, with the sector reporting whānau as reluctant to access primary care or the Outreach Immunisation Service (OIS) during Alert Level 3 and 4 lockdowns. This particularly affected on-time (i.e. at 6 months) immunisation coverage for Māori, although the 8-month coverage for Māori is 1% higher than the same time last year. The DHB, PHO and Immunisation Advisory Centre continue to support primary care continue to recall children for immunisations and to refer to the OIS.*
- Pacific	✓	
5. Better help for smokers – Primary Care	✓	
6. Better help for smokers – Maternity	✓	
7. Raising Healthy Kids	✓	

KEY INDICATORS
SCORECARD VARIANCE REPORT

Indicator	On target	Variance commentary
8. Breast screening coverage	✓	
9. Cervical screening coverage	✖	*Cervical screening coverage remains below the 80% target. The coverage rate is most concerning in Māori, at 50%. Cervical screening coverage declined over the past 3 years nationally and locally. The recent COVID-19 restrictions had a significant impact on completion of cervical screens, which are largely provided in primary care. Of the greatest concern are women who have never been screened, or have not been screened for 5 years or more. NSU*

Indicator	On target	Variance commentary
		will implement the HPV Primary Screening Programme, which offers some significant advantages for improving equity and coverage, such as self-testing. The implementation timeframe is not yet confirmed.
10. Preschoolers enrolled in DHB oral health services	✓	
- Māori	✘	*Enrolment volumes of Māori pre-schoolers are lower than expected, despite the implementation of automatic enrolments from birth lists for all three metro Auckland DHBS. Work is currently underway to understand why this may be, using comparative data between ARDS vs. NIR enrolments born in April 2020 to identify any discrepancies in ARDS' reporting algorithm.* *The ARDS outreach programmes are an effective way to identify Māori pre-schoolers who are not yet enrolled with ARDS, such as the Assessment and Fluoride Varnish Programme at Kohanga Reo, language nests and early childhood centres that have high volumes of Māori and Pacific children. Due to national restrictions on the provision of dental services during COVID-19, ARDS was unable to continue these outreach programmes during Alert Levels 3 and 4. In Alert Levels 1 and 2, ARDS Community Engagement Coordinators approached some centres to re-commence these programmes.* *The ARDS Booking and Scheduling Standard Operating Procedures were updated in early 2020 to reflect the need to confirm ethnicity of every child for both biological parents at the time of booking. This is because the birth lists from which we automatically enrol our tamariki assign the mother's ethnicity to tamariki, so the father's ethnicity is not reflected. ARDS continues to work with staff to support this process. Our newly introduced Telehealth Oral Health Promotion Pēpi Programme completed almost 2,000 phone assessments with whānau of our 12-15 month old tamariki as their first*

Indicator	On target	Variance commentary
		contact with our service during Alert Level 3 in August 2020, which provided an excellent opportunity to update this ethnic information. Work is currently underway to develop and continue this programme.
- Pacific	✓	
- Asian	✓	
11. Urgent diagnostic colonoscopy in 14 days	✓	
12. Opportunities for hand hygiene taken	✓	
13. Hip and knee operations given prophylactic antibiotic in time	✓	
14. Mental Health waiting within 3 weeks in 0-19 year olds	✖	*The impact of the COVID-19 pandemic was in effect by the end of March. Only urgent and acute cases were seen in person. While tele-health options were offered to non-urgent referrals, not everyone took up this option and many chose to wait. This time period also includes an increased wait time due to psychologist strike action, resulting in reduced workforce capacity for a considerable period of time.* *A service-wide project was commenced, with the objective of improving flow into and through the service. Initially, the focus is on improving systems and processes at the referrals/triage, initial assessment phase. Increased use of tele-health as an ongoing option (post-COVID-19) for families is also being explored.*
15. Mental Health waiting within 8 weeks in 0-19 year olds	✖	
16. Addictions waiting within 3 weeks in 0-19 year olds	✓	
17. Addictions waiting within 8 weeks in 0-19 year olds	✓	

FOCUS ON PRIORITY POPULATIONS SCORECARD VARIANCE REPORT

Indicator	On target	Variance commentary
Health promotion		
18. Total clients engaged with Green Prescriptions (YTD) - Māori	✓	
- Pacific	✓	
- South Asian	✖	*Although the provider did not meet the annual target, their result improved over the year, with 17.3% of clients being of South Asian ethnicity in Q4. The provider is continuing their promotional work with this community.*

Indicator	On target	Variance commentary
Immunisation		
19. Pertussis vaccination in pregnancy	✓	
- Māori	✖	*We continue to make good progress increasing vaccine uptake in pregnancy, exceeding the target in the total population. To raise awareness for our Māori and Pacifica hapu mothers, we launched a public awareness campaign featuring a young Pacific woman. The SMILE campaign contains health promotion messages for women and their whānau on being Smoke and Alcohol Free, Mental Wellbeing Matters, Immunise, Lie on your Side, and Eat Healthy. The DHB's antenatal clinic vaccinator service is now embedded and is also looking at options for immunisation in the community alongside community midwifery clinics. Antenatal immunisation coverage will be impacted by COVID-19, as many clinic appointments were delivered virtually, thus removing the opportunity for opportunistic vaccination.*
- Pacific	✖	
- Asian	✓	
20. Flu vaccine in 0-4 year olds hospitalised for respiratory illness	✓	
- Māori	✓	
- Pacific	✓	
21. Increased immunisation at age 5 years	✓	*Coverage for the total population at 5 years of age improved 2% at June 2020 from June 2019. This reflects the hard work of the sector during the measles outbreak.*
- Māori	✖	*Coverage of Māori at 5 years of age has been improving, although there was a decrease in coverage for 2020 compared with the same time last year. COVID-19 had an impact on immunisation, with sector reports of families/whānau reluctant to go to primary care for immunisation or receive services from OIS. Improving 4-year-old immunisation coverage for tamariki Māori is part of a Green Belt Quality Improvement project. The new NIR team implemented a track-and-trace process for the 4-year-olds (not undertaken by the previous NIR provider) and started a significant data clean-up due to reconcile the NIR with children's updated DHB of domicile. The new NIR team also gained access to the*

Indicator	On target	Variance commentary
		B4SC database, which will help to support contacting eligible patients.
- Pacific	✖	*Pacific coverage improved 3% from the same time last year. See comments above.*
- Asian	✓	
Primary health care		
22. Primary Care enrolment rate – Māori	✖	*We continue to focus on three key areas:* • *Hospital-based facilitated enrolment across our main hospital sites: delayed but has been re-started after COVID-19* • *Work with Māori health providers to ensure they are constantly checking the enrolment status of their clients: completed and is monitored regularly* • *Data match between Māori health providers and PHOs to find whānau who are not enrolled: delayed by COVID-19 but is underway*
23. Eligible patients without HbA1c in the last 15 months	✓	
- Māori	✖	*Primary Care's ability to undertake routine diabetes care was and continues to be affected by COVID-19, but PHOs are working with their practices to re-engage them in BAU, including identifying patients with elevated HbA1c and those without an HbA1c within the last 15 months, and work to re-engage these patients with their primary care team to work together to help improve their diabetes management.*
- Pacific	✓	
24. Eligible patients with HbA1c ≤64 mmol/mol in the last 15 months	✖	*Primary Care's ability to undertake routine diabetes care was and continues to be affected by COVID-19, but PHOs are working with their practices to re-engage them in BAU, including identifying patients with elevated HbA1c and those without an HbA1c within the last 15 months, and work to re-engage these patients with their primary care team to work together to help improve their diabetes management.*
- Māori	✖	
- Pacific	✖	
25. Māori with prior CVD prescribed triple therapy	✖	*Primary Care's ability to undertake CVD risk assessment and risk management was and continues to be affected by COVID-19, but PHOs are working with practices to re-engage in BAU, which includes CVD risk assessment and management.*
26. Pacific with prior CVD prescribed triple	✓	

Indicator	On target	Variance commentary
therapy		
27. ASH rate per 100,000 in 45-64 year olds	✓	
- Māori	✓	
- Pacific	✓	
28. Mean decayed, missing, filled teeth (DMFT) at Year 8	✓	
- Māori	✖	*COVID-19 significantly impacted ARDS service delivery. During Alert Levels 3 and 4, routine oral health services were not provided, as per Dental Council New Zealand (DCNZ) and Ministry of Health directives. Only 24 tamariki met the emergency essential care criteria for an appointment in March and April, during Alert Levels 3 and 4, and only 3 tamariki in August, during Alert Level 3. With the move to Alert Levels 1 and 2 (including 2.5), the service recommenced routine appointments; however, on-going DCNZ requirements impact service productivity and access (e.g. enhanced Infection Prevention and Control requirements and the extensive resource involved in contacting whānau of tamariki to ask COVID-19 pre-screening questions by phone prior to their appointment). This reduced appointments completed per day to an average of 7 children per chair per day, vs. 11 children pre-COVID-19.* *The ARDS COVID-19 Recovery Plan entails offering appointments to tamariki identified as requiring treatment and those waiting the longest for their routine examination. Resources are distributed to tamariki living in our highest need communities. This means our 5-year-old and Year 8 tamariki who attended this year will be our highest needs children and therefore more likely to experience dental caries and have higher DMFT than their non-high-risk counterparts. This need will be reflected in their caries free status and DMFT score.* *The ARDS COVID-19 Recovery Plan also means longer appointment lengths for our tamariki as more treatment is required; hence fewer appointments are completed per day vs. pre-COVID-19. With the on-going DCNZ requirements, ARDS*
- Pacific	✖	

Indicator	On target	Variance commentary
		anticipates service delivery will continue to be impacted over the coming months. This includes the provision of services for our 5-year-old and Year 8 tamariki before their transfer to the Adolescent Dental Service.
- Asian	✓	
29. Children caries free at age 5 years	✖	*Please see comment above.*
- Māori	✖	
- Pacific	✖	
- Asian	✖	
Mental health		
30. Mental Health service access (age 0-19 years)	✖	*The Provider Arm provides only a portion of the overall access counts, which varies by age and ethnic groups. Comparing two 12-month periods (Apr 2017 to Mar 2018 vs. Apr 2018 to Mar 2019), the number of distinct Auckland DHB residents seen by Provider Arm services in the more recent period is ahead of, or fairly similar to, the first period. Because of population fluctuations when these numbers are converted to a rate, we see some marginal gains for the 0-19 year old age group overall and for Māori. The access rates for the other age groups are marginally down across Total and Māori.*
- Māori	✓	
31. Mental Health service access (age 20-64 years)	✖	*Please see comment above.*
- Māori	✓	
32. Mental Health services access (age 65+ years)	✖	*Please see comment above.*
- Māori	✓	

OUTPUT CLASS 1: PREVENTION SERVICES SCORECARD VARIANCE REPORT

Indicator	On target	Variance commentary
Health promotion		
33. Pregnant smokers referred to incentives programme (YTD)	✓	
34. Number of clients engaged with Green Prescriptions (YTD)	✖	*During the COVID-19 response, from late March through to May, the provider was unable to provide their usual services. Their referrers were also focused on the COVID-19 response. These two factors led to a large decrease in referrals for Q4.*
Population-based screening		

Indicator	On target	Variance commentary
35. B4 School Checks completed (YTD)	✘	*Assessments of children were suspended during the COVID-19 lockdown as per Ministry guidance; the lockdown also delayed staff recruitment. Normal service resumed in Alert Level 2 and the focus is on children missed during lockdown, those about to turn 5 years old, living in higher deprivation index areas, and who are Māori or Pacific.*
36. New-borns offered hearing screening within 1 month	✓	
Auckland Regional Public Health Service		
37. Tobacco retailer compliance checks conducted (YTD)	✘	*Tobacco retailer compliance checks for 2020 were significantly affected by the COVID-19 pandemic, as smokefree officers were redeployed to support the ARPHS response. Compliance activity will resume as capacity allows.*
38. Positive pulmonary tuberculosis cases contacted in 3 days	✓	
39. By-protocol initial contact for high risk enteric disease	✓	

Output Class 2: Early Detection and Management

Scorecard Variance Report

Indicator	On target	Variance commentary
Primary health care		
40. Primary Options for Acute Care (POAC) referrals (YTD)	✘	*No data update since Q2. Data delays, particularly from primary care, are expected as a result of COVID-19.*
41. Primary care survey – appointment timeliness question	✓	*No data update since Q2, as this national survey was discontinued in 2020; no suitable replacement was implemented, with delays attributed to COVID-19.*

Output Class 3: Intensive Assessment and Treatment

Scorecard Variance Report

Indicator	On target	Variance commentary
Acute services		
42. ED admissions with 'unknown' flag if alcohol related (in 10-24 year olds)	✓	
43. Eligible stroke patients thrombolysed	✓	
44. ACS patients with coronary angiography in 3 days	✓	
Elective (inpatient/outpatient)		

Indicator	On target	Variance commentary
45. Non-urgent diagnostic colonoscopy in 42 days	✘	*During April and May (Alert Levels 3 and 4), the majority of procedures were deferred. Prior to COVID-19, the service agreed to outsource a number of colonoscopies to improve the wait times in preparation for bowel screening. This started in late June 2020.* *The service is scheduling patients waiting the longest with the aim to reduce the maximum wait times.*
46. Patients waiting >4 months for FSA (ESPI 2)	✘	*COVID-19 and Hospital Level 2 severely impacted our ESPI 2 position. FSA waitlists were reviewed to ensure patients with the highest clinical risk are seen first. Services are planning recovery and undertaking additional clinics where possible. Focus is on equity of access and reducing clinical risk.*
47. CTs completed within 6 weeks	✓	
48. MRIs completed within 6 weeks	✘	*Performance against the MRI target of 95% of referrals completed within six weeks increased in July 2020 to 69.1% (69.9% general and 62.6% for Cardiac MRI) compared with performance of 61.3% in June 2020. The department currently has a significant number of Medical Imaging Therapist vacancies, which is starting to significantly impact capacity. Successful recruitment of a new graduate MRI MIT will commence in September 2020. We were unsuccessful with further recruitment of qualified staff, given the issues with the Medical Radiation Technologist Board (MRTB) not recognising the clinical competence of international candidates without a post-graduate qualification. In the interim, we employed another international MRI MIT as a student (intern), taking our current number of students up to 5.8 against a background of 2.8 qualified staff. Despite a proactive recruitment plan, no further appointments were made.*
Quality and patient safety (HQSC)		
49. Staph bacteraemia rate per 1,000 inpatient bed days	✓	
50. Older patients assessed for the risk of falling	✘	*The Falls and Pressure Injuries Steering group acknowledge that we continue to not meet the 90% target. Initial scoping indicates confusion regarding answering*

Indicator	On target	Variance commentary
		the audit and issues with the Assessment and Care plan form. Work was immediately undertaken to revise the audit questionnaire and transition from a paper-based audit to an app to further facilitate simplification. This work was completed in April 2019, and while this showed some initial improvement, the 90% target remains unachieved. The Falls Assessment and Care plan form was revised and implemented in January 2020. Due to COVID-19 interruptions, it is unclear if this resulted in improvement; early indications are that the care plan marker is now meeting target but additional work is likely required to improve the assessment results. From an outcome point of view, Auckland DHB is reporting a similar number of SAC 1 and 2 falls as previous years, thus we do not believe patient care has declined. However, this remains a safety concern and a further work plan will be developed to improve compliance and therefore safety for the older person. Please see monthly results below.
51. Older falls risk patients with an individualised care plan	✓	
52. Fractured NOF from falls per 100,000 admissions (rolling 12 months)	✓	
53. Hip and knee procedures given the right antibiotic in the correct dose	✓	
54. Surgical site infections per 100 hip and knee operations	✓	
55. Inpatient survey – medication side effects question	✘	*No data update since Q2, as this national survey was discontinued in 2020; no suitable replacement was implemented, with delays attributed to COVID-19.*

	Target	Oct 2019	Nov 2019	Dec 2019	3-month average
Patients with a Falls Assessment	**90%**	**86.5%** (148/171)	**88.0%** (161/183)	**81.0%** (141/174)	**85.2%** (450/528)
Patients with a Falls Care plan	**90%**	**89.0%** (65/73)	**87.5%** (77/88)	**94.4%** (67/71)	**90.1%** (209/232)
HQSC Patients with a Falls Assessment	**90%**	**77.6%** (59/76)	**84.8%** (78/92)	**90.5%** (57/63)	**84.0%** (194/231)
HQSC Patients with a Falls Careplan	**90%**	**88.6%** (39/44)	**93.3%** (56/60)	**93.6%** (64/66)	**92.1%** (139/151)

OUTPUT CLASS 4: REHABILITATION AND SUPPORT SERVICES SCORECARD VARIANCE REPORT

Indicator	On target	Variance commentary
Home-based support		
56. HBSS clients with clinical interRAI and care plan	✓	
Palliative care		
57. Referrals that wait >48 hours for a hospice bed	✓	

Northern Region Service Annual Plan 2020/21

Recommendation

1. **That the Board receive the Northern Region Service Annual Plan 2020/21**
2. **That the plan be uploaded to the DHBs website in conjunction with the DHBs other annual plans.**

Prepared by: Ailsa Claire, Chief Executive Officer

1. Executive Summary

The Northern Region Service Annual Plan 2020/21, approved by the Minister of Health is submitted for the Boards information.

2. Introduction/Background

The Regional Service Plan focuses on regional work for 2020/21, meeting statutory, national and regional expectations to deliver an effective, safe, efficient, and sustainable healthcare system. This regional plan for 2020/21 complements the work being undertaken by the regional DHBs as set out in their Annual plans.

The New Zealand Public Health and Disability (Planning) Regulations 2011 require the Regional Service Plan to contain both a strategic and an implementation element. The implementation element must be reviewed annually and the Regional Plan updated annually for agreement with the Minister of Health.

Chris Hipkins, the Minister of Health on 16 October 2020, approved the Northern Region Service Annual Plan 2020/21.

The approval does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health nor does approval of the Plan constitute approval of any capital business cases that have not been approved through the normal process.

3. Conclusion

The Northern Region Service Annual Plan 2020/21 be received by the Auckland District Health Board and be uploaded to the DHB website in conjunction with the DHBs other Annual Plans.

Attachment 9.2.1
"Northern Region Service Annual Plan 2020/21".

The Northern Region Service Plan

Annual Plan 2020/21

Regional collaboration actions to ensure the best health for the people living in our Northern Region.

[This page intentionally left blank]

Hon Chris Hipkins

MP for Remutaka

Minister of Education
Minister of Health
Minister of State Services

Leader of the House
Minister Responsible for Ministerial Services

16 October 2020

Ms Ailsa Claire
Lead Chief Executive for Northern Regional District Health Boards
Auckland District Health Board
ailsac@adhb.govt.nz

Dear Ailsa

Northern Regional Service Plan 2020/21

This letter is to advise you that I have agreed the Northern Region Service Plan (RSP).

This plan marks year three of the strategic implementation of your Long-Term Investment Plan (NRLTIP). Your region continues to progress its key priorities informed by the NRLTIP and subsequent findings from regional 'deep dive' work to align with the New Zealand Health and Disability review. The plan also advances the region's legislative obligations and commitment to achieving health equity for Māori, acknowledging that the COVID-19 pandemic presents an opportunity to reset the health system to enable a more pro-equity approach.

My approval of your RSP does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health (Ministry). Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

I would like to thank you and your staff for your valuable contribution and continued commitment to delivering quality health care to your population and wish you every success with the implementation of the 2020/21 RSP.

Please ensure that a copy of this letter is attached to the copy of your signed RSP held by each DHB Board and to all copies that are made available to the public.

Ngā mihi nui

Chris Hipkins
Minister of Health

+64 4 817 8706 | Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand | c.hipkins@ministers.govt.nz | beehive.govt.nz

[This page intentionally left blank]

Foreword

This 'Northern Region Service Plan' sets out the actions that the Northern Region DHBs will progress through joint working during 2020/21. This plan responds to the MoH Regional Service Planning guidance.

As leaders we recognise the WAI2575 tribunal findings that our health system needs to fundamentally change to live up to Te Tiriti expectations. The COVID-19 pandemic health response presents an opportunity to reset the New Zealand health system to secure a better future for Māori and for all our communities as we work to recover waiting times standards. This includes addressing vulnerable clinical services in need of more resilient and regionally coherent models of care.

For parts of our Region the gap in life expectancy for Māori compared to non-Māori has reduced substantially, but areas of our Region remain with up to 9 years' difference. There are differences in eligibility for care that depend on where people in our Region live, not clinical need. Our intention is that wherever you receive healthcare across our Region you should expect consistently high quality care, fast access, comparable survival chances and good outcomes.

These intentions are shared by many of our clinical service leaders, across care settings, and by those who finance, fund and plan services. They resonate with our Iwi partners, and communities we serve. Yet they will not be fully realised through existing ways of DHB working. We are taking the opportunity to put in place a different approach so we can achieve our goals for the Region's patients and communities. This begins with a new model of regional leadership, which will change the way we go about tackling our biggest challenges. It will create the space our leaders need to act strategically, consider issues safely based on a principled approach, and to harness the talents and strengths in our organisations for the benefit of the whole Region.

Building on the shared experience of joint working in the Region, our intent is:

- To put into practice the principle of "One team" with a singular purpose in our regional leadership, committed to the primacy of equity across our entire geography
- To adapt our services to the needs and rights of the patients and whānau who use them, rather than expecting patients to adapt to the way our services work
- To set leadership expectations of our teams, such that our clinical and managerial leaders own, and demonstrate, new behaviours and values in line with our collective intent
- To embed collective working, by working through difficult conversations and issues in order to secure collective agreement to move together with an agreed common approach
- To determine our approach by what delivers best value for our patients, relative to the collective resources of the Region. We will ensure that in aggregate, none of our organisations will be worse off as a result of our collaborative strategy than they would be by pursuing an individual approach
- To move to create and recognise centres of excellence in our functions and our clinical services, allowing specialisation and focus, rather than seeking as DHBs to be 'all things to all people' whilst ensuring individual DHB governance needs are met.

Embracing new ways of working and leading change is part of an ongoing conversation. We will take this conversation forward together in the coming months as the government responds to the findings of the Health and Disability System Review. We recognise the rapid reforms and gains made in the response to COVID-19 across the Northern Region health sector, and the dedication of our health workforce to make a difference in the health and wellbeing of our communities. We commit our on-going support to help them deliver an equitable, effective, efficient and sustainable health service, and progress our LTIP strategy, as we implement our plans for 2020/21.

Harry Burkhardt

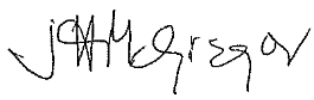
Chair

Northland District Health Board

Nick Chamberlain

Chief Executive

Northland District Health Board



Judy McGregor
Chair
Waitematā District Health Board

Andrew Brant
Acting Chief Executive
Waitematā District Health Board

Pat Snedden
Chair
Auckland District Health Board

Ailsa Claire
Chief Executive
Auckland District Health Board

Vui Mark Gosche
Chair
Counties Manukau District Health Board

Margie Apa
Chief Executive
Counties Manukau District Health Board

Contents

Introduction 1

A Northern Region 'Strategy' and 'Implementation' Plan. 1

COVID-19 Context and Impact on Planning 1

Part One – Strategy 4

Te Tiriti o Waitangi - Progressing our Commitments Together 4

The Long Term Strategic Planning Framework 5

Northern Region Strategic Direction 6

Responding to Health Care Issues 8

Our Strategies 8

- Seven Northern Region Strategic Responses 8
- New Care Models Delivered Through Balanced investment 9

Part Two - Implementation Plans for 2020/21 12

Overview of Our Plan for 2020/21 14

- Five Programmes of Regional Work 14

Programme One – Improve Equity 14

- Achieving Health Equity for Māori 14
- Achieving Health Equity for Pacific Peoples 15
- Equity Led Planned Care Recovery 15

Programme Two - Improve Public & Population Health, Primary & Community Care 17

Programme Three - Health Service Improvements and Model of Care Change 18

- Child Health 18
- Frailty and Healthy Aging 18
- Cancer Services 19
- Mental Health & Addiction 19
- Cardiovascular Services 19
- Stroke 19
- Major Trauma Services 20
- Hepatitis C 20

Programme Four - Improved Diagnostic Service Delivery 20

- Laboratory 20
- Radiology Services 20

Programme Five – 'Enablers of Health System Transformation and New Care models' 21

- Workforce 21
- Data and Digital 22
- Capital Programme 24
- Collaborative Resourcing Framework 24

Governance, Oversight and Working Arrangements 25

- Funding Mechanisms to Deliver the Northern Region's Programmes of Work 25

Appendices 26

Appendix One: Quarterly Milestone Action Plans 28

Appendix Two: Governance Leadership and Partnerships in More Detail 42

Appendix Three: Northern Region Service Design Principles 46

Introduction

A Northern Region 'Strategy' and 'Implementation' Plan.

This Regional Service Plan focuses on regional work for 2020/21, meeting our statutory, national and regional expectations to deliver an effective, safe, efficient, and sustainable healthcare system. This regional plan for 2020/21 complements the work being undertaken by our DHBs as set out in their Annual plans.

The New Zealand Public Health and Disability (Planning) Regulations 2011 require the Regional Service Plan to contain both a strategic and an implementation element. The implementation element must be reviewed annually and the Regional Plan updated annually for agreement with the Minister of Health[1].

To meet this requirement, we have structured this plan into two sections:

1. The **'Strategy'** section summaries the challenges facing the Northern Region health system together with our Region's key strategic responses. These build upon strategic themes and thinking:
   - Initially outlined in the Northern Region Long Term Investment Plan, Jan 2018
   - Detailed in the NZ Triple Aim, legislative obligations, national strategies and Government priorities
   - Highlighted by the NZ Public Health and Disability Review, 2020
   - Arising from the COVID-19 pandemic response.

   As well as summarising the Northern Region 'Direction of Travel' we highlight the relationships between our long term intent and our key priorities over the coming year. This strategic context frames our work-plans 'line of sight', and intervention logic, demonstrating that regional collaboration efforts are focussed upon solving the most significant challenges being faced by our health system.

2. The **'Implementation'** section details the regional work that will be progressed in 2020/21. This section provides an overview of:
   - The key objectives and deliverables, that have been identified and agreed as areas of regional work focus to address our regional priorities
   - Our regional governance and oversight structures.

   A collated view of the quarterly milestones for the Northern Region programme of work is provided in Appendix One. This programme view and milestone summary provides a measurable goal-based view of Region's work plan to allow oversight of the progress being made by the Northern Region.

COVID-19 Context and Impact on Planning

2020 has been an exceptional year. The COVID-19 pandemic dramatically affected DHB and regional planning and delivery processes. Regional resources have been deployed to support the COVID-19 response. DHB partners have also been diverted from participation in regional and strategic work to focus upon more immediate COVID-19 operational responses. The continuing pandemic recovery phase will require ongoing regional support and consume the focus of regional and stakeholder teams. We will need to continue to deploy our resources flexibly throughout 2020/21 to adapt to the developing situation.

As a result of the national emergency and the suspension of regional planning it has not been possible to follow the usual development pathway for the regional service plan. It has not been possible to obtain input and commitment from all the key stakeholders that would normally be engaged during a 'typical' regional planning process. This, together with unknown future demands on resources, results in increased uncertainty regarding the scope of work that can be progressed and achieved in the next 12 months.

Despite this, we are detailing, as far as possible, the regional work plan intent and expected deliverables. This plan enables regional alignment of effort and provides a focus for our work. Uncertainty may reduce as the year progresses and the environment, including clarification of any additional and new priorities as a result of COVID-19, stabilises. Nonetheless we anticipate a more iterative, adaptive work programme and will manage changes through the year by means of 'variation-control' communications through the regional quarterly reporting process between our Region and the MOH.

[1] MoH Annual Regional Service Planning Guidance for 2020/21

Northern Region Service Plan

Part One – Strategy

[This page intentionally left blank]

Te Tiriti o Waitangi - Progressing our Commitments Together

The Northern Region DHBs recognise and respect Te Tiriti o Waitangi as the founding document for Aotearoa New Zealand; encapsulating the relationship between the Crown and Iwi. Te Tiriti protects what whānau Māori, hapū and Iwi treasure, maintains Māori expressions of tino rangatiratanga and guides partnership with Māori to achieve Māori health equity.

This Regional Service Plan supports and advances our legislative obligations and commitment to achieving health equity for Māori. In response to the Waitangi Tribunal's WAI2575 Hauora report (2019), a principle based framework sets out our Tiriti based commitments. Our commitment to the four principles is summarised:

- **Partnership**

  Partnership with Māori to create a more responsive regional health system, designed to achieve intergenerational wellbeing for Māori. To date this has been supported through strengthened partnerships with Mana Whenua and Mataa Waka across the region. The Northern Iwi-DHB Partnership Board, Kōtui Hauora, has been formed as a partner to the three northernmost DHBs and in the south CMDHB has had a partnership relationship with Mana Whenua I Tāmaki Makaurau for many years.

  Māori representation at operational levels is also essential to this RSP; enabling Māori to lead important pieces of work and co-design solutions for services that are not achieving health equity.

- **Equity**

  Māori have a right to fairness and freedom from discrimination. Working to achieve Māori health equity; both rights and needs based, will continue across all work and organisations. Service Design Principles were created in 2019, to underpin development of new and redevelopment of existing health services. Health equity is woven throughout these Design Principles. A focus on Māori health gain ensures we identify and respond to system failures by co-designing equity focused solutions.

- **Options**

  Māori have a right to be able to access hauora services; services that align to Māori views of health and wellbeing. Where, how and by whom healthcare services are provided plays a major role on the quality and value of that service to Māori. A concentrated and deliberate effort is needed to establish, invest in, and support kaupapa Māori services and service providers.

- **Active Protection**

  As promised in Te Tiriti o Waitangi, protection of taonga; Māori culture, traditions and language. Throughout the health sector we all have a responsibility to protect, encourage and use Māori knowledge, Māori experts and tikanga Māori (Māori customs). This will enhance the care we provide and the services we fund.

  Māori leaders in the health the sector are our taonga and will be supported and developed. Non-Māori will be supported to strengthen the important role they play in active protection.

The Northern Region acknowledges the Te Rōpū Whakakaupapa Urutā[2] insight that the COVID-19 pandemic presents an opportunity to reset the Health system to achieve a better future for Māori through developing and implementing deliberate and determined pro-equity approaches:

"Inequity is part of our past and current health system. Māori have a right to, and need for a different future. Achieving a better future will require systemic transformation of the health system, grounded in different values, a different worldview, a different mix of people at the table, different power dynamics and different thinking. It will require a health system that it is held accountable for meeting its Treaty of Waitangi obligations."

We reaffirm our commitment to the goal of achieving full health equity for Māori, and pursuing this together through our strategy and our regional work programme in 2020-21.

[2] The national Māori Pandemic Group

The Long Term Strategic Planning Framework

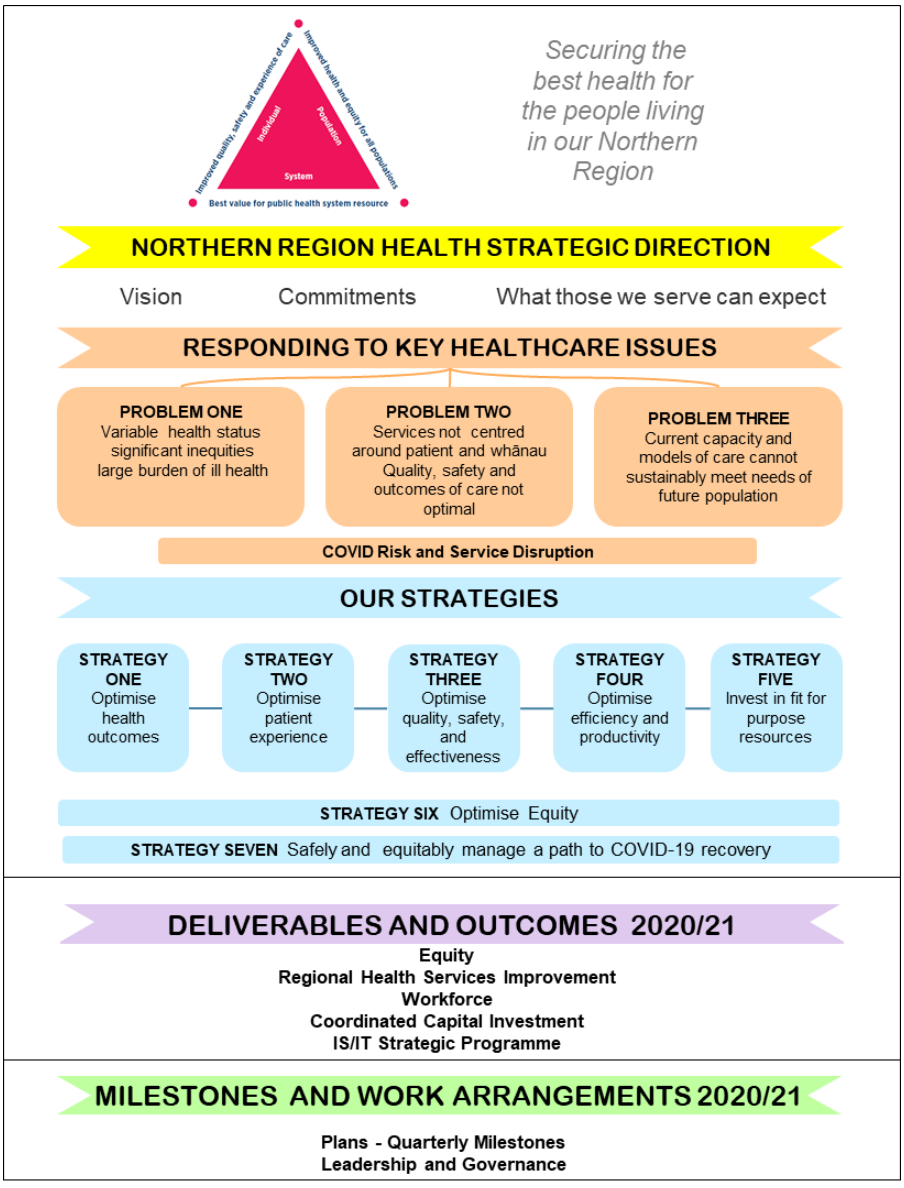
Our strategic direction and long term intent remains as set out in the Northern Region Long Term Investment Plan (NRLTIP) as we move into year 3 of implementation. The key priorities for regional action are informed by the NRLTIP, together with:

- The findings of subsequent regional 'deep dive' work as tested for alignment with the NZ Health and Disability Review
- Recent learning from COVID-19 pandemic service reforms.

The Northern Region long term strategy, together with the Ministry of Health's priorities, continues to be the foundation for our Region's work plans framing the regional work 'line of sight', and intervention logic.

The Northern Region Long Term Strategic Planning Framework (as outlined in Figure 1, below) drives our intervention thinking.

Figure 1: The Northern Region Long Term Strategic Planning Framework



Our regional long term strategic planning framework considers national, regional and local context and environments. Our strategic direction aligns with regional and national strategic direction statements; these include:

- The New Zealand healthcare triple aim
- The Northern Region Long Term Investment Plan, 2018
- Other contextual plans, such as: the NZ Disability Strategy, DHB Strategic and Annual plans, Māori Health plans, and the Healthy Ageing Strategy
- The National Regional Service Planning Guidance 2020/21.

Northern Region Strategic Direction

Our vision outlines a prevention-oriented, integrated and collaborative health network, delivering responsive care without boundaries, providing care in the best settings, by multidisciplinary teams connected by technology. We emphasise patients & whānau as expert decision makers, supported and respected as partners in care, having the information they need to achieve their health & wellbeing goals and ability to communicate with care teams.

Figure 2: Northern Region Vision

One Vision for the Future

- Our vision for care flows from **Te Tiriti O Waitangi**, honouring the beliefs, values and aspirations of Māori patients and whānau, staff and communities alongside Non-Māori. Universal and targeted services throughout the Region will be developed and operated in ways that give expression to The Treaty articles:
    - **Partnership –** all partners will work together and act in accordance with mutual good faith, trust and reasonableness.
    - **Equity –** guarantee of fairness and freedom from discrimination whether conscious or unconscious. As we advance Māori wellbeing we are commited to innovation and change to achieve Māori equity. This wil involve dismantling systems and practices that have maintained or hidden health inequities between Māori and non Māori .
    - **Options –** As Tiriti o Waitangi partners, Māori have the right to choose their social and cultural path to wellbeing. We will protect the rights of Māori to choose health and wellbeing services that value and nurtuer their beliefs, knowledge and strengths.
    - **Active Protection –** requiring full participation in decision-making processes and judgments as to what is reasonable in the circumstances. This relates to Māori interest as part of the promises made in Te Tiriti o Waitangi where there is a commitment that all Māori culture, traditions and taonga will be protected
- We will deliver care through a prevention-oriented, integrated collaborative network with home, primary, community, and hospital settings centred on the needs of patients, whānau & communities
- We will deliver responsive care without boundaries, providing care in the most appropriate setting, by teams with the right skills & technology working across settings, services and organisations
- We will consolidate services where this can improve quality and outcomes of care, and localise services where increased access will improve equity and population health
- Patients will be supported and respected as expert decision-makers and partners in care to actively shape care plans to meet their goals, and have the information they need to monitor their daily health, achieve their goals, and communicate with their care teams.

Our vision of a whole of system approach, including enhanced integration across the community-hospital interface, is a key concept driving the changes we are planning in our Region. Our Vision is also expressed as a health system delivery ‘Commitment Statement’.

Figure 3: Northern Region Strategic Commitments

We commit to becoming a prevention-oriented integrated, collaborative regional health system.

We will plan home, community, primary, secondary and tertiary services as a single population to optimise health outcomes, efficiency, quality and equity.

We will engage people, whānau and families in their health and wellbeing,

extending & balancing service choices across settings, locations & times.

We will jointly invest in our people, our processes, our technology, and our facilities, for the maximum health and equity gain for the populations we serve,

to fix today's issues, future-proof for our fast growing population,

and accelerate changes in how we deliver care.

To ensure our partners, consumers, communities and our staff fully understand the implications of our Vision for the Future, we have detailed what those we serve can expect from Northern Region Health Services. Figure 4 provides this, patient-centred, articulation of our service design principles.

Figure 4: "What can I expect from future health services in the Northern Region?"

What Can I Expect from Future Health Services in the Northern Region?

I can expect to live for longer, and spend more of that time in good health, regardless of where in the Region I live, my ethnicity or my economic situation.

I can expect the health system to do more to help me maintain and improve my health, to be proactive and to intervene early and promptly when I develop problems with my health.

I can expect to have choices in the care that I receive and the services I use, with all services responsive to me, personalising care to my goals, my preferences, my culture, and my values.

I can expect to be treated as a whole person, my physical, mental, spiritual, and social needs considered in my care, and to access my information easily.

I can expect no decision about me without me, and for my choice for whānau to be meaningfully involved in my care to be embraced.

I can expect to be treated by skilled, motivated, caring, team oriented professionals; reflective of our diverse community, collaborating across disciplines and across the services I need.

I can expect joined-up services and continuity from the team involved in my care, and no longer need to repeat my details as I progress through treatment, with my time treated as valuable.

I can expect to travel less for the care I often need, accessing care both face to face and through technology at times that are convenient for me.

Because most of my care is more convenient, I am willing to travel to regional centres that have the best expertise in less common problems, to get the best health outcomes.

I can expect that services are able to provide evidence-based cost effective treatment effectively and efficiently, and in fit-for-purpose accessible facilities conducive to good care.

I can expect consistently high quality care wherever I am treated in the Region.

I can expect a non-disabling health system that strives for no needless death, no needless disease, no needless suffering or pain, no needless helplessness, no needless delay, & no needless waste.

Responding to Health Care Issues

Three Significant 'Long Term' Challenges

The NRLTIP three strategic problem statements continue to be the most significant long term issues that we face, and need to address, across our Region:

1. Inequity, variable health status and a large burden of preventable ill health
2. Services not centred around patients and whānau, and sub-optimal quality, safety & outcomes
3. Needs of a rapidly growing, aging population cannot be met in a clinically or financially sustainable way, within current capacity and models of care.

In the coming year our service planning places greater emphasis upon regional working to address the first of these problem statements. Equity is the key issue we need to address in our Region. We will still need to transform at scale and expand at pace. This remains critical to avoid our services becoming overwhelmed, and for us to address inequity in health outcomes in our Region. We need a balanced portfolio of regional work to address the issues we face.

One New, But Highly Significant, Short to Medium Term Challenge

The recent COVID-19 pandemic has raised on-going issues relating to risk:

- Of new outbreaks of COVID-19
- That the health of our population and our quality of care be diminished due to disruption of normal service operations
- That we fail to harness increased innovation to equitably address the changes that COVID-19 makes to health needs.

Our Strategies

Seven Northern Region Strategic Responses

We reaffirm our NRLTIP six long term strategic responses and add a seventh, to equitably manage a safe path to COVID-19 recovery.

The Northern Region 'whole of health system' response to COVID-19 has enabled rapid change and evolution in models of care across tier 1 and tier 2 services. Northern Region work practices, trialled during the COVID-19 response period, have created an imperative to focus on faster, shorter, lifecycle projects and initiatives that will address equity and deliver change.

<table>
<tr><th colspan="5">Six Priority Long Term Strategic Responses</th><th>One, Immediate, COVID-19 Recovery Strategy</th></tr>
<tr><td>1. Optimise health outcomes
Prevent, Intervene Early, Planned Proactive Care, targeted to need</td><td>2. Optimise patient experience</td><td>3. Optimise quality, safety, & effectiveness</td><td>4. Optimise efficiency & productivity</td><td>5. Invest in fit for purpose resources
Workforce, Facilities, Clinical Equipment, Information Technology</td><td>7. Safely manage a path to COVID-19 recovery</td></tr>
<tr><td colspan="6">6. Optimise equity in outcomes, experience, quality, productivity and required infrastructure</td></tr>
</table>

New Care Models Delivered Through Balanced investment

Our Long Term Strategy will deliver new care models though balanced investment in facilities, technology and community capacity. The investment strategy in the NRLTIP is described under three themes:

Accelerate
'Accelerating model of care change programmes to maximise health outcomes' The Accelerate theme encompasses any model of care change programmes in the Region. These investments will change how we deliver care to maximise health outcomes for our current and future populations. These investments directly involve model of care change, or are necessary to support new models of care.
Future Proof
'Future proofing our capacity for expected demand' The Future Proof theme captures those investments intended to right size regional capacity to ensure fit for future purpose services against expected demand. These investments will ensure the Region is able to sustainably deliver the optimal health outcomes for our population by developing sufficient capacity to meet expected demand.
Fix
'Fixing our current facilities and existing assets to make them more fit for modern purpose' 'Fix' investments are those which are intended to address our backlog maintenance burden, either through remediation or the replacement of assets and infrastructure. As a result of the size of our maintenance burden, this is the largest of our investment themes in terms of current planned expenditure.

Our 'Accelerate' Strategic Interventions address our major challenges

Problem statement one: Health status is variable and there are significant inequities for some population groups and geographic areas as well as a large burden of ill health across the Region.

As a region to deliver our LTIP strategy we will:

- Invest in co-designed population health interventions, particularly those which address known modifiable risk factors, including smoking, obesity and hazardous use of alcohol, which have a disproportionate impact on the health of Māori and Pacific populations
- Invest in patient activation for self-care - empowering our patients and whānau with the knowledge, skills and confidence to manage their own health and healthcare
- Shift towards 'proactive care', supported by extensive use of digital technology including predictive analytics to power early intervention
- Work with inter-sectoral partners to address social determinants of health, both at the level of whānau/families and at the system level (e.g. influencing social and economic policies).

Problem statement two: Health services are not sufficiently centred around the patient and their whānau, and in certain areas the quality, safety and outcomes of care are not optimal.

As a region to deliver our LTIP strategy we will:

- Co-design services with those groups most affected to ensure changes in care provision meet their unique health and cultural needs
- Increase communication, collaboration and coordination across the health system to ensure all services connect with each other, and work across boundaries and borders
- Standardise care pathways to reduce unwarranted variability in care to ensure quality and adherence to best practice across the Region, accrediting providers against standards for the full pathway
- Develop an integrated care system led by primary care clinicians that focuses on proactively preventing and managing the impact of long term conditions, providing comprehensive and continuous health and social care.

Problem statement three: The needs of a rapidly growing, ageing and changing population cannot be met in a clinically or financially sustainable way with our current capacity and models of care.

As a region to deliver our LTIP strategy we will:

- Balance care across all settings by investing in: cost-effective public health interventions; primary and community based services; different types of hospital based services; and increased productivity across the whole system, increasing the range of services provided outside of our acute hospitals to mitigate the demand placed on acute facilities
- Increase our investment in intermediate care settings, particularly for our older patients, with options for enhanced care in community and home-based settings that equip our health practitioners with the skills and technology to be mobile and connected with specialist expertise when necessary
- Extend service delivery across all settings, locations and times which will allow us to maximise outcomes, access to care and make better use of expensive clinical equipment
- Invest in digital technologies that offer significant opportunities to improve the quality, efficiency and productivity of all health services
- Develop a more agile and flexible workforce, with the capability and diversity to deliver more integrated healthcare, prevention, self-care and to deliver care closer to the patient's home.

Our plans provide clarity about future models and the role of our hospitals

We will accelerate the pace at which we introduce new models of care across the Region. Model of care changes will include:

- **Investing in population health and targeted prevention efforts** to improve health outcomes and reduce inequities. To do this we will: work with our high need communities; target known major causes of health loss in the Region such as obesity; screen and intervene early to prevent sickness; and empower people and patients to take ownership of their health by improving their health literacy
- **Investing in community care** to improve experience, outcomes, equity, and to re-balance care across all settings. A network of Community hubs will provide a greater range of ambulatory, diagnostic, elective and intermediate care outside of hospital settings
- **Investing in the acceleration** of IS/IT to support both our integrated regional healthcare network and our population health approach, enabling greater access for our less well served populations & supporting all care settings to provide seamless care pathways
- **Strengthening our workforce** with the capacity and skills required to deliver on our strategy. We will develop and expand our clinical and non-clinical workforce as well as the necessary capabilities to make them flexible, mobile and capable of working at the top of their scope
- **Investing in hospital delivery** to support the shift towards a DHB supported integrated care network. We will:
    - identify what services should be centralised and what services can be localised to improve the quality, safety and outcomes of care
    - shift certain services out of hospitals to alleviate short term demand pressures
    - Improve the flow of older patients through acute care to improve outcomes while also alleviating pressure on our hospitals
- **Implementing** each of our deep dive reviews to optimally configure services or maintain our assets to meet future demand. We will take forward recommendations for Elective Care, Cancer, Frailty, Laboratory services, Mental Health, Radiology, Primary and Community Services, Public and Population Health and Workforce.

Our agreed plans for the next 20 years provide for differentiated roles for hospital sites:

- **Short Stay Surgery** – Greenlane Clinical Centre and Waitakere will focus on day stay activity. The Elective Surgery Centre and Manukau Surgical Centre will focus on minor and intermediate short stay surgery predominantly of less than 3 days' stay

- **Procedure Specific Units** – We will develop sub regional centres across the Elective Surgical Centre, the Manukau Surgical Clinic and Green Lane, to deliver hip, knee, ophthalmology and dental surgery with a 'centre of excellence' model
- **Complex Surgery** – North Shore Hospital and Middlemore Hospital will deliver intermediate and complex surgery to their local population. Middlemore Hospital will continue to be the regional provider of burns, plastics and spinal services. Whangarei Hospital will deliver a range of minor intermediate and complex surgery to its local population, partnering with the Metro DHBs to deliver specialist care, and with Northland's community hospitals to deliver care to its geographically dispersed population.
- **Tertiary and Quaternary Services** – Auckland City Hospital will increasingly focus its elective service delivery on tertiary and quaternary services with some elective services for its local catchment delivered from other sites. The region will retain Starship as a level 6 paediatric hospital with a supra-regional and national role, and KidzFirst as a level 5 service.

Our long term investment priorities inform our regional work programme

Our investment requirements focus on meeting a moderated medium growth projection.

1. **Capital Investment in our facilities**

- Expanding hospital capacity to meet short, medium and long term demand
- Remediating, reconfiguring and rebuilding our current facilities to better meet the needs of our population, including the Whangarei Hospital site development
- Reorganising clinical services to reflect the differentiated roles of our sites and clinical service networks
    - Expansion to meet the needs of West Auckland, and to decongest North Shore
    - Decongestion of Auckland City Hospital to enable a focus upon complex care
    - Decongestion of Middlemore site enabling a focus upon acute activity and development of the Manukau site to accommodate planned care
- Planning for a new site south of metro Auckland within 10 years, and the option of a new northern metro site in 15-20 years.

2. **Parallel investment in accelerating model of care changes to compliment facilities investment**

- To increase our capability to analyse, target, and improve population health interventions and proactive care
- To strengthen operational expenditure in population health preventative, interventions, primary and community care, and a wider range of services available in community hubs, expanding current sites and developing new sites & services in areas of high need
- Investing in our workforce capacity and capability, and in modernising our IS/IT systems as the backbone of our new networked care models.

As a result of this balanced approach to investment by 2036/37 we will reduce the growth in acute bed capacity requirements for the period to 2036/37 by around 22%, reducing growth to 1,600 additional beds above the 2016/17 baseline. This approach is modelled to release $800m in projected annual opex cost growth to fund alternative non-hospital based service delivery and our new models of care.

Northern Region Service Plan

Part Two - Implementation Plans for 2020/21

[This page intentionally left blank]

Overview of Our Plan for 2020/21

This section of our Regional Service Plan details:

- The elements of work that are being progressed, via a region wide approach, to help address our Region's strategic priorities
- The particular **deliverables and outcomes** that each element of this work-plan expects to achieve in the 2020/21 year
- A collated view of the regional work-plan **key quarterly milestones** set out in appendix one, to enable oversight and monitoring of progress, and achievements during the 2020/21 year.

Five Programmes of Regional Work

During 2020/21 our Region will focus effort and resource upon five programmes of regional work. The five programmes cover the health service areas that most require regional attention to address our strategic issues. Some of the work areas are new this year, others are continuation of work areas already underway, or paused, during COVID-19. The five programme work areas are:

1. Improve Equity
2. Improve Public & Population Health and Primary & Community Care
3. Health Service Improvements and Model of Care Change
4. Improve Diagnostic Service Delivery
5. "Enabling Services", Aligned to Service Developments and Supporting Change.

Our first programme includes the key priority of developing resilient regional configuration and models of care for vulnerable services. This forms a key part of an equity led recovery of our services, whilst tackling both recent and longstanding issues. If services are not resilient, then consistent outcomes of care will not be achieved reliably, leading to inequity. The eight services prioritised for reform during 2020/21 provide early opportunities for the region to model our new leadership behaviours and approach.

This Implementation Plan 2020/21 also reflects a full commitment to service areas that the MoH Guidance identifies as being common priorities for all four NZ regions during the coming year[3]:

Programme One – Improve Equity

Achieving Health Equity for Māori

Strategic overview

Achieving health equity for Māori is a key Crown commitment under the Te Tiriti o Waitangi and the foremost priority for our Region. An enhanced regional programme and leadership will be established in 2020/21. The intent is to set foundational activities to better understand, quantify and track inequities across the Northern Region.

Summary of regional programmes and activities for 2020/21

Our Region will progress both equity specific and cross-cutting equity actions within other programmes. Emerging themes, arising from Māori Equity leads, for activities in 2020/21 include:

- (Re)establishing a Regional Māori Health Leadership group
- Developing a Māori Health Plan and agreeing key priorities for the Northern Region
- Developing a Regional Māori Health Equity Dashboard to better quantify and prioritise key equity gaps and track progress over time
- Completing a rapid collation of equity learnings from the COVID-19 response and continuing those that are sustainable.

[3] MoH Guidance identifies as priorities for 2020/21:

- Building on the strong **data and digital Regional ICT** Investment portfolio.
- Setting out five regional actions to support DHB local **Workforce** initiatives
- Progressing the specified **National Hep C Programme** requirements consistent with the National Hep C Action Plan.
- Delivering on the detailed **cardiac and stroke** priorities for regional work
- Outlining actions and timeframes to implement the **NZ Framework for Dementia Care.**

We also set out Māori Health equity actions within our other regional programme plans, as detailed in this Regional Service Plan, including:

- A strong equity approach applied to post-COVID planned care recovery actions
- Targeted equity initiatives within our clinical network priorities e.g.
    - Cancer equity initiatives focussed on lung cancer for Māori
    - Cardiac
    - Targeted equity work in Mental Health, particularly reductions in tobacco use in inpatient facilities, equity recommendations in the AOD model of care and work on youth forensics
- Workforce strategies to monitor and support initiatives to increase Māori participation across occupational groups in the Northern Region.

Achieving Health Equity for Pacific Peoples

Strategic overview

Pacific peoples as a collective group are one of the fastest growing, most diverse and most youthful populations in Aotearoa New Zealand and make up 12% of the Northern Region and nearly a quarter of the Counties Manukau district (LTIP, 2018). Two-thirds of Aotearoa New Zealand's Pacific population (230,000) live in the Auckland region. Pacific peoples represent 16 distinct ethnic groups, languages and cultures and contribute significantly to cultural, social and economic life New Zealand. Despite this, Pacific peoples continue to experience poor socio-economic well-being and poor health outcomes. The impact of these disparities is evident across all ages and important health measures. There is a seven to eight-year gap in life expectancy between Pacific and non-Māori/non-Pacific ethnicities. A new work programme will be established in 2020/21 to give stronger effect to Pacific health equity, building on and aligning with Ola Manuia, the National Pacific Health and Wellbeing Strategy 2020-25.

Summary of regional programmes and activities for 2020/21

The key activities for 2020/21 will be decided and guided by a reviewed and re-established Regional Pacific Health Equity Working Group. This group will provide mandate to and support for projects and activities that accelerate Pacific peoples' health equity across Metro-Auckland. This will include a focused list of activities that benefit from a collaborative approach, including those that are funded regionally. Regional priorities for 2020/21 include:

- Review and re-establish the Regional Pacific Health Equity working group and the Pacific health pipeline of initiatives to focus on areas of regional collaboration for Pacific health
- Improve equity of access for Pacific people in key planned care pathways, particularly regionally vulnerable services and those significantly impacted by COVID-19
- Build enhanced analytics and insight into decision making by developing a Pacific insight framework and population health data
- Support ARPHS to establish a Pacific case and contact management response model, which will provide a framework for future investigation and management of notifiable communicable diseases.

Equity Led Planned Care Recovery

The Northern Region has a focus on 6 areas of work as part of the 'equity led planned care recovery' work plan:

1. **Māori Health Response**
    - Establish Māori Clinical Governance
    - Clinical prioritisation in elective care to address inequity in timely access as services recover
    - Navigator support for Māori whānau to improve the co-ordination and timeliness of service provision across planned care services, and ensure our health system adapts to Māori needs and preferences to improve access, experience and outcomes
    - Expansion of Māori mobile care units and wraparound community health services
    - Establish data to support equity gap identification & priorities including mental health.

2. **Pacific Health Response**
    - Establish Pacific clinical technical advisory group
    - Expand navigator support for Pacific whānau to improve the co-ordination and timeliness of service provision across planned care services and ensure our health system adapts to Pacific whānau needs and preferences to improve access, experience and outcomes
    - Expansion of Pacific mobile care units and wrap-around community health services
    - Establish data to support equity gap identification & priorities including mental health.

3. **Resilient Regional Configuration and Models of Care for Vulnerable Services**
    - Implement a six step rapid solution design methodology for priority services to deliver equity through resilient 52-week service arrangements, with named executive leadership and dedicated project and commissioning support
    - Implement the approach within phase one services:
        - ORL Services arrangements including Adult, Paediatric & Head & Neck
        - Improved integration and wait times for Oral Health Services
        - Implementing regional Ophthalmology Strategy with integrated services
        - Resilient regional arrangements for Vascular Services
        - Agreed service leadership and configuration of Sarcoma Care
    - Implement the approach within phase two services
        - Commission and regionally agree funding arrangements for new Non-Surgical Orthopaedic pathways
        - Maxillo-facial Surgery services
        - Regional Spinal Pathways and services.

4. **Primary Care Response**
    - Expand & evaluate Access to Diagnostics for 6 months in co-ordination with tier 2 diagnostics recovery plans
    - Extend and align the use of POAC to improve the primary care health system response
    - Progress expanded coverage of Healthcare Home principles to enable new ways of working in primary care
    - Put in place communications resources about patient and whānau benefits to sustain virtual assessment approach and ensure effective proposals to use tele-health funds
    - Review Māori and Pacifica experience of alternative (virtual) models of delivery.

5. **Mental Health Response**
    - Evaluate new pathways & ways of working including hospital at home
    - Extend and enhance provider responses that work well & enhance equity.

6. **Systematic Planned Care Recovery**
    - Establish regional analysis, monitoring and decision support of waiting lists, outpatient diagnostic and elective treatment to support regional improvement initiatives
    - Stocktake, and Impact assess, the regional capacity and demand and cost impact of harmonising regional clinical thresholds across all specialties, informing change plans
    - Establish and enhance regional networks to support collaboration for diagnostics and treatment including radiology, endoscopy and surgery
    - Put in place a collaborative approach to sourcing and managing private sector capacity utilisation & cost, including long term arrangements for wet-lease and DHB SMO models.

We will incorporate the learning from new ways of working together to deliver this programme with appropriate ongoing regional and local governance arrangements.

Programme Two - Improve Public & Population Health, Primary & Community Care

Prior to COVID-19, regional work was underway to review benefits that might be achieved in the areas of:

1. **Public and Population Health.** To recommend actions that the Region needs to take to achieve gains. Recommendations are now expected to be structured around three themes:
   - Strengthening the Infrastructure to Deliver Core Public Health Functions - doing the basics well and ensuring that core functions (particularly those provided by public health units) are robust and sustainable
   - Developing / strengthening a Public Health / Prevention System – reorienting the system to a focus on prevention and determinants of health
   - Investing in Priority Areas that will deliver shorter term gains (3-5 years) in equity and health outcome. Potential areas of focus in this area include: Obesity; Alcohol; Tobacco; Early years; and Mental health promotion.

2. **Primary and Community Care**. To describe a broad strategic direction, and to identify the areas of system redesign that are required to achieve that strategic direction. Regional work was undertaken to address three significant Primary and Community Care challenges, to:
   - Improve outcomes and reduce inequities
   - Meet changing patient expectations and rising demand
   - Deliver a modern, high performing and sustainable service

   A high level action plan has been developed with draft recommendations intended to help focus attention upon the changes that we need to make in our delivery systems

The draft findings are already established for each of the above two areas of work. In 2020/21 we will:

- Reconcile and align the strategic planning and design work with the findings of the Ministers' Review of the New Zealand Health and Disability Sector
- In the case of the Public and Population Health work, we will incorporate the findings of a regional Māori Health Review of the conclusions
- Agree the findings of the completed review and establish an action plan for year 1 priorities at regional, DHB and locality levels
- Identify the investment path required to 'bend the curve' of demand on hospital based services.

These actions are expected to be completed in Quarter One, with action to identify and quantify the multi-year investment path required to 'bend the curve' of demand on hospital based services to inform DHB financial and funding strategies by Quarter Two.

Addressing the Obesogenic Environment and Tackling Alcohol related Harm

This year marks the first year of a shared investment by all four region's DHBs in developing public health advocacy to achieve greater influence on the structural and commercial determinants of health for our populations. Through collaboration with public health networks, the health promotion agency and national leaders, priorities to be finalised are expected to include plans to:

- Adopting best practice in DHB health food policy and practice
- Review and enhance Alcohol position statements and harm minimisation plans to reflect best practice
- Adopt and ensure consistent measurement and implementation of key alcohol programmes, informed by the World Health Organisation SAFER framework
- Advocate to improve the opportunities for place-based strategies to address the inequity faced by Māori, Pacific, and high deprivation communities.

Programme Three - Health Service Improvements and Model of Care Change

This programme of work comprises clinical networks focussed upon implementing service improvements with regards to:

- Populations of interest (Child, and Frail or Older person)
- Health services for people managing long-term conditions (Cancer, Mental health and addictions, cardio-vascular, Stroke)
- Two areas of regional and national focus (Major trauma and Hepatitis C).

We summarise, below, the deliverables and outcomes that we have set as our targets, to be attained during 2020/21, against each of these listed focus areas.

Child Health

We place emphasis upon three areas of work:

- Child Development Services – Transform and Expand Plan.

  Progress the second of a four year programme of service quality improvement to establish: consistent entry and exit criteria; service provision that both matches need and redresses the equity gaps; strengthening the regional workforce to address the corresponding step-up in capacity; and, through innovation projects, develop care pathways with whānau supporting coordinated care

- Chronic Cough management for Bronchiectasis prevention

  Progress the development of Koira4Rukahukahu / Lungs4Life model of care using an evidence-based approach to: identify young children with severe early pneumonia or chronic cough, and proactively engage their whānau in follow-up to manage and prevent progression into chronic lung infection and damage (bronchiectasis). The work will complete a model of care, with relevant analysis, to enable a regional business proposition to prevent this disease, which has an excess occurrence in Māori and Pacific children

- Optimising Child Health through the COVID19 era. The region will implement
  - A regional child health dashboard which supports monitoring and addressing of equity gaps
  - The National Child Health Information Platform (NCHIP) for ADHB, WDHB and NDHB.

Frailty and Healthy Aging

- Reach regional agreement upon a consistent ‘frail patient’ assessment process at the hospital front door and:
  - Commence implementation of the agreed process
  - Agree flows and pathways to fast track frail patients through the hospital system
- Identify and agree opportunities to develop and improve community based services
- Know the risks and have agreed mitigation plans for any further COVID-19 outbreaks in ARC
- Develop strategies to address the inequity for Māori that flow as a consequence of ARC subsidy for aged care being centred on residential settings
- Commence development of an outcome framework (start with one area of regional work)
- Support the Northern Region DHBs to implement the regional priorities identified by the Dementia Framework Stocktake
- Collate a schedule view of significant Frail Elderly related process improvement project work being progressed by services in our Region.

Cancer Services

- Progress implementation of interventions to improve equity of access and outcomes for Lung Cancer for Māori and Uterine Cancer for Pacific Women
- Continue to support and develop the head and neck tumour stream priority initiatives
- Initiate local delivery of medical oncology:
    - Complete implementation for end-to-end breast tumour stream provision; and then
    - Agree a plan and progress implementation for expansion of local delivery of medical oncology to other tumour streams
- Bowel screening and colonoscopy wait time recovery
    - Support regional review of endoscopy services and the role of FIT testing in symptomatic patients in conjunction with the national pilot programme, and surveillance guideline changes
- Progress technology related improvements
    - Complete business case and procurement for Regional Oncology Electronic System (ROES)
    - Pilot of a MDM solution for Gynae-Oncology
- Develop a collaborative regional plan for 2021/22 with the Cancer Control Agency to address national requirements from the New Zealand Cancer Action Plan and regional priorities identified through the Northern Region Integrated Cancer Service Board to deliver the LTIP Cancer recommendations.

Mental Health & Addiction

- Develop services that best meet the needs of people who are high users of inpatient services with the aim of improving the quality of life for these service users in community settings, and reducing high occupancy levels in the inpatient units
- Progress priorities in relation to AOD model of care changes. Complete the framework for the delivery of AOD services in the Region with a specific focus on services for Māori, Pacific, Youth and the women in their maternal/ perinatal period
- Review models of care of specialist services to enhance access and choice for people with a focus on equity and a particular focus on Māori Youth and Pacific Maternal Mental Health and Addiction.
- Identify the learnings from service delivery during the Covid-19 pandemic, with focus on telehealth, that should be embedded into practice to enhance service delivery from both a staff and service – users; and develop an implementation plan to progress.

Cardiovascular Services

- Develop plans to promote equity of cardiac outcomes across ethnicities and geographical areas in the Region. This to include focusing on areas such as CVDRA, Heart Failure, access to investigations and therapy
- Deliver improvements against our key health targets and measures, (including intervention rates, medication adherence reports, and waiting list management targets / CVD risk management) in the areas of: Cardiology; Cardiothoracic; Cardiac surgery; and access to Echo
- Agree a regional work plan to address workforce constraints including growing our most vulnerable cardiac workforces, (echo sonographers and physiologists) & workforce required to reduce Echo wait time to a 6-week maximum
- Progress areas such as TAVR and EP to best support the Region.

Stroke

- Raise awareness of stroke.

  This will include engaging with the launch of the 3-year national FAST campaign (deferred due to COVID-19 but now expected to launch in Q2 of 2020/21). Two areas in the Northern Region – Northland and South Auckland – have been nationally designated as ‘priority regions’ for targeted approaches to reach Māori and Pacific people aged between 40-65 years

- Implement the regional stroke rehabilitation priorities from the national stroke rehabilitation strategy.

  This work will focus on improvements to care transitions, psychological support for patients and their whānau, and access to community based rehabilitation and transition programmes.

Major Trauma Services

- Increase the number of Māori/ Pacific Island representatives onto the Network
- Undertake a regional clinical audit review of potentially preventable deaths of trauma patients who die within the Region (Royal Australasian College of Surgeons (RACS) review of NZ Trauma system 2017 recommendation)
- Achieve regional agreement upon a pathway for moderate brain injury that is locally implemented, and measures to enable monitoring of outcomes for moderate brain injuries
- Identify and implement major trauma education strategies for inpatient ward trauma nurses which is taken up by a minimum of eight nurses in the Region
- Work, together with the National Trauma Network, to:
    - Scope their research project to identify patient outcome measures for long-term trauma outcomes aligned to wider regional PROMs approach
    - Identify a nationally agreed trauma rehabilitation pathway
- Achieve regional agreement upon rehabilitation standards of care so that patients with major trauma are screened for PTSD and patients with bilateral non weight bearing injuries are referred to a rehabilitation consultant or service
- Promote a discharge plan in the community for complex pain management
- Conduct a snap audit to regionally review awareness and adherence to Destination Guidelines (following one year of implementation) and identify potential changes.

Hepatitis C

Deliver services across the Northern Region, in accordance with the MoH service contract:

- Provide targeted testing of patients most at risk for HCV exposure
- Raise Patient and General Practice/ Community team awareness and provide education about HCV
- Enhance the delivery of an integrated hepatitis C service through community based HCV testing and providing community-based on-going education and support for risk reduction (Needle exchange services, Community Alcohol and Drug Services, primary care and social service agencies)
- Improve access to treatment through collaborative work between primary and secondary care
- Utilise laboratory data to identify people who have been diagnosed with possible and active HCV infection who could benefit from treatment but have been lost to follow up
- Encourage the use of Hepatitis C Champions within PHOs and general practice teams
- Better understand the cascade of care across demographic measures to ensure equity of access to diagnosis and management / treatment.

Programme Four - Improved Diagnostic Service Delivery

Laboratory

- Implement the communications and change strategy
- Improve Informatics and Modeling – including a regional business information tool
- Service review and support for 1-2 key services, including completion and implementation of the immunopathology project
- Prioritise LIS upgrades
- Implement a regionally agreed process for POCT in priority equity areas
- Initiate project to deliver one quality framework across network of labs
- Deliver workforce projects based on the 2019/20 recommendations.

Radiology Services

- Complete a rapid piece of regional work to identify any opportunities and initiatives that would help deliver a sustainable radiology waitlist improvement
- Deliver radiology asset management planning, identifying future capacity steps to align with long term demand expectations
- Undertake workforce planning outlining sourcing / retention initiatives.

Programme Five – 'Enablers of Health System Transformation and New Care models'

Workforce

The Northern Region aims to grow and develop a sustainable workforce that meets the health care needs of our population, plus those others, that we also serve, from outside of our Region. This means a workforce that is: agile; technology enabled and engaged in life-long learning; represents our diverse communities; partners with patients and whānau; and uses prevention, early intervention and health literacy approaches.

To achieve this, we need our workforce to be engaged, healthy and resilient, and prepared to work differently; culturally, behaviourally and professionally, enabling them to work closer to the top of their professional scopes and to engage in skill sharing and skill delegation.

The Northern Region Workforce Strategy, as endorsed by the Region in July 2019[4] outlines seven key areas of focus to address both our immediate and long term health workforce development challenges:

1. Develop a workforce founded on and that reflects the aspirations of our Treaty of Waitangi partnership
2. Improve pacific health outcomes by growing the Pacific workforce and ensuring cultural safety training for all staff
3. Address immediate workforce needs
4. Deliver sustainable workforces in support of the Northern Region Long Term Health Plan (NRLTHP)
5. Support new ways of working (model of care, skill mix)
6. Address unfairness and disparity in employment, pay and progression
7. Strengthen workforce reporting, planning and development at all levels of the system.

In 2020/21 we will continue to implement strategies that give effect to these key areas and that respond to the new supply and demand challenges as a result of COVID-19. These initiatives are:

- Monitor and support initiatives to increase Māori and Pacific participation across occupational groups, in particular securing funding for a Māori health gain approach to health management and leadership development.
- Work to grow and develop the participation and leadership of people with disabilities within our regional health workforce and design for accessibility and inclusion in our employment practices
- Deliver reviews into eight selected allied health, scientific and technical workforces and implement regional recommendations arising from these
- Establish a regional approach to assess and improve digital and technology readiness in clinical, non-clinical and support workforces
- Set up workforce development based alliances with health education providers, to influence quality of training and readiness of future workforces, in particular optimising student clinical placements, and progress workforce 'red flag' issues for the Region such as anaesthetic technicians and cardiac workforces
- Strengthen regional workforce planning to enable delivery of the Northern Region long term health plan in particular, providing future workforce planning aligned to new theatres build, and in the shorter term plan for, and act to, secure and prepare our workforce(s) in the post COVID-19 setting by developing a regional medical workforce(s) plan.

The Region will flex the workforce programme to accommodate emerging national workforce priorities and to support and participate in the national fora initiatives.

[4] Health Workforce Deep Dive, Strategy Paper #1, Enabling our workforce, 24 July 2019

Data and Digital

The Northern Region Information Systems Strategic Plan (ISSP) and Regional Roadmap provide the direction for the Regional ICT Investment Portfolio[5]. The ISSP is a key enabler of the long-term regional health strategy and has significant regional commitment, particularly with reference to:

- Enabling delivery of an 'integrated regional health system'
- The 'bend the curve' initiatives, as required to reduce demand for additional acute beds.

The ISSP outlines four Investment Portfolios. These are:

1. Strengthen and modernise our **ICT Foundations**
2. Become experts at **Interoperability and Data-sharing**
3. **Simplify and harmonise** our complex layers of applications
4. Work effectively together as a **capable region.**

Delivering Change in a Context of Increasing ICT Risk

The healthAlliance shared service is our primary delivery agent for all DHB ICT initiatives. Funding is the primary constraint that shapes our FY2020/21 implementation plan, as well as our plans for the out-years. The Region has a legacy of significant underinvestment in IS and the funding baseline is insufficient either to fully maintain the current ecosystem, or to fix it. The ISSP is predicated on an $800m capital plan over 10 years, with new Crown funding required over that time of approximately $350m.

The position and constraints the Region faces are well known, having been regularly communicated to the Ministry of Health over recent years; and reiterated in both the National Asset Management Plan report; and the NZ Health and Disability Review.

Four critical Northern Region 'Horizon One' ISSP initiatives have not received funding (comprising: TaaS; Identity and Access Management; Health Information Platform; and HARP). Of the $125m of new Crown funding support requested for Horizon One, $17.1m has been made available. The impact of this funding shortfall is that the delivery of expected benefits/outcomes will be delayed and the Northern Region's technology risk (including cybersecurity) will increase from 'very high' to 'extreme' in the FY2020/21 year.

We are now starting to plan for Horizon Two-'Transform' in line with our ISSP timeline, but it is apparent that:

- The Northern Region's 'Affordability review' recognising DHB financial constraints has meant acceptance of increased residual risk, particularly related to devices and infrastructure (a reduction of $450m of Opex/ Capex spend from the initial ISSP was achieved).
- Delays in key infrastructure initiatives, due to pausing projects for the 'Affordability Review' coupled with vendor certification issues, have increased residual risk in our environment and slowed delivery of Horizon One outcomes (Foundations).

The Region is heading into Year 3 of Horizon One- (Foundations), and also moving out of our Region's immediate COVID response with project delays, or projects at risk, across each of the horizons of our ISSP implementation plan, as shown in the table below.

Portfolio	On Track	Delayed/ At risk
1. Strengthen our ICT Foundations	• IaaS Service Establishment • Workspace	• IaaS delivery • Cyber-security • Network remediation* • Identity & Access Management*
2. Become experts at Data-sharing & interoperability	• MuleSoft/ IEP • Regional Clinical Portal • Data-Sharing & Interoperability projects (standards-oriented)	• HIP* • Business Intelligence
3. Simplify/ harmonise applications	• RCCC (some delay)	• HARP*
4. Become a capable region	• New governance • 10 year IS financial plan	• Regional IS operating model

* Anticipated national funding for the ISSP, other than for RCCC, has not been made available.

[5] Version 1 of the ISSP developed in FY17/18. Version 2 & Roadmap approved at RGG and DHB board levels in FY18/19.

COVID Response

The COVID-19 pandemic created urgent demands on the Northern Region health IT service to support the health sector's response. Our response drove significant IT progress over the space of several weeks; mostly impacting in areas that were already planned in the ISSP (for example in data sharing and tele-health). Our Region's clinical IT context is vastly different from where we were prior to COVID-19. The COVID experience has changed our:

- Understanding of what we can do with existing systems and structures
- Priorities for the near-medium term.

The Northern Region's COVID-19 ICT response can be summarised as:

- Large investment in devices/ user hardware
- Acceleration of: move to cloud; Regional Clinical Portal; non-contact/ remote clinics in primary/ secondary care and supporting telehealth infrastructure and IS; data sharing initiatives; use of MS Teams (and other remote communication technologies); development and rollout of 'paperless' outpatient clinics, including outpatient e-prescribing
- Fragile IS foundations exposed – particularly cyber-security and cloud readiness
- IS governance and speed of operation gelled and improved
- Services and service models are fragmented between DHBs, and between DHBs and Tier One services
- Infrastructure funding requests prepared ('shovel ready' applications) to address funding shortfalls.

COVID related IS work is on-going, as the Northern Region now gears up to support border control requirements.

Data and Digital Objectives

The Region is committed to avoid going backwards and to lock-in and build on the gains made during COVID. We intend to make the most of the momentum in clinical and system cultural change that has commenced, and ensure improvements are embedded with robust IS/IT infrastructure and support. We have also gained new perspective to our thinking regarding:

- The need to strengthen new models of care outside the hospital/clinic previously highlighted in the Northern Region Health Services Plan (NRLTIP) as critical to reducing demand on the sector
- The importance of proactively addressing equity issues, and particularly meeting out obligations under the Treaty of Waitangi, in service design and IS enablement
- Embedding gains in delivery of remote care in primary & secondary care under extreme conditions.

Work has been completed on the initial round of 'vendor aggregation'. We have completed detailed analysis of how the various pieces of our Region's IS ecosystem can best fit together to achieve our longer term goals and align with the Health System Design Council's principles. This work:

- Informs and endorses decision-making around core applications, eg RCCC and HARP, and the way they need to work together to deliver the best outcome
- Will be a major input into the Horizon Two 'Planning and Mobilisation' phase of work, that we will undertake in the next 12 months.

Other key themes within the Horizon Two planning include:

- Accelerating and completing Foundational projects (Horizon One and FY20/21 Action plan)
- Leverage and embed gains related to:
    - Remote/ non-contact clinics
    - Shared information (standards-based)
    - Regional IS Operating model – pace and flexibility
- Equity to the fore: Māori, Pasifika, vulnerable populations
- Productivity and performance – theatres, ambulatory, ASH
- Model of care changes: Aged Residential Care, joined up Tier One, public health.

Successful delivery of the Northern Region plan has dependencies on the Ministry of Health's continued delivery of expected outcomes from these initiatives:

- Interoperability roadmap
- Certification for industry partners
- Sector data and information strategy (standards and nHIP)
- Digital Identity programme
- Digital Investment Board planning and appropriation
- Review of health sector privacy code.

Capital Programme

The long term goal of the capital programme of work is to maintain the development of, and provide delivery oversight for, the future investment path for significant health capital investments. The Capital Programme of work has a particular focus on three, regional asset related, challenges:

- Variable condition of existing assets (facilities, infrastructure and clinical equipment),
- Anticipated considerable growth in demand
- The need to develop asset capacity and capability for different care models, to improve health equity and outcomes for our population.

The Regional Capital Investment Group (RCIG) has responsibility for overseeing the capital programme of work to ensure that the planning, delivery and on-going management of our capital investments will meet the future needs of our population. The RCIG ensures our approach to capital investment planning and delivery:

- Is consistent with Northern Region long term health planning strategic direction
- Gives effect to national and regional policy
- Supports regionally consistent, good practice investment planning principles and processes, including:
    - Capital business case development (including quality assurance and regional endorsements)
    - Capital project delivery activities
    - Asset management
- Adopts a continuous quality improvement approach to capital planning and investment delivery
- Provides oversight and coordination of delivery of the investment programme at a regional level.

The capital programme objectives, to be progressed during 2020/21, are:

- **Regional Capital Investment Group (RCIG)**
    - Drive alignment of the Capital Investment Programme with stated regional service demand, capacity and capability expectations, including consideration of any changes following the Region's COVID-19 response.
- **Process Improvement and Quality Assurance working group (PIQA)**
    - Provide a 12-month plan for regional and national business case review and endorsements
    - Develop agreed business case standards, review and quality assurance approaches
    - Implement a capital programme reporting schedule to provide visibility of key programme measures (e.g. business case progress, funding access, capacity delivery, asset condition)
    - Agree a regional capital investment programme benefits framework.
- **Capital Build and Works working group (CBAW)**
    - Develop a Regional Capital Delivery Plan and a monitoring and reporting framework
    - Provide visibility of quantity surveying approaches and assumptions
    - Provide visibility of capital delivery escalation/contingency assumptions
    - Scope an approach to the capital delivery supplier market.
- **Asset Management Planning working group (AMP)**
    - Agree a Regional Asset Management Policy and Strategy
    - Agree a Regional approach to asset performance and Levels of Service.

The Northern Region will continue to engage with the Ministry of Health to advise and collaborate on Regional Capital programme initiatives where they closely align with National work streams. This will include, as a minimum, the following initiatives during 2020/21:

- Developing regionally consistent business case standards
- Asset Management Policy and Strategy
- Levels of service / asset performance measures.

Collaborative Resourcing Framework

Our NRLTIP includes a commitment to maximise resource use in the region to ensure we live within our means whilst optimising health gain for our populations. This aligns with the Health and disability system review expectation that DHBs become accountable for both outcomes and equity for local populations and for contributing to the wider health system's effectiveness. In 2020/21 we will

- Review and strengthen our rules of engagement to ensure that adverse financial impact on individual DHBs from clinical and service changes do not present a barrier to optimal solutions for patients
- Enhance our ability to track and report on the Northern Region's overall financial, service and outcome performance.

Governance, Oversight and Working Arrangements

This year, influenced by changes to regional working arrangements put in place to deal with the COVID pandemic, we will be refining our oversight arrangements for regional work. These reflect two new approaches

1. Less emphasis upon defining longer term direction of travel, regional policies and principles; those already agreed as part of the NRLTIP process remain valid; they define our regional strategy sufficiently to continue to provide a long term shared direction across our Region
2. Increased emphasis placed upon:
    - Simplified oversight and governance of regional work - enabling more frequent and rapid critique of the value-add from regional work being progressed
    - Tactical, and operational, interventions across a short to medium term time horizon; while also ensuring interventions are aligned to our Region's stated long term aims
    - Initiatives progressed as a rolling programme of shorter duration work plans. This provides, greater flexibility to respond to opportunities more rapidly and to deliver gains quickly.

Our arrangements will continue to respond to significant changes in the Iwi partnership arrangements that impact on the totality of our healthcare reform programme.

Regional working arrangements particularly help to support working across DHB boundaries and the alignment of regional work to regional goals. These supporting mechanisms include:

- Our governance arrangements, for regional service planning work and oversight, ensure the engagement of senior executive, and Board leadership from across our four DHBs:
    - Key regional plan work areas each have DHB executive leadership
    - Regional clinical networks are led by senior clinicians from our four DHBs
- Consideration of applicable national, regional and local plans and strategies ensure that planned activities are well informed and evidence based, and that each have a measurable outcomes focus
- Operations managers, planning and funding managers, hospital, primary and community clinicians; finance managers, information systems specialists and HR managers participate across our major areas of regional work and contribute to regional planning
- Potential impacts from regional service work or actions, are identified and communicated; particularly those with impact on enablers (Data & Digital, workforce development, and/or capital investment).

Appendix Two sets out, in detail, the roles of key entities, agencies and partners as they relate to our plans.

Funding Mechanisms to Deliver the Northern Region's Programmes of Work

The NRA manages the operational budget for supporting the delivery of the health service design, health service implementation, and regional capital and workforce components of the regional plan. The Northern Region DHBs fund the NRA for this regional service on a population based funding formula (PBFF) basis.

Regional delivery of Data & Digital priorities is the responsibility of Health Alliance (hA). hA is funded by DHBs based on the deprecation associated with DHB assets that have been transferred from DHBs to hA. Additional funding may be agreed from DHBs as part of the annual IS/IT planning and budgeting cycle dependent upon priorities and requirements associated with annual IS/IT development plans.

Many Northern Region entities and individuals across the continuum of care contribute resource to delivering the RSP in the form of time participating in workshops and regional meetings. It also includes development or review of deliverables. The cost of this time is met by those organisations and individuals.

The regional priorities and work plans are developed and endorsed by regional clinical networks, regional work groups, the executive sponsor, and DHB Boards. The Regional Governance Group provides oversight and the governance for this process. The work is progressed by both the NRA and hA in collaboration with DHB and other key stakeholder resources. The resource requirements are identified in parallel with the finalisation of the regional plans:

1. The NRA undertakes a budgeting process under the governance of the NRA Board.
2. HealthAlliance undertakes a budgeting process under the governance of the hA Board.

Regional activity that needs capital funding follows the guidance of the Capital Investment Committee. Funding requirements are identified as part of the DHB business case process. Capital approvals follow local DHB, regional capital committee, and national approval processes, complying with national investment approval guidelines.

Northern Region Service Plan

Appendices

[This page intentionally left blank]

Appendix One: Quarterly Milestone Action Plans

Quarterly Milestone Action Plans

	Action Points	Target Completion Date			
		Q1	Q2	Q3	Q4
Programme One: Improve Equity					
Achieving Health Equity for Māori					
1	(Re)establish a Regional Māori Health Equity Leadership Group		X		
2	Develop a regional Māori health plan including priority outcomes, target disease states and intervention logic			X	
3	Develop a regional Māori health equity dashboard to track progress against priority outcomes in 2				X
4	Complete a rapid collation of equity learnings from the COVID-19 response and their potential sustainability (e.g. navigator models). Provide recommendations on: • What to be built into business as usual • Preparedness for subsequent outbreaks/waves		X		
5	Develop a methodology to apply to service design and development, on how to embed an equity approach and with whom building on the Regional Service Design principles			X	
6	**Māori Equity Outcome Activities (EOA) elsewhere in this plan:** • Equity Led Planned Care Recovery, post COVID-19 (below) • Equity approaches to lung cancer for Māori (see Cancer section below) • Targeted equity actions in the cardiac network (see Cardiac section below) • Targeted equity work in Mental Health, particularly the planned reductions in tobacco use in inpatient facilities, equity recommendations in the AOD model of care and work on youth forensics (see Mental Health section below) • Monitor and support initiatives to increase Māori participation across occupational groups in the Northern region (see Workforce section below)			X X 	 X X X
Achieving Health Equity for Pacific Peoples					
1	Review and re-establish the Regional Pacific Health Equity working group membership and terms of reference; to focus on areas of regional collaboration for Pacific health		X		
2	Review the Pacific health pipeline of initiatives; to ensure alignment with current Pacific health equity priorities and clear objectives and measures to monitor progress			X	
3	Build enhanced analytics and insight into decision making by developing a Pacific insight framework and population health data				X
4	Improve Pacific equity and access in prioritised planned care pathways, overseen by the Pacific Clinical Technical Advisory Group		X		
5	Support ARPHS to establish a Pacific case and contact management response to COVID-19, which will provide a platform/model for future investigation and management of notifiable communicable diseases			X	

Appendix One: Quarterly Milestone Action Plans

	Action Points	Target Completion Date			
		Q1	Q2	Q3	Q4
6	Support delivery of six additional Health Science Academies and the existing programme, aligned with best practice		X		
7	Support initiatives that strengthen the Pacific health workforce training and development pipeline				X
8	**Pacific Equity Outcome Activities (EOA) elsewhere in this plan:** • Equity led planned care recovery post COVID-19 (below) • Equity approaches to uterine cancer for Pacific Women (see Cancer section below) • Targeted equity actions in the cardiac network (see Cardiac section below) • Targeted equity work in Mental Health, particularly the planned reductions in tobacco use in inpatient facilities, equity recommendations in the AOD model of care and work on youth forensics (see mental health section below) • Monitor and support initiatives to increase Pacific participation across occupational groups in the Northern Region (see Workforce section below)			X X 	 X X X
Equity Led Planned Care Recovery					
1	**Māori Health Response** • Implement Māori Clinical Governance Recommend and Agree upon • Clinical prioritisation in elective care to address inequity in timely access as services recover • navigator support for Māori whānau to improve the co-ordination and timeliness of service provision across planned care services • Expansion of Māori mobile care units and wraparound community health services • How to establish data to support equity gap identification & priorities including mental health • Next Steps to implement identified improvements	X	X X X	X X	
2	**Pacific Health Response** • Impolement Pacific clinical technical advisory group Recommend and Agree upon • Navigator support for Pacific whānau to improve the co-ordination and timeliness of service provision across planned care services • Expansion of Pacific mobile care units and wraparound community health services • Establish data to support equity gap identification & priorities including mental health • Next Steps to implement identified improvements	X	X X	X X	

Appendix One: Quarterly Milestone Action Plans

	Action Points	Target Completion Date			
		Q1	Q2	Q3	Q4

3	**Resilient Regional Configuration and Models of care for Vulnerable Services**
	• Develop Resilient Solutions for Phase One Services (ORL; oral health; ophthalmology; vascular; sarcoma care)
	  ○ Rapid review of selected services resulting in proposed solutions that to address equity impacts related to COVID-19
	  ○ Further refinement of proposed solutions
	  ○ Regional agreement on solutions
	  ○ Support implementation of solutions
	• Commence work on Phase Two Services (Non-surgical orthopaedic pathways; maxillo-facial surgery; Regional spinal services)
		X	X
			X
			X
			X
				X	X

4	**Primary Care Response** • Expand & evaluate Access to Diagnostics for 6 months in co-ordination with tier 2 diagnostics recovery plans • Extend and align the use of POAC to improve the primary care health system response • Review Māori and Pacifica experience of alternative (virtual) models of delivery		X X X		
5	**Mental Health Response** • Evaluate new pathways & ways of working including hospital at home • Agree steps to extend and enhance provider responses that work well & enhance equity		X	X	
6	**Systematic Planned Care Recovery** • Establish regional analysis, monitoring and decision support of waiting lists, outpatient diagnostic and elective treatment to support regional improvement initiatives • Complete change plans based on stocktake and impact assessment of the regional capacity and demand and cost impact of harmonising regional clinical thresholds across all specialties, • Establish and enhance regional networks to support collaboration for diagnostics and treatment including radiology, endoscopy and surgery • Put in place a collaborative approach, to sourcing and managing private sector capacity utilisation & cost, including long term arrangements for wet-lease;DHB SMO models; and DHB agreements upon local/regional controls		X X X	X	

Appendix One: Quarterly Milestone Action Plans

	Action Points	Target Completion Date			
		Q1	Q2	Q3	Q4
Programme Two: Improved Public & Population Health, and Primary & Community Care					
Public and Population Health					
1	Reconcile and align the Draft Northern Region Public and Population Health strategic planning and design work with the findings of the Ministers' Review of the New Zealand Health and Disability Sector	X			
2	Agree Northern Region Public and Population Health Regional Plan • Key Challenges • Strategic Direction • Areas of system redesign • Recommended change actions	X			
3	Agree Northern Region Action plan to implement agreed changes	X	X		
4	Identify and quantify the multi-year investment path required to 'bend the curve' of demand on hospital based services to inform DHB financial and funding strategies		X		
Primary & Community Care					
1	Reconcile and align Northern Region Primary and Community Services strategic planning and design work with the findings of the Ministers' Review of the New Zealand Health and Disability Sector	X			
2	Agree Northern Region Primary and Community Service Regional Plan • Key Challenges • Strategic Direction • Areas of system redesign • Recommended change actions	X			
3	Agree Northern Region Action plan to implement agreed changes	X	X		
4	Identify and quantify the multi-year investment path required to 'bend the curve' of demand on hospital based services to inform DHB financial and funding strategies		X		
Addressing the Obesogenic Environment and Tackling Alcohol-Related Harm					
1	Establish the structure of the National Public Health Advocacy Team, including the membership of the NPHA Steering Group	X			
2	Investigate areas of work that DHBs can undertake in the obesity space	X			
	Carry out a stock take of DHB Healthy Food & Beverage Policies		X		
	Revise the National DHB Healthy Food & Beverage Policy to reflect best practice				X
3	Investigate areas of work that DHBs can undertake in the area of alcohol-related harm	X			
	Carry out a stock take of DHB alcohol position statements and alcohol-related harm minimisation strategies		X		
	Identify areas of improvement in current DHB alcohol-related harm practices			X	
	Work with DHBs to support these improvements to reflect best practice				X

Appendix One: Quarterly Milestone Action Plans

	Action Points	Target Completion Date			
		Q1	Q2	Q3	Q4
Programme Three: Health Service Improvements and Model of Care Change					
Child Health					
1	**Child Development Services Expand and Transform Programme** • Deliver Child development services to 420 new children in the region by 30 June 2021 • Support regional implementation of service innovations which demonstrate the ability to close equity gaps and improve service quality • Scope a defined regional programme of work to establish consistent entry and exit criteria to CDS, case mix modelling and outcomes framework • Develop and implement a regional workforce development plan for CDS				X X X X
2	**Koira4Rukahukahu/ Lungs4Life** • Implement the regional model of care				X
3	**Optimising Child Health through the COVID-19 era** • Implement a regional child health dashboard which supports monitoring and addressing of equity gaps • Implement the National Child Health Information Platform (NCHIP) for ADHB, WDHB and NDHB				X X
Frailty and Health Ageing					
1	**A consistent 'frail patient' assessment process at the hospital front door** • Establish assement process and agree the implementation plan • Commence implementation of a 'Regional Automated Case Recognition Tool' initially across the Auckland metro DHBs • Agree patient flows and pathways to fast track patients through the hospital system	X	X		X
2	**Agree opportunities for community based service development** • Recommend 5 actions to reduce inequities relating to frail vulnerable adults patients (supported by analysis regarding the scale and location of existing inequities) • Compare and contrast current DHB community based services • Assess the scale of opportunity and indicative cost benefit relationships • Detail options for improvement for each DHB • Agree prioritised actions for each DHB • Report on the role of technology in the recognition and support of frail older patients in primary care, and inform IS strategic planning on behalf of this group.		X	X X X	X X X
3	**Targeted intervention in primary care/community (COVID-19 recovery)** • Periodic review of COVID-19 risk in ARC and the community. • Risks of COVID 19 are identified and mitigations addressed				X X
4	**Develop strategies to address inequity for Māori associated with the services of home and ARC based support** • Identify variance in long term care utilisation by ethnicity • Identify variation in home based support approaches • Identify options to reduce inequity and optimise outcomes • Recommend upon potential strategies to be implemented	X X	X	X	
5	**Development of outcomes framework (impact and outcomes)** • Demonstrate framework development in one area of regional work				X

Appendix One: Quarterly Milestone Action Plans

	Action Points	Target Completion Date			
		Q1	Q2	Q3	Q4
6	**Implementation of the New Zealand Framework for Dementia Care** • Develop and agree implementation plans for top regional priority actions (Early diagnosis - Refresh of the Cognitive Impairment Pathway and training on this, including the MoCA assessment tool replacement) • Commence priority implementations	X	X		
7	**Schedule view of significant Frail Elderly related projects** • Ensure regional visibility of the schedule of work underway in the Region to enable knowledge sharing and transparency of programmes (e.g. Kare Project).				X
Regional Integrated Cancer Services					
1	**Equity** - Progress implementation of interventions to improve equity of access and outcomes regionally for the following agreed priority areas:				
(1a)	a. Lung Cancer for Māori				
	i. Reestablish the Northern Region Lung Tumour stream strengthening Māori participation.	X			
	ii. Agree a work plan and priorities for the tumour stream incorporating recommended regional interventions.	X			
	iii. Progress priority 2020/21 interventions according to the agreed work plan and priorities				X
	iv. Revise and reestablish regular MDM reporting to monitor progress against agreed measures		X		
(1b)	b. Uterine Cancer for Pacific Women				
	i. Establish Pacific participation in the tumour stream to lead a work stream on Uterine Cancer for Pacific Women		X		
	ii. Review and agree an updated work plan for the tumour stream incorporating a focus on Uterine Cancer for Pacific Women and building on work undertaken in 2019/20		X		
	iii. Progress priority initiatives for 2021/22 according to the agreed work plan				X
2	**Head and Neck Cancer (HNC)** - Continue to support and develop the HNC Tumour Stream: • Develop a 5 year strategic work plan for Regional HNC Service based on "gap analysis" from Accreditation Process • Progress priority 2020/21 initiatives according to agreed time-lines in the work plan. • Complete development of HNC QPI reporting requirements for application nationally		X X		 X
3	**Local Delivery of Medical Oncology** • Complete implementation for end-to-end breast tumour stream provision of local delivery of medical oncology. • Agree a plan and progress implementation for expansion of local delievery of medical oncology to other tumour streams.	X			 X
4	**Bowel** • Support regional review of endoscopy services and the role of FIT testing in symptomatic patients in conjunction with the national pilot programme, and surveillance guideline changes	X	X	X	X
5	**Technology** • Complete Business Case and procurement process for Regional Oncology Electronic System (ROES) • Progress implementation of the (ROES). • Pilot MDM solution for Gyane Oncology, informing options for a future MDM platform regionally.	X	 X X		

Appendix One: Quarterly Milestone Action Plans

	Action Points	Target Completion Date			
		Q1	Q2	Q3	Q4
6	**Regional Governance and Strategy** • Develop a collaborative regional plan for 2021/22 with the Cancer Control Agency to address national requirements from the New Zealand Cancer Action Plan and regional priorities identified through the Northern Region Integrated Cancer Service Board to deliver the LTIP Cancer recommendations.				X
7	**Regional Radiotherapy** • Complete review of model of care to support local delivery of Radiotherapy aligned with the updated and agreed regional Radiotherapy Capacity plan.			X	
8	**Faster Cancer Treatment** • Continue to support DHBs to achieve Faster Cancer Treatment 31 day measure (SS1) and 62 day measure (SS11), including providing monthly and quarterly reporting to DHB	X	X	X	X
9	**EGGNZ** -Deliver work to support related services (deliver to national contract)	X	X	X	X
Mental Health and Addiction					
1	**High Users (MH07))** • Develop a Business Case for the development of Intensive Community solutions for 2 cohorts that are high users of inpatient services due to lack of suitable community options: o People over 55 years of age with escalating health needs who cannot be cared for in the current range of services o People with cognitive impairment and mental health conditions who require intensive support to live in the community. • Develop a regional review process for people who utilise more than 100 days of inpatient care within one year, with the aim of reducing the number of people who are high users of inpatient services for more than 2 consecutive years		X	X	
2	**Addiction** • Finalise the AOD Model of care • Progress a regional approach to vaping in the Northern region with the aim of decreasing the % of Māori and Pacific service users presenting to inpatient services who are regular tobacco smokers from 80% to 60% within 2 years. • Identify at least two initiatives from AOD Model of Care to be progressed in 2020/21 that would benefit Identified priority groups – Māori, Pacific and Youth	X	X	X	
3	**Youth Forensics** • Finalise model of care for Youth Forensics to accommodate increased demand, increase integration of service with AOD and CAMHS, and significantly enhance cultural support available to Rangatahi who are referred to Youth Forensic Services.		X		
4	**Dual Disability Services** • Develop options to best meet the current demand of specialist dual disability input.				X
5	**Maternal Mental Health Services** • Implement strategies based on qualitative research undertaken in 19/20 to provide equitable access to maternal mental health services by Pacific Island and Asian Mothers..			X	
6	**Workforce Development** • Finalisation of scope and a project team to forecast the composition of the workforce required in Specialist Mental Health and Addiction Services over the next five years, and strategies to attain this workforce.				X

Appendix One: Quarterly Milestone Action Plans

	Action Points	Target Completion Date			
		Q1	Q2	Q3	Q4
7	**MH&A performance** • Develop key performance measures to track outcomes that Specialist Mental Health and Addiction Services can influence with a focus on equity.			X	
8	**Learnings from COVID- 19 pandemic** • Identify learnings from service delivery COVID-19 that would be of on-going benefit to service users and staff. • Development and implementation of plan to cement learnings in business as usual. • Develop opportunities to embed telehealth as a service delivery option for service users/whānau based on experience and feedback during the Covid-19 lockdown.	X		X	
Cardiovascular Services					
1	**Equity** • Develop plans to promote equity of cardiac outcomes across ethnicities and geographical areas in the region. • This to include, but not limited to, areas such as Cardiac Surgery, Rheumatic Heart disease, Heart Failure and timely access to investigations and therapy	X		X	
2	**Workforce issues** • Continue development and advocacy of the most vulnerable cardiac workforces, e.g. echo sonographers and physiologists, by agreeing a regional work plan focusing on this. Workforce growth projections will aim to reduce Echo wait time to a 6 week maximum			X	
3	**Regional Service Development** • Progress areas such as TAVR and EP to best support the Region • Agree and progress improvement actions required for regional achievement of standing KPIs in: Cardiology and Cardiothoracic Health Targets; Intervention Rates for both Cardiology and Cardiac surgery; Medication adherence reports (CVD Risk Management), Waiting list management targets, Access to Echo.			X X	
4	**ECG Transmission by Ambulance Process** • Centralise and monitor effectiveness of after-hours STEMI coordinator role and revise 'ECG transmission by Ambulance' monthly meetings to include broader STEMI issues	X			
5	**Collaborate across Clinical Networks- Atrial Fibrillation** • Work collaboratively with the Stroke Clinical Network to further develop plans to improve outcomes for priority populations		X		
6	**Community Cardiac Arrest project** • Produce an outcome report on the Hokianga AED project • Continue working with the Community Cardiac Arrest National Working group and apply learnings from the Hokianga AED project to other deprived areas within the Northern Region.		X		X
7	**Heart Failure** • Update of National heart failure registry • Regional registry enrolment using Ministry of Health provided representative patient cohorts • Regular regional reporting of quality improvement indicators		X	X	X

Appendix One: Quarterly Milestone Action Plans

	Action Points	Target Completion Date			
		Q1	Q2	Q3	Q4
8	**Pathways** • Update or review pathways for CVDRA and Hyperlipidaemia; • Cardiac Catheterisation Complications, Heart Murmurs in adults, ECG Images • Integrate the Northern Region and NZ STEMI guidelines and pathways.		X		X
Stroke Services					
1	**Stroke Awareness and Prevention** • Support the dissemination of national FAST campaign messages using primary care, DHB and Iwi – DHB partnership networks • Develop regional approaches with consumers, primary care, DHB and Iwi-DHB partnership networks around stroke awareness and prevention in the priority regions • Support implementation of regional AF/ Stroke working group recommendations for improved management of AF in primary care			X	X X
2	**Hyperacute Stroke Pathway** • Review and address regional inequities in acute stroke care • Review NDHB afterhours support			X	X
3	**Stroke Rehabilitation** • Implement regional stroke rehabilitation priorities • Develop and implement a regional discharge information pack • Work with Iwi-DHB Partnerhips to improve access to community rehabilitation for Māori • Complete establishment of Auckland City Hospital integrated stroke unit • Implement Regional Collaborative Community Care (RCCC) Solution for community rehabilitation		X	X	X X X
4	**Data** • Commence regional reporting of new MoH stroke indicators			X	
5	**Workforce** • Coordinate and support the regional and national stroke education programme				X
Major Trauma Service					
1	**Māori/ Pacific Island representation** • Increase the number of Māori/ Pacific Island representatives onto the Network	X			
2	**Royal Australasian College of Surgeons (RACS) review of NZ Trauma system 2017** • Implement RACS recommendation (2.11.8) 'Regional Trauma Committee to undertake clinical audit of trauma patients who die within the Region'.	X			
3	**Moderate Brain Injury** • Regionally agree and endorse a pathway for moderate brain injury that is locally implemented • Identify variables to monitor outcomes for moderate head injuries			X	X
4	**Training Education and Research** • Identify and implement major trauma education strategies for inpatient ward trauma nurses which is taken up by a minimum of eight nurses in the Region • Work together with the National Trauma Network to scope their research project to identify patient outcome measures for long-term trauma outcomes aligned to wider regional PROMs approach				X X

Appendix One: Quarterly Milestone Action Plans

	Action Points	Target Completion Date			
		Q1	Q2	Q3	Q4
5	**Rehabilitation** • Work with the National Trauma Network rehabilitation project to identify a nationally agreed trauma rehabilitation pathway • Establish regional agreement for the following rehabilitation standards of care; ○ Patients with major trauma are screened for PTSD ○ Patients with bilateral non weight bearing injuries are referred to a Rehabilitation Consultant/ Service ○ Promotes a discharge plan in the community for complex pain management.			X	X
6	**Destination guidelines, after one year of implementation** • Conduct a snap audit to regionally review Destination Guidelines for awareness and adherence. • Identify changes to guidelines. • Identify variables to monitor outcomes that include an equity lens concerning ethnicity and rural measures. • Identify variables that measure service sustainability		X	X	X X
Regional Hepatitis C Service					
1	**Progress key existing HCV initiatives** • Provide education and awareness in the general public on HCV and its risk factors • Undertake education and awareness across key stakeholders to facilitate HCV diagnosis and treatment for at risk communities • Facilitate the delivery of HCV services through primary care undertaking the Laboratory look-back review of identified patients	X X	X X	X	X X
2	**Service development** • Undertake a micro-elimination project with the Northern Region's Corrections Department at Wiri Men's prison • Undertake line of sight on the cascade of care for key demographics to ensure equity of access and treatment for cure. • Facilitate a micro-elimination project within a marae based health service	X	X X	X	
3	Receive and consolidate **quarterly reports** from the Northern Region's DHBs which detail progress and opportunities across the Region's: • Community Alcohol and Drug Service • Needle exchange • Corrections Department facilities • Primary care and other community providers • Secondary services Complete the Ministry's KPI reporting template (due in Q2 and Q4)	X	X X	X	X X

Appendix One: Quarterly Milestone Action Plans

	Action Points	Target Completion Date			
		Q1	Q2	Q3	Q4
Programme Four: Improved Diagnostic Service Delivery					
Regional Networked Community & Acute Laboratory Services					
1	**Workforce: Scientific and Technical Professional Development and Leadership** • Scope and establish key objectives • Establish project team and project lead • Agree regionally consistent framework (in line with MECA) • Implement	 X X		 X	 X
2	**Framework: Regional Quality Framework** • Scope and establish key objectives • Establish project team and scientific lead • Develop regional quality framework • Implement regional quality framework • Review options for informatics and modelling including regional BI tool • RFP (if required) and implementation	 X X	X X X X 	 X X 	 X X
3	**IS: Phase 2 of Labs IS Roadmap** • Milestones as per ISSP	X	X	X	X

4	**Programme Fundamentals**
	• Implement the communications and change strategy on project by project basis
	• Service Reviews
	  ○ Complete immunopathology review
	  ○ 2nd key service
		X	X
			
			X
				X	X
					
					X

Regional Radiology					
1	Identify and implement options to attain a **sustainable diagnostic waitlist** • Scan – current demand/ capacity relationships and opportunities for change options • Focus - develop workplans to deliver benefits through a combination of agreed priority practice change and/or capacity configuration • Act – Demonstrate real improvement In waitlist, through workplan implementation	X	X	X	X
2	**Asset Management Planning** • Deliver a plan outlining the required replacement and acquisition of additional equipment; informed by demand forecast and clinical pathway analysis and Radiology Information system requirements				X
3	**Workforce** • Identify key future workforce pressure points and staff requirements informed by demand forecasts developed as part of the sustainable waitlist and asset management planning process • Support recruitment and retention of identified vulnerable workforces with ongoing review of vacancies and coordinated planning of training, recruitment processes, retention incentives and workforce wellbeing initiatives (Qtly review and action identification) • Progress actions arising from the Northern Region request to MRTB that they change regulations for MRI training requirements to enable International (and National) recruitment *(Actions in partnership with MoH and Northern Region Workforce)*	 X X	 X X	X X X	X X X

Appendix One: Quarterly Milestone Action Plans

	Action Points	Target Completion Date			
		Q1	Q2	Q3	Q4
Programme Five: Enabler' Services					
Workforce Development					
1	Monitor and support initiatives to increase the Māori and Pacific participation across occupational groups in the Northern Region: • Progress the case to secure funding for a Māori health gain approach to health management and leadership development • Support the Northern DHBs in the delivery of their respective and collective action plans to grow their Māori and Pacific workforces.	X X	X X	X X	X X
2	Deliver reviews into selected allied health, scientific and technical workforces and implement regional recommendations arising from these: • Undertake reviews across eight prioritised allied health professions - Physiotherapy, Occupational Therapy, Speech Language Therapy, Dietetics, Social Work, Psychology, Audiology, and Allied Health Assistant/Kaiāwhina workforces o Stage 1 Northland and Stage 2 Auckland Metro • Implement regional recommendations related to the: o Theatres Workforce Review o Reviews for medical imaging and cardiac workforces	X X X	X X	X X X	
3	Establish a regional approach to assess and improve digital and technology readiness in clinical, non-clinical and support workforces: • Compile a summary of existing and planned digital readiness and learning initiatives • Identify opportunities and priorities according to DHB workforces or groups e.g. allied health talking therapies		X	X	
4	Set up workforce development based alliances with health education providers, to influence quality of training and readiness of future workforces: • Explore options for micro-credentialing and optimising student clinical placements, and other models that fast track workforce readiness • Identify and progress workforce red flag issues for the Region e.g. anaesthetic assistant and cardiac sonography workforces	X	X X	X X	X X
5	Strengthen regional workforce planning to enable delivery of the Northern Region Long Term Health Plan and in the shorter term, respond to the supply and demand challenges as a result of Covid-19: • Design for increased accessibility and inclusion in our employment practices for people with disabilities. • Improve understanding of future workforce demand aligned to Northern Region growth priorities and capital planning initiatives. Provide future workforce planning aligned to new Theatres build • Plan for and act to secure and prepare our workforce(s) in the post Covid-19 setting and to support increasing demand across our vulnerable communities. Develop regional medical workforce(s) plan.	X		X	

Appendix One: Quarterly Milestone Action Plans

	Action Points	Target Completion Date			
		Q1	Q2	Q3	Q4
Data and Digital					
The table below provides a summary of the FY20/21 milestones for each of the ISSP key Horizon One initiatives and ISSP Planning for Horizon Two. This includes on-going delivery of in-flight multi-year initiatives and the embedding of new initiatives arising from the COVID response. It is important to note that many of the projects cross multiple years ie may not start or finish in FY20/21					
1	**Cloud Sub-Programme**				
	• IaaS Migrations Business Case Approval	X			
	• IaaS Migrations – Year 1 (Rolling Migrations)	X	X	X	X
	• IaaS Service Establishment		X		
	• FPIM Wave 2 (HealthSource & Counties Manukau DHB)				X
2	**Workspace Sub-Programme**				
	• Windows 10 - Design	X			
	• Windows 10 - Implementation				X
	• Office 365 – Design	X			
	• Office 365 – Implementation				X
	• Workspace/UEM - Design	X			
	• Workspace/UEM - Implementation				X
	• Device Refresh***	X	X	X	X
3	**Infrastructure Sub-Programme**				
	• CORE Firewall – Cutovers		X	X	
	• CORE Firewall – Decommisson				X
	• Internet Puiblic Cloud Connectivity – Go Live*				X
	• F5 Load Balancer – New Solution Go Live	X			
	• F5 Load Balancer – Application Migrations Go Live				X
4	**Teleco/Telehealth Sub-Programme**				
	• PABX Top 6 Remediation – Business Case	X			
	• PABX Top 6 Remediation – Phase 1 SIP and SBC Services				X
	• Secure Communcation – Business Case	X			
	• Secure Communcation – Phase One Critical Messaging				X
5	**RCCC Sub-Programme**				
	• Regional Community and Colloborative Care (RCCC) – Design			X	
	• Identity & Access Management (IAM) – Design**			X	
	• Health Information Platform (HIP) - Design **			X**	
6	**HARP Sub-Programme**				
	• Hospiltal Administration Replacement Programme (HARP) Design				X*
7	**DSI (Digital)**				
	• API Gateway and Operating Model – Design*	X			
	• API Gateway and Operating Model – Implementation				X
	• Shared Primary Care Summary – Phase 2 rollout (AKL Metro) plus Phase 3 design (Regional + access + APIs)		X		
	• DSI – Other	X	X	X	X
8	**Application Stabilisation Sub-Programme**				
	• Risk Stablisation – Various Apps	X	X	X	X
	• Cyber – Various	X	X	X	X

Appendix One: Quarterly Milestone Action Plans

	Action Points	Target Completion Date			
		Q1	Q2	Q3	Q4
9	**NSP Sub-Programme** • Regional Roadmap V2.0 • RISDOM and Operating model • ISSP Strategy Refresh (ISSP V3.0)		X X	 X	
10	**Regional Clinical Portal (RCP)** • RCP ADHB – Go Live (full) • RCP NDHB – Go Live • Regional 'Paperless Clinics'	X X	 X 	 	
	***Business Case not approved as at 19/6/2020 - Funding Dependent** ****Not funded beyond Design Phase**				
Capital Programme of Work					
1	Agreed business case standards and quality assurance approach • 12 month schedule for Business Case review and endorsements • Agreed Business Case standards, workflow and templates • Training package to support business case quality standards	 X 	 	 X 	 X
2	Capital programme reporting schedule • Agreed key programme measures and reporting format • Regular reporting to Regional governance groups	 X 	 X	 	
3	Regional Capital Programme Benefits framework • Common framework of outcomes, benefits, indicators and measures for Capital projects • Agreed Regional Capital Benefits framework	 	 X 	 	 X
4	Regional Capital Delivery Plan • Agreed Capital Delivery Plan framework and approach • Regional Capital Delivery Plan report delivered quarterly	 	 	 X 	 X
5	Regional Asset Management Planning • Agreed Regional Asset Management Policy • Agreed Regional Asset Management Strategy • Agreed Asset Performance / Levels of Service approach	 X 	 	 X X	

Appendix Two: Governance Leadership and Partnerships in More Detail

Regional Governance, Leadership and Oversight Groups and Forums

The COVID-19 pandemic led to developments across our regional oversight and regional working arrangements, some of which we are retaining to strengthen and simplify regional work oversight. Ongoing arrangements will be subject to review and refinement as part of our post COVID response.

Our Governance and Oversight structure comprises three key governance groups which oversee all clinical and business services activities:

1. Regional Governance Group (RGG)

RGG is a steward for regional decision making. It operates within Board delegations to Chairs and as such the RGG has no formal delegations. It is the guardian of the 'regional direction of travel' and ensures that progress is made against the actions. RGG holds the Regional Executives Forum to account for delivery.

Membership comprises DHBs Chairs, with Chief Executive Officers (CEOs) and Chief Medical Officers (CMOs) attending in an ex officio capacity and others by invitation.

The Regional Governance Group:

1. Provides a collective regional forum to address, monitor and influence current and long term planning of regional health services and capital planning
2. Shapes thinking on the regional direction, particularly in relation to long-term planning of regional health services
3. Identifies any issues impacting on the ability of the Region to efficiently deliver health services to the Northern Region population
4. Agrees annual and longer term strategic priorities and the Regional Service Plan
5. Approves regional strategy and ensures alignment with the New Zealand Health Strategy
6. Monitors progress and performance against regional plans
7. Deliberates as a collective group and drives a regional collaboration agenda
8. Acts as an escalation point for regional issues that cannot be resolved in other groups
9. Periodically reviews the effectiveness of the regional working framework and the establishment or disestablishment of regional groups.

2. Kōtui Hauora and Mana Whenua i Tāmaki Makarau

The Northern Region has two Iwi-DHB Partnership Boards to engage Iwi/Māori in an empowering partnership that aims to achieve Pae Ora (Healthy Futures), providing ownership and oversight of health sector actions within the scope of Māori health gain. These two partnership Boards, Kōtui Hauora in the North of our Region and Mana Whenua i Tāmaki Makarau in the southern part of our region, each:

- Help determine Māori health outcomes and Māori health equity priority areas
- Provide Māori health leadership, advice and guidance across all DHB funded and provided services, activities, and workforce to help our DHBs meet their Treaty of Waitangi and statutory obligations to Māori
- Oversee resource allocation and investments made for the purpose of achieving Māori Health outcomes and advancing Māori wellbeing
- Engage experts and advisors to carry out work and complete specific tasks on behalf of the Partnership Board.

In addition to regional Māori partnerships, each respective DHB has existing local level partnerships with iwi, hapū, manawhenua groups, and Māori groups that further support engagement with specific communities, enhance service provision to Māori, and ensure equitable resource allocation across the system to achieve our Treaty obligations. These local partnerships are the foundation of a strong regional network for Māori health.

Appendix Two: Governance Leadership and Partnerships in More Detail

3. Regional Executives Forum

The Regional Executives Forum is accountable to the Regional Governance Group. In addition, each member is accountable to their Board and management and shall inform their own organisation of the activities of the Regional Executives Forum that may be significant for their DHB.

Membership includes the CEOs, CMOs and Chief Financial Officers (CFOs) from each DHB, with the expectation being that the CFOs will attend quarterly with all papers copied to them. The Regional Executives Forum:

1. Provides leadership for the regional agenda, ensuring that sound advice is provided to the Regional Governance Group to inform discussions and recommendations in regard to regional strategy
2. Is accountable to the Regional Governance Group for the development of and delivery of the regional plan/s that are aligned with the New Zealand Health Strategy and northern region Long term investment plan principles and strategic framework
3. Monitors performance against plans and service level agreements
4. Considers risks to the Region's operations, strategies and plans
5. Addresses operational and other issues that are within the delegations of individual members
6. Ensures there are appropriate regional groups and networks to support effective regional collaboration and strategy implementation and monitors the effectiveness of regional groups.

Where not otherwise stated, key Regional Service Plan programme level reporting is to the Regional Executive Forum, supported by a range of more detailed and project specific oversight arrangements. These have included a health service design authority to set strategy and a health service implementation group to commission changes in models of care, and will be included in a review and simplification of governance in Quarter one, recognising the establishment of a regional workforce group to oversee and drive the delivery of the agreed workforce deep dive strategy and regional work plan.

Appendix Two: Governance Leadership and Partnerships in More Detail

Regional Capital Investment Group – is responsible for:

- Fulfilling the functions and expectations of the Regional Capital Committee with regard to business case approvals
- Driving Capital planning system process improvements
- Oversight of Facilities, Infrastructure, and Clinical Equipment planning and delivery; ensuring quality assurance and control of the planning process and the capacity and capability to implement and deliver the approved works.

- **ISSP Design Authority** – is responsible for governing and controlling design components associated with the programme to deliver the future state services and business processes associated with the new models developed by the Health Service Design Authority and Implementation Steering Group, and maintaining the ISSP Roadmaps which guide priorities and sequencing of change.

- **ISSP Delivery Programme Steering Group –** is accountable for delivery of the suite of sub programmes and projects in the ISSP to meet clinical and operational service requirements, realise intended benefits, and deliver the programme of change to time, and to budget.

Entities, Agencies and Partnerships

- **District Health Boards (DHBs)**

  DHBs take the lead on assessing the health needs of populations and funding services to meet these needs. They deliver predominantly hospital and community specialist services. DHBs sponsor the governance groups and, in partnership with the signatories of this plan, provide oversight of performance against the priority goals and achieving improvements in patient outcomes.

  DHBs have responsibility and accountability for integration and the performance of primary care in their districts. This is expected to be achieved by continuing to build local partnerships through collaboration and forming alliance agreements. Other DHB activities include:

  - Active participation of clinicians and managers in networks and the delivery of DHB and regional priorities
  - Supporting the development of and investing in locality care partnerships/networks, Integrated Family Health Centres and neighbourhood healthcare homes
  - Aligning funding to the Regional Plan and DHB priorities
  - Supporting primary care partners and the Whānau Ora providers.

- **The Northern Regional Alliance (NRA)**

  NRA works in conjunction with the four northern DHBs to achieve the Region's and the Minister's priorities and to support the effective implementation of policy directions and objectives. In particular, the NRA will support the four Northern DHBs in areas where there is benefit from working regionally. The NRA leads the delivery of the long term health service planning and implementation activities, and provides a range of regional and national services for DHBs including workforce operations, emergency management, regional contracting and public health advocacy.

  The NRA also supports links with the Health Workforce Directorate (MoH), and Health Quality and Safety Commission (HQSC) to ensure that the regional and national priorities are aligned.

  The NRA focusses its resources upon supporting the prioritised areas for regional working. The key drivers for NRA engagement are:

  - Nationally mandated that we engage regionally/can demonstrate regional support
  - Regionally consistent view of information is required
  - Activity impacts multiple DHBs/services/portfolios
  - Increase consistency/reduce variation
  - Reduce duplication/cost and improve efficiency/effectiveness
  - Economies of scale /effective use of scarce resource
  - Engagement of wide range of stakeholders required
  - "Independent facilitation/co-ordination" of process required
  - Capacity and technical capability available to support timely delivery of key activities
  - Leverage regional knowledge and "infrastructure"/linkages.

Appendix Two: Governance Leadership and Partnerships in More Detail

- **HealthAlliance New Zealand (hA)**

  healthAlliance is the regional business services agency for the four DHBs. The key service activities are finance (transactional processing), procurement, supply chain, information services, and Regional Internal Audit Services. The activities of this organisation are governed by the healthAlliance New Zealand Board which comprises seven directors including one representative from each DHB and two independent directors. HealthAlliance leads the delivery of the business services, including Information Systems Strategic Plan (ISSP).

- **Alliance Partnerships in Primary Care**

  Primary care providers are critical to the delivery of the regional 'direction of travel'. PHOs are a key mechanism to drive changes to clinical practice associated with delivering a greater breadth of services locally. They will likely have a stronger focus on planned care for high-needs populations to prevent acute and unplanned admissions, and supporting older and frail people to live independently.

  The one Northland PHO and the seven Auckland PHOs have key areas of focus, including:

  - System outcomes to design and implement optimal performance based on the use of System Level Measures (SLM's) to drive clinically led quality improvement
  - New models of care that optimise self-directed care at home and in the community
  - Developing fit for purpose practice models that deliver proactive patient centred care
  - Information infrastructure to enable integrated and self-directed care
  - Governance to drive and sustain the change agenda, the next step is to develop a single Alliance Leadership Team (ALT) for metro Auckland.

- **Other Social Sector Agencies**

  Linkages with other social agencies are important in the delivery of regional Service Plan, particularly with regard to Child Health. The health outcome for many of the children in the care of health services depends on addressing the upstream determinants of health. Children with, or at risk of, rheumatic fever and respiratory conditions will receive preferential access to housing services to address structural and functional overcrowding and to enable warmer houses. Initiatives often involve collaboration with agencies such as Oranga Tamariki - Ministry for Children), education providers, and Te Manatū Whakahiato Ora - Ministry of Social Development to deliver whole of system care to the most vulnerable children and their families.

- **Aged Residential Care**

  Aged Related Residential Care (ARRC) comprises a number of operators who provide residential care for our elderly. Cooperation and collaboration with the range of ARRC providers is important in the implementation of activities to reduce acute presentations from residential care and increase advanced care planning activities, and to improve the safety of patients from falls and pressure injuries.

- **Non-Governmental Organisation (NGO) sector**

  This sector is very important to many aspects of our regional strategic direction, particularly Frail and Elderly, Mental Health and Addictions, Cancer, and Child Health. Relationships with each of these areas are important to share information, align activities and ensure consistent messages are being provided, regardless of where our population seeks help.

Appendix Three: Northern Region Service Design Principles

Appendix Three: Northern Region Service Design Principles

Ten Service Design principles	
The needs & rights of the patient & whānau come first	• The patient and their whānau/family are meaningfully involved in decision making and supported for increased self-management, autonomy & control of their lives • Culturally proficient patient & whānau centred care, responsive to individuals and their whānau/family needs and priorities including the beliefs, values and aspirations of Māori • Prompt access to care choices at accessible times and locations • Services accountable to the communities and patients/whānau they serve
Same standard of care across the region, delivered flexibly	• Regardless of location, socio-economic status, gender, ethnicity, tangata whenua or tangata o te tiriti status of individuals and communities • Regionalised ways of working with standardised processes that meet National Standards • Convergence to consistent eligibility for care based on clinical need
Iwi Partnerships	• Services value & utilise insights & knowledge of mana whenua & partner organisations to improve, responsiveness, & effectiveness to Māori and accelerate Māori health gain • Service developments & planning align to iwi aspirations for the health & wellbeing of their whānau to create high impact, useful and sustainable healthcare interventions • Promising techniques and interventions that value Māori intelligence and Māori led solutions for enhancing Māori wellbeing will be adopted
Designing out inequities	• Care model development will assess inequities and recommend responses in universal services, and targeted services where appropriate • Care models will be informed by experience-based design involving populations served, including ensuring active Pacific and Māori perspectives and engagement • Service models are Mana-enhancing, built on the right to health for all & achieve tangible health outcomes determined by patients and their whānau • Enabling environments underpinned by Universal Design for social inclusion
Investing Upstream	• The most cost-effective interventions along the pathway will be prioritised for scaling • Pathways will rebalance investment for allocative efficiency: Upstream into prevention, earlier detection & early intervention and downstream to rehabilitation and reablement
Coordinated, easy to use care	• Patients and their whānau/family have a clear, single point of contact at all times • Transitions of care are planned and supported taking a whole of life approach • Transparent decision-making & patient information flow along the entire patient pathway • All team members across settings, including patients, have access to patient information • Services work across sectors to help address social determinants of health and achieve broader wellbeing goals including social inclusion, participation and realising potential
Workforce and Staff Wellbeing	• A highly skilled, well trained, accredited, competent workforce capable of working at the top of their clinical scope with our diverse population across the region • An accelerated transition to a workforce representative of our population • Patient/whānau-centred cost-effective care put above traditional role boundaries & practices to deliver best possible experience & outcomes at every single engagement • Appropriate tools and systems are available to deliver collaborative team based care • Learning and improvement (individual, team and system) and progression are fostered • Te Tiriti o Waitangi principles as standard practice amongst our entire workforce
Best possible outcomes	• Services are outcomes focused, and care is planned and designed using community identified outcomes and patient reported outcome measures • Services will be consolidated where increased volume improves outcomes • Treatment discussions will occur in a multidisciplinary team setting • Improvement and equity will be measured against agreed criteria • Population health evidence will strongly inform model of care choices
Sustainable services	• All services transition to clinically sustainable configurations & models of care • Service design reflects best practice benchmarks of efficiency, productivity, and utilisation of assets to deliver population needs within a sustainable funding allocation • Best use is made of capacity in our region with a planned approach to both public and private facilities to best meet demand and address inequities in a sustainable manner • Approaches will leverage on the distinct strengths of each DHB • Services targeting vulnerable individuals/whānau are funded to achieve greater impact
Incubating Innovation	• We will cultivate disruptive delivery models to tackle long standing problems • Learning from and leading international best practice will inform our models of care • Networks & Services that operate as Centres of Excellence will disseminate knowledge for rapid spread of evidence-based cost-effective interventions & innovation.

Maternity Services Data Update Paper

Recommendation

That the Board receives this maternity services data update paper.

Prepared by: Rob Sherwin Director; Deb Pittam Director Midwifery; Bridget Cooper Interim General Manager
Endorsed by: Jo Gibbs, Director of Provider Services, Auckland DHB.
Endorsed by Executive Leadership Team: **Yes** Date: Friday, 16 October 2020

Glossary

Acronym/term	Definition
ACH	Auckland City Hospital
LMCs	Lead Maternity Carers (for example, midwife, obstetrician)
Primiparous	Women who have given birth once

Introduction

At the request of the Board, a summary is provided of some of the latest data from the Women's Health Service, Annual Clinical Report (ACR) 2019[1] and the recently published New Zealand Maternity Clinical Indicators 2018[2]. The ACR includes data from 2019 and previous years. The NZMCI data allow peer comparison with other DHBs for the 2018 data.

Birth Numbers by Lead Maternity Carer at ACH and within NZ

New Zealand - In 2018, there were 58020 births, with 94.5% (54829) cared for by midwives, 5.3% (3075) cared for by Private Obstetricians, 0.2% (116) cared for by GPs and 0.1% (58) unknown LMC.

ACH - In 2018, there were a total of 6,481 births, with 2,769 (42.7%) cared for by self-employed midwives, 1,747 (27.0%) cared for by ADHB-employed community and high risk medical midwives and 1,958 (30.3%) cared for by Private Obstetricians.

ACH - In 2019, there were a total of 6,660 births, with 2,891 (43.4%) cared for by self-employed midwives, 1832 (27.5%) cared for by ADHB-employed community and high risk medical midwives and 1,933 (29%) cared for by Private Obstetricians.

Thus in 2018 approximately two-thirds (1,958 of 3075) of all NZ women under the care of a private obstetrician birthed at ACH. Data from the ACR shows that just under half of these women (868, 44%) were non-ADHB domiciled.

The data also shows that at ACH the proportions of different LMCs at birth, differs significantly from the national data.

Place of birth of ADHB domiciled women

In 2018, of the 5,260 ADHB domiciled women who gave birth, 4251 (81%) birthed at ACH and 1,009 (19%) birthed elsewhere. Of these 1,009 ADHB domiciled women who birthed elsewhere, Table 1 shows that 521 (52%) of these women birthed in primary or low acuity, secondary birthing units outside of ADHB (Waitakere 338, Birthcare 153, Botany Downs 12, Papakura 5).

Table 1 Place of birth and ethnicity of ADHB domiciled women who birthed in 2018

Facility name	Māori	Pacific	Asian	Euro/Other	Total
Auckland City Hospital	310	514	1,522	1,905	4,251
Middlemore Hospital	55	189	77	36	357
Waitakere Hospital	45	32	162	99	338
North Shore Hospital	12	13	60	46	131
Birthcare Auckland	14	16	33	90	153
Botany Downs Hospital	3	5	2	2	12
Papakura Obstetric Hospital	1			4	5
Other	5	2	1	5	13
Grand Total	445	771	1,857	2,187	5,260

Non-ADHB domiciled women birthing at ACH

In 2018, 2,188 non-ADHB domiciled women birthed at ACH, with 884 (40%) women cared for by LMC self-employed midwives, 868 (40%) cared for by private obstetric LMCs and 433 (20%) cared for by ADHB-employed midwives/high risk teams.

In 2019, 1440 elective/planned caesarean sections were performed within ACH. 325 elective caesarean sections were performed for non-ADHB domiciled women who were cared for by private obstetricians, and 117 for women cared for by self-employed midwives, which equates to 3-4 half day theatre sessions per week. In addition, induction of labour was commenced for 308 non-ADHB domiciled women who were cared for by private obstetricians. 73% of non-domiciled women cared for by Private Obstetricians, underwent either induction of labour or elective caesarean section.

In 2019, 65.7% (4373) of wāhine giving birth at ACH lived in the Auckland DHB area. This proportion has dropped significantly from 70.7% in 2006. Data presented later in this paper (Table 2) will show that women who birth under the care of private obstetricians have significantly higher intervention rates compared to women cared for by other LMCs.

This data can be summarised as:

- a significant number of low risk ADHB domiciled women birth outside of ACH and outside of the ADHB catchment area (the proximity of a specific birthing unit may influence choice as will patient choice about the facilities that are available); and
- a significant number of low risk non-domiciled women have secondary care interventions within ACH.

'Standard Primip' Data

The New Zealand National Maternity Clinical Indicators can be used for national comparison of maternity-related outcomes, for 'low risk' women who are giving birth for the first time. These are

women in their first pregnancy, who are aged between 20-34 years old, who birth at term (37-41 weeks of pregnancy), who are carrying a single baby that is presenting head down and who have no medical or obstetric complications.

The data in Table 2 shows that 'standard primips' birthing at ACH have a lower spontaneous vaginal birth rates compared to the NZ average. The NZ average data comes from all secondary and tertiary units. On a quarterly basis, within the WHS, the 'standard primip' data for ACH, by LMC at birth is published and compared to the last available national data. These data show there is significant variation in intervention rates, for low risk women in their first labour, that are not accounted for by obstetric or medical factors.

Table 2: Standard Primip data for women birthing at ACH in 2019

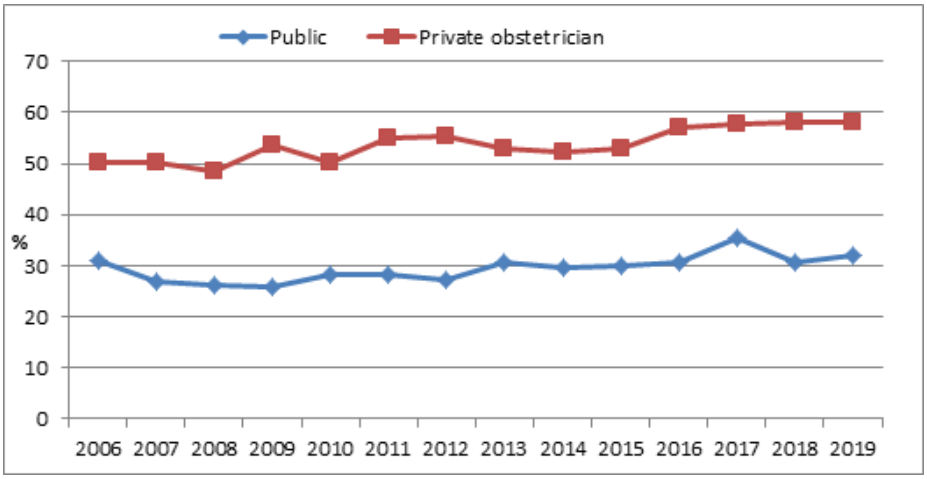
		Private Obstetricians				Self Employed Midwives				ADHB-employed Community Midwives			
NZ Average 2018		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Total number Std Primips		58	76	61	79	121	124	136	128	57	36	61	58
% Spontaneous vaginal birth	**57.5%**	17.2	22.4	24.6	30.4	47.1	43.5	47.1	44.5	63.2	33.3	52.5	63.8
% Instrumental vaginal birth	**20.5%**	20.7	23.7	26.2	16.5	29.8	29	29.4	26.5	15.8	27.8	19.7	15.5
% C-Section	**20.7%**	62.1	53.9	49.2	53.2	23.1	27.4	23.5	28.9	21.1	38.9	27.9	20.7
% Induction of labour		36.2	39.5	29.5	30.4	31.4	29.8	28.7	35.1	19.3	36.1	29.5	22.4

NZ Averages 2018: data from NZ Maternity Clinical Indicators 2018 for all secondary/tertiary facilities

Data for all primiparous women

The data above shows that the intervention rates for the 'standard primip' vary depending upon LMC at birth. If a wider lens is used to look at caesarean section rates for all women in their first labour (figure 1), not just the 'standard primip', a significant and persistent difference in intervention rates exists between patients cared for in the public and private sectors.

Figure 1: Graph showing the caesarean section rates for women birthing for the first time, cared for by private obstetricians and within the public system at ACH.

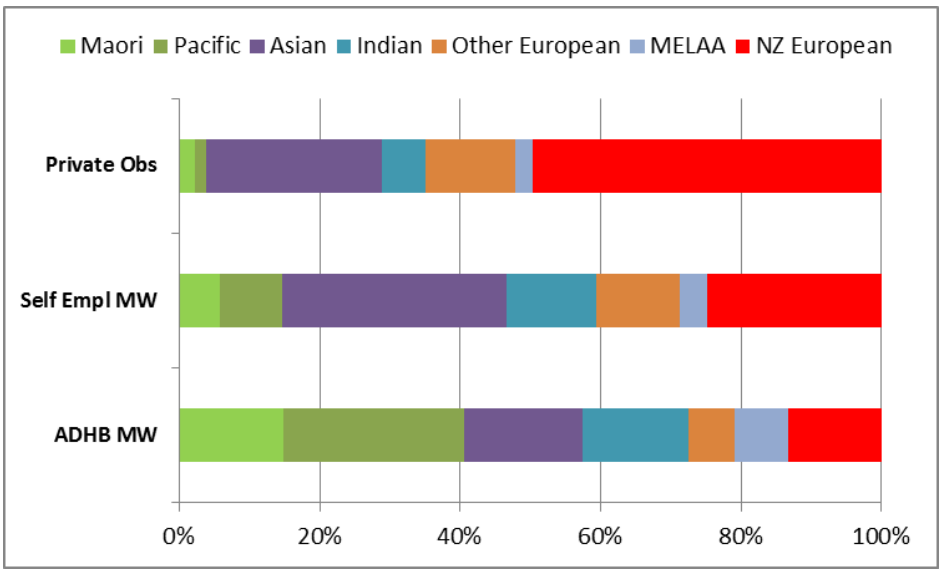


Interventions for women in their first labour have significant impacts on future pregnancies as overall in 2019, 70% of women who have a caesarean section in their first birth will go on to have a planned caesarean section in their next pregnancy. This rate varies depending upon LMC at birth; ADHB MW as LMC; 66.8%, self-employed MW as LMC 56.6% and private obstetricians 82.1%.

Intervention rates for all women who birth at ACH

In 2018, 14% of the women who birthed at ACH were classified as standard primips; their outcomes can be directly compared. The outcomes for the remaining 86% of women, who birth, are more difficult to compare, as obstetric and medical factors may be different for women who contract care from different LMCs. Women who are unable to secure care from self-employed midwives or private obstetricians are cared for by the ADHB midwifery team. The ethnicities of women who book with the different LMCs are shown below.

Figure 2: Ethnicity of women categorised by LMC at birth (2019)

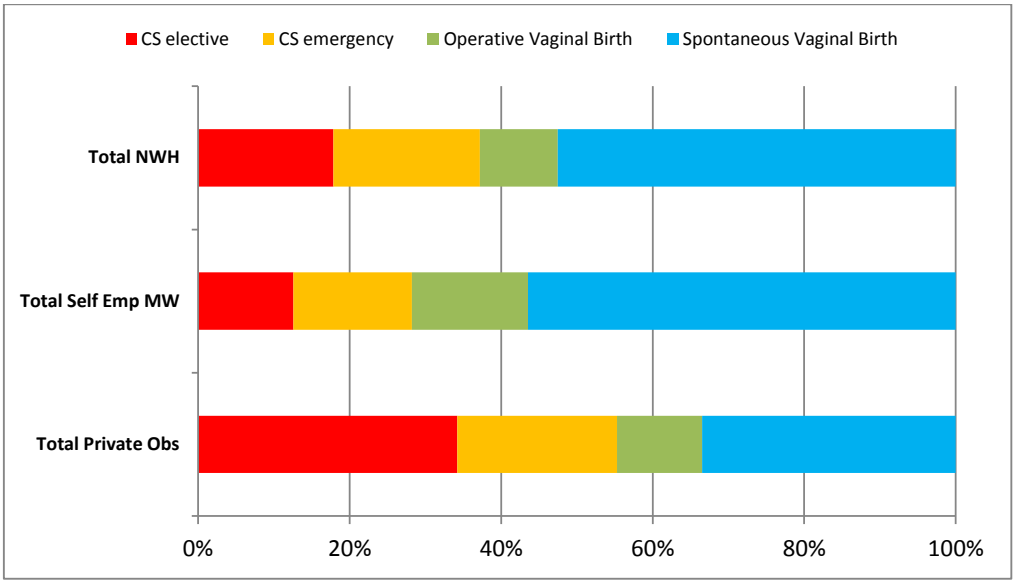


MELAA is Middle Eastern, Latin American and African

These data show that the proportion of Māori (15%) and Pacific (26%) women cared for by ADHB midwives is much higher than for other LMCs and half the patients cared for by private obstetricians are NZ European, with Māori (2%) and Pacific (2%).

As shown in Table 2 the intervention rate for 'standard primips' varies depending upon the LMC at birth. In addition, as shown below in figure 2, the overall intervention rates for all the women who birth at ACH vary depending upon the LMC at birth.

Figure 2 Intervention rates for all women birthing at ACH in 2019 by LMC at birth



Outcomes for wāhine Māori

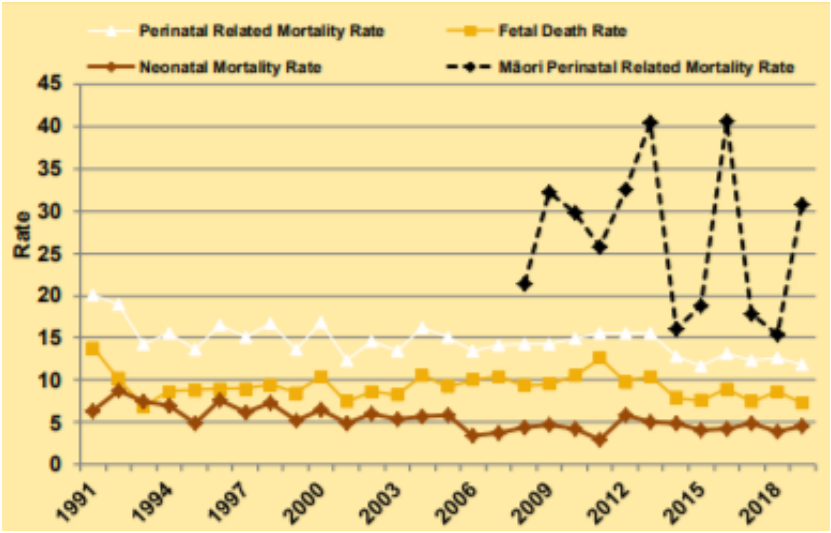
In addition the data within the ACR allows the pregnancy outcomes to be assessed based on ethnicity.

Within the Auckland DHB environment wahine Māori:

- Are more likely to book late or not at all (as do Pacific women). In 2018 within New Zealand 72.7% of women registered with an LMC within the first trimester (first 13 weeks of pregnancy). For NZ European women, who are resident within the ADHB area, the rate was 81.6%, for Māori 58.3% and Pacific 39.8%.
  In 2019, 58 wāhine were not registered for antenatal care (up from 38 in 2018, and the highest number since 2009), of whom 26 were Māori and 25 Pacific.
- Have a higher incidence of Small for Gestational Age (SGA) babies, especially if mothers are young.
- Have a higher incidence of premature babies and therefore experience more admissions to special care and neonatal units. Among ADHB resident women, the spontaneous preterm birth rate is highest among wāhine Māori at 6.1% compared to 3.1% for European for 2015-2019)
- Have lower exclusive breast feeding rates (77% Māori, 73% Pacific and 83% NZ European)

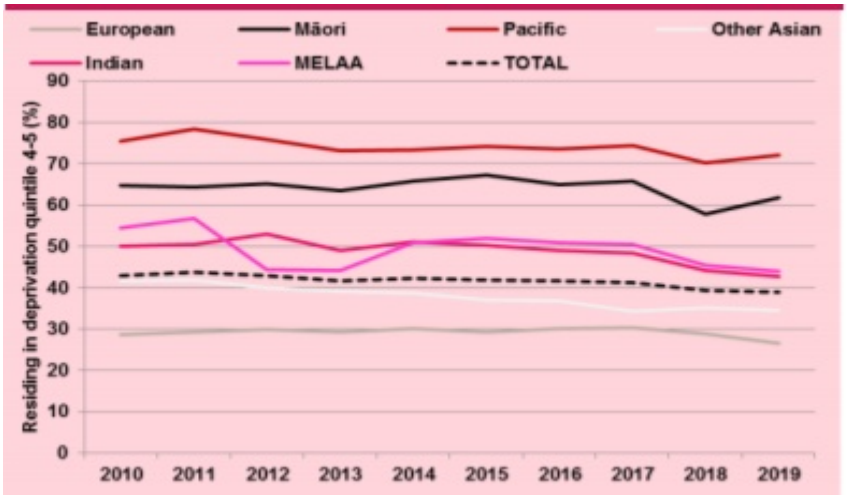
- Have higher rates of smoking, before, during and after birth. In 2019 52% of Māori wahine and 13% of Pacific women were smoking at the time of issue of postnatal, safe sleep devices (pepi-pods and wahakura)
- Experience higher numbers of Sudden Unexplained Death in Infancy (SUDI)
- Have a shorter inpatient stay
- Experience higher numbers of stillbirths and poorer perinatal outcomes (as do Pacific and Indian women). In 2019, perinatal related mortality with rates approximately twice as high amongst Māori as non-Māori (see figure 3 below).

Figure 3 Perinatal related mortality rates for Māori and all wāhine), fetal death rate and neonatal mortality rate NWH 1991-2019 (all rates expressed as deaths/1000 births)



- Are more likely to live with significant deprivation (see figure 4)

Figure 4 Graph showing the changes in proportion of mothers living in the most socio-economically deprived areas (Census area centile scores 6-10).



In summary, this data shows that in 2018, of the 5,260 ADHB domiciled women who gave birth, 4,251 (81%) birthed at ACH and 1,009 (19%) birthed elsewhere. Of the ADHB domiciled women who birthed outside of ACH, 521 (52%) birthed in primary or low acuity, secondary birthing units. In contrast, 2,188 non-ADHB domiciled women birthed at ACH, with 884 women cared for by LMC self-employed midwives and 868 (40%) cared for by private obstetric LMCs. These women birthed with high intervention rates.

When reviewing the intervention rates for women, irrespective of their DHB of domicile, the most comparable data comes from comparing intervention rates for the 'standard primip' data; low risk women in their first pregnancy. This data shows that intervention rates are higher than the NZ national averages for many of the LMC groups practicing at ACH.

References

1) ADHB Women's Health Service Annual Clinical Report 2019
https://nationalwomenshealth.adhb.govt.nz/healthprofessionals/annual-clinical-report/national-womens-annual-clinical-report/

2) New Zealand Maternity Clinical Indicators 2018
https://www.health.govt.nz/publication/new-zealand-maternity-clinical-indicators-2018

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 23 September 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]
4. Action Points	**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 Personnel costs including Annual Leave Accruals	**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	**Commercial Activities** Information contained in this report is	That the public conduct of the whole or the relevant part of the meeting would

Update	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.	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]
8.1 People and Culture Sub-Committee 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]
8.2 Finance, Risk and Assurance Committee 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]
9.1 Annual Report 2021	**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 express obligation of confidence or which was supplied under compulsion is enclosed 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]
9.2 COVID 19 Governance Arrangements	**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. **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]
9.3 Three Year Planned Care Update	**Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication 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]
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 Auckland DHB Violence and Abuse Prevention Governance Group – 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. **Obligation of Confidence** Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report. **Protect Health or Safety** Information relating to the health and safety of the public 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]
11.2 heathAlliance 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]
11.3 HealthSource 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]
11.4 On-going Work and Arrangements for the IMT/ NRHCC Regional COVID response	**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]
12.0 General Business	**N/A** 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]