AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Open Board Meeting

Wednesday, 31 March 2021

10:00am

Note:

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

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

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Published 25 March 2021

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
31 March 2021

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	Dame Naida Glavish	Chief Advisor Tikanga and General Manager Māori Health – ADHB/WDHB
Tama Davis (Board Deputy Chair)	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Fiona Lai	Meg Poutasi	Chief of Strategy, Participation and Improvement
Bernie O'Donnell	Michael Shepherd	Director Provider Services
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	
	Carly Orr	Director of Communications and Stakeholder Engagement
	Marlene Skelton	Corporate Business Manager
	(Other staff members who attend for a particular item are named at the start of the respective minute)	

Agenda

Please note that agenda times are estimates only

10.00am	**0.**	**KARAKIA**
10.05am	**1.**	**ATTENDANCE AND APOLOGIES**
10.07am	**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?
10.10am	**3.**	**CONFIRMATION OF MINUTES - 27 January 2021**
10.15am	**4.**	**ACTION POINTS**
10.20am	**5.**	**EXECUTIVE REPORTS**
	5.1	Chief Executives Report
	5.2	Health and Safety Report

	5.3	Human Resources Report
11.00am	**6.**	**PERFORMANCE REPORTS**
	6.1	Financial Performance Report
	6.2	Funder Update
11.30am	**7.**	**COMMITTEE REPORTS**
	7.1	Hospital Advisory Committee
	7.2	Metropolitan Disability Support Advisory Committee
11.45am	**8.**	**DECISION REPORTS**
	8.1	Hospital Advisory Committee – Terms of Reference
	9.	**INFORMATION REPORTS**
	9.1	Code of Conduct for Crown Entity Board Members
	9.2	Statement of Performance Expectations (SPE) Performance Report Quarter Two 2020/2021
	10.	**GENERAL BUSINESS**
Noon	**11.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Next Meeting:	26 May 2021 at 10.00am A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

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Attendance at Board Meetings

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

2020/2021

Members	8 July 20	12 Aug 20	23 Sept 20	4 Nov 20	16 Dec 20	27 Jan 2021	31 March 2021
Pat Snedden (Board Chair)	1	1	1	1	1	1	
Joanne Agnew	1	1	1	1	1	1	
Doug Armstrong	1	1	1	1	1	x	
Michelle Atkinson	1	1	1	1	1	1	
Zoe Brownlie	1	1	1	1	1	1	
Peter Davis	1	1	1	1	1	1	
Tama Davis	x	1	1	1	1	1	
Fiona Lai	1	1	1	1	1	1	
Bernie O'Donnell	1	1	1	1	1	1	
Michael Quirke	1	1	1	1	1	1	
Ian Ward	1	1	1	1	X	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	23.11.2020
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	Co-Director – AllHuman Board Member – Waitakere Health and Education Trust Partner – Team Leader, Community Action on Youth and Drugs	02.12.2020
Peter DAVIS	Retirement portfolio – Fisher and Paykel Retirement portfolio – Ryman Healthcare Retirement portfolio – Arvida, Metlifecare, Oceania Healthcare, Summerset, Vital Healthcare Properties Chair – The Helen Clark Foundation	22.12.2020
William (Tama)	Director/Owner – Ahikaroa Enterprises Ltd Whanau Director/Board of Directors – Whai Maia Ngati Whatua Orakei	18.02.2021

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 Director - - Board of New Zealand Health Partnerships Elected Member – Ngati Whatua o Orakei Trust Board	
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 National Board-Urban Maori Representative – Te Matawai Board Member - Te Mātāwai. National Māori language Board Owner/Operator– Mokokoko Limited Senior Advisor to DCE – Oranga Tamariki Engagement Advisor – Ministerial Advisory Panel – Oranga Tamariki	05.03.2021
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
27 January 2021

Minutes of the Auckland District Health Board meeting held on Wednesday, 27 January 2021 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
Michelle Atkinson	Joanne Gibbs	Director Provider Services
Zoe Brownlie	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Peter Davis	Meg Poutasi	Chief of Strategy, Participation and Improvement
Tama Davis (Board Deputy Chair)	Shayne Tong	Chief Digital Officer
Fiona Lai	Sue Waters	Chief Health Professions Officer
Bernie O'Donnell	Justine White	Chief Financial Officer
Michael Quirke	Dr Margaret Wilsher	Chief Medical Officer
Ian Ward	**Auckland DHB Senior Staff Present**	
	Alistair Forde	Director Occupational Health and Safety
	Carly Orr	Director Communications
	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)	

Welcome

The Board Chair, Pat Snedden welcomed Carly Orr, Interim Director Communications, replacing Rachel Lorimer while she was on secondment, to her first Board meeting.

The Board Chair, Pat Snedden also welcomed all members and staff back for a new-year thanking all for their determination and character displayed in their handling of the difficult time during COVID 19 last year.

Bereavement

The Board Chair, Pat Snedden advised the Board that Doug Armstrong had suffered a bereavement during the Xmas-New-Year break with the passing of his wife and he had sent the Boards condolences and best wishes to Doug.

KARAKIA

Tama Davis led the Board in a Karakia to open the meeting.

1. ATTENDANCE AND APOLOGIES

That the apology of Board Member Doug Armstrong be received.

That the apologies of Executive Leadership Team members Mel Dooney, Chief People Officer, Margaret Dotchin, Chief Nursing Officer and Mark Edwards, Chief Quality, Safety and Risk

Officer be received.

2. REGISTER AND CONFLICTS OF INTEREST

There were no new interests to register and no conflicts of interest with any items on the open agenda to record.

3. CONFIRMATION OF MINUTES 16 DECEMBER 2020 *(Pages 9-28)*

The Board Chair, Pat Snedden advised that he had been able to have a very constructive conversation with Jo Agnew around how members respond to the formation of minutes. One of the things that is to be practiced by members this year is that if they, during the course of debate, wished their opinion to be specifically annotated with their name attached that this will occur to ensure members feel that their views have been fully represented.

Resolution: Moved Jo Agnew / Seconded Tama Davis

That the minutes of the Board meeting held on 16 December 2020 be confirmed as a true and accurate record.

Carried

4. ACTION POINTS (*Page 29)*

Maternity Services Engagement Plan

See Confidential report 9.4

Development of multi lingual pod cast videos on the NZ Health and Disability system

To be considered at the March Board meeting.

Effect COVID had on long term antibiotic therapies

Email to Board 24 December 2020 providing required information.

5. EXECUTIVE REPORTS

5.1 CHIEF EXECUTIVE'S REPORT *(Pages 49-54)*

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

COVID 19 Update

There is concern about the new strains of the virus being detected not only in the United States and United Kingdom but also Brazil and South Africa due to their increase in transmissibility.

Bowel Screening

Auckland District Health Board launched the National Bowel Screening Programme, for the Auckland population in December. The screening programme enables people in the community between the ages of 60 and 74 to access free life-saving screening tests.

Debbie Holdsworth gave advice that the screening programme provided the reassurance of a

quality indicator of a 28 day time period so clinicians had to keep a close eye on symptomatic waiting times which would assist in reducing patient anxiety from the time of testing until a care plan was in place.

Starship Foundation - Whare Hauora opens in Point England

The Starship Foundation has begun to move away from merely supporting children's services that are within the hospital and to look too at services within the community. Launched in partnership with the Starship Foundation and Point England School, the Whare Hauora means care can be delivered in the community for the community.

The Board Chair, Pat Snedden commented that nursing services in this type of setting were fundamentally important in assisting in managing the health conditions that these children face given home their environments and personal circumstances. The observation of cultural nuances and management of those is what prevents these children from ending up in hospital. This type of work should be undertaken as often as possible and in the most vulnerable areas.

Celebrating International Year of the Nurse and Midwife at Te Toka Tumai

The impact of COVID-19 meant that many of the original plans to celebrate this event had to be adapted. A video was one way this had been done. Nurses and midwives from right across Te Toka Tumai shed a light on their careers, including: how they became a nurse or midwife, what makes being a nurse or midwife just so special, how things have changed during their careers and what advice they had for the next generation.

Regional Clinical Portal

In December the move from Concerto to Regional Clinical Portal (RCP) was completed. The Regional Clinical Portal makes it easier for clinicians to view patient records.

Code Black response

A Code Black policy and mandatory training has been introduced to ensure everyone knows what to do in the very rare times these events take place.

Board members were advised that if they used their Auckland DHB email they could go onto Ko Awatea Learn and set up an account to undertake that training or any other training housed on that portal.

Auckland City Mission Appeal

The Te Toka Tumai team once again came together to support the Mission's Christmas appeal. Collection points for food, toiletries and gifts were put in place and a Give a Little page set up for cash donations. The appeal received more than 4,500 items and $4,815 in cash donations. While there were less items than in previous years it was partly due to the fact that the Employee Support Centre was being established at the same time and some items were channelled in that direction.

The Employee Support Centre has been very successful. The champions for the centre are directing people to the support that is available but in a way that is not reminiscent of charity but is more about how the organisation can support its own staff.

New Year Honours for Te Toka Tumai whānau

Dr Annabel Kirsten Finucane, ONZM has been made a Companion of the New Zealand order of Merit (CNZM) for her services to health, particularly paediatric heart surgery.

Dr Margaret Wilsher commented that Kirsten had trained at Auckland and was a House Officer at Greenlane Hospital committing early on to a career in paediatric heart surgery. This was a very arduous training programme as general surgery must be completed first and then the cardiac training programme. Kirsten also trained abroad coming back with experience that placed Auckland DHB in the top 10% in the world in terms of technical ability.

Distinguished Professor Ian Reid has also been made a Companion of the New Zealand order of Merit for services to medicine. Dr Margaret Wilsher commented that Ian Reid was the Deputy Dean across the School of Medicine and a very distinguished clinical academic. He is an endocrinologist and an expert in bone disease particularly osteoporosis having published over 450 papers on the subject and being considered a world expert on the subject.

Dr Christine Foley has been made an Officer of the New Zealand order of Merit (ONZM) for services to victims of sexual assault. Christine is less well known as she works in an area that is less visible to clinical staff or the general population so it is to be applauded that she is recognised for all the quiet hard work she has done in the background. Ailsa Claire commented that it is very difficult to create an area and feeling of safety in what is effectively a hospital site but it has been done incredibly well by this service.

Te Kauae Raro Award 2020

The Te Kauae Raro award recognises a Māori Nurse or Midwife who has made a significant contribution to Māori Health in our hospitals or community. This year's winner was Natalie Keepa, Acting Charge Nurse, Ward 42.

Farewell to Prof Stephen Munn, Clinical Director, Liver Transplant Services

Prof Stephen Munn retired quietly after a distinguished career during which time he established the liver transplant service and the clinical practice committee.

Stephen established the Liver Transplant Service after being recruited back from the Mayo Clinic to do that. He also established the Northern Region Clinical Practise Committee being an expert in health technology assessment giving advice to both our Ministry and the Australian Government.

To set up one major service in a life time is laudable but to be able to set up two is outstanding.

Performance of the Wider Health System

The hospital continues to experience a large number of people attending the Emergency Departments, particularly the Children's Emergency Department. The admission rate has actually gone down indicating that many of the people coming to the EDs are people that should have perhaps gone through Primary Care first but were unable to do so over the Christmas period.

The Board Chair, Pat Snedden asked Debbie Holdsworth whether there was any data being received through the COVID 19 process that indicated that enrolments in PHOs were

changing significantly either up or down. Advice was given that this had not be observed but what was of concern was the increased vaccine hesitance in the Māori community which seemed to be the result of the influence of Social Media and had the potential to affect the COVID 19 vaccine rollout mid-year.

The Board Chair, Pat Snedden commented that the natural place to have this issue addressed was via the Iwi Board Partnership. It needed to be addressed quickly and could be done so through Kotuhi Hauora.

Debbie Holdsworth drew attention to the last Board meeting where the differential impacts for Māori and Pacific babies, in terms of vaccination rates, was highlighted. In relation to immunisation, and although Pacific babies experienced a second wave lockdown, their figures showed a good recovery. However, for tamariki Māori there appears to be a wave one lockdown effect that has persisted and immunisation figures have not recovered. Social media has had an effect such that Māori whanua who would once have invited clinicians into their homes to have vaccines administered are now not allowing that. Karen Bartholomew added that this was also a concern for the Māori mobile units.

It is believed that there needs to be some national leadership on vaccine hesitancy for Māori.

Bernie O'Donnell commented that the Māori community needed trusted community voices to combat the effect of social media. There are already trusted leaders that could be utilised to speak up in support of vaccination.

Finance Report

The financial performance is on track to meet the budget for this financial year.

The Board Chair, Pat Snedden asked whether there was anything in the financial landscape that would derail the agreed year end position with the Minister of a $45M unfavourable budget. Ailsa Claire advised that a whole range of risks were being managed but that at this point the budget was on track.

Actions

1. **That Margaret Wilsher with the Boards endorsement acknowledges the contribution of Prof Stephen Munn.**
2. **That Tama Davis and Bernie O'Donnell provide names of trusted Māori leaders to the Iwi Partnership Board and encourage Kotuhi Hauora to take the matter of Māori vaccine hesitancy up.**

Resolution:

That the Chief Executives report for 24 November 2020 – 10 January 2021 be received.

Carried

5.2 Health and Safety Report *(Pages 41-48)*

Alistair Forde, Director Occupational Health and Safety asked that the report be taken as read, advising as follows:

There have been some good observations carried out in the January period with a positive uptake in following process and engagement.

Maturity and Cultural Shift

There has been an improvement of the quality of data lodged in Datix which is driving a cultural shift. There is more evidence to support narrative which points to a reduced injury rate associated with some of the more potential serious injuries.

The Lead/Lag data is a good initiative where more data is now coming back from the Directorates which provides a clearer sense of overall reporting across the DHB as well as visibility of key risks. This will help drive maturity in the reporting.

The following points were raised during discussion of maturity and culture shift:

The Board Chair, Pat Snedden asked whether in terms of the emotional intelligence of the leadership in this area was a corresponding shift in the mind set of people about the priority of Health and Safety being seen? Alistair Forde advised that this had always been there but is more a case of capability. People are motivated to do the right thing and understand from a personal perspective what health and safety means but delivering it in the context of work and the organisation there is a capability gap. The work plan focuses on building that capability, keeping people aware and understanding what their risks are so that they can prioritise correctly.

The Board Chair, Pat Snedden asked whether the organisation was getting better, sharper and more focused leadership on this area given that for most managers they have other foci. Alistair Forde advised that to get to that stage was a gradual shift that would require 12 to 18 months.

Advice was given that leadership comprised around 700-800 staff and strategic stakeholders. When these people are stood up effectively this would drive the required cultural shift.

Biological Hazards

There has been some good feedback and observations around hospital controls in relation to the new COVID variant strains. There is a high degree of understanding in how the hospital is to manage COVID and any community outbreak.

Contractor Management

Work is being done with some of the large contractors in relation to the pre-qualification process to strengthen that area so they are providing robust documentation.

Contracts within the Provider Arm are being looked at to ensure that health and safety components are clearly specified within.

This work is part of the SAFE 365 programme of work focused on improving Auckland DHB contractors understanding of the organisations health and safety requirements and the

improvement of their management systems to increase maturity in this area.

In February there are workshops scheduled with 150 contractors to focus on specific areas and communicate the intent of what Auckland DHB is doing in this space over the next two years.

HASANZ GM Safety Forum

This forum attracted the attendance of big corporates and well established organisations.

There were some common themes across all these organisations that were highlighted and now form the focus for the GM Safety Forum work programme:

• Safety leadership and governance

• Mental health/wellbeing

• Capability building and talent development for Health and Safety leaders

• Critical control alignment and reassurance

This will enable them to advise the government around particular resourcing needs and how to address some of the corporate risks that organisations will be facing in the next few years.

The Board Chair, Pat Snedden made an observation that it was surprising that big well known and well established organisations were still operating at this level and were not at a level of maturity that would satisfy an expert. Auckland DHB should be the encourager of those companies to significantly move there health and safety systems forward. People have to be doing the right thing.

Resolution:

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

Carried

5.3 Human Resources Report *(Pages 49-54)*

In the absence of Mel Dooney, Chief People Officer, Ailsa Claire, Chief Executive asked that the report be taken as read advising that it was the quarter two report and that the plan was significantly on track. Ailsa drew attention to the "People Analysis" Dashboard commenting that the point to note was when consultants and staff used to support COVID are subtracted from the workforce the Board is exactly in the position with the number of staff it was anticipated having at this time. However, the data is showing as high and this is due to the situation with annual leave. The annual leave targets that were required to be met over the holiday period have not been met.

The Board Chair, Pat Snedden commented that the more serious challenge was moving to a zero based budget for the 2021/2022 financial year and when considering the statistics in the dashboard it was not clear how that was to be achieved. Ailsa Claire advised that if staffing was being looked at to be part of financial solution it had to be born in mind that the biggest staffing pool the DHB had was its nursing staff. The Board had to rollout the nursing staffing requirements for CCDM by the end of this financial year. That programme matches the acuity

of the patients with the number of staff on the wards while also factoring in the requirement for staff to take annual leave. It was unlikely that reductions would be found in this area.

The savings work plan originally put in place had been overtaken by COVID 19 requirements with those staff tasked with making the identified savings seconded to COVID 19 duties. It has made the savings work plan a challenge to implement. There had also been growth in a number general of costs associated with procurement where the Board had historically tended to make a saving.

The Board Chair, Pat Snedden commented that it would be helpful to now have with each months reporting some commentary on what has been done in order to anticipate what is required for the 2021/2022 financial year zero based budget.

Resolution:

1. **That the Board receives the Q2 Pūmanawa Tāngata Status Report noting the progress which has been made since the Board signing off the plan in September 2020**
2. **That the Board receives the Q2 Te Toka Tumai People Dashboard – Quarter 2 2020/21**

Carried

6. PERFORMANCE REPORTS

6.1 Financial Performance Report *(Pages 55-61)*

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

For December the business as usual result was largely on track being unfavourable by $340K leaving the Board with a year-to-date favourable variance of $2.3M when COVID 19 and Holidays Act costs are excluded.

Traditionally a wash-up accrual for the Holidays Act cost was done at year end the Ministry has now requested that this be done every month. For the month of December an accrual has been made loosely based on last years provision as a very high level estimate which has yet to be tested with EY.

The forecast is on track to achieve the $45M deficit budget and while that comes with challenges it is currently on track to be achieved. The challenge lies with the next year's budget and outlying year's budget impacts.

It is unfortunate that COVID 19 has overtaken some planned savings work this year that was key to delivering cost reductions for 21/22. The challenge now is to look at how business as usual and COVID 19 work are going to co-exist and the effort required to start driving some of the savings initiatives, such as procurement at the same time as managing BAU and the catch-up required in the area of planned care. The other interesting factor to manage comes with the volume shifts that have been seen in the last 9 months and understanding what might now be a permanent versus a temporary volume shift. This is key to being able to

estimate the impact for the next financial year.

Michael Quirke asked why the favourable BAU situation experienced in November of $2.5M is not being seen in the forecast. It was agreed that this was a misstatement of the forecast, and that the correct reflection was a reduction from $45M BAU forecast to $42.8m deficit.

Ian Ward commented that he felt that it was not appropriate for a forecast to appear in a public document without explanatory notes and in its current state it was better considered in confidential until full reasoning could be supplied.

Fiona Lai made an observation that she would find it easier to understand the budget if charts were provided showing where revenue and expenses emanated from.

The Board Chair, Pat Snedden reminded Board members that prior to the start of COVID 19 the Board had a training plan that incorporated an internal Board tutorial around the financial landscape that this DHB worked within. Some Ministry of Health training had been supplied but it would be good to have some workshops provided by the Finance and Planning and Funding teams to highlight how the system worked and how all the variable pieces fit together.

Action

That the Chief Financial Officer and the Director of Funding provide some one hour workshops focusing on the how the financial and funding system worked and to provide some deep dives into the areas that will affect whether the Board will see budget clarity toward year end or not along with the variables involved with that situation.

Resolution:

That the Board Receives this Financial Report for the five months ending 30 November 2020

Carried

7. COMMITTEE REPORTS - NIL

8. DECISION REPORTS

8.1 DHB Governance Programme: 'Seat at the Table' – Appointment of Board Observers *(Pages 62-66)*

The Board Chair, Pat Snedden advised that this programme was an invitation to engage with people who it was thought would benefit from experiencing what it was like to sit at a Board table making decisions.

Tama Davis, Deputy Board Chair advised that Waitemata and Counties DHBs had been involved with the programme and learning from their experience had been used when presenting this report and providing an opportunity to increase the Māori and Pasifika presence at not just this Board table but preparing them for other wider Board appointment opportunities. It was also an opportunity for current Board members to share their wealth of experience with potential future leaders.

Zoe Brownlie commented that she had some questions around the recruitment process and the definition of a "young person", a "person with a disability", and what mentoring will look like which could be covered in general conversation around the table.

The Board Chair, Pat Snedden advised that the programme was promoted by the Ministry of Health and was an important initiative in attempting to find a pipeline of people and to provide an opportunity for them to gain some experience without the authority associated with decision making. They are people who are already established and capable with cultural competency I their own areas but in this instance can be observer and questioners and experience first hand how a Board actually functions.

Fiona Lai commented that she fully supported the programme to develop young people to be governors of the future. Fiona reminded members that the Auckland DHB served a population which included 40% of Asians and she felt it would be fair to consider their involvement also.

Fiona Lai commented that this was an observer role and that in terms of speaking rights that should be granted by invitation only. Those on the Board represented constituents and were answerable to the community and people as part of this programme were not.

Michelle Atkinson asked about the definition applied to "young" and what age range that encompassed. Pat Snedden commented that outstanding people with a drive and interest in getting themselves equipped to be valuable in a governance setting which can be quite formidable for many. There needs to be a degree of maturity to be able to manage that.

Ian Ward commented that he personally would not support this being at Board level but could do so at Committee level. Committees provided a degree of detail and depth and a level of interrogation which allowed a person to learn more and understand how the hospital functioned. This was not always the case at Board level.

Bernie O'Donnell commented that this was a mentoring kaupapa and not an invitation to be a Board Member and thought that the optimum age was between 25 and 35. He felt that the community demographic should be reflected and supported being inclusion of the Asian voice. If participants are invited to air their views they should feel competent to do so and be able to do so in a safe environment. It can be difficult for younger people to express their views in front of the Board because of member's perceived expertise, age and who they might be. He did agree with Ian around their input because that input was merely an opportunity for them to learn

Jo Agnew commented that she saw this as a foundation programme to identify potential people who would be active Board members in the future. Jo had some reservations about confidentiality of information that they were exposed to. However, this type of programme is nothing new with the concept having been around for many years.

Michelle Atkinson commented that she felt the Committee level provided too much detail to get ones head around and that as a new member herself she found the Board meeting easier to understand. She didn't feel that sensitivity of information was such an issue as they could be asked to leave for that item.

Zoe Brownlie commented that she would want to ensure that the recruitment process was

all inclusive with a broad reach being utilised.

Tama Davis advised that it was not promoted that mentees attend all Board meetings scheduled in the year, that it could be a mix tailored to the mentees experience and the work that they were currently involved with and the environment that they would be coming from. There are general guidelines for how these mentees would be supported by mentors and there is also a process for recruitment.

The Board Chair, Pat Snedden commented that as Zoe Brownlie was Chair of the People and Culture Sub-Committee she assist Tama with the recruitment process. He also asked that Ian Wards commentary around the correct placement of mentees should be is taken note of. Any decisions around the programme are to be brought back to the Board by circulated resolution so that the programme could be got up and running for the year.

Resolution: Moved Pat Snedden / Seconded Tama Davis

That the Board:

1. **Receives the DHB Governance Programme: 'A Seat at the Table' Observers report for January 2021.**
2. **Approves the appointment of three Board Observers to Auckland DHB where two are proposed as external appointments and a third from internal staff members**
3. **Gives consideration to appointing two or three board members as mentors, one of these to be Tama Davis.**
4. **That Tama Davis and Zoe Brownlie manage the recruitment process and report back to the Board via circulated resolution to obtain final approval.**

Carried

8.2 Committee Membership - Appointment of an additional board member to the Disability Support Advisory Committee and required subsequent amendment of the Terms of Reference *(Page 67)*

There was no discussion.

Resolution: Moved Pat Snedden / Seconded Tama Davis

That the Board:

1. **Amend the Terms of Reference for the Disability Support Advisory Committee to allow membership to comprise up to four Board Members**
2. **Approve the appointment of Zoe Brownlie to the Disability Support Advisory Committee.**

Carried

8.3 Nomination process to hA Board *(Pages 68-74)*

The Board Chair, Pat Snedden advised that he would like to get this process concluded over the next month.

There were no questions.

Resolution: Moved Pat Snedden / Seconded Tama Davis

That the Board:

1. **Agree the process as outlined in the report**
2. **Give the Board Chair and Deputy Chair the authority to make the final selection on behalf of the Board**
3. **Note that the appointment must be endorsed by the three remaining regional DHBs prior to healthAlliance being notified.**

Carried

9. INFORMATION REPORTS - NIL

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

Resolution: Moved Pat Snedden / Seconded Jo Agnew

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
3. Confirmation of Confidential Minutes 16 December 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. Confidential 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]
5. Risk 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 [Official Information Act 1982 s9(2)(i)]** **Prevent Improper Gain** **Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]**	**That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]**
6. Chief Executive 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.** **[Official Information Act 1982 s9(2)(i)]**	**That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]**
7. 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 [Official Information Act 1982 s9(2)(i)]** **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 [Official Information Act 1982 s9(2)(j)]**	**That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]**
8. Committee Reports - NIL	**NIL**	
9.1 Abortion Services	**Commercial Activities**	**That the public conduct of the**

Tender	**Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]** **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 [Official Information Act 1982 s9(2)(j)]**	**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 Capex Variation Requests – BFTF	**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 [Official Information Act 1982 s9(2)(i)]**	**That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]**
9.3 Capex Variations Requests – General	**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 [Official Information Act 1982 s9(2)(i)]** **Prevent Improper Gain** **Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]**	**That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]**
9.4 Maternity Services Engagement Plan	**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 [Official Information Act 1982 s9(2)(i)]** **Negotiations** **Information relating to commercial and/or industrial negotiations in progress is**	**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]**

	incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	
10.Discussion Reports	**Nil**	
11.1 HealthSource New Zealand Limited – Organisational Performance 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 [Official Information Act 1982 s9(2)(i)]**	**That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]**

Carried

The meeting closed at 11.25pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 27 January 2021

Chair: _____ Date: _____

Pat Snedden

Action Points from 27 January 2021 Open Board Meeting

As at Wednesday, 31 March 2021

Meeting and Item	Detail of Action	Designated to	Action by
27 Jan 2021 Item 5.1	**Prof Stephen Munn - Acknowledgment** That Margaret Wilsher with the Boards endorsement acknowledges the contribution of Prof Stephen Munn.	Margaret Wilsher	Closed
27 Jan 2021 Item 5.1	**Maori Vaccine Hesitancy** That Tama Davis and Bernie O'Donnell provide names of trusted Māori leaders to the Iwi Partnership Board and encourage Kotuhi Hauora to take the matter of Māori vaccine hesitancy up.	Tama Davis Bernie O'Donnell	Verbal Update
27 Jan 2021 Item 6.1	**Board Financial Workshops** That the Chief Financial Officer and the Director of Funding provide some one hour workshops focusing on the how the financial and funding system worked and to provide some deep dives into the areas that will affect whether the Board will see budget clarity toward year end or not along with the variables involved with that situation.	Justine White Debbie Holdsworth	(Following completion of MoH workshops on Financial Governance in mid April) TBA

Chief Executive's Report

TE TOKA TUMAI
Auckland DHB

5.1

Recommendation

That the Chief Executives report for 11 January 2021 – 14 March 2021 be received.

Prepared by: Ailsa Claire (Chief Executive)

1. Introduction

This report covers the period from 11 January 2021 – 14 March 2021.

2. Events and News

Honouring Waitangi Day

History is the best storyteller and the mini-documentary series, Takahinga ō Mua, produced by Māori TV provides the true tales of the people and the events that helped shape our nation.

This year in the lead up to Waitangi Day we held screenings of Takahinga ō Mua for our people to learn about the events that helped shape our nation. The mini-documentary series was also available for our kaimahi to view after Waitangi Day.

Pay equity for DHB admin employees

An initial agreement has been reached between the Public Service Association (PSA) and the country's 20 District Health Boards in the bargaining for Clerical and Administration Pay Equity. A work programme to develop a national pay rate and job banding structure is in place. This will contribute to a proposal for a full pay equity settlement by mid-2021. This is progressing well. In the interim we, along with other DHBs, are gathering information to be able to meet the settlement.

Celebrating Pride in Health

Every year, we recognise the rich diversity of our team and the people we serve in Tāmaki Makaurau by celebrating Pride in Health.

This year to celebrate PRIDE we turned the pedestrian crossing at Auckland City into a rainbow crossing and our Rainbow Employee Network hosted Rainbow information stands and a Rainbow lunch.

We are a proud part of the Rainbow Tick community, which is a way of ensuring we continually improve our processes, our environment and our culture. We want Te Toka Tumai to be a great place to work where everyone gets a true welcome; however they identify their race, gender, ethnicity or sexual orientation.

Employee Support Centre

Our Employee Support Centre was set up last year as a place where our people can get career development advice, financial advice and wellbeing support alongside additional support provided by other services and agencies. **Most recently, free breakfasts have been introduced, and are now available for those who need them.**

The employee support centre is funded by our Manaaki Fund. Launched in April 2020, in partnership with the Auckland Health Foundation (the official charity of Auckland DHB's adult health services), the Manaaki Fund provides a way for our 11,000 Auckland DHB kaimahi to support colleagues who have been financially impacted by COVID-19.

Women's Health Hui

The Women's Health Directorate began an important piece of engagement work with a hui on March 1. The hui was designed to start a conversation with our people about identifying and removing barriers to equity for Māori wahine and Pacific women as well as other service users; ensuring the same level of care and treatment is offered.

The hui was intended to be face to face, but due to alert level 3 it was conducted over Zoom. Whilst not ideal, it was more important to make a start.

A Communications and Engagement Specialist has been recruited to support this kaupapa and this person will co-ordinate the full engagement plan and work with the Women's Health Leadership Team to reach out to our communities, with a focus on our partnership with Māori and engagement with Pacific. What we hear will be translated into recommendations and reported back to the Board.

Community Rehabilitation

The Community Rehabilitation Team has been working closely with Māori and Pacific stroke patients. The goal is to build relationships and to enhance the transition of care from a hospital setting to a community setting. The overall aim of this work is to make sure patients and their whānau feel more confident about their return home and know what to expect and when to expect it.

2. 1 COVID-19 Update

Vaccination rollout

The vaccine clinic for Auckland DHB staff opens in late March. It will operate 7 days a week, including on public holidays.

Auckland DHB is following the Government's sequencing framework. Staff will be invited to get vaccinated when it's their turn.

We've trained and recruited vaccinators, observers and administrators to help the vaccine clinic run smoothly. A booking system has been developed for the Northern Region DHBs and information will securely link to the Ministry Of Health's COVID-19 Information Register.

After the first dose of the vaccine staff will automatically be sent an invitation for their second dose.

The Auckland DHB team are also assisting with staffing the Community Vaccination Centres being set up across Auckland. Our people have many questions about the vaccination and we are supporting them to get the vaccine by providing regular forums to ask questions and get regular updates.

This rapid set up has been possible with lots of willing people across our DHB supporting the programme, despite the hospital being incredibly busy.

Responding to COVID-19 in the community

The COVID-19 response team continues to support the organisation to manage any changes to alert levels. When changes to alert levels for Auckland have been announced, such as the movement to alert level 3 being announced late in the evening on Saturday 13 February, the team have been able to respond with speed.

We have good systems and processes to manage changes to the incidence of COVID-19 in the community. We continue to improve these systems as we experience changes in alert levels.

2. 3 Notable programmes and events

National Healthcare-associated Infection Survey

In early March, the Health Quality and Safety Commission carried out the National Healthcare-associated Infection Survey at Auckland DHB.

This national survey will provide insights to help make improvements that should reduce healthcare-associated infections both locally and nationally.

We were the first DHB to take part in the survey which involved reviewing the clinical records of all adult inpatients.

We look forward to seeing the results of the survey.

3. Communication and Engagement

3. 1 External Communication

Between 11 January and 14 March 2021 we received 114 requests for information, interviews or access from media organisations. This included requests to interview clinicians about the COVID-19 vaccine and requests for information on the capacity of the hospital and demand over summer, elective caesarean section intervention rates and diabetes care for young adults. Around 18 per cent of the enquiries over this period sought the status of patients admitted following incidents such as road traffic or water incidents.

We responded to 46 Official Information Act requests over this period.

3. 2 Internal Communication

For this period, 722 emails were received. Of these emails, 92 were non-communications-related and where appropriate, were referred to other departments and services at Auckland DHB.

- Nine editions of Pitopito Kōrero | Our News, the weekly email newsletter for all employees, were distributed.
- Nine editions of the Manager Briefing were published for all people managers.
- The latest edition of Te Whetu Mārama | Nova was published.
- Six COVID-19 update webinars were held.
- 19 COVID-19 update emails were sent out to all employees.

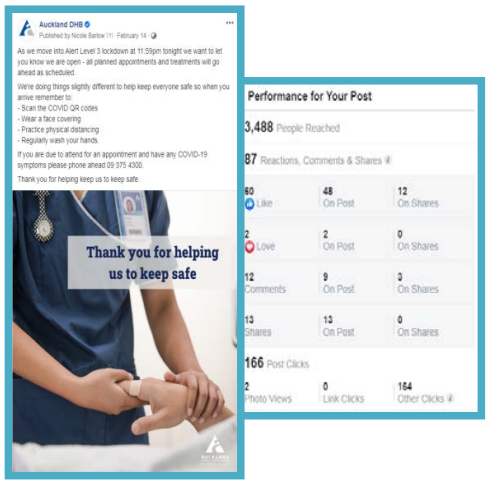
3. 3 Social Media

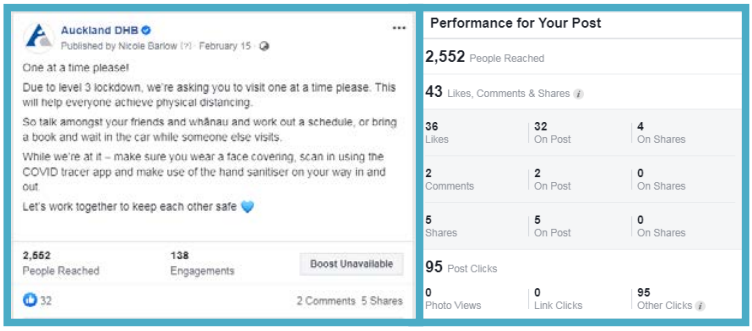
We continue to engage with our community on social media, celebrating achievements and sharing important health messages.

Some of the information we have shared includes:

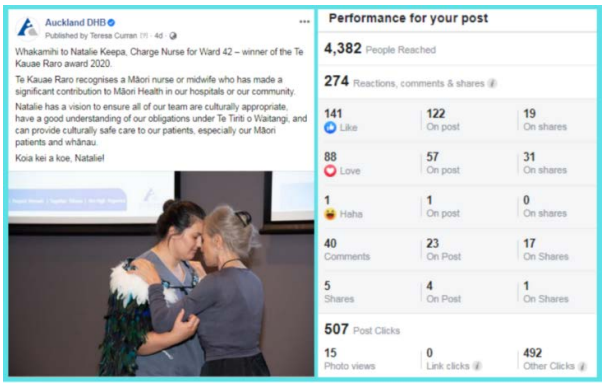
- COVID-19 alert level updates and safety updates
- The oral and maxillofacial surgery service using 3D printed models to plan and prepare for surgery.
- Research into the efficacy of tocilizumab or sarilumab on COVID-19.
- International Women's Day – celebrating some of our amazing women across Auckland DHB
- Celebrating 1,000000 COVID tests carried out in the Northern Region
- Guardians of the future – measles vaccine campaign

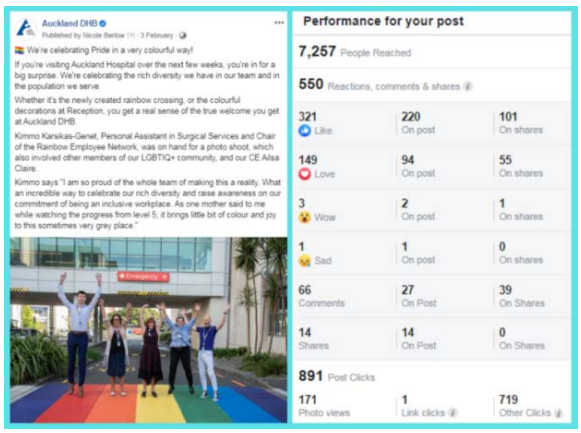
COVID-19 posts





Facebook posts with most engagement





4. Our People

4. 1 Local Heroes

Congratulations to our recent local heroes, Gemma Hinkesman, Staff Nurse, Critical Care and Sally Roberts, Clinical Head of Microbiology and Clinical Lead for Infection Prevention. Here are their nominations:

Gemma Hinckesman, Staff Nurse, Critical Care

"Gemma went above and beyond for our family. She was patient, kind, caring and so thoughtful. Gemma listened carefully to every word and was intuitive, predicting needs we didn't even know were needed. She made the long nights spent waiting and worrying more comfortable. Not only did she do everything in her power to make my mum comfortable, she did everything to help our family feel comfortable.

Gemma deserves recognition for her hard work and kindness. She made all the difference to our heart-breaking experience and we will never forget what she did for our family."

Sally Roberts, Clinical Head of Microbiology and Clinical Lead for Infection Prevention

"During the first months of COVID-19 testing, Sally provided invaluable guidance and support to the laboratory leadership team. Her common-sense approach and her ability to focus on what is important meant that critical decisions were able to be made quickly.

Sally offered advice on PPE and Health and Safety requirements and was able to calmly reassure staff that by following PPE requirements they were safe.

Sally worked tirelessly to drive high quality standards."

4. 2 Colin McArthur – Research extraordinaire

One in 12 critically ill COVID-19 patients could be saved after a discovery that two drugs, already used to treat other conditions, are also effective in treating the virus. Our very own Dr Colin McArthur, one of the trial's senior researchers, says these findings will help critical care teams around the world improve outcomes for the most severely ill COVID-19 patients. The discovery, published in the New England Journal of Medicine, has been described by experts as a phenomenal step forward in combating the deadly virus.

Ka pai Dr McArthur.

4.3 Te Kauae Raro award

Congratulations to Natalie Keepa, Charge Nurse for Ward 42 – winner of the Te Kauae Raro award 2020.

Te Kauae Raro recognises a Māori nurse or midwife who has made a significant contribution to Māori Health in our hospitals or our community.

Each year, the previous recipient passes over the Te Kauae Raro korowai. This builds a sustainable whakapapa and honours the mauri and mana that lives within all our Māori nurses and midwives. Natalie was presented the award by 2019 recipient, Linda Chalmers.

Natalie has a vision to ensure all of our team are culturally appropriate, have a good understanding of our obligations under Te Tiriti o Waitangi, and can provide culturally safe care to our patients, especially our Māori patients and whānau.

Ka pai, Natalie!

2019 recipient Linda Chalmers, passes over our Korowai to our 2020 recipient, Natalie Keepa.

4. 4 Senior Leadership changes

In February Jo Gibbs, Director of Provider Services was seconded from Auckland DHB to the Ministry of Health as National Director Operations for the COVID-19 vaccine rollout.

She is working alongside Sue Gordon, Deputy Chief Executive COVID-19 Health System Response, to lead the delivery of the immunisation programme nationally. Jo is a very experienced health leader, and she will be an invaluable addition to the team planning the COVID-19 vaccine work programme.

Dr Mike Shepherd will be the interim Director of Provider Services during Jo's secondment.

5. Performance of the our health system

Priority Health Outcomes Summary

	Status	Comment
Acute patient flow (ED 6 hr)		Feb 85%, Target 95%
Improved access to elective surgery (YTD)		91% to plan for the year, Target 100%
Faster cancer treatment		Feb 95%, Target 90%
Better help for smokers to quit:		
• Hospital patients		Feb 95%, Target 95%
• PHO enrolled patients		Dec Qtr 82%,Target 90%
• Pregnant women registered with DHB-employed midwife or lead maternity		Dec Qtr 100%,Target 90%
Raising healthy kids		Feb 100%, Target 95%
Increased immunisation 8 months		Dec Qtr 93%, Target 95%

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

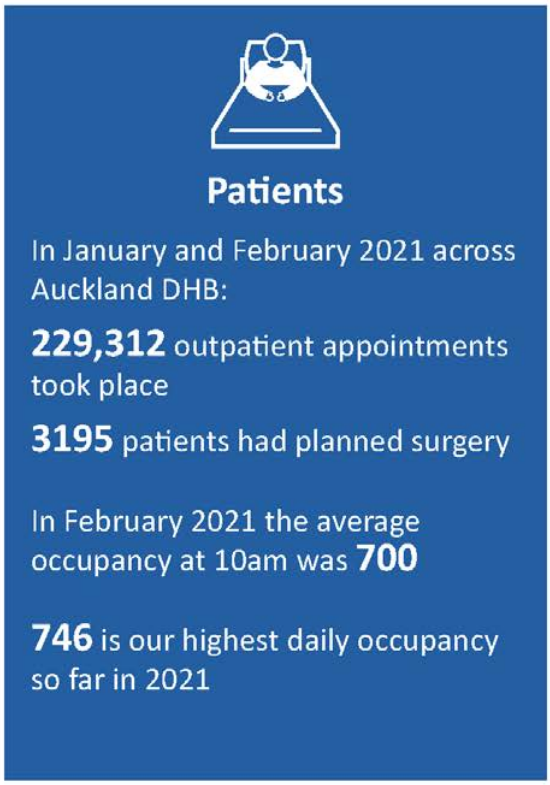
6. Financial Performance

DHB Financial performance against the budget for the eight months ending 28 February 2021 is a deficit of $62.6M, against a budgeted deficit of $11.5M, thus unfavourable by $51.1M. This unfavourable variance is attributed to an increase in the provision for non-compliance with the Holidays Act of $26.7M and unfunded Covid impacts of $27.1M. The consolidated Business as Usual (BAU) operational result (excluding these extraordinary items) is favourable to budget for the year to date by $2.6M, mainly reflecting clinical equipment donated to the DHB by the Ministry of Health.

At a divisional level, the Provider Arm result is $53.4M unfavourable to budget (mainly due to unfunded Covid impacts and unbudgeted Holidays Act provision). The Funder Arm result is $1.9M favourable to budget and the Governance and Admin Arm result is also favourable to budget by $378K. The year end forecast result is a deficit of $102M against the approved budget of $45M reflecting a full year Holidays Act impact of $40M, unfunded Covid impact of $19M and BAU favourable to budget by $3M.

The first draft of the 2021/22 Annual Plan was submitted to the Ministry in March 2021 with a deficit budget of $41M. We are still waiting to receive the 2021/22 Funding Envelope advice which will inform the final budget position.

7. Auckland DHB at a glance



Health and Safety Report

Recommendation

That the Board receives the Health and Safety Performance Report for March 2021.

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

 Te Tiriti o Waitangi in action	*Occupational health, safety and wellbeing has a close alignment with the Kia Ora tō Wāhi Mahi vision through the development of safety culture and leadership, empowering and developing our leaders to help us flourish and grow by supporting our leaders' capability to nurture their own wellbeing and the wellbeing of their team and keep their people safe, and improving connections and collaboration across the DHB.*
 Eliminate inequity	*This report details how we are ensuring integrity associated with meeting ethical and legal obligations, and how we are working towards eliminating inequity and strengthening our cultural diversity.*
 People, patients and whānau at the centre	*This report provides information on how the work we are doing that supports patient safety, workplace safety, visitor safety, worker health and wellbeing. Health, safety and wellbeing risks and programmes are inherently focused on staff, patients, visitors, students and contractors.*
 Digital transformation	*This report provides information on the progress of work in progress to enhance our OH&S information management system and integrate data within the service and across QSR*
 Resilient services	*This report provides information on the progress of work programmes and strategies to implement effective resourcing solutions that meet our organisations newfound need for Occupational Health and Safety, promote a culture for our people where we empower and promote good processes and reliable systems to enable delivery of resilient services, information and insight into workplace incidents and what Auckland DHB is doing to respond to these and other workplace risks.*

1. Performance Summary

1.1 Lead Indicators

Description	January	Previous Month (December)	3mth Trend	6mth Trend
Leadership Observations	125	104	↓	↓
Leadership Discussions (H&S Rep Meetings, Regional H&S Technical Advisory Group (TAG) ACC/Safe 365	49	135	↓	↓
Training (Inductions/PPE/Patient Handling)	213	213	↓	↓
Audits/Inspections	107	121	↓	↑
N95 Respirator Fit Testing Appointments*	233	125	-	-

- N95 Fit Testing appointments for February totalled 1,020.
- Leadership activities reduced in January due to staff annual leave over the Christmas/New Year period.

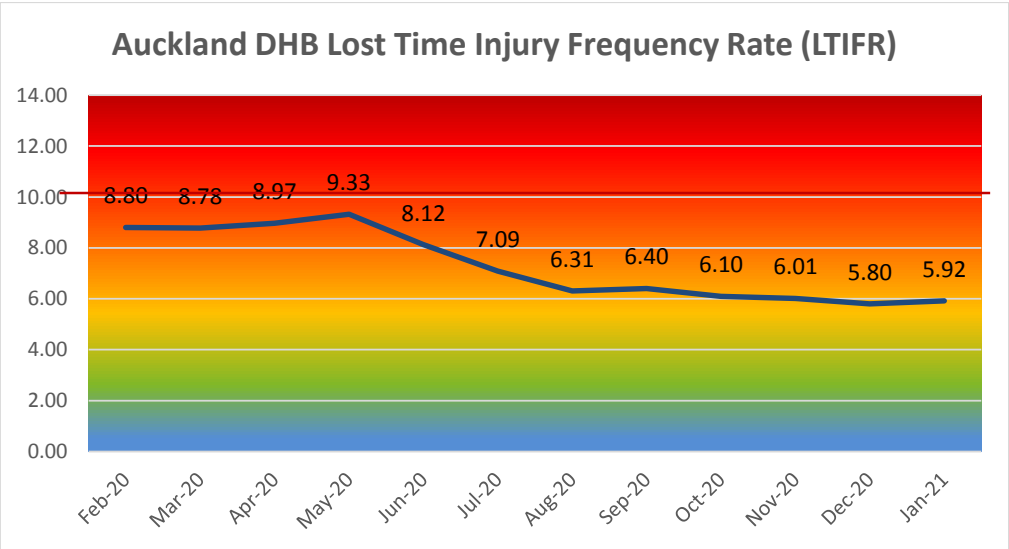
- The decrease in training and formal inspections relates to the expected decrease in overall activity over the holiday period. Additionally, our tracking system for online and workplace inductions has not yet been updated with data for the current year.
- Review of the inductions and internal training reporting system is required to provide workplace managers and Health and Safety Advisors with visibility.

**This figure is based on fit tests delivered by Occupational Health Nurses and In Team Fit Testers. N95 Mask Fit Testing has transitioned to a mixed model of delivery with In-Team Trainers now fully operational. Our lead indicator has been modified to reflect the number of N95 Fit Test Clinic appointments attended specifically for fit testing.*

1.2 Lag Indicators

Description	Target	January	Previous Month	3mth Trend	6mth Trend	12mth Trend
Total Recordable Injury Frequency Rate (TRIFR)(per 1,000,000 hrs)	-	26.34	**25.27**	23.72	21.61	25.20
LTI Frequency Rate (LTIFR)(per 1,000,000 hrs)	10.00	5.92	**5.80**	6.01	6.31	8.80
All Injury Frequency Rate (AIFR)(per 1,000,000 hrs)	-	95.95	**96.96**	96.44	109.00	112.70

a. 112 injuries were reported in January, including 15 that required medical treatment and 9 resulting in lost time.
b. The three leading causes of workplace injury were ergonomic hazards (including repetitive tasks, manual work, and patient handling), workplace violence and sharps.
c. The quality of data and information in Datix continues to require improvement. Feedback from users indicates that work on refining the classifications is vital and will be of significant benefit.
d. Active coaching of managers to support them to improve the quality of their incident reporting has commenced. The availability of improved information will better enable identification and implementation of effective preventive actions following incidents.



2. Risk Analysis

2.1 WorkSafe Notifiable Incidents

There have been two Notifiable events on Auckland DHB sites, involving an electric shock and a leg fracture.

The electric shock incident is currently under formal investigation by the Auckland DHB Health and Safety team. Once the investigation has been completed and official findings are available, the Board will be updated.

Both the electric shock and leg fracture incidents were notified to WorkSafe New Zealand. WorkSafe New Zealand, after review of the information filed, has indicated that no further immediate action is required.

2.2 Key Risks

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

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

Biological Hazards: The re-emergence of COVID-19 in the community means this risk remains at High. We note that the COVID-19 vaccination programme has commenced in New Zealand and a tiered approach is being undertaken. More information on this is included in section 4.1 below.

Contractor Management: The Contractor Management Framework continues to be implemented for Auckland DHB contractors. A select group of contractors (circa 300 as part of the Making Health Safer ACC sponsored programme) have been chosen as a pilot group to 'test drive' the Contractor Management Gold Standard Framework, setting DHB expectations/requirements, contractor safety philosophy and how the new Auckland DHB contractor management framework benefits contractors. Two contractor workshops were completed in February with a third scheduled on 5 March 2021. The immediate goal is to ensure the pilot group have as a minimum requirement a Totika certification and, for more complex higher risk contractors, a refreshed safety maturity profile. The pilot phase is expected to be completed by 31 March and lessons learnt applied to the remainder of Auckland DHB contractors (circa 7,000 contractors).

A workshop with Commercial contractors has been set for 2 March as part of the wider roll out. Some resistance continues to be experienced by segments of the contractor base, questioning their need to have basic safety requirements in place. Work continues with all contractors to improve their understanding of Auckland DHB safety requirements using multi-media including videos, general communication, workshops and soon to be initiated contractor newsletter and quarterly contractor workshops. Learning from the Auckland DHB pilot continues to be shared with other DHBs with the third contractor management seminar held in late February.

Health and Safety Maturity: Work commenced in late February on 'refreshing' the safety maturity profiles of Auckland DHB Directorates. Health and safety staff will be engaged in this programme of work along with key stakeholders from each Directorate to ensure rigour in the process, knowledge transfer and capability. This work parallels the work undertaken at a sector level with the national benchmarking exercise just completed across 20 DHBs (results to be released soon) with the safety maturity refresher allowing Auckland DHB to understand its current baseline safety maturity, areas

of strength and weakness and recommendations for safety improvements to enhance internal safety performance and maturity. An insights report will be produced for discussion at the completion of the programme and presented at the next Board and Finance Risk and Assurance Committee.

Workplace Violence and Aggression: A recent incident in the Adult Emergency Department initiated the team to engage the Workplace Violence (WPV) Advisor to run a session on the DHB's Offensive Weapons policy. The session covered the policy as a whole, and follow up on dealing with a variety of scenarios. During the session the new Code Black option was also discussed and those staff that had not as yet completed the online module were encouraged to do so.

We have started an in depth review of front facing staff in some of our higher risk areas (Te Whetu, Child Health, and Emergency Dept.) to understand whether current controls around managing and/or preventing Workplace Violence are working. Initial discussions are highlighting that staff facing WPV daily are highly stressed, that there is a culture of acceptance of WPV resulting in this being normalised, and a high proportion of informal controls that are not being validated.

There was no CALM communications training completed by new employees across any directorate in December 2020. Advisors have been asked to encourage their directorate staff to complete this mandatory training.

3. Observations

We completed 20 site visits from which we made 125 observations. Of those observations, 53 were assessed as Safe, 42 as At Risk, and 30 as Significant At-Risk.

The Significant At-Risk observations made in January related to the following hazards:

- High-risk repetitive tasks that could result in injury;
- Documentation requirements for emergency response drills;
- Additional / enhanced risk assessment reviews required for high-risk workplaces;
- Enhanced review / response to ergonomic risks in workplace design & equipment selection / replacement;
- Support systems for students or volunteers working in workplaces that have a significant exposure to violent patients;
- Engineering and administrative controls around hazardous substances;
- Clarification of operational responsibility for traffic management;
- Obstruction of fire escape routes; and,
- Contractor management.

Where practicable, our observations were shared with people leaders responsible for the workplaces observed.

4. Key Initiatives and Activities

4.1 Regional COVID Vaccination Centres

Activities to swiftly implement Community Vaccination Centres to enable vaccine delivery to the public within the NRHCC Vaccination Programme public are in progress. The first of an anticipated six SVCs has been established at 31 Highbrook Drive, East Tamaki, with the first vaccinations performed on 9 March 2021.

As the declared PCBU, Auckland DHB have recruited key roles and led the development of draft risk assessments to ensure preparedness to activate this and further regional vaccination centres in a safe and prompt manner. Being greenfield sites there is a requirement to develop new systems and procedures covering operations, health and safety, security and traffic management while also engaging staff and third parties to lead, manage and operationalise each site. Vaccination volumes commenced at lower levels to allow systems and processes to be tested, refined and adapted. There have been no unexpected incidents of significance to date. In the coming weeks, robustness and the levels of supporting documentation will be enhanced.

As was the case with site one, having limited time between site selection, site availability and start up (all compressed into a 2 to 3-week timeframe) is sub optimal and increases risk. We will begin formally reporting on the progress and status of this key piece of work to the next FRAC and then Board meeting.

4.2 N95 Fit Testing

Following the Ministry of Health recall of duckbill masks, Occupational Health and Safety have been running intensive fit testing clinics to transition around 1,000 of our people safely into an N95 before the end of March 2021. This rapid fire project utilises a mix of Occupational Health and Safety Nurses and In-Team fit testers and impacts on ability to progress some BAU activities.

4.3 Cytotoxic Drugs

WorkSafe Guidelines 'Cytotoxic Drugs – Keeping Workers safe when handling Cytotoxic Drugs and Related Waste' were published at the end of November 2020. The ADHB's 'Medications – Cytotoxic's Administration' Policy was updated prior to this and is currently in draft awaiting all relevant approvals. The ADHB policy encompasses what is included in the Worksafe guidelines but is more comprehensive. While we await the regional working group's decision on Closed System Delivery and as 'there is currently no form of health monitoring which is sufficiently specific to adequately measure the effects of exposure to cytotoxic drugs or related waste' we have approached the ESR to look at the possibility of providing environmental 'wipe' sampling for areas that administer cytotoxic medications. The ESR are currently looking at this in more detail as to whether it will be a service they can provide.

4.4 Digital Transformation

Occupational Health Patient Management System: Estimates have now been provided by healthAlliance and the vendor Medtech to enable a regional costing model and a recommendation to be made on the Patient Management system upgrade. The Metro Auckland Occupational Health group needs to be convened to agree costs and determine the delivery approach.

Medtech have performed a review of our system set up and provided recommendations for training and system configuration. These have been accepted.

4.5 Occupational Health and Safety Work Plan

Monitoring and Audit

At its November 2020 meeting the Finance, Risk and Assurance Committee requested further information be provided on how regularly an external audit would be undertaken, how internally within the DHB progress would be monitored and requested an explanation of the sequencing of the Action Plan and risk assessment against that sequencing.

The review of the draft Work Plan included a risk-based evaluation to determine when the Actions would be designed, reviewed and approved. The considerations for timing and completion of the Actions are as follows.

- Regional Internal Audit report
- Safe 365 Contractor maturity report
- Time and available resources
- Complexity and capability for supporting the delivery of the Actions e.g. injury management and prevention
- Auckland DHB risk assessment criteria

We will be putting in place an annual HSE Audit Schedule shortly to monitor improvements internally which will be reported back to both Board and FRAC every 6 weeks. This will also include a baseline maturity assessment from Safe 365 and an external audit planned for November 2021.

Te Tiriti in Action

Engagement with relevant Māori experts on strengthening the content in the Work Plan that demonstrates our commitment to Te Tiriti o Waitangi has commenced, including seeking appropriate representation on the H&S Governance Committee.

4.6 Occupational Health & Safety Service Development

A number of key roles have been successfully recruited to including an Associate Nurse Director Occupational Health & Infection Prevention. Current focus remains on increasing our capability and capacity in order to strengthen our health and safety advisory services and improve systems and processes to support increased productivity and deliver against the Occupational Health and Safety Work Plan.

5. Auckland DHB Health and Safety Governance Committee

The Auckland DHB Health and Safety Governance Committee meet six-weekly. The last meeting was on 10 February 2020. The previous minutes were accepted by the H&S Governance Committee.

Key discussion points were:

- Guidance on future Directorate reporting to the Governance Committee
- Key activities in Occupational Health
- N95 Fit Testing and PortaCount consumables
- Uptake of the Lone Worker app
- Union updates
- Health and Safety Representative training
- Directorate Safe365 Baseline refreshers
- Traffic management at ADHB sites

The next meeting is on 31 March 2021.

6. External audits

Nil.

7. Topical Health and Safety information

7.1 Workplace Mental Health and Wellbeing

As part of an update on the Worksafe Mentally Healthy Work programme delivered in November 2020 the following key points were of relevance to Auckland DHB:

- The Health and Safety at Work Act requires PCBUs to identify and eliminate risks to mental health as far as reasonably practicable as a part of their duty of care.
- There are psychosocial risks in work design, work environment, and in relationships (the social and organisational context) and from individual factors.
- Over a 12-month period in 2019, the Worksafe Segmentation and Insights Programme identified that prevalence of:
    - Anxiety was higher in workers in the medical field (50%)
    - Bullying or Harassment in the workplace was higher amongst workers in healthcare and social assistance (25%)
- The percentage of workers in the Health and Social Assistance sector reporting work-related depression or anxiety in the last 12 months was 38%

Why is good mental health important to PCBUs?

- The burden on workers, their families and the wider economy from work-related ill-health far outweighs the burden from work-related injuries. Mental ill health is a significant part of this.
- Reduced mental health is now the primary cause of lost working days in most Westernised countries.
- The cost of at-work related productivity loss (that is, 'presenteeism') can be 1.5 times greater than the cost of absenteeism.
- It is estimated that mental health problems costs New Zealand business at least $1.6bn pa.
- Nearly half of the surveyed workers (44.4%) in Massey's Workplace Barometer Study (Healthy Work Group, 2020) returned scores indicating potentially high psychosocial risk, e.g., workplace strain and depression.

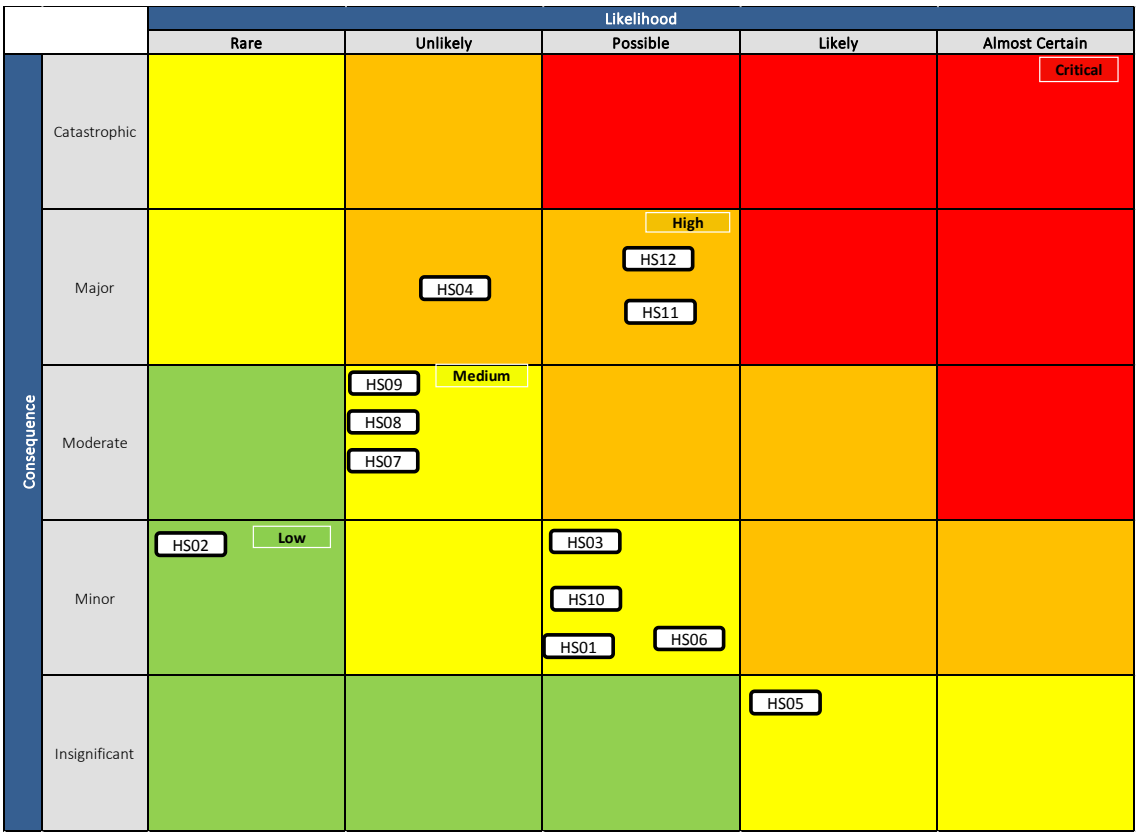
What is mental health?	What is mentally healthy work?	What is mental harm?
DEFINITION FROM THE WORLD HEALTH ORGANISATION, 2014	WORKSAFE POSITION STATEMENT, SEPTEMBER 2020	WORKSAFE POSITION STATEMENT, SEPTEMBER 2020
Mental health is defined as a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.	Mentally healthy work is where risks to people's mental health are eliminated or minimised, and their mental wellbeing is prioritised.	Mental harm is significant cognitive, emotional, or behavioural impact arising from, or exacerbated by, work-related risk factors. Mental harm may be immediate or long-term and can come from single or repeated exposure to risks.

Auckland DHB's Kia Ora tō Wāhi Mahi programme encompasses similar priorities and principles and there is good alignment between the approaches of Auckland DHB and that of Worksafe. We plan to present a deep dive on workplace wellbeing to the next Board meeting.

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

Open Meeting: Human Resources Report

Auckland DHB People Dashboard – Quarter 3 2020/21

Recommendation

That the Board receives the Quarter 3 Pūmanawa Tāngata Status Report, noting the progress which has been made across all aspects of the plan.

Prepared by: People & Culture Senior Leadership Team
Endorsed by: Mel Dooney (Chief People Officer)

This Paper is presented for the Board's information.

The Pūmanawa Tāngata Status Report for Quarter 3 gives a brief commentary of this quarter's activity current status, and the next quarters planned activity under each of the Key Result Areas under the plan. In the June meeting it is envisioned we will bring back for the Board's attention the activity planned for the 21/22 Financial Year. In advance of that work if there are any areas of particular concern or focus that the Board would like considered by the team, this feedback would be welcomed.

Whilst progress against the whole plan is pleasing in many areas, allowing for the distraction which the COVID-19 response and Vaccination program, there are one area of particular note in the last year the team would like to highlight.

KRA4: Kia ora tō Wāhi Mahi - the Employee Centre.

You will recall in previous papers we have discussed the need to establish a centre which services the needs of our employees – particularly focussing on those on low incomes who may need further support as a result of COVID.

We outlined that the approach to establishing the centre is grounded in te whare tapa whā, recognises mātauranga Māori and acts to address wellbeing in a holistic sense. The kaitiaki of the centre are committed to further developing the application of mātauranga Māori into centre operations and is supported by the Māori Workforce Experience team who are based in the centre.

The centre is funded in part by our people through the Manaaki Fund and is being developed in partnership – doing with our people, rather than to them. In doing so it ensures the approach taken is mana enhancing through the implementation of sustainable support and programmes that:

- Demonstrate that we value our employees and are responsive as an employer to their health and wellbeing.
- Facilitate a workplace culture of trust and support.
- Encourage and improve employee health and wellness and eliminate healthcare inequities, by honouring the beliefs, values and aspirations of our employees, families and communities and by taking a holistic approach in meeting employee health and wellbeing needs.
- Support employees financially in times of personal hardship.
- Provide access to information and services that enable employees to make decisions that will positively impact them and their families.

- Provide learning opportunities and a career path for those employees that want to develop their skills and move to other roles within the Auckland DHB.

The following provides detail of the specific initiatives currently offered and/or proposed within the Employee Support Centre for 21/22.

Table 1: CURRENT & PROPOSED INITIAVES

Initiative	Overview
Kāhui Hononga Network Hui	Monthly hui for kaimahi Māori across the organisation. Centred on whanaungatanga and rangatiratanga
Rangatahi Programme	Hosting Introduction Days x6, Work Experience Weeks x3 & a Summer Cadetship (April – December) with potential reach of < 180 students per annum.
Māori Patient and Whānau Champions hui	Monthly hui for champions of Māori Health gain
Kaumatua	Access to mātauranga Māori from a Kaumatua 2 half days a week
Pacific Cultural Navigator support	Cultural support and immediate relief assessment 2 half days a week
HR Consultant support	Tuesdays 12 – 1pm. Access to Union Delegates onsite in the centre is also being scoped
EAP counsellor	Offered Tuesdays 12 – 2pm. By confidential appointment or walk-in.
City Mission food parcels	As required
BNZ 1:1 Financial Wellbeing Check-Ups	Support to understand and manage personal finances including: ➢ KiwiSaver/retirement savings ➢ Budgeting ➢ Financing a home
MSD (Ministry of Social Development) liaison appointments	By appointment or walk-in. Priority support and information to facilitate access to benefits that supplement income.
Group fitness	2 times per week. Delivered by Auckland City Council under our gym membership contract for employees who earn <$55K
Pātaka Kai (open food pantry)	Give what you can – take what you need
ESOL	**63%** of TO THRIVE employee group identify as Asian or Pacifica and may have English as a second language (ESOL). Currently running ESOL programmes for To Thrive from the centre.
Social work support	Support to navigate agencies and help stabilize current situations. Possibility to co-locate within existing Inpatient Allied Health teams (Clinical support)
Mindfulness	Once a week. Teaching staff mindfulness and relaxation to help support their wellbeing.
Career development programmes	Currently delivered via To Thrive group from the centre.
Annual health checks	Encouraging and enabling wellness among our employees contributes to Auckland DHB's vision of healthy communities. On-site health checks are a convenient and proactive way to identify potential health issues and provide education and support to employees. Currently offered as part of To Thrive and paid for by Patient Management Services PMS
Digital Literacy workshops	One-hour digital literacy workshops designed initially for To Thrive pilot, now BAU. Could be run at the centre as and when required for those seeking support to learn the basics.
Green Px Healthy Lifestyle consultations	In the centre one day per week. Lifestyle, activity and nutrition consultations with personalised action plans, follow ups and access to free community

	programmes and discounted Auckland Council recreational facilities.
Citizens Advise Bureau Outreach	CAB Outreach in the centre one day a week providing employees with information on: *Citizenship & immigration *Rental housing *Relationships *Food banks (Q3 pilot)
Breakfast	For the employees we know are coming to work hungry. Toast, fruit and spreads available in the centre Mon – Fri from 8.00am
Occupational Health clinics	Return to work support and/or management of underlying health concerns
Cultural events/celebrations	Language Week, Chinese New Year, Diwali, Matariki etc.
Graduation ceremonies	ESOL, CDP, Step-Up programmes
Social and networking space	Culturally safe space to connect, relax, network
Scholarships	Career development opportunities documented and promoted. Ability to provide two scholarships per annum @$10,000 each towards an allied health or non-nursing qualification.

The following table shows the support and initiatives provided to staff to date. What has also progressed in the last quarter is we have secured permanent space for the centre on Level 4 of the Support building. We have employed a kaimahi Māori Centre Coordinator who will be responsible for ensuring people are welcomed and the various programs are delivered & continuously approved. We have also established a steering group & have developed a funding proposal we are taking to the Auckland Health Foundation to assist with funding both further fit out of the space and support with some of the envisioned support.

Table 2 – SUPPORT PROVIDED TO OUR EMPLOYEES TO DATE:

Support	Notes:
Cultural Navigator / Social Worker support (2 half days per week)	95 assessments completed since July to date either f2f or by phone
City Mission food parcels	225 food parcels provided to staff 29 July to date
Grocery vouchers	274 vouchers at a total of $27,200
Petrol vouchers	34 petrol vouchers issued at a total of $2030 from May 1 to date
Warehouse vouchers (donated by AHF)	350 Warehouse vouchers issued at a total of $40,400 from May 1 to date
Staff lunches	A total of 4935 meals provided to 500 of our low paid workers across the various lockdowns
Priority MSD	17 priority referrals made
Pātaka Kai – *Give what you can, take what you need*	Stood up over Christmas with good uptake. Pātaka Kai resumes again from 22 Feb.
Safety and other relevant DHB communications delivered in ways that are appropriate and easily accessed	Written information available e.g. copy of unwired workers weekly briefing, Auckland wide food bank information, centre services, free gym membership forms, etc.
HR Support	Tuesdays 12 – 1pm

EAP (Pacific Counsellor)	Tuesday afternoons by appointment or walk-in
BNZ Financial Health Check-Ups	Tuesday afternoons by appointment or walk-in
Group fitness sessions	Twice a week at both ACH and GCC (Tuesdays and Thursdays)

What is also particularly pleasing is the feedback we have had from those who use the centre. There is a real sense of being valued and have a place of their own.

"The employment centre gives opportunity to all staff to know there is a place where they can go and have a chat or coffee or just time out, but also to seek services that may help them. The feedback I have received from staff is they are 'happy to have a place to just chill'. 'It's a friendly place'. 'It's good to have exercise classes'. 'Can't wait to have computer classes'. Many are also thankful for the food and clothing the centre has been able to supply." ***P Martin – HCA Centre Champion***

This is not just about the pandemic; it's about giving ourselves and our children the opportunity to improve our lives and change the direction." ***S Fuimaono, Orderly Centre Champion***

Pūmanawa Tāngata Status Report - Quarter 3 2020/21

Key Result Areas	WHAT	Status	Status comment	This Qtr activity	Next Qtr Planned activity
KRA1: Continue to strengthen our organisational culture and values	On-going promotion/recognition and development of our values		On Track	Increasing mentions of the values in all CE communications; recognition channel "Shout Outs" proving popular with staff, encouraging mentions of the values in nominations.	Incorporating the values into the Employment Value Proposition work, starting to use Te Reo versions of values in our internal communications channels.
	Demonstrate our commitment to improving communications, garnering feedback and engagement		On Track	Working group assembled to look at a variety of 2-way social platforms; Communications Strategic Plan developed in consultation with Comms and Stakeholder Engagement leadership team.	Free trial of Workplace, or Facebook for Work (free until May); investigating a tool that transcribes videos into 25 different languages - applications for communications and learning; Communications Strategic Plan to be socialised with key senior leaders, particularly highlighting the core projects/events/plans to be promoted to staff in the following 2 quarters.
	Continue partnership, inclusion and diversity work		On Track	**Rainbow:** Developing Transgender E-learning modules with Te Toka Tumai Rainbow Network **Accessibility:** Partnership agreement with Hearing Accredited Workplace. Speakers & Hearing Assessments have been offered as part of Hearing Awareness month. **Union partnership:** Weekly COVID-19/vaccinations briefing meetings for all union partners in place. Collaboration with the PSA and NZNO on Redeployment Guidelines for deployments to Super Vaccination Sites.	**Rainbow:** Module development continues **Accessibility:** Audit Hearing Accredited workplace general workplace assessments and noise risk assessments completed and action plan created. **Union partnership:** Continue weekly COVID-19/vaccinations briefing meetings. Engage with unions over Management of Sick Leave Guidance.
	Creating a Just Culture		On Track	E-module called Managing Employee Behaviour in a Just Culture design is underway. Updating of Disciplinary and Termination policies continues. • Number of courses run to date since February 2020: 28 (a number were cancelled due to COVID) • Total Number of employees trained in Just Culture to date: 483	E-module completed. Disciplinary and Termination policies completed. Additional HR supporting mechanisms for Managers being scoped for 21/22.
KRA2: Uphold Te Tiriti o Waitangi as our framework to eliminate racism, build cultural safety & achieve health equity	Deliver Ngā Pou Akoranga		Delayed	Socialising Framework with key internal stakeholders.	Framework approved by SLT and new learning options deployed.
	Te reo me ōna Tikanga Māori		Delayed	Engagement process with Māori Health underway.	Continue engagement process with Māori Health.
	Embed Cultural Safety across organisation		Delayed	Phase one E-learning prototype developed for SLT feedback	Phase One deployed into organisation.
	Work with Priority Directorates: Q3 Focus has been Cancer & Blood.		Delayed	**C&B:** Wānanga Series planning underway but delayed. Planning for deployment in April 2021. Met with Board Chair and Deputy Board Chair re kicking off first session. Leadership Insights work delayed but ready for presentation to C&B Leadership team. The other three priority directorates continue to engage their workforce in Te Tiriti and Equity training.	**C&B:** Wānanga Series implemented. Leadership development programme approved and in process of being implemented. Continue to engage with priority directorates. Learnings from these will continue to inform iterations of KRA 2 rollout for the wider populations.
KRA3: Grow and develop nga Kaimahi Māori	Increasing Capacity		On Track	Kaimahi Māori steering group formation near completion; Talent Advisor recruitment WIP.	Finalise recruitment of all kaimahi Māori Experience roles; Rangatahi Programme starts for 2021.
	Increasing Capability & Leadership		On Track	Tuakana-Teina mentoring programme scoping WIP; Senior Consultant role currently advertised.	Pilot Tuakana-Teina programme; Māori Leadership Programme scoped.
	Better Experiences.		On Track	Kāhui Hononga Network rescoped. First monthly hui kicks off in April with Māori leader Dr. Anthony Jordan guest speaking; 0.5FTE HR Consultant appointed.	Stay interviews scoped for pilot with Kaimahi Māori in Cancer & Blood Services.
KRA4: Implement 'Kia Ora tō wāhi mahi'- the Te Toka Tumai Health Workplace plan	Employee Welfare Centre		On Track	The Employee Centre Coordinator commenced 15 March. We have completed a fundraising proposal to discuss with Auckland Health Foundation to support both centre fit out and operations / development activities. We have used some of the funds received to date, to provide a range of ongoing supports and to purchase furniture for the centre. The Kaimahi Māori Experience team now cohabitating in this space which is creating great synergies. The centre is being utilised to support our people with information and Q&As regarding the COVID vaccine. Feedback from staff is that they are grateful to have the employee centre and the support offered within. They are finding it a welcoming and safe space. Many are also utilising and thankful for the food and vouchers the centre has been able to supply.	Further develop suite of services/programmes. Official launch, blessing and naming of the centre. Approved funding plan in place.
	Healthy Workplace plan / strategy		Delayed	Complete draft plan/strategy and test with staff, readiness for endorsement at board.	Finish draft strategy/plan. Take strategy to board and communicate across organisation. Complete Feasibility process of measuring wellbeing tools.
	Short Term Action Plan: Leadership capability to support wellbeing		Delayed	Scoped staff council/forum concept and structure. Established core project group for improving connections (people/initiatives knowledge base) through digital platforms.	Staff council/forum test concept and establish appropriate forum. Complete 3 month digitalisation platform tialed with leading for healthy workplace/wellbeing interest group.
	Short Term Action Plan: Feeling Safe & Supported at Work		On Track	EAP review and recommendations. Established current state.	Design support framework with suite of tools and communicate to organisation. Recommend areas for action.
	Short Term Action Plan: Occupational Health		On Track	Publish tools for managers for managing Sick Leave, Loss time injuries and redeployment. Create an Occupational Health Data Set.	Publish Occupational health data set to organisation. Business case for wellbeing index survey deployment.
	Short Term Action Plan: Systems of Work		On Track	Progress MOS enhancement work.	MOS tools trialled to improve flow of information.
KRA5: Attract & grow a workforce that is fit for the future	Talent Acquisition Strategy		Delayed	Work continues on the Employment Branding project. This has been diverted slightly as we support the Vaccination Centre sourcing and recruitment however this is still on track. Recruitment and workforce data reporting project is underway and on track. Candidate Experience insight project delayed as we wait the results of a Privacy Impact assessment for the survey platform.	Employment Branding project is timed to conclude in the next quarter with implementation set to begin. Support of the Vaccination Centre recruitment will continue however will be matured into established as a specific portfolio separated from our business as usual activity. Pending a positive return of the Privacy impact assessment, our work to focus on Candidate experience will proceed. With the establishment of the Māori Workforce Experience team, our focus on system review in our recruitment processes can be undertaken.

Pūmanawa Tāngata Status Report - Quarter 3 2020/21

Key Result Areas	WHAT	Status	Status comment	This Qtr activity	Next Qtr Planned activity
	Talent Management		On Track	Pilot groups have been selected - Kaiārahi Nāhi (n = 9) & Te Manawa o Hine - Māori Midwives (n = 4) and key stakeholders / Māori leaders have been engaged. Stakeholder briefing will be held this quarter.	Talent Management process to be implemented with Kaimahi Māori in the two pilot groups.
KRA6: Make it easier to work here - improving the manager and employee experience of people processes	HR Customer led improvement programme		On Track	HR pain points identified but action delayed due to Covid-19 response taking priority.	Identify priority improvement opportunities, develop Action Plans and begin implementation.
	HRIS Strategy		On Track	A regional meeting facilitated by Deloitte is scheduled for 19 March to discuss the employee experience from a process and systems perspective. In addition funding has been approved for the HR bot.	Actions from the Deloitte meeting as required and implementing the first task using the bot. It is expected that the implementation of a bot will deliver efficiencies through the reduciton in datat entry and timeliness to data being updated in the HR systems . We anticipate a minimum of 2 processes are automated by end of June 2021.
	Mandatory Training		On Track	Reporting on Mandatory Training is currently being piloted with a number of areas. Once feedback has been gathered the report will be refined for deployment across the organisation.	Mandatory Training compliance report deployed to all managers.
	Workforce Dimensions Implementation		On Track	Kronos, ADHB & healthAllianceve delivered in Q3 - ADHB completed remaining workbooks incl business structures workbooks - Steering Committee signed off the proceed to Solution Development document - Kronos delivered the base line solution - Solution design workshops attended for scheduling and timekeeping - Feedback on solutions delivered back to Kronos for implementation - Reporting survey for reporting requirements delivered - Emp data sent (2,500 emps) for functional testing in Dev. Test scripts underway	Activity for this quarter to June 2021: - healthAlliance to provide technical integration and Application Programming Interface Development - DHB functional solution walkthroughs - Test scripts complete - healthAlliance to set up Secure File Transfer Protocol - Solution Development with DHBs workshops for integration - Functional testing begins - Analytics demonstration - Integration Development - Development of change management and training materials
	Holidays Act		At Risk / Delayed	Delays in the procurement process for a remediation partner have caused an overall delay to the start of Remediation (paying current and ex-employee underpayments from 2010) and Rectification of processes and data(future-state compliance). Remediation payments to correct staff will take 18-24 months to calculate from when a partner begins work. There are Holidays Act issues that need to be resolved at a national level e.g. RMO Transfer, PAYG (Casual) employees, Definition of what is a week etc. which impact all DHBs. These are currently being worked through with the unions and the Labour Inspector.	Finalise governance structure and resourcing for rectification and remediation. Appoint project resources and arrange backfill. Continue to work with the unions on outstanding issues.

Financial Performance Report for the period ending 28 February 2021

Recommendation

That the Board receive this Financial Report for the eight months ending 28 February 2021

Prepared by: Auxilia Nyangoni, Deputy Chief Financial Officer
Endorsed by: Justine White, Chief Financial Officer
Date: 22 March 2021

1. Executive Summary

For the year to date period ending 28 February 2021, the DHB realised a deficit of $63M, which was $51M unfavourable to the budgeted deficit of $11M. The result by division and showing the Covid impacts is as follows:

Result by Division	For the eight months ending 28 Feb 2021		
	Actual	Budget	Variance
Funder	14,477	12,600	1,878 F
Provider	(77,445)	(24,048)	53,398 U
Governance	344	(35)	378 F
Net Surplus / (Deficit)	**(62,625)**	**(11,483)**	**51,141 U**
COVID-19 Net impact on bottom-line	(27,106)	0	**27,106 U**
Holidays Act Impact	(26,667)	0	**26,667 U**
BAU Net impact on bottom-line	(8,852)	(11,483)	**2,631 F**
Net Surplus / (Deficit)	**(62,625)**	**(11,483)**	**51,142 U**

The year to date $51M unfavourable variance result was driven by $53M adverse variance in the Provider Arm (mainly due to Covid and Holidays Act impacts), slightly offset by favourable variances in the Funder and Governance Arms. The underlying Business as Usual (BAU) operations' result was overall favourable to budget by $2.6M as shown above.

2. Summary Result and Financial Commentary for February 2021

$000s	Month (Feb-2021)			For the eight months ending 28 Feb 2021			Full Year (2020/21)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Income									
Government and Crown Agency	154,742	145,062	9,680 F	1,191,328	1,162,360	28,968 F	1,769,066	1,742,995	26,071F
Non-Government and Crown Agency	8,085	8,771	686 U	69,048	70,555	1,507 U	138,096	105,660	32,436F
Inter- District Flows	60,821	60,598	223 F	477,534	484,784	7,250 U	741,315	727,176	14,139F
Inter-Provider and Internal Revenue	1,539	1,565	26 U	12,133	11,981	152 F	18,570	18,242	328F
Total Income	**225,187**	**215,996**	**9,191 F**	**1,750,043**	**1,729,680**	**20,363 F**	**2,667,046**	**2,594,073**	**72,973F**
Expenditure									
Personnel	96,803	93,051	3,752 U	815,129	774,136	40,993 U	1,260,068	1,184,077	75,991U
Outsourced Personnel	2,357	1,605	752 U	22,959	12,836	10,123 U	27,058	19,254	7,804U
Outsourced Clinical Services	4,740	3,934	806 U	32,295	29,767	2,528 U	49,582	45,976	3,607U
Outsourced Other Services	8,121	7,395	726 U	59,578	59,158	420 U	98,866	88,737	10,129U
Clinical Supplies	25,217	25,609	392 F	219,960	216,072	3,888 U	331,687	326,698	4,989U
Funder Payments - NGOs and IDF Outflows	63,130	62,490	640 U	517,900	499,920	17,981 U	770,823	749,879	20,943U
Infrastructure & Non-Clinical Supplies	18,909	18,724	185 U	144,847	149,274	4,426 F	230,888	224,496	6,392U
Total Expenditure	**219,277**	**212,807**	**6,470 U**	**1,812,668**	**1,741,163**	**71,504 U**	**2,768,972**	**2,639,117**	**129,854U**
Net Surplus / (Deficit)	**5,911**	**3,189**	**2,722 F**	**(62,625)**	**(11,483)**	**51,141 U**	**(101,925)**	**(45,044)**	**56,881 U**

Result by Division	Month (Feb-2021)			For the eight months ending 28 Feb 2021			Full Year (2020/21)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funder	1,840	1,575	265 F	14,477	12,600	1,878 F	11,234	18,900	7,666 U
Provider	4,645	1,583	3,062 F	(77,445)	(24,048)	53,398 U	(114,059)	(63,882)	50,177 U
Governance	(574)	31	606 U	344	(35)	378 F	900	(61)	961 F
Net Surplus / (Deficit)	**5,911**	**3,189**	**2,722 F**	**(62,625)**	**(11,483)**	**51,141 U**	**(101,925)**	**(45,044)**	**56,881 U**

COVID-19 Net impact on bottom-line	6,632	0	**6,632 F**	(27,106)	0	**27,106 U**	(19,925)	0	**19,925 U**
Holidays Act Impact	(3,333)	0	**3,333 U**	(26,667)	0	**26,667 U**	(40,000)	0	**40,000 U**
BAU Net impact on bottom-line	2,612	3,189	**577 U**	(8,852)	(11,483)	**2,631 F**	(42,000)	(45,044)	**3,044 F**
Net Surplus / (Deficit)	**5,911**	**3,189**	**2,722 F**	**(62,625)**	**(11,483)**	**51,142 U**	**(101,925)**	**(45,044)**	**56,881 U**

Commentary on DHB Consolidated Financial Performance

1.1.1 Month Results

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

Revenue for the month of February 2021 is favourable to budget by $9M (4.3%). This variance reflects $11M additional Covid income realised which fully offset small unfavourable movement in BAU revenue. Significant variances in revenue categories include:

- $9.7M (6.7%) favourable Government and Crown Agency revenue mainly reflecting unbudgeted Covid funding and movements in BAU operations revenue mainly MoH devolved contract revenue with associated costs.

Expenditure for the month of February 2021 is unfavourable to budget by $6.5M (-3.0%). $7M of this variance is due to unbudgeted Covid costs ($4M) and the Holidays Act provision increase ($3M); this is partially offset by slight favourable cost movements in BAU operations. Significant variances include:

- $4.5M (-4.8%) unfavourable variance in combined Personnel and Outsourced Staff costs reflecting Covid-19 impact $1.1M unfavourable, Holidays Act remediation $3.3M unfavourable and the BAU variance is very close to budget at $0.1M unfavourable. FTES are overall 140 unfavourable to budget for the month with 100 of these relating to Covid.
- The remaining balance of the unfavourable variance in expenditure for the month is driven by various insignificant movements across other expenditure categories.

1.1.2 Year to Date Results

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

Total Revenue is favourable to budget YTD by $20.4M (1.2%), mainly driven by a net favourable Covid impact of $28M, with BAU revenue being $8M unfavourable. Significant variances in revenue categories include:

- $29M (2.5%) favourable Government and Crown Agency revenue. This includes $39.4M additional revenue realised for Covid for community testing, offset by $10M unfavourable revenue in BAU operations mainly MoH devolved contract revenue with corresponding cost reduction.
- $1.5M (-2.1%) unfavourable Non Government and Crown Agency revenue, largely driven by the following movements:
  - Non Resident revenue $7.3M unfavourable – primarily reflecting reduced Pacific contract cases as a result of Covid-19.
  - Retail Pharmacy revenue $4.7M favourable (mostly offset by additional cost of goods sold).
  - New MOH funding for the Integrated Primary Mental Health Initiative $1.5M favourable.
  - Research Income $1.7M favourable (offset by additional research costs so bottom line neutral).
  - Donations $1.3M favourable - this income fluctuates from month to month depending on timing of larger donations for key projects.
- $7.3M (-1.5%) unfavourable Inter-District Flows, mainly from unfavourable impact of Covid-19 funding.

The year to date expenditure variance of $72M (-4.1%) includes Covid impact of $55M, Holidays Act provision impact of $27M, partially offset by $10M favourable movements in BAU operations. Significant variances are:

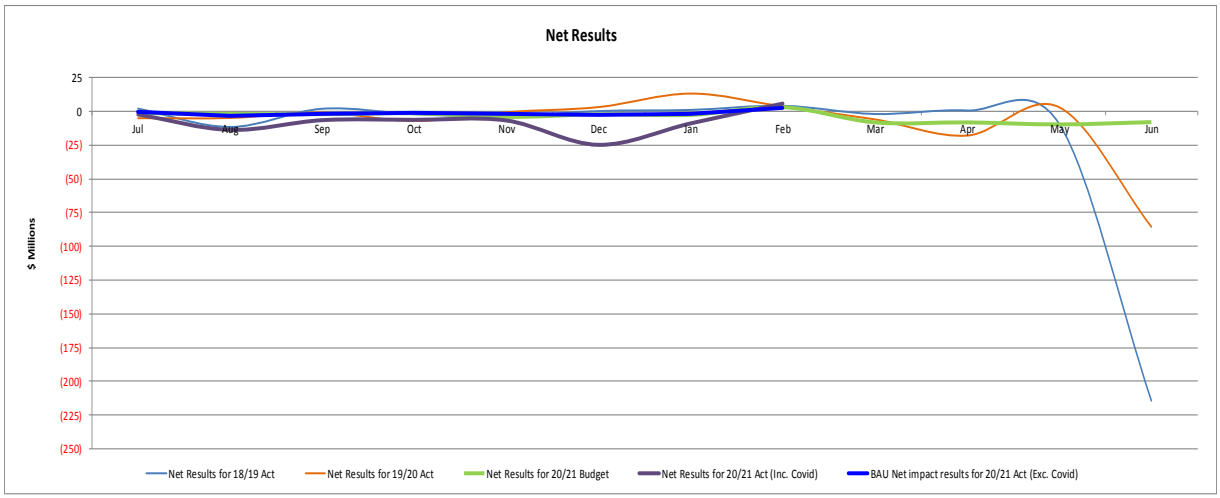
- $51M (-6.5%) unfavourable variance in Personnel/Outsourced Personnel costs, reflecting **u**nbudgeted Covid-19 related expenditure of $20.6M, increase in the provision for Holidays Act liability of $26.7M. FTEs for the YTD are 179M unfavourable, with 157 of this variance relating to Covid FTEs.
- $2.5M (-8.5%) unfavourable in Outsourced Clinical Services, with the key variances as follows:
  - Unbudgeted Covid-19 related expenditure of $0.4M (for laboratory send-away tests).
  - Diagnostic Genetics $0.6M unfavourable due to delayed 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 $0.5M unfavourable for which additional one off MOH funding has been received.
  - Additional outsourcing in Ophthalmology in order to meet contract $0.7M unfavourable.
- $4M (-1.8%) unfavourable in Clinical Supplies, this variance is due to Laboratory consumable costs which are $4.8M unfavourable mainly for Covid-19 tests, with offsetting additional revenue. Excluding these costs, the underlying Clinical Supplies BAU variance is $0.9M favourable, reflecting overall volume performance slightly below contract.
- $18M (-3.6%) unfavourable variance in Funder NGOs expenditure & IDF outflows, mainly reflecting unbudgeted Covid cost impact of $27M (with corresponding Covid revenue), and also offset by IDF outflows being $9M favourable from prior year adjustments and current year quarterly Primary Health Organisation (PHOs) wash-ups.
- $4M (3%) favourable variance in Infrastructure & Non Clinical Supplies costs, with the key variances being:
  - Unbudgeted Covid-19 related expenditure of $3.7M
  - Cost of Goods Sold $3.8M unfavourable for retail pharmacy, offset by additional retail revenue for the year to date.
  - Capital Charge $7.7M favourable due to the reduction in the capital charge rate from 6% to 5%, combined with a reduction in the final Crown equity position at 30 June 2020 (compared to the budget) due to the increase in the Holidays Act provision at June 20 year end.
  - Interest & Finance Charges $0.3M favourable.
  - All Other Operating Expenses such as Professional Fees, Training, Travel & Accommodation $3.4M favourable.

Year End Forecast Result

The year-end forecast deficit is $102M against the full year planned deficit of $45M. The $57M variance to budget reflects the increase in the Holidays Act provision of $40M and $19M Covid impacts, partially offset by the BAU position which is forecast to be favourable to budget by $3M. The Holidays Act provision required for 2020/21 is subject to expert estimation at year end.

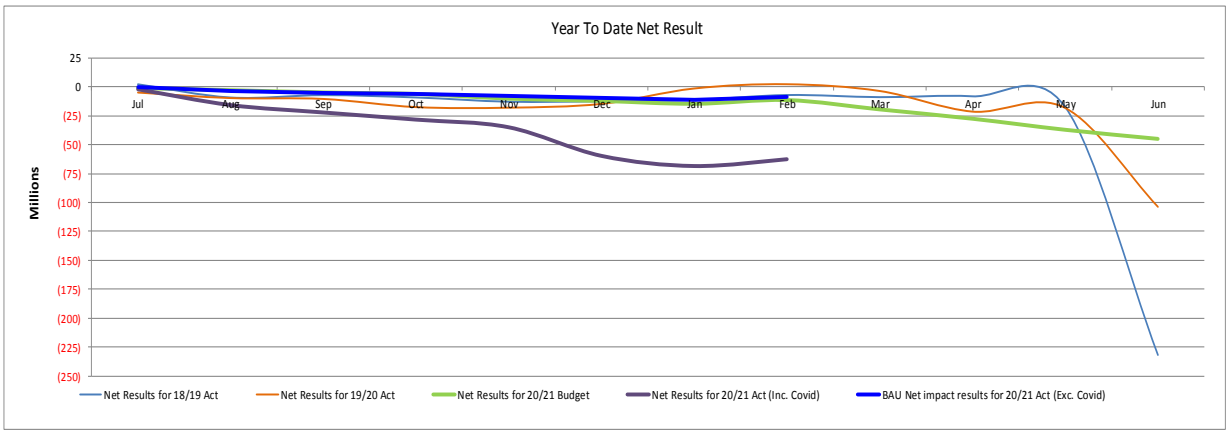
3. Performance Graphs

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	(85.513)	(103.821)
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 (Inc. Covid)	(2.167)	(13.626)	(6.409)	(6.173)	(6.650)	(24.722)	(8.787)	5.911					(62.624)
BAU net results for 20/21 Act (Exc. Covid)	(0.464)	(2.839)	(1.959)	(0.668)	(1.588)	(2.369)	(1.539)	2.612					(9)

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)	(103.821)
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 (Inc. Covid)	(2.167)	(15.793)	(22.202)	(28.375)	(35.026)	(59.748)	(68.535)	(62.624)				
BAU Net impact results for 20/21 Act (Exc. Covid)	(0.464)	(3.303)	(5.262)	(5.963)	(7.551)	(9.920)	(11.459)	(8.847)				

4. Financial Position

4.1 Statement of Financial Position as at 28 February 2021

$'000	28-Feb-21			31-Jan-21	Variance	30-Jun-20	Variance
	Actual	Budget	Variance	Actual	Last Month	Actual	Last Year
Public Equity	948,501	977,992	29,491U	942,854	5,647F	919,427	29,074F
Reserves							
Revaluation Reserve	599,151	599,151	0F	599,151	0F	599,151	0F
Accumulated Deficits from Prior Year's	(792,726)	(790,846)	1,880U	(792,726)	0F	(688,960)	103,766U
Current Surplus/(Deficit)	(62,623)	(11,483)	51,140U	(68,534)	5,911F	(103,819)	41,196F
	(256,198)	(203,178)	53,020U	(262,109)	5,911F	(193,628)	62,570U
Total Equity	**692,303**	**774,814**	**82,511U**	**680,745**	**11,558F**	**725,799**	**33,496U**
Non Current Assets							
Fixed Assets							
Land	347,122	347,122	0F	347,122	0F	347,122	0F
Buildings	602,400	632,741	30,341U	605,180	2,780U	624,109	21,709U
Plant & Equipment	85,168	95,305	10,136U	83,987	1,181F	86,655	1,487U
Work in Progress	127,254	146,045	18,791U	121,947	5,307F	73,193	54,061F
Total PPE	1,161,945	1,221,213	59,268U	1,158,237	3,708F	1,131,079	30,865F
Investments							
- Health Alliance	74,375	75,057	682U	74,268	107F	74,268	107F
- Health Source	271	-	271F	271	0F	271	0F
- NZHPL	6,572	5,266	1,305F	6,626	55U	7,084	512U
- Other Investments	518	-	518F	518	0F	518	0F
	81,735	80,323	1,412F	81,683	52F	82,141	406U
Intangible Assets	1,886	9,827	7,941U	1,950	64U	2,216	330U
Trust Funds	16,944	15,970	974F	17,132	188U	15,970	974F
	100,565	106,121	5,555U	100,766	201U	100,327	238F
Total Non Current Assets	**1,262,510**	**1,327,334**	**64,824U**	**1,259,003**	**3,507F**	**1,231,407**	**31,103F**
Current Assets							
Cash & Short Term Deposits	191,818	82,808	109,011F	170,408	21,410F	135,902	55,916F
Trust Deposits > 3months	21,095	16,394	4,701F	21,883	788U	16,394	4,701F
ADHB Term Deposits > 3 months	-	15,000	15,000U	5,000	5,000U	15,000	15,000U
Debtors	43,369	45,325	1,956U	26,071	17,298F	45,325	1,956U
Accrued Income	68,687	53,611	15,076F	70,425	1,738U	66,672	2,015F
Prepayments	7,628	6,835	792F	8,677	1,049U	4,622	3,006F
Inventory	16,142	27,511	11,370U	16,187	46U	15,396	746F
Total Current Assets	**348,739**	**247,484**	**101,254F**	**318,651**	**30,088F**	**299,311**	**49,428F**
Current Liabilities							
Borrowing	(2,543)	(1,925)	618U	(2,536)	7U	(1,828)	716U
Trade & Other Creditors, Provisions	(237,345)	(166,302)	71,044U	(220,765)	16,580U	(177,892)	59,453U
Employee Entitlements	(569,500)	(524,748)	44,752U	(563,822)	5,677U	(524,748)	44,752U
Funds Held in Trust	(1,384)	(1,376)	8U	(1,384)	0U	(1,384)	0U
Total Current Liabilities	**(810,772)**	**(694,350)**	**116,422U**	**(788,508)**	**22,264U**	**(705,851)**	**104,921U**
Working Capital	**(462,034)**	**(446,866)**	**15,168U**	**(469,857)**	**7,824F**	**(406,541)**	**55,493U**
Non Current Liabilities							
Borrowings	(13,385)	(16,592)	3,207F	(13,613)	228F	(10,136)	3,249U
Employee Entitlements	(94,788)	(89,061)	5,726U	(94,788)	0F	(88,931)	5,857U
Total Non Current Liabilities	**(108,173)**	**(105,654)**	**2,519U**	**(108,401)**	**228F**	**(99,067)**	**9,106U**
Net Assets	**692,303**	**774,814**	**82,511U**	**680,745**	**11,558F**	**725,799**	**33,495U**

Commentary

The major variances to budget are summarised below:

Property, Plant and Equipment:
The variance reflects capital expenditure tracking below budget as at February 2021. 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 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)	208,041
Income in Advance	29,304
Total	237,345

4.2 Statement of Cash flows as at 28 February 2021

$000's	28-Feb-21			For the eight months ending 28 Feb 2021		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Revenue Received	209,725	215,769	6,044U	1,759,702	1,727,449	32,253F
Payments						
Personnel	(91,125)	(93,051)	1,926F	(764,519)	(774,722)	10,203F
Suppliers	(23,416)	(48,211)	24,794F	(380,903)	(398,419)	17,516F
Capital Charge	(17,316)	(3,807)	13,508U	(17,316)	(30,457)	13,142F
Payments to other DHBs and Providers	(63,130)	(62,490)	640U	(517,900)	(499,920)	17,981U
GST	1,559	0	1,559F	(101)	0	101U
	(193,428)	(207,559)	14,131F	(1,680,739)	(1,703,518)	22,779F
Net Operating Cash flows	**16,297**	**8,210**	**8,087F**	**78,962**	**23,930**	**55,032F**
Investing						
Interest Income	165	227	62U	1,653	1,816	163U
Sale of Assets	2	0	2F	29	0	29F
Purchase Fixed Assets	(6,333)	(19,067)	12,734F	(67,680)	(143,203)	75,523F
Investments and restricted trust funds	5,893	0	5,893F	10,393	0	10,393F
Net Investing Cash flows	**(273)**	**(18,840)**	**18,567F**	**(55,605)**	**(141,387)**	**85,782F**
Financing						
Interest paid	(40)	(99)	59F	(481)	(789)	308F
New loans raised	0	0	0F	5,695	8,356	2,661U
Loans repaid	(221)	(253)	32F	(1,731)	(1,770)	39F
Other Equity Movement	5,647	7,451	1,804U	29,074	58,566	29,491U
Net Financing Cash flows	**5,386**	**7,099**	**1,712U**	**32,558**	**64,363**	**31,805U**
Total Net Cash flows	**21,411**	**(3,531)**	**24,942F**	**55,915**	**(53,094)**	**109,009F**
Opening Cash	170,408	86,339	84,070F	135,902	135,902	0F
Total Net Cash flows	21,411	(3,531)	24,942F	55,915	(53,094)	109,009F
Closing Cash	**191,819**	**82,808**	**109,011F**	**191,819**	**82,808**	**109,011F**
ADHB Cash				190,509	76,605	113,904F
A+ Trust Cash				963	5,857	4,894U
A+ Trust Deposits - Short Term < 3 months & restricted fund deposits				347	346	1F
				191,819	**82,808**	**109,011F**
ADHB Short Term Investments 3 > 12 months				0	15,000	15,000U
A+ Trust Short Term Investments 3 > 12 months				21,095	16,394	4,701F
ADHB Long Term Investments				-	-	0F
A+ Trust Long Term Investment Portfolio				16,944	15,970	974F
Total Cash & Deposits				**229,858**	**130,171**	**99,686F**

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 16 December 2020.

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

Glossary

AAA	-	Abdominal Aortic Aneurysm
ARC	-	Aged Residential Care
ARDS	-	Auckland Regional Dental Service
B4SC		B4 School Check
CIR	-	COVID Immunisation Register
CTC		Community Testing Centre
CVD	-	Cardiovascular Disease
DCNZ		Dental Council of New Zealand
DHB	-	District Health Board
FPA	-	Family Planning Association
GP	-	General Practitioner
HBHF	-	Healthy Babies Healthy Futures
HC	-	Health Coach
HCSS	-	Home and Community Support Services
HIP	-	Health Improvement Practitioner
HPV	-	Human papillomavirus
HVAZ	-	Healthy Village Action Zones
IPMHAS	-	Integrated Primary Mental Health and Addiction Services
IPS	-	Individual Placement and Support
LARC	-	Long Acting Reversible Contraception
MELAA	-	Asian & Middle Eastern Latin American and African
MMR	-	Mumps, Measles and Rubella
MoH		Ministry of Health
MSD	-	Ministry of Social Development
NA-HH		Noho Āhuru – Healthy Homes
NCHIP	-	National Child Health Information Platform
NCSP	-	National Cervical Screening Programme
NGO	-	Non-Governmental Organisation
NIR	-	National Immunisation Register
NRHCC	-	Northern Region Health Coordination Centre
NSU	-	National Screening Unit
PFO	-	Planning, Funding and Outcomes
PHO	-	Primary Health Organisation
SPPGG	-	Suicide Prevention and Postvention Governance Group
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 the last update provided on 16 December 2020. Please note this is the same report provided to the CPHAC Committee for at its meeting 18 March 2021.

2. Planning

2.1 Annual Plans

The first draft of the 2021/22 Annual Plan was submitted to the Ministry of Health (MoH) on 8 March 2021. Feedback on the first draft is expected from 9 April from the MoH. The Plan will subsequently be updated and the second draft – post Board approval – is due with the MoH by mid-June.

2.2 Annual Reports

The audit approved 2019/20 Annual Report has been finalised, presented to parliament and now published to the DHB's website.

Development of the timeline for 2020/21 audit and development of the 2020/21 Annual Report has commenced.

3. Primary Care

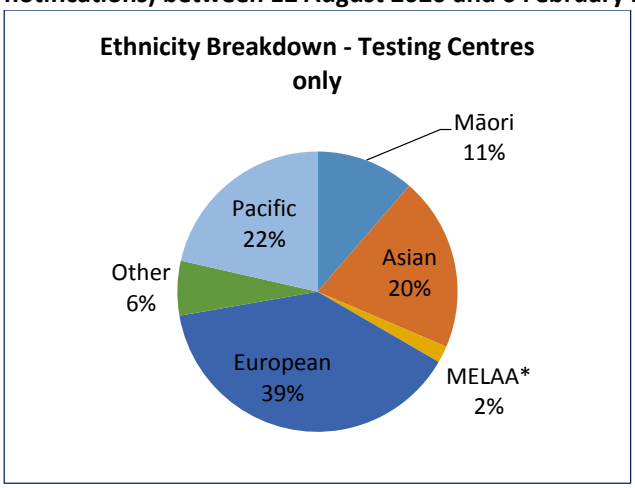
3.1 Response to COVID-19

The primary care team, with staff working within both the DHB and the Northern Region Health Coordination Centre (NRHCC), continues to support the Metro Auckland response. With the pandemic response entering a more settled phase, the team have been re-prioritised to support COVID vaccination planning.

The framework of semi-permanent fixed site Community Testing Centres (CTCs) and mobile testing units that was established in July last year is still in place. General practices and urgent care clinics also continue to support our COVID-19 testing programme. This Framework was able to adapt quickly during the recent surge in testing demand due to the three positive community cases that were confirmed in January. To meet increased demand for testing over this period two addition 'pop-up' testing sites were stood up at Victor Eaves Park (28 – 30 January) and North Harbour Stadium (27 January – 1 February). 11,284 swabs were taken during this period of heightened risk through CTCs, mobile testing units and 'pop-up's alone (28 January 2021 – 6 February 2021).

Since the August COVID-19 outbreak (between 12 August 2020 and 6 February 2021), CTCs and mobile clinics completed 330,152 swabs, while another 266,399 swabs were taken through general practice and urgent care clinics across metropolitan Auckland.

Graph 1. Proportion of tests taken at CTCs and mobile testing clinics by ethnicity (Source: e-notifications) between 12 August 2020 and 6 February 2021.



* Middle Eastern Latin American and African

COVID-19 vaccination programme

Planning for how our metro-Auckland primary care network will support the rollout of the COVID-19 vaccination programme is underway; the PFO Primary Care Team will lead this work. This is a part of a larger regional process to develop and execute a COVID-19 vaccination roll out starting with tier 1 (border staff and their whānau) and tier 2 (front line health workers), and eventually leading to the whole community vaccination roll out.

Mobile Outreach Health clinics

During COVID-19 Alert Level 4, approximately 500 rough sleepers were accommodated in motel units ("managed accommodation") across metropolitan Auckland; 41% of these people are Māori and 15% are Pacific. Auckland and Waitematā DHBs successfully implemented mobile health clinics to provide health services to those living in managed accommodation from 1 July 2020 to 30 September 2020.

The mobile health clinics are nurse-led and have 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 evaluation of the services demonstrated the benefits of the Auckland/Waitematā programme to Māori and Pacific people. These services have been extended to 31 March 2021 to continue providing services to people in managed accommodation.

Your Health Summary

The 'Your Health Summary' Shared Primary Care Summary is an on-going initiative that provides clinical information to better support high quality patient care when a patient accesses care at an alternative setting to their 'medical home'. This might be because their practice has closed due to COVID-19 or they are accessing care at an Urgent Care Centre or hospital. The programme provides a secure centralised repository of summary primary care information for all patients in the Auckland region that is accessible for patient care by appropriate health practitioners in other settings. There is the ability for patients to opt off the system.

Your Health Summary is an important component of a high functioning regional health care system to enable quality continuity of care. There is a focus to achieve high coverage for Māori, Pasifika, people living in quintile 5 areas, and people 65 years and older as these population groups have on average higher healthcare needs, require healthcare more often and may be more mobile regarding where they seek healthcare.

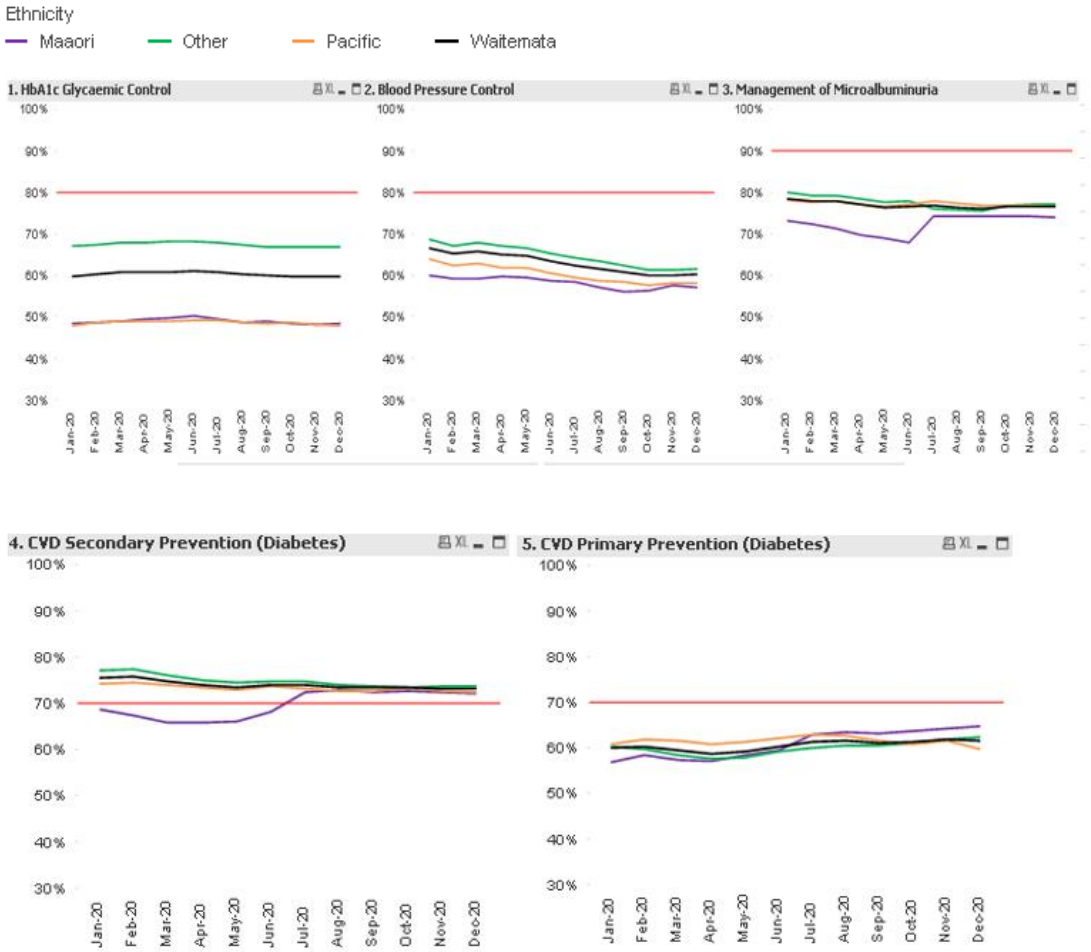
Primary Healthcare Organisations (PHOs) have agreed to make this a priority area to improve the rate of uptake.

3.2 Diabetes

The following are some key facts from the latest (December 2020) diabetes quarterly report for Auckland DHB. At the end of quarter two 2020/21 the following can be noted:

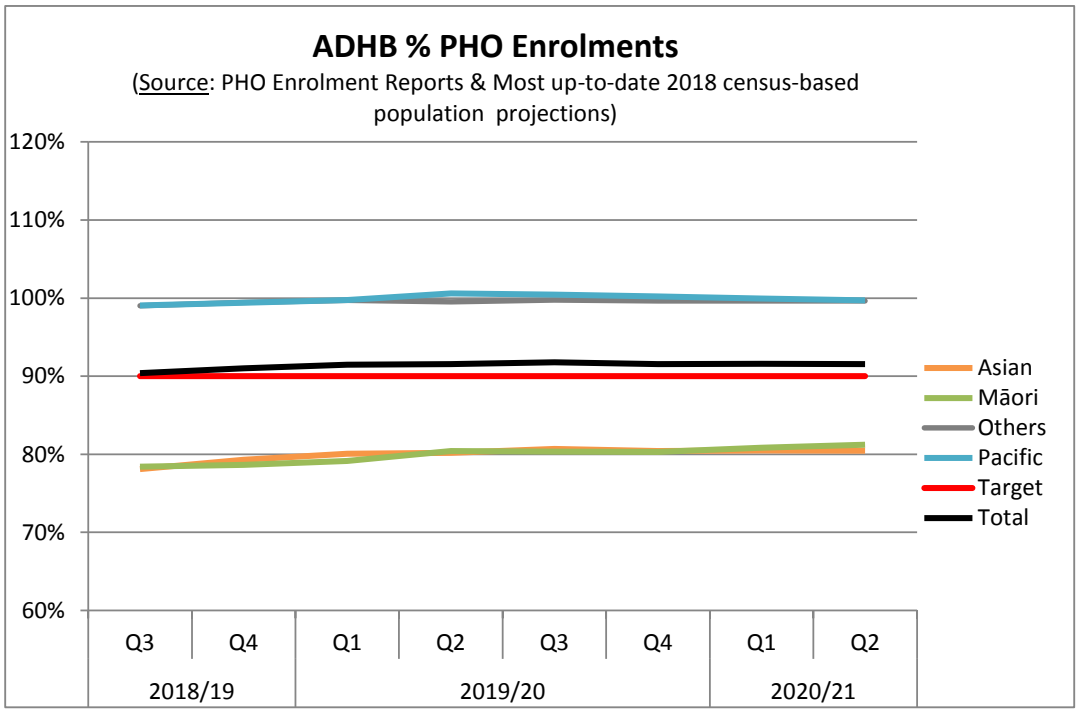
- Despite COVID-19 performance against six of the seven indicators, with the exception of blood pressure management and CVD primary prevention in Pacific people has remained within +/- 3% of their January 2020 result.
- Performance against the diabetes control (HbA1c) indicator remains consistently poor with stark inequities for HbA1c with almost 25 percentage points across ethnicities.
- Auckland DHB have the lowest percentage (11%) of patients with diabetes without an HbA1c result within the last 15 months in the region at the end of December compared to the other metro Auckland DHBs

The following graphs present the performance between January 2020 and December 2020 (NB: the target is represented by the red line).



3.3 PHO Enrolment

Below is the most recent PHO enrolment data from quarter three 2018/19 to Q2 2020/21. The data is sourced from the National Enrolment System and the most up-to-date population projections based on the 2018 census.



NB: * 2018/19 Q3 new data source (National Enrolment System) and 2020 update of 2018 census population projections

4. Health of Older People

4.1 Aged Residential Care

Planning is underway for the COVID-19 vaccination roll out to aged residential care for both residents and staff; it is in the initial stages but indicative numbers of residents and staff have been collated and all Aged Residential Care (ARC) facilities in metro Auckland have completed a survey providing relevant information to inform the process.

The COVID-19 preparedness status of ARC remains a focus. There is a Northern Region structure to oversee this work comprising the following groups:

- ARC COVID-19 Steering Group – to identify and agree the areas that require a consistent and aligned regional response to ensure effective prevention and management of a COVID-19 outbreak in an ARC facility
- ARC COVID-19 Operations Working Group – to address planning relevant to operations including logistics, PPE, vaccination planning
- ARC COVID-19 Clinical and Public Health Working Group - to provide clinical and public health recommendations to the Steering Group on specific topics e.g. principles for resident transfer decisions, infection prevention and control support/protocols, principles for staff stand downs.

4.2 Home and Community Support Services

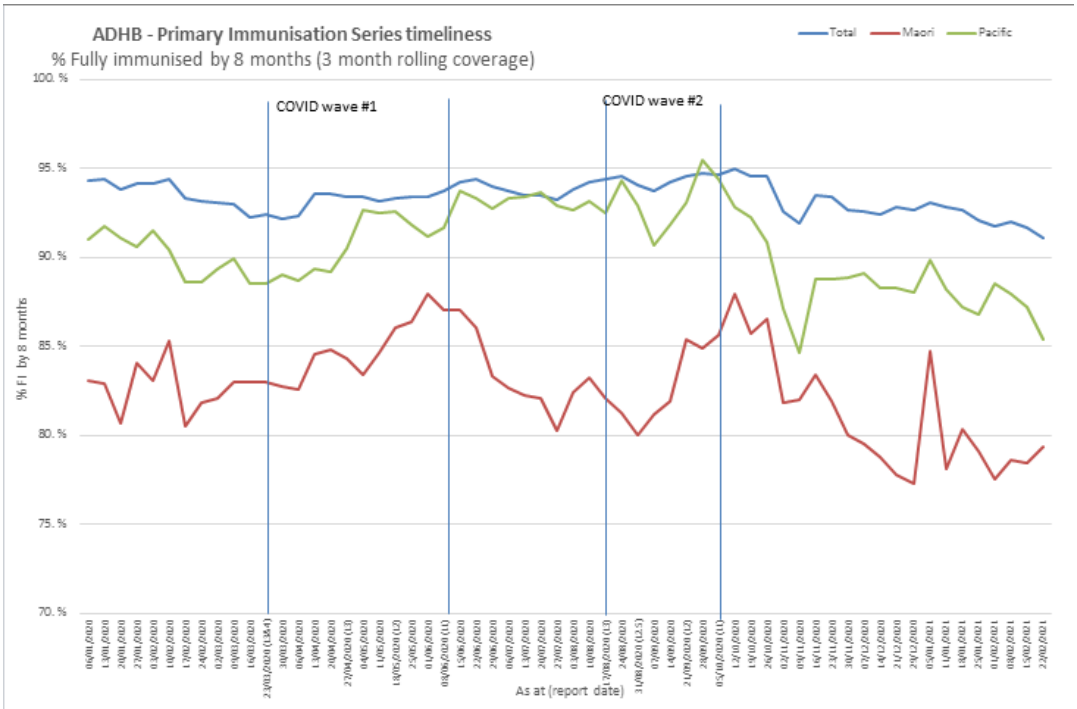
The national framework and service specification for Home and Community Support Services (HCSS) was published at the end of last year. The approach is a restorative HCSS model using a casemix methodology to group people with similar levels of assessed needs together and enables services to flex up and down to respond to real time client needs. There is a requirement for all DHBs to transition to this model by 1 July 2022. The new model is not dissimilar to the current model in place at Auckland DHB and review of key changes that would be required in order for the DHB to transition to the national service specification has been undertaken. Work is underway with the HCSS providers and DHB Community Services to determine if it is feasible to transition to the new service specification on 1 July 2021; noting that the service speciation currently being used has not been updated for several years.

5. Child, Youth and Women's Health

5.1 Immunisation

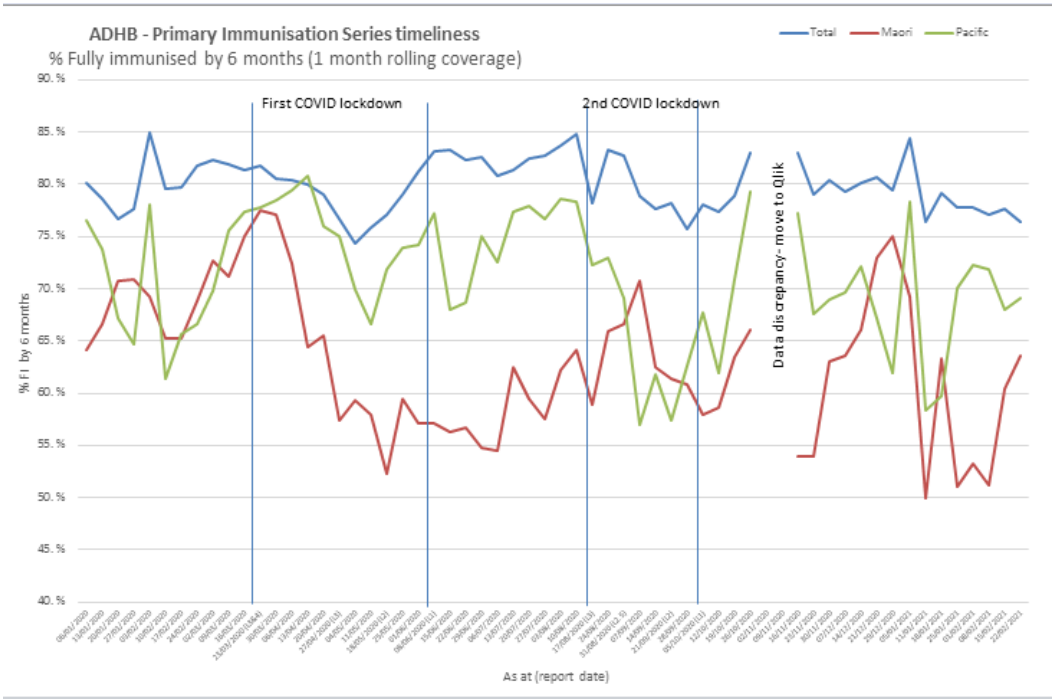
5.1.1 Childhood Immunisation Schedule Vaccinations

As previously indicated, COVID-19 will have an impact on immunisation coverage – the impact on on-time immunisation is being reflected in the coverage at 8 months. Auckland DHB is currently not achieving the 95% target, with coverage as at 22 February 2021 at 91% for the total population and 79% for tamariki Māori – at the same time last year, coverage was 93% for the total population and 81% for tamariki Māori.



PFO continues to monitor the impact on "on-time" immunisation as measured at 6 months of age, particularly the rolling 1-month coverage which demonstrates the "real time" coverage although is more prone to fluctuation due to smaller population size. As demonstrated by the graph below, coverage has fallen during the lockdowns, with recovery as we have moved into level 1, however the drop in coverage is more sustained for tamariki Māori. Another drop occurred around the festive season, which fit with the pattern of previous years due to competing family priorities and practices

not being open, there had been recovery until we had the third COVID lockdown. When looking at the more stable 3 month coverage (not graphed), we are seeing coverage improving towards pre-COVID levels for Pacific and Total, but there Māori coverage has not recovered.



We are working with our Māori Health Gain team colleagues on an analysis of the factors impacting immunisation coverage. The ethnicity insights from the Qlik platform demonstrate Māori as having more than twice the rate of opt-off and decline (8.1%) compared to non-Māori (3.4%). We are supporting the Māori Health Gains team on their initiative to engage with iwi to support positive immunisation messages. As part of this support, we have re-run immunisation coverage on the Qlik platform for an insight into vaccine hesitancy by ethnicity – at the same time last year, our Māori decline/opt-off rate at 8 months is estimated to have been 8.6%, whilst the total population was 2.5%.

Review of other DHBs reflects that we are not alone with high Māori decline rates, with other DHBs experiencing rates as high as 18% at 8 months (Whanganui DHB). Reports from the sector continue to reflect the impact of a viral video by a Māori social media influencer, as well as rhetoric from some church groups and political candidates against immunisation having an impact. We have requested assistance from the MoH at a National level to promote immunisation. We are also working with our colleagues in Counties Manukau on hosting a hui of child health providers to identify the factors for vaccine hesitancy and delay, and strategies to address these.

We have been working with our PHO colleagues to support them with data access with the move to the Qlik reporting platform. The next focus is ensuring all PHOs can access identifiable lists of their Māori tamariki to ensure focus is directed to this area.

The move to the Qlik platform for immunisation coverage has seen some data issue discrepancies, now affecting the 18-month coverage following the schedule changes in October 2020. This has been escalated to the MoH.

5.1.2 Measles

Work as part of the national MMR catch-up focused on 15 to 30 year olds, particularly Māori and Pacific, continues, with the Auckland strategy to increase awareness of the need to be immunised and increasing access to the vaccine.

Since the campaign was soft launched by Minister Genter in July 2020, 476 MMR doses had been recorded on the NIR for Auckland DHB 15 to 30 year olds, with 544 doses claimed for to the end of January 2921. Of these 44 were to Māori (32 claimed) and 85 to Pacific (95 claimed). The discrepancy between NIR and claims data is recognised as a challenge with not all opted onto the NIR, not all providers having access to the NIR.

Whilst the volume is lower than desired, this still represents a great achievement with the MMR catch-up competing with COVID, as well as having limited promotion. The Ministry/Health Promotion Agency resources were not available until late October/November.

Following our focus groups with rangitahi Māori and Pacific people aged 15-30; we have adapted the national communications suite based on their feedback. Posters, leaflets and campaign t-shirts have been distributed to primary care and GP practices.

The MoH has commissioned digital and audio advertising. The DHB is also commissioning washroom advertising in malls across the DHB, as well as social media postings.

The vaccine numbers will start to increase in the coming months with events scheduled in our enhanced school based health service schools and tertiary institutes (campus and halls of residents). A health promotion event the project was supporting Ngati Whatua Orakei with on Waitangi Day was cancelled due to COVID concerns. There are also discussions about health promotion events at community libraries following focus group feedback. Contracts are now in place with Family Planning Association (FPA) and the Regional Sexual Health Clinics, with negotiations progressing with private occupational health providers. An initiative is also being explored to deliver MMR to patients receiving Bicilin injections.

5.1.3 COVID vaccine

The MoH has confirmed the replacement for the National Immunisation Register (NIR) – the "National Immunisation Solution" will be released to support the COVID-19 vaccination information and then will be extended to include replacing the entire NIR by early 2022.

The Immunisation Programme Manager and NIR team leader have been part of a subject matter expert workshop in reviewing the new COVID Immunisation Register (CIR) and how it could be used in practice for delivering the COVID vaccine, particularly in the first phase of MIQ and border workers.

5.2 Uri Ririki – Child Health Connection Centre

The Uri Ririki - Child Health Connection Centre (UR-CHCC) and National Child Health Information Platform (NCHIP) is starting to deliver real and tangible results. A total of 102 Auckland babies previously missing from the NIR were identified via NCHIP and linked in with GPs or outreach for immunisation follow up in Q2 20/21. In the same quarter, the Ministry of Social Development (MSD) shared new contact details for 9/19 (47%) of babies who were previously unable to be located by any of the child health service providers.

NCHIP data is now actively being used to investigate which babies are missing their first Well Child Tamariki Ora (WCTO) core check (4-6 weeks). Following a data quality check, priority is given to Māori, Pacific or babies living in areas of high deprivation (Quintile 5) for direct whānau contact to link them with an appropriate WCTO provider of their choice. A 6-month evaluation of this Newborn Enrolment Process project is planned for March 2021.

As at 28 February 2021, Auckland DHB received 1,610 referrals to Noho Āhuru – Healthy Homes (NA-HH). This included 6,059 family members getting access to healthier home interventions. Of the referrals received, 566 (35.2%) were for families with a newborn baby or hapu woman.

The service has received new promotional resources, which are being promoting to referrers and community agencies over the coming months. These resources have been prepared with the services new name and imagery, and include a number of new tools such as posters and 'table talkers' alongside pamphlets similar to those that have been in use for the last couple of years. Consultation with service delivery partners was included in the design phase. Further feedback will be sought from referrers and partners in 3-4 months to inform any changes required before a further print run.

Summer students completed an audit process for Auckland DHB and Waitematā DHB whānau referred to the NA-HH service. Report of audit results is in preparation. These audits will help identify opportunities to strengthen on-referral and support in a number of domains in addition to core healthy housing interventions.

5.3 Well Child Tamariki Ora and B4 School Check

All providers have continued to provide face-to-face WCTO services under COVID-19 alert level 1. Phone screening still occurs before undertaking home visits.

Recent data as shown in the table below shows that providers have managed to catch up those tamariki that had missed their core checks during the lock downs with the exception of the Pacific population. Overall, for the period (November- December) of 2020, the Auckland DHB WCTO services delivered a total of 1,423 core checks compared to 1,407 for the same period of 2019.

WCTO Core checks November – December 2020 and November – December 2019

	Asian	European	Māori	Pacific	Other	Unknown	Total
Nov-Dec 2020	176	236	497	438	44	32	1,423
Nov-Dec 2019	192	227	423	514	46	5	1,407

The WCTO core checks in the table above do not include Plunket data. The MoH funds Plunket directly, however, Plunket is now required to share some information with the DHBs and therefore we expect to have some monitoring data from them going forward. Auckland DHB is working with Plunket to establish a data sharing process.

COVID alert levels have impacted B4 School Check (B4SC) services but the provider has worked hard to catch up the tamariki.

The table below shows that the B4SC coverage was on target for January 2021 for the high deprivation, Māori and Pacific tamariki. The overall coverage was slight below the target. The provider continues to prioritise tamariki who are close to their fifth birthday, Māori, Pacific and children living in areas of high deprivation (Quintile 5). It is positive to note that despite COVID lockdowns, coverage for children is on track.

B4SC Comparison Auckland DHB January 2020 and January 2021

Percentage of eligible population checked	High deprivation	Māori coverage	Pacific coverage	Overall coverage
January 2020	48.8%	53.5%	51.1%	48.6%
January 2021	54.6%	53.2%	53.8%	50.3%

Auckland DHB has continued to achieve the Health Target with 100% of obese children identified in the B4SC programme being offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions in January 2021.

5.4 Rheumatic Fever

Work is ongoing for the four short-term/high impact initiatives in the Auckland DHB and Waitematā DHB regions in support of managing Rheumatic Fever (RhF) as follows:

- *Identification of culturally safe ways to increase referrals to NA-HH initiative.* A procurement process has been completed to recruit both kaupapa Māori and Pacific researchers who will use guidance from families to develop resources. Planning is underway to gather insights from health workers who will be 'end users' of the resources
- *Piloting of whānau support worker programme*. Work is underway to develop a service specification for this programme alongside the nursing service, which will partner with the social workers in NA-HH, as there are synergies between the two programmes.
- *Piloting dental health services for adults with Acute RhF / Rheumatic Heart Disease*. Early costings and pathways 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 working with a Public Health Physician Registrar on opportunities for increasing awareness, which may include schools and pharmacy settings.

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.

Over the past two-years, there has been a significant focus on improving the systems and processes that support equity and attendance. This has included undertaking initiatives such as: Saturday clinics; the supportive treatment pathway; the development of a small-centralised booking and scheduling team; implementing new booking practices; and focusing on the date in which the child was last seen, rather than their recall date.

However, the COVID-19 pandemic had a significant impact on service performance, as routine oral health care (as per Dental Council of New Zealand (DCNZ) guidance) was unable to be provided during Alert Levels 3 and 4. Consequently, ARDS was unable to operate for eleven weeks in 2020. In addition, the DCNZ has issued new infection control and pre-screening requirements. This has impacted on productivity and means the service is unable to operate its usual model of care (where the majority of children are seen while at school, without a parent present). The overall situation has resulted in a significant increase in the number of children in arrears. It is estimated that arrears grew approximately 0.8% each week during Alert Levels 3 and 4 when the service was unable to operate.

There is also concern that the DCNZ requirement to screen all children prior to their appointment has created barriers for accessing care and will further perpetuate oral health inequities. That is, the service has experienced challenges in reaching some families/whānau to complete the pre-screening requirement. Those children whose parents cannot be contacted are missing out on their dental examination and preventative treatments.

Improvement Plan

An improvement plan has been developed and is being implemented to focus on improving service performance, without further exacerbating oral health inequities. Specifically, the plan aims to:

- reduce the number of children with an incomplete episode of care ('under treatment')
- reduce the number of long waiting children
- reduce arrears
- improve chair utilisation
- improve attendance

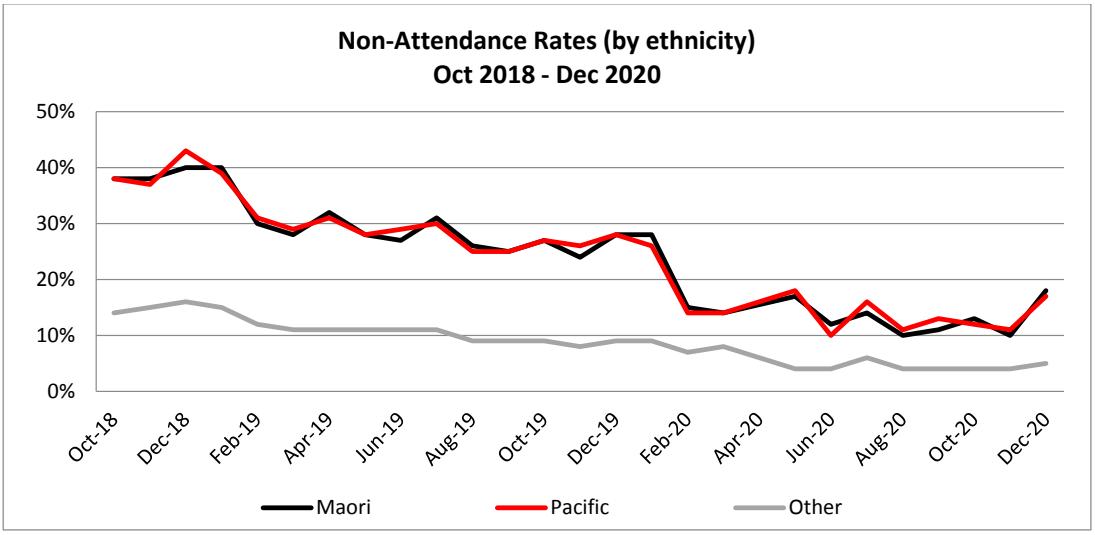
In addition to the improvement plan:

- The Northern Region Chief Executives have allocated $560k to support a redesign of Oral Health service provision for children and adolescents across the continuum.
- $195k has also been allocated from the MoH DHB led Improvement Sustainability fund to ARDS to redesign and reconfigure the service in order to optimise productivity and operational efficiency; improve oral health outcomes; and reduce oral health inequities.
- 10.50 FTE additional (over-recruited) new graduate oral health therapists have been recruited, who will commence with the service in January 2021.
- A pilot programme, using elements from the Scottish ChildSmile programme, is currently being scoped to be delivered in high-need communities in West Auckland from mid-2021. The pilot will be used to design a targeted mode of care, which, over time, will reduce oral health inequities and see sustained improvements in the oral health status of children. It will also assist in determining the cost and feasibility of extending the programme to other areas of Auckland.

Progress to Date

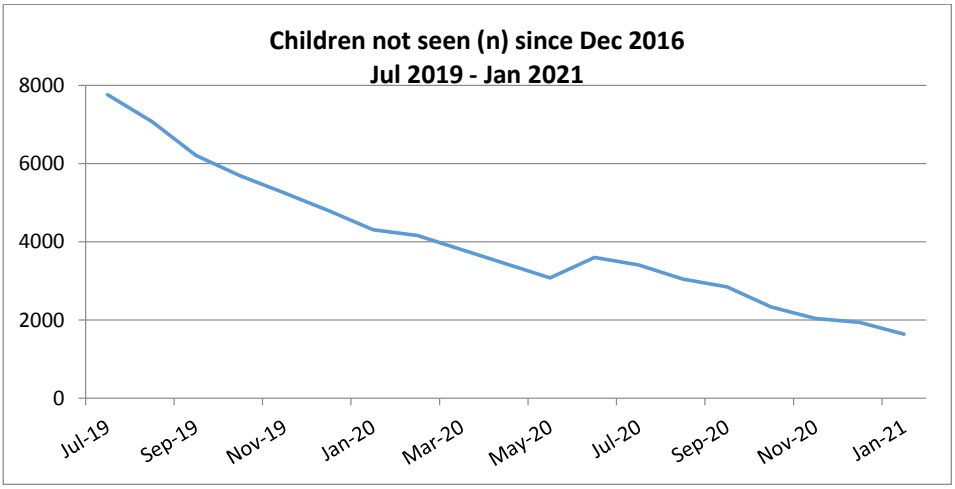
Non-attendance rate

Over the past two-years, there has been a significant focus on improving the systems and processes that support equity and attendance. This has included undertaking initiatives such as: operating Saturday clinics; implementing a structure pathway to locate children and support them to attend appointments; development of a centralised booking and scheduling team; and implementing new booking practices. These initiatives have resulted in a significantly improved attendance rate. As demonstrated in the graph below, non-attendance rates have improved across all ethnicities and the gap between Māori/Pacific and other children has narrowed.



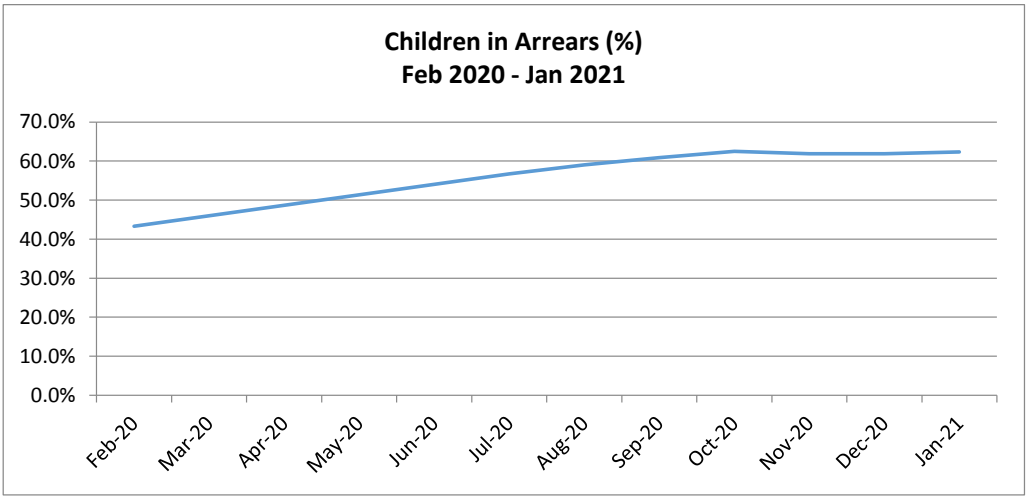
Long waiting children

As demonstrated in the graph below, there continues to be a steady reduction in the longest waiting children. The service continues to prioritise these children and progress by team is being tracked weekly. The supportive treatment pathway is being utilised to support children and whānau to access the service but COVID-19 pre-screening requirements continue to create challenges in supporting children who experience barriers to accessing care.

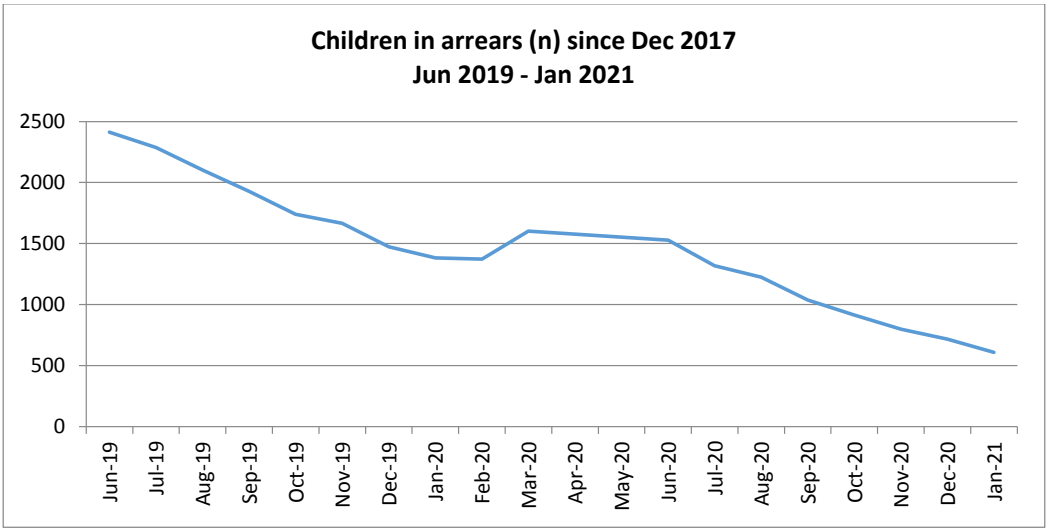


Arrears

The growth in arrears has been stabilised and the first reduction since the onset of COVID-19 was seen in November 2020. There was a slight increase in arrears in January 2021 due to planned clinic closures over the Christmas and New Year period. However, improvement is now being seen – over the first week of February 2021, arrears have reduced by 0.5%.



Of note, there has been on-going improvement in the number of children in arrears the longest. This is demonstrated in the graph below. This has been supported by the introduction of a new patient prioritisation co-ordinator role, which ensures that each clinic receives regular lists of children they need to prioritise for care and ensure that progress continues to be made.



In summary, COVID-19 has had a significant impact on community oral health service provision. The ARDS has implemented an improvement plan, which focuses on prioritising resources to children with the greatest oral health needs. Improvements have been seen across a number of domains, including attendance rates, and arrears growth has been stabilised.

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

A total 138 referrals were received by the service in 2020. Of these, eight referrals did not meet the eligibility criteria and five declined to take part in the service. Of the 125 wahine who are accepted into the service, 13% have completed their episode of care. The remaining are currently under

treatment (83) or have their initial appointment booked (26). A majority of booked appointments (66%) have been with the dentist, compared with 34% with the therapist. The length of appointments reflects the needs with an average appointment being 45 to 60 minutes long. About 34% of wahine needed longer (90 minutes) appointments. A majority of active referrals are Pacific (53%) and Māori (39%) wahine. Nearly half of wahine seen by the service are aged in their 20s and are 42% in their 30s. About 6% are in their late teenage years and 2% are in their 40s.

5.6 Contraception

We continue to monitor uptake of the Long Acting Reversible Contraception (LARC) service in primary care and promote the opportunity to providers. We are working with the provider arm to ensure that services provided within DHB services are captured accurately.

The MoH has commissioned the preparation of National Contraception Guidelines; these were published in December and are available on the MoH website. The guidance is currently being integrated into the Health Pathways platform. A training package has been released by FPA. This training, which has been commissioned by MoH, will provide some free training for health practitioners to access LARCs training. To date we are still not clear on the number of training places available. We understand that online modules have been developed and our team are coordinating requirements for the practical demonstration and assessment component of the 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. We have signalled this may include additional training, as concern remains that FPA programme will not be sufficient to meet the demand and need to significantly improve coverage of service provision and address access barriers.

5.7 Cervical Screening

Cervical Screening coverage for Auckland DHB remains significantly below the coverage target of 80%, updated coverage based on the revised population forecast shows an 8.7% increase in coverage for the total population with coverage now reported at 69.6%. The coverage rate remains inequitable for Māori, while the revised population forecast has increased coverage for Māori (now 57.8%); there is a 22% difference in coverage between Māori and 'Other' women who are meeting 80% coverage. Coverage for Pacific and Asian women also remains inequitable at 61.3% and 59.3% respectively (noting that there is currently no outcome inequity for Asian women, however this remains for both Māori women and Pacific women).

Coverage among Māori, Pacific and Asian women has declined over the last three years while coverage for Other women has increased slightly. 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 (NSU) 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. The HPV self-testing research continues in the Māori Health Pipeline.

A project to evaluate the effectiveness of incentives for cervical screening is being developed by the Māori Public Health Registrar, and will be implemented early in the 2021. This is based on the maternal smoking cessation incentives programme, and a range of incentives schemes across the country, however there is not currently high quality evidence evaluating their effectiveness and reach.

A number of guidelines changes have been implemented, some of which came into effect during the April-May 2020 lockdown period. There appears to be a good level of understanding of the updated guidelines in the sector following a webinar provided by the Coordination Service that has had over 200 views to date. We have worked to update the Health Pathways guidance to reflect these changes; this went live on 27 November 2020.

6. Mental Health and Addictions

6.1 Individual Placement and Support (IPS)

IPS is an internationally recognised and evidence-based integrated approach to employment support for people with mental illness and/or addiction. Meaningful employment can play a critical role in recovery and therefore, Auckland DHB has funded IPS for many years. This consists of employment consultants being co-located within several specialist mental health services. The service is currently delivered by five NGO FTE. This is very successful, however, this level of FTE is significantly below national modelling for adequate employment consultant ratios and as such, the service is not able to meet the demand for it.

MSD funded an expanded high fidelity IPS model at Waitematā DHB under Oranga Mahi, a cross-agency established in 2016 to deliver a set of cross-agency prototypes for clients living with health conditions or disabilities. The outcomes from this provided MSD the evidence for IPS and the significance of employment in enabling recovery for people with mental illness and/or addiction. The PFO team has worked with MSD in Waitematā DHB and have advocated for an expansion of the IPS service in Auckland DHB.

We now have an opportunity to work in partnership with the MSD to increase the number of employment consultants and thus expand the delivery of service. A Letter of Intent has been received from MSD. This confirms investment of up to $1M to expand the IPS service for a trial period of 12 months. Negotiations are being concluded with MSD and the plan is for Auckland DHB is to run a competitive process to identify provider/s, with delivery starting within 6 months.

6.2 Rapau te Ahuru Mowai – Homelessness Transitions Pilot

Rapau te Ahuru Mowai, the Mental Health and Addictions Homelessness Transitions Pilot (the Pilot), is an action from the Aotearoa New Zealand Homelessness Action Plan, a central government-led and cross-agency plan that has been developed to prevent and reduce homelessness.

The Aotearoa New Zealand Homelessness Action Plan (the Plan) sets out an overarching framework with actions to improve the wellbeing and housing outcomes of individuals and whānau who are at risk of, or experiencing, homelessness. The Plan had 18 immediate actions to be put in place in 2020. The Homelessness Transitions Pilot is one of these 18 actions. This initiative seeks to address the urgent issue of people stuck in inpatient services who no longer clinically need to be there as they are homeless and without a suitable discharge address. The central goal of the Pilot is to help strengthen and improve the responses of Mental Health Inpatient Units when discharging service users/tāngata whaiora (who have experienced or are at risk of homelessness) back into the community.

The Homelessness Transitions Pilot will take place over 4 years and help approximately 100 people transition from acute mental health and addictions inpatient units into the community, with housing and other wraparound support. The programme will be trialled in two sites – Auckland and Waikato. The key components of the Pilot include:

- flexible home-based services, tailored to meet the unique needs of individuals in scope for this initiative
- provision of housing through access to the public and private market/social or supported housing
- provision of mental and physical health services
- provision of broader support services

The Pilot aims to support adults with complex mental health and addictions and other needs requiring specialist health services to gain and maintain wellbeing in a community setting. The target cohort includes adults who:

- are transitioning out of acute mental health and addictions inpatient units
- are homeless or do not have suitable accommodation
- have wider wellbeing support needs
- who are able to live in the community with support

A high proportion of tangata whaiora who have an extended stay in mental health and addictions inpatient units are Māori. The Homelessness Transitions Pilot initiative will include a focus on providing culturally appropriate support that responds to the needs of Māori.

There are two parts of this procurement:

1. Wrap-around Services including Flexi-fund (Budget: $4,298,592.86 – four-year total)
2. Property Sourcing and Housing Co-ordination / Tenancy Management Services (Budget: $1,452,814.00 – four-year total).

PFO has started an open procurement process for a joint proposal for both aspects of the Pilot. In order to meet government contractual expectations, it is anticipated that contracts will be signed by early May and the service start shortly after that.

6.3 Suicide Prevention update:

Data reported from the Coroner (for the purposes of postvention work until publically released by that Office); indicate some concerning trends in suspected suicides in the Auckland DHB area. Included in this data was information about suspected suicides linked to a small rural community which has had caused great distress to the affected whānau and community at large. Various forms of support have been provided for the whānau and community at through our postvention response group which includes specific suicide prevention training by Le Va, an NGO provider.

Mental Health 101 training is scheduled to be delivered within Auckland DHB. One of the training sessions is Lifekeepers, a specific suicide prevention programme, delivered by Le Va and funded by the Ministry of Health. Mana ake ake is the Māori version of Lifekeepers and these programmes aim to equip frontline community workers, community leaders in churches, marae and other relevant community hubs. There will be two training sessions for Auckland DHB and Waitematā DHB area in March 2021.

The Suicide Prevention and Postvention Governance Group (SPPGG) continue to meet monthly with a focus on implementing the draft Suicide Prevention Action Plan 2020/23. A board paper has been developed for endorsement, however, relevant parts of this action plan have operative and reporting to the MoH has occurred through the DHB reporting process.

There is an ongoing review currently in progress regarding the suicide notification pathway and postvention response. Working in collaboration at regional level has been very useful and productive during this review process.

6.4 Integrated Primary Mental Health and Addiction Services

Integrated Primary Mental Health and Addiction Services (IPMHAS) is a Ministry funded initiative based on the recommendations of He Ara Oranga. It aims to expand access to primary mental health and addiction services with a particular focus on those with mild to moderate needs. In the metro Auckland region, a range of providers (including the three DHBs, PHOs and NGOs) collaborated as the Auckland Wellbeing Collaborative in putting together a proposal for this funding. The proposal was successful and Auckland DHB became the contract holder, on behalf of the Auckland Wellbeing Collaborative for IPMHAS.

Naming of collaborative, launch and website

The collaborative acknowledges with great appreciation Robert Clark, Barry Bublitz and colleagues (Manawhenua I Tāmaki Makaurau) for the gift of the name for the Auckland Wellbeing Collaborative, Tū Whakaruruhau - To stand and Shelter. The Pohutukawa is our tree, with a strong base, and many branches coming together to stand in and shelter under. These branches can be the communities we serve; the partners and providers in the collaborative and the different services or elements to this overall programme.

Te Tumu Waiora and Awhi Ora, both come with their unique whakapapa, and sit inside the collaborative within these branches, as gifted identities within this overall programme.

An official launch for Tu Whakaruruhau is being initiated by Auckland DHB CEO and the Programme Board in liaison with Office of the Minister of Health. A date is yet to be confirmed. A wider communications process will occur around the time of the launch.

Stage 1 of the Tū Whakaruruhau website became live from Friday 26 February (for the Auckland Wellbeing Collaborative) http://www.aklwellbeingcollab.co.nz/

The website is intended to respond to several information needs within Tū Whakaruruhau:

- **People in need** – information about the new service and how to access services within primary care
- **Providers** – information about the roles and functions within the new services and about the role of the enablement team.
- **Careers** – information for people who may want to work in one of the services within the Auckland Wellbeing Collaborative.

Planning for 2021/22 contract and rollout schedule

During the 2020/21 year there was an under spend of the IPMHAS contract. On 12 February 2021, an initial meeting was held with the MoH to discuss use of the under spend. Tim Wood facilitated the discussion as Chair of Programme Leadership Board and represented, Ailsa Claire, as the contract signatory.

The MoH team agreed to the proposal tabled by the Auckland Wellbeing Collaborative for the use of underspend as follows:

1. Bring forward 11 practices into this contract year; and
2. Fully fund the initial two months of 2021/22 (July and August 2021.

The MoH team confirmed funding for existing service contract volumes into 21/22 and for the full cost of the Enablement Team and workforce support into 21/22.

Planning for new practices 21/22

The Enablement team proposed a roll out plan for 21/22 of around 51 practices by June 2022.

The MoH Team responded with indication of the level of investment/ practices being about right but for over a 2-year period rather than the 1 year period proposed by Tū Whakaruruhau. This would result in the roll slowing down significantly.

The Strategic Sponsor Governance Group, Programme Leadership Board and Auckland Primary Care Leadership Group are keen to advocate for not slowing down and a letter has been written to Dr Ashley Bloomfield and Toni Gutschlag requesting they review the proposed slowing down of implementation in Auckland given the success to date, rising need given the impact of COVID-19 and concern over an increase in suspected suicides in the region.

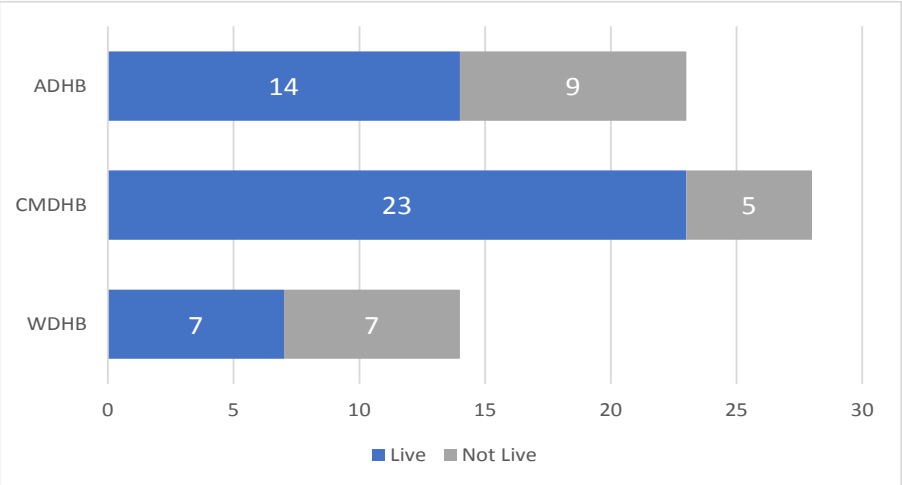
The MoH have indicated they would confirm a potential contract value and volumes in early March. The enablement team continue to work on the roll out of new practices for 21/22 using several modelling options. We are trying to take into account the best opportunity for reach to high needs communities (enrolled Māori, Pacific and Youth) along with logistics of implementation, coverage for PHOs and DHBs, and potential impact of mental health funding in future.

Implementation of IPMHAS Contract 20/21

Across metro Auckland, as of the end of January 2021, there are now 44 practices "live", 14 more than end of October report. Awhi Ora is available in more practices outside of this contract in the Auckland DHB and Waitematā DHB areas.

Auckland DHB now has a total of 24 practices being implemented to June 2021 (Fig 1). Since November 2020, Auckland DHB has had three new practices go live with several in set-up, recruitment and training phase during January and February. (see Table 1 for list of "live" practices)

Figure 1. Comparison by DHB – actual practices vs proposed number by June 2021



NB. This figure has changed from n=18 since Nov 20. The difference between previously planned 18 and now planned 24 practices includes: additional 8 practices from 11 new ones, addition of Aotea Health (yet to be added to Fig 1) and withdrawal of Tongan Health Society n=3 practices).

Table 1: List of practices now operational in Auckland DHB area as of end Jan'21-

Facility Name	PHO
Auckland University of Technology City*	Auckland PHO
Avondale Family Health Centre	AH+
Avondale Health Centre	Auckland PHO
Local Doctors Glen Innes	Total healthcare
Local Doctors Mt Roskill	Total healthcare
Orakei Health Services	National Hauora Coalition
Ostend Medical Centre	ProCare
Piritahi Hau Ora Trust	Auckland PHO
Stoddard Rd	ProCare
The Doctors Onehunga	ProCare
Three Kings Accident & Medical Clinic	National Hauora Coalition
Turuki Charitable Trust - Panmure	ProCare
University of Auckland, Student Health Centre	ProCare
Waiheke Medical Centre	Auckland PHO

We are drawing on underspend in this contract year to bring forward 11 additional practices: Eight of these are in the Auckland DHB area and three in Waitematā DHB. Funding for the 11 new practices does not start until March and April funding (Table 2).

Table 2: 11 Additional Practices added to 20/21 rollout schedule

Practice	PHO
New Al-Dawa Medical & Dental Surgery	AH+(Avondale Cluster) March
Rosebank Road Medical Services Limited	AH+ (Avondale Cluster) March
Hong Kong Surgery Limited	AH+ (Otahuhu Cluster) April
Lifeline Medical Services Limited	AH+ (Otahuhu Cluster) April
Otahuhu Family Medical Centre Limited	AH+(Otahuhu Cluster) April
Queen Street Medical Centre Limited	AH+ (Otahuhu Cluster) April
Singha Zenith Limited	AH+(Otahuhu Cluster) April
Auckland City Mission/Calder Centre	Auckland PHO April

As of the week of 22 February 2021, we are now also fast tracking into this year implementation into Aotea Health on Great Barrier Island, due to increased need. Planning started on 25th February 2021. A flexible approach will be required given the circumstances of the Island.

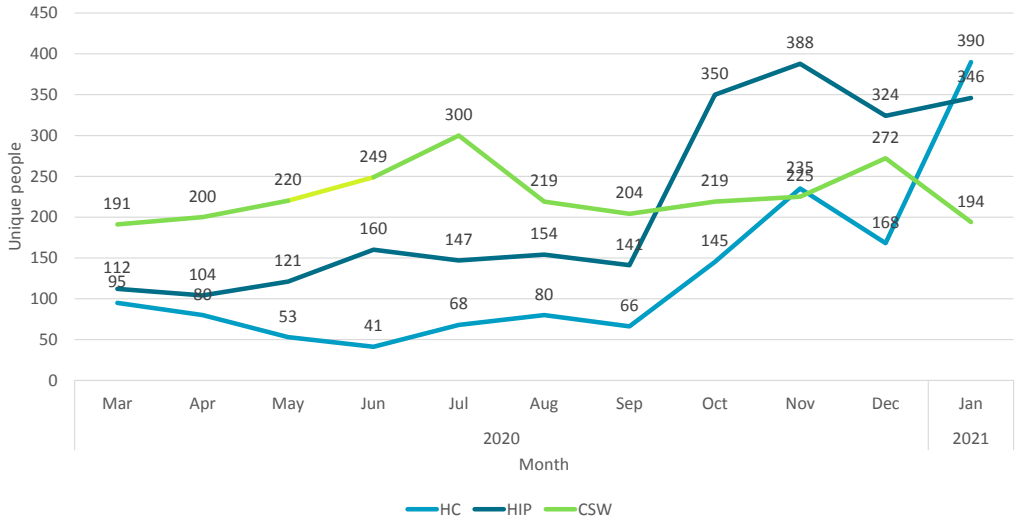
People Seen

Implementation has continued through all of the COVID19 alert level restrictions in Auckland. Across Tāmaki Makaurau, from the 1st March 2020 to the end of January 2021, 5,137 people (unique individuals) have been seen by Health Coaches (HCs); 6,967 people by Health Improvement Practitioners (HIPs); 1,884 people by Awhi Ora support workers: and 5,071 people through Wellness support (CMDHB only).

In the Auckland DHB area this was 390 people by HC, 346 people by HIPs and 194 people by Awhi Ora. (See Fig 2.) The Christmas period and summer holidays with leave taken had some import for

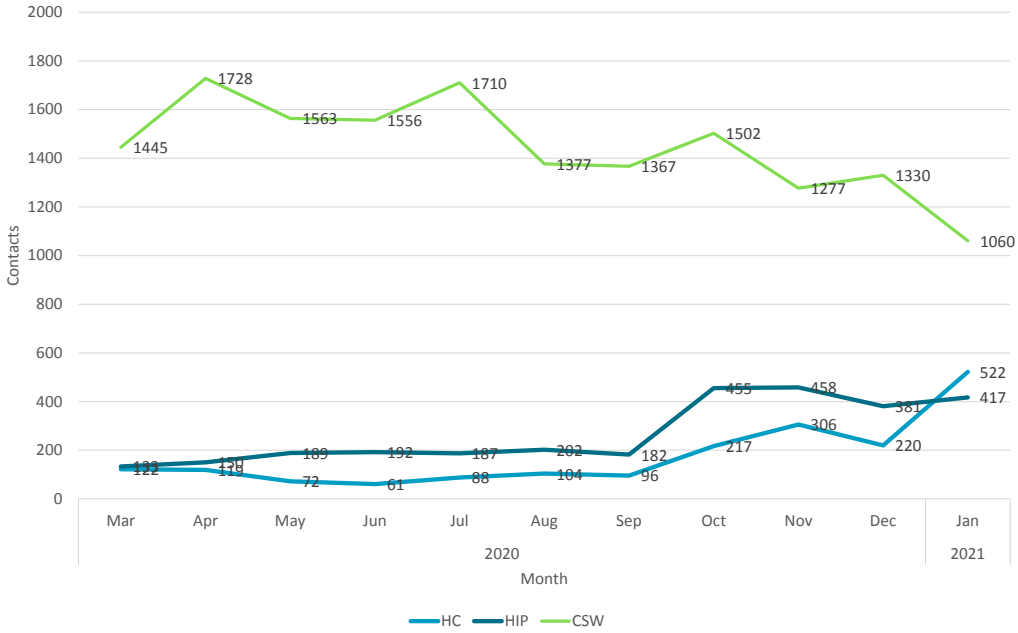
HIPs and Awhi Ora. We are looking into to understanding the big change for HCs to see what has influenced this.

Figure 2. Auckland DHB- Unique people seen by role.



Contacts for Auckland DHB area increasing for HIPs and HCs but not for Awhi Ora (See Fig 3). There was concern shared that some Awhi Ora providers in Auckland DHB were at peak capacity and not due for an increase in allocation of hours until February. The increase was fast-tracked by the Funder to start as soon as the provider had the capacity to do more.

Figure 3 Auckland DHB – Contacts



Are we seeing the high priority populations?

For Auckland DHB, since the start of the contract start, Awhi Ora/CSWs have seen the higher percentage of Māori (18%) followed by HIPs (15%). However, in total only 13% of people seen in practices that are operating the model in the Auckland DHB area are Māori. (Table 3). This may

change over coming months with three of the Kaupapa Māori and Māori providers now providing services (Orakei Health (NHC); Piritahi Trust, Waiheke Island (Auckland PHO); and Turuki Panmure (ProCare)). The enablement team are concerned about this low figure and need to do further investigation to map this against the ratio of % Māori pop for the practices that are operating the model, then review access in those practices if this is significantly different. Work is also starting on Equity in the enablement team in terms of quality improvement initiatives related to the model and responsiveness to Māori, and in how we measure equity.

HCs have highest contact with Pacific people (47%) then Asian population; Awhi Ora currently have the highest contact % with European; HIPs currently have highest percentage contact with European then Asian (Table 3). This needs to be checked against the ratio of those populations across the practices with the model.

The reach to Māori and Pacific populations is slightly different for Metro Auckland over all (see Table 4.) The enablement team will also be looking to better understand the differences across the region.

Table 3. Ethnicity of People seen- Auckland DHB

Role	Māori	Pacific	European	Asian	MELAA	Other
Health Coach	8%	47%	11%	26%	3%	5%
Health Imp Practitioner	15%	14%	34%	29%	4%	4%
Comm Support Worker/ Awhi Ora	18%	15%	35%	17%	8%	7%
Total	**13%**	**24%**	**27%**	**27%**	**4%**	**5%**

Table 4. Overall – Metro Auckland

Role	Māori	Pacific	European	Asian	MELAA	Other
Health Coach	22%	41%	21%	12%	1%	2%
Health Imp. Practitioner	22%	25%	31%	16%	2%	2%
Comm Support Worker/Awhi Ora	16%	13%	44%	13%	5%	3%
Total	**22%**	**32%**	**28%**	**14%**	**2%**	**2%**

General practice specialist advice and support for Auckland and Waitematā DHBs

Auckland DHB and Waitematā DHB provider arm mental health and addiction services leadership have worked together to plan for the enhancement of the current support provided from secondary services, and interface with, primary care. The proposal from the two DHBs has evolved from solely an enhanced GP-Psychiatrist phone line noted in the contract to now incorporate:

- Clinical Nurse specialist to provide advice, consultation and coaching support to mental health credentialed nurses. Implementation planning work has started this month with the employment of a part-time project manager who is also supporting health pathways work. The project manager is a very experienced senior nurse and very familiar with both Waitematā DHB and Auckland DHB.
- Auckland DHB will fund 0.5FTE SMO phone line. Discussion is occurring between Auckland DHB and Waitematā DHB on this.
- Strengthening priority health pathways to support transition between primary and secondary care services.

7. Pacific Health Gain

7.1 Pacific Regional response to COVID-19

The Pacific Health Gain team continue to support the NRHCC in testing and responding to surges of COVID-19, and the rollout of the COVID-19 vaccination. We are managing our resources accordingly, and ensuring our providers are enabled to be a critical part of the region's response to COVID-19. This includes the timely flow of information between the NRHCC and the provision of Pacific led health services like Mobile Clinics (discussed below).

7.2 Pacific Mobile service

The Tongan Health Society Pacific Mobile service provides support to individuals and families that find it very difficult to access primary care services. This service is being extended to 30 June 2021 with an understanding that it will deliver further COVID-19 testing and support the COVID-19 Vaccine immunisation programme, when required.

7.3 Positive Parenting and Active Lifestyle (PPAL)

In the past 6 months, 25 PPAL programmes were delivered to 130 parents with 100 graduating over the same period. The remaining thirty parents will complete their programme by March 2021. An additional 20 parents enrolled for the one on one programmes will graduate by March 2021. In total, 150 parents have participated in PPAL programmes over the past two quarters.

7.4 Healthy Village Action Zones

44 churches in the Healthy Village Action Zones (HVAZ) Network have supported Pacific health providers as well as the NHRCC in its COVID -19 response. During the August outbreak, 16 Pacific churches agreed for their church facilities to be used for COVID-19 pop-up testing sites. This improved access for Pacific families and communities to access COVID-19 testing at sites that were local and familiar to them. Both HVAZ Parish Nurses and Coordinators were redeployed to pop-up testing sites to assist the operational aspects of the site and to help families access food parcels and other social, financial and housing support available.

7.5 MMR Vaccination plan

Samoan and Tongan community groups with extensive networks across the Auckland region have been identified and approached to support the promotion of the MMR campaign through various channels. An intergenerational approach which includes educating and promoting the MMR vaccine to parents, grandparents will be adopted as a way of encouraging and supporting those aged 15-30 years old to seek an MMR vaccination and make an informed decision.

7.6 Self-Management Education/Diabetes Self-Management Education Programmes.

Two SME/DSME programmes were completed in February 2021. Each programme consists of six week Self-Management Education workshops and two Diabetes self-management workshops. A total of 40 participants completed the programme of which 90% of the participants experience multiple long-term conditions.

7.7 Fanau ola Integrated services

Over 50% of the annual target number of new enrolments of families or households was achieved by December2020. Many Pacific families continue to struggle with unemployment, financial hardship and financially instability, living with extended family to share daily living costs, living with existing chronic conditions for example diabetes. This has been exacerbated by the COVID-19 pandemic which continues to cause some fear, confusion and anxiety affecting Pacific families and communities.

In response, the fanua ola integrated service providers actively work with each family and/or household to understand what are the pressing priorities and what would be most helpful for them. A holistic response which considers and includes the ethnic language, cultural and spiritual affiliations of the family or household is provided. Services may include but is not limited to access to social service housing and financial support, couple relationship counselling, mental health support, health education on a wide range of topics including asthma, cardiovascular disease, high blood pressure, high cholesterol, pre diabetes and diabetes.

8. Māori Heath Gain

8.1 COVID-19 specific responses and service

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)

For the previous quarter, our focus was on re-establishing the Māori Mobile Units that were redirected to COVID-19 testing following the August outbreak. We have maintained three mobile testing units operating across both Auckland and Waitematā DHBs.

To date the three mobiles have:

- A total of 649 contacts(with 241 through marae based clinics)
- 80 flu vaccinations
- 88 child vaccinations
- Six GP enrolments
- Over 500 wellbeing assessments and accompanying wellbeing support
- 83 strep throat swabs
- 28 referrals to other agencies and care providers

These mobiles will form a critical part of the wider COVID-19 response and management going forward. All three are capable of supporting/leading the vaccination roll out or testing strategy in high needs communities, where an outreach strategy is important to ensure access for residents.

8.2 Māori Pipeline Projects

8.2.1 Māori Health Plan Acceleration Projects

Breast Screening Data Match: A data match was undertaken between primary care enrolment and the breast screening services of the Northern Region to identify Māori women not currently enrolled in breast screening and invite them to be screened. Across the region, 730 Māori women were enrolled in the breast-screening programme. This project is now complete and a draft report is being prepared to share with stakeholders.

Cervical Screening High Grade Project: Our previous research project on HPV self-testing for cervical screening in Waitematā DHB and Auckland DHB identified a large group of women who had a history of an abnormal previous screening result (high grade; at high risk of cervical abnormality/cancer) who had not been followed up. This project sought to systematically identify these women and offer

screening via an alternative service based on Māori values. Unfortunately, the National Cervical Screening Programme (NCSP) declined to provide the required data to triage the women efficiently and offer service to those most at risk, citing legal reasons. The project has therefore had to change direction, instead creating an audit tool to be used at practice level. The audit tool has been completed and undertaken in three pilot practices by the project team, and has subsequently been trialled as a self-audit tool with approval by the College of General Practice to accredit the tool for use nationally. Lessons learned are being shared with the NCSP and locally with cervical screening stakeholders.

8.2.2 New Services

Lung Cancer Screening Project: This is a large-scale collaborative project with Otago University, Waitematā DHB and Auckland DHB, led by Professor Sue Crengle and supported by a Māori-led steering group. The Consumer Advisory Group Te Ha Kōtahi, developed from participants in the previous focus groups and surveys, has met twice and supported a range of project material development. A Decision Aid tool is under development, and Health Literacy NZ have been engaged to assist with development of participant materials. A pilot with four to six general practices will get underway when the ethics approval is granted. The team are awaiting research-funding decisions for a larger trial and additional studies.

AAA Screening: The data analysis for the abdominal aortic aneurysm (AAA) risk prediction for Māori, as part of the original project, is underway. A small number of practices unable to complete the original Māori AAA project have been offered to have screening undertaken for their population. A small team is working together on invitations. The Pacific AAA screening project (under the Māori Health Pipeline as it is the same team) has completed the pilot with Tongan men, and moved on to offer screening to other Pacific ethnic groups. Kōtui Hauora agreed to consider AAA screening extension to Northland DHB; discussions are underway.

Hepatitis C: the Ministry of Health have agreed to the Northern Region leading the datamatch for the country, a proposal is currently being finalised. The project will support appropriate datamatching to enable the re-offer of treatment to those with known Hepatitis C who have no record of receiving treatment. The project focuses on elimination for Māori first, with the clinical team led by a Māori pharmacist.

PHO enrolment: This was the first project in the DHB to formally undertake a Māori Data Sovereignty Assessment and act on its results (Iwi and MoU partner governance and decision making about the data). The data match with Māori providers has been closed-off although not all providers in Waitematā DHB and Auckland DHB provided their data. Counties Manukau DHB was originally involved in the project, however their providers chose not to participate. The project demonstrated a significant number of people enrolled in Māori providers were not enrolled in primary care, which means the project can progress to Phase 2, which is the development, with Māori providers of either a facilitated primary care enrolment service or an alternative offer of service.

8.2.3 New Models of Care

Kapa Haka Pulmonary Rehabilitation: This project seeks to use Kapa Haka as an intervention to improve respiratory fitness and determine whether it can on its own, or augmented, be used as pulmonary rehabilitation. The project developed out of Dr Sandra Hotu's PhD studies, and was on hold for some time as this work was completed. It has now been restarted with the support of Kapa Haka expert Annette Wehi and whānau, and physiotherapists from DHBs across metro Auckland.

8.3 Healthy Babies Healthy Futures

The Healthy Babies Healthy Futures (HBHF) programme is on track despite COVID-19 disruptions to educating parents in nutrition and physical activity. The programme is seeking additional funding to develop videos suitable for 15 e-Learning courses and as a video resource for live webinars and face to face workshops. The community partnership grants particularly with Kōhanga Reo and church based groups will be a main feature for educating Māori and Pasifika parents in the 2021 – 2022 year. The Asian community enjoys a large waiting list of parents ready to learn while the South Asian community have exceeded their targets also.

Table 1: HBHF Key measures July 1st 2020 - Jan 31st 2021

	TextMATCH Enrolments		Programme (6 courses) enrolments		Lifestyle reviews collected - 6 weeks post	
PROVIDER	**Actual**	**Performance**	**Actual**	**Performance**	**Actual**	**Performance**
HealthWEST - Māori	140	105%	67	84%	35	62%
FONO - Pasifika	121	91%	106	126%	53	94%
TANI – South Asian	176	132%	134	159%	91	162%
CNSST - Asian	186	139%	322	335%	102	159%
Total	623	138%	629	175%	281	141%

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 and Former Refugee Health Gain team continue to support NRHCC to provide culturally appropriate guidance for the current COVID-19 response in the Auckland region. The team continue to work and liaise with ethnic leaders and community partners in promoting and disseminating the key information and messaging from NRHCC in relation to the current outbreak. The team is supporting Office of Ethnic Communities in producing culturally appropriate short videos on the importance of following official COVID-19 instructions.

The team is in consultation with key trusted Asian and Middle Eastern, Latin American and African (MELAA) ethnic partners in collating feedback on COVID-19 vaccine hesitancy to inform culturally appropriate messaging via NRHCC.

The team is providing feedback from an Asian and MELAA perspective into the development of the COVID-19 Public Health Strategy and Operational Programme (led by MoH).

9.2 Increase access and utilisation to Health Services

Indicator: Increase by 2% the proportion of Asians who enrol with a PHO to meet 90% by 30 June, 2021

The number of Asian enrolees Q1 2021 has increased by 542 for Auckland DHB, compared to last quarter. The Waitematā DHB PHO enrolment is 80%.

(The population projections '2020 Update' (based on Census 2018) is used for the analysis of Q1 2021. Earlier (e.g Q4 2020), the '2019 Update' which was based on Census 2013 was used).

The team have provided input into the Refugee Health Handbook Edition 2 and into the Migrant and Refugee section of the Health Pathways page.

We continue to work with community stakeholders and promote the updated resources and flyers, on the NZ Health and Disability System. Work is underway in producing the NZ Health and Disability System awareness raising video in Arabic.

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)

In October 2020, the New Zealand government agreed to resettle refugee and asylum seekers under emergency priority (people who need protection because they face an immediate life-threatening situation, deportation, detention or imprisonment) referred by the United Nations Refugee Agency (UNHCR).

As part of this, a variation to the existing eligibility criteria in the *Improving access to general practice services for former refugees and current asylum seekers* agreement is being made to include a new category – 'quota refugee emergency cases referred by the United Nations Refugee Agency (UNHCR)'. This is to ensure that those arriving under the emergency quota and resettling in the metropolitan Auckland region are able to access the funded services under the existing aforementioned agreement.

Earlier in February, the Government announced that New Zealand's Refugee Quota Programme will be resuming, and small groups of refugee families will start arriving for resettlement from mid-February 2021.

The team has provided feedback into Ministry of Health review, conducted by PWC on Mental Health Pathway and settlement support available for Former Refugees after they are resettled in the communities.

Hospital Advisory Committee Meeting 17 February 2021 – Draft Unconfirmed Minutes

Prepared by: Marlene Skelton, Corporate Business Manager

Recommendation

That the unconfirmed minutes from the Hospital Advisory Committee meeting held on 17 February 2021 be received.

Minutes
Hospital Advisory Committee – Provider Equity Meeting
17 February 2021

Minutes of the Hospital Advisory Committee – Provider Equity meeting held via a Zoom meeting commencing at 8:30am

Committee Members Present	**Auckland DHB Executive Leadership Team Present**	
Jo Agnew (Deputy Committee Chair chaired in the absence of Tama Davis)	Ailsa Claire	Chief Executive Officer
Doug Armstrong	Mark Edwards	Chief Quality, Safety and Risk Officer
Michelle Atkinson	Michael Shepherd	Interim Director Provider Services
Heather Came	Sue Waters	Chief Health Professions Officer
Zoe Brownlie	Justine White	Chief Financial Officer
Peter Davis	Dr Margaret Wilsher	Chief Medical Officer
Fiona Lai	**Auckland DHB Senior Staff Present**	
Bernie O'Donnell	Dr John Beca	Director Surgical, Child Health
Michael Quirke	Hineroa Hakiaha	Co-Director Mental Health
	Emma Maddren	Interim Director Starship Child Health
	Rob Sherwin	Director Women's Health
	Tracy Silva Garay	Co-Director Mental Health
	Carly Orr	Director of Communications
	Marlene Skelton	Corporate Business Manager
	Wendy Stanbrook-Mason	Deputy Chief Nursing Officer
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

KARAKIA

The Karakia was led by Board member Bernie Davis.

1. APOLOGIES

That the apologies of William (Tama) Davis (Committee Chair) and Pat Snedden (Board Chair) ex officio member be received.

That the apologies of Executive Leadership Team members Mel Dooney, Chief People Officer, Margaret Dotchin, Chief Nursing Officer, Dr Debbie Holdsworth, Director of Funding – Auckland and Waitemata DHBs, Meg Poutasi, Chief of Strategy, Participation and Improvement and Shayne Tong, Chief Digital Officer be received.

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

There were no conflicts of interests to any item on the open agenda.

The following changes to the interest register are required:

Heather Came

Delete - Co-President of the NZ PHA and add, interim chair of the AUT branch NZ PHA

Bernie O'Donnell added:

Senior Advisor to DCE – Oranga Tamariki

Engagement Advisor – Ministerial Advisory Panel – Oranga Tamariki

3. CONFIRMATION OF MINUTES 18 NOVEMBER 2020 *(Pages 9-19)*

Resolution: Moved Michael Quirke / Seconded Michelle Atkinson

That the minutes of the Hospital Advisory Committee meeting held on 18 November 2020 be approved

Carried

4. ACTION POINTS

There were no open action points to consider.

5. PERFORMANCE REPORTS

5.1 Provider Arm Operational Update (*Pages 20-23)*

Mike Shepherd, Interim Director Provider Services asked that the report be taken as read, advising as follows:

Kaiārahi Nāhi rōpū and Pacific Care Navigation Service

The organisation is looking to lock in the systems improvements based on the intelligence that has been gathered and supporting those services with required improvements. This fits in well with the planned care portfolio of work.

Women's Health and Perioperative Review

Women's health and the surgical perioperative review issues have previously been signalled to both this committee and the Board. It is worth noting that that these are broad, complex review and engagement consultations. It is a real sign of organisational maturity that the amount of time and energy on such a broad engagement strategy with a really deep equity focus is able to be undertaken. This work is progressing well, but obviously with the amount of work involved will continue over a medium term timeframe.

COVID 19

A key observation from the recent outbreak was the organisations realigned approach to using the escalation planning tool. This allowed the organisation to pivot and adjust its response in a systematic way. There has been a great response from staff. It has allowed clear communication in a rapid timeframe to both the Community and our people around our expectations and has allowed us to maintain the really important planned care that is

required to be delivered as well as keeping our people in our Community safe.

The following was raised in discussion:

Jo Agnew referred to page 20 of the agenda referring to the process for formal evaluation of the Kaiārahi Nāhi rōpū and the Pacific Care Navigation Service approach and asking when a report was likely to come to the Hospital Advisory Committee. Advice was given that this was unknown at this point but would be followed up. It was agreed that this become an action.

Peter Davis congratulated management on the quality of the presentation material relating to the out patients toolkit and theatre management and asked whether there would be any reporting back on, for example, whether the theatre management tool made a difference to the proportion at which theatres were used across the board. He noted that there had been a slight 5% to 6% increase in utilisation of theatres at Greenlane and commented that it would be interesting to get a report back on how well both the theatre initiative and out patients toolkit were performing in improving the efficiency and even the equity of the operation.

Peter Davis had a further question around the maternity service asking whether GPs and Community midwives were involved as the maternity journey starts well before a woman presents at the hospital. The journey is a very lengthy one of which the hospital accounts for only two or three days with much more happening before and after.

Ailsa Claire advised that the work around the maternity pathway related to the gestational time, early pregnancy and the required pregnancy checks all the way through to birth. There was a separate program on the first hundred days which was run out of the Funding and Planning service which can be reported back on. What is before committee members now is particularly related to the gestational time and birth pathway for women.

Mike Shepherd added that other stakeholders in the community would be engaged with around the maternity and delivery pathway agreeing that the hospital presentation was only a small segment of the journey. These pathways mostly have medium term time frames and there is no doubt that they are a combination of service change and technology and they carry some uncertainty and that is why they are monitored very closely in terms of their outcomes and efficacy.

Zoe Brownlie drew attention to page 20 of the agenda and the Kaiārahi Nāhi rōpū report asking for statistical clarification. Were the 500 Māori and 470 Pasifika patients being supported out of 1000 or some other percentage?

Ailsa Claire advised that this was particularly targeted to where inequities had been identified so was initially focused on people who were long waiters and people who did not appear to be going through the pathway correctly. To be clear, this process is not designed to support every Māori or Pacific person coming through the system. It exists to investigate where there are clear issues for individual people and where the system is not providing the

required support.

Bernie O'Donnell commented that if there was not a clear picture of the woman's health status before they come into hospital care then it is hard to monitor their well being through the pathway and when they leave the hospital. It is important to start to understand what is to be measured and to also start to understand that there are other players in the primary care sector and there is a need to know how they work in conjunction with what is happening at the hospital. It is about how they present to the hospital and what happens to them after they leave the hospital. This is an opportunity to be able to develop a good robust monitoring system.

Ailsa Claire commented that this is a difficult and very extensive problem hindered by the way that the maternity service is currently set up. Auckland DHB were partnering with the National Hauora Coalition who have a scheme called 20/40 where they are looking at how to work with primary care and engaging every person right from the beginning of their maternity journey and following them all the way through. The DHB is also looking at how it supports women when they are pregnant and how we develop services in such a way that they are more consistent with what Bernie was describing.

Bernie O'Donnell commented that he was not just referring to service for Māori women but to the overall service framework.

Ailsa Claire clarified for Doug Armstrong that Auckland DHB had a regional role in Women's Health but did not actually have a national role except when it came to genetic and maternal fetal medicine. Doug was assured that the review would consider the complex work undertaken by the Auckland DHB in terms of the regional and national service offered. This area was a challenge for many of the Auckland DHB Services which strive to balance their responsibility to the local community to deliver a good service as well as delivering a regional and national service.

Michael Quirke commented that he supported Peter Davis's comments. He noted the increases seen at the theatre utilisation level and the fact that management were turning to investigating what these successes could look like in other services. What Michael wanted to know was as other specialities were engaged what suite of best fit models of care were available for them to choose from or were they being given the freedom to actually look at these success stories and build their own. What was the approach being promoted?

Michael Shepherd advised that it was a bit of both. It was clear that there were some systemic wide improvements that could be made. However, there was a need for the services to be able to look at their own data, understand their own challenges and complexities and utilise those solutions which made the most sense for them. There is a need for certain systems and processes in place that provide us with assurance, accuracy and quality. It is a matter of working with a service and highlighting the things that are compulsory and then the elements where opportunities exist to adjust based on service requirements and understanding how services interact. There are a myriad of complexities

across services and it is our challenge to work with them to embrace their uniqueness but also to make sure that that they're delivering an efficient and quality service in the best possible way.

There were no further questions.

Action

That the results of the formal evaluation of the Kaiārahi Nāhi rōpū and Pacific Care Navigation Service approach be reported back to the Hospital Advisory Committee when completed.

Resolution:

That the Hospital Advisory Committee receives the Provider Arm Operational Exceptions Report for February 2021.

Carried

5.2 Financial Update (Pages 24-33)

Justine White, Chief Financial Officer asked that the report be taken as read, advising that the report was to the month of December 2020.

The Board was sitting at $3.5M unfavourable at a business as usual level at a budget of $45M unfavourable

The actual raw number is $71M against a $21M deficit year to date, but that $71M is affected by the COVID 19 impacts attributable in the first six months of the year, which is about $25.9M.

The Ministry of Health has instructed that the Holidays Act provision be put through on a monthly basis. Starting from December there is a catch up for the previous six months shown which is why there is $20M provided in this report. This cost was not included in the planning for the $45M unfavourable plan for the year so therefore it is actually showing it as an unusual item so that subsequent clear comparisons can be made.

The net bottom line on page 20 of the agenda shows a figure of $25,137M against $21,600M being what had been planned for this year.

Key risk remains around FTE in terms of annual and sick leave pressure. The January result shows a reversal so there has been a lot of annual leave taken in January, giving people a chance to refresh but also provides a positive impact which starts to reverse a bad position.

Pressure on clinical supplies as a result of the mix of things that are being done remains and is a million or two over in terms of what was planned. This is outlined on page 28 of the agenda. There has also disruption of supply through international shipping routes that has

forced investigation of alternative product.

The following was raised in discussion:

Jo Agnew drew attention to page 28 of the agenda and the unfavourable position of diagnostic genetics due to delayed repatriation asking for an explanation.

Justine White advised that this was where Auckland DHB had outsourced testing but in anticipation of being able to bring the work back in-house which had now been delayed leading to a slight negative impact on the budget.

Doug Armstrong asked the Chief Executive whether in her opinion the Board would be able to recover the $3.5M by the end of the financial year. Advice was given that if COVID and the Holidays Act adjustment was fully funded by the Ministry the Board would be on planned budget.

Justine White added that the forecast at the moment is that the Board would achieve budget at a DHB level. In the Provider Arm it is anticipated that the position would be bettered by $2.5M which is reflective of a donation that was received in November 2020. The overall DHB budget is $45M deficit and is planned to be about $42.5M deficit based on what is known right here and right now. This may not be the case should there be further lockdowns that have impacts on production.

Doug Armstrong was provided with an explanation of the RMO situation as outlined on page 28 of the agenda with Margaret Wilsher advising that at the beginning of the calendar year the DHB take on more RMOs than are needed because there is steady attrition throughout the year, but there is only the one recruitment cycle. The DHB carry a number of supernumeraries which helps cover leave or unexplained gaps providing a little leeway over the summer months when there is a need for other staff to go on holiday, but the net effect at the end of the year is that we are in balance.

Heather Came drew attention to page 26 of the agenda and asked if ethnic breakdown of FTE could be provided so that it is clear what is happening in terms of recruitment of Māori staff.

Zoe Brownlie added that this issue had come up in the People and Culture Subcommittee recently and while attempts are being made to collect that data it is not at a stage yet that it can be reported on.

Heather Came commented that any time FTE data is presented it needs to include ethnicity data. As an EEO employer of a number of years this data should have been collected as a matter of course.

Margaret Wilsher added that the People and Culture report does carry ethnicity data, most accurate for new employees but for some of our most senior long serving employees the

data is possibly not so reliable.

Action

That the Chief People Officer be advised that any time FTE data is presented it include comparable ethnicity data.

Resolution:

That the consolidated statement of financial performance for December 2020 be received.

Carried

5.3 Director Equity Update – Child Health *(Pages 34-44)*

John Beca, Director of Child Health Surgical and Emma Maddren, Interim Director Starship Child Health asked that the report be taken as read, advising as follows:

Emma Maddren advised that there had been a range of equity activity underway for some years with the expectation that it would increase opportunities for Māori and Pacific leaders and further develop the governance structures around our Te Tiriti o Waitangi related activity. Important progress made in recent months has been having a dedicated Kaumātua, Sonny Niha (Te Orewai, Ngāti Hine, Ngāpuhi) appointed and the appointment of Toni Shepherd to the Māori Health Lead and a recent appointment of Mareta Hunt to the Safe Kids leadership position.

Haumaru Hononga (Safety in Partnership) is a staff group first established within Puawaitahi (child protection multi-agency centre with Te Puaruruhau (Starship Child Protection), Police and Oranga Tamariki) in 2019 which deals with cultural safety and practice in that setting. There is a close relationship with Ngāti Whātua around the work undertaken in this area.

John Beca added that he particularly wanted to highlight the work done in the cellulitis pathway which had led to quite a dramatic reduction and avoidance for the need for admission for children with cellulitis and a significant reduction in the number of bed days as well as improving the situation for one of the most complex groups of patients, those requiring spinal surgery, reducing their length of stay and also work around days stay and avoiding cancellations.

Within the resilient services and critical care capacity there are on-going challenges related to the PICU project which was slightly delayed while getting approval from the Ministry. The result is that there are some concerns around completion before winter 2022. The design and build for that will need to be restarted.

The neonatal intensive care unit which, after a period of being very quiet during the initial lockdown, has been extremely busy for the last two or three months and this has resulted in two pregnant mothers needing to be transferred out of region because the entire region was

full. There is a project underway looking at staffing levels and some alternative models of care to address this.

January budget results show that the financial position has been improved. The service was $3.4M favourable as people were off on annual leave. Of the $15 million unfavourable, $12M of that was COVID related. A facet seen throughout children's hospitals within Australasia is that the COVID lockdown has produced a huge drop off of acute volumes. $10M can be attributable to volumes just not being present. There has also been a temporary loss of some of the Pacific Islands work.

The following was raised in discussion:

Peter Davis drew attention to the paragraph at the top of page 40 of the agenda and the comment around unfavourable inpatient volumes and asked what the incentives were to reduce Inpatient volumes if you are actually getting paid for them. He acknowledged the pathways that were being developed that would reduce those cases for inpatient care, but was referring to unnecessary ambulatory sensitive hospitalisations particularly among the under fives which is very high, particularly in a disadvantaged group. Peter would like to see a budgetary system set up that would actually maximise rewards for keeping people out of hospital rather than getting paid according to in- hospital volumes.

John Beca replied that there were a number of projects on-going, some of which were funded by the Foundation in terms of pathways to keep children out of hospital but also to look generally at how Starship was funded overall.

Peter Davis added that he was interested in a different funding model but would like the Executive Leadership team to look at how that might be carried over to other parts of the organisation. At present, if Services are paid on inpatient volumes and that is what they have to maintain there is little incentive to try to lower those volumes.

Mike Shepherd was very clear that as an organisation the focus was on keeping people out of hospitals. This funding anomaly is not a perverse incentive that is being chased. It is a particular issue around some of the specialised services. When that specialised service is delivered well they are able to maintain people in their home DHB. This work is often done via telephone consultations and there is no doubt the current funding mechanisms don't always recognise that. This places an administrative burden on staff to measure and capture that work. This is an area we will continue to investigate and have been looking at with the Ministry of Health to identify national funding mechanisms in order to capture and remunerate the activity.

Peter Davis then drew attention to the performance and medication errors with major harm commenting that all Directorates showed zero errors which Peter found difficult to believe. Mark Edwards advised that there were no reported errors with major harm and actually the rate of major harm from medication error is very low. Peter Davis then commented that this

data should be digital and automatically produced.

Mark Edwards clarified that this data was not all available online or electronically monitored. The incidence of medication error is high in our current system but the incidence of harm through medication error is very low. It is recognised that there should be an e-prescribing system and the DHB was certainly trying to progress that through a queue of digital initiatives. Once that state is achieved there would be opportunities to manage and triangulate data in a range of different ways.

Bernie O'Donnell drew attention to Page 37and point three in the plan saying he would like to see some sort of profile on the kind of Māori kaimahi that exists. Being Māori is one part of the equation the other part is around that person actually being fit for purpose to work with the communities. Whether they carry the Māori values with them or they are learning about them during their work is a different scenario. Ideally, we want them to come with their tikanga and then apply their learning's along with their medical background to the role. It would be good to understand the kind of skills sets and capability that our Māori and Pasifika workforce bring to the kaupapa in terms of what is trying to be achieved. Bernie asked if this was possible to determine. It is only when this state is arrived at that transformative change can occur.

Emma Maddren commented that this was the aspiration of the service and exactly where the service would like to be. There is a way to go and that was one of the reasons why Matua Sonny Niha had been engaged to be part of the Services leadership. The Service is also bringing together Māori staff from across the directorate.

Emma Maddren added that when you are talking about recruitment you are talking about whether you have appointed a Māori candidate from your pool of candidates and obviously one of the really important things is to make sure that you have Māori candidates coming forward for the positions and that the advertising and promoting of these roles occurred in such a way that the right candidate was attracted to the right role.

Bernie O'Donnell commented that what he would really like to see a next level where it was possible to identify the capacity that Māori staff bring with them and what positive results had been made and then to monitor those to show progress.

Mike Shepherd commented that it was quite hard to profile people and do them justice in a written report. Mike would like to spend some time with Bernie O'Donnell working through how this could be done effectively.

Action

That the following questions be answered in August when the Child Health Directorate next reported.

1. **What the actual number of Māori staff was.**
2. **Who were these people and what were their capabilities and their ability to undertake this kaupapa for Māori and Pasifika.**

3. **What budget existed to allow these people to perform their roles.**

Resolution:

That the Director Equity Update – Child Health report for January 2021 be received.

Carried

5.4 Director Equity Update – Mental Health *(Pages 45-58)*

Hineroa Hakiaha and Tracy Silva Garay Co-Directors Mental Health asked that the report be taken as read.

Hineroa Hakiaha reflected on the journey he and Tracy Silva-Garay had embarked on.

In June 2020 Tracy Silva Garay and Hineroa were appointed to their roles. The interview panel decided that it would be good to have two co directors within Mental Health and Addictions; one Māori the other non Māori to assist with the equity movement within Auckland DHB.

Mental Health and Addictions is developing the way forward with te ao Māori, addressing how it would progress that journey of equity. Tracy and Hineroa have spent almost six months to building their relationship together, where it could be demonstrated to their teams, to the directorate and the rest of Auckland DHD that there was an obvious partnership. It had not been an easy journey for either of them. Being nurses and drivers in the Mahi that they do, they are proud of where they have come from and proud of what they have done to date on the journey of equity.

Part of that equity strategy and journey comes from the strategy of 2023 – Te Toku Tumai. When we did the stock take on what it was that was needed to be doing to help move the strategy of 2023 forward it was clear we needed to look at what we were doing as a directorate and what the most pressing things that needed to be addressed in 2021. We decided to focus on training and what currently existed and whether it was appropriately and utilised.

Staff work here because they want to be here, they want to share their skills and do the best that they can for our people. With that in mind we looked at how to create a space and a place to grow our teams. There is a staff of 800 with 72 Māori and 86 Pasifika in the Directorate.

We looked at what are were doing as a directorate in terms of building capability and capacity, and how to support our teams to become capable to work with Māori and Pacific.

In January through March a training package framework is being developed and in April through June the actual training will take place with the leadership groups such as the director leadership team, the service centre directors, operation managers, clinical team leaders and managers and charge nurses.

To be more supportive around this training there will be champions within the teams and services. The challenge will be finding Māori staff who will undertake this role. This will require another set of training for them to be able to deliver to that role.

The following was raised in discussion:

Heather Came commented that it was great to see a co-governance model and wished Hineroa and Tracy the very best with the equity journey.

Jo Agnew drew attention to page 56 of the agenda requesting clarification around screening for family violence asking what form that screening takes as the current result is showing red. What plans were there to address this? Tracy Silva-Garay advised that there was an Allied Health Director leading this work. It required on-going conversations with teams about the importance of screening for family violence. Often clinicians were reluctant to do that if there were other family members present. There were often opportunities for this conversation to occur even if it was not at that first assessment but at another subsequent meeting.

Michael Quirke noted that a housing specialist role was identified in 2017 and asked whether that role had been filled and work actually begun. Advice was given that the role was being recruited for. There were significant mental health and addiction issues to address so along with the housing specialist role there were one or two to pilot sites that had been chosen by the Ministry of Health which would run over the next four years with the expectation that we will start to work with people to get them not only sustainable housing, but individualised packages of care to support them to be able to maintain their housing and wellbeing.

The housing specialist role has been in train for the last three years. Collection of data was required to show that Te Whetu Tawera, our 58 bed adult Inpatient unit, would have at any one time at least 15 out of those 58 people clinically ready for discharge, but that there were significant barriers to their discharge. One of those barriers being housing.

When people have to remain longer than clinically indicated in the unit they actually start to deteriorate and actual harm occurs. Work is being done with an NGO on recruiting a person through the NGO and setting up processes for that person to work with the community outreach service. This service deals with a high rate of Māori so potentially between 50% and 60% of those people are Māori, usually homeless, often with forensic backgrounds and often coming from prison.

There is also an NGO partner role that was started as a trial during the last level three Auckland region lockdown where some NGO resource was used to support people to an earlier discharge. It was noted during the March 2020 lock down that Te Whetu Tawera for the first time ever went down to 75% occupancy because there was the provision of motels for homeless people. Once that lockdown ended there was a massive surge in referrals and a 66% increase in the number of admissions.

A one year pilot with a 0.5FTE role was established to go into Te Whetu Tawera to identify people on admission who perhaps may be discharged early and who with some outside support and the right packages of care could get back to a normal life much more quickly.

Peter Davis drew attention to page 46 of the agenda and community treatment orders where it was highlighted that there were issues over access to free medication and asked for an explanation. Tracy Silva-Garay advised that it was found when talking to whanua that they wanted the patient to remain on a CTO because of issues of access to medication. An audit revealed that barriers to coming off a CTO were not always related to clinical decision making but also access to medication. There is now twice yearly training provided so improve staff understanding of the issues and to imbed some more consistency around the use of the mental health plan.

Peter Davis drew attention to page 55 of the agenda where the "funder to provider revenue wash up for the CSW service transferred to the funder" was mentioned asking what that meant with Tracy advising that it was a change proposal that occurred in 2019. As a result of consultation process, the CSW Service at Point Chevalier was disestablished with a transfer or resource to the NGO sector with its focus on community based wellbeing and recovery, whereas the DHB provider's core business is the delivery of specialist clinical services.

NGO CSWs are one of the largest groups of the mental health and addiction workforce. NGOs see people in their own homes; support people to address some of the social determinants that impact upon their mental health and, importantly, are community based, well connected with other agencies and able to see people closer to home as per the Government's health strategy. Workforce development that takes place in this sector is focused on the delivery of this model. The core business of NGOs is supported by a management infrastructure that is fit for purpose for the non-registered community support workforce.

The Service Coordination Team has been strengthened via the appointment of a full time Clinical Team leader to lead and manage the team and to coordinate wider management of access to support hours and placements across CMHCs and NGOs. The team has been centralised to support effective engagement with key stakeholders, supporting an integrated effective single referral pathway and timely response and consistency of service delivery across the Directorate.

Bernie O'Donnell commented that this is what he envisaged that the future would look like when recruiting for the co-director role and was an endorsement of the decision to have mental health co-directors. He acknowledged that it would not have been an easy transition and thanked both for their effort.

Resolution:

That the Director Equity Update – Mental Health for January 2021 be received.

Carried

5.5 Director Equity Update – Women's Health *(Pages 59-69)*

Rob Sherwin, Director Women's Health asked that the report be taken as read, advising as follows:

Noting that the report format is new. Nicole Pihima who is the Associate Director of Midwifery for Māori Health and equity has helped shape this new format.

Not included in the report is an update about the external expert advisory panel reviewing the four maternal incident reports. The panel have met twice on-line and they are about to start interviewing people who were part of the review panels for those four maternal deaths. When they have feedback it will be provided to the Committee and Board.

On 1 March the Board Chair, Chief Executive and other interested board members along with the Leadership Team will be present at a hui to outline what is trying to be achieved with the engagement plan which is to surface the inequities within women's health and some of the possible solutions to achieve equity. That piece of work is anticipated to be completed in June with a paper to the Board outlining some possible solutions to the inequities.

The following was raised in discussion:

Peter Davis drew attention to page 56 of the agenda and the scorecard showing a New Zealand average induction for labour was 7.6% but the Auckland average is five times that rate; not only for private obstetricians but across self employed midwives in the community. Rob Sherwin commented that the New Zealand average reported is from 2017. Since then there has been national policy which has basically increase the number of women who would be offered induction of labour in an effort to reduce stillbirths.

Since 2017 there had been some new New Zealand averages released. They are always about three or four years behind the current data set. Personal experience from the UK is that the average induction rate goes up about 10% every year. It is probable that the primip data will now be around 25% since the change in national policy. New Zealand guidelines were written by Auckland practitioners we follow the New Zealand guidelines pretty much to the letter, other units don't. We would expect to be at least at or above the New Zealand average because of our practice at Auckland DHB

It was explained that while the induction rate had changed for the above reasons, that was not the case for caesarean section rates where Auckland DHB was a clear outlier with higher rates than everywhere else in the country.

Peter Davis drew attention to the same table and intact lower genital tract figures where across the country the figure is 27% but for Auckland DHB it is in the single figures asking if that was due to another change in practice or are we again, an outlier? Rob Sherwin advised that unfortunately Auckland DHB was an outlier. The episiotomy rate showed that Auckland

DHB was much more of an interventionist with this practise than the rest of the New Zealand.

Peter Davis commented on the statement made that the IT system was technically and functionally obsolete, saying it was depressing to hear this yet again. Rob Sherwin advised that there were a number of legacy systems that required attention and Ministry approval to change had been obtained for this particular one. The DHB were trying to get its systems more up to date and robust but that requires a lot of investment.

The lesson learned from the recent maternal deaths revealed that the most vulnerable women often move domicile between the different DHBs and the new system allows sharing of information between those different DHBs and to protect and care for these most vulnerable women. There are equity and health outcome benefits from the new systems.

Resolution:

That the Director Equity Update – Women's Health for January 2021 be received.

Carried

6. RESOLUTION TO EXCLUDE THE PUBLIC (*Pages 70-71)*

Resolution: Moved Zoe Brownlie / Seconded Fiona Lai

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. Karakia Attendance and 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	**Commercial Activities Information contained in this report is related to commercial**	That the public conduct of the whole or the relevant part of the

Confidential Minutes 18 November 2020	**activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public** [Official Information Act 1982 s9(2)(i)]	meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Confidential Action Points - Nil	**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** [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Vulnerable Service 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]
6.1 Major Risk & Issues – Verbal 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** [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.2 Planned Care – Programme Update - Presentation	**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** [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain**	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

	Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	[NZPH&D Act 2000]
7.1 Clinical Quality and Safety Report	**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]

The meeting closed at 12 noon.

Signed as a true and correct record of the Hospital Advisory Committee meeting held on Wednesday, 17 February 2021

Deputy Chair: _____ Date: _____

Jo Agnew

Disability Support Advisory Committee Meeting 10 February 2021 – Draft Unconfirmed Minutes

Prepared by: Marlene Skelton, Corporate Business Manager

Recommendation

That the unconfirmed minutes from the Disability Support Advisory Committee meeting held on 10 February 2021 be received.

The following item from within the draft minutes are submitted by the Disability Support Advisory Committee for consideration and approval by the Board.

This item is:

	Auckland DHB Accessibility – Accessibility ✓*(Was item 6.2, Pages 24-62 on the Disability Support Advisory Committee agenda for 10 February 2021)*
	That the Board: 1. **Request healthAlliance to join the Accessibility ✓ programme** 2. **Noting that healthAlliance procure on behalf of the four regional DHBs who belong to the programme that when they procure on Auckland DHBs behalf that the process aligns with the Accessibility ✓**

Minutes
Disability Support Advisory Committee Meeting
10 February 2021

Minutes of the Disability Support Advisory Committee meeting held on Wednesday, 10 February 2021 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton, Auckland commencing at 8:30am

Committee Members present	**Auckland DHB and Waitemata DHB Staff present**	
Jo Agnew (Chair)	Nigel Chee	Acting General Manager, Maori Health
Michelle Atkinson	Mel Dooney	Chief People Officer, Auckland DHB
Zoe Brownlie	Marlene Skelton	Corporate Committee Administrator
William (Tama) Davis	Adele Thomas	Organisational Development Practice Nurse
	Sue Waters	Chief Health Professions Officer
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

0. KARAKIA

Tama Davis drew attention to the Āke Āke Application which is an interactive user-friendly guide to the Māori language, customs and traditions. The following Karakia could be found there and was an appropriate one to use when opening a meeting. Tama then led the committee in the karakia.

Karakia Mo Te Katoa

E te Kaihanga e te Wāhingaro
E mihi ana mo te hā o tō koutou ōranga
Kia kotahi ai o mātou whakaaro, i roto i te tū wātea
Kia U ai mātou ki te pono me te tika
I runga i tō ingoa tapu
Kia haumie kia huie Taiki eē.

1. ATTENDANCE AND APOLOGIES

That the apology of Michelle Atkinson for lateness be received.

That the apologies of Ailsa Claire, Chief Executive Officer Auckland DHB, Dr Karen Bartholomew, Director, Health Outcomes for Auckland and Waitemata DHBs and Dr Debbie Holdsworth, Director of Funding – Auckland and Waitemata DHBs be received.

2. CONFLICTS OF INTEREST

Tama Davis advised that his interest, "Board Member – Freemans Bay School" could be removed.

Zoe Brownlie advised that she had a potential conflict of interest when it came to discussion of Accessibility ✓ work given her involvement with the sector. The Committee agreed that there was no profound conflict of interest and that Zoe could discuss and vote on Accessibility ✓ issues.

3. CONFIRMATION OF MINUTES 12 NOVEMBER 2020 (Pages 7-14)

Michelle Atkinson asked that on page 9 of the agenda it be referenced that it was she that proposed that the Terms of Reference be amended to reflect that there be a minimum of two appointed members with lived experience of disability, one of those being Māori.

Resolution: Moved Tama Davis / Seconded Jo Agnew

That the amended minutes of the Disability Support Advisory Committee meeting held on 12 November 2020 be confirmed as a true and accurate record.

Carried

4. ACTION POINTS (Page 15)

There were no outstanding actions to discuss.

5. CHAIR'S REPORT - Verbal

The Disability Support Advisory Committee Chair, Jo Agnew welcomed Zoe Brownlie as a new member of the Disability Support Advisory Committee.

Jo commented that a key focus for this year was to establish the membership of the committee and to ensure that external membership was appropriately appointed as per the terms of reference.

Tama Davis asked what the process would be and was advised by the Chair that it would be a three month process from the time of identifying external members and gaining Board approval. It would be appropriate for the Committee to have an out of cycle Zoom meeting to endorse membership and refer to Board.

Action

The Chief Health Professions Officer and the Corporate Business Manager are to develop and circulate a process for submission of names, interview and selection and provide to Committee members.

6. STANDING ITEMS (Pages 14-62)

6.1 Disability Strategy Implementation Plan 2016-2026 (Pages 14-23)

The Chief Health Professions Officer, Sue Waters asked that the report be taken as read, advising as follows:

Noting that this was a foundation document and that the Strategy goes through from 2016

to 2026 remaining under active review. Those areas denoted in red type through the report indicated change occurring since the last reporting period.

Much work had been undertaken in the Facilities space with access being integrated into the new projects and builds. Sue Waters drew attention to page 19 of the agenda which depicted security improvements made when upgrading ward entrances so that doors open automatically upon approach. Signage is being standardised at the front of wards also to show where the doors open and the location of intercoms.

The following was covered during discussion of the report:

Jo Agnew drew attention to page 18 of the agenda and outcome - "Better understanding of the needs of Deaf people" and the Auckland DHB scheduled Hearing Awareness Workshop in March to coincide with Hearing Awareness month; asking who was attending and whether this was voluntary attendance. If it was, how would it be ensured that overall awareness was spread throughout the organisation? Advice was given that the Communication team were managing that aspect and would start a campaign a month out from the workshop using all available channels.

Jo Agnew asked whether within each ward champions existed and was advised that Disability Champions exist and work with the services and then wards and areas. In terms of hearing impairment an organisation wide approach is being followed as allowing different solutions in different directorates has not been proved to be helpful. Consistency is required to provide a good outcome.

Tama Davis was advised that Adele Thomas ran an Accessibility Steering Group which covered all elements of disability and which the Disability Champions attend. Sue herself also had regular conversations with Allied Health Directors on these issues.

Tama also asked how it was ensured that disability work undertaken within the hospital was imbedded in the continuity of that service delivery and was advised by Sue Waters that for hospital patients it would be run through the internal accessibility processes but for Primary Care and other contracted out-patients there is less influence to be had. Although the Health and System Disability System Outcome review would likely pick this up.

Zoe Brownlie was advised that the terms "disabled people", "people with a disability" and "people with an impairment"; were all terms acceptable when reporting to the Disability Support Advisory Comittee.

Zoe also drew attention to page 17 of the agenda and outcomes - "3 Record the number of staff with impairments working for the DHB" and "4 Ensure DHB Diversity and Equality work includes disabled people", requesting an update on where the organisation was with each and was advised that this information was not currently available as people were required to self-identify and there were many reasons why they would choose not to do so. Sue Waters referred Zoe to the November meeting agenda and item 6.3 covering Disability Data and Alerts advising that this was a national piece of work led by Capital and Coast DHB. It had proved to be a difficult area to move forward in the past for each DHB who had attempted this individually and it was recognised that a national system was required across all DHB's.

Jo Agnew drew attention to page 21 of the agenda and the mention of another workshop asking what managers were involved with it and whether this too was voluntary attendance. Adele Thomas advised attendance would be voluntary with communications going out to encourage attendance and with managers asking services to identify people to attend. As this is around people's awareness of the culture and general understanding of disability, Sue Waters advised that making it mandatory would not achieve this. The organisation already had a large amount of mandatory training which it did not get 100% compliance with.

Jo Agnew requested that after the workshop there be an evaluation of who attended and that this report be bought back to the committee. Jo added that it must be possible to pick out which services had issues that would benefit from the workshop training. Sue Waters advised that services naturally leaning toward disability impairment and rehabilitation culture could be readily identified over those acute service areas. As the workshops were focused on awareness raising any evaluation would be made against that criteria and the spread across the organisation in terms of where priority areas lay.

Zoe Brownlie drew attention to outcome 21 - Engage regularly with the disability sector and community and asked what the level of engagement was. Sue Waters advised that the engagement was not good in all areas so the organisation tended to focus on its mainstream suppliers. There has been a review undertaken across metro Auckland by the NRA and a report and recommendations will be presented to the appropriate committees in due course.

Tama Davis asked about outcome 20 - "Increase cultural awareness of disability" and how that was tracking being advised by Adele Thomas that a request had gone to a number of organisations to help with co-design and that responses were pending. Tama wished to know what the alignment was with the Boards KRAs and the Boards overall strategy. Mel Dooney advised that while thinking had been done around this it had not been executed yet. Tama sought assurance that this work would be aligned with the corresponding KRA.

Jo Agnew drew attention to page 22 of the agenda and outcome 27 - Continue the implementation of the Health Passport across both DHBs asking what had come from the meeting with Capital and Coast. Sue Waters advised that this was the national work referred to earlier in the discussion led by Capital and Coast DHB but involving all DHBs. Capital and Coast had a prototype applied last year that failed. It was agreed then that there should be one national system rather than each DHB having its own electronic solution. The work being done on Disability Data and Alerts will also flow through to the electronic portal.

Advice was given that if a person presents who does use a health passport that information can be utilised through outpatients otherwise they go through ED and are generally admitted to a specialty ward. If the ward is a rehabilitation area throughout their stay their goals would be identified. If they ended up in an acute surgical area this would be less likely to happen than in those other areas and this is where additional work needs to occur and why Disability Champions are an important component so that this can be addressed.

Tama Davis was advised that the Health Passport was an opt-in tool. The origins of the Health Passport came from the UK. They had similar issues to address. It was designed so that people moving through the system could take their information with them. The application is slightly different there as the population is denser and the way that the health system is structured is a little different in terms of the way services are commissioned. It was an easier environment to use the tool in. Our environment is more complex as there are many more contracts with external disability providers and to try to get consistency with something that is essentially a booklet and to make sure that it moves with the patient through all those places is difficult.

Action

1. **That the last Disability Support Advisory Committee agenda be sent to Zoe Brownlie for information.**

Resolution:

That the Disability Strategy Implementation Plan 2016-2026 be received.

Carried

6.2 Auckland DHB Accessibility - Update November 2020 (Pages 24-62)

Adele Thomas, Organisational Development Practice Nurse asked that the report be taken as read, advising as follows:

What had been undertaken since last reporting was work that centred around training, particularly co-designing face-to-face modules with Maori and Pacific Services. A lunchtime speaker series is being organised.

The following was covered during discussion of the report:

Jo Agnew suggested that a parent or member of a family who has someone who is profoundly intellectually disabled be organised as a speaker. Unfortunately that group of people do not get the best service from within our organisation. It would be good to be able to demonstrate that lived experience. All are entitled to quality healthcare.

Zoe Brownlie asked for an update on the four areas highlighted in red and how they were being progressed.

Adele Thomas advised that the new builds area was focused on access which was seen in photographs provided in outcome 11. Work was being done with healthAlliance around their policy wording. They undertake procurement on the regional DHBs behalf and consistency was required with the DHBs policy on disability. Sue Waters commented that to progress this, the regional DHBs needed to determine whether they wished health Alliance to join the Accessibility ✓ programme in the same way we are joined for health and safety and risk management. The second consideration is that their policies will align with their strategies and they will not see the necessity for change but Auckland DHB can specify that when they procure on our behalf that we want it to align with the Accessibility ✓.

Tama Davis considered that this was the path to pursue and that health Alliance should be asked to join the Accessibility ✓ programme. Zoe Brownlie also felt that it should be a recommendation to the Board that the Board specify to health Alliance that when they procure on our behalf that the process aligns with the Accessibility ✓.

Tama Davis wanted some clarification around what the local response in terms of regional implementation and needs were. Sue Waters advised that the implementation strategy tabled and discussed at this meeting was built around the regional aspect across the metro Auckland DHB's who continued working together.

Zoe Brownlie drew attention to page 27 and the auditing of the website. Advice was given that the Communications team was committed to undertaking that work however they had been delayed by COVID 19 and the delivery of a website rebuild. The delivery date for this work would be reported at the next Committee meeting.

Action

That a delivery date be sought from the Communications Team for the completion of an action to conduct an audit of the DHBs website and intranet to determine accessibility.

Resolution: Moved Michelle Atkinson / Seconded Zoe Brownlie

That it be recommended to the Board that it request health Alliance to join the Accessibility ✓ programme given that they procure on behalf of the four regional DHBs who belong to the programme.

Carried

[Secretarial Note: Item 8.1 was considered next.]

7 PREVIOUS AND ON-GOING METROPOLITAN WIDE DISAC WORK (Pages 63 - 74)

7.1 Child Development Services Programme of Work(Pages 63 - 74)

Denise Janes and Tim Jelleyman were in attendance to present the report and answer questions.

In the 2019 wellbeing budget additional funds were provided to Child Health Services to address wait lists and to allow additional children to access the services. The money is allocated regionally.

There are three strands to the work in the northern region. There is the expansion funding which has gone into additional FTE uplift for Child Health Services and an inter sectorial pilot with the ministries of education and health and a number of other agencies being involved looking at Maori and Pacific children. The second strand deals with NRA funding for two days a week for each DHB for quality improvement in child development services. The third strand deals with funding from the Ministry for innovations with the Northern region having 11 innovations with 4 being led by the Northern Regional Alliance and the remainder by the DHBs. These are detailed in Appendix three of the report.

Running alongside this is national work focused on looking at a new operating framework for Child Development Services. The Ministry of Education has developed the He Pikorua practice framework for learning support and RTLB practitioners. This is being considered for adaption/adoption.

Tim Jelleyman commented that this presented great opportunities for the region in terms of gaining a better understanding of the data. Being on a regional basis allowed for a bigger shift in outcomes. If it is successful it could be expanded nationally.

The following was covered during discussion of the report:

Jo Agnew drew attention to page 69 of the agenda and mention of visiting neurological therapists noting that the criteria for the three metro DHBs was quite different and standardisation would be the factor that made the difference. Densie Janes added that the Quality Improvement Group was looking at alignment of packages of care/bundles of care for whanau and prioritisation for entry of children into the services. A full year of quality improvement work has allowed a stocktake of what is actually occurring and this second year will focus on alignment and appropriate criteria.

An explanation of the enhanced gateway was provided with Denise Janes commenting that this work was being led by Northland and Auckland DHBs where assessment and provision of strategies for communication were being looked at. Communication screening with speech language therapists has been implemented. Communication Passports had been provided that go back to schools and early childhood centres. The passport focuses on how that child communicates, their strengths and weaknesses and what support they might need in simple

straightforward terms. The pilot has seen 100 children through that enhanced gateway already who are now at the evaluation stage.

Tama Davis was advised that it was not yet known where this pilot would end up as evaluation work was still to be undertaken. There was alignment work required between the Ministries of Education and Health around getting the communication passports back into the schools. In broader terms have been inter sectorial meetings to look at better delivery and how successes might be moved across the sector.

Michelle Atkinson was advised that the work produced by the Youth Transitions Project had been included in the resources used for the Adolescent Transition Pathway. Tim Jelleyman commented that there were some very good historic pockets of work that had been drawn upon.

Jo Agnew drew attention to page 72 of the agenda and mention of the workforce development plan asking what was occurring with it and whether an equity lens had been applied to it. Denise Janes advised that this had just been scoped and a contractor was coming in to deliver that piece of work. This was someone who was experienced in the Allied Health area. At this stage the contract is still being worked on but an equity lens has definitely been applied. This applies to all four DHBs in all disciplines involved with child health.

Tama Davis thanked Denise Janes and Tim Jelleyman for the presentation and paper as it had provided a good overview of what work is required, what is in train and what is still to come.

Sue Waters commented that the improvement work in this programme had not been run through the Disability Support Advisory Committee in the past and felt that it should continue to be reported here on a quarterly basis. There was general agreement for this.

Resolution:

That the Child Development Services report be received.

Carried

[Secretarial Note: Tama Davis at this point closed the meeting with a Karakia]

8. INFORMATION REPORTS (Pages 75- 78)

8.1 Amended Terms of Reference – approved by Board on 27 January 2021

This report was submitted for information.

Michelle Atkinson drew attention that the incorrect version had been updated and that the 16 December additions be added to the TOR.

Resolution:

That the report "Amended Terms of Reference DiSAC January 2021" be updated to reflect the changes made by the Board at its meeting on 16 December.

Carried

9. GENERAL BUSINESS (Pages enter page range)

Ministry of Health Attendance at DiSAC Meetings

The Committee Chair, Jo Agnew advised that she had arranged for Amanda Bleckmann to attend future meetings of the Disability Support Advisory Committee as her experience with

under 65 funding issues had in the past been of great benefit to the committee in a wider understanding of funding.

[Secretarial Note: Item 7.1 was considered next.]

The meeting closed at 9.45am.

Signed as a true and correct record of the Disability Support Advisory Committee meeting held on Wednesday, 10 February 2021

Chair: _____ Date: _____

Jo Agnew

Terms of Reference for the Hospital Advisory Committee

Recommendation

That the Board approve the Terms of Reference for the Hospital Advisory Committee.

Prepared by: Marlene Skelton, Corporate Business Manager
Endorsed by: Ailsa Claire, Chief Executive and Michael Shepherd, Director Provider Services

Executive Summary

At the March 2020 HAC meeting the Hospital Advisory Committee Terms of Reference were considered and approved for submission to Full Board.

While the minutes of that Hospital Advisory Committee meeting were referred for information to the next available Board meeting, unfortunately, the Terms of Reference themselves were overlooked.

With this committee now operational, it is requested that the Terms of Reference for the Hospital Advisory Committee be endorsed.

AUCKLAND DISTRICT HEALTH BOARD
Terms of Reference
Provider Equity Committee
Last Issued: Revised: March 2020

Establishment
The Committee is established by the board ("Board") of the Auckland District Health Board ("Auckland DHB") under section 32 of the New Zealand Public Health and Disability Act 2000 ("Act"). The Board may amend the terms of reference for the Committee from time to time.

Functions of Committee

a) The Committee must:
   - Ensure provision for Equity and Treaty of Waitangi responsiveness
   - Monitor the quality and safety of clinical services provided by Auckland District Health Board.
   - Monitor the financial and operational performance of the hospitals, community and related services provided by the Auckland DHB especially in relation to the Minister's letter of expectation.
   - Assess strategic issues relating to the provision of clinical services by the Auckland DHB
b) The Committee must give the Board advice and recommendations on that monitoring and assessment.
c) The Committee has the authority, delegated by the Board, to commission specific pieces of work to assist it meeting the Terms of Reference for the Provider Equity Committee.

Responsibilities
To carry out its functions, the Committee will monitor, raise specific issues and endorsements, and advise the Board on the:

a) Provision of hospital, community and related services by the Auckland DHB including key operational and financial issues
b) Overall activity levels and performance of hospital, community and related services when assessed against the Auckland DHB's annual plan and relevant legislation
c) Management by the Provider Services of operational and financial risk
d) Management by the Provider Services of clinical quality and risk issues
e) Management by the Provider services of the delivery of the Auckland DHB's health services delivery programme and other hospital facilities projects

Relationship with Board and Management

a) The Committee is established by and accountable to the Board. The Committee's role is advisory only, and unless specifically delegated by the Board from time to time in accordance with clause 39(4) of Schedule 3 of the Act, no decision-making powers are delegated to the Committee.
b) The Committee shall receive all material and information for its review or consideration through the Chief Executive Officer or delegated member of the Executive Leadership Team.
c) The Committee shall provide advice and make recommendations to the Board only, and is not authorised to give any directions or issue any instructions to Auckland DHB officers or employees.

Membership

a) The Committee shall comprise up to sixteen members in total, inclusive of Board members and external appointees, but less as deemed necessary by the Board.
b) Any number of Board members may be appointed to the Committee by the Board.

c) The number of externals who can be appointed (where a number is stated) is a ceiling not a fixed requirement.
d) The Board will endeavour to appoint, as members of the Committee, persons who together will provide a balance of skills, experience, diversity and knowledge to enable the Committee to carry out its functions. In particular, the Board will ensure that the Committee provides for Māori representation in accordance with section 36 of the Act.
e) The Board will resolve to appoint persons to be members of the Committee and will appoint one of their number chairperson.
f) The Board will appoint any external appointees as members in accordance with the following process:
    - The Board will determine the number of additional appointments to be made and the criteria to be used to make those appointments.
    - Individuals wishing to seek appointment to the Committee will be invited to submit an application to the Board. A copy of the terms and conditions of appointment will accompany the invitation.
    - The request by the Board for applications may be published in the New Zealand Herald.
    - The Chair and Deputy Chair of the Board together with the Chief Executive Officer will evaluate the applications in accordance with the criteria determined by the Board and make recommendations to the Board as to the proposed appointments.
    - The Board will make the final appointments (if any) to the Committee.

Meeting Procedure

a) The Committee shall meet eight times each year. Meetings shall be conducted in accordance with:
b) The requirements of the Act
c) The Standing Orders of the Auckland DHB
d) The Chief Executive Officer, Director of Provider Services, and Chief Quality, Safety and Risk Officer are not members of the Committee however their attendance at meetings of the Committee is required. The Committee may invite other Auckland DHB officers and employees to attend as required.
e) The Committee may appoint a sub-committee from time to time in accordance with the requirements of the Standing Orders of the Auckland DHB.

Code of Conduct for Crown Entity Board Members

Recommendation

That the Board:

1. **Receives the letter from Peter Hughes, Public Service Commissioner of Te Tumu Whakarae mō Te Kawa Mataaho dated 18 March 2021**
2. **Notes the requirement to comply with the minimum standards set out in the code of conduct (section 18(1))**
3. **That the Corporate Business Manager update the existing Board Governance Manual to include reference to this new code and ensure that there is no inconsistency with other material currently published within that manual.**

Prepared by: Marlene Skelton, Corporate Business Manager
Endorsed by: Pat Snedden, Board Chair
Date: Wednesday, 24 March 2021

1. Executive Summary

Peter Hughes, Public Service Commissioner of Te Tumu Whakarae mō Te Kawa Mataaho has for some time been consulting on the development of a code of conduct for the board members of Crown entities. As feedback received has been positive he has made the decision to now apply the code.

Pursuant to section 17(3) of the Public Service Act 2020 the Code of Conduct for Crown Entity Board Members will be applied with the date of commencement for application of the code being 19 April 2021.

2. Introduction/Background

Board members are required to comply with the minimum standards set out in the code of conduct (section 18(1)). [Attachment 9.1.1]

The date of commencement for application of the code will be 19 April 2021. The commencement date has been deferred to allow time for the board to make any arrangements necessary for implementation of the code.

3. The new Code of Conduct

The code is written at a generic and high level. The Public Service Commissioner has specified in the code that a board should have in place a board charter or governance manual to guide its activities which includes ethics provisions for board members as appropriate to support these standards and that suit the entity's particular circumstances.

The key precept is that board members "act in the spirit of service" and maintain personal integrity, professional conduct and act lawfully.

This Board has an existing Board Governance Manual and the Corporate Business Manager will update it to include reference to this new code and ensure there is no inconsistency with other

material currently published in that manual. Chapter 7 relates to the behaviour of board members. [Attachment 9.1.2]

4. Conclusion

It is recommended that the Auckland DHB Board notes the requirement to comply with the minimum standards set out in the code of conduct (section 18(1)) and that the Corporate Business Manager update the existing Board Governance Manual to include reference to this new code and ensure that there is no inconsistency with other material currently published within that manual.

Te Kawa Mataaho
Public Service Commission

18 March 2021

Mr Pat Snedden ONZM
Chairperson
Auckland District Health Board
Private Bag 92189
Epsom
Auckland 1142

By email: patsnedden@adhb.govt.nz

Dear Pat

Notice applying a code of conduct for the Board Members of Auckland District Health Board under section 17(3) of the Public Service Act 2020

As you will be aware I have been consulting with boards and others on the development of a code of conduct for the board members of Crown entities. I am pleased with the support boards have given and the work of an across boards team in preparing a draft code.

I recently conducted consultation on the draft code. Feedback has been very positive with good support for its introduction. As a result I have decided to apply the code.

Application of the code of conduct

Pursuant to section 17(3) of the Public Service Act 2020 I hereby apply the Code of Conduct for Crown Entity Board Members, a copy of which is attached, to the board members of your entity. Your board members are required to comply with the minimum standards set out in the code of conduct (section 18(1)).

The date of commencement for application of the code will be 19 April 2021. The commencement date has been deferred to allow time for your board to make any arrangements necessary for implementation of the code.

Changes from the consultation draft

For your information, based on feedback received, I have made one change from the draft code issued in consultation. I have deleted the sentence "We avoid wherever possible any conflicts of interest with our board roles or the appearance of a conflict, current or future" from the conflicts of interest standard as it could have been seen to be expanding on board members obligations in the Crown Entities Act 2004. This doesn't detract from the importance of thorough and regular management of interests.

Level 10, RBNZ Building | 2 The Terrace | PO Box 329
Wellington 6140 | New Zealand
Phone +64 4 495 6600

Implementation of the code of conduct

The code is written at an overall level. I have specified in the code that a board should put in place a board charter or governance manual to guide its activities which includes ethics provisions for board members as appropriate to support these standards and suit the entity's particular circumstances. Boards usually already have such provisions or their own code of conduct in place and this step may just involve ensuring there is no inconsistency with the Code of Conduct for Crown Entity Board Members.

Your role

Thank you for your leadership in these matters. Your high standards of integrity are a vital part of the government's and the public's trust and confidence in the public sector. I also encourage you to continue to support your management in emphasising the importance of integrity throughout your entity.

Yours sincerely

Peter Hughes (he/him)
Te Tumu Whakarae mō Te Kawa Mataaho
Public Service Commissioner | Head of Service

Code of Conduct
For Crown Entity Board Members

Te Kawa Mataaho
Public Service Commission

Crown entities deliver public services, exercise significant powers and directly impact the lives of New Zealanders. To be effective, Crown entities must have the trust and confidence of New Zealanders and the Government.

9.1

ACTING IN THE SPIRIT OF SERVICE

Boards oversee the operations and performance of Crown entities. As board members we bring to our roles a spirit of service to the community and a desire to improve the wellbeing of New Zealand and New Zealanders, including of Māori consistent with Te Tiriti o Waitangi. A key requirement of our roles is to act with the highest levels of integrity and professional and personal standards.

RESPONSIBILITIES UNDER THIS CODE

PERSONAL INTEGRITY

We are honest and open

We act with honesty and with high standards of professional and personal integrity.

We are truthful and open. We speak up in board meetings on decisions or advice that may be detrimental to the public interest.

We are fair

We deal with people fairly, impartially, promptly, sensitively and to the best of our ability.

We do not act in a way that unjustifiably favours or discriminates against particular individuals or interests. We help create an environment where diverse perspectives and backgrounds are encouraged and valued. We treat other members and staff employed by the entity with courtesy and respect.

We speak up

We report unethical behaviour when we see it. We treat all concerns raised by others seriously.

We support the entity to have clear policies and procedures in place that help expose serious threats to the public interest, and encourage open organisation cultures where all staff feel safe speaking up.

PROFESSIONAL CONDUCT

We use our positions properly

When acting as a member, we do not pursue our own interests at the expense of the entity's interests.

We do not misuse official resources for personal gain or for political purposes. We behave in a way that reflects well on the reputation of the entity and do not do anything to harm that reputation.

We never seek gifts, hospitality or favours for ourselves, members of our families or other close associates. We inform the Chair or other proper authority, or otherwise follow our entity's procedures, in relation to any offers of gifts or hospitality. We ensure that, where a gift or hospitality is accepted, it is recorded in a register as required under the entity's procedures.

Issued by the Public Service Commissioner under section 17(3) of the Public Service Act 2020 to apply to board members of statutory entities (excluding corporations sole) and Crown entity companies (excluding Crown Research Institutes and their subsidiaries)

IMPLEMENTATION

This Code sets out minimum standards of integrity and conduct. The board should put in place a board charter or governance manual to guide its governance activities, which includes ethics provisions for board members as appropriate, to support these standards and suit the entity's particular circumstances.

This Code should be read in conjunction with the collective and individual duties of members as set out in the Crown Entities Act 2004. This Code does not override any statutory provisions including those in an entity's empowering legislation, the Crown Entities Act 2004, the Public Service Act 2020, the Public Finance Act 1989 and the Companies Act 1993. This code is not intended to limit the ability of an entity or statutory officer to act independently in regard to any statutorily independent function.

We use information properly

We use information we gain in the course of our duties only for its intended purpose and never to obtain an advantage for ourselves or others or to cause detriment to the entity.

We are well informed about privacy, official information and protected disclosures legislation. We fully comply with entity procedures and only disclose official information or documents when required to do so by law, in the legitimate course of duty or when proper authority has been given.

We are politically impartial

We act in a politically impartial manner. Irrespective of our political interests, we conduct ourselves in a way that enables us to act effectively under current and future governments. We do not make political statements or engage in political activity in relation to the functions of the Crown entity.

When acting in our private capacity, we avoid any political activity that could jeopardise our ability to perform our role or which could erode the public's trust in the entity. We discuss with the Chair any proposal to make political comment or to undertake any significant political activity.[1]

We use care, diligence and skill

We carry out our work with care, diligence and skill.

We give proper consideration to matters and seek and consider all relevant information.

ACTING LAWFULLY

We meet our statutory and administrative requirements

We understand and act in accordance with all statutory and administrative requirements relevant to our roles.

We play a full and active role in the work of the board and fulfil all our duties responsibly. We respect the principle of collective decision-making and corporate responsibility. This means once the board has made a decision, we support it. We follow board protocols for public comment.

We identify and manage conflicts of interest

We identify, disclose, manage and regularly review all interests.

We become familiar with, and follow, all conflicts of interest requirements, including those of the board, the entity, and all statutory and professional requirements including the Crown Entities Act 2004, sections 62-72.

[1] *These provisions apply to elected board members in the same way as to appointed members. However elected board members have a relationship with their constituency in addition to their accountability to the responsible Minister. Elected Board Members must consider how to maintain that relationship while, as for all members, ensuring their actions do not jeopardise the effective governance of the entity.*

CHAPTER 7: BEHAVIOUR OF MEMBERS

It is essential the Board conducts its business in accordance with the highest ethical and professional standards. General guidance on the behaviour expected of Board members is provided in this section. Guidelines that specifically address behaviour during meetings can be found in the Auckland DHB Conduct Standards and the Standing Orders.

General behaviour

In order to undertake a role on the Board effectively it is important that all members adhere to the Auckland DHB Code of Conduct and exhibit the behaviour expected of such a role.

At all times Board members should act responsibly and respectfully, with integrity and courage. They must be willing to act on and remain collectively accountable for all decisions made by the Board. Members are expected to be fully prepared and punctual for meetings and to consistently attend and participate in those meetings.

Key principles

Courage

- Be independent thinkers, and have the courage to challenge colleagues
- Be willing to stand for and communicate their independent position on matters of strategic importance

Integrity

- Demonstrate the highest ethical standards and integrity in personal and professional dealings
- Consistently conduct office to the best of their abilities

Respect

- Always engage constructively and respect others' point of view
- Respect the separation of governance and management

Responsibility

- Be informed and responsible governors at all times, using resources carefully and as intended.
- Uphold their responsibility to Auckland DHB, the Auckland DHB population, and the Minister of Health

Behaviour in meetings

In order to ensure meetings are productive and as efficient as possible, members and any other person in attendance should observe the following behaviour guidelines:

- Be polite and respectful with all in attendance, ensuring that compassion and concern is shown for others.
- Any matters raised should be objective in nature, without any personal references or undermining.
- Views and contributions of all attending should be respected and acknowledged. Members must be prepared to work through sensitive matters diplomatically.
- Full attention should be given to the speaker, with no interruptions or side discussions.
- Wherever possible, closure on an issue should be achieved before moving to a new issue.
- The Chair, and others as necessary, should ensure all in attendance are clear on a question or point before discussion on that issue commences or action is agreed.
- If information required to successfully pursue a discussion is not available, the matter will be parked until the information becomes available.
- All members will assist the Chair in upholding these behaviours and to challenge others who are diverging from agreed values and standards.

Other Guidance Governing Behaviour

Another good source of guidance around behaviour and conduct exists on the State Services Commission website.

https://ssc.govt.nz/our-work/integrityandconduct/

Statement of Performance Expectations (SPE) Performance Report: Quarter Two 2020/21

Recommendation:

That the Statement of Performance Expectations (SPE) Performance Report - Quarter Two 2020/21 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)

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. Performance against these measures is published in our Annual Report and audited by Audit NZ.

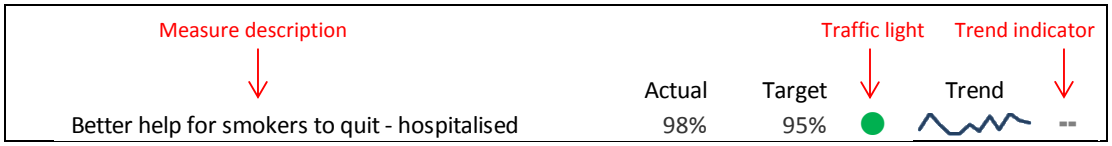
The measures in this report reflect those in the 2020/21 Annual Plan. A focus on equity is reflected in the extended number of measures monitored by ethnicity. This report excludes indicators that measure volumes without a specified target or those for which data is available only annually.

The performance achieved in Q2 was generally good, given that many of our community and hospital services continue to be affected by COVID-19.

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 two 2020/21

Metro Auckland DHBs priority health outcomes and other key indicators scorecard

Quarter 2, 2020/21

	Auckland DHB			Waitematā DHB			Counties Manukau DHB		
Priority health outcomes	Actual	Target	Trend	Actual	Target	Trend	Actual	Target	Trend
Shorter stays in EDs	89%	95%	▼	92%	95%	▼	88%	95%	▼
Planned Care Interventions (YTD)	96%	100%	--	106%	100%	▲	111%	100%	▼
Faster Cancer Treatment - within 62 days	97%	90%	▼	91%	90%	▲	90%	90%	--
Increased immunisation at age 8 months	93%	95%	--	92%	95%	--	91%	95%	--
- Māori	78%	95%	▼	76%	95%	▼	75%	95%	▼
- Pacific	89%	95%	▼	93%	95%	▲	90%	95%	▼
Better help for smokers - Primary Care	82%	90%	▼	79%	90%	--	84%	90%	▼
Better help for smokers - Maternity	100%	90%	--	80%	90%	▼	*92%*	*90%*	
Raising Healthy Kids	100%	95%	--	100%	95%	--	100%	95%	--
Key indicators									
Breast screening coverage	63%	70%	▼	66%	70%	▲	67%	70%	▼
Cervical screening coverage	70%	80%	▲	70%	80%	▲	65%	80%	--
a. Preschoolers enrolled in DHB oral health	101%	95%	▲	99%	95%	▲	91%	95%	▲
- Māori	85%	95%	▲	76%	95%	▲	76%	95%	▲
- Pacific	101%	95%	▲	101%	95%	--	96%	95%	▲
- Asian	95%	95%	▲	91%	95%	▲	83%	95%	▲
Urgent diagnostic colonoscopy in 14 days	93%	90%	▼	96%	90%	▼	100%	90%	--
b. Opportunities for hand hygiene taken*	*86%*	*80%*	▼	*90%*	*80%*	▼	*86%*	*80%*	▼
c. Hip/knee procedures given ABx in time*	*99%*	*100%*	--	*98%*	*100%*	▼	*99%*	*100%*	▲
b. 0-19 yo Mental Health waiting ≤3 weeks	*69%*	*80%*	--	*65%*	*80%*	▼	*73%*	*80%*	▼
b. 0-19 yo Mental Health waiting ≤8 weeks	*81%*	*95%*	--	*89%*	*95%*	▼	*88%*	*95%*	▼
b. 0-19 yo Addictions waiting ≤3 weeks	*93%*	*80%*	▼	*74%*	*80%*	▼	*97%*	*80%*	▼
b. 0-19 yo Addictions waiting ≤8 weeks	*97%*	*95%*	▼	*92%*	*95%*	▼	*97%*	*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. >100% results are due to mismatch of population projection and ARDS database ethnicity categorisations
b. Q1 2020/21 result
c. Q4 2019/20 result
d. November 2020 result
e. Metro Auckland DHBs result
f. Q3 2019/20 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 2, 2020/21

Focus on priority populations	Actual	Target	Trend
Health promotion			
% of total clients engaged with GRx (YTD) - Māori	15%	11%	
% of total clients engaged with GRx (YTD) - Pacific	20%	17%	
% of total clients engaged with GRx (YTD) - South Asian	18%	18%	
Immunisation			
Pertussis vaccination in pregnancy	63%	50%	
- Māori	36%	50%	
- Pacific	46%	50%	
- Asian	73%	50%	
Flu vaccine in 0-4 yo hospitalised for respiratory illness	33%	30%	
- Māori	26%	30%	
- Pacific	26%	30%	
Increased immunisation at age 5 years	92%	95%	
- Māori	82%	95%	
- Pacific	90%	95%	
- Asian	91%	95%	
Primary health care			
Primary Care enrolment rate - Māori	81%	90%	
Eligible patients without HbA1c in last 15 mo	11%	<12%	
- Māori	17%	<12%	
- Pacific	13%	<12%	
Eligible patients with HbA1c ≤64 mmol/mol in last 15 mo	60%	65%	
- Māori	48%	65%	
- Pacific	48%	65%	
Māori with prior CVD prescribed triple therapy	59%	70%	
Mean decayed, missing, filled teeth (DMFT) at Year 8	0.50	<0.63	
- Māori	0.60	<0.63	
- Pacific	0.73	<0.63	
- Asian	0.42	<0.63	
Children caries free at age 5 years	46%	61%	
- Māori	33%	61%	
- Pacific	25%	61%	
- Asian	45%	61%	
Mental health			
d. Mental health service access (age 0-19 years)	*3.43%*	*3.15%*	
d. - Māori	*5.79%*	*6.11%*	
d. Mental health service access (age 20-64 years)	*3.97%*	*3.50%*	
d. - Māori	*11.85%*	*10.90%*	
d. Mental health service access (age 65+ years)	*3.14%*	*2.92%*	
d. - Māori	*4.12%*	*3.64%*	

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. >100% results are due to mismatch of population projection and ARDS database ethnicity categorisations
b. Q1 2020/21 result
c. Q4 2019/20 result
d. November 2020 result
e. Metro Auckland DHBs result
f. Q3 2019/20 result
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Auckland DHB Statement of Performance Expectations scorecard

Quarter 2, 2020/21

	Actual	Target		Trend	
Output Class 1: Prevention Services					
Health promotion					
Pregnant smokers referred to incentives programme (YTD)	75	55	●		▲
Number of clients engaged with Green Prescriptions (YTD)	1,708	2,125	●		▼
Population-based screening					
B4 School Checks completed (YTD)	43%	45%	●		▲
Newborns offered and hearing screened w/in 1 month	96%	90%	●		▲
Auckland Regional Public Health Service					
e. Tobacco retailer compliance checks conducted (YTD)	5	30	●		--
e. Positive pulmonary TB cases contacted in 3 days	93%	90%	●		▼
e. By-protocol initial contact for high risk enteric disease	100%	95%	●		--
Output Class 2: Early Detection and Management					
Primary health care					
POAC referrals (YTD)	2,637	3,018	●		▲
Output Class 3: Intensive Assessment and Treatment					
Acute services					
b. Alcohol-related ED admissions (10-24 year-olds)	*6.8%*	*<14%*	●		▼
b. Stroke patients receiving thrombolysis and/or clot retrieval	*12%*	*12%*	●		▼
ACS patients with coronary angiography in 3 days	88%	70%	●		▲
Elective (inpatient/outpatient)					
Non-urgent diagnostic colonoscopy in 42 days	65%	70%	●		▲
Patients waiting >4 months for FSA (ESPI 2)^	5.6%	<0%	●		--
CTs completed in 6 weeks	76%	95%	●		▲
MRIs completed in 6 weeks	56%	90%	●		▼
Quality and patient safety (HQSC)					
b. Staph bacteraemia rate per 1,000 inpatient bed days	*0.25*	*<0.25*	●		▼
b. Older patients assessed for the risk of falling	*83%*	*90%*	●		
b. Older falls risk patients with an individualised care plan*	*94%*	*90%*	●		
b. #NOF from falls per 100,000 admissions (rolling 12 m)	*5.0*	*<9.7*	●		▲
c. Hip/knee procedures given antibiotic in correct dose*	*92%*	*95%*	●		▼
c. Surgical site infections per 100 hip and knee operations	*0.43*	*<0.97*	●		▲
Inpatient respondents with 'very good', 'excellent' care	86%	90%	●		▼
Outpatient respondents with 'very good' or 'excellent' care	89%	90%	●		▼
Output Class 4: Rehabilitation and Support Services					
Home-based support					
f. HBSS clients with clinical interRAI and care plan	*96%*	*95%*	●		
Palliative care					
Referrals that wait >48 hours for a hospice bed	0%	<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

^ 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

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PRIORITY HEALTH OUTCOMES
SCORECARD VARIANCE REPORT

Indicator	On target	Variance commentary
1. Shorter stays in EDs	✖	*We experienced recurrent constraints, largely resourcing in Starship, and increased demand in November-December 2020, closure of urgent care clinics over Christmas, continuing high levels of staff illness and capacity constraints across admitting specialities for AED.* *To improve performance, we are reviewing Starship inpatient flow and planning for 2021, and completing data analysis of model of care, implemented women's health pathway and the quality improvement learning system for AED.*
2. Planned Care Interventions	✓	
3. Faster Cancer Treatment – within 62 days	✓	
4. Increased immunisation at age 8 months	✓	
- Māori	✖	*The coverage is not unexpected with the impact of COVID-19 as this cohort of children was born and/or due their 6-week immunisations during the first lockdown and due their primary series during the second lockdown.* *Vaccine hesitancy is increasing for Māori, at 6%, and is at 4% for Pacific (vs. 2.4% for the total population).* *The sector reports that many Pacific people remain anxious about COVID-19 in the lower alert levels.* *Māori and Pacific mobile clinics from MoH COVID-19 funding offered opportunistic immunisations; discussions continue on how these units could support catch-up childhood immunisations.*
- Pacific	✖	
5. Better help for smokers – Primary Care	✖	*Primary care resources continue to be stretched due to the COVID-19 response, with less focus on other conditions, such as smoking. Only one DHB in the country achieved the target in Q2; Auckland DHB was ranked 7th out of the 20 DHBs.*
6. Better help for smokers – Maternity	✓	
7. Raising Healthy Kids	✓	

KEY INDICATORS

SCORECARD VARIANCE REPORT

Indicator	On target	Variance commentary
8. Breast screening coverage	✖	*Total coverage is below target for Q2. Coverage in Māori women is consistently below target and is currently at 63%. Coverage in Pacific women is 71% and met the target as of December 2020. Impacts on coverage as a result of COVID-19 restrictions are likely, due to significant reduction in coverage in the most recent 12-month period. Breastscreen Auckland Ltd, the lead service provider, is in transition to Breastscreen Waitematā Northland; this is also expected to affect coverage for Q2 as Breastscreen Auckland Ltd began to wind down operations.*
9. Cervical screening coverage	✖	*Cervical screening remains below target, at 70%. Coverage for both Māori and Pacific women is significantly below this, and decreased further during Q2 than for other women, indicating systemic inequities in the catch-up of screens. COVID-19 restrictions had an impact on completion of cervical screens; however, the decline in coverage both nationally and locally has been the trend for 3-4 years. The delay in the introduction of HPV primary screening and the removal of cervical screening as a performance measurement target are contributing factors to this trend. Cancer risk is higher in Māori and Pacific women who are unscreened or have not been screened for >5 years; these groups remain a priority.*
10. Pre-schoolers enrolled in DHB oral health services	✓	
- Māori	✖	*There is an improvement in pre-school enrolment coverage for tamariki Māori in 2020, due to introduction of an automatic process for birth nomination to the oral health service in Auckland DHB in 2018. 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 and does not reflect the father's ethnicity.*

Indicator	On target	Variance commentary
		ARDS continues to work with staff to support this process. Across a range of child health services, Māori children have lower enrolment, access and utilisation than non-Māori. Auckland and Waitematā DHBs introduced the National Child Health Platform (NCHIP), a child health enrolment and milestone system. NCHIP allows a child's key health checks to be collated from birth through to six years of age; and from a range of difference service providers within a single integrated dataset. To ensure the use of NCHIP improves access and equity, it is implemented as part of Uri Ririki - Child Health Connection Centre (UR-CHCC). UR-CHCC will manage the database and analyse it to inform active follow-up with families, providers and other agencies when children are missing out on services.
- 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	✖	*We were impacted by the first two lockdowns; we continued to see urgent referrals in person, and offered telehealth for non-urgent assessments, but many families chose to wait.* *We continued to see a surge in referral rates, which impacted our waiting times. In some weeks, the referral numbers were more than 50% higher than the same weeks last year. There was an increase in the acuity and complexity of clients, which has an impact on wait times.* *We completed the first part of a service-wide improvement project to improve flow into and through the service. We are implementing some changes in the referral management process. Part of this project has seen us actively monitor and assess clients on the waitlist and provide one-off assessments to determine the client's needs.* *We continue to offer telehealth as an option for both initial assessment and ongoing intervention.*
15. Mental Health waiting within 8 weeks in 0-19 year olds	✖	

Indicator	On target	Variance commentary
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	✓	
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 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, removing the opportunity for opportunistic vaccination.*
- Pacific	✖	
- Asian	✓	
20. Flu vaccine in 0-4 year olds hospitalised for respiratory illness	✓	
- Māori	✖	*Coverage for eligible Māori and Pacific 0-4 year olds increased both to 26% as at December 2020, up from 9.8% and 14%, respectively, in 2019. This reflects significant work by the sector during the COVID-19 pandemic, where there was alternative immunisation delivery, e.g. public health nurses delivering alongside their BAU; the DHB created a rapid response influenza vaccination team that*
- Pacific	✖	

Indicator	On target	Variance commentary
		offered home visits and pop-up clinics, which were well received. The new OIS model also offers influenza vaccination to eligible children referred for overdue immunisation and the new Māori and Pacific mobile units also offered influenza vaccination to children. Lists of 0-4 year-olds eligible for funded influenza vaccine due to hospitalisation were provided to PHOs, who actively worked with their practices on recalling these children and held additional promotional activities during COVID-19.
21. Increased immunisation at age 5 years	✓	*Coverage for the total population at 5 years of age increased slightly over this quarter and remains stable against the same time last year. COVID-19 affected coverage at 5 years of age, and the gains made during the measles outbreak were not sustained.*
- Māori	✖	*Coverage of Māori at 5 years of age was improving, although there was a decrease in coverage for 2020 vs. the same time last year. COVID-19 affected 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 4-year-olds (not undertaken by the previous NIR provider) and continue to undertake significant data clean-up due to reconcile the NIR with children's updated DHB of domicile. The NIR team also gained access to the B4SC database, which will support contacting of eligible patients and a data-sharing process with MSD is now embedded.*
- Pacific	✖	*Pacific coverage improved 2% from the same time last year. See comments above, the gains made during the measles outbreak were not sustained during the COVID-19 situation.*
- 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: recently*

Indicator	On target	Variance commentary
		re-started after COVID-19 disruptions • *Work with Māori health providers to ensure they are constantly checking the enrolment status of their clients: this is monitored regularly* • *Data match between Māori health providers and PHOs to find whānau who are not enrolled: delayed by COVID-19, although a report is currently 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; 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. We are starting to see patients who were due their diabetes reviews during one of the COVID-19 lockdowns coming into primary care for their diabetes reviews, and we expect the number of people without an Hb1A1c within the last 15 months should start to improve in the coming months.*
- Pacific	✖	
24. Eligible patients with HbA1c ≤64 mmol/mol in the last 15 months	✖	
- 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; PHOs are working with practices to re-engage in BAU, which includes CVD risk assessment and management.*
26. Mean decayed, missing, filled teeth (DMFT) at Year 8	✓	
- Māori	✓	
- Pacific	✖	*Over the past two years, there was a significant focus on improving the systems and processes that support equity and attendance rates for Māori and Pacific children. However, the COVID-19 pandemic had a significant impact on service performance, as routine oral health care (as per Dental Council NZ (DCNZ) guidance) was unable to be provided during Alert Levels 3 and 4. Due to the DCNZ requirement to screen all children prior to their appointment, the service experienced challenges in reaching*

Indicator	On target	Variance commentary
		some families/whānau to complete the pre-screening requirement. Those children whose parents could not be contacted are missing out on their dental examination and preventative treatments. 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 ongoing DCNZ requirements, ARDS 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	✓	
27. Children caries free at age 5 years	✖	*Please see DMFT comments above.*
- Māori	✖	
- Pacific	✖	
- Asian	✖	
Mental health		
28. Mental Health service access (age 0-19 years)	✓	
- Māori	✖	*The Provider Arm provides only a portion of the overall access counts, which varies by age and ethnic groups.*
29. Mental Health service access (age 20-64 years)	✓	
- Māori	✓	
30. Mental Health services access (age 65+ years)	✓	
- Māori	✓	

OUTPUT CLASS 1: PREVENTION SERVICES SCORECARD VARIANCE REPORT

Indicator	On target	Variance commentary
Health promotion		
31. Pregnant smokers referred to incentives programme (YTD)	✓	
32. Number of clients engaged with Green Prescriptions (YTD)	✗	*The provider did not engage with some referrals prior to Christmas, instead holding them over to contact after the summer holiday period.*
Population-based screening		
33. B4 School Checks completed (YTD)	✓	
34. New-borns offered hearing screening within 1 month	✓	
Auckland Regional Public Health Service		
35. Tobacco retailer compliance checks conducted (YTD)	✗	*Programme delivery was significantly affected due to staff redeployment to ARPHS' COVID-19 response.*
36. Positive pulmonary tuberculosis cases contacted in 3 days	✓	
37. 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		
38. Primary Options for Acute Care (POAC) referrals (YTD)	✗	*The estimated volumes are calculated based on the annual clinical services funding per DHB. The volumes are estimated using the previous 'average clinical cost per case'. This is historically at around $224 per case, but is no longer indicative due to the varying value of case reimbursements. However, the service provision is tracking within allocated clinical services budget.*

OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT SCORECARD VARIANCE REPORT

Indicator	On target	Variance commentary
Acute services		
39. Alcohol-related ED admissions (10-24 year-olds)	✓	
40. Stroke patients receiving thrombolysis and/or clot retrieval	✓	

Indicator	On target	Variance commentary
41. ACS patients with coronary angiography in 3 days	✓	
Elective (inpatient/outpatient)		
42. Non-urgent diagnostic colonoscopy in 42 days	✖	*The service made improvements in September and November, related to outsourcing.* *The service increased the maximum compliance measure from 78% to 96%, achieved by booking patients with the longest waiting times.* *The service continues to aim to meet the compliance targets by improving booking and scheduling practices, implementing a nurse specialist to contact patients prior to their procedure and recruiting a SMO to cover leave.*
43. Patients waiting >4 months for FSA (ESPI 2)	✖	*ESPI-2 performance continues to improve, and particular focus is being given to long waiting patients, equity and clinical risk. Additional clinics are being undertaken whenever possible.*
44. CTs completed within 6 weeks	✖	*Additional weekend sessions are planned for February to June 2021.*
45. MRIs completed within 6 weeks	✖	*Additional outsourcing continues from February to June 2021*
Quality and patient safety (HQSC)		
46. Staph bacteraemia rate per 1,000 inpatient bed days	✓	
47. 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. 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, therefore, we do not believe patient care has declined. Technology issues with our patient safety app means we have reverted back to a paper-based audit and this appears to be adversely affecting results. An external vendor was engaged to help fix the audit issues and these should be in place for the April 2021 audit. This remains a safety concern and a further work plan will be*

Indicator	On target	Variance commentary
		developed to improve compliance and therefore safety for the older person.
48. Older falls risk patients with an individualised care plan	✓	
49. Fractured NOF from falls per 100,000 admissions (rolling 12 months)	✓	
50. Hip and knee procedures given the right antibiotic in the correct dose	✓	
51. Surgical site infections per 100 hip and knee operations	✓	
52. Inpatient respondents with 'very good' or 'excellent' care	✓	
53. Outpatient respondents with 'very good' or 'excellent' care	✓	

OUTPUT CLASS 4: REHABILITATION AND SUPPORT SERVICES SCORECARD VARIANCE REPORT

Indicator	On target	Variance commentary
Home-based support		
54. HBSS clients with clinical interRAI and care plan	✓	*No data since Q3 2019/20 due to COVID-19; data is expected for Q3 2020/21.*
Palliative care		
55. Referrals that wait >48 hours for a hospice bed	✓	

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
3.0 Confirmation of Confidential Minutes 27 January 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.	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 – 2021/2022 Auckland DHB Annual Plan	**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]
4.0 Confidential 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]
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 [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

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
6.1 Chief Executive 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. **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 [Official Information Act 1982 s9(2)(j)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 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 [Official Information Act 1982 s9(2)(i)] **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 [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.1 Finance, Risk and Assurance 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]
8.2 Hospital Advisory 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	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

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
	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 [Official Information Act 1982 s9(2)(j)]	sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.1 Neurology Patient Repatriation and Debt Write-Off	**Privacy of Persons** Information relating to natural person(s) either living or deceased 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 Home Haemodialysis Supplier Contract 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. **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 [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
10.0 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 COVID Vaccination Programme	**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	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]

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
	made public at this time [Official Information Act 1982 s9(2)(j)] **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)]	
11.2 Leonard Road Lease	**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 [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
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]