AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Open Board Meeting

Wednesday, 29 June 2022

10:00am

Note:

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

Marion Davis Library
Building 43
Auckland City Hospital
Grafton

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

Published 23 June 2022

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.

Open Agenda
Meeting of the Board
29 June 2022

Venue: Marion Davis Library, Building 43
Auckland City Hospital, Grafton

Time: 10:00am

Board Members Pat Snedden (Board Chair) Jo Agnew Doug Armstrong Michelle Atkinson Zoe Brownlie Peter Davis Tama Davis (Board Deputy Chair) Fiona Lai Bernie O'Donnell Michael Quirke Ian Ward **Seat at the Table Appointees** Krissi Holtz Maria Ngauamo Kirimoana Willoughby Shannon Ioane	**Auckland DHB Executive Leadership** Michael Shepherd — Interim Chief Executive Officer Dr Karen Bartholomew — Director of Health Outcomes – ADHB/WDHB Mark Edwards — Chief Quality, Safety and Risk Officer Dr Debbie Holdsworth — Director of Funding – ADHB/WDHB Auxilia Nyangoni — Acting Chief Financial Officer Sarah McLeod — Acting Chief People Officer Sue Waters — Chief Health Professions Officer **Auckland DHB Senior Staff** Jennie Montague — Head of Executive Services (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

KARAKIA

10:02 **1.** **ATTENDANCE AND APOLOGIES**

10:04 **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?

10:05 **3.** **CONFIRMATION OF CONFIDENTIAL MINUTES 18 MAY 2022**

4. **ACTION POINTS** - Nil

10:10 **5.** **EXECUTIVE REPORTS**

5.1 Chief Executive's Report

5.2 Health and Safety Report

10:30 **6.** **PERFORMANCE REPORTS**

6.1 Financial Performance Report

10:45	**7.**	**COMMITTEE REPORTS**
	7.1	Community and Public Health Advisory Committee - Executive Committee Report
	7.2	Hospital Advisory Committee – Provider Equity Plans Draft
	8.	**DECISION REPORTS - Nil**
	9.	**INFORMATION REPORTS -Nil**
11:15	**10.**	**GENERAL BUSINESS**
11:30	**11.**	**RESOLUTION TO EXCLUDE PUBLIC**

Next Meeting: This is the final meeting of the Te Toka Tumai – Auckland DHB Board as the DHB transitions to Health New Zealand 01 July 2022

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Attendance at Board Meetings

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

2021/2022

Members	28 July 21	29 Sept 21	3 Nov 21	15 Dec 21	26 Jan 22	23 Feb 22	6 April 22	18 May 22	29 June 22
Pat Snedden (Board Chair)	1	1	1	1	1	x	1	1	
Joanne Agnew	1	1	1	1	x	1	1	1	
Doug Armstrong	1	1	1	1	1	1	1	1	
Michelle Atkinson	1	1	1	1	1	1	1	1	
Zoe Brownlie	x	1	1	1	1	1	1	1	
Peter Davis	1	1	1	1	1	1	1	x	
Tama Davis	x	1	1	1	1	1	1	1	
Fiona Lai	1	1	1	x	1	1	1	x	
Bernie O'Donnell	x	1	x	x	1	1	1	x	
Michael Quirke	1	1	1	1	1	1	1	1	
Ian Ward	1	1	1	1	1	1	1	1	

Seat at the Table

Members	26 May. 21	28 Jul. 21	29 Sep. 21	3 Nov 21	15 Dec. 21	26 Jan 22	23 Feb 22	6 April 22	18 May 22	29 June 22
Kirimoana Willoughby	1	nm	nm	x	nm	x	1	1	1	
Krissi Holtz	1	1	1	1	1	1	1	1	x	
Maria Ngauamo	1	1	1	1	1	x	1	x	x	
Shannon Ioane	1	nm	nm	1	nm	1	1	1	1	

Key: 1 = present, x = absent, # = leave of absence, c = cancelled nm = non member

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 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	08.06.2022
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)* NZX shares which may include from time to time the health related shares EBOS , Fisher and Paykel Healthcare,Ryman Healthcare, Green Cross Healthcare	21.10.2021
Zoe BROWNLIE	Co-Director – AllHuman Board Member – Waitakere Health and Education Trust Partner – Team Leader, Community Action on Youth and Drugs Advisor – Wellbeing, Diversity and Inclusion at Massey University	26.05.2021
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) DAVIS	Director/Owner – Ahikaroa Enterprises Ltd Whanau Director/Board of Directors – Whai Maia Ngati Whatua Orakei Director – Comprehensive Care Limited Board Director – Comprehensive Care PHO Board	10.05.2022

	Board Member – Yellow Brick Road 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 Board Member – Auckland Health Foundation Director to Emerge Aotearoa Trust and Emerge Aotearoa Limited Strategic Director, Maori – UniServices (wholly owned by The University of Auckland)	
Krissi HOLTZ	Primary Employer – ASB Bank	07.07.2021
Shannon IOANE	Member – Public Service Association (PSA) Employee at Starship Children's Hospital – Allied Health/Child Health ADHB	07.07.2021
Fiona LAI	Member – Pharmaceutical Society NZ Casual Pharmacist – Auckland DHB Member – PSA Union Puketapapa Local Board Member – Auckland Council Member – NZ Hospital Pharmacists' Association Board of Trustee – Mt Roskill Primary School Vaccinator	21.11.2021
Maria NGAUAMO	Employee – NZ Ministry of Foreign Affairs and Trade (MFAT) Pacific Health Scholarship – Ministry of Health	04.04.2022
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 Kura Ratapu – Radio Waatea - Wife	08.07.2021
Michael QUIRKE	Chief Operating Officer – Mercy Radiology Group Director of Strategic Partnerships for Healthcare Holdings Limited Board Director – healthAlliance Director - New Zealand Musculoskeletal Imaging Limited	19.05.2022
Ian WARD	Director – Ward Consulting Services Limited Director – Cavell Corporation Limited Trustee of various family trusts Oceania Healthcare – wife shareholder	21.05.2020
Kirimoana WILLOUGHBY	Employer – Ngati Whatua Orakei Whai Maia Ltd Director – The Hearing House Board	01.03.2022

Minutes
Meeting of the Board
18 May 2022

Minutes of the Auckland District Health Board meeting held on Wednesday, 18 May 2022 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 10:00am

Board Members Present Pat Snedden (Board Chair) Jo Agnew Doug Armstrong Michelle Atkinson Zoe Brownlie Tama Davis (Board Deputy Chair) Michael Quirke Ian Ward **Seat at the Table Appointees** Kirimoana Willoughby Shannon Ioane	**Auckland DHB Executive Leadership** Ailsa Claire — Chief Executive Officer Margaret Dotchin — Chief Nursing Officer Dr Mark Edwards — Chief Quality, Safety and Risk Officer Dr Mike Shepherd — Director Provider Services Auxilia Nyangoni — Acting Chief Financial Officer Sue Waters — Chief Health Professions Officer **Auckland DHB Senior Staff** Jennie Montague — Head of Executive Services Megan Wiltshire — Director of Communications **Others** Nerissa Navarro — Coordinator (Other staff members who attend for a particular item are named at the start of the respective minute)

KARAKIA

The Karakia was led by Tama Davis.

1. ATTENDANCE AND APOLOGIES (Page 5)

That the apologies of Board members Bernie O'Donnell, Fiona Lai and Peter Davis be received.

That the apology of Maria Ngauamo and Krissi Holtz, Seat at the Table members be received.

That the apology of Michael Shepherd for late arrival (11.00am) be received.

That the apology of Ailsa Claire for temporary absence from the meeting for 15 minutes to join a Zoom call at 12.00 be received.

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

Michael Quirke advised that he is no longer Chairman and Convenor of Child Poverty Action Group and asked that the Conflict of Interest Register be updated.

3. CONFIRMATION OF MINUTES 6 APRIL 2022 (Pages 9-28)

Resolution: Moved Pat Snedden / Seconded Jo Agnew

That the minutes of the Board meeting held on 06 April 2022 be confirmed as a true and

accurate record.

Carried

4. ACTION POINTS (*Page 29)*

[Secretarial note: Item 4.1 was discussed later in the meeting when Michael Shepherd was present; Item 10.2 of the Action Points register (Nursing shortage – deep dive) was moved to the Public Excluded Board Agenda]

4.1 Waitangi Tribunal Report on Covid Alignment *(Pages 30-32)*

[Secretarial note: it was agreed that further details and discussion on this topic will be done in Item7.1]

5. EXECUTIVE REPORTS

5.1 Chief Executive's Report (Pages 33-41)

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

Winter readiness / Vaccination

The Covid infrastructure that has served us well during the Omicron outbreak is being utilised to support the work that is happening across the region through winter. Whanau HQ, as well as Māori and Pacific teams and providers are supporting people who are at risk of serious illness or have had serious illness regardless of the cause of that illness. This support has been critical in helping to stop people from being admitted, and in discharges. Along with the winter issues, it is projected that there would be an outbreak of another Covid variant, and people thinking that Covid is over and mask use in particular is not being promoted.

This year's flu vaccination uptake across the wider community has not been as good as in previous years, including with DHB staff. This is proving to be a challenge because a severe flu season is expected this year given that NZ borders have reopened and NZ has not seen serious widespread flu infection in the last two years.

Ailsa Claire commented that Covid might have caused quite a significant vaccine resistance in the community. Jo Agnew was advised that in order to increase uptake, we have moved to roving vaccinators who go on all the wards, for example, doing opportunistic vaccination of any patient or family member who also would like to be vaccinated.

Transition to HNZ and MHA

There are task forces within Health NZ and Māori Health Authority – one supporting the transition, Workforce, Planned Care, Hospital, Winter Resilience and Vaccination. The Auckland DHB CE leads the Task Force on Winter Resilience and the Task Force on Vaccination.

Tū Pono Āroha – Patient Administration System (PAS)

Tū Pono Āroha programme is progressing well and at pace. While the implementation of the

new system is not going to happen during the current Board's tenure, it is moving forward and on track to schedule.

Starship Foundation Fellowship Project

The Starship Foundation Fellowship recipient (Dr Zoe Vetten) is researching on a cardiac condition. This is a good example of the work with the Foundation and the hospital to reduce emergency admissions and certainty around treatment pathway.

Communications

It has been a busy period for the Communications and the OIA team as there seems to be an increase in more complex requests. The communications team has been doing a number of internal briefings on hospital winter readiness via staff webinars.

New Senior Leader Appointed

The Māori Health Lead for Patient Management Services has been appointed, along with additional leadership roles that have been recruited to.

Sterile Science Services

Last month, Auckland DHB celebrated the International Sterile Sciences Day to acknowledge the work of Sterile Sciences Services. This group of people does an outstanding job processing the surgical instruments.

National Health Target Performance

Meeting the national health targets is a challenge at the moment; however, the Faster cancer treatment target is maintained. It was noted that there is a very small group of people who are receiving cancer treatments generally, and they and other people may be affected by the significant backlog in planned care services.

Vaccination is an area that is becoming a concern, specifically child immunisation. It is very likely that we may see flu and mumps circulating with the opening of the borders. There is a lot of planning and on-going work to catch up on the group of people who have not had their MMR vaccine when vaccination rates around New Zealand were between 40 and 60%. This group would now be in their late teens and early twenties. The Māori and Pacific providers who were particularly supporting people during COVID are helping by using that outreach and network to look at the people that have not been vaccinated, including the catch up on vaccinations. Ailsa Claire advised that the vaccination strategy for children is separate and different from this group.

Financial Performance

The favourable position is attributed to reduced provision of services. It is an unusual situation to be in. We are, in fact, running tens of millions here of our budget provision, but we're also significantly behind on that payment.

The discussion covers the following:

Kirimoana Willoughby expressed her concern regarding transitioning all the work around

equity and across the DHB Directorates to Health NZ. Ailsa Claire explained that all staff will transition into Health NZ, and some will transition into Māori Health Authority (MHA). There is a very clear recognition that some people to go into the Māori Health Authority, but if all significant Māori leaders and others move out of Health NZ then there would be an impact on the whole equity within HNZ. There would be a mixture of people whose roles would logically transfer and a mixture of people who are part of the daily business of the organisation and they would not transfer unless they applied for roles in the MHA. There will be a number of roles HNZ and MHA will be advertising. Ailsa Claire confirmed Kirimoana Willoughby's understanding that it's the management structure that is changing, and that initiatives like Kaiārahi Nahi and Oranga Coordinators will continue. These are important initiatives to Auckland DHB.

[Secretarial note: The Board Chair paused the discussion for 5 minutes to enable Doug Armstrong to resolve technical issues with Zoom; Doug Armstrong made the following comments later on in the discussion]

Doug Armstrong asked about the status of supplies and supply chain issues in light of the coming flu season, uncertain relapses of COVID, among other things; specifically around the availability Covid drug, the availability of proper PPE, and the N95 mask which was the recommended type to use. Ailsa Claire advised that Auckland DHB is not currently experiencing any supply issues, including vaccines. The Covid vaccine supply is in fact sufficient for a forth COVID vaccine if a second booster should be required. Regarding the Covid drug, the protocols for dispensing that medication are with the individual GP as they are clinically accountable for that prescription. The mask supply is also sufficient. The bigger concern however is people not wearing masks anymore. N95 masks are not required as the evaluation has shown that level 2 (procedure masks) that are worn in most clinical circumstances all currently wearing are perfectly effective under normal circumstances.

Resolution:

That the Chief Executives report for 21 March 2022 – 1 May 2022 be received.

Carried

5.2 Health and Safety Report (Pages 42-48)

Mark Edwards, Chief Quality, Safety and Risk Officer asked that the report be taken as read, advising as follows:

Auckland DHB is a very busy organization with capacity issues, and that is impacting on our ability to progress some of the health and safety work, in particular the setting up of the Fatigue working group which has been pushed to June due to availability. Our union partners have indicated that they would like to progress that faster as do wee but we have to work within our current capacity. Progress is being made on a worker participation agreement underway. In fact, just before this meeting there was a two-hour workshop outline the principles and the areas that are going to be covered. An external facilitator was present and it is expected that this will lay the foundation for good pathways and mechanisms for our

workers to engage in the health and safety system. The Wellbeing audit has been put on hold. There is a plan and the team understand the risks and issues on wellbeing from both the health and safety and people and culture point of view. The Regional Internal Audit is aware of this and the plan was to proceed with the audit in the spring when things are projected to be less busy. The team will be drafting a paper for the next FRAC meeting to outline the plan.

Mark Edwards confirmed for the Board Chair Pat Snedden that there is still an issue with external contractors subscribing fully to the DHB health and safety process. DHB is not at that stage yet where we do not engage with these contractors for this reason. We are still risk rating all our internal contracts, and we have not reached that stage yet where we refuse to work with any individual contractor, thus we are carrying some of the risks ourselves.

Mark Edwards clarified that there are already processes around pre-qualification and working together between PCBUs. This formalises the Tōtika framework and going forward, makes that part of the contract management system once it is in place; all new contracts will have those clauses written in a standard way and there would be a process for contractors to work through. The team had made progress as fast as they would to in getting all the contractors signed up to the Tōtika framework.

Kirimoana Willoughby was pleased to see that there is a plan and agreed approach around fatigue management. She commented that the transition is adding to the pressures that clinicians and DHB staff experience in their day-to-day mahi. In terms of the incidents in Mental Health, Mark Edwards advised that fatigue was not a factor in these incidents.

Ian Ward asked if Mark Edwards' concern about the number of staff in the Facilities team dedicated to health and safety has been progressed with Facilities lead Allan Johns. Mark Edwards advised that in the health and safety structure, there is currently one within Facilities team and a separate team which is for the rest of the business team. The internal health and safety for Facilities is mostly done through contract with Aqua Heat. Facilities Management's health and safety team oversee the project work and other pieces of work. As part of the contracts with FIRP certain contractual obligations under health and safety will have to be met by all the contractors. Mark Edwards' team has asked for these two teams to be work together more formally.

Shannon Ionne asked about the increased incidents in Mental Health Services as stated in the report and noted the inconsistent staff practices and the need to put in controls to try and mitigate assaults. Mark Edwards advised that there is an increasing awareness of reporting, in particular in the mental health area and as well as an observation that the environment has changed over the last few months, the two factors being the increased resourcing in health and safety and the Mental Health Directorate has involved more engagement with the leadership team and the individual services; and the dedicated health and safety advisors as well as the workplace violence coordinator working more closely in that area. This means there is more resource than we've had before with the Mental Health and Addictions Directorate focused on staff safety. After one of the incidents that happened in the ACOS service earlier in the year, changes were made in the way that briefings and daily work are conducted so that every day there is a more formal risk assessment of the patients

or clients that the teams are going to visit. There is also a new position in next year's budget for a program manager for workplace violence, which will help to make that workplan actionable across the organisation.

Michael Quirke asked if the health and safety team will employ escalation tactics within contractor organisations with those contractors that are not engaging with Tōtika.

Mark Edwards advised that this has been discussed with Facilities Management, and they have not asked for this to happen for now but will consider in the future.

Resolution:

That the Board receives the Health and Safety Report for May 2022.

Carried

6. PERFORMANCE REPORTS

6.1 Financial Performance Report (Pages 49-53)

Auxilia Nyangoni, Acting Chief Financial Officer asked that the Financial Performance report as at 31 March 2022 be taken as read, advising as follows:

The result for April 2022 has now been submitted to the Ministry.

For the month of April, we are $1.3M unfavourable position, primarily driven by the additional provisions for the IDFs and planned care volumes not delivered in the month on a year to date basis. In terms of our year end forecast, we are expecting to be better because of new information around wash-ups.

We are in good position also in terms of cash flow. The cash flow forecasts were used to plan for capital funding next year for capital, which has been submitted to the Ministry. To answer the question at the last FRAC meeting regarding the Board making decisions on forward funding, Auxilia Nyangoni received a written confirmation from Rosalie Percival at the Interim Health NZ that that that is all in order as long as the items are on items on our prioritised list.

Pat Snedden summarised the financial performance by noting that Auckland DHB is significantly ahead of its budget and highlighted the irony that we are in this position because we have not actually delivered some of the planned care, which is negative to financial outcomes when they're delivered. He noted that there is currently no financial stress but there is pressure on delivery as a result of workforce shortage due to constrained market. Mike Shepherd agreed with the observation and advised that the Provider services are doing a good job and being fiscally prudent, however they would rather spend in order to deliver more health care to our communities.

Auxilia Nyangoni advised, the only other item that can affect the bottom line is the actuarial valuations for retring gratuities and long service leave. Pat Snedden was advised that the revised forecast in March is the position that the Crown expects the DHB to be at by year end.

Kirimoana Willoughby sought clarification to better understand the workings around planned care. Ailsa Claire added that when items are accrued for, it means that the DHB assume the loss. Some of the expenditure is related to Covid that is why we get additional funding. Every month there is an estimate of that loss (accrual), and this is put in the budget and comes out against the balance. Even with that loss, the DHB is still ahead of the plan (forecast) or in a favourable financial position.

In response to Kirimoana Willoughby's concern regarding the DHB's inability to meet deadlines on planned care Ailsa Claire advised that the big concern is at the moment is the DHB not having the capacity largely because of staffing and high acute demand that diminish the services' ability to do the planned care we would want to. In effect this means patients who are in the P3 and P4 categories are waiting for a considerable length of time for their treatment. Therefore the issue is not about money, but rather that the hospital does not have the staff and the capacity to deal with those categories at the moment. It is expected to get worse during the winter.

Ailsa Claire considered Kirimoana Willoughby's comment that the issue may not be being highlighted enough to the community. Ailsa reflected that strategy has been to make sure that the outpatients are kept going so we are to evaluate and monitor patients' illness while they are on the waiting list. By doing that, if anyone's situation seriously deteriorates, they could be moved up their category and monitor them and assist them to manage their illness whilst they are on the waiting list. This is particularly important in terms of prioritising Māori and Pacific patients. It is important that the community know they can get the urgent care they need, when they need it.

Doug Armstrong agreed that the waitlist is a challenge, and highlighted that people in his age group have been waiting for specialist appointments which keep getting delayed. The GPs who are supposed to be monitoring proactively are not able to do so either because of capacity in the community.

Tama Davis added that while the DHB is being fiscally prudent in the way funding is used he concurred with Doug Armstrong noting that we are not always aware of the waiting lists, and if there is no active communication between provider and primary care, and GPs are not communicating with their waitlist members, there have been instances when patients come off the list altogether, unaware of that fact until they become further unwell and end up on the waiting list at a different level.

Mike Shepherd acknowledged that there are always improvements that that we can make. He reminded the Board that in late November, the Board was asked to ask the Ministry of Health and others to communicate more proactively around the global nature of the problem. The Ministry responded in a way by setting up the planned care taskforce. We also need the public to be involved in their in their own health care and to help them so they know this information and contribute to it. In some areas, there was an attempt to proactively connect with everyone on the waitlist – it has not been a very successful approach in terms of equity. We run the risk of worsening inequity because it is often the people who do not have the greatest need that we hear back from the people who don't have the greatest need. The focus now is on using Kaiarahi Nahi and Pacific care navigators

as well the service teams to keep track of the waitlists, to communicate as proactively as we can around that and to communicate with primary care.

Resolution:

That the Board Receives the Financial Report for the period ended 31 March 2022

Carried

7. COMMITTEE REPORTS

7.1 Hospital Advisory Committee Executive Report (Pages 54-60)

Waitangi Tribunal Report on Covid Alignment

Dr Mike Shepherd, Director of Provider Services asked that the Waitangi Tribunal Report [Item 4.1 page 30] be taken as read, advising as follows:

The action was to provide a response to the Waitangi Tribunal Findings around COVID 19 response. Most of the Waitangi Tribunal findings were directed more at that community response to COVID. The findings provided good challenges to us from a provider arm perspective. In terms of alignment to our strategic approach (middle column), there is recognition that these are a range of ongoing opportunities, and that they are all aligned with the work that the Provider Services are currently trying to progress.

Mike Shepherd advised that, on hindsight the response to the report should have come sooner, and have engaged NRHCC for a combined response. The Board was asked for feedback on the response provided which will be shared with NRHCC to consider and to respond to from a community provision perspective.

Addressing Mike Shepherd, Kirimoana Willoughby commended the authors of the Waitangi Tribunal report on Covid alignment. She commented that the report shows that Auckland DHB is starting to understand how Māori think and the structures that they live in, operate in and that Auckland DHB are starting to structure service delivery around that to achieve Māori health outcomes. She appreciates that the Board is able to provide feedback, and gave the Provider Services Director a big 'ka pai' for making good progress in understanding Māori health issues.

Hospital Advisory Committee Executive Report

Mike Shepherd, Director of Provider Services asked that the Hospital Advisory Committee Executive Report be taken as read, advising as follows:

Clinical Information System (Badgernet) for Women's Health

Acknowledgment was given to Women's Health Directorate which has been under extreme pressure for a long period, particularly midwifery staffing. They continue to maintain a safe service despite this, which is a real tribute to the people involved. The service also managed to roll out Badgernet, the new maternity clinical information system over the last few weeks

- a really fantastic achievement to get that done. It was noted that while Badgernet is used nationally and internationally, the team feedback is that the system requires modification to enhance the Te Tiriti and equity work. There are fields and functionality in the systems that are not fit for purpose for New Zealand setting. The team recognise that and will be working the nationally to enable system modifications.

Shannon Ioane commented that the storytelling around Te Pūriri o Te Ora in the HAC report is consistently different to other services reports. She wondered if there is something happening within that service where the reflection of the report is always so and asked if there are lessons for other service to learn from.

Michael Shepherd advised that Te Pūriri o Te Ora was originally identified as a service in Women's Health, Child Health and Mental Health as a priority to enhance activities around any response to Te Tiriti and equity which progressed well in terms of resourcing. Troydyn Raturaga is working with the Provider Services to help progress the initiative, and to use the knowledge to roll it out across other Directorates, working together with the Māori Health team. The Haematology model of care was cited as an example where the Provider Director led Te Tiriti training sessions to enhance the narrative approach and make sure that those lead to the conclusion of projects. The services challenged themselves with questions and teaching Ti Tiriti and equity in the planning and approval process for projects, and follow through in the project delivery.

Shannon Ioane commented that the storytelling here is special and she would personally be proud of that if she were working in the service. This needs to be known to all staff, especially during this time of Covid and winter coming, so they could be proud of what the service is about and what they are doing. She noted that there is good opportunity to make this story known wider.

Mike Shepherd agreed and gave assurance that the story is generated within the service themselves and many see it as a clear, positive progression of the service. There continues to be a need to engage staff and bring them all on this journey, and that is what the leadership is doing a great job at.

Michael Quirke commented that the report reads well and there are a lot of good news stories despite ongoing pressures, and a lot of reasons to celebrate, like the success of Kaiarahi Nahi moving from pilot, and now being a part of the organisation long-term. He was keen to know how the service switched to Badgernet, whether there was an intention to train staff first and then implement the system, or just be agile enough to learn on the job because of staffing pressures.

Mike Shepherd advised that the model the service used was both training and learning on the job and further noted that the workflow is easy enough to embed in the system and this is one of the benefits that staff sees in Badgernet. He added that in designing our patient administration system, we expect to see more whānau linking and added fields for iwi affiliation. Badgernet is an internationally developed system and the service continues to work with the vendor along with other DHBs to make improve the system and make it more fit for purpose.

Jo Agnew was advised that the appointment of Dawson Ward as Māori Health Lead for Surgical Services has already been announced.

Referring to the Perioperative Services equity update (item 2.2, page 55), Kirimoana Willoughby asked for further clarification on what it means when it says "stressful and worrisome… at the time of surgery".

Mike Shepherd advised that there has been reluctance from some patients to come to hospital during the Covid outbreak for fear that they may be exposed to the virus. There is also the delay in the delivery of service where patients have been waiting for their appointments, and their condition needs to be reviewed, and/or patients need additional tests, and then the Covid test prior to their surgery. These all add up to the complexity of the surgery. The third factor has to do with the pressure in the hospital – services are having to postpone and reschedule surgery, not so much around acute care, but on planned care. Organising whanau and things around them can be complicated and stressful for people.

Regarding the Surgical Services equity update, Kirimoana Willoughby noted the long waiting list for Māori and Pacific. Michael Shepherd advised that the current work is more nuanced and more directed prioritisation process. This has been difficult due to the long list of patients waiting. The services are doing a combination of clinical acuity, ethnicity and waiting time. Work is underway in the region and in the whole country to enhance prioritising patient process. There could be risks associated with making it more complicated as it could become hard to apply.

On the Women's Health Directorate update around supporting the provision of LARC (Long Acting Reversible Contraceptives in primary community environments close to home for Māori, Pacific and other high needs groups, Kirimoana Willoughby wondered why there is a focus on Māori and high needs groups to have contraception.

Michael Shepherd acknowledged that the statement is ambiguous, as the service do not suggest that they are encouraging contraception for those groups. The focus is on access – people who need or request for contraception can access it. In particular, LARC is hard to access because of its cost.

Doug Armstrong commented that this was the point he was trying to make at the last Finance, Risk and Assurance Committee (FRAC) meeting – that anyone in any socio-enonomic group who needs contraception should be able to access it at no cost.

Resolution:

That the Board receives the Hospital Advisory Committee report for May 2022

Carried

7.2 Disability Support Advisory Committee Executive Report (Pages 61-75)

Sue Waters, Chief of Health Professions asked that the report and associated papers be received:

Auckland DHB Accessibility Update – Adele Thomas, Practice Lead Organisational

Development joined via Zoom;

Covid-19 NRHCC Disability Response – Katie Danie, Senior Programme Manager for Covid-19 Vaccination Programme NRHCC joined via Zoom

Child Development Services (CDS) Programme of Work – Denise Janes, NRA joined via Zoom

The discussion covers the following:

Auckland DHB Accessibility Update

Auckland DHB is now on its fourth year as member of the Accessibility Tick programme. The four northern region DHBs are all members of the Accessibility Tick programme and are already working together, including planning for the transition to Health NZ and the Māori Health Authority. The Metro Auckland DHBs are working with Te Roopu Waiora to develop training for disabled Māori.

Pat Snedden asked what the kind of support the Board can give in the new environment. Adele Thomas commented that Health NZ should have visibility and a strong focus on accessibility and disability from the onset. Pat Snedden agreed that the DHB should assist in this aspect.

Sue Waters advised that the CEO of Health NZ (Margie Apa) and Māori Health Authority (Riana Manuel) are aware of possible impact the transition may have if disability services are moved from their current position to the Ministry for Disabled People. The HNZ/MH intend to work very closely with the Ministry for Disabled People.

Covid-19 NRHCC Disability Response

The paper outlined the activities in the COVID vaccination programme for the last few months. The same report has been presented to Waitemata and Counties Manukau DHBs. The focus currently is on supporting disability residential providers with their outbreak response, flu vaccines and overall wellness promotion to the disability sector from the NRHCC.

Jo Agnew commended the work they do in the Metro Auckland are and noted that it is a good platform to launch from when the transition to the new organisation happens.

Child Development Services (CDS) Programme of Work

The Child Development Services are still awaiting a ministerial announcement as to where these services will sit, whether it will be under Health New Zealand or under the new Ministry for Disabled People. There will be implications if it is going to move to the new Ministry for Disabled People particularly on the interface between health needs and disability needs. It is a service that straddles to meet health and disability needs.

Katie Daniels commented that services for children are very siloed across education and health so having CDS under the new ministry has some real potential. Katie continued that for the very early journey and the very young children who have health and disability needs health are an important to the way care is coordinated for the child.

Ailsa Claire advised that there is a distinction between the commissioning of the services and the provision of the services. The understanding is that it is commissioning of the services that are being considered, and it might not the provision of the services. There is no decision yet on how the commissioning of services would come about.

Resolution:

That the Board receives the report from the Disability Advisory Committee

Carried

8. DECISION REPORTS

8.1 Amended Occupation Health and Safety Policy (Pages 76-78)

Mark Edwards asked that the paper be taken as read, advising as follows:

The policy is an update of the organisation-wide Health and Safety policy that has become outdated. It went through a brief, rather than formal process to get it updated process just to tide it over for a while until it has a formal, widely consulted update. It has been through the Health, Safety and Wellbeing Governance Committee. There are a few changes, the main change being on the language used which is more modern. There is acknowledgement that there is still more work to do when it finally gets into formal consultation and revision.

Resolution: Moved Pat Snedden / Seconded Jo Agnew

That the Board:

1. **Receives the amended Occupational Health and Safety Policy.**
2. **Notes that:**
   a) **The policy is due for review by June 2022.**
   b) **The amendments made to the policy are interim to enable Auckland DHB to have a current policy in place whilst a full strategic review takes place over the next 12 months in collaboration with workers and our union partners.**
3. **Approves the amended interim policy for adoption**

Carried

9. INFORMATION REPORTS - NIL

10. GENERAL BUSINESS

10.1 Petition to Auckland DHB Board received from Richard Stein Chairman, Crohn's and Colitis New Zealand Charitable Trust *(Pages 79-82)*

Board Chair Pat Snedden asked Dr Mike Shepherd, Director of Provider Services, to provide information about the service and outline the management view on the petition.
Mike Shepherd advised that Auckland DHB has had previous correspondence with the organisation, including responding to OIAs.

He provided the following information about the service: Auckland DHB runs a Regional Inflammatory Bowel Disease service which is of excellent standard. It is primarily outpatient-based, with a relatively small number of children and young people in active treatment. The team does not consider it an urgent need or a priority to change the service. However, the team strives to improve and deliver better outcomes, particularly as science advances. The service has made every effort to make sure that children have a named paediatric gastroenterologist, and if they live outside Auckland, they have a closer to home link with local services and a paediatrician. Work has been done around a national pathway and protocol via the clinical network. There's a very short waiting time, notwithstanding COVID, for children needing endoscopy and a very comprehensive pathway, up to and including the transition to adulthood. The team continues to look at improvement opportunities to increase resources to provide these children, such as enhancing psychology services.

At this time, given other DHB issues, further resourcing for this team in the form of a nurse specialist is not an urgent priority.

Ian Ward agreed with Mike Shepherd's comments about priorities given the description of the service.

Zoe Brownlie agreed, adding that the response to the petition needs to state that this is not a priority at the moment.

Kirimoana Willoughby was keen to know if children living within the Auckland DHB area have enough support and if there is communication to families with children suffering from this disease that service is available, regardless of whether they are Māori or non-Māori.

Michelle Atkinson asked if there is patient experience information to support this need. Mike Shepherd advised that there has been no specific survey for this group of patients and would not suggest the need for such a small cohort. However, the service has regular contact with these patients, and their encounters would be included in the organisation's Patient Experience survey.

Zoe Brownlie maintained that this is not for the Board to comment on the individual budgeting decisions and clearly should be for the management team to decide based on priorities set.

Mike Shepherd further commented that the petition is targeted at a service that is a small example of the myriad of local and national services. Making these types of assessments and, ultimately, funding decisions are what the Board entrusts Management to make. He does not see anything in the petition that changes the decision of the Directorate team.

Michael Quirke commented that this can be emotive and compelling when the Board do not know the whole story and suggested that there might be a further response.

The Board Chair moved that the petition be referred back to the Director of Provider Services, Dr Mike Shepherd, to respond, mentioning in the detail of the response that the Board had a thorough discussion and concluded that it is within the Provider Services to prioritise spending.

Resolution: Moved Pat Snedden / Seconded Jo Agnew

That the Board

1. **Receive the petition from Richard Stein regarding a request for Auckland DHB employ a specialty nurse in Starship Community Services**

2. **The Director of Provider Services provides a written response to Richard Stein reflecting the conversation at the Board.**

Carried

11. RESOLUTION TO EXCLUDE THE PUBLIC (Pages 83-)

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
1.0 Attendance and Apologies	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]
2.0 Conflicts of Interest	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]
3.0 Confirmation of Confidential Minutes 6 April 2022	**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]
3.1 Circulated Resolution FIRP Tranche 2 Central Plant & Tunnel Contract Approval 03 May 2022		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]
4.1 Nursing Shortage – Deep Dive	**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)] **Obligation of Confidence** Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
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]
6.1 Chief Executives	**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 Report - verbal	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]
6.2 Update on the transition to Health New Zealand and the Māori Health Authority – verbal update	**Obligation of Confidence** Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 People and Culture 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 [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]
8.2 Hospital Advisory Committee Executive	**Prejudice to Health or Safety** Information about measures protecting the health and safety of	That the public conduct of the whole or the relevant part of the

Report	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)]	meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.1 NRHCC Retrospective Contract Approvals	**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]
9.2 50 Grafton Infrastructure Renewal Business Case	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [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 Taylor Centre Relocation to 50 Grafton Road Business Case	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [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]
9.4 Capex Variations Approval for: 160 Grafton Road fitout project; Carpet to vinyl flooring replacement A32 project; Linac cooling system upgrade; Hospital orderly management system project	**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	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]

	Information Act 1982 s9(2)(k)]	
9.5 Clinical Transcription and Dictation Business Case	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **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)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
10.1 Provision for Continuity of Independent advice to Auckland DHB during the transition to Health NZ	**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]
11. Information Reports - Nil	n/a	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
12 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]

Resolution: Moved Pat Snedden / Seconded Tama Davis

Carried

The meeting closed with a Karakia by Tama Davis at 12.00pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 18 May 2022

Chair: _____ Date: _____

Pat Snedden

Chief Executive's Report

TE TOKA TUMAI
Auckland DHB

5.1

Recommendation

That the Chief Executive's report for 2 May 2022 – 12 June 2022 be received.

Prepared by: Ailsa Claire (Chief Executive) and Mike Shepherd (Acting Chief Executive)

1. Introduction

This report covers the period from 2 May 2022 – 12 June 2022.

2. Events and news

2.1 Winter response

As predicted, our hospitals are very busy with high emergency department presentations due to winter illness. While this is not unexpected, we've seen the impact of acute respiratory illnesses, in particular significant influenza cases, earlier than usual while we are also still caring for COVID-19 patients.

We've been planning for a challenging winter and, as such, have a number of streams of work underway to support our teams. This means despite the level of pressure, we're doing well with our response.

Two areas of focus are:

- The reintroduction of ***Task Teams*** to support our patients through the winter months. These teams, which we've enabled previously during the Omicron surge and industrial action, will be clinically-focused predominantly comprised of nurses and allied health staff. Their focus will be ward based, supporting patients, assisting with discharges and admissions, liaising with clinical teams to support priorities within our clinical areas.
- The recruitment of ***Hospital Supporter*** roles, new positions introduced to help support our clinical staff with their day-to-day mahi. After seeing the value in temporarily redeployed 'Ward Supporters' during our COVID-19 surges and industrial action, Hospital Supporters are being introduced as permanent fixtures for teams.

These are great roles that can act as a gateway for people to enter the health workforce and we hope to see these people able to move up into Health Care Assistant roles if they wish to.

We're conscious of the impact of wait times our patients and their whānau and are grateful to all our kaimahi for continuing to provide fantastic care for our patients and communities. Our messaging to the public continues to be that our emergency departments are available for people requiring acute and emergency care.

2.2 Flu campaign

Campaigns are underway nationally and locally to encourage everyone to get their flu vaccine this year, which can help protect against four different strains of the virus and reduce the need for hospitalisation.

With current flu cases on the rise, we are continuing our focus to support our kaimahi to get vaccinated for flu. As is consistent nationally, rates are lower than in previous years, largely believed to be due to 'Vaccine Fatigue' following the COVID pandemic.

Roaming vaccinators continue to offer the flu vaccination to our clinical teams, and our patient vaccinators working on wards are also able to vaccinate staff on request.

2.3 Transition to Health New Zealand and the Māori Health Authority

A number of interim appointments have been made to Health New Zealand that have seen senior health leaders from across Aotearoa seconded from their current jobs to lead nationally significant portfolios.

As part of these announcements, Ailsa Claire has left her role as Chief Executive of Te Toka Tumai Auckland DHB to lead a national taskforce focused on the health workforce. This is an area of critical importance to the sector and the decision to pull together all parties to create a national focus on attracting, growing and retaining staff is timely and will be very welcome.

Mike Shepherd has been appointed as acting Chief Executive until 1 July and will then take over as Interim District Director to lead the organisation under Heath New Zealand.

A programme of work is underway within Te Toka Tumai to look at how we transition into the new entities.

2.4 Administration and Clerical Pay Equity settlement

A historic agreement that addresses a long-standing undervaluation of Health Administrators and clerical staff across all District Health Boards has been ratified.

This is a workforce critical to the smooth running of our hospitals and the delivery of healthcare. The pay equity settlement covers more than 10,000 kaimahi (mainly women) and provides a new pay system with a standard structure, solving the issue of widely variable rates. It also provides a process to maintain pay equity in the future.

The settlement has been four years in the making with the Public Service Association (PSA) working in partnership with DHBs across Aotearoa.

2.5 International Midwife Day

We celebrated International Midwife Day on 5 May with some kai, coffee and conversation. While the going has been tough, as the team navigates the added complexities the COVID-19 pandemic brings, their commitment and aroha for the māmā, pēpi and whānau in their care has never wavered. Thank you to all our incredible midwives who work tirelessly in our communities and our hospitals.

2.6 International Nurses Day

In honour of International Nurses Day on 12 May, we celebrated the valuable mahi our Nurses and Healthcare Assistants do every day with free coffee and sweet treats. Nurses and HCAs are one of the largest workforces here at Te Toka Tumai and part of the day also focused on recapping the many initiatives underway to help resolve challenges we are currently facing, such as staffing shortages, noting that these are not isolated to us as a DHB, but are shared internationally.

2.7 Focus on World Hand Hygiene Day

This year we celebrate 10 years of all 20 DHBs participating in the Hand Hygiene New Zealand (HHNZ) programme with HQSC. Since 2012, NZ hand hygiene compliance has increased from 62.1% to 86.7%. For Auckland DHB, compliance has increased from 68% in 2012 to 87% in 2021.

To celebrate the success of hand hygiene at Auckland DHB, two wards were recognised with the best compliance over the 5 years - Adult haematology day stay and Paediatric haematology/oncology ward 27 for achieving 96% compliance and 94.5% compliance respectively over the 5 years.

2.8 Pink Shirt Day

On 20 May we celebrated Pink Shirt Day - Kōrero Mai, Kōrero Atu, Mauri Tū, Mauri Ora – Speak Up, Stand Together, Stop Bullying.

Teams from across Te Toka Tumai dressed in pink and decorated their offices pink – an opportunity to show that we will not tolerate bullying, harassment, and discrimination.

3. Communication and Engagement

3. 1 External Communication

Between 2 May 2022 and 12 June 2022, there were 65 requests for information, interviews or access from media organisations. This included requests for information about the impact of industrial action, hospital preparedness for winter and the ongoing response to COVID-19.

Around six per cent of the enquiries over this period sought the status of patients admitted following incidents such as road traffic incidents and water incidents.

We responded to 28 Official Information Act requests over this period.

3. 2 Internal Communication

There has been a high volume of organisation-wide communications to ensure we keep our people informed of key developments, in particular in relation winter planning:

- **Six** editions of Pito Pito Kōrero | Our News, the weekly email newsletter for all employees, were distributed.
- **Six** editions of the Manager Briefing were published for all people managers.
- **Eight** Winter Response emails were sent out to all employees.
- **Eleven** other Staff Alert emails were sent out to all employees
- **Two** Health NZ updates were sent out to all employees (other Health New Zealand information was shared through regular channels and on a Hippo intranet page)
- **Two** all staff webinar was broadcast.

For this period, 988 emails were received and actioned.

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:

- NZSL Flu vaccine Pink Shirt Day Winter messaging Bowel screening awareness House Officers of the Month Hospital Supporter role Local Hero – Deborah Harrison

Top performing social media posts

4. Our People

4.1 New Senior Leaders appointed

Director of Māori Nursing

Evelyn Hikuroa has been appointed as Director – Māori Nursing.

Evelyn comes from the Unitec Institute of Technology where she worked as a nurse lecturer and Māori health champion. Evelyn has extensive experience in teaching Māori health and many years working in a variety of nursing roles. She is very aware of the health inequities Māori face and wants to improve healthcare experience and health outcomes for our whānau through systemic change.

4.2 Celebrating our people and services

Queen's Birthday Honours

Marjet Pot ONZM, Kaiwhakahaere Women's Health Intelligence was recognised in the Queen's Birthday Honours for her significant contribution to women's health in Aotearoa.

Marjet volunteered with the Auckland Home Birth Association in the 1980s. She was part of a small volunteer group working with medical professionals and consumers to set up the Midwifery Standards Review Committee (MSRC) peer review forum. She helped expand the programme from an annual review of independent midwives and has trained others in the programme nationwide.

She has worked for Auckland DHB in several roles since 1976 and has made significant contributions to a range of initiatives at National Women's Health, including improving services to women and their babies and information technology.

Marjet had a lead role in the closure of National Women's Hospital and the move to Auckland City Hospital in 2004. She became Project Manager of the National Women's Health Annual Clinical Report in 2003, ensuring the document meets high epidemiological standards and that maternity information is accurately recorded. She led a team on the project '100 Percent Equity of Access to Newborn Metabolic Screening – A National First'.
She was made a Life Member of the College of Midwives for her work in helping establish the national midwifery review framework.

Long Service Awards

In June we celebrated long service milestones of our kaimahi. Each recipient received a gift pack along with their award, sponsored by The Auckland Health Foundation.

We had almost 550 people celebrating 20, 30 and 40 years of service to health at Te Toka Tumai Auckland DHB - the award events were cancelled in 2021 due to COVID-19 so there were two years' worth of long service awards to catch up. To keep people safe, sessions were held online. It was heart-warming to hear the stories of people's contributions and as we move into a new era with Health New Zealand we are in good hands with the amazing kaimahi we have working with us.

Local Heroes winners continue to shine

Andrew Meisner, Section Leader

"Andrew contentiously works together and aims high at delivering great service that ultimately benefits our patients and supports the clinical team to deliver care. "

Mel Williams - Clinical Midwife Specialist

"Mel's professionalism and genuine compassion helped us through what has been the hardest time in our lives, she was truly caring and made sure we were treated with respect and kindness."

Monica Miranda, Physiotherapist

“Monica is extremely passionate about improving the lives of her patients and she does a fantastic job of it. Her work in the cardiac rehab exercise programme has seen an improvement in the health, confidence and quality of life in countless people post cardiac event or surgery. Her approach is patient centred and lines up with the values of Auckland DHB perfectly. “

Deborah Harrison, Senior Physiotherapist

“Deborah has enabled us to put together a life worth living for my father after his stroke. We would not have been able to do this without her professional skills, interest, and care, which went far beyond 'just doing her job'.”

5. Priority Health Outcomes Summary

National Health Targets Performance Summary

	Status	Comment
Acute patient flow (ED 6 hr)		May 79%, Target 95%
Improved access to elective surgery (YTD)		80%, Target 100%
Faster cancer treatment		May 89%, Target 90%
Better help for smokers to quit: • Hospital patients • PHO enrolled patients • Pregnant women registered with DHB-employed midwife or lead maternity		May 94%, Target 95% R/U as PHOs are no longer funded by ADHB for this service, Target 90% R/U, Target 90%
Raising healthy kids		April 100%, Target 95%
Increased immunisation 8 months		Jan - Mar Qtr 86.8%, Target 95%

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

R/U: Result Unavailable

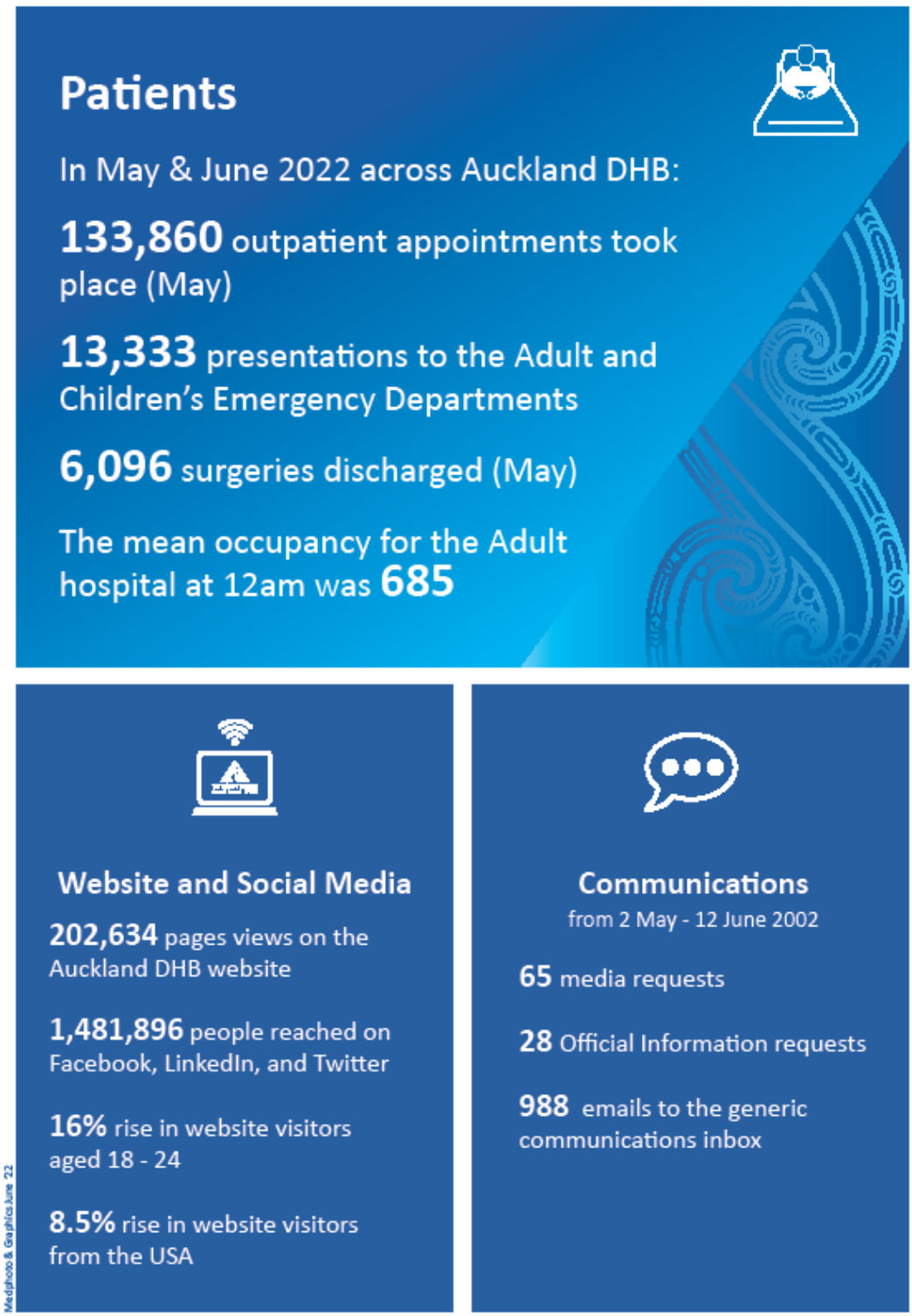
6. Financial Performance

The 2021/22 Annual Plan approved by the Board in August 2021 included a budget deficit of $73M comprising $40M for an increase in the liability for non-compliance with the Holidays Act and $33M for Business as Usual (BAU) operations.

The financial result for the eleven months ended 31 May 2022 is a surplus of $20.6M against a budgeted deficit of $65.0M, thus favourable to budget by $85.6M. The favourable position was realised in all three DHB arms, with $62.3M of this relating to Business as Usual Operations and $23.3M relating to net COVID-19 impacts. The main driver for the favourable position is release of $41M IDF and Planned Care wash-up provisions in May following MoH advice that we will only wash-up for the month of July 2021 and Quarter 2. The balance of the favourable position is driven by FTE vacancies in the Provider ($28M) and favourable demand driven services in the Funder, mainly in pharmaceuticals, aged residential care, carer support and labs, plus some prior year adjustments.

COVID-19 funding for the YTD was $263M, this covered vaccinations, community testing, Public Health Services, laboratory testing, quarantine, border control and other Covid-19 response costs. Related COVID-19 costs in the same period were $239.7M, hence the $23.3M favourable impact YTD, with this mainly driven by release of IDF/Planed Care wash-ups and favourable labs.

7. Auckland DHB at a glance



Health and Safety Report

Recommendation

That the Board receives the Health and Safety Report for June 2022.

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

Glossary

BBFA	Blood and/or Body Fluid Accident
HSR	Health and Safety Representative
HSWA	Health and Safety at Work Act (2015)
LTI	Lost Time Injury (work injury claim)
PCBU	Person Conducting a Business or Undertaking
PES	Pre-employment Health Screening
SI	Safety Intervention (previously MAPA)
SMS	Safety Management System
SPEC	Safe Practice Effective Communication (SPEC)
SPIC	Safe Practice in the Community
WPV	Workplace Violence and Aggression
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*

	*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. Executive Summary

The purpose of this report is to provide an update on the progress of Occupational Health and Safety risk related activities since May 2022.

Since the last report there have been no changes in risk ratings to the 12 key health and safety risks monitored.

One WorkSafe Notifiable Event occurred in this reporting period, arising from a slip on a wet floor that resulted in a fracture injury for a staff member. The incident has been investigated and information has been passed to WorkSafe for their review.

We noted no serious incidents around WPV. This contrasts from the previous Board report and we note increased awareness as well as planning and support activities progressing, particularly in the Mental Health and Addictions Directorate, which are aimed at mitigating this risk. The next period is likely to be challenging as there is typically higher exposure to WPV in the Emergency Department and it is predicted that there will be a sustained high number of patient presentations.

We are continuing to work through the contractor and supplier engagement for the Tōtika Scheme with the help of our Directorate leadership as well as centralising the governance of the contract management process in line with our regional activities.

The Health and Safety team report that there continues to be active management of fatigue across Directorates. Observations generally indicate that controls are working, with services managing this risk well. However, the Health and Safety Advisors note that the provision of more information and education would be beneficial across all levels of management around the identification and management of fatigue.

We are progressing closer collaboration and alignment of the Corporate and Facilities Health and Safety teams. To help gain further clarity around the performance and ongoing day to day management of the key risks related to Working at Heights, Hot Works, Confined Spaces and Asbestos the Facilities team will report these as they currently manage these interactions directly with the workforce.

The Health, Safety and Wellbeing Governance committee met on 31 May 2022. Areas of discussions and focus on the agenda were Directorate performance, key risks, worker participation and engagement, and staff safety and fatigue management.

2. Risk Analysis

2.1 WorkSafe Notifiable Events

There has been one WorkSafe Notifiable Event in this reporting period, with a staff member slipping on a wet floor surface resulting in a fracture. An investigation has commenced, with the H&S team

finalising the investigation report, along with additional control recommendations to be confirmed with the service area.

2.2 Key Risks

Summary

Since the last report, there has been no change in the risk ratings. There are currently six key risks rated as high with the remaining six risks rated either medium or low.

During May seventy-six WPV incidents were reported, which was slightly down against the twelve-month average of eight-seven incidents per-month. During this reporting period, there were no WorkSafe notifiable WPV incidents, in contrast to the previous two months. The current work with the Mental Health and Addictions directorate to improve the immediate and longer-term controls around WPV is raising awareness of WPV across the directorate.

We note that there is a risk of an increase in WPV incidents over the next period in the Adult Emergency Department as the number of patient presentations is predicted to remain at or above the current high levels. This can be accompanied by longer than usual wait times for patients and whanau and our past observations indicate that these conditions tend to precede an increase in WPV-related incidents. We are raising awareness around this and we are ensuring controls are in place to reduce the overall effect during what could be a heightened period of WPV risk.

We are continuing to engage with contractors and focusing on ensuring clarity of information around compliance to the Tōtika programme, to assist with increasing the number of completed assessments and registrations. We have engaged a resource for the next six months to assist contractors and ADHB contract owners through the current process and we are engaging key stakeholders within ADHB to help progress this and regional work.

There were twenty-two reported moving and handling incidents in May. This is consistent with the reported two-year average of twenty-two reported incidents. The Moving and Handling Steering Committee has met with its key advisors and will shortly finalise its Terms of Reference and its committee membership to enable it to begin work to deliver on its key priorities and to agree and implement its programme of work.

Fatigue Management risk remains high with the constrained staffing situation and continuing high levels of workforce sickness, which is anticipated to continue over the next few months with Covid-19, influenza and other respiratory illnesses. Observations generally indicate that controls are working, with services managing this risk well. However, the Health and Safety Advisors note that the provision of more information and education would be beneficial across all levels of management around the identification and management of fatigue. As previously reported, the next steps will see a focus on establishing a Fitness for Work Steering Committee. The purpose of this committee will be to guide the development and implementation of a Fatigue Management work plan to describe, monitor, report and audit the actions around fatigue identification and the systematic management of fatigue across the organisation.

With regard to the balance of the 12 key risks monitored by the Health and Safety team, there have been no significant changes to note with respect to the environment or the controls.

We have commenced an initiative with the Facilities team to collaborate more closely and integrate key Health and Safety work activities between the Corporate and Facilities HS teams. This will enable us to better use our combined resources to effect meaningful change as well as provide more

effective assurance to key ADHB stakeholders. To help gain further clarity around the performance and ongoing day to day management of the key risks related to Working at Heights, Hot Works, Confined Spaces and Asbestos the Facilities team will report these as they currently manage these interactions directly with the workforce. which will likely gain in significance due to the increasing FIRP construction activities ramping up over next few months.

3. Key Initiatives and Activities

3.1 Digital Transformation

The contract to upgrade to our current Occupational Health Patient Management System has now been signed.

The project can now upgrade our patient management system (Medtech 32) over to its latest version (Medtech Evolution) which will increase our productivity and allow us to start systemising many of our manual tasks as well as providing additional security and privacy for staff records.

3.2 Occupational Health and Safety Work Plan

We will be employing an OHS Systems Manager to help guide and support the development of the ADHB Health and Safety system as well as to assist managing the broader impact of changes that are likely to occur as Health NZ is established and develops expectations around Health and Safety systems for Districts. Our expectation is that this role will significantly speed up the integrated delivery of the OHS system, progress with which has proven difficult with the competing demands of pandemic-related activities. We also anticipate improved reporting and assurance related activities will result from the implementation of this role.

3.3 Occupational Health

The Occupational Health Steering Committee had been reviewing its risk register and focusing on process improvement opportunities. It has also endorsed process changes that will enable Occupational Health and Safety to invoice ACC for the non-work-related injury services it has been providing. It is intended that this revenue stream will support some of the expanded core services relating to vulnerable workers.

4. Auckland DHB Health, Safety and Wellbeing Governance Committee

The Health, Safety and Wellbeing Governance committee met on 31 May 2022. Key areas of discussion and focus on the agenda were Directorate performance and key risks, worker participation and engagement, and staff safety and fatigue management.

Training and support for HSRs including the proportion of HSRs achieving Unit Standard S29315 was of particular interest to our union partners, as was the removal of visitor screening and additional controls being put in place to ensure staff, patient and visitor safety.

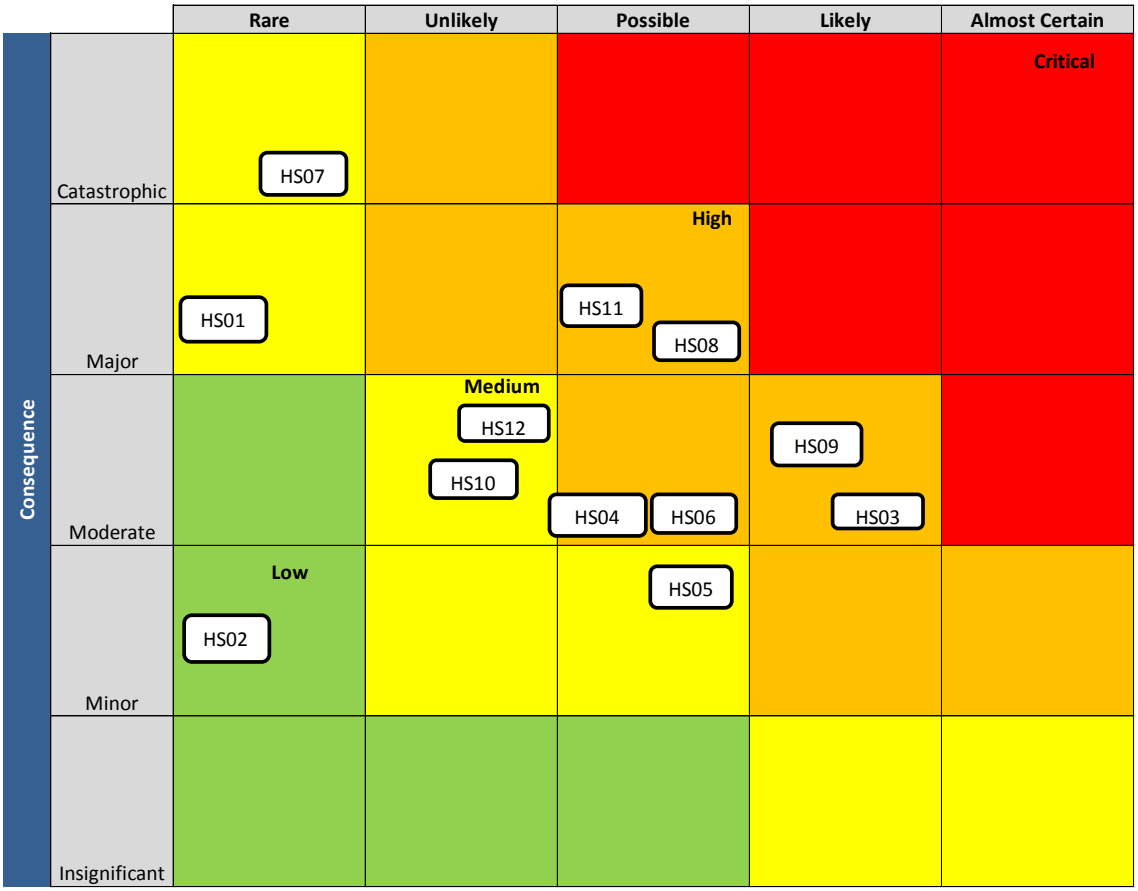
The committee also completed a self-evaluation of its performance and considered improvements to its Terms of Reference and expansion in membership. These changes will be further considered further at the committee's next meeting on 12 July 2022 prior to being implemented.

5. Internal audits

None

Appendix 1

Risk Heat Map



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 (except Covid-19)

Appendix 2

Health and Safety and Environment Key Risk Audit Schedule

Key Risk	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
HS11 - Workplace Violence and Aggression	✓	✓	✓	✓	x	✓		✓		✓							
HS 12- Biological Hazards	✓	✓	✓	✓	x	✓		✓		✓							
HS08 - Contractor Management	✓	✓	✓		x	✓		✓		✓							
HS04 -Lone Worker Protection		x		✓			✓			✓							
HS 01 - Asbestos Management		x		✓			✓	✓		✓							
HS 03 - Manual Tasks (including patient handing)		x		✓	x		✓			✓							
HS 06 - Working at Heights			x		x			x									
HS07 - Hot Works			x		x			x		✓							
HS09 - Fatigue Management			x	x	x	x		✓									
HS10 - Hazardous Substances				✓	x	x		✓	✓								
HS05 - Vehicles and Driving				✓		x			✓								
HS02 -Confined Spaces				✓		x			✓								

Key: ✓ = completed x = not completed

Financial Performance Report for the period ended 31 May 2022

Recommendation

That the Board Receives the Financial Report for the period ended 31 May 2022

Prepared by: Angela Sinclair, Acting Deputy Chief Financial Officer
Endorsed by: Auxilia Nyangoni, Interim Chief Financial Officer
Date: 20 June 2022

1. Statement of Financial Performance for the period ending 31 May 2022

The financial result for the month of May 2022 is a surplus of $37.1M which is $46.9M favourable against the budgeted deficit of $9.8M. For the year to date (YTD), a surplus of $20.6M was reported against a deficit budget of $65.0M, thus favourable to budget by $85.6M.

The significant favourable variance for the month impacting the YTD position is due to releasing $41M wash-up provisions for IDFs and Planned Care following MoH advice that DHBs will only wash-up for the month of July 2021 and Quarter 2 to December 2021.

The full year forecast has also improved as a result to a surplus of $20.49M, against the full year budget deficit of $73M, thus $93.49M favourable. The forecast position is expected to be $70M favourable in BAU (mainly driven by FTE vacancies and Funder demand driven favourable variances in pharmaceutical, Aged Residential Care, labs and prior period adjustments). Net Covid-19 impact is also expected to be favourable $23.5M for the full year.

The summary financial performance for the month and YTD are summarised in the Table below:

$000s	Month (May-2022)			Year to Date 2021-22			Full Year (2021-22)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Income									
Government and Crown Agency	211,220	161,189	50,031 F	2,000,475	1,772,780	227,695 F	2,175,241	1,935,832	239,409F
Non-Government and Crown Agency	7,606	8,446	840 U	89,729	93,058	3,328 U	99,072	101,508	2,436U
Inter- District Flows	95,878	66,133	29,745 F	732,828	727,462	5,366 F	782,875	793,595	10,720U
Inter-Provider and Internal Revenue	(2,030)	1,535	3,566 U	16,153	16,934	781 U	14,628	18,469	3,841U
Total Income	**312,674**	**237,303**	**75,371 F**	**2,839,185**	**2,610,233**	**228,952 F**	**3,071,817**	**2,849,404**	**222,412F**
Expenditure									
Personnel	116,646	111,299	5,347 U	1,259,209	1,194,543	64,665 U	1,373,748	1,307,404	66,344U
Outsourced Personnel	4,681	2,355	2,326 U	53,984	25,910	28,075 U	60,865	28,265	32,600U
Outsourced Clinical Services	5,290	3,806	1,484 U	44,123	41,873	2,249 U	47,870	45,652	2,218U
Outsourced Other Services	3,233	7,376	4,143 F	81,205	81,141	63 U	92,788	88,518	4,270U
Clinical Supplies	28,643	30,341	1,697 F	313,514	320,860	7,346 F	347,714	349,726	2,012F
Infrastructure & Non-Clinical Supplies	20,894	18,141	2,753 U	268,318	199,376	68,943 U	296,719	217,498	79,221U
Funder Payments - NGOs and IDF Outflows	96,185	73,778	22,407 U	798,270	811,562	13,292 F	831,621	885,340	53,719F
Total Expenditure	**275,573**	**247,097**	**28,476 U**	**2,818,622**	**2,675,266**	**143,356 U**	**3,051,325**	**2,922,404**	128,921U
Net Surplus / (Deficit)	**37,101**	**(9,793)**	**46,894 F**	**20,562**	**(65,033)**	**85,595 F**	**20,491**	**(73,000)**	**93,491 F**

Result by Division $000s	Month (May-2022)			Year to Date 2021-22			Full Year (2021-22)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funder	3,126	0	3,126 F	31,820	0	31,820 F	34,000	0	34,000 F
Provider	32,747	(9,785)	42,532 F	(16,587)	(65,025)	48,437 F	(18,846)	(73,000)	54,154 F
Governance	1,229	(8)	1,237 F	5,329	(8)	5,337 F	5,337	0	5,337 F
Net Surplus / (Deficit)	**37,101**	**(9,793)**	**46,894 F**	**20,562**	**(65,033)**	**85,596 F**	**20,491**	**(73,000)**	**93,491 F**
COVID-19 Net impact on bottom-line	35,401	(1)	**35,402 F**	23,316	(4)	**23,320 F**	23,528	0	**23,528 F**
Holidays Act Impact	(3,334)	(3,334)	**0 F**	(36,669)	(36,669)	**0 F**	(40,000)	(40,000)	**0 F**
BAU Net impact on bottom-line	5,033	(6,459)	**11,493 F**	33,915	(28,361)	**62,275 F**	36,963	(33,000)	**69,963 F**
Net Surplus / (Deficit)	**37,101**	**(9,793)**	**46,894 F**	**20,562**	**(65,033)**	**85,595 F**	**20,491**	**(73,000)**	**93,491 F**

Commentary on Significant Variances for the Year to Date

Revenue

Total revenue YTD is favourable to budget YTD by $229.0M (8.8%). The key variances are as follows:

- Covid-19 response funding $180.5M favourable covering vaccinations, community testing, ARPHS, laboratory testing, MIF, border control and other response costs.
- Covid-19 Provision for planned care and IDF revenue wash-up during lockdown and surge months $4.0M unfavourable, noting that provisions previously made of up to $41M have been released in the month following MoH advice on wash-ups for the year.
- MOH Nursing Pay Equity funding $39.6M favourable offsetting actual costs incurred.
- ACC revenue $6.6M favourable primarily reflecting two upsides for the Non Acute Rehabilitation (NAR) contract, (i) one-off backdated prior period volume wash-up ($2.4M) and (ii) backdated and on-going price increase ($4.2M).
- Donation Income $1.9M favourable reflecting additional funding received for projects.
- MOH base revenue $7.8M favourable relating to prior period wash-up settlements.
- Other Income $6.7M unfavourable reflecting additional revenue assumed for budget initiatives not yet received.
- Funder Other Government revenue $1.7m favourable due to prior year revenue received from ACC for cost of patients in interim care facilities prior to 2019-20.

Expenditure

Total expenditure YTD is unfavourable to budget by $143.4M (-5.4%). The key variances are as follows:

- Combined Personnel and Outsourced Staff costs $92.7M (-7.1%) unfavourable, with the key variances as follows:
  - Unbudgeted Covid-19 related expenditure of $72.9M.
  - BAU costs $19.4M (1.6%) unfavourable, with the key variances as follows:
    - Nursing Pay Equity costs $39.6 M unfavourable (offset by additional funding).
    - BAU FTE 351 below budget $27.6M favourable.
    - Lower annual leave taken than the phased assumption $6.6M unfavourable due to lower annual leave taken during Covid-19 lockdown and surge periods.
- Outsourced Clinical costs $2.2M (-5.5%) unfavourable due to outsourced lab tests, radiology and clinical services.
- Clinical Supplies are $7.3M (2.3%) favourable to budget being an $8.1M favourable BAU position reflecting reduced volumes during Covid-19 lockdown combined with a $0.8M Covid-19 unfavourable variance.
- Infrastructure & Non Clinical Supplies $68.9M (-34.6%) unfavourable, related to unbudgeted Covid-19 expenditure $62.0M (e.g. vaccination and community testing centre leases and urgent facilities work, with offsetting Covid-19 revenue) and BAU costs of $8.1M (5.2%) unfavourable reflecting facilities and IT project costs.
- Funder payments to NGOs and IDFs $13.3M (1.6%) favourable mainly due to:
  - Utilisation variances across Funder NGO demand driven services mainly:
    - Personal Health $23.7M favourable: largely driven by Pharmaceuticals $17.7M and Laboratory Services $3.4M.
    - Health of Older People $8.7M favourable: mainly Residential Care $8.5M favourable.
    - Mental Health $3M unfavourable: mainly Integrated Primary Mental Health.
    - Public Health $16.2M unfavourable due to Covid-19 expenditure and fully offset by Covid-19 revenue.

Volumes

Overall volumes are reported at 94.1% of base contract for the year to date - this equates to $85.0M below contract of which $4.0M is subject to wash-up liability for Planned Care (excluding August and September which the MOH have advised won't be subject to wash-up) and IDFs.

FTE

Total FTE (including outsourced) for the month of May 2022 was 10,609 FTE which is 206 higher than budget. Of this Covid-19 FTEs were 404 above budget and BAU is 198 FTE below budget, mainly driven by Nursing and Allied Health FTE vacancies.

2. Statement of Financial Position as at 31 May 2022

$'000	31-May-22			30-Apr-22	Var	30-Jun-21	Var
	Actual	Budget	Variance	Actual	Last Mth	Actual	Last Year
Public Equity	1,013,112	1,079,864	66,752U	1,002,830	10,281F	964,383	48,729F
Reserves							
Revaluation Reserve	643,988	643,988	0U	643,988	0F	643,988	0U
Accumulated Deficits from Prior Year's	(888,955)	(944,206)	55,252F	(888,955)	0F	(792,742)	96,213U
Current Surplus/(Deficit)	20,565	(9,793)	30,358F	(16,537)	37,101F	(96,229)	116,794F
	(224,403)	(310,011)	85,609F	(261,504)	37,101F	(244,983)	20,581F
Total Equity	**788,709**	**769,853**	**18,857F**	**741,327**	**47,382F**	**719,400**	**69,310F**
Non Current Assets							
Fixed Assets							
Land	397,089	397,089	0F	397,089	0F	397,089	0F
Buildings	602,615	666,405	63,790U	593,930	8,685F	621,314	18,699U
Plant & Equipment	85,003	99,627	14,624U	84,252	751F	91,861	6,858U
Work in Progress	166,259	195,707	29,449U	160,661	5,598F	96,596	69,663F
Total Property, Plant & Equipment	1,250,966	1,358,828	107,862U	1,235,932	15,034F	1,206,860	44,107F
Investments							
- Health Alliance	72,996	79,676	6,680U	78,787	5,791U	79,676	6,680U
- Health Source	271	-	271F	271	0F	-	271F
- NZHPL	6,454	7,295	841U	6,530	76U	7,295	841U
- Other Investments	654	-	654F	654	0F	-	654F
	80,375	86,971	6,596U	86,243	5,867U	86,971	6,596U
Intangible Assets	1,736	12,566	10,830U	975	761F	2,751	1,015U
Trust Funds	37,625	17,577	20,048F	36,705	920F	17,577	20,048F
	119,736	117,114	2,623F	123,922	4,186U	107,299	12,437F
Total Non Current Assets	**1,370,703**	**1,475,942**	**105,240U**	**1,359,855**	**10,848F**	**1,314,159**	**56,544F**
Current Assets							
Cash & Short Term Deposits	273,024	133,607	139,417F	245,144	27,880F	202,469	70,555F
Trusts/Restricted Funds Deposits > 3months	-	10,707	10,707U	2,482	2,482U	10,707	10,707U
ADHB Term Deposits > 3 months	-	-	0F	-	0F	-	0F
Debtors	40,547	44,859	4,312U	49,945	9,398U	44,859	4,312U
Accrued Income	153,979	76,452	77,527F	102,957	51,022F	76,452	77,527F
Prepayments	7,530	5,274	2,255F	7,633	103U	5,920	1,610F
Inventory	18,438	16,275	2,163F	18,917	478U	16,275	2,163F
Total Current Assets	**493,518**	**287,174**	**206,344F**	**427,077**	**66,441F**	**356,682**	**136,836F**
Current Liabilities							
Borrowing	(3,640)	(2,828)	812U	(3,630)	10U	(2,828)	812U
Trade & Other Creditors, Provisions	(270,520)	(222,902)	47,618U	(257,697)	12,823U	(222,902)	47,618U
Employee Entitlements	(691,357)	(653,653)	37,704U	(673,940)	17,417U	(616,986)	74,371U
Funds Held in Trust	(1,423)	(1,410)	13U	(1,423)	0F	(1,410)	13U
Total Current Liabilities	**(966,939)**	**(880,793)**	**86,147U**	**(936,690)**	**30,249U**	**(844,126)**	**122,813U**
Working Capital	**(473,422)**	**(593,619)**	**120,197F**	**(509,613)**	**36,192F**	**(487,444)**	**14,022F**
Non Current Liabilities							
Borrowings	(15,304)	(19,196)	3,893F	(15,647)	344F	(13,949)	1,355U
Employee Entitlements	(93,268)	(93,274)	6F	(93,268)	0F	(93,366)	98F
Total Non Current Liabilities	**(108,572)**	**(112,471)**	**3,899F**	**(108,916)**	**344F**	**(107,315)**	**1,257U**
Net Assets	**788,709**	**769,853**	**18,857F**	**741,327**	**47,383F**	**719,400**	**69,310F**

3. Statement of Cash flows as at 31 May 2022

$000's	Month (May-2022)			Eleven months ended 31 May		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Revenue Received	271,153	237,086	34,067F	2,772,598	2,607,839	164,759F
Payments						
Personnel	(98,931)	(104,631)	5,700F	(1,183,697)	(1,121,208)	62,489U
Suppliers	(57,512)	(53,632)	3,880U	(653,912)	(576,888)	77,024U
Capital Charge	0	(2,899)	2,899F	(17,114)	(31,893)	14,780F
Payments to other DHBs and Providers	(96,185)	(73,779)	22,406U	(798,269)	(811,569)	13,300F
GST	4,541	0	4,541F	2,315	0	2,315F
	(248,087)	(234,942)	13,145U	(2,650,677)	(2,541,558)	109,119U
Net Operating Cash flows	**23,066**	**2,144**	**20,922F**	**121,922**	**66,281**	**55,640F**
Investing						
Interest Income	505	219	286F	3,295	2,409	886F
Sale of Assets	70	0	70F	172	0	172F
Purchase Fixed Assets	(12,871)	(27,360)	14,489F	(100,281)	(257,088)	156,807F
Investments and restricted trust funds	7,214	0	7,214F	(4,510)	0	4,510U
Net Investing Cash flows	**(5,082)**	**(27,141)**	**22,059F**	**(101,325)**	**(254,679)**	**153,354F**
Financing						
Interest paid	(52)	(100)	48F	(837)	(1,101)	265F
New loans raised	0	0	0F	5,254	7,697	2,444U
Loans repaid	(334)	(254)	80U	(3,184)	(2,542)	643U
Other Equity Movement	10,281	15,318	5,037U	48,728	115,481	66,753U
Net Financing Cash flows	**9,895**	**14,964**	**5,069U**	**49,961**	**119,535**	**69,575U**
Total Net Cash flows	**27,879**	**(10,033)**	**37,912F**	**70,558**	**(68,862)**	**139,420F**
Opening Cash	245,144	143,640	101,505F	202,468	202,468	0F
Total Net Cash flows	27,879	(10,033)	37,912F	70,556	(68,861)	139,417F
Closing Cash	**273,024**	**133,607**	**139,417F**	**273,024**	**133,607**	**139,417F**

ADHB Cash	266,276	120,091	146,185F
AHREF Trust Cash	5,325	11,765	6,440U
ADHB - Domett Ave Restricted Funds < 3 months	1,423	1,751	328U
Closing Cash	**273,024**	**133,607**	**139,417F**
ADHB - Short Term 3 > 12 months	0	0	0F
AHREF Trust Deposits - Short Term 3 > 12 months	0	10,707	10,707U
ADHB Deposits - Long Term >12 months	0	0	0F
AHREF Trust - Long Term Investments > 12 months	37,625	17,577	20,048F
Total Cash & Deposits	**310,649**	**161,891**	**148,759F**

CPHAC EXECUTIVE COMMITTEE REPORT

Planning Funding and Outcomes Update

Recommendation:

Note the key activities within the Planning, Funding and Outcomes Unit.

7.1

Prepared by: Kate Sladden (Funding and Development Manager Health of Older People), Ruth Bijl (Funding and Development Manager Women, Children & Youth), Leani Sandford (Portfolio Manager, Pacific 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
AF	-	Atrial Fibrillation
ARC	-	Aged Residential Care
DHB	-	District Health Board
HCSS	-	Home and Community Support Services
HPV	-	Human papillomavirus
MMR	-	Mumps, Measles and Rubella
MoH		Ministry of Health
NA-HH		Noho Āhuru – Healthy Homes
NCHIP	-	National Child Health Information Platform
NGO	-	Non-Governmental Organisation
NHI	-	National Health Index
NIR	-	National Immunisation Register
NRHCC	-	Northern Region Health Coordination Centre
PFO	-	Planning, Funding and Outcomes
PHO	-	Primary Health Organisation
UR-CHCC		Uri Ririki - Child Health Connection Centre

1. Purpose

This report provides a brief update on Planning and Funding and Outcomes (PFO) activities and areas of priority. Note that most of the team are supporting the current outbreak response across a range of activities.

2. Primary Care

2.1. Vaccinations, Testing and Whānau HQ

We have been working closely with the NRHCC and providers to ensure that required services remain in place throughout the winter period. This includes ensuring that contracts and funding remain for some services, while several testing sites have been decommissioned and resources redeployed across other parts of the sector. We have supported vaccination centres to increase the scope of vaccinations they can provide with all Māori and Pacific led sites now offering influenza vaccinations.

Areas of focus have been:

- Winter planning - We continue to support the metro Auckland Community provider Winter Planning Group leading the NRHCC/DHB ground level response to pressure on the entire NGO sector.
- A winter resilience plan has been developed and socialised with the primary care sector, while work continues on a plan for hospices.
- Retinal screening redesign - Work continues to improve the access to retinal screening services across metro Auckland and improve efficiency of the retinal screening pathway.

2.2 Urgent Care Clinics

Urgent care clinics have come under increasing pressure in the past 12 months as workforce shortages, and growing costs have impacted heavily on this part of the sector. Recently, Auckland DHB committed extra resources to support overnight services at Whitecross Ascot to support their winter response efforts. We continue to work closely with Whitecross clinics across Auckland.

3. Health of Older People

3.1. Aged Residential Care

As at the 30 May 2022 87% (n = 60) ARC facilities in ADHB have had an Omicron exposure event/outbreak since the 1 February with 30% (n = 1124) of residents testing positive for COVID-19. The vast majority of ARC facilities with COVID-19 positive residents have coped exceptionally well. Most exposure events have been self-managed by the facilities with daily updates to the DHB. A small number of facilities, assessed as medium risk, have required more intensive input from the DHB.

Planning is happening for the rollout of the second COVID-19 booster in July.

Preparation for winter is underway as seasonal viruses such as influenza and RSV are expected to be more prolific this winter along with COVID-19. To date 82% of residents in ARC facilities within ADHB have had a flu vaccine.

Workforce, particularly shortages of registered nurses, remains a significant issue with the potential to get even more severe during winter. Mitigating measures are being used by ARC facilities including registered nurses on call rather than on-site, revised resident care plans, 12 hour shifts for RNs.

There is concern in the ARC sector as pay parity for ARC registered nurses is yet to be addressed and this exacerbates the significant workforce shortages. The Pay Equity Settlement that covers healthcare assistants was due to end on 30 June 2022. The Ministry has informed the sector that there will be an interim wage adjustment effective from 1 July 2022 for this workforce.

3.2. Home and Community Support Services

Winter planning with Home and Community Support Service (HCSS) providers is underway and prioritisation of services to high need and/or socially isolated clients, as used during the Omicron surge, may be required if there is a reduced workforce.

The increase in the mileage rate by five cents to 63.5 cents per kilometer that was approved for a temporary period (15 March to 30 June 2022) has been extended. HCSS support workers are also covered by the Pay Equity Settlement so will be receiving the interim wage adjustment from the 1 July 2022.

4. Child, Youth and Women's Health

4.1. Immunisation

Childhood Immunisation Schedule Vaccinations

As a consequence of the COVID-19 pandemic the equity gap in antenatal and childhood vaccination particularly for tamariki Māori has greatly increased such that tamariki Māori are now an acutely vulnerable group to vaccine preventable disease. Child immunisation rates have fallen below the level required to protect against measles and pertussis outbreaks.

We note that this is a national issue and that COVID-19 priorities have largely absorbed health care service capacity. In addition, access to vaccination services has been impacted by lockdowns, COVID-19 isolation periods and the confidence whānau feel to attend for vaccination events. An indicator of the stress in the systems is that general practices are referring children to the outreach immunisation services at 30% beyond projected monthly capacity for 2022 across the Auckland and Waitematā DHB region.

The COVID-19 Northern Regional Health Coordination infrastructure is being utilised to improve immunisation rates for routine childhood vaccinations. However, there are competing vaccination demands which include older adults for the 'flu programme and youth in the MMR catch-up programme'.

Recognising this is a national issue, there has been a recently established National Taskforce on Immunisation. The regional response needs to be urgent and agile because of the protracted and cumulative effects of the COVID-19 pandemic and lockdowns in the Metro-Auckland region, and needs to link in with the national taskforce.

This month we have raised the issue with the Metro Auckland Clinical Governance Forum (MACGF) seeking their advice and leadership on what is required to achieve an urgent, whole of system response to increase childhood immunisation coverage in particular for tamariki Māori. In response, an urgent Metro-Auckland Immunisation Governance Group (child and antenatal) was formed to work collaboratively and with urgency with MACGF members and across the health sector and community to identify and leverage workforce, resource and funding to achieve immediate results. The group is Chaired by a Māori Paediatrican, with three nominees from MACGF representing primary care.

At the national level, the Ministry of Health has announced three priorities to improve measles protection:

1. Address the equity gap in MMR rates for Māori and Pacific tamariki
2. Increase the uptake of dose 2 at 15 months, with particular focus on the second dose event
3. Deliver a catch-up campaign for those born 1989 – 2004.

The Ministry announced a temporary funding uplift for the MMR immunisation administration fee from 16 May 2022 till 30 July 2022. General practices and pharmacies can claim an additional equity weighted fee for immunisations given to Māori and Pacific people.

Pharmacist vaccinators and provisional pharmacist vaccinators were enabled to administer influenza vaccine to children aged 3 years and over from mid-April 2022.

Work has been progressing slowly to deliver integrated immunisations (meaning co-administration of vaccines for the whole whānau) through the NRHCC COVID -19 programme across several work streams. This is reported elsewhere.

PHOs and General Practices continue to offer Māmā/Pēpi clinics as a dedicated time and space for childhood immunisation. PHO Immunisation Coordinators are still supporting practices that have workforce pressures by assisting with immunisation recalls, running immunisation clinics where required and other BAU activities.

Auckland DHB has developed a Recovery Action Plan in consultation with Primary Health Organisations (PHOs), Māori and Pacific Health Gain teams, and regional partners to improve immunisation rates. The Ministry of Health (MoH) provisionally approved this in August 2021, with subsequent implementation of the plan. This plan will be updated with advice from the newly formed Metro-Auckland Immunisation Governance Group.

Activities completed to date include:

- The DHB funded a communication campaign to promote childhood immunisation. This included radio and retail advertising from January 2022, as well as social media posting and future posters and key messaging engagement activities. Child immunisation posters were distributed late May 2022 to practices, community pharmacies and WCTO providers.
- A fridge magnet was developed and is sent out with the 'Welcome to NCHIP/NIR' letter to the whānau of all newborns, providing a visual reminder of the upcoming immunisations (6 weeks, 3 months and 5 months' events, including WCTO). This resource was translated into Te Reo, Samoan and Tongan.
- A 'birthday card' concept for 4-year-olds to inform families/whānau of the various health checks due at 4 years of age. The card includes the Uri Ririki Child Health Connection Centre phone number for parents to contact if they require assistance in booking appointments. The team will check contact details and refer the children to the relevant service to book appointments. We will evaluate the effectiveness of this initiative in late 2021/22.

In May 2022, the immunisation rates were trending upwards especially for Māori and Pacific.
As of 30 May 2022, the 3-months rolling average for **8 months of age** has increased slightly for Total population at 87%, improved for Pacific 81% and tamariki Māori 78%.

The coverage for **24 months of age** for tamariki Māori has also increased to 73%, while both Total 85% and Pacific 75% coverage rates had remained the same.

Below is a table comparing childhood immunisation coverage over the last two weeks, including the decline/opt-off rates across Total, Māori and Pacific population.

Auckland DHB Childhood Immunisation Coverage												
3 month rolling average	**Week of 30/05/2022**						**Week of 23/05/2022**					
Milestone Age	**Total**	**Maori**	**Pacific**	**Total Decline & Opt-off**	**Maori Decline & Opt-off**	**Pacific Decline & Opt-off**	**Total**	**Maori**	**Pacific**	**Total Decline & Opt-off**	**Maori Decline & Opt-off**	**Pacific Decline & Opt-off**
8 months	87%	78% ↓	81%	2%	6%	5% ↑	87%	79%	81%	2%	6%	3%
24 months	85%	73% ↑	75% ↑	4%	6%	8%	85%	72%	74%	4%	6%	8%
5 years	78% ↓	70% ↓	76% ↑	4% ↑	9%	3% ↑	79%	72%	74%	3%	9%	2%

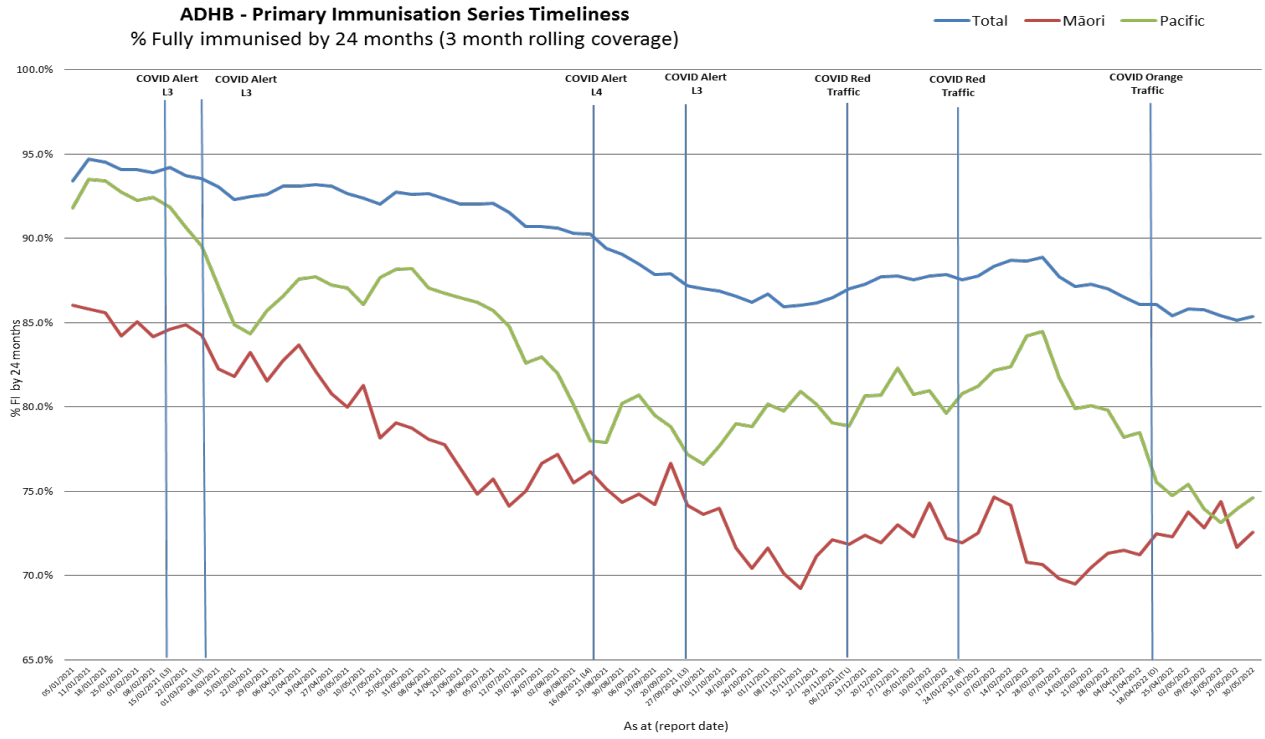
4.2. Measles

Work has continued as part of the national Measles Mumps and Rubella (MMR) catch-up focused on 15 to 30-year olds, particularly Māori and Pacific, with the Auckland strategy to increase awareness of the need to be immunised and increasing access to the vaccine. Since the campaign was launched by Minister Genter in July 2020, 2,823 new MMR doses have been recorded on the NIR for 15 to 30 year olds in Auckland DHB to the end of May 2022. Of these 309 were for Māori and 545 to Pacific. The DHB MMR team have given over 1,500 MMR doses across Auckland and Waitematā, taking a holistic approach and offering a catch up of Boostrix (pertussis, 475 vaccines) and HPV (748 doses) in schools, and meningococcal (101 doses) in tertiary residential facilities.

The Ministry of Health have announced that the programme has a further extension to 30 June 2022. The programme has been impacted by COVID -19 lockdowns with planned school and tertiary vaccine events being cancelled. There have been a number of health promotion and vaccination events occurring on tertiary sites since they returned to in-person teaching, including partnering with a community pharmacy to vaccinate. Work with Family Planning and Regional Sexual Health continues, along with private Occupational Health Providers although this has been slowed by their 'flu vaccination focus.

The DHB project team has undertaken a number of opportunities for confirming MMR immunisation status and offering vaccination alongside COVID-19 vaccination in community pop-ups and Vaccination clinics.

ADHB and WDHB have sponsored the Pasifika festival held at The Cloud over Queen's Birthday weekend. Unfortunately, on-site vaccination was not approved by event organisers, instead the project team is working with Green Cross Health and Chemist Warehouse to have a number of MMR vaccinating pharmacies support the event by promoting vaccination in their pharmacies and having anyone vaccinated entered into a DHB prize draw.



4.3. Uri Ririki – Child Health Connection Centre

The UR-CHCC team continue to support population health with National Immunisation Register (NIR), National Child Health Information Platform (NCHIP) and Noho Āhuru (NA-HH). A significant number of staff were directly affected by COVID-19.

The National Immunisation Register (NIR) administrators are being impacted by continual NIR server outages, generally at least once per day, often for 20-30 minutes at a time, with the NIR outages totaling over 34 hours since the start of the year, the regularity of these outages has worsened in 2022 whilst we await for the replacement National Immunisation Solution (NIS). When the NIR has an outage there is a loss of connection, preventing data from being entered or reviewed, or reports being run - given the state of immunisation coverage, every minute lost to a NIR outage makes it even harder to follow up our overdue children, and when clinics phone the NIR for an immunisation status check that cannot be provided, likely impacting opportunistic immunisation being offered. The Ministry of Health have now created a response team and Orion as the NIR developer are attempting to identify and correct the issues. The NIS replacement is underway, with the CIR having a form for recording 'flu vaccination, however 'flu vaccines given in primary care still message to the NIR and have seen the normal influx of messaging errors.

We are collaborating with NRHCC to facilitate NIR access to COVID-19 vaccination clinics (including outreach) to be able to offer MMR as part of the integrated immunisation initiatives. HealthAlliance have been supporting addressing a glitch with a data entry access mode to the NIR that has not functioned since a 2020 change in platform, however at this stage only NIR Immunisation status check access is available and the NIR team will support with data entry from paper records.

Use of NCHIP continues to evolve, with an update to the system about to be launched which will include the 12m immunisation event and some rules to autoclose events children are now too old to receive which will better support highlighting of overdue events. Access to NCHIP has been made available through Regional Clinical Portal and also to Plunket. Our Well Child Tamariki Ora network are now also onboarding and are enthusiastic about how this system will support their service provision. We are working with Plunket to widen NCHIP access to reach more of the WCTO nursing team, focusing first on the highest need areas. NCHIP continues to support children being enrolled with a WCTO provider – a process for children aged seven weeks old without a WCTO provider results in whānau of around 5 to 10 Auckland DHB children each week being contacted by the Newborn Enrolment Coordinator to support their enrolment. The NCHIP team is now sending the "help weave your child's protection" magnet to all Māori, Pacific and Q5 children as part of their "welcome to NIR-NCHIP" letter.

The 'Lost to Service' pathway with Ministry of Social Development (MSD) continues, however receiving data back has been a challenge during COVID-19 lockdowns. There were 16 ADHB children referred via this pathway during May 2022, with MSD able to provide updates on 10 children. The UR-CHCC are also reviewing this process for utilizing our Nohu Āhuru database for children who are lost to service before sending to MSD, with confirmation received from the WDHB Privacy and Security Group on a process.

The Māori Immunisation Case review meetings have had a refresh – the group now meets fortnightly (instead of monthly) and discusses all Māori, Pacific and Q5 children who have turned 6 months of age in the last two weeks (as opposed to the monthly meeting discussing all children who have turned 6 months old) and are not fully immunised – this change expands to include all our vulnerable tamariki in a more timely manner. We are now able to utilize the NCHIP Discover system to support preparation of these meetings which has increased time efficiency. There were 72 ADHB children discussed at case review in May 2022, with 31 children having updated contact details able to be identified via this case review to enable follow-up for overdue milestone events.

NA-HH received 85 referrals in May. Referral numbers have been strong during 2022, this year NA-HH has received the most referrals for any year since the programme started in 2017. The backlog of assessments due to COVID-19 and vacancies in delivery teams continues to be a challenge and the Hub team is working with all teams to support assessment volume and quality. The Safekids Home Safety Device Programme is now being delivered as part of the NA–HH service. Demand is high amongst whānau for beds and bedding and there are several initiatives underway to meet the need.

4.4. Before School Check (B4SC)

Auckland DHB did not achieve the 67.5% target for the high deprivation group, Māori, Pacific, and the overall eligible total population in quarter 3 (Q3). This is largely due to COVID-19 outbreaks which together with the previous lockdowns created a backlog of checks. Many appointments for the checks were either cancelled or had to be rescheduled due to whānau isolating and also staff isolating.

The providers of the B4SC service have collaborated on developing engagement plans for the rest of the financial year. Auckland DHB has agreed to focus on Māori, Pacific and Quintile 5 families – to meet monthly targets and reduce the backlog.

Planned activities to meet monthly targets and reduce the backlog are: The Vision and Hearing team (VHT) and Plunket B4SC team are meeting every two weeks to plan on re-engaging whānau; the providers will be providing checks at community events organised by the Auckland DHB Māori and Pacific Health Gains Teams; increased home visiting as well as cold-calls; running clinics in schools in high needs areas; and a backpack provided to Q5 whānau only.

In addition, due to Omicron, Early Childhood Education Centres (ECEs) were not allowing in the B4SC nurses. In response, a communication to inform ECEs that B4SC are a critical service was developed by the Community Paediatrician and the providers to arrange access for the B4SC nurses to complete the checks. More ECEs are now allowing the B4SC nurses back into their centres.

Further, the Ministry of Health is leading a transition action planning for some tamariki that may not have a completed B4SC before they start school in 2022.

The table below shows the percentage of high deprivation, Māori, Pacific and eligible population checked in Q3.

Percentage of high deprivation, Māori, Pacific and eligible population checked

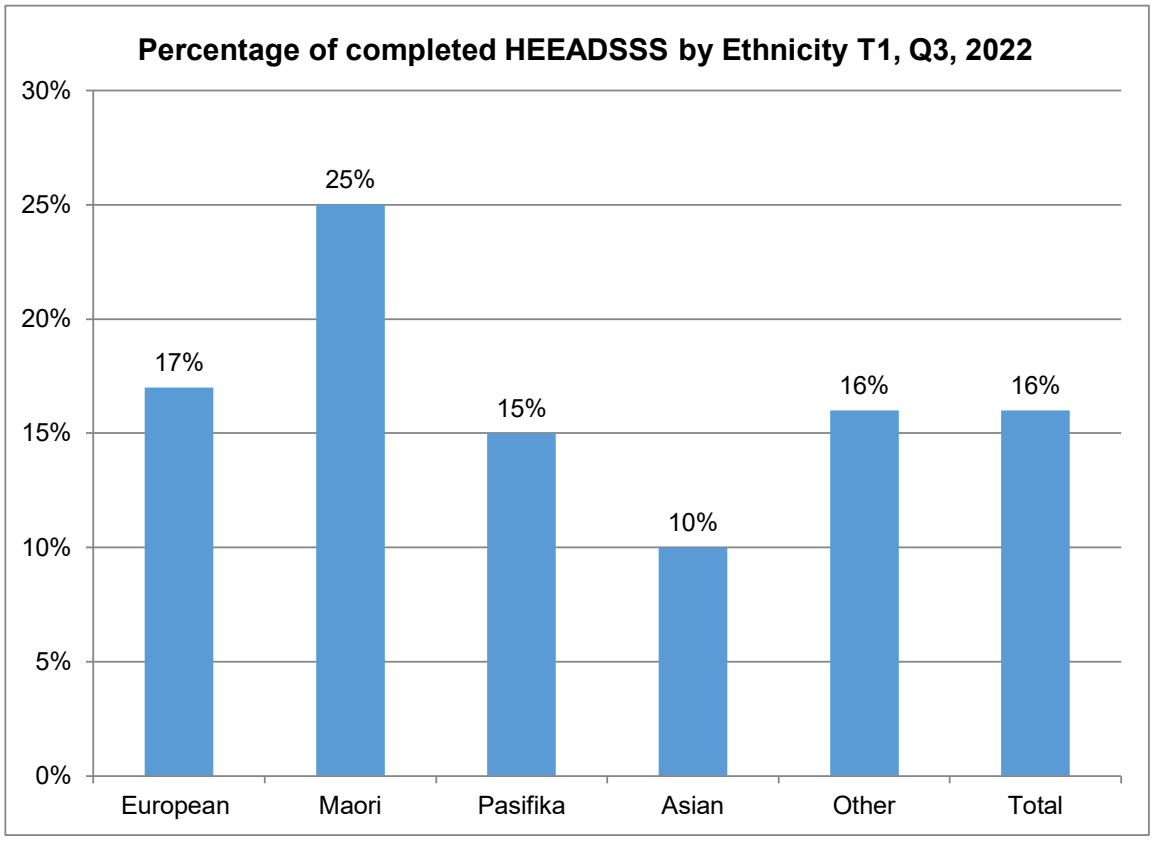
Results	High deprivation	Māori coverage	Pacific coverage	Overall coverage
Quarter 3				
Auckland DHB				
Percentage of eligible population checked	30.4	34.9	28.9	26.3

4.5. Youth Health – Enhanced School Based Health Services

The Enhanced School Based Health Services (ESBHS) programme is delivered in ten low-decile secondary schools, Alternative Education settings and the Teen Parent Unit in Auckland DHB. The programme provides youth friendly, confidential, and easy to access health services – the nurse is available at school every day, supported by a visiting general practitioner and clinical psychologist. Through this programme about 9,000 secondary school students have improved access to primary healthcare in Auckland DHB.

In Term 2, school nurses are continuing to provide the routine care they normally offer alongside a huge increase in demand for COVID related support. Schools are still continuing to have a large number of symptomatic students at school having to be isolated and sent home with advice about how to isolate, test and manage. Nurses have also continued with HEADDSSS assessments using YouthCHAT or brief assessments when YouthCHAT is not available. They act on any issues raised as they usually would. It has been, and continues to be, a very disruptive time for students and school health teams, but the teams continue to offer high quality healthcare and support to students. However, at the end of Term 1, HEADSSS completion rates are lower than previous years.

The graph below shows the percentage of completed HEEADSSS assessments in Auckland DHB funded schools. In total 16%, Year 9 students have had their assessments in Term 1.



4.6. Rheumatic fever

Numbers: The downward trend in rheumatic fever notifications since mid-2020 has continued; the ARPHS Notifications Update for the period January to March 2022 reported the lowest number of acute rheumatic fever notifications in the metro Auckland region since reporting commenced in 2010. During this period just six cases were notified across metro Auckland, none were in the ADHB district. The figure below shows cumulative counts by DHB:

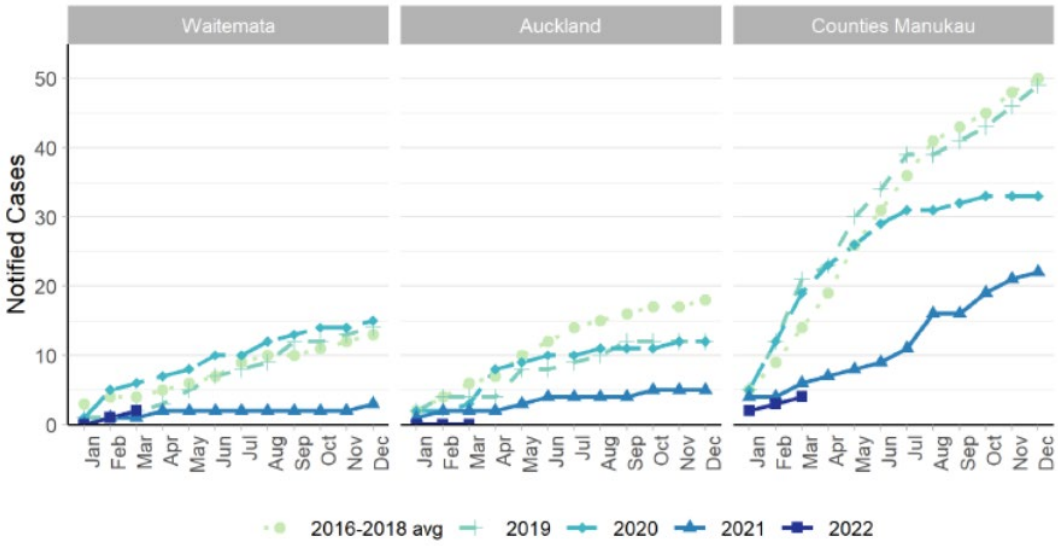


Figure 1. Cumulative monthly count of ARF cases by DHB and year, 2016-2022, Auckland Region (ARPHS/EpiSurv Data)

This trend reflects a significant reduction in the number of cases amongst young Pacific people, who have carried the major burden of rheumatic fever. Contributing factors include reduced participation in large events, border closures, possibly less Group A Strep (GAS) in the community. It remains unclear why this has occurred and why the reduction has not occurred for young Māori. This is the subject of a specific MOH project.

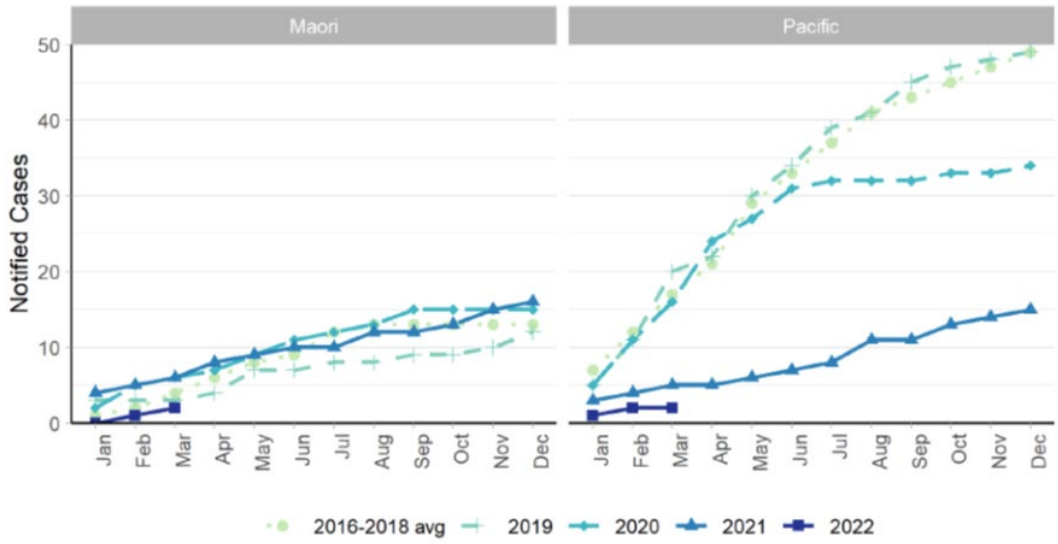


Figure 2. Cumulative monthly count of ARF cases, Maori and Pacific 0 to 19 year olds by year, 2016-2022, Auckland region (ARPHS / EpiSurv Data)

Governance: An ADHB RhF/RHF Governance group has been established led by Anthony Hawke.

The Rheumatic Fever Governance Group will:

- Facilitate a co-ordinated cross-functional Rheumatic Fever (RF)/ Rheumatic Heart Disease (RHD) service within Auckland DHB
- Maintain oversight of RF/ RHD management with Auckland DHB
- Review data to examine equity of access to healthcare services for RF and RHD patients and identify systemic issues
- Review clinical outcomes and quality data from the RF/ RHD clinical disease management group in regard to the treatment of RF and RHD and escalate any issues of concern to the Clinical Quality Board
- Review and endorse funding requests and business cases for enhancement of services and outcomes for RF and RHD patients
- Agree solutions for operational issues presented to the board that require senior leadership intervention
- Facilitate development of a regional service in preparation for the Health Services NZ implementation.

Membership includes representatives from ADHB Rheumatic Fever / Rheumatic Heart Disease Management Group (Simon Briggs, Alison Leversha), Child Health (John Beca, Emma Maddren), Adult and Long-Term Conditions (Samantha Titchener), Adult Medical (Barry Snow), Cardiovascular Services (Mark O'Carroll, Joanne Bos, Miriam Wheeler), Māori Lead/Chair (Anthony Hawke), Pacific Lead/Co-chair (ex Corina Grey), Primary Care (Jim Kriechbaum).

ADHB Projects:

Four projects are underway:

1. Free dental care (via a community dental provider) for adults with rheumatic heart disease. An evaluation is planned to include oral health status, interventions and lived experience
2. Translation of RhF animations into Te Reo, Samoan and Tongan. Animations include: How does Rhf affect my heart, penicillin injections for RhF, how to protect your heart after RhF, what does a normal heart look like, how to look after your teeth after RhF, sore throats, https://www.kidshealth.org.nz/rheumatic-fever-videos
3. A registered nurse to support patients and their whānau to identify and address unmet health need. Exploring lived experiences and working with the small group of patients with the poorest adherence to secondary prophylaxis.
4. Social worker and community health worker support for adults with RhF. The DHB long term conditions team were unable to recruit to the roles. This will now be provided via Māori and Pacific community providers.

All pilots have been funded through contracts which end in this month. A change in bicillin adherence reporting from service perspective (~80% on time delivery per quarter) to person perspective (% on time delivery over 12 months for each person) has identified a significant proportion of people who require intense support and different ways of working. Full adherence = all 12 or 13 doses over the year received on time.

4.7. Contraception

Contraception provision, including on-boarding new providers, continuing to support training and provision of clear advice to access services continues in the programme. Clinicians providing IUCDs are well positioned to upskill in the provision of other women's health procedures, and the opportunity to engage with other services is promoted to providers.

4.8. Cervical Screening

Cervical Screening coverage across New Zealand including Auckland DHB is below the national performance target of 80%. Screening coverage has been persistently inequitable. The table below shows the three year coverage to end of quarter March 30 2022 compared with period to March 2020.

Table: NCSP coverage (%) in the three years ending 30 March 2020 and 2022 by ethnicity, women aged 25–69 years, Auckland DHB and Total NZ Coverage:

Ethnicity	ADHB 3 year coverage, March 22	National 3 year coverage March 22	ADHB 3 year coverage, March 20	National 3 year coverage March 20
Māori	51.8%	55.7%	56.2%	61.8%
Pacific	52.8%	56.7%	61.5%	64.7%
Asian	50.3%	55.6%	53.4%	57.4%
Other	77.7%	75.0%	75.3%	76.5%
Total	**63.1%**	**67.3%**	**64.6%**	**70.1%**

The National Cervical Screening Programme (NCSP) has seen drop off in coverage nationally in all ethnic groups, this downward trend is evident year on year in the past three consecutive years. In Auckland DHB this trend is replicated, however some recovery is observed among 'other' women, who represent non-Māori, non-Pacific and non-Asian women. The inequity in 'recovery' trends further exacerbates existing inequities in coverage. Furthermore, Māori and Pacific women have a higher incidence of cervical cancer morbidity and mortality. Recovery activity must retain a focus on Māori and Pacific women's participation in screening, women who have never been screened or are very overdue for screening or those with increased risks such as a previous abnormal result which has not been followed up completely or according to guidance.

NCSP records suggest that some seven thousand Māori and Pacific women in ADHB would need to be screened (in addition to usual activity) to reach the coverage target 80% in these ethnic groups.

NCSP are preparing communications for health promotion of re-engagement with screening services. Stakeholders in primary care who are the main provider of cervical screening to the population, report varying levels of capacity to both provide screening services within their practices, and in relation to women's capacity to engage in screening currently. Dedicated Support to Screening Services report capacity is available and engagement from women is variable at present.

We have recently made additional funds provided by MOH for equity catch up available through POAC claiming mechanism for primary care and other organisations to claim. Existing fees can be claimed for screening provided to Maori and Pacific women, for any cervical screen that is due according to the NCSP guidelines. The additional fees provide an opportunity to claim additional

funds for providing screening with increased accessibility – after usual business hours, at weekends, in community settings or with community partners. Promotion of this opportunity will commence now that the contracts and claiming mechanisms are in place.

Further work to prepare for the shift to HPV primary screening at the National Screening Unit is on-going, this change is anticipated from July 2023.

4.9. Abnormal Uterine Bleeding

The team is supporting Auckland district's contribution to the regional Abnormal Uterine Bleeding (AUB) project. We are working closely in Auckland and Waitematā DHBs, and coordinating with CMH and Northland for a regionally consistent programme. This is a Pacific led initiative with the local work chaired by Dr Aumea Herman. The project is a response to high rates of endometrial cancer experienced by Pacific women. There are strong alignments with this work with the Northern Region Integrated Cancer Service (NRICS) endometrial cancer work programme.

An advisory group with representation of Pacific leadership, consumers, secondary and tertiary services, Māori representatives and primary care leaders has been driving the programme, Child, Youth and Women team in PFO are providing project management support to deliver the agreed improvements.

Communication around the new clinical criteria for the pathway, including updating the Health Pathway is well developed.

Improved access to appropriate diagnostic procedures and management from primary care, including funding for provision of pipelle biopsy, iron infusion and other management tools such as Mirena IUCD in primary care are key changes in the programme. Funding approval for these in secured and contracts are in place to enable claiming via the POAC service. This will achieve a high level of consistency with CMH existing programme.

Education for primary care clinicians is developed to provide online education modules and practical training, to enable more clinicians to upskill in the appropriate procedures (pipelle biopsy) as well as familiarize themselves with the new pathway and patient management.

We continue to work with CMH to develop a consistent pathway to support GP to GP referral to support access to be able to be implemented in this programme and possibly others.

An evaluation component to understand the efficacy of the pathway, and inform improved communication strategies around abnormal uterine bleeding and associated health issues is also underway.

4.10. Iron infusion in primary care

Child, Youth and Women team has built on the previous work of the Primary Care team in PFO to enable provision of iron infusion in primary care at no cost to patients. Provision of the iron infusion itself is funded for many patients by a PHARMAC special authority, according to certain criteria. Auckland and Waitematā DHBs have now been able to fund the administration fee associated with providing the iron infusion in primary care. The criteria for these will align across the three metro DHBs, providing welcome consistency. The improved access to iron infusion "closer to home" and at significantly reduced cost and inconvenience is likely to make a material difference to the wellbeing of people experiencing significant anaemia, including pregnant women, women experiencing very heavy menstrual bleeding and others. Previous analysis indicates that iron deficiency anaemia is more prevalent among Māori and Pacific people.

Preparation of updated Health Pathway and advice to primary care on the new opportunity will be undertaken to align with the claims funding being made available in the coming weeks.

5. Mental Health and Addictions

The Individual Placement and Support (IPS) employment support service has been extended through a joint RFP process across both Counties Manukau DHB and Auckland DHB. With a programme developed at Waitematā and funded by the Ministry of Social Development, an additional 16 employment consultants / kairapu tūranga mahi join mental health teams across the two districts – meaning that 400 to 600 additional people per year will have access to practical support to enter the labour market. The service is delivered in collaboration with Workwise and Mahitahi Trust and has been gifted the name "Kāpuia".

Employment consultants / kairapu tūranga mahi were welcomed in March by Auckland DHB at Manawanui Marae in Point Chevalier.

In March of this year, a proposal to fund additional FTE at The Mt Albert Club was approved and implemented. The Mt Albert Club is a flourishing day programme in Auckland DHB with a membership of approximately 70 whaiora, of which 20% are Māori. There is an average attendance per day of 31 whaiora. The new FTE is a dedicated cultural facilitator who will support The Mt Albert Club in their journey to incorporate te ao Māori into all aspects of the programme.

6. Pacific Health Gain

The focus is to continue to encourage uptake by Pacific communities of the Covid vaccination boosters and vaccinations for children aged between 5-11years; and to include the delivery of the flu vaccinations in all vaccination events. To date the number of boosters, paediatric and flu vaccinations is steadily increasing across the Auckland DHB area. However, to bolster the vaccination uptake, the Tongan Health Society is setting up short term vaccination sites in the community (Pop up events), an approach that was started last year. The short-term vaccination sites provide a range of settings that are culturally appropriate and accessible for Pacific communities, such as churches, community halls, and at cultural events.

Pacific Community Leadership Forums (Pacific ethnic specific groups –Samoa, Tonga, Cook Islands, Niue Fiji, Tokelau, Tuvalu, Kiribati and Rotuma) have been established by Alliance Health Plus. Some of the smaller nations have agreed to form the leadership groups across Auckland and Counties Manukau DHB areas. This will strengthen the community voices as their population are smaller. These groups include Tokelau, Tuvalu, Kiribati and Rotuma. The forums provide a way to engage with diverse Pacific communities quickly and efficiently about Covid response activities, information and the promotion of available resources.

Pacific Navigators are working with and amongst Pacific communities. The navigators are connectors providing communities with COVID-19 information, resources, education, linking people to welfare support and providing overall support to access COVID-19 vaccinations. The Pacific Navigators are working across the metro Auckland area which provides a regional platform to discuss current insights, convey consistent COVID-19 messages and implement similar engagement approaches when appropriate.

The Tongan Health Society is operating a Pacific Outreach Mobile health service in the ADHB area. The service provides additional focused capacity in the community to ensure COVID-19 cases are rapidly identified and managed appropriately to reduce the risk of Pacific community transmission. It also deploys primary health services to Pacific people who have an identified clinical need and who may not otherwise access primary care services.

Etu Pasifika Auckland formerly known as Mt Wellington Integrated Healthcare and The Tongan Health Society is delivering Whanau HQ services (COVID Care in the Community) to Pacific families in ADHB. The service is led by Pacific clinicians who work with whānau to complete a comprehensive household and detailed patient assessment. The service provides on-going engagement and monitoring and links whānau to existing social services where necessary.

7. Māori Health

7.1. COVID response services

The metro DHBs have a significant amount of funding committed to Māori led COVID response services. The Māori Health Gain team are working closely with Māori providers to pivot their teams to other important responses beyond COVID. Although COVID will remain in our communities, we have been working with providers to align their COVID response teams with their existing services.

8. Māori Health Pipeline

The Pipeline is one of the three prioritised areas of focus for Kōtui Hauora. The Pipeline is currently expanding in terms of project scale and staff.

8.1. Te Oranga Pūkahukahu Lung Cancer Screening Programme

This collaborative research programme is led by Professor Dr Sue Crengle (Waitaha, Kāti Mamoe and Kāi Tahu) with the Pipeline team. The team recently celebrated the first successful completion of 50 CT scans. Recruitment of primary care clinics remains a significant challenge with COVID-19 and winter pressures, however the team are working on a range of strategies. Participants report very positive experiences of both the risk assessment process and the CT scan process.

The associated COPD study will get underway shortly, after COVID-19 restrictions on the ability to perform spirometry safely, mobile vans approved by IP&C including HEPA filters and appropriate ventilation have been secured and will be deployed soon.

The team continue to plan for the expansion of the programme from October 2022 to Counties and Northland (Northern region area), with a focus on testing the performance of the risk prediction model for Māori.

8.2. Abdominal Aortic Aneurysm and Atrial Fibrillation (AAA/AF) Screening

This programme is being extended to Northland DHB, as requested by Kōtui Hauora. With project management resource now secured locally in Te Tai Tokerau. A second AAA screener has now been trained, and will be available to support the Northland expansion, and the expansion of the project to Pacific women (Pacific men were completed in 2021).

8.3. HPV Self-Testing Implementation Studies

Waitematā DHB and Auckland DHB have had a research programme for HPV self-testing for cervical screening since 2016. The new implementation research programme focuses on specific areas

relevant to the national implementation of HPV primary cervical screening planned for 2023, and has received additional funding by the Ministry of Health to expand further enabling three pathways:

- Pathway 1: GP clinic-led opportunistic offer of self-test
- Pathway 2: Offer via telehealth coordination hub with mailed-out, home-based testing
- Pathway 3: Offer via other partners in different clinical and community settings

Since November 2021 there have been three participating Tamaki Health clinics offer self-testing through Pathway 1, with nearly 1,000 women offered a self-test to date. The team are working closely with the laboratory and colposcopy services to provide results management and support through to follow up. Pathway 2 and 3 are awaiting an ethics amendment approval and National Kaitiaki Group approval and will then commence.

The results of the COVID expedited study, undertaken in Sept-Oct in 2021 is due for publication shortly.

8.4. Hepatitis C lookback and re-offer project

After a pause in the project two new part-time clinical leads have been appointed, a datamatch re-build using TestSafe local data undertaken and quality checked, a project data collection tool built, and the programme restarted. Contact efforts continue to be prioritised by clinical priority and ethnicity. Results of the completed contacting are expected in August. The project is in close contact with the Ministry of Health team leading the national Hepatitis Action Plan, and supporting a national lookback programme and Hepatitis register development.

9. Asian, Migrant and Former Refugee Health Gain Update- COVID-19

The Asian, new migrant and former refugee health gain project manager continues to support the Northern Region Health Coordination Centre (NRHCC) team to provide culturally appropriate guidance for the current COVID-19 cases, vaccination roll out plan and translated COVID-19 vaccine resources. This has included;

- Working with the MoH Equity Team to set up a dedicated pathway for Ethnic Community organisations who are providing COVID social support to be able to order RAT kits in bulk.
- Liaison between the NRHCC Outreach Team and Community organisations in organising vaccination drives. Example of the recent event organised by the Auckland Tamil Association on Sat 7th May 2022. Another example is an event on 17th June (Friday) at the Mt Roskill Masjid (Mosque). This is the first time such an event will be organised at the Mosque which has a very large congregation (approximately 450-500). Learnings will help us refine our engagement with this community.
- Regular e-updates on COVID-19 information communicated to stakeholders and e-members.
- Supporting regular data reporting on Asian and MELAA vaccination status to guide targeted outreach to ethnic partners
- Supporting ARPHS Case and Contact Management, Covid Response Unit in liaising with Community Leaders to ensure culturally appropriate support is provided to places of worship that have been locations of interest.
- Continue to work with Communications and Engagement Manager, Asian & MELAA to create appropriate collaterals for Ethnic Communities. Some examples include:
  - vaccination Q&A article published on Skykiwi this week in Chinese
  - Q&A's with Dr Hari Talreja featured in Indian Weekender
  - **call to action on getting boosters : S**hort videos with Dr Wu (Simplified Chinese), Dr Ali (Arabic) and Pharmacist Vicky (Traditional Chinese)

- Dr Ali speaking in Arabic and Pharmacist Vicky Chan speaking in Cantonese on frequently asked questions – videos available here
- a number of flyers/social tiles were created in February to support the 'Big Boost' month
- Vaccination drive-through sites posters in a range of languages
- 'How to look after you and your loved ones' flyer in Arabic I Farsi I Dari I Simplified Chinese I Traditional Chinese I Vietnamese I Korean I Punjabi I Hindi

- Promoting the Flu Campaign and creating collaterals for the metro-Auckland region available in the following languages in pdf (click on language):
  - Arabic
  - English
  - Hindi
  - Japanese
  - Korean
  - Simplified Chinese
  - Spanish

  Jpeg versions of the flyers have also been created for ease of sharing through social media platforms for stakeholders (available here)

Adult Community and Long Term Conditions

Owner: Samantha Titchener

Date: April 2022

TE TOKA TUMAI

Ngā whāinga	Kei hea tātou ināianei? Where are we now?	Ki hea te tihi o te hiahia? Where do we want to be?
1 – Te Tiriti o Waitangi in action	• We want to strengthening our partnership with the development of a Māori leadership Ropu and Māori Health Lead • Some of our teams understand and can articulate the principles of Te Tiriti o Waitangi, we will look to actively develop this across all aspects of our Directorate • Active partnership with appointment of our New Māori Health leader • We continue to seek ways to uphold Te Tiriti o Waitangi obligations and set expectations in partnership with our Māori Health leader	• Ensure we Identify and formalise Māori Health Leadership within each Service • Routinely evaluate initiatives to ensure they enable the principles of Te Tiriti o Waitangi • Support the system to collaborate with Iwi, Hapu and representative kaupapa Māori providers at service level. • Te Reo is used in everyday communication and our people have confidence in using Te Reo in their working life. • Ethnicity data, to evaluate the performance and service utilisation to inform our decisions. • Use our understanding of our Te Tiriti obligations to support integrated models of care to align with Te Mana Hauora Māori's vision and values • All our staff are up skilled to build cultural capability to achieve Pae Ora. • All plans and priorities will be agreed in partnership with our Māori Health Lead and kaimahi Māori ropu.
2 – Eliminate inequity	•Ethnicity data across services has improved enabling the services to target specific projects and respond to inequity •Our services are failing to engage Māori – our models of care do not provide for Māori and Pasifika patients •Our community hubs may not be situated in the right places to deliver for Māori •Some of our models of care are advancing partnership – partnering with Māori leaders in design and using patient experience to improve •We continue to see DNA rates that indicate high areas of inequitable service	• All priorities identified are informed by data and we utilise outcome data to track progress and measure success • All Services identify what equitable access looks like based on current NZ health data protocols • All our waitlists are consistently reviewed and pathway entry criteria in services reflect the need for earlier access by Māori and other priority populations • We will work with Māori leaders and our patients to provide models of care that are appropriate and are accessible • We develop a model of HITH that demonstrates Tino Rangatiratanga, Oritetanga and whanaungatanga • We reduce the barriers to engagement for all priority populations as identified by each service • We use language that reflects our accountabilities to health consumers and obligations under Te Tiriti o Waitangi • Māori partnership will be a part of all Directorate decision making • We develop and utilise models of care that improve access for our high-risk Pacific Peoples with Diabetes • Each Service identifies and implements a project or action/s to improve a specific area of inequity
3 – People, patients and whānau at the centre	• Our people report varying experiences when joining our directorate • Our people are not always given the tools to do their best work • We have high turnover rates in some services – Community • We have not invested time into understanding Kaimahi Māori workforce and their journey • We have Māori leadership in some business units and services. There is opportunity to increase capability to ensure our workforce reflects the population we serve	• Our patients and whānau to feel valued and welcome • We review our feedback enablers to strengthen hearing from our staff, patients and whānau • We provide work areas that are fit for purpose and that reflect Kaupapa Māori– Building 17, regional Sexual Assault Services and Point Chevalier • We understand our Māori workforce, their journey and have Māori leadership represented in our Directorate Leadership Team • We call out our own personal bias and actively work on breaking them down. • Our people stay and feel valued
4 – Digital transformation	• We have some ethnicity data however it is not consistent across all services • We do not have real time data across all services • We are not using our data to support knowing where our biggest inequities in services are and taking action to address these issues	• We have ethnicity data across all services and can readily access it • We utilise our data to make meaningful changes on equity – what are our priority areas that need focus on reducing inequities • We develop knowledge for delivering on our equity commitment • We design IT systems where Māori have the authority and decision making on how they would like to engage with our Outpatient Services
5 – Resilient services	• Clinic locations for services may not be accessible for Māori and their whānau • We have targeted our effort to support complex discharges across the organisation • Governance structures are in place in the Directorate to capture quality, risk and health and safety performance • Acute Frailty pathway has commenced on a reduced bed base • Acute NOF pathway has not commenced	• There is more work to be done to ensure sustainable model for complex discharging- which has been designed upholding Kawanatanga • NOF and frailty pathways to improve whānau centric care are in place and we will partner with Māori to seek feedback on the programme of work • We will work alongside Māori to design resources specific to older adults that engages Māori and their whānau - e.g: complex discharge, understanding aged care sector, community supports available. • We have shared care models with Primary Care that supports the follow up of patients with long term conditions
6 – Financial sustainability	• Contracts and Services are not always reflective of patient needs and requirements • A/L balances have risen during COVID • Uncertainty around Health New Zealand changes and impacts on funding and cost budget.	• Sustained delivery of agreed PVS 22/23 and FTE within budget • Savings programme is in place with metrics agreed for delivery of the programme • Contractual arrangements within services are reviewed to ensure they reflect needs of the services and specifically deliver for Māori • AL is planned proactively to support financial sustainability and staff wellbeing

Me pēhea tātou e tae ki reira?	Te Kaitohutohu	Due by
Our people are supported to expand their knowledge of Te Reo & Te Tiriti o Waitangi	All	Q1-4
All new pathways have Māori leadership or representation in their development	SCD/Ops	Q1
We will complete facilities capital process to improve our work areas – valuing our staff and mitigating H&S	GM/Ops Manger	Q4
All services will review new/revised data to ensure they capture ethnicity inequities leveraging power BI dashboards as opposed to static reporting and act on the data findings	SCD/Director	Q4
We develop an action plan in partnership with kaimahi Māori and the Māori health team to understand priority areas to enhance engagement with patients and whānau	GM/MD	Q4
We implement initiatives to enable whānau to be partners in care	All	Q3

He pēhea te āhua o te angitu? What does success look like?	Current 21/22	Target 22/23
% of staff who have accessed Ko Awatea Online Hub:Building cultural safety to achieve Pae Ora	TBC (EN)	20%
% of leaders who have completed the MDP module 'Leading for Equity'	TBC (EN)	90%
% of leaders who have completed Critical Analysis of Te Tiriti o Waitangi	5%	90%
% of new pathways/MOC on the Directorate action plan which have Māori leadership on the steering group	2	8
All currently approved capital projects will be delivered within 12 months	0	5
% of new or revised reports that have ethnicity data included	Not measured	100%
# of changes in service delivery to better engage with Māori and Pacific/Improve engagement rates.	1	5
# of services who have specific examples of projects, services and/or programmes jointly planned and delivered with Māori providers	1	5
# of partners in care initiatives	0	3

Adult Medical Services

A3 owner: Barry Snow, Director

Provider Directorate Plan 2022/23

Date: June 2022

TE TOKA TUMAI Auckland DHB

Ngā whāinga	Kei hea tātou ināianei? Where are we now?	Ki hea te tihi o te hiahia? Where do we want to be?
1 – Te Tiriti o Waitangi in action	• Appointment of a Māori Health Lead within leadership team • Kaimahi Māori capability built to respond to COVID • Low representation of Kaimahi Māori in our workforce including at leadership levels • Recruitment of Māori kaimahi is poor because existing models of care don't attract or appeal to Māori • Limited opportunity to partner with iwi and Hauora providers • Variably understanding of Te Tiriti o Waitangi and Tikanga • Clinical, operational and service processes/pathways don't evidence Te Tiriti o Waitangi	• Reconfiguration of directorate to a partnering leadership model • Increase in Māori Leadership capability • Attract, recruit and retain kaimahi Māori workforce, increase Oranga Coordinators across services, and improvements delivered and knowledge shared • Each service has a committed plan to meet Te Tiriti o Waitangi obligations and these are confirmed with service actions • Greater partnership with Ngāti Whātua, NGOs and Hauora, Māori community providers • Te Tiriti o Waitangi and Tikanga training completed at directorate and service levels for all kaimahi • Māori Health Leads are included in all clinical, operational and quality hui to implement strategies that evidence Te Tiriti o Waitangi in action
2 – Eliminate inequity	• Some measurement by ethnicity and prioritisation of Māori & Pacific on wait lists • Limited understanding of where inequities for Māori exist and action to address • Policies and pathways that dont reflect commitments to mitegate or eliminate inequities or consider obigations to Te Tiriti o Waitangi	• Equity improvement plan for each service developed with clear initiatives to achieve tangible outcomes. Removing access barriers for Māori and Pacific across all services • Measurement: Maori ethnicity gathered which is discussed at all service operational, quality and DLT hui • Equity Training: increased completion % for staff, all leadership staff, and ensured for new hires within 3 months
3 – People, patients and whānau at the centre	• Progress made on service integration (e.g. acute stroke and rehab) and models of care closer to home (e.g. Kereru dialysis centre opened, Hospital in the Home initiated) • Quality agenda in early stages of development to support improvements in delivery of patient care. Low visibility of quality improvement initiatives across directorate • H&S incidents – frequent workplace violence incidents reported • Coordination of care between hospital and community is often rated poorly	• Service delivery closer to home – identify and implement opportunities (further HiTH support, infusions) • Quality agenda defined and coordinated across the directorate with accessible list of initiatives that come out of reviews (e .g. AERC) and respond to patient feedback "you said, we did", review of risk register, SAC review presented with ethnicity of the person • M & M process to include CEA, MHL and wider team; Maori Health Leads are aware of datix events for Māori for timely response to patients • H&S directorate level plan agreed with initiatives to reduce incidents. • Improve implementation and integrate Whānau as Partners in Care
4 – Digital transformation	• Increasing but still limited ability or use of technology for remote communication • Variable data/reports to help us understand patient outcomes and service delivery • A number of manual/paper-based supporting processes in place across the directorate	• Improve IT availability and use in clinical areas including Zoom, telehealth, increased e-referrals and e-rosters • Strengthened relationship with BI and Tū Pono Aroha • Strengthen provisioning of Maori specific data • Make existing data more accessible through improved reporting and dissemination & "data citizens" within directorate.
5 – Resilient services	• Successful COVID response across services • Planned Care wait lists exceed capacity of services to recover • Acute Patient Flow demand exceeding capacity of services leading to increasing risk • Capacity of Renal dialysis has not grown with demand leading to high OT and AL • Multiple HR initiatives with some good uptake across services	• Complete implementation of COVID response (e.g. negative pressure resus) • Planned care support to reduce wait lists in Gastroenterology, Respiratory Sleep and Neurology; w/ regional engagement • Renal capacity improved, additional facility work completed to support dialysis (Kea House, Carrington add'l 4 stations) • Acute Flow: ED triage area improved, Gen Med sustainable model, Hospital Supporter & Oranga Coordinators roles integrated • Clear, coordinated HR initiatives that support wellbeing and staff retention
6 – Financial sustainability	• Limited cost reduction plan and variable mitigation plans to manage PVS • Very high levels of excess annual leave across services • Some waste/non-value add activities found across services	• Increase understanding of finances at a service level • Budget oversight of all leadership teams promoted • Identify opportunities for removing waste/non-value activities to improve efficiency

#	Me pēhea tātou e tae ki reira? How are we going to get there?	Te Kaitohutohu	Due by
1	Formalise and extend Ngā Rōpū in directorate	MHL / Director	Q2
	Increased completion of Te Tiriti training	Director	Q3
	Recruitment and retention practices support Māori candidates and kaimahi	Director	Q3
2	Equity profile developed for each service within Adult Medical.	MHL / GM	Q4
	Māori quantitative and qualitative and systems put in place to support improvement	MHL / GM	Q3
	Each service supported to implement equity improvements (incl Oranga coord)	MHL / SCDs	Q4
3	Quality and H&S agenda prioritised, defined and implemented	GM / AHD	Q4
	Service delivery closer to home (HiTH, Neuro Infusions, Sleep)	SCDs	Q3
	Implementation of new Whānau as Partners in Care initiatives	ND / MHL	Q4
4	Data /reporting future state plan defined and agreed with services and BI	GM	Q4
	Provide zoom capability to all wards / CNs, install comms for isolation areas	GM	Q2
5	Level 2 Triage and Waiting Areas safe and welcoming (short & long term solutions)	SCD-Level 2	Q1, Q4
	6 hour target plan developed and implemented	SCD-Level 2	Q4
	Endoscopy recovery plan agreed and implemented (incl collaboration w region)	SCD-Gastro	Q4
	Sleep service direction and plan agreed (incl collaboration with region)	SCD-Respiratory	Q4
	Renal strategy defined with clear workforce and facility requirements	SCD-Renal	Q1
	Implementation of Gen Med model of care and initiatives.	ND, SCD-Gen Med	Q3
	Neurology wait list reduced	SCD - Neuro	Q2
	Infectious Diseases model refined for sustainable COVID response	SCD – ID	Q2
6	Cost reduction plan including management of PVS defined and implemented	Ops/SCD	Q3

#	He pēhea te āhua o te angitu?	Current (2021/22)	Target (2022/23)
1	Create Māori Rōpū governance for partnership and Tino Rangatiratanga	~50%	90%
	Staff have signed off completion of all cultural training or evidence		
	Representative employment of kaimahi Māori across all services	3.9%	7.8%
2	Equity plan developed for each service with quarterly review w/ DLT	2 developed	8 plans developed
	Each service implements equity improvement initiative(s) in 22/23, incl whānau room kaupapa as per Dame Naida Glavish & Oranga Coordinators	0	8 or more improvements
	Māori and Pacific wait time <= Other in Endoscopy, Sleep, Neuro	TBC	All 3 services
	Data measures with inequities identified; ethnicity dashboard developed	Commencing	Delivered
3	Quality and H&S agendas defined and coordinated across directorate	Not developed	2 x Implemented
	Service delivery closer to home (HiTH, Neuro Infusions, Sleep)	1/3 Commenced	3/3 Implemented
	Whānau as Partners in Care – Kōrero Mai and Virtual Visiting Implemented	Commencing	10/10 Wds Implemented
4	Data citizens and reporting requirements identified for each service	Partially	Fully
	IT improvements for all ward areas, incl whiteboards with ethnicity	Partially	10/10 Wds Implemented
5	ED triage and waiting improved, Oranga Coordinators integrated	TBC	Implemented
	Improve against 6 hour target	73%	> 80%
	Colonoscopy & Gastroscopy targets recovered	P1: 72%; P2 col: 57%; P2 gas: 20%; P3: 71%	P1 90%<14d, P2 70% <42d, P3 70%<84d
	Shorter wait times for sleep service, enhance bariatric surgery patients	Mean wait 407 days	90% < 120 days
	Renal FTE in place to manage current dialysis demand	Partial development	Delivered OT/AL reduced
	DCCM ICU Sustainability Model Implemented	In progress	Complete
	Gen Med LOS and Occupants reduce	ALOS > 4 days	3.5 days
	Neurology ESPI and overdue FU reduced	250 breach; 1450 FU	TBC
	ID model refined for sustainable COVID response	Under review	Implemented
6	Balance directorate budget	$6.4M Unfavourable	Breakeven position

Āhua Tohu Pōkangia – Perioperative Services

A3 owner: Nigel Robertson, Director

Date: June 2022

TE TOKA TUMAI Auckland DHB

Ngā whāinga : Our priorities	Kei hea tātou ināianei? Where are we now?	Ki hea te tihi o te hiahia? Where do we want to be?
1 – Te Tiriti o Waitangi in action	• Māori Health Lead appointed to Directorate Leadership Team • Tika Rōpu – governance and partnership established. • Māori remain under-represented in our workforce and we recognise there are opportunities to improve Kāwanatanga. • Centralised provision of services (one size fits all) that does not fully engage Māori leaders • Work in partnership with Surgical services to manage all Māori patients. • Limited understanding of how institutional racism and bias impact on Perioperative service structure and delivery	• Service design and development in partnership with Māori leaders and iwi representatives to ensure Te Ao Māori informs and drives the work we do • Māori Health Leads and Kaimahi Māori have a key strategic role in co-designing services. • Recognise and manage bias in the system and enable re-organisation of the perioperative pathway to address this • Our Māori service users and their whānau experience a culturally safe service • We protect and honour the beliefs and values of Māori patients, staff and communities. • We enable support Māori staff and whānau to feel safe to express and share their culture within our organisation
2 – Eliminate inequity	• Monitor and prioritise Māori and Pacific patients in planned care. • Emerging visibility of the equity impact of our services • Partnering with Kaiārahi Nāhi and Pacific navigators to optimise pre-operative preparation for surgery • Scrum process and e4P dashboard to gather data on wait times for patients, searchable by ethnicity • Tika Rōpu included in reviewing business cases and capex submissions • Targeting our efforts to improve opportunities for Māori and Pacific employees, including prioritisation in staff recruitment • Involvement of Tika Rōpu members on interview panels, including interview packs to reflect Te Ritenga	• Partnering with surgical services and community/iwi providers to reduce access barriers to the health system. • We have a solid understanding of the equity impact of our current service delivery and explicitly consider equity impacts in all decisions re: service design/resourcing. • Measuring and reporting health outcomes for all community and ethnic groups and ensuring equitable access • Monitoring and reporting the equity impacts of all Perioperative service delivery and proactively learning to mitigate those equity risks. • A workforce that reflects the diversity of our community.
3 – People, patients and whānau at the centre	• Developing understanding of the value of Kaupapa Māori and its application to Perioperative services • Acknowledgment of the importance of whanaungatanga • We recognise the impact of SARS-CoV-2 global pandemic on staff wellbeing, recruitment, retention and planned care delivery • Encourage use of Te Reo Māori in everyday interactions with patients, whānau and staff members. • Exploring different models for improving staff and whānau wellbeing and sustainability • Nurse Navigator teams embedded in directorate leadership team and planning meetings. • Flexible workforce	• Acknowledgement of Kaupapa Māori and whanaungatanga as part of our Tikanga best practice guideline across perioperative services • We work in partnership with our people, patients and whānau to co-design services that respond proactively to the needs of our diverse population • Embrace and enact Te Whare Tapa Whā on the perioperative journey of our patients and in the wellbeing of our Kaimahi Māori • All Māori and Pacific having Kaiārahi Nāhi and navigator team not just the exception i.e. patient cancelled / non contactable • Framework / structure including Tika Rōpu, it's role and how it is incorporated as BAU for embedding the articles in all Perioperative activities • We work with Te Toka Tumai Employee Support Centre to improve the wellbeing of our workforce
4 – Digital transformation	• Enabling better data use with Power BI dashboards for PiMs to understand OR's at a glance and e4P to identify risks /inequities. • T-doc upgrade due • Tū Pono Āroha project planning underway • Improved service visibility to other stakeholders with better use of data • Continue to explore and provide virtual consultation space in pre-assessment clinic • First efforts to reach out into community / whānau space to undertake clinic consults • Utilising data to guide decisions on session allocation, patient prioritisation, utilisation of resources	• Significant improvement of visibility of where our patients are and how we prioritise them according to defined criteria including ethnicity • Involvement in the development implementation of Tū Pono Āroha supporting integrated care solutions for patients and Perioperative service staff maintaining and building on current systems and ensuring T-Doc is stable • Surgical and other stakeholders have BAU access to dashboards of OR activity and planning functionality for booking patients • Develop virtual clinic appointments in conjunction with Tika Rōpu and Māori health lead, with outreach to community based healthcare providers and whānau • Building on current IS - Extending Safersleep to the patient bedside in PACU
5 – Resilient services	• We recognise the risk that regional, national and international workforce shortages place on perioperative services • We are engaged with workforce recruitment and retention project as part of a regional initiative. • Working to enhance workforce diversity and explore and remove barriers for Kaimahi Māori • Improve visibility of staffing models of care to other stakeholders • Developing flexible workforce model with RNAA course for anaesthesia assistance and PACU work for anaesthetic technicians • Working with surgical services to re-model Auckland City hospital case mix under Health NZ governance • Commencing Manaakitia/Schwartz rounds with wider craft groups as a staff wellbeing initiative • Commencing discovery phase of sterile sciences services department re-design on Grafton site • Supporting Brachytherapy business case to enhance care of wāhine	• Workforce imbalance rectified, with fewer vacancies and ability to run all services • We are fully staffed to our budgeted FTE • Better engagement with Kaimahi Māori and Pacific prospective staff • Other stakeholders have better understanding of perioperative staffing models • Flexible workforce embedded and new MOC explored for scrub role in the OR. Create an educational pathway for staff to be flexible across the roles • Discussions with AUT about scrub module in the new perioperative practitioner course • Wellbeing initiatives embedded as BAU for all staff • Clear view of revised case mix for ACH within Northern region, HNZ and long-term relationship with private providers for planned care established • Sterile sciences service department re-design project underway
6 – Financial sustainability	• Regular review on MOC and procedure volumes to ensure service size – several budget bids submitted for MOC changes to reflect service demands • Prudent minor capex management to stay within budget envelope • Appropriate due diligence on major capex and fleet replacement to ensure best user experience and value • Working with surgical services to minimise harm to capital items in clinical use • Awaiting 2022/23 final budget	• All services right-sized, with agreed MOC to service procedural demand, including after-hours service • Fleet replacement and other major capex items completed for 2022/23 round • Regionally focused provision of services will be the norm • Maintain financial awareness with responsible decision making • Maintain sustainability of service within budget • Ensures best use of funds – be creative

#	Me pēhea tātou e tae ki reira? How are we going to get there?	Te Kaitohutohu : Owner	Due by	He pēhea te āhua o te angitu? What does success look like?
1	Continue to work with surgical and other stakeholders to embed strategic roles for Māori leaders and kaimahi in all directorates	*Nigel Robertson*	Q4	Kaimahi Māori are involved in decision making through prioritised agendas and leadership within all decision making forums
	Use hui and other communication strategies to inform and educate staff on Te Tiriti and Tikanga Māori as they relate to healthcare systems	*Nigel Robertson; Leigh Anderson*	Q4	Design and implement programme if education for all staff utilising in-service times
	Co-design perioperative service improvements in partnership with Tika Rōpu and MHL network for improved community engagement	*Nigel Robertson*	Q4	Documented co design engagement strategy to be referenced and adhered to
2	Further development of patient pathway dashboards to better understand barriers to care based on ethnicity and social disadvantage	*Nigel Robertson; Wendy Guthrie*	Q4	Visible patient pathway dashboards which are referenced for scheduling purposes
	Collaborative work with surgical services to establish clear waitlist management parameters to eliminate inequity	*Nigel Robertson; Wendy Guthrie*	Q4	Documented waitlist parameters to be referenced by Surgical and Perioperatiave
	Work with the recruitment team to break down barriers to employment for Māori and Pacific staff	*Leigh Anderson*	Q4	Documented processes to support and encourage the employment and on boarding of Māori and Pacific staff
3	Whakawhanaungatanga is at the centre of our work with professional stakeholders and partners (patients, whānau, health providers)	*Nigel Robertson*	Q4	Services are co-designed to proactively respond to the needs of a diverse community
	Work with our Maori leadership and wellbeing leaders to embed the principles of Te Whare Tapa Whā for our patient and Whānau plus our staff through hui and learning sessions both, kanohi ki te kanohi and on-line	*Nigel Robertson* *Leigh Anderson*	Q4	Te Whare Tapa Whā is referenced within the structure of meeting agendas and minutes; used within our communication strategy and taught within the teaching package at inservice education times Improved staff retention/reduced staff turnover
	Work to further develop and embed the principles of the Kaiārahi Nāhi and Pacific navigator teams to the wider workforce	*Leigh Anderson*	Q4	Our workforce better reflects the values and diversity of the community
4	Further develop dashboards to improve visibility of patient pathway by maintaining data analysis and workforce development	Nigel Robertson	Q4	Improved and accurate tracking of patient journey through the perioperative service
	Work with the BI team to collaborate on tools to improve efficiency and productivity in the surgical patient pathway	Nigel Robertson; *Wendy Guthrie*	Q4	
	Explore ways to reach community based Whānau and providers to deliver care and assessment of patients virtually	*Nigel Robertson*	Q4	Primary and community health providers have greater access to our service information and advice for patients and whānau
5	Use all tools at our disposal to optimise recruitment and retention of staff and skill-mix, with special attention to the future workforce required for re-modelled facilities	*Leigh Anderson*	Q4	Staffing to establishment is achieved for all craft groups, with a "plus 1" scope of practice introduced for nursing and AH staff "Plus 1" – means an extended role of scope of practice is offered to all staff
	Continue to develop the flexible workforce, through HPCAA scope of practice change and education/training initiatives with tertiary providers	*Leigh Anderson*	Q4	We have a clear strategic view of role and direction of Te Toka Tumai within the Northern District of HNZ, with the ability to implement relevant MOC changes
6	Work within budget parameters as determined by governance of NZ healthcare and ensure best value for our service when making budget decisions	*Alison West*	Q4	Long-term major capex and fleet replacement planning is maintained in out –years under HNZ Work with regional partners to achieve financial sustainability Service is right-sized to deliver according to demand forecasting

Cardiovascular Services

A3 owner: Joanne Bos, Interim Director

Date: March 2022

TE TOKA TUMAI Auckland DHB

Ngā whāinga : Our priorities	Kei hea tātou ināianei? Where are we now?	Ki hea te tihi o te hiahia? Where do we want to be?
1 – Te Tiriti o Waitangi in action	• Our services are not tailored to the needs of Māori • We do not involve Māori or consider the articles of Te Tiriti o Waitangi principles enough in service design • Staff have varying degrees of understanding of the articles of Te Tiriti o Waitangi and Tikanga Māori • Limited Māori leadership capacity • There is no Māori representation on the Transplant Board	• All design decision making is aligned with the artides of Te Tiriti o Waitiangi • Services have been reviewed and changes implemented in partnership with Māori to better meet Māori needs • All DLT members have an understanding of the articles of Te Tiriti o Waitangi and Tikanga Māori • All ward senior members have an understanding of the artides of Te Tiriti o Waitangi and Tikanga Māori • Tikanga best practice is embeded in all services, including outpatients • All Māori patients have a positive experience that reflects their cultural needs • Māori leadership capacity increased • Transplant Board has permenant Māori leadership representation
2 – Eliminate inequity	• Our data and reporting provides limited insights into differences in health outcomes by ethnicity • High numbers of Māori patients unable to attend outpatient appointments • Patient pathways do not optimally provide for (or attract or appeal to) our Māori and Pacific patients • Our Māori and Pasifika workforce numbers do not reflect or meet the needs of the community we serve • Māori and Pacific face barriers to access services for a variety of reasons, including the cost of transport	• All data and reporting related to service delivery and outcomes, indudes a breakdown by ethnicity • 90% or more Māori and Pacific patients attend outpatient appointments • Patient pathways are reviewed and changes implemented in partnership with Māori and Pacific • Our workforce understands cultural safety and reflects the community we serve • Easy to access options are available to address the cost of travel and other barriers to treatment for Māori and Pacific
3 – People, patients and whānau at the centre	• Whānau visiting patients are not always received and treated with compassion and cultural sensitivity • Māori health services having varying degrees of input into patient and Whānau journey	• Whānau of patients are considered partners in care and are treated with respect and cultural sensitivity • Māori health service engaging at earlist opportunity to support Whānau as required
4 – Digital transformation	• There is no electronic link between orders for diagnostic tests and the results and in some cases, processes are completely paper based	• Electronic order entry and results sign off is implemented for all echocardiograms and planned for all diagnostic tests
5 – Resilient services	• The vascular service is very vulnerable across the region • High waitlist numbers and wait times for patients across many of our services • Mortality rates for first time CABG patients are higher than ANZ benchmarks • Overall the directorate has high levels of sick leave and high annual leave balances • ECHO wait times are significant risk	• A regional vascular services model is implemented that provides a resilient, regional service • All waitlists achieve their performance metrics • Mortality rates for first time CABG patients are trending towards ANZ benchmarks • Sick leave taken and annual leave balances are trending towards organisation targets • ECHO wait time reduced to safe time period
6 – Financial sustainability	• Under delivery of elective throughput impacting on our revenue position • Reduced revenue from international patients due to COVID-19	• Sustained delivery of agreed 2022/23 Price Volume Schedule - improved revenue positon • Revenue from international patients returns to pre-Covid levels

#	Me pēhea tātou e tae ki reira? How are we going to get there?	Te Kaitohutohu : Owner	Due by
1	A review of our Vascular outpatient service led by kaimahi Māori has commenced	Director / GM/ SCDs	Q3
	Te Tiriti o Waitangi education sessions for Directorate leaders	MHL	Q4
	Plan and commence rollout of Tikanga Best Practice in all services to improve cultural safety and engagement for staff and patients	MHL	Q4
	Continue the work of the COVID response Ropu to support Māori inpatients	GM/ND/MHL	Q1
	Increase Māori Health Leadership capacity	Director/GM/MHL	Q3
	Permenanent appointment of Māori Leadership on the Transplant Board	GM/MHL	Q1
2	Gather data to understand and address the barriers to access, including Transport	OMs / MHL	Q3
	Update all operational and outcome reporting to include an ethnicity breakdown	GM / SCDs / OMs/ MHL	Q2
	Undertake an assessment to understand the impact of our current recruitment processes on Māori and develop an improvement plan	DLT	Q3
3	Develop guidelines for whānau of patients that recognise their role as partners in care and their cultural needs, aligned with the organisation-wide policy	NUMS/ MHL	Q1
4	Implementation of electronic orders and signoff for echocardiograms	GM	Q2
5	Implement the agreed regional vascular services model to improve resilience	SCD / GM / OM/MHL	Q1
	Develop and implement an equity focused improvement plan for waitlists	GM / OMs /MHL	Q1
	Establish a cross-directorate working group to review and optimise clinical outcomes	Director	Q1
	Develop and implement leave management plans for individuals with excess leave	NUMs/Oms	Q2
6	Cost saving targets identified and reported against for directorate	Ops Mgrs / SCDs/NUMs	Q1
	Performance against PVS is monitored monthly to address barriers to achievement	GM	Q1
	When COVID restrictions allow, re-establish relationships with Tahiti	GM	Q1

#	He pēhea te āhua o te angitu? What does success look like?	Current (end 2021/22)	Target (2022/23)
1	A review of the Vascular O/P service to improve service for Māori has commenced	Not started	In progress
	Monthly Quality Review meetings include a standing agenda item to educate the Directorate Leadership Team on Te Tiriti o Waitangi and equity	0	1 per month
	DLT have completed specific Te Tiiriti o Waitangi workshop	Pending	Completed
	Commence rollout of Tikanga Best Practice in CVICU and cardiology outpatients. Māori Health Lead to partner with ward and unit leadership to implement education for the articles of Te Tiriti o Waitangi and Tikanga education	Not started	Completed
	Permanently resource surge response ropu to create a support team for Māori	Pilot	Established
	Increased Māori Leadership capacity	Planned	Established
	Māori leadership attends and contributes to all Transplant Board hui	Planned	Established
2	Attendance by Māori and Pacific referred for an O/P appointment increases	75%	90%
	Data is gathered to understand the barriers to appointment attendance	Not started	In progress
	An ethnicity breakdown is included in all operational and outcome reporting	Inconsistent	Consistent
	The proportion of Māori and Pacific staff is increased	Māori – 3.5% Pacific – 4.0%	6%
3	Consistent application of guidelines for whānau as partners in care across the directorate	Inconsistent	Consistent
4	Business case for electronic orders and sign-off for ECHOs is unapproved	Initiated	Completed
5	Implementation has commenced for the vascular regional services model	Planned	In Progress
	ESPI 2 and ESPI 3 compliance is increasing and consistent across ethnicities	Breaching	Compliant
	Mortality rates for first time CABG patients are trending towards ANZ benchmarks	Outlier	In-line
	Excess Annual Leave and # of staff with Sick Leave>80 hrs is reduced	A/L = 18% S/L = 200	A/L = 6% S/L = < 100
6	0% negative variance against budget	35%	0%

Clinical Support Services

A3 owner: Ian Costello, Director

Date: June 2022

TE TOKA TUMAI Auckland DHB

Ngā whāinga	Kei hea tātou ināianei? Where are we now?	Ki hea te tihi o te hiahia? Where do we want to be?
1 – Te Tiriti o Waitangi in action	• On-going training for GMs and Directors on Te Tiriti o Waitangi and a plan for DLT training is being developed • All services engaged in Rangatahi programme, including a proposed 2FTE internship in Phlebotomy • Māori leadership development pathways in development, including MHLs appointed • Developing a strategic 1 year on-boarding program to ensure cultural safety and competence in Labs • Māori leadership undertaking reviews of services; developing recommendations for alignment with Te Tiriti o Waitangi and formulating 1-3 year work plans • Joint recruitment approach with Patient Management Services. Entry and career pathways agreed, prioritising Māori.	• All our staff are committed to providing culturally safe care • Every service has a culturally engaged and empowered workforce • All services are successfully implementing clear strategies for Māori workforce recruitment and career development • All service leaders have an understanding of, and are applying articles of Te Tiriti o Waitangi into services plans and decision making • Greater representation of Māori in leadership roles, including fully integrated MHL roles in all service development • Kaimahi Māori rōpū are supported by Māori Health Leads and greater rōpū within the organisation • MHL have agreed work plan based on CSS and Māori Directorate A3's with agreed actions and time frames
2 – Eliminate inequity	• Options to gather specific feedback on quality, equity performance and patient experience is developing • Equity measures embedded in service scorecards • Services are identifying improvements required, focusing on patient's need and access to treatment • Ethnicity breakdown provided for all Radiology waiting lists • Māori patients are being prioritised across modalities within Radiology • Interventional Radiology Māori patients outside of Auckland are prioritised and provided with transport and accommodation. • Identified high DNA rates within Radiology and Allied Health	• All data and reporting related to service delivery and outcomes includes a breakdown on ethnicity • Māori and Pacific patient experience is measured, reported and improvement targets identified • All services are successfully implementing clear strategies for Pacific workforce recruitment and career development • Radiology and Allied Health booking and scheduling supports equity and alignment to organisational strategy • Barriers to access across all services are easily identified and solutions embedded • Strategic on boarding to ensure cultural competence and safety in all services
3 – People, patients and whānau at the centre	• Regional strategy review of access to Diagnostic imaging • Further development of Telehealth and innovative service access underway in Allied Health and Laboratories • Health and Wellbeing staff groups in development, including promoting Kia Ora tō Wāhi Mahi resources • High staff turnover in certain services • Māori applicants are prioritised and short listed during recruitment • Bereavement care pathway review underway • Facilities inadequate to support healthy workplace and clinical quality in laboratories and radiology	• People and wellbeing strategy and actions embedded across all services • Our people are equipped and supported to lead and be successful • Patients experience a service that meets their expectations and can easily feedback comments for improvement • Novel and innovative service models remove barriers to patient and whānau access • Whānau as partners in care principles are embedded in Directorate services • All people leaders apply Kia Ora tō Wāhi Māhi resources to create a healthy workplace together • All services have an action plan based on stay interviews and exit interviews • Bereavement care pathway improvements implemented • Facilities in labs and radiology support a healthy workplace , quality service delivery and minimise exposure to hazardous substances
4 – Digital transformation	• Robotics Process Automation review completed, priorities agreed and pilot completed in CRO • Exploration of 3D printing opportunities within Clinical Engineering • Reporting and analytics options under review for all services • Machine learning opportunities and market scan underway • Digital opportunities identified and a strategy agreed for each service • Telehealth, digital consultations and communication options identified • Funding approved for E-Ordering scoping and design requirement • E-prescribing business case in development • Digital Pathology platform business case in development with region	• Robotics Process Automation implemented where appropriate • Reporting and analytics that support continued service improvement and inform clinical services across DHB • Machine learning opportunities identified and a strategy agreed • Digital solutions quality, safety and efficiency benefits fully realised • Telehealth, digital consultations and communication implemented where value is clear • Implement/align a 3D printing strategy for the organisation/region • Fully implemented e-ordering and e-prescribing system
5 – Resilient services	• Workforce, capacity plans, business models under review as part of COVID recovery • Regional clinical networks in development for Laboratories and Radiology • Safety 1 and Safety 2 culture education and training in planning stage • Outcome based measures identified, options for measuring and reporting in review • H&S structure is being embedded • Just Culture training completed for all service leadership roles. Just Culture approach to decision making embedded at Directorate level. Further role out and role modelling to continue • Effective systems and processes in place to identify, capture and respond to risk and safety issues • Career frameworks for Pharmacy, Clinical Engineering, Radiology, Allied Health and Laboratories agreed. New consultant roles implemented in Allied Health. Review options for other services • Talent mapping completed at service leadership level • Awaiting funding approval to transfer the Pt Information to a more secure platform	• Capacity plans, business models and workforce strategies support quality, efficiency, diversity, equity, Directorates and org priorities • Regional clinical networks established for Laboratories and Radiology that support regional management of capacity and demand • Our services have agreed research strategies aligned to strategic priorities • Safety 1 and Safety 2 culture embedded across all services • Outcome based measures identified and regularly reviewed • H&S oversight and compliance fully embedded including Safe 365 • Just Culture is embedded in decision making • We have effective systems and processes in place to identify, capture and respond to risk and safety issues • Career framework for all services in place. Top of scope working and strategies implemented • Talent development strategies developed and implemented • Professional leadership structure implemented in all services. Supervision framework implemented where appropriate • Systems support protection of patient information and privacy
6 – Financial sustainability	• Service and business models under review, including funding and service billing approach to align with Health NZ. Deliver a balance budget against the 2022/23 allocation • Priorities and unmet need options agreed with other Directorates • Savings plans agreed with all services • Significant capital investment in facilities and equipment replacement programme will be necessary within the next 5-years, potentially with insufficient capital funds available	• A funding model that reflects our true costs across the directorate and enables achievement of a balanced budget • A systematic process used to establish and budget for staffing FTE and skill mix, to ensure the provision of timely, appropriate and safe services using Trendcare and Care Capacity Demand Management (CCDM) methodology where appropriate • Reporting capability supports our referring clinical services to manage demand and identify appropriate use of services/ tests/ imaging including Choose Wisely • Benchmarking against international practices for our quality & safety metrics and for services (e.g. staffing levels) • An agreed strategy for managing key equipment replacement and facilities constraints building on the developed 10 year plan

Clinical Support Services

A3 owner: Ian Costello, Director

Date: June 2022

TE TOKA TUMAI Auckland DHB

#	Me pēhea tātou e tae ki reira? How are we going to get there?	Te Kaitohutohu	Due by
1	Embed recruitment strategy Finalise Māori language option in PAS Māori leadership development pathway and talent mapping agreed Māori Health lead workplan in development	GM/HRM/SCD/Ops GM/Ops Director/HRM	Q1 Q1 Q2
2	Capability needs assessment of priority workforce groups Equity adjuster implemented in Rads and AH with support of navigator team Māori and Pacific DNA strategy developed for Rads and AH Embed Pacific recruitment strategy Finalise Pacific language options in PAS	GM/AHD/SCD/Ops	Q3
3	Review access to diagnostic imaging, booking and scheduling in Radiology as part of TDI programme Labs facilities options review completed	GM/Ops	Q3 Q1
	MSK pathway implemented AH OP metrics agreed	AHD/SCD GM/SCD	Q4 Q2
4	HTRAC business case implemented RPA processes implemented 3D printing strategy complete E-orders and e-prescribing business case development underway	SCD/Ops/GM/HITM GM/HITM GM/HITM	Q3 Q2 Q4
5	Career frameworks implemented for Pharmacy, Clin Eng and Allied Health Career frameworks development for Labs and Rads Professional leadership structure agreed and implemented for Labs and Rads Workforce and capacity plans completed for Labs and Rads Leadership structure implemented in Rads PAPU strategic partnership model implemented	AHD AHD/GM/SCD AHD/GM/SCD GM/SCD Dir/GM/SCD Director	Q3 Q3 Q4 Q3 Q3
6	Request with hA to enable ethnicity data made available in the LIS	Pending	Pending
	Savings plans completed & tracked	GM/FM/Ops	Q2
	Planned care delivery on tack	GM/Ops	Q1

#	He pēhea te āhua o te angitu? What does success look like?
1	Māori workforce representative–recruitment, retention strategies fully implemented All Māori staff who wish to be on career progression / leadership pathways have the opportunity Māori language option available in booking and contact centre Māori Health lead work plan completed and priorities agreed and being implemented
2	Workforce capability build plan scoped and implemented Understand barriers to access for Māori and Pacific patients across all services and solutions implemented in partnership Pacific workforce representative–recruitment, retention strategies fully implemented Pacific language options available in booking and contact centre
3	Improved access to diagnostic imaging through TDII programme implemented Improved access to AH outpatient services implemented Labs and Rads facilities upgrade agreed and in implementation Staff turnover reduced
4	E-orders and e-prescribing implemented RPA process implemented and demonstrating benefits HTRAC implemented and efficiencies achieved 3D printing strategy agreed for the region
5	Career frameworks approved and implemented for Pharmacy, Clin Eng & Allied Health Professional leadership roles in place across all services Leadership structure in Rads PAPU quality improvements achieved
6	Planned care Radiology and Allied Health trajectory Service savings plan PAPU savings realised

Mental Health and Addictions

A3 owner: Hineroa Hakiaha & Tracy Silva Garay, Co- Directors

TE TOKA TUMAI Auckland DHB

Ngā whāinga	Kei hea tātouināianei? Where are we now?	Ki hea te tihi o te hiahia? Where do we want to be?
1 – Te Tiriti o Waitangi in action	To Tatou Taituara Haerenga •Our Equity Journey is in place and we have begun the journey with our people together - 'He waka eke noa' •Understanding Mana Whenua and Crown true partnership - the partner Journey begins to eliminate racism, strengthen cultural safety practice, begin cultural competency to achieve health equity	To Tatou Taituara Haerenga In everything we do, we will reflect Te Tiriti in action and in 2022/23 we will specifically focus on the following: •Everyone is on the journey to ending unjust and unfair Māori health inequities by growing a capable workforce that achieve tangible health outcomes for whānau Māori •Supporting matauranga Māori –Māori knowledge and intelligence , utilising concepts of Haere Mai, Manaaki, Tūhono, Angamua, the values of Te Toka Tumai to inform and embed an equity driven workforce and culture at all levels of the directorate •Trust and shared decision making - Māori oversight and ownership of decision-making process necessary to achieve Māori health equity •Shared understanding of true Tiriti partnership by the people leaders across the directorate that is embedded and implemented •People leaders supporting cultural competency teams
2 – Eliminate inequity	To Tatou Taituara Haerenga: Dismantle policies and drivers that cause inequity: We have begun the journey together with our people across the MH Directorate. Use of data: Data is collected by ethnicity to support identification and monitoring of inequities	To Tatou Taituara Haerenga: In everything we do, we will look to eliminate inequities and in 2022/23 we will specifically focus on DLT leadership in the services in true partnership to lead and support eliminating of policies, procedures and processes, and the use of data, to support the dismantling of institutional racism
3 – People, patients and whānau at the centre	Care Planning: HQSC Connecting Care pilot project on care planning and communication across inpatient and community completed in 2 sites. We do not have a standardized care planning process across all services	Care Planning: Care Planning will be in place across all services
	Zero Suicide: No consistent approach to suicide prevention across our services. Tira Tumanako Governance Group for Zero Suicide established	Zero Suicide: Implement the Zero Suicide Framework in all services (beginning with pilot site in C&Y portfolio group) over 3years
	Incident Reviews: Incidents reported reflecting the humanity of those impacted. HQSC project to involve whanau in incident review processes completed, but limited reach in terms of progress and learnings	Incident Reviews: Re-organise our processes and system where information is compassionate of tangata whaiora korero, and addresses institutional barriers and racism Have a cohesive process that involves tangata whaiora and whānau in the incident review process to inform service improvements and ensure Te Tiriti compliant and equity enablement
	Our People •Workforce Strategy and Plans in place for Nursing and Medical workforce •Allied Health workforce plan in draft •Medical sustainable framework process underway 2022/23 •Administration and management development framework developed •Wellness group but no directorate wide Wellness Plan •Succession mapping completed and needs ongoing review •Workforce does not reflect our population and we do not have a suitably equitable or targetted recruitment process	Our People •Nursing Strategy renewed for 2022 – 2025 •Allied Health workforce plan implemented •Medical workforce plan is rolled across all services is reviewed and rolled out 2022/23 •Medical sustainable framework process developed and implemented 2022/23 •Administration and management development framework in place •Staff actively engaged and supported in the development and implementation of a Wellness Plan •Succession mapping updated, further leaders identified and associated leadership support initiated •Recruitment of a workforce that is equitable with the use of Te Rau Ora's Recruitment Model and a MH recruitment campaign
	DLT Visibility: Increased visibility via webinars and Zoom. Staff feedback indicates a desire for this to be on going, as well as face to face contact	DLT Visibility: DLT visible and known to all staff across the Directorate - Whanaungatanga with Staff that is face to face
4 – Digital transformation	Technology: Lack of technology negatively impacts upon flow across adult acute MH services. Capital committed for adult services acute flow technology & business case accepted	Technology: Technically enabled acute flow and care planning across 9 adult services
	Telehealth: Telehealth is not widely used out of COVID lockdown	Telehealth: Increased use of telehealth as part of access and choice for tangata whaiora and whānau and where clinically indicated
5 – Resilient services	Integrated Primary Mental Health: Lack of cohesive & integrated approach between specialist mental health services & primary care	Integrated Primary Mental Health: Primary care receives increased support from specialist services to manage people presenting with mild to moderate mental health issues
	COVID response plans: COVID response plans are well established and resiliency plans are in place.	COVID response plans: COVID plans are refreshed and updated in line with MOH DHB guidelines
	MHCAS: Need to support ED staff in caring for people presenting to ED in MH and A crisis.	MHCAS: Staff in ED feel more confident in providing compassionate care to people presenting in MH and A crisis
	Housing: Auckland DHB is a pilot for the Homelessness transition initiative to house 70 people over the next 4 years for people with severe mental health issues and high and complex needs based on the Housing First model.	Housing: Tangata whaiora with complex MH and housing needs have sustainable housing with appropriate support services to live well in the community
	Employment: Insufficient intensive placement consultants to meet fidelity and support people with severe MH issues into employment	Employment: Increased resourcing to better support people with severe mental health issues into sustainable employment
	Just Culture: Managers have had access to DHB Just Culture Training but this has not extended to informal managers/influencers.	Just Culture: All people leaders and influencers have completed Just Culture training and are implementing this approach in their environment
6 – Financial sustainability	Financial Sustainability: MH funded by FTE input. In the process of refining CCDM	Financial Sustainability: Adequately staffed with a competent and confident workforce
7 – Quality, Safety and Risk	Quality Safety and Risk: Mental Health Directorate Quarterly Quality, Safety and Risk meetings with our service groups	Quality Safety and Risk: Embed an integrated quality, safety and risk framework that is aligned with the ADHB

Mental Health and Addictions

A3 owner: Hineroa Hakiaha & Tracy Silva Garay, Co- Director

TE TOKA TUMAI Auckland DHB

#	Me pēhea tātou e tae ki reira? How are we going to get there?	Te Kaitohutohu: Owner	Due by
1	Te Tiriti in Action - To Tatou Taituara Haererenga • Te Tiriti Training for Leaders to honour the Treaty partnership and address institutional racism and to walk the talk of honouring Te Tiriti in our services • Critical Te Tiriti Analysis training for leaders to implement into practice undertaken • MH&A Tiriti Compliance Tool is developed and tried and tested for its rigor and in use on Policies • Pōwhiri processes for all new staff members continuing to be reviewed	Co-Director Maori	Q2
	• Rukuhia te io tangata: Deep dive into data to review if we have what is needed across our services, identify our gaps and develop a plan • Training provided by AUT to small group of cultural leaders to read the data and understand the narrative. Extend out to our SCDs, OPS, NUMs. • Information explorers are trained and grown in the Directorate to support data extraction and analysis at service level	SCD Maori	Q2
2	Eliminate Inequity - To Tatou Taituara Haererenga • Develop a framework that can support the Directorate to have policies that are Treaty compliant and equity able. • Develop a plan to implement the framework within the Directorate • Use of data use to evidence inequities and support the Directorate to address access to services for Maori • Develop a tool from training forums (3) that recognises inadequate Tiriti compliant policies that will eliminate inequities • Utilise the Pae Ora model to implement policies.	Co-Director Maori	Q3
3	Care Planning • Update the audit framework and audit contemporary care plans • Develop and trial a new care plan process • Provide training to support this work	Allied Health Director	Q3
	Zero Suicide • Implement the seven elements of the Zero Suicide Framework (ZSF) across the Directorate, initially within the Child and Youth Portfolio, including CAMHS and Regional Services – the seven elements are Lead, Improve, Train, Identify, Engage, Treat and Transition • Co-governance lived experience and Maori group is recruited and the whanaungatanga process has begun.	Allied Health Director	Q4
	Incident Reviews • Engage in Phase 2 of the HQSC serious events and restorative practice • Develop process for distributing and sharing learning summaries is in place • Embed systems and processes that have been developed	Co-Director	Q3
	Our People • Workforce planning Nursing strategy 2022 – 2025 to be completed • Allied Health workforce plan draft published, socialised and implemented. • Allied Health career framework is implemented • Regular SMO engagement undertaken • Develop a pipeline of future psychiatrists in MH&A • MH Act training is provided. • Develop and implement a Wellness Plan • Succession Mapping: Engage informal leaders as well as formal leaders in the plan of mapping • Keep offering opportunities for people to act up/cover be seconded	Nurse Director, AH Director, Medical Leaders, DAMHS, SCDs, General Manager, Operations Managers, HR Business Partner	Q4
	Visibility of DLT • Continue with Engagement plan implemented previously with people leaders and staff, including Directorate wide, however face to face halted due to Covid • Re-instigate Engagement with level 4 leaders via breakfast meeting started and halted due to Covid • MH intranet is kept up to date and reviewed • Regular weekly webinar series post COVID with Level 3 managers and monthly Directorate wide webinars	Co-Director	Q2

#	He pēhea te āhua o te angitu? What does success look like?	Current (2020/21)	Target (2021/22)
1	Te Tiriti in Action - To Tatou Taituara Haererenga • All people leaders have completed the training and have a plan to implement in their service • Service leaders will be able to support their teams to undertake Critical Te Tiriti analysis of all current policies, new policies and any change proposals	To be commenced	Pending
	• People leaders and their teams are analyzing data to monitor and address inequities • Data is routinely collected on ethnicity across all of our services • Individual service groups will be utilising data as part of their approach to decreasing inequity	To be commenced	Pending
2	Eliminate Inequity - To Tatou Taituara Haererenga • The framework has been implemented, reviewed and refined as necessary • Ethnicity data is captured and utilized to inform inequities for Māori	To be commenced	Pending
3	Care Planning • Documented care plan process/policy • All clinical staff trained • Evaluation process reveals high uptake with fidelity	To be commenced	Pending
	Zero Suicide • Zero Suicide Framework is understood within the Mental Health Directorate • Zero Suicide Framework is implemented within the Child and Youth portfolio	To be commenced	Pending
	Incident Reviews • Process for distributing and sharing learning summaries is in place. • Increase in Tangata Whaiora and whanau who are invited to participate in incident reviews and feedback on their experience • Consider using a restorative justice lens on the Complaint process	Commenced	Pending
	Our People • Engagement with nursing staff to develop the next 3 year strategy • AH workforce plan is signed off by key stakeholders and socialised through AH workshops • Monthly SMO and RMO meetings occur • Medical staff attend MH ACT training • Work with HR and Director of Training to improve training opportunities offered to registrars. • Identify secondment and leadership opportunities for SMOs • Wellness Plans developed at the local team level to meet the needs of kaimahi • Succession mapping: Succession maps updated for 2022-2023 • People engaged in leadership opportunities such as acting up, secondments, training	Commenced	Pending
	Visibility of DLT • MH Directorate virtual whakatau established to fit with Covid 2022/23. • DLT will have attended MDTs, business meetings and establish meeting with level 4 leaders. • Engagement survey shows improvement in engagement and visibility of people leaders. • Hits on intranet site and feedback on content/ongoing management • Regular webinars will have taken place	Commenced	Pending
4	Digital Transformation • Technology is in place and utilised to support adult acute flow and stakeholders, including tangata whai ora, whanau, primary care and specialist services	In progress	Pending
	Telehealth • Adult services have access to, and are utilising technology for adult acute flow work • Level 4 leaders promote use of virtual care with clinicians, and service users are aware of the choice to engage with services through virtual care • Increase proportion of Zoom consultation as compared to telephone	In progress	Pending

Mental Health and Addictions

A3 owner: Hineroa Hakiaha & Tracy Silva Garay, Co- Director

TE TOKA TUMAI Auckland DHB

#	Me pēhea tātou e tae ki reira? How are we going to get there?	Te Kaitohutohu : Owner	Due by
4	Digital Transformation: HIT capital business case to support adult acute flow work approved and implementation phase underway	General Manager	Q4
	Telehealth • Identify barriers, and address, where possible, to support virtual care uptake for clinicians and service users • Develop case for all staff in mental health to have laptops 2022/23 • Ensure in the development of new facilities that telehealth spaces are available Provide information to whaiora about the choice of virtual care and review uptake	General Manager	Q2
5	Integrated Primary Mental Health • Review process occurs 9 month post implementation to obtain GP feedback • Primary care nurse specialist position is re-scoped to meet the needs of primary care	Co-Director	Q3
	COVID Response Plans: Keep abreast of changing environment and guidelines and refresh as appropriate	Nurse Director	Ongoing
	MHCAS • Functional MHCAS Steering group comprised of MH and ED leadership oversees implementation of the MHCAS project plan • Project plan for 2022/23 developed in collaboration with ED, including training, feedback loop for ED staff, tangata whaiora and whanau	General Manager	Q3
	Facilities All services have clear maintenance plans that are regularly monitored • Directorate wide approach to ensuring facilities, including temperature control, meet Health and Safety regulations • All upgrades to existing facilities, or alternative facilities, are driven by MOC • Taylor Centre: Business case for permanent alternative facility to fit CMHC contemporary model of care completed	General Manager	Q2
	Acute flow Across Adult Services • Review project findings progressed to confirm, and identify options to address, bottlenecks across the system • Undertake literature review of contemporary models for community acute services • SMO component of URS review is undertaken • Plan developed for Core 24/7 model	Co-Director	Q2
	Housing • Rapua Te Āhuru Mōwai- ADHB Mental Health Homelessness Pilot service model is co-designed, fit for purpose and implemented • Continual review and refinement of the model involving key stakeholders • Housing Specialist role in TWT to source appropriate housing once housing assessment and whaiora housing needs identified by social work team • Housing coordinator role in TWT to support whaiora with their own housing to be discharged in a timely manner, through access to enhanced support hours for up to 3 weeks for whaiora	General Manager	Q2
	Employment • Implementation of expanded IPS model • Establish a Regional Governance Group and ensure there is an equity lens	General Manager	Q4
	Just Culture: Continue to embed the Just Culture framework in all people related processes	Nurse Director	Q2
6	Financial Sustainability • MH Funded by FTE input • Be actively engaged in the Health NZ and Maori Health Authority new structure	General Manager	Pending
7	Quality Safety and Risk • Reinstate Q, S and R process with service groups • Nurse call systems replacement for CFU and TWT • Anti-ligature work undertaken in CFU	Co-Director	Q3

#	He pēhea te āhua o te angitu? What does success look like?	Current (2020/21)	Target (2022/23)
4	Integrated Primary Mental Health • Post implementation satisfaction questionnaire indicates that GPs are happy with the service provider • Increase in primary care credentialed nurses, communities of practice established • Training and clinical supervision are offered to all credentialed nurses • The NS role is re-scoped and fit for purpose	To be commenced	Pending
	COVID Response Plans • All staff are aware of COVID plan and where to find it. • All plans are on HIPPO.	In progress	Pending
	MHCAS • MHCAS Project plan implemented and updated. • Maybe add some more in here about what will be realised from the project plan	To be commenced	Pending
	Facilities • Facilities are well maintained, meeting health and safety requirements for clients, whanau and staff. • Facilities that are upgraded, or new to MH, support the delivery of a contemporary MOC for the service • Taylor Centre: Procare House refurbishment and move is progressed	In progress	Pending
5	Acute Flow Across Adult Services • Options to address Acute Flow issues identified along with recommendations • Literature review completed to inform options for future community acute MOC • SMO component of URS implemented and embedded • Implementation of agreed plan for Core 24/7 model	In progress	Pending
	Housing • People who fit the criteria for Rapua Te Āhuru Mōwai are referred to, and housed through, the new service • Reduction in people with high and complex needs not being discharged when clinically ready due to inability to access appropriate housing • Housing sourced for homeless whaiora in TWT that ensures they are on a sustainable housing pathway • Whaiora with existing accommodation, and whanau, have their support needs identified and addressed to support timely discharge from Te Whetu Tawera.	In progress	Pending
	Employment • Additional IPS consultants integrated into services ensuring an equitable approach is taken to which services they are located with • Increase in service users supported to access employment and education	In progress	Pending
	Just Culture • Healthier reporting culture realised through greater incident reporting • Feedback from staff who have been involved in Incident Review processes shows alignment with Just Culture principles • Our people are socialised to Just Culture 'See me for who I am'	In progress	Pending
6	Financial Sustainability • Adequately staffed with a competent and confident workforce	In progress	Pending
7	Quality Safety and Risk • Framework implemented and reviewed across the MH Directorate • Nurse Call system replacement is completed • CFU is anti-ligature compliant in the HDU	In progress	Pending

Patient Management Services

A3 owner: Alex Pimm, Director

Date: June 2022

TE TOKA TUMAI Auckland DHB

Ngā whāinga Our priorities	Kei hea tātou ināianei? Where are we now?	Ki hea te tihi o te hiahia? Where do we want to be?
1 – Te Tiriti o Waitangi in action	• Māori kaimahi are progressively being supported into leadership roles • Māori Health Lead in post in directorate and active part of leadership team • People leaders undertaking Te Tiriti o Waitangi training as it's available in the organisation • All Māori candidates that meet essential criteria for positions are offered interviews • The use of te reo and karakia is embedded; with the improvement of te reo pronunciation and use • Te Tiriti o Waitangi is often not addressed in Policies.	• More Māori leadership capability in decision making roles • Developed internal career pathways for Māori staff with other directorates • People leaders complete Te Tiriti o Waitangi training and learnings applied throughout directorate mahi • Constant improvement of te reo, karakia and tikanga best practice • Our policies reflect our Te Tiriti o Waitangi obligations
2 – Eliminate inequity	• To Thrive programme is available to eligible staff, this continues to develop accessibility for Māori and Pacific staff • We acknowledge the importance that equity plays in health; however we're at the beginning of this journey • Cultural training is not available for all our staff	• Strengthened recruitment into entry level roles, with a presence at various available forums e.g. HCA Earn and Learn, hospital supports, partnering with Ngāti Whātua • All staff understand and able to articulate what equity is in Te Toka Tumai • Cultural training available for all our staff • Our workforce reflects the diversity of the Auckland population • Developed career progression pathways in place and opportunities are shared with staff focusing on To Thrive staff members
3 – People, patients and whānau at the centre	• Capturing of patient experience metrics are limited to specific services • Limited patient representation in service design and reconfiguration initiatives • Limited understanding of service impacts on the overall patient experience but strong desire to do best for patients and whānau • Flexible working policies introduced where feasible • Appropriate union engagement; variable staff engagement but improving worker participation in key work • Redesigned health and safety committee	• Patients and whānau have a positive experience within our services at all times • Patients and whānau are engaged in key service developments • Good quality patient experience data is available for all appropriate services • High levels of staff engagement across all services • Leaders are capable and competent • Performance and development plans in place for all leaders and managers • Evidence that good quality, standardised staff induction and orientation programmes in place and utilised • Effective systems and processes in place to identify, capture and respond to risk and safety issues
4 – Digital transformation	• Increasing use of live dashboards to support real-time decision making • Limited or out-dated technology in place to support service delivery • Data quality and accuracy issues due to multiple entry of the same information, transcribing information from system-to-system and permissive systems	• Technology is used to support service improvement and day-to-day operations • Technology is used to support staff engagement • People are enabled to do their job to the best of their ability • Quality, safety and efficiency gains through use of technology are realised
5 – Resilient services	• Services are sometimes reactive despite significant improvement in planning and forecasting • There can be delays for service to respond to changes in demand • Service models have remained unchanged in some areas, whilst significant change has occurred in other services	• Services are able to flex to meet demand, remaining responsive to patient needs • Patients wait no longer than necessary • Consistency across service models
6 – Financial sustainability	• Higher than desired spend on overtime, excess annual leave and agency usage • Delivered within budget largely due to significant staff vacancies	• Sustainable financial position that supports best practice and high quality service provision • Minimal usage of overtime and agencies • Resourcing decisions supported by evidence and best practice
7 – Quality, safety and risk	• Integrated quality and safety into our everyday conversations, with particularly focus on risk • Quality and safety data is limited and doesn't always include the patient's voice or support decision making and prioritisation • Large numbers of policies that require review being worked-through and need an equity lens • Restraint action plan in place, policy revised and processes being reviewed	• Improved use of Datix and other data for incident reporting and response action planning • Service risks are known and escalated with mitigation plans in place • Up-to-date policies and procedures in place • Culture of assessment and de-escalation with restraint being an intervention by exception

#	Me pēhea tātou e tae ki reira? How are we going to get there?	Te Kaitohutohu : Owner	Due by
1	• Development of 'our people' Māori strategy • All staff complete Te Tiriti o Waitangi and tikanga best practice training offered org wide • Review PMS policy and guidelines to ensure Te Tiriti o Waitangi is upheld	Māori Health Lead	Q4
2	• Cultural competency training to be available for all staff • Targeted recruitment strategies partnering with mana whenua	Director/ Māori Health Lead	Q4
3	• Unions and workers (including HSRs) to be supportive to participate in key programmes of work • Continue to support embedding of Whānau as Partners in Care work	Director / Nurse Director	Q4
	• Continue to deliver the To Thrive programme and evolve programme in response to feedback • Wellbeing addressed by everybody for everybody, everyday	Director	Q3
4	• Access to quality data to enable service improvement where required • Implement new orderly and transit digital system	Director	Q4
5	• Continue to support the roll-out of Care Capacity Demand Management across the org • Further embed capacity and demand modelling into day-to-day work and use to plan services	Director	Q4
6	• Live within our means	General Manager	Q4
7	• Development of a comprehensive risk register for each service • Use all available data to tell our story and identify service priorities	Director	Q4

#	He pēhea te āhua o te angitu? What does success look like?	Current (end 2021/22)	Target (end 2022/23)
1	• All Māori staff to have opportunity to move through developmental and leadership pathways • All leadership roles will have completed and embedded Te Tiriti o Waitangi and tikanga best practice training • Māori staff numbers are reflective of the DHB population or greater • Policies have been adjusted to recognise Te Tiriti o Waitangi obligations	Pending	Pending
2	• All key leadership roles will have completed cultural training • Our workforce reflects the diversity of the DHB population	Pending	Pending
3	• We understand what's important to our patients from our services by using the patient portal	Pending	Pending
	• Reduction in staff turnover and unplanned leave • Level 4 and 5 NZQA qualification courses are in place • Identified managers have participated in Management Development Programme • Employee Support Centre accessible to our staff, 12 champion roles active	Pending	Pending
4	• Digital technology (orderly and transit system) in place	Pending	Pending
5	• Services are responding to predicted variances in demand	Pending	Pending
6	• Year-end budget position is breakeven	Favourable	Break-even position
7	• Each service has a comprehensive risk register in place • Service performance metrics established for each service	Pending	Pending

7.2

Ratonga Hāparapara - Surgical Services

A3 owner: Duncan Bliss & Richard Sullivan, Directors

TE TOKA TUMAI Auckland DHB

Ngā whāinga : Our priorities	Kei hea tātou ināianei? Where are we now?	Ki hea te tihi o te hiahia? Where do we want to be?
1 – Te Tiriti o Waitangi in action	• Directorate are beginning our journey of understanding how we uphold Te Tiriti o Waitangi. • Facilitate opportunities for Māori staff to be supported to leadership roles within the directorate are in their infancy. • Establishing environment to proactively attract, recruit and grow Māori talent • Bicultural signage, facilities are currently inconsistent across the directorate	***Kāwanatanga*** • Completed Te Tiriti o Waitangi and Leading for Equity training • Te Reo Māori and Karakia is embedded within the Directorate • Proactive Māori workforce development – leadership pathways and succession planning • Shared understanding and language for people leaders that focuses on culturally safe service provision for Māori whānau • Whānau feedback loop • All kaimahi have undertaken training to facilitate culturally safe care for staff ***Tino Rangatiratanga*** • Setup a Surgical Services Māori Cultural advisory group – Ratonga Hāparapara rōpū • Our directorate attracts and retains Māori talent through our vision and commitment to equitable outcomes, and supporting career and leadership development • Proactively attract, recruit and grow Māori talent • Work in partnership with Māori service providers ***Ōritetanga*** • Create an environment that is welcoming, and recognised by kaimahi and whānau. • Use of te reo greetings by kaimahi • Address Māori kaimahi shortfall through implementation of non certified or non registered workforce and advocate for tangata whaiora • All DLT have completed Te Tiriti o Waitangi and Leading for Equity training • Embed an SOP addressing barriers to attendance are overcome through assistance with travel costs, kai vouchers etc. • Bicultural signage is consistent across the directorate ***Wairuatanga*** • Promote events such as Te Wiki o Te Reo Māori week, Waitangi day celebrations, Matariki awards and promotion for Kaimahi Māori across the directorate • The use of Te Reo Māori and Karakia encouraged across the service • Educating ourselves in the updated Te Tiriti o Waitangi principles, and educating the workforce in Tikanga Māori
2 – Eliminate inequity	• Shared commitment to Māori health equity and action • The Kaiārahi Nāhi rōpū are identifying where inequities are throughout the Māori patient journey from surgical waitlist to procedure • Pacific Health Navigators are utilised to improve the patient journey, identify and address system issues and barriers to access and reduce the waiting time, initially from wait listing to surgical treatment across all surgical services • Priority focus on reducing waiting times for Māori patients and Pacific patients	• Expand equity competence across multi disciplinary teams - RACS equity training and org wide offerings • Leaders are supported to improve communication, patient experience and outcomes through cultural safety and mana engagement principles • Service re-design/system change based on equity findings and insights continue • Focus earlier in the planned care pathway • Reduce waiting times within compliance of MoH guidelines, prioritising Māori patients and Pacific patients • Barriers to attendance are overcome • Explore community models of care with health partners • Priority equity adjusters i.e. move all Māori to P1 or P2 rather than 1up or 30 days given per inequity such as lower life expectancy, Higher Mental Health rates, bias.
3 – People, patients and whānau at the centre	• Building a workforce that better reflects the communities we serve by focusing on Māori candidates in recruitment pathways and practices • Creating extended roles to support the patients through their surgical journey i.e. Oranga Co-ordinators • Historical medical model that doesn't allow us to place patients and whanau at the centre of care • High turnover within our workforce with policies leading to our people fitting into institutionised systems • Surgical periop review (number of reviews)	• Directorate attracts and retains Māori talent • Intentional opportunities for kaimahi Māori to connect through new and existing forums • Policies that support Whānau partners in care • Hospital in the home supported and utilized • Partner with our people to create the safe and healthy workplace that we strive for • 7 principles from the surgical/periop review

Ratonga Hāparapara - Surgical Services

A3 owner: Duncan Bliss & Richard Sullivan, Directors

TE TOKA TUMAI Auckland DHB

Ngā whāinga : Our priorities	Kei hea tātou ināianei? Where are we now?	Ki hea te tihi o te hiahia? Where do we want to be?
4 – Digital transformation	• The equity adjusted weighting tool is being used for Urology bookings, and being developed for other services (standardise) • Real time data dashboard available and in use by the Kaiārahi Nāhi rōpū in 9 services • Real time data dashboard available and in use by the Pacific Health Navigators in 9 services	• The equity adjusted weighting tool for surgical booking is in use and embedded in each of our services and staff are aware and understand the why • Real time data dashboard is used to track all Māori patients across priority services • Real time data dashboard is used to track all Pacific patients across priority services • Alerts/Service Now that track through the patient journey
5 – Resilient services	• Workforce • Neurosurgery physical restructure • Surgery/Trauma Service Review • Surgery Perioperative review completed • Regional Services being established inline with health reforms from July 1st 2022 • Changing culture of use of 3rd party providers • Living with COVID	• Maintain two way directorate communication using multiple channels that connect our people with leaders, each other, priorities, support that's needed and what is happening that is making a difference • Effective and efficient services that respond to surges in hospital capacity, unplanned events, changes in technologies resulting in increased demand, and maintain delivery of planned care across the Directorate. • Staff well-being is a high priority ensuring they can deliver high quality healthcare
6 – Financial sustainability	• Unfavorable financial position with revenue wash-up risk for acute over delivery displacing planned care • CAPEX list • Leave balances increasing	• Deliver a balanced budget against the 2021/22 allocation with minimised disruption through capacity constraints
7 – Quality, Safety and Risk	• Systems and processes implemented to have directorate overview of Quality, Safety and Risk using the organisational tools available • Four members of our Surgical rōpū are Champions for Māori patient experience • The 'Just Culture' programme has been identified as a DHB priority and the Directorate see it as a key focus area over the coming year	• Building on the progress made by capturing themes across tools and creating an action to support the needs captured • Focus on timely action by working with the QSR Directorate • Improved mechanisms to increase feedback from Māori whānau • All people managers completed and putting into practice the Managing Employee Behaviour in a Just Culture module

#	Me pēhea tātou e tae ki reira? How are we going to get there?	Te Kaitohutohu : Owner	Due by
1	Establish targeted Te Tiriti o Waitangi leadership needs analysis and support	Director	Q1-Q4
	Prioritise capability building and career development for kaimahi Māori	HRM	Q1-Q4
2	Embed online modules that build capability in equity	HRM	Q1-Q4
	Embed coaching programme from the Kaiārahi Nāhi rōpū in each service through Nurse Specialists across the Directorate	ND	Q4
3	Scope and implement improved recruitment processes and practices	HRM	Q1-Q4
	Establish and embed surgical rōpū, and other opportunities to connect, for kaimahi Māori within the Directorate and across the organisation	HRM	Q1-Q4
4	Scope and implement equity adjusted weighting tool across all surgical services	Director	Q4
	Scope and implement real time data dashboard for priority services	Director	Q3
5	Bed increase across Neurosurgery and General Surgery fully recruited to, with a focus on increasing our Māori workforce	ND	Q1
6	Monthly tracking of financial performance	Director	Q3
7	Implementation of the complaints and reporting racism module within Datix across the Directorate	Director	Q4

#	He pēhea te āhua o te angitu? What does success look like?	Current (end 2021/22)	Target (2022/23)
1	DLT and People Leaders that have completed organisation wide Te Tiriti o Waitangi training	40%	100%
	% of kaimahi Māori as members of DLT or People Leaders	10%	26%
	DLT and People Leaders that have completed organisation wide equity training	45%	70%
	Services that have re-designed/adjusted their service delivery and pathways based on Kaiārahi Nāhi findings, insights or coaching programme	15%	100%
2	% of Māori patients services fail to engage/do not attract	19.58%	5%
	% of Pacific patients services fail to engage/do not attract	17.20%	5%
	% of Māori patients that have waited for periods beyond MoH guidelines	42%	Non-Māori Non-Pacific 40%
	% of Pacific patients that have waited for periods beyond MoH guidelines	36%	Non-Māori Non-Pacific 40%
3	% of Māori workforce across the Directorate	3.2%	8%
	# of Māori attending Directorate specific opportunities to connect	1.9%	15%
	# of Māori attending organisation wide opportunities to connect (i.e. Kāhui Hononga hui and network)	5%	100%
4	Services that have an equity adjusted weighting tool in use	100%	100%
	Priority services that have a real time data dashboard in use	0	7
5	Beds opened to agreed established volume	12%	5%
6	Year-end budget position is balanced	40%	20%
7	Datix modules implemented across all services	Forecasting unfavourable	On budget
	% of Māori patients who engage in feedback mechanisms	0%	100%
	DLT and People Leaders that have completed all organisation wide Just Culture training	TBC	TBC

Starship Child Health

TE TOKA TUMAI

Ngā whāinga	Kei hea tātou ināianei? Where are we now?	Ki hea te tihi o te hiahia? Where do we want to be?
1 – Te Tiriti o Waitangi in action	• Committed to applying Te Tiriti o Waitangi in action & developing awareness of equity across the CHD. • Early steps towards recognizing the status of mana whenua and mātāwaka. • Emerging understanding of our obligations and commitments under Te Tiriti o Waitangi. • Recent appointment of Māori to key leadership roles including foundation funding in place for additional Māori Health Team roles • Haumaru Hononga operating within Puawaitahi to improve outcomes and experiences of Māori and promote equity • Racism exists within CHD	• Prioritise, privilege & resource Māori health from indigeneous rights-based perspective. • Develop solutions by Māori for Māori. • Mana whenua and iwi relationships/partnerships are developed with strong engagement and reciprocity principles. • Māori appropriately represented at all levels of governance, decision-making. • Māori data sovereignty observed across CHD. • Racism within CHD is recognised and addressed. • Active partnership with Māori providers to enable service integration and planning. • Leaders have comprehensive understanding of Te Tiriti o Waitangi, equity and anti-racism practice and begin to challenge the dominant health discourse.
2 – Eliminate inequity	• Commited to equity programme guided by equity profiles to identify and begin to resolve inequities within services. • Range of equity initiatives underway: patient focused booking, was not brought programme, kaiārahi nāhi and Pacific care navigators, priority whānau and tamariki project, pathways and outcomes programme, including framework for measuring impact on equity	• Directorate policies & strategies align with Te Tiriti o Waitangi, Pae Ora, Te Toka Tumai Pou • Robust health equity analysis routinely undertaken across policy and fiscal decisions. • Māori health equity inititiatives prioritised and funded. • Performance improvement, monitoring and accountability mechanisms in place to ensure equitable health outcomes for Māori. • Te reo, tikanga, taonga tuku iho and indigenous models of health embedded across CHD • Clinical pathways and service reviews ensure equitable health outcomes for Māori.
3 – People, patients and whānau at the centre	• Māori workforce does not reflect service use and feel unsupported. • Series of Hone Hurihanganui/Heather Came workshops delivered. • Range of directorate wide and service specific equity intiatives underway. • Workforce fatigue managing competing priorities as clinical, service and social complexities increase and COVID-19 continues. Significant workforce shortages. • We do not resource or utilize culturally appropriate mechanisms to seek patient and whānau voice.	• Workforce is culturally safe, committed and equipped to address racism and discrimination in all its forms. • Workforce is responsive to the health needs and aspirations of Māori. • Māori workforce reflects service use. Pacific workforce reflects service use. • Workforce resourced to meet the increasing complexity of our case mix and patient communities. • Routinely utilise patient and whānau feedback to design solutions by Māori for Māori. • Clinical pathways reflect insights and expertise of patients and their whānau.
4 – Digital transformation	• Data inadequately identifies health inequitites • Data is stored in diverse and ad hoc databases. • We have a comprehensive digital library of clinical guidelines • Increased utilisation of telehealth and other virtual service-delivery • Our digital and community engagement capability is segmented and accessible to only some parts of the Directorate.	• Capture data to understand the biggest inequities for Māori • Utilise data to inform and make meaningful changes to services and clinical pathways. • Service equity dashboards assist CHD to be accountable. • Data is stored appropiately and data sovereignty processes are established. • Data collection and management systems integrated across organisation, region and nationally. • Timely access to data insights to support operational and strategic decision making and prioritisation.
5 – Resilient services	• Regional critical care capacity impacts on planned care. PICU redevelopment 2-years to completion. • Reviews are planned/underway for vulnerable services: pain and respiratory. Review methodology does not prioritise Māori health equity. • Community services heavily impacted by COVID secondments. • 6 clinical pathways completed and 3 implemented. Methodology doesn't prioritise Māori health equity. • Clinical pathways and outcomes and clinical excellence functions not integrated.	• Critical care capacity safely meets acute and planned care needs. Pathways optimised to safely deliver high quality care in non critical care settings. • Integrated approach to pathways and outcomes that prioritise Māori health equity. • Clinical pathway and reviews prioritise Māori health equity.
6 – Financial sustainability	• Activity-based funding model does not reflect true costs. • COVID impacts ability to forecast and recover activity and costs. • Non-resident revenue heavily reliant on patients from Tahiti and has reduced. Pricing structure inconsistent. • No sustainable funding allocated to key Māori roles or Te Tiriti o Waitangi and equity within CHD.	• Capacity–based funding mechanism for national services. • Legislated as National Children's Hospital and funded as such. • Sustainable and diversified non-resident revenue stream. • Clinical Documentation Improvement programme embedded within CHD. • Sustainable funding for Māori Health, Te Tiriti o Waitangi commitments and acheiving health equity within CHD.

#	Me pēhea tātou e tae ki reira?		Due	He pēhea te āhua o te angitu? What does success look like?	Current	Target (2022/23)
Te Tiriti o Waitangi in action	Embed Starship Rautaki across Directorate, socialise Starship Rautaki widely across the sector to facilitate relationships within sector, hāpū and iwi.	MHT/SLT	Q1-Q4	Starship Rautaki undergone consultation with Māori leadership, kaimahi Māori & agreed by SLT & launched via a ward-show	Starship Rautaki in development, consultation ongoing	Launch and ward-show engagement, operationalisation completed
	In collaboration with stakeholders including mana whenua, Kiingitanga and iwi chairs develop and implement strategy to commence child health agenda conversations.	MHT/SLT	Q1-Q4	Starship with the support of mana whenua, Kiingitanga, key stakeholders in the sector colloborate to develop a comprehensive Te Tiriti Based Child Health Agenda	Currently no collective child health agenda vision within iwi or health spaces	The result will be the commencement of the intersectoral development of a Te Tiriti based child health agenda for Aotearoa
	In collaboration with stakeholders, develop indigenous child health research strategy to underpin a research centre of excellence.	MHT/SLT	Q1-Q4	Starship recognised as an international centre of excellence for indigenous child health research	No indigneous research strategy for Child Health	Indigenous strategy developed and positioned for implementation
	Review Starship governance and structure requiring TOW compliance, relationships with mana whenua and iwi.	SLT/MHT	Q3	Starship's governance structures actualise equity through Te Tiriti o Waitangi	Starship's governance structures are not Te tiriti compliant	Recommendations for SLT and Clinical Excellence Governance developed. Prioritised documentation CTA reviewed
Eliminate inequity	Attract, recruit and retain Maori into leadership roles throughout Starship Child Health	MHT/SLT	Q2	Te Tiriti-based approach to Māori leadership	2 designated Māori leadership roles in place	8 additional Māori leadership and Māori health team positions appointed to.
	Implement cultural safety workforce development plan.	MHT/SLT	Q1-4	All staff have capability to practice Te Tiriti o Waitangi in action and contribute to achieving health equity.	Variable	Project Manager appointed. Workforce deelopment programme launched. Community of Practice established.
	Build capacity to obtain high quality ethnicity data across services. Monitor equity data and use it to inform operational decision making.	MHT/SLT/Ops	Q1-4	Equity dashboards publically visible.	Equity data variably available and utilised but not integrated	BI appointed to inform operational decision making. Develop consistent approach for equity monitoring in planned care.
People, patients and whānau at the centre	Grow and resource the Starship Maori Health Team. This includes but is not limited to a team of clinical and non-clinical kaimahi that work as a team to provide kaupapa Māori support to whānau 24/7.	MHT/SLT	Q1-4	Māori Health Team that has capacity and capability to proactively engage with whānau 24/7, work on cultural shift within the workforce and systems change.	Adhoc response to whānau depending on availability. Inability to contribute to important projects due to workloads.	Business case raised for funding of kaimahi Māori response team that serves Starship Hospital, Starship Child Protection and Starship Community. Māori Health Team begin to receive Crown Funding rather than charitable funding.
	Develop capacity to safely engage and include whānau voice/feedback into all aspects of service delivery, service review and development plans.	SLT/MHT/SDig	Q1-4	Whānau engagement is routinely included in service improvements, reviews and informs key decision making	Whānau voice consistently occurs within Starship Digital but is absent from other spaces	Whānau experience position appointed. Resources and policies to support whānau engagement developed.
	Develop way finding and navigational tools to enhance patient experience , especially focused on Māori whānau.	MHT/SLT/Proj	Q1-4	Māori whānau are apppropriately supported throughout all parts of their journey with Starship	Multiple inputs, inequitable across Directorate	Improvement project implemented and resourced.
Digital transformation	Enhance Starship Digital capability.	SLT/GM/SDig	Q1-4	Digital engagement expertise available to support services across Starship	Expertise and resource applied to small part of child health services.	Additional digital engagement roles appointed. Digital engagement approach for Starship described.
Resilient services	Define clinical and cultural outcomes for priority services including PICU, NICU, CED.	MHT/SLT/Pways	Q1-4	Clinical outcomes agreed for priority services. Cultural outcomes included for priority services.	Variable reporting of clinical outcomes.	Clinical outcomes agreed for priority services. Ethnicity data and experience captured in priority services.
	Increase critical care capacity enabling more equitable service delivery	SLT/DS	Q1-4	Cricitical care capacity matches demand	Funding for additional PICU positions confirmed. Recruitment challenging. Business Case for additional NICU beds drafted.	Recruit to addtional PICU FTE. Secure funding for additional NICU beds.
	Develop employee brand strategy for Starship that reflects Rautaki Starship	SLT/GM	Q1-4	Starship recognised as an employer of choice and workforce demands are met. Kaimahi Māori workforce reflects service use.	Traditional recruitment strategies failing to meet demands. Kaimahi Māori 4.5% of workforce.	Recruitment /brand insights reported. International recruit strategy piloted. Māori workforce strategy developed and funding sought.
Financial sustainability	Describe and obtain funding that reflects Starship Child Health's national/regional services, capability and capacity. Includes recognition of complexity and increasing mental health need. Advocate for Starship Child Health to be legislated as the National Children's Hospital of Aotearoa.	MHT/SLT	Q3-4	Capacity funding model clearly articulated & advocacy plan developed	There is national/regional reliance on Starship. Signifcant capacity and capability not funded – significant component of capacity and capability is (e.g. infectius diseases expertise, eating disorders) agreed mechanism not recognised within new structures.	Plan to resolve with Health New Zealand, Māori Health Authority, Mister of Health.
	Develop pricing model for overseas patients	SLT/GM/Ops	Q3-4	Variable pricing model in place that recognises Starship's responsibilities within the Pacific and supports quality/volumes benefits for specific services	One-dimensional funding model in place that doesn't recognise different funding streams	Pricing model agreed

Te Pūriri o Te Ora – Cancer and Blood Services

A3 owner: Fritha Hanning, Director

Date: June 2022

TE TOKA TUMAI Auckland DHB

Ngā whāinga : Our priorities	Kei hea tātou ināianei? Where are we now?	Ki hea te tihi o te hiahia? Where do we want to be?
1 – Te Tiriti o Waitangi in action	• The Wai 2575 Hauora Waitangi Claim has made us aware of our shortfalls on Te Tiriti o Waitangi	• Co-monitored performance and quality with our Tiriti partner • Enact a bi-cultural partnership through Pou Ārahi • Māori whānau have a great experience whilst in our care • Proactively attract, recruit and grow Māori talent • Work alongside Māori service providers
2 – Eliminate Inequity	• Our system is fixed and rigid and often unable to bend to meet what whānau want and need • We concentrate on treatment only, which is too often delayed	• Any door in our whare is the right door for whānau and we all advocate for and manaaki whānau at every opportunity through their journey • Get involved in the complete pathway of care, with a focus on prevention and screening
3 – People, patients and whānau at the centre	• We depend on a "push" mechanism and don't work to "pull" in referrals • Our services are concentrated in Te Papakāinga Atawhai o Tāmaki (Auckland City Hospital)	• Whakamana whānau as partners in care • Connect with whānau before we receive a referral • Whānau know how to, and can, access our services whenever they need • Reach all places where whānau Maori live (ngā papakāinga o te marae, home fires of the community)
4 – Digital Transformation	• Gains made under FCT team • Limited use of research to inform meaningful change • We are heavily paper based with limited use of, and fluency across digital systems/platforms	• Embed use of data to inform and continue improvement in performance • Better understanding of what Maori data sovereignty looks like in action • Improve access to real time data to improve and inform quality of our services • Better connected to primary care partners, other services, and DHB information applications and systems
5 – Resilient Services	• Many parts of our workforce have historically felt disempowered • There is readiness to learn more about Te Tiriti o Waitangi, and how we can all be agents of change	• Our leaders create a psychologically safe place • Foundational change that rebuilds our service on Mātauranga Māori, thereby expressing mana whenua aspirations to manaaki all manuhiri in the rohe
6 – Financial Sustainability	• Our practice is concentrated in a small number of super specialists • Under resourced and over budget	• Match capacity and capability to actual need in the community by distributing clinical autonomy across all professions • Our fiscal responsibility stems from prevention, with a focus on remedying the causes of the causes of poor health and poor care
7 – Quality, Safety and Risk	• The culture of Quality, Safety and Risk is unevenly adopted across our Directorate	• Apply a critical Te Tiriti o Waitangi analysis tool to policies, projects and outcomes • Deliver Academic Cancer Care to the Northern Region • Ensure a standardised closed system in drug administration across LDO centres • Provide a safe physical environment for our whānau whilst they are on-site

#	Me pēhea tātou e tae ki reira? How are we going to get there?	Te Kaitohutohu	Due by
1	Engage in meaningful relationship with our Tiriti partner to collaborate on aspirations, as they align with Ngāti Whātua health priorities , to help determine measures/metrics for the new year	Director	Q1
	Scope necessary reporting pathways to ensure accountability and effective co-monitoring with mana whenua and other Māori Providers	Pending	Pending
	Formalise relationship with and collaborate with Hāpai Te Hauora (i.e. HRC Cancer Equity bid, advocacy in tobacco control, screening)	Pending	Pending
	Formalise relationship with and collaborate with Ōrākei Marae and other mana whenua rōpū (i.e. via Āwhinatia te Tangata).	Pending	Pending
	Scope recruitment, development and leadership opportunities for kaimahi Māori	Pending	Pending
2	Strengthen Āwhinatia Te Tangata programme	Pending	Pending
	Scope and implement policies for priority whānau	Pending	Pending
	Progress integrated cancer service model of care transformation	Pending	Pending
3	Scope and implement mahi that whakamana whānau as partners in care	Pending	Pending
	Strengthen community networks with primary and community care	Pending	Pending
	Progress Brachytherapy Bunker	Pending	Pending
	Progress Haematology Model of Care Redesign	Pending	Pending
4	Scope best practice when working with Māori tissue and data	Pending	Pending
	Improve access for Maori whānau to participate in research trials	Pending	Pending
	Improve access for Maori whānau to telehealth trials.	Pending	Pending
	Scope and implement accessing real time data to track whānau along their pathway	Pending	Pending
	Determine and update priority metrics to report (develop Te Pūriri o Te Ora super scrum pack)	Pending	Pending
	Establish and implement the Raurau ngaehe regional oncology electronic prescribing solution to replace current paper based systems	Pending	Pending
	Progress pilot 'Te Puehu Tūārangi' to match service utilisation to unmet need in the community	Pending	Pending
5	Strengthen best practice and capability build of our workforce	Pending	Pending
6	Scope dissemination of skills by disseminating key clinical skills beyond the SMO workforce, and building and broadening the training available to Nurses (i.e. Nurse led, whānau ora based clinics)	Pending	Pending
7	Audit prioritised documentation/pathway with endorsed Tiriti Analysis Tool	Pending	Pending
	Procure and implement a standardised closed system transfer device in drug administration across local delivery of oncology centres	Pending	Pending
	Progress ACTC, haematology, COVID positive infusions, PRRT relocation.	Pending	Pending
	Progress business case and requirements for development of level four space adjacent to oncology acute service including spaces that whakamana whānau as partners in care, an Adolescent Young Adult space,. and space for haemophilia services.	Pending	Pending
	Audit prioritised documentation/pathway with endorsed Tiriti Analysis Tool	Pending	Pending

#	He pēhea te āhua o te angitu? What does success look like?	Current (End 21/22)	Target (End 22/23)
1	# of projects that are jointly planned, delivered and monitored with Hāpai	Pending	Pending
	# of projects that are jointly planned, delivered and monitored with Ōrākei Marae	Pending	Pending
	% of kaimahi Māori	Pending	Pending
	# of kaimahi Māori in Tiers 1-3/People Leaders within the Directorate	Pending	Pending
	% of kaimahi Māori offered development or leadership programmes	Pending	Pending
	# of pathways that have been adjusted as a result of insights from Āwhinatia te Tangata	Pending	Pending
2	% of Māori whānau services fail to engage/do not attract	Pending	Pending
	% of Pacific whānau services fail to engage/do not attract	Pending	Pending
	# of clinics successfully delivered within the community alongside Māori providers	Pending	Pending
	# of patient resources that have been reviewed and improved	Pending	Pending
3	Whānau rooms refurbishment completed with kaitiaki assigned	Pending	Pending
	# of areas with signage and re-naming spaces implemented	Pending	Pending
	# of patient resources that have been reviewed and improved	Pending	Pending
	# of community hui attended by Directorate representatives	Pending	Pending
4	# of researchers who are assessed as being competent to work with Māori tissue and data	Pending	Pending
	# of Māori whānau fully informed about trial participation	Pending	Pending
	% of Māori whānau we effectively track in real time from referral	Pending	Pending
	# prescriptions implemented via Raurau ngaehe	Pending	Pending
	# of community sites identified by 'Te Puehu Tūārangi' as being most impactful to deliver clinics	Pending	Pending
5	# of DLT and People Leaders that have completed and implemented Tiriti competency workshops provided org wide	Pending	Pending
	# of DLT and People Leaders that have completed and implemented cultural safety workshops provided org wide	Pending	Pending
	# of kaimahi that are activated as Champions of Māori Health and Equity	Pending	Pending
	% of kaimahi that have progressed in their individual competencies journey from unfamiliar to comfortable-racism	Pending	Pending
	% of kaimahi that have progressed from unfamiliar to comfortable-cultural safety	Pending	Pending
	% of kaimahi that have progressed in their individual competencies journey from unfamiliar to comfortable-tikanga	Pending	Pending
	% of new kaimahi welcomed with pōwhiri	Pending	Pending
	# of whānau offered pōwhiri	Pending	Pending
	% of DLT and People Leaders proactively using wellbeing tools	Pending	Pending
	% of staff turnover	Pending	Pending
6	# of Nurses successfully trained up to lead clinics	Pending	Pending
	% of clinics that are nurse-led and delivered in the community	Pending	Pending
	Year-end budget position breakeven	Pending	Pending
7	# of services or pathways that have been adjusted based on Tiriti Analysis tool	Pending	Pending
	% of chemotherapy treatments delivered via closed system	Pending	Pending

Women's Health Service

A3 owner: Julie Patterson, Director

Date: June 2022

TE TOKA TUMAI Auckland DHB

Ngā whāinga : Our priorities	Kei hea tātou ināianei? Where are we now?	Ki hea te tihi o te hiahia? Where do we want to be?
1 – Te Tiriti o Waitangi in action	Currently there are too few primary birthing options which meet the needs of whānau.	Midwifery led primary birthing facility with culturally appropriate options, leveraging Te Manawa O Hine and community midwife services while reducing attendances at Women's assessment unit (WAU) / Labour and birthing unit (LBU).
	Treaty partners are under-represented in our work force.	To have a workforce representative of our Treaty Partnership and that is culturally competent.
2. Eliminate Inequity	Māori and Pasifika women with suspected cancer want to feel more culturally and clinically supported and want to navigate our services more easily	Māori and Pasifika cultural and navigation support enhanced with a new focus provided for patients who may have cancer.
	Māori, Pasifika and Indian women are more likely to book late for ante-natal care.	Early and effective antenatal care; we prioritise resources towards those not currently receiving early and effective care or who experience barriers to access for care.
	We want to ensure unfair barriers to fertility services which may disadvantage some communities e.g. Māori and Pasifika are identified and removed.	Service and funding models are designed to eliminate inequities. Clear options for (a) optimised funding models to redistribute resources e.g. targeted improvement in access to publicly funded fertility care and, (b) gaps and opportunities for improving equity of the service.
3 – People, patients and whānau at the centre	Patient feedback is not consistently measured, reported or used for service improvement.	Findings from feedback are used to develop and embed quality improvements across WH and are incorporated into a strengthened governance framework. Increased consumer engagement across the directorate.
4 – Digital transformation	There are robust data collection, analysis and systems for the many WH Services. We want to enhance this within sub-specialties to make data more accessible and less resource intensive.	Enhance information sharing, data capture and analysis to include all of the WH Service. Focus in particular on increasingly effective gynae cancer data.
	The Maternity clinical information system (MCIS) has been implemented to enhance the previous Healthware system and overcome fragmented, paper-based maternity record keeping.	Complete implementation, training and clinical staff ownership of the system ensuring scheduled enhancements are successful and support systems are in place.
5 – Resilient services	We have a backlog of gynaecology planned care due to Covid-19 related disruption, as well as apparent increase in demand.	Increase the volume of gynae attendances to reduce the backlog Clear reporting about demand, capacity and utilisation in forward and rear view. A test regional gynaecology pathway will serve as an enabler of future regional approaches.
	The Women's Assessment Unit is handling a higher volume and complexity of attendances in an environment unsuited for the current and projected Service needs.	WAU is able to efficiently accommodate future volumes and complexity in a welcoming environment. Separation of gynae and maternity assessment if capacity/efficiency gains possible. Stage two of planned upgrades underway.
6 – Financial sustainability	SMOs are frequently required to cover RMO duties. In addition, RMOs frequently work extra hours and don't provide positive run feedback.	SMOs cover RMO shifts infrequently and by exception. RMO's hours of work consistently fall within acceptable limits and the WH run is viewed positively.
	Contraception, especially long-acting reversible contraception (LARC) uptake, is low following early medical abortion (EMA) with higher risk of repeat unintended pregnancies. Access to EMA and dating ultrasound scan is variable throughout the region.	Timely EMA is accessible in primary care settings, with better access to contraception and dating USS. This reduces harm and cost.
	WHS are predicting a break-even end of year position.	Aim to break-even and make service improvements
7 – Quality, Safety and Risk	After hours roster re-design project to improve safety and enable protected rest for SMOs has been disrupted by Covid-19.	New SMO acute roster model is agreed, facilitating rest and minimising daytime impacts to planned care.
	The existing governance system within WH is reactive and requires enhanced co-ordination across the service.	Effective, proactive WH governance system, including updated incident review processes. Greater visibility and transparency of challenges and opportunities across WH. Up-to-date and meaningful quantitative assessment of directorate and sub-specialty service performance.
	The volume and complexity of obstetric care is increasing. Emergent care requires sufficient access to emergency theatre.	Clear reporting of performance around access to emergency theatre and associated risk. Mitigation plan which takes into account future requirements. The nature and extent of delays contributing to maternal post-partum haemorrhage and poor neonatal outcomes are well understood and a management plan is in place.
8 – People, Culture and Values	Shortages persist in multiple workgroups within the service. People and skills shortages nationally and internationally make recruitment difficult. This means the majority of work groups are significantly understaffed and rely on existing staff working additional hours.	Existing safety thresholds for FTE are consistently met whilst operating at full capacity, with a corresponding reduction in additional duties we ask staff to perform. Design and implement expanded nursing practice models in gynaecology. Midwives and SMOs operating at top of scope with support from HCAs, MCAs and other WH team members. Pipeline of talent is matched to service needs and brings staff on in advance of demand and turnover
	During 2020/21 the WH service has been forced to focus more on short-term responsive yet tactical planning with siloed management functions.	Increasing medium-long term strategic planning with more integrated and effective leadership model focussed on achieving the right care, at the right time, in the right place, by the right people. Useful two-way communication channels from leadership to frontline.

Women's Health Service

A3 owner: Julie Patterson, Director

Date: June 2022

TE TOKA TUMAI Auckland DHB

#	Me pēhea tātou e tae ki reira? How are we going to get there?	Te Kaitohutohu : Owner	Due by
1	Co-design primary birthing services focussed on creating a culturally welcoming service and partnership model of care.	Director of Midwifery	Q4
	Creation, promotion and prioritisation of development and employment opportunities for Māori throughout women's health services. Lift the cultural competency of our team through access to and attendance at Te Tiriti o Waitangi and cultural competency education.	Director	Q2
2	Support our existing Māori and Pasifika navigators to extend to HiSCan and other services. Continue to develop Pacific Women's clinic.	SCD Secondary Gynae	Q3
	Engage with communities to develop maternity services. Ensure culturally appropriate environment within maternity services.	Director of Midwifery	Q4
	Map patient journeys and compare current and future operational and funding models. Identify barriers to, and enablers of, more equitable service e.g. BMI thresholds and access to public fertility services.	SCD Secondary Gynae	Q2
3	Embed findings from quality of life questionnaires and patient experience feedback into quality and safety improvements across our Directorate.	General Manager	Q3
4	Scope the requirements of a system to improve intelligence and insights around local gynae cancer care and survival, supported by business case that includes procurement and implementation.	SCD Regional Gynae / General Manager	Q4
	Support development, enhancement, support systems and staff training related to MCIS, including MMPO integration.	General Manager	Q2
5	Explore regional pathways to increase capacity.	SCD Secondary Gynae / Gynae Ops Manager	Q1
	Improve efficiencies through improved planning & optimised utilisation of existing capacity		Q2
	Increased capacity e.g. additional clinics through extra staff and facilities and contracted cases through private providers.		Q2
	Work with Facilities to complete stage one improvement. Partner with staff, patients and professional designers to design WAU future functions, staffing model and flow based on patient journeys and pathways e.g. induction, gynae assessment and DAU.	Director Midwifery / SCD Secondary Maternity and Gynae	Q3
6	Engage SMO's, ASMS and the working group to develop the acute roster facilitating protected rest, whilst mitigating day time impacts, and compatible with changes to acute model of care / pathways.	General Manager	Q3
	Effective, pro-active WH Governance system, including strengthened incident review processes. Review of leadership roles within governance structure.	Director	Q1
	Review of baseline and target indicators for WH services.	General Manager	Q1
	Work with perioperative service to establish clear evidence of whether access to emergency theatre is within acceptable limits. Scope pragmatic, safe options for improving access if required.	SCD Regional Maternity / SCD Women's Health Anaesthesia	Q3
7	Employing an additional 3 RMOs will reduce the need for SMO cover and reduce the collective workload of the RMOs, providing a more positive experience.	General Manager/Maternity Operations Manager	Q3
	Reconfigured EDU service with enhanced nursing roles; improved access, availability of LARC and future training options for community access e.g. POCUS.	SCD Regional Gynaecology Daystay	Q4
	Budget holders are taking accountability for and managing their budgets	All	Q4
8	Continuation and improvement of structured recruitment plans for all workgroups.	Medical Director / Director of Midwifery	Q3
	Subsidised training programs in critical areas including midwifery, nursing and sub-speciality medical staffing.	Medical Director/Director of Midwifery	Q4
	Additional focus on improving staffing models and innovations to optimise workflows for existing workforce.	Medical Director/Director of Midwifery	Q2
	A focussed strategic planning sprint giving rise to a longer term, patient centric plan.	Director	Q1
	Renewed level 2 forum and cadence, facilitating multi-party active management of the plan.	General Manager	Q1
	This will be supported by the appointment of a medical director.	Director	Q2
	A focus on strengthening staff communication channels, and improving engagement.	Director	Q2

#	He pēhea te āhua o te angitu? What does success look like?	Current	Target (2022/23)
1	A co-designed primary birthing strategy is finalised, including identification of appropriate facilities.	Pending	20 Dec 2022
	80% of WH staff have completed mandatory cultural competency training modules	Pending	30 Jun 2023
	We have a target workforce diversity profile in place	Pending	30 Jun 2023
2	Navigation and support for wāhine with suspected cancer	Pending	31 Mar 2023
	Pasifika Women's Clinic improvements	Pending	31 Mar 2023
	Māori, Pasifika and Indian women book earlier for maternity care	Pending	30 Jun 2023
	Options for decision on equity plan for fertility.	Pending	20 Dec 2022
3	Clear set of baselines and targets for qualitative and quantitative analysis of patient feedback is established.	Pending	31 Mar 2023
	A reduction in patient complaints within WH.	Pending	30 Jun 2023
4	Scope, options and associated funding for establishment of gynae cancer data system known.	Pending	30 Jun 2023
	MCIS fully implemented, developed and utilised high quality clinical information system	Pending	20 Dec 2022
5	Target: >10% uplift in gynae attendances	Pending	30 Sep 2022
	Facilities that staff and patients agree are fit for purpose	Pending	20 Dec 2022
6	Test of new model underway.	Pending	20 Dec 2022
	New WH Governance Structure	Pending	30 Sep 2022
	Reduction in adverse events	Pending	30 Jun 2023
	Refresh and confirm baseline performance indicators for WH services	Pending	30 Sep 2022
	Clear reporting of emergency theatre access, utilisation and risks	Pending	30 Sep 2022
7	Recruitment of 3 additional Women's Health RMOs	Pending	31 Mar 2023
	Regional access to EMA closer to home improves.	Pending	30 Jun 2023
	Referrals seen within 14 days improves from 80 to 85%.	Pending	30 Jun 2023
	Number of women accessing LARC after EMA increases	Pending	30 Jun 2023
	Be in a surplus	Pending	30 Jun 2023
8	Within 24 months >90% staffing in all work groups.	Pending	30 Jun 2023
	Employee turnover falls below 10%	Pending	30 Jun 2023
	Completed service strategic planning sprint.	Pending	30 Sep 2022
	Employee engagement score	Pending	30 Jun 2023

Resolution to exclude the public from the meeting

Recommendation

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1.0 Apologies	N/A	
2.0 Conflicts of Interest	N/A	
3.0 Confirmation of Confidential Minutes 18 May 2022	**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]
3.1 Minute of a special board meeting: Acting Chief Executive Appointment 1 June 2022 – 30 June 2022	N/A	
3.2 Minute of a special board meeting: HNZ – Management Representations Questionnaire	N/A	
3.3 Circulated Resolution of the Board: Approval of EECA Loans and Grants for the Buiolding A32 LED Lighting Renewal Project	N/A	
4.0 Confidential Action Points	N/A	
5.1 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	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

	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)]	under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 Chief Executive's Report - verbal	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.2 Update on the transition to Health New Zealand and the Maori Health Authority – verbal 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)] **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]
7.1 People and Culture 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	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

	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)]	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	**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)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.1 NRHCC Retrospective contract Approvals	**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]
9.2 Replacement Equipment for the National Newborn Metabolic Screening 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 [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 Building for the Future: Starship PICU Atrium Redesign Variation	**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]
9.4	**Commercial Activities**	That the public conduct of the whole

FIRP Tranche 3 Seed Funding Business Case	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)]	or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.5 Approval of Ophthalmology Phacoemulsification Equipment, Consumables and Maintenance New Contracts Set-up	**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]
9.6 Capex Variations Approval for: BadgetNet MCIS; Starship Radiology General X-Ray Room (S3) Replacement; Infusion Pump Fleet Replacement; Point Chevalier Clinical Centre (Rehab Plus) – Clinic Room and Renal Dialysis Expansion	**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]
9.7 Update on Resolving the Post Implementation Review (PIR) and Independent Validation (IV) Backlog	**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]
9.8 Fraud Questionnaire – Auckland DHB	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the

Response	prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	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]
9.9 Letter of Representation for the year ended 30 June 2022	**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]