AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Open Board Meeting

Wednesday, 12 August 2020

10:30am

Note:

- **Open Meeting from 10:30am**
- **Public Excluded to follow**

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

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Published 6 August 2020

Agenda
Meeting of the Board
Wednesday 12 August 2020

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

Time: 10:30am

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

Agenda

Please note that agenda times are estimates only

10.30am **1. ATTENDANCE AND APOLOGIES**

2. REGISTER OF INTEREST AND CONFLICTS OF INTEREST

Does any member have an interest they have not previously disclosed?

Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?

3. CONFIRMATION OF MINUTES 8 JULY 2020

10.35am **4. ACTION POINTS**

10.37am **5. EXECUTIVE REPORTS**

5.1 Chief Executives Report

5.2 Health and Safety Report

11.10am	**6.**	**PERFORMANCE REPORTS**
	6.1	Financial Performance Report
	6.2	Planning and Funding Outcomes Update
11.50am	**7.**	**COMMITTEE REPORTS - NIL**
	8.	**DECISION REPORTS - NIL**
	9.	**INFORMATION REPORTS**
	9.1	2021 Meeting Schedule
	9.2	Digital Transformation – Presentation by Shayne Tong [30 minutes]
12.20pm	**10.**	**GENERAL BUSINESS**
	10.1	Presentation to Rosalie Percival
12.30pm	**11.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Next Meeting:	Wednesday 23 Sept 2020 at 10am A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

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Attendance at Board Meetings

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

2020/2021

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

Attendance at Board Meetings

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

2019/2020

Members	03 Jul. 19	14 August 19	25 Sep. 19	06 Nov. 19	18 Dec. 19			
Pat Snedden (Board Chair)	1	1	1	1	1			
Joanne Agnew	1	1	1	1	1			
Doug Armstrong	1	1	1	1	1			
Michelle Atkinson	1	1	1	1	1			
Judith Bassett	1	1	1	1	r			
Zoe Brownlie	1	1	1	1	1			
Peter Davis					1			
Tama Davis					1			
Fiona Lai					1			
Bernie O'Donnell					1			
Lee Mathias	1	1	1	1	r			
Robyn Northey	1	1	x	1	r			
Michael Quirke					1			
Sharon Shea	1	1	1	1	r			
Gwen Tepania-Palmer (Deputy Board Chair)	1	1	1	1	r			
Ian Ward					1			
Key: 1 = present, x = absent, # = leave of absence, c = cancelled, resigned = r								

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

Register of Interests – Board

Member	Interest	Latest Disclosure
Pat SNEDDEN	Director and Shareholder – Snedden Publishing & Management Consultants Limited Director and Shareholder – Ayers Contracting Services Limited Director and Shareholder – Data Publishing Limited Trustee - Recovery Solutions Trust Director – Recovery Solutions Services Limited Director – Emerge Aotearoa Limited and Subsidiaries Director – Mind and Body consultants Ltd Director – Mind and Body Learning & Development Ltd Shareholder – Ayers Snedden Consultants Ltd Executive Chair – Manaiakalani Education Trust Director – Te Urungi o Ngati Kuri Ltd Director – Wharekapua Ltd Director – Te Paki Ltd Director – Ngati Kuri Tourism Ltd Director – Waimarama Orchards Ltd Chair – Auckland District Health Board Director – Ports of Auckland Ltd Chair – Counties Manukau Audit, Risk and Finance Committee Member – Health Partners Ltd	08.07.2020
Jo AGNEW	Professional Teaching Fellow – School of Nursing, Auckland University Casual Staff Nurse – Auckland District Health Board Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Shareholder – Karma Management NZ Ltd (non-Director, majority shareholder) Member – New Zealand Nurses Organisation [NZNO] Member – Tertiary Education Union [TEU]	30.07.2019
Michelle ATKINSON	Director – Stripey Limited Trustee - Starship Foundation Contracting in the sector Chargenet, Director & CEO – Partner	21.05.2020
Doug ARMSTRONG	Trustee – Woolf Fisher Trust *(both trusts are solely charitable and own shares in a large number of companies some health related. I have no beneficial or financial interest – 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 – 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)* Meta – Moto Consulting Firm – (*friend and former colleague of the principal, Mr Richard Simpson)*	20.04.2020
Zoe BROWNLIE	Director – Belong Director - GenderTick Partner – CAYAD, Auckland Council	20.07.2020
Peter DAVIS	Retirement portfolio – Fisher and Paykel Retirement portfolio – Ryman Healthcare Retirement portfolio – Arvida, Metlifecare, Oceania Healthcare, Summerset, Vital Healthcare Properties	19.11.2019

William (Tama) 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 Board Member – Supporting Families Auckland Board Member – Freemans Bay School Board Member – District Maori Leadership Board Iwi Affiliations – Ngati Whatua, Ngati Haua and Ngati Tuwharetoa	01.07.2020
Fiona LAI	Member – Pharmaceutical Society NZ Pharmacist – Auckland DHB Member – PSA Union Puketapapa Local Board Member – Auckland Council Member – NZ Hospital Pharmacists' Association	10.12.2019
Bernie O'DONNELL	Manager – Manukau Urban Maori Authority Chair – Board of Trustees – Waatea School Deputy Chair – Marae Trustees – Nga Whare Waatea marae Executive Member – Secretary – Te Whakaruruhau o Nga Reo Iriangi Maori Director – Maori Media Network Te Matawai Funding Panel – Te Pae Motuhake o Te Reo Tukutuku Member – Ministry of Corrections Reference Group for AOD, Alcohol and other Drugs Addictions	19.03.2020
Michael QUIRKE	Chief Operating Officer – Mercy Radiology Group Convenor and Chairperson – Child Poverty Action Group Director of Strategic Partnerships for Healthcare Holdings Limited	27.05.2020
Ian WARD	Director – Ward Consulting Services Limited Director – Cavell Corporation Limited Trustee of various family trusts Oceania Healthcare – wife shareholder	21.05.2020

Minutes
Meeting of the Board
08 July 2020

Minutes of the Auckland District Health Board meeting held on Wednesday, 08 July 2020 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 10am.

Board Members Present	**Auckland DHB Executive Leadership Team Present**	
Pat Snedden (Board Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Dr Karen Bartholomew	Director, Health Outcomes Auckland and Waitemata DHBs
Doug Armstrong	Mel Dooney	Chief People Officer
Michelle Atkinson	Joanne Gibbs	Director Provider Services
Zoe Brownlie	Dr Debbie Holdsworth	Director of Funding – Auckland and Waitemata DHBs
Peter Davis	Rosalie Percival	Chief Financial Officer
Fiona Lai	Meg Poutasi	Chief of Strategy, Participation and Improvement
Bernie O'Donnell	Sue Waters	Chief Health Professions Officer
Michael Quirke	**Auckland DHB Senior Staff Present**	
Ian Ward	Sarah McMahon	Communications Manager – Media and External
	Marlene Skelton	Corporate Business Manager
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

Karakia

Bernie O'Donnell led the Board in a Karakia.

1. ATTENDANCE AND APOLOGIES

That the apology of Tama Davis (Deputy Board Chair) be received.

That the apologies of Executive Leadership Team members Margaret Dotchin, Chief Nursing Officer, Mark Edwards, Chief Quality, Safety and Risk Officer, Shayne Tong, Chief Digital Officer and Dr Margaret Wilsher, Chief Medical Officer be received.

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

The Board Chair, Pat Snedden requested that his register be amended with the removal of "Board Member – Counties Manukau DHB."

3. CONFIRMATION OF MINUTES 20 MAY 2020 *(Pages 9-39)*

Correction of Michelle Atkinson's name on pages 30 and 33 in of the agenda within the open minutes.

Resolution: Moved Pat Snedden / Seconded Zoe Brownlie

That the minutes of the Board meeting held on 20 May 2020 be confirmed as a true and

accurate record.

Carried

3.1 Confirmation of the Open Minutes of the Board meeting of 18 June 2020 *(Pages 40-41)*

Resolution: Moved Pat Snedden / Seconded Jo Agnew

That the minutes of the Board meeting held on 18 June 2020 be confirmed as a true and accurate record.

Carried

4. ACTION POINTS *(Page 42)*

Supporting the Government Push for Increased Equity in Healthcare

The Board Chair, Pat Snedden advised that the information paper supporting the Government Push for Increased Equity in Health which was to be revised and presented to this Board meeting would be put on hold in light of the content within the recently released Health and Disability System Review document and the appointment of a new Minister of Health. Pat also advised that he and the other regional DHB chairs would be talking with Minister Hipkins in a Zoom video conference on Thursday and the issue of equity would no doubt be raised at which time the Minister may provide guidance on how he wished the matter to be managed going forward.

5. EXECUTIVE REPORTS

5.1 CHIEF EXECUTIVE'S REPORT *(Pages 43-52)*

Ailsa Claire, Chief Executive Officer asked that the report be taken as read, drawing attention to items as follows:

- In May the DHB received a three-year certification to provide health care service. This follows the full certification audit in February which assessed the DHBs clinical departments against the Health and Disability standards.
- Two students from Auckland Grammar visited the hospital to present Chief Executive Ailsa Claire with notes of thanks for all essential workers at Auckland DHB. These notes of thanks are displayed in level 5 of the hospital.
- Communication with patients and the community via videos and webinars promoting that the hospital was a safe place to come to. There is still comment coming in from people on the impact and challenges of having to come through health services during lockdown. This was understandable as they were not able to have a support person with them. However, the visitor situation is now back to normal.
- The Local Hero wards have been maintained and catching up with the ones that were not done through COVID. A positive action undertaken on HIPO is to allow a "Shout Out" process highlighting teams that have done good work.
  Ailsa advised that the staff had managed their way through COVID with remarkable skill. Initially there was high adrenalin in the face of what looked like was going to be an overwhelming situation and there was a lot of training undertaken. As there has

been a move to the new normal it is recognised that this is not a reversion back to where we were before. At any one time there are two wards of patients in the hospital that have COVID like symptoms whom must be treated as COVID positive until such time they are tested. Obviously it is flu season and this exacerbates the situation as they meet the criteria. That means that people working in those wards have to be in full PPE managing all the implications of that. The staff have been quite amazing. In normal circumstances we would deep clean a few hundred rooms a month and that went to several thousand a month. Patient safety was put before all else. Pat's attendance at the staff webinar and thanking staff for their efforts was highly appreciated.

- The acute patient flow fluctuates but remains close to what it should be. The access to elective surgery dropped but it is now at a level greater than pre COVID levels so some of the wait list is being dealt with. The big issue now is that people who would have been referred to the tertiary services were not going through the secondary services during the Covid 19 lockdown and now they are and those wait lists are starting to increase.

  It was asked how the private sector was performing in relation to its interface with the hospital. Advice was given that the private sector was largely dealing with their ACC catch-up and catch-up of private work but there was some availability for outsourcing. The volumes with the private sector previously agreed are being continued with; ophthalmology, orthopaedics and a newly agreed contract for colonoscopy catch-up in the area of imaging.

  Ailsa Claire advised that weekend work is being undertaken but care is being taken not to exhaust staff.
- Financial performance is on target. What was signed off by the Minister was a $20M deficit budget from $2.4B turnover. The Board has been able to say with a degree of confidence that it has been able to land that budget subject to the classification of the COVID 19 direct costs and the continued revision around the Holidays Act issue. Rosalie Percival advised that as far as Auckland DHB is concerned the Holidays Act work is on track and the Board is now in a position to have the review that is part of the process, signed off by MBIE and then would move to the remediation stage of paying out. The only delay will be in having to go to market to obtain resource to process it.

  Peter Davis asked whether the legislation was going to be reworked and was advised that there was a revision to the legislation but those working with it felt that it still did not address a number of issues. The legislation is difficult to implement practically in anyone's payroll system.

  Pat Snedden commented that the Board would pay out historically what is owed as a result of the determination in line with the legislation however; the point is the Board will still have an ongoing exposure that it will have to manage and accrue for. Pat also commented that the Board would normally expect quite a high level of turnover of staff in an ordinary year but as a result of the COVID circumstance that turnover had not been seen. Advice was given that turnover in the last few months had significantly dropped. There is not the movement between DHBs nor is there the same level of retirements or overseas movement. Mel Dooney, Chief Human

Resources Officer advised that normally there would be 50 movements a month but in the months of April and May that had halved and June it had halved again. The DHB is losing less than ten people per month which is unprecedented. In addition to that there have been a record number of people seeking to increase their hours, requests from people wanting to come back from maternity leave early and where the Board would have had doctors going overseas as fellows; that is not happening. The ability to manage in this environment is very constrained and a challenge in the 2020-2021 financial year.

There is a requirement on the Board to meet the CCDM nursing agreement and all of these issues affects the net FTE number.

- Doug Armstrong asked whether the organisation was actively promoting remote contact with the patients in connection with elective surgery and ongoing care. Could the Board say that it had a different way of interacting with patients that is saving time. The Chief Executive, Ailsa Claire advised that, yes, this was occurring especially in follow-ups. There is an intense programme of work being undertaken to ensure that the required technology is in place and that the Board is meeting Privacy Act rules.

Resolution:

That the Chief Executives report for June 2020 be received.

Carried

5.2 Health and Safety Report *(Pages 53 – 60)*

Sue Waters, Chief Health Professions Officer, in the absence of Mark Edwards, Chief Quality, Safety and Risk Officer asked that the report be taken as read advising that what was before the Board was the overarching health and safety report for the organisation.

The Board Chair, Pat Snedden reminded Board Members that the Chair of the Finance, Risk and Assurance Committee had made a very clear statement that the Board must resolve the issues around Lone Workers and Workplace Violence as the issues had been on the Boards radar for some time.

Alistair Forde, Director Occupational Health and Safety presented the report.

Alistair opened by providing some personal background advising that he had spent 10 years in Australia working on large construction projects while not giving him the health background did provide a very good understanding of the key elements of health and safety. Alistair had worked with the Reserve Bank, EQA and EQC and also Crown Fibre partner around Enable. The key learning in the last few months was an understanding of the organisations passion for trying to move health and safety forward.

Leadership Observations

This is a key piece of work around engaging leadership in a more meaningful way to get insights from them cross the organisation. The focus currently is with the Occupational Health and Safety team who are learning and going through the process. It is behaviour focused and aimed at getting an understanding of how we actually behave in the workplace

around managing health and safety related issues and improvements.

The other focus of this is around maintaining legal requirements related to health and safety and ensuring compliance is being met, that the right things are being done at the right time.

Indicators

Lag indicators show the recordable injuries across the organisation. One five people within the organisation has had an injury and this is an area where the organisation could perform better. More investigation is required in terms of understanding the context around severity of these injuries.

Peter Davis commented that he did not understand the lag indicators and required some international benchmarking so that he could see what was expected of a hospital of our size and complexity of work and what could be expected of a well-run hospital.

Jo Gibbs, Director Provider Services agreed that benchmarking with a bigger international complex health organisation was the right thing to do as we are encouraging people to report the most minor injuries and management would not want to stop that from occurring.

Jo Agnew asked if there was any collaboration with other DHBs and the Health and Safety Commission and any correlation of numbers. Ailsa Claire advised that pre COVID there was work being undertaken on looking at what was happening in other government departments via TAS to share learning. The hospital does need to be compared to another large complex health organisation because there are unique issues. When junior doctors start with the organisation needle stick injuries increase and are reported as an injury. It is not like an ordinary business because there are also patient moving and handling issues to consider.

Lone Workers

There is a deep dive to go to the Finance, Risk and Assurance Committee on 22 July.

It has been found that the reporting on Datix needs more analysis because some of the issues reported are not related to physical violence but are of a verbal nature between staff, patient or public.

Occupational Health and Management of Airborne Hazards and Viruses

COVID prompted education around secure fitting of PPE and other processes required in the management of airborne viruses. Two and half thousand staff have gone through a train the trainer model to ensure that there is ongoing assessment and validation throughout the hospital that PPE is worn correctly and processes are being followed.

Vulnerable Staff

The self-assessment of staff revealed that there were 1800 staff that were at increased risk during COVID 19. There were controls put in place to manage that and that any vulnerable members in their bubble were also being managed as well in the context of the relationship between work and home.

Information Technology

This is around contact tracing and the software programme MedTec 32 and how to build more resilience into that software programme and what capacity is invested in for the short

and medium term. The key when this is resolved is to get an indication of how much less resource intensive approaches need to be taken around these processes. The expectation is that the Board will know over the next few months where it stands with the current software and moving forward what the solutions are in relation to the national solution for contact tracing and how full integration is to be achieved.

The following was covered during discussion:

- Michael Quirke commented that the 1:5 ratio of injuries is concerning and he was interested in learning what type of injuries make this up and any trends associated with it. That high number does suggest a strong reporting culture but it could also suggest that training has gone down if more meeting, discussing and doing is occurring.
  Michael asked if Alistair had any advice around key areas that the Board should be paying closer attention to. Alistair advised that the area of injuries was important and particularly understanding the severity behind them. There is still work to be done to formalise the injury management process so that the management of injuries can be systematised as they happen and getting people back to work earlier. There is another aspect to this around injury prevention. There is a lot of information capture and reporting but the information is not being disseminated as well as it could be. The key thing is the behaviour-based management approach and leadership. .
- Ailsa Claire advised that the Health and Safety report has been a challenge to formulate and to provide the type of information that the Board wished to see. She asked that if a Board member had a particular interest in this report that they work with Mark Edwards and Alistair Forde to determine what they wished to have reported to Board. The Board Chair, Pat Snedden advised that the Board had been focused on Health and Safety seriously for some time now. Learnings were being gained all the time and since the Pike River mining disaster the whole view of health and safety had changed. The Board was determined to make the hospital a safe place to be and it needed sophisticated analysis and data to make that possible but it also needed to comprehend what it had in front of it and to be able to determine where the emphasis should be. The Board is looking at becoming more adept at understanding what it needs to know to be good stewards. This is a great opportunity for 3 or 4 Board members to work with the business to address that question of being good stewards.
- Zoe Brownlie drew attention to page 59 of the agenda and the figure of 36% of induction being completed and asked how that number could be increased. Ailsa Claire advised that during COVID 19 all face-to-face training was ceased and the organisation entered a phase of online training. Work is being done at reinstituting a hybrid model of online and face-to-face training. She also advised that inductions are completed but the record is the problem. If more can be done online then that would automatically trigger completion and a clearer view of the % of training completed.

Action

Board members to put their names forward to the Board Chair so that a small cohort of members work with Mark Edwards and Alistair Forde to address the question of what we need to do to be better and safer in our space.

Resolution:

That the Health and Safety Report for June 2020 be received.

Carried

5.3 Human Resources Report *(Pages 61-62)*

Mel Dooney, Chief People Officer asked that the report be taken as read, advising as follows:

- The purpose of this report is to provide an update on the People Progress to Plan with a status on each of the Human Resource work streams since May 2020 and it is important to note that work is still being impacted by regional work being done post lock down.
- During June a number of areas have either been restarted or program content redesigned based on what we have learned. Of note is progress made during June towards developing a draft People and Culture Strategy which will support delivery of the key strategic objectives of Te Toka Tumai. This work will also outline the activity for 20/21 People Plan. It is envisioned this will come for the Board's review and engagement at the August Meeting.

The following was covered during discussion:

- The Board Chair, Pat Snedden asked Mel Dooney what had been most challenging post lock down for her and her team to manage. Mel Dooney replied that people's behaviour is different and the team is having to understand what is driving that. There is significant change in people's behaviour with respect to their employment with a much more cautious approach being evident. People are wanting to increase their hours and that could be a reflection of the fact that they may belong now post lockdown to a one income family. The level of economic impact from COVID 19 is yet to fully make itself known. Retirement savings have been impacted by the share market volatility. The churn that was normally seen is no longer evident and the team must understand why that is and be responsive and in tune with what is happening. Then there is the change that the use of telehealth has made to employment. The Union partners are very interested in the effects of this and what it might mean going forward.
- Jo Agnew referred to page 62 of the report and was advised that the traffic light reporting was to indicate progress to plan of projects. Mel Dooney advised that there was more amber reporting at the moment which was a direct result of the effect of COVID 19.
- Doug Armstrong commented that his reading of the Heather Simpson report indicated that the organisation was spending a lot more time in getting people through to the practise front when benchmarked against similar countries. There

have been various reports dealing with MRI technicians getting a higher salary in the private sector and wondered how our contracting out was adding to this.
Sue Waters responded to the MRI and MRT issue advising that any outsourcing being undertaken is based on the current capacity of the private providers. We are managing flow and volumes so that a step increase in staff investment does not have to be made in order to undertake the outsourcing. That way Auckland DHB preserves its current staffing model and current ability to put volumes through as planned. The MRTB are coming to discuss with Auckland DHB alternative registration pathways before a review of their scope is undertaken on the basis of addressing a number of concerns that Auckland DHB has repeatedly raised with them. While this can be seen as something of a breakthrough concerns had to be raised repeatedly, work had to be undertaken with the regional network which itself raised some collective concerns about the impact on patients and patient safety and access to services. The MRTB replied that on the basis of those concerns that they would bring forward the scope of their practise review by 12 months. However, this would take 12 months and problem exists now so it was asked how Auckland DHB could work with them in a way that would satisfy them as a regulator that who they were registering had competence and that Auckland DHB itself was providing a competent workforce.

- Doug Armstrong asked that the Board Chair, in discussions with the Minister of Education and Health, bring up the issue of academic upgrading as it is costing the DHB a lot of money and it is being done at the behest of the professional organisations and teaching institutions and against the DHBs best interests.
- Zoe Brownlie drew attention to page 61 of the agenda and the issue of quarterly updates. Mel Dooney advised that the progress made in 6 weeks was not enough to enable a more substantive report to be provided. Ailsa Claire advised that the People and Culture Sub-Committee had been reshaped to consider more detailed work allowing the Board to receive the high-level reporting with assurance from the People and Culture Sub-Committee that issues are being dealt with.
- Bernie O'Donnell drew attention to page 67 of the agenda and the development of the strategy and what involvement Maori staff had in that. Mel Dooney advised that pre COVID there had been meetings scheduled with directorates around their progress to the plan and what they were seeking from Human Resources. These were rescheduled but in the interim Maori staff were involved in discussions around development of the strategy and worked with the Human Resources team to improve the process.
- Michael Quirke commented that the lack of staff churn should not be seen as a particularly bad thing as it provided some consistency which offered efficiencies and he encouraged the Human Resources team to investigate these. Mel Dooney agreed and said her concern was the need to manage this more effectively and understand why it was occurring in order be responsive and in tune with what was happening.
- Fiona Lai commented that the lack of churn prevented the loss of organisational knowledge. New starts requiring induction and training comes with a cost attached. Ailsa Claire replied that there was a delicate balance that needed to be maintained. Auckland DHB is a training facility and New Zealand health relies on the bigger

organisations to take on new graduates. Nationally is a lot of work is being undertaken on the pipelines, looking at training and accreditation to understand what can be done to provide a good training environment.

Resolution:

1. **That the Board receives the Auckland DHB Human Resources report to June 2020.**
2. **That the Board agrees the updates against the People and Culture plan and resolves that future updates be quarterly.**

Carried

6. PERFORMANCE REPORTS

6.1 Financial Performance Report *(Pages 63-69)*

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

That there would be no formal year end result until 22 July 2020. As long as the Ministry allowed the budget to be adjusted for the $30M required for Holiday Pay and the $25M of unfunded cost for COVID 19 the DHB will meet its obligation of a $20M deficit budget.

There is an issue around annual leave accrued and annual leave taken. 96% of annual leave accrued was taken in the past year however this year it had dropped to 87% as a result of the COVID 19 lockdown.

Ian Ward commented that disclosure in the accounts of these issues would be important and Rosalie Percival advised that there would be two separate disclosures to cover Holiday Pay and all the elements affected by COVID 19.

It was advised that while staff were encouraged to take leave during levels three and four of COIVD 19, many people either chose not to as they could go nowhere or they were part of essential teams used for telehealth, staffing aged care residential homes or other essential response issues.

Resolution:

That the Board receives the Financial Report for the eleven months and Year to Date ending 31 May 2020

Carried

6.2 Planning and Funding Outcomes Update *(Pages 70-87)*

Dr Debbie Holdsworth, Director of Funding – Auckland and Waitemata DHBs and Dr Karen Bartholomew, Director, Health Outcomes Auckland and Waitemata DHBs asked that the report be taken as read, advising as follows:

- Since the report was published there have been some changes to the border which has resulted in most of the Primary Care Team and some of the Health Gain Team

going back into the NRHCC to managing the swabbing and supporting the health response at the border. That does have an impact on planned activity.

- COVID has provided some opportunities for innovation as outlined on page 81 of the agenda with the introduction of the Whakatau Mai Wellbeing Sessions but there are also some casualties as a result of the change in the economic climate with reduced funding.
- The Ministry are now funding a catch-up campaign for measles, mumps and rubella and there will be a particular focus on Maori and Pacific.

Maori Health Pipeline

Dr Karen Bartholomew advised as follows:

- The breast cancer screening Maori health pipeline project is now complete. Auckland DHB had the highest uptake for Maori women in the northern region with 50% of the women screened in the project being from Auckland DHB. There is no population register for breast screening so the DHB is not able to identify women who are not involved in the programme so this project was a data match using national data sets to identify Maori women not on the programme and invited them to be screened. 365 Maori women were identified and enrolled and 244 of those women have been screened so far. Due to that success we have now included a hospital data match because the original data match was with people enrolled at the PHO and Maori have a lower PHO enrolment rate. This provides an opportunity to catch the women that are not enrolled with them.
- The lung cancer screening focus group were completed pre COVID and during COVID the surveys for 300 eligible Maori and 100 of their whanau were completed. The cost effectiveness piece of work was also completed and is awaiting publication. A Maori Consumer Advisory Group is being formed with a number of enthusiastic people from the focus groups and surveys who will walk along-side the design for the remainder of the programme.

  It was advised that the information from the focus groups and surveys is being used to design the trial based on what people have indicated that they wanted and how they wanted it to work. The plan is well underway for the initial trial. Two different invitations methods are being looked at for an initial trial of 500 Maori. There is strong collaboration with the Australian partners who are undertaking similar work with Aboriginal populations in Australia.

  There are two grant applications being submitted and a pitch is being worked up to put to funding consortium. It will take a number of funders to allow this piece of work to proceed. The aim is to break the work down into smaller pieces such as smoking cessation, management of COPD and some work around blood sample bio banking.
- The Kapa Haka pulmonary rehab work is back underway. Dr Sandra Hotu who is the lead for that work has completed her PHD. The project steering group has also managed to get Annette Wihi, a Kapa Haka expert, to support the work and to assist in the design of the integration of the two programmes.
- The Pacific AAA programme (*screening programme looking for swelling of large*

blood vessels traveling down the legs) has been restarted with a Tongan pilot that has had a 100% uptake from the first clinics. The Pacific AAA work is based on the success of the Maori AAA screening, with a number of large AAA being identified. There were a number of co-benefits arising around smoking cessation, high blood pressure detection and cardiovascular risk and atrial fibrillation as part of that programme. Those Maori identified as AAA have all since had operations or follow up.

The following was covered during discussion:

- Clarification was provided to Bernie O'Donnell around how Kapa Haka as a traditional Maori form of dance exercise and relationships were a core component. Dr Karen Bartholomew advised that Maori have a disproportionate burden of respiratory disease and there is a low uptake of pulmonary rehabilitation and we know that low uptake is around how the service is designed and effort it takes to get to clinics. It has been found that a lot of people go to Kapa Haka even if they don't attend other appointments and whether the two things could be combined. This is being used as a genuine research question to determine whether it is appropriate to combine a cultural method and a clinical tool because we do not want to lose any of the positive elements of Kapa Haka.
- The structure of the pathway is designed to be modular, starting with a prototype, testing the feasibility and then looking at a case for investment.
- Fiona Lai drew attention to page 84 of the agenda and the increased proportion of Asians who enrol with a PHO; making two points. The first around indicators for ethnicity reporting and the second around new Asians migrants not knowing how to navigate the system to get enrolled with a PHO. Chinese in particular do not commit to one GP as it takes time to earn their trust and they prefer a Chinese speaking GP whom they can understand and relate to.

  Karen Bartholomew advised that Ministry of Health standards are used for ethnicity reporting that utilise standardised groups that are comparable across all of the outcome metrics reported. Karen acknowledged that, "Asian" is a high or super level of reporting and that there are a number of levels of granularity beneath that. The Asian Health Team has been championing getting more granular reporting. Data exists for some areas only at this point. An international benchmarking exercise was undertaken down to that level of granularity which can be shared with Board members.

  Dr Debbie Holdsworth advised that the team did have an Asian Health Manager who had identified those issues and which is why a significant portion of work with this cohort focuses on education on how to navigate the health system. There will be an updated joint Waitemata-Auckland DHB Asian Health Plan which will be brought through the next joint CPHAC meeting for endorsement.

  Ailsa Claire advised that a lot of work had been done with Asian students and the Department of Immigration had been asked to include that information in their material so that a new migrant could gain an understanding on how to access health services. The University Health Services team were actively working with the DHB on that process as well.

The Board Chair, Pat Snedden suggested that Fiona Lai connect with Samantha Bennett, Asian Health Gain Manager to share information and gain a sense of confidence around how this is being progressed by the Planning and Funding Team.

- Bernie O'Donnell was advised that the Asian population was being targeted specifically as they made of 40% of the Auckland population. The benchmarking report showed that there are very few health inequities in that cohort. There are some well-defined inequities in some sub-groups so the effort is only being focused where there is inequity. The key issue for this group is PHO enrolment and making sure that Asians are seeking care though primary health care and ensuring that a culturally appropriate response exists for what is a very large proportion of Auckland's population.
- There was some discussion around the census data and the point made that if the Auckland DHB population is counted as being less than historically reported then the amount of activity related to each individual is seen to be increased. This is discouraging position to be in as no one can say with any confidence what the Auckland DHB population should be.
- Peter Davis asked whether the DHB was in a better position to ensure any conditions in relation to aged care facility audits were actually undertaken. Ailsa Claire advised that these were COVID specific audits relating to preparedness around infection control. These audits did provide insight on what was required by way of providing support to bring infection control standards up to the required level. This work was ongoing with facilities. A level of infection control was being asked of them that would not normally be required.
- Peter Davis also asked for clarification around the level of dental pain relief given that a school dental service existed and this should have been picked up on. He was advised that there was current regional work aligning the dental pathway, in terms of the causes of the dental extractions this was an issue starting pre-school and that a comprehensive report and plan had been provided to CPHAC on the issue, and this is regularly reported on.

Resolution:

That the Board note the key activities within the Planning, Funding and Outcomes Unit since the last update provided on 20 May 2020.

Carried

7. COMMITTEE REPORTS - NIL

8. INFORMATION REPORTS - NIL

9. INFORMATION REPORTS

9.1 Taking bigger strides: Sustaining health services and tackling persistent health inequity through national public advocacy to address structural and commercial determinants of obesity and alcohol related harm *(Pages 88-91)*

The Board Chair, Pat Snedden advised that this report was outlining an attempt to deal with persistent health inequity in the areas of obesity and alcohol related harm.

Resolution: Moved Pat Snedden / Seconded Zoe Brownlie

That the board:

- **Note that DHB Chairs and Chief Executives have agreed to establish a new National Public Health Advocacy team.**
- **Note that DHBs have agreed to provide $400,000 initial funding for the establishment of this team.**
- **Note that Dr Rob Beaglehole, dentist and public health specialist from Nelson Marlborough DHB has been appointed to lead this team.**
- **Note that this work is on hold while the health sector is focused on the COVID 19 response although background preparatory work is underway.**

Carried

10. GENERAL BUSINESS

10.1 Committee Membership and Appointment of Chair for CPHAC - Commissioning Health Equity Advisory Committee *(Confidential Pages 81-82)*

[Secretarial Note: In accordance with resolution 10.1.6 the report and decision related to this item have been transferred to this the open agenda under general business.]

Resolution: Moved Pat Snedden / Seconded Zoe Brownlie

That the Board:

1. **Accept the resignation of Peter Davis as Chairperson of CPHAC and reaffirm his continuing membership of the CPHAC - Commissioning Health Equity Advisory Committee**
2. **Accept the resignation of Dr Teulia Percival from the HAC – Provider Equity Committee**
3. **Approve the appointment of Dr Teulia Percival as an externally appointed member of the CPHAC - Commissioning Health Equity Advisory Committee and the**
4. **Approve the appointment of Dr Teulia Percival as Chairperson of the CPHAC - Commissioning Health Equity Advisory Committee and as a member of the Auckland Metropolitan Advisory Committee - Community and Public Health Advisory Committee**
5. **Approve the first meeting date of the CPHAC - Commissioning Health Equity Advisory Committee post COVID 19 as Wednesday, 2 September 2020 at 1.30pm**
6. **Transfer this report and decision to open agenda following the conclusion of this meeting.**

Carried

11. RESOLUTION TO EXCLUDE THE PUBLIC (*Pages 92-94)*

Resolution: Moved Pat Snedden / Seconded Jo Agnew

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Apologies	N/A	N/A
2. Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Confidential Minutes 20 May 2020	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3.1 Confirmation of the Confidential Minutes of the Board meeting of 18 June 2020	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Action Points	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982

		[NZPH&D Act 2000]
5.1 Risk Management Update	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 Chief Executives Confidential Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 Human Resources Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.1 Finance, Risk & Assurance Committee Minutes – for information	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.1 Starship Paediatric Intensive Care Unit Bed Expansion and	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information

Atrium Redevelopment	be prejudiced or disadvantaged if that information was made public.	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 Chiller – Replacement Capex	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.3 Committee Membership and Appointment of Chair for CPHAC – Commissioning Health Equity Advisory Committee	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

Carried

The meeting closed at 2.25pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 08 July 2020

Chair: _____ Date: _____

Pat Snedden

Action Points from 8 July 2020 Open Board Meeting

As at Wednesday, 12 August 2020

Meeting and Item	Detail of Action	Designated to	Action by
26 Feb 20 Item 5.2	**Health and Safety Report** That a report be made to the Board on "% local Health and Safety Induction completed", what was done, what changed and what the situation looks like with the passing of six months.	Mark Edwards	12 August 2020 See Item 5.2 Performance Summary – Lead Indicators
8 July 2020 Item 5.2	**Health and Safety** Board members to put their names forward to the Board Chair so that a small cohort of members work with Mark Edwards and Alistair Forde to address the question of what we need to do to be better and safer in our space.	Pat Snedden	12 August 2020

Chief Executive's Report

Recommendation

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

Prepared by: Ailsa Claire (Chief Executive)

1. Introduction

This report covers the period from 9 June 2020 – 20 July 2020. It includes an update on the management of the wider health system and is a summary of progress against the Board's priorities to confirm that matters are being appropriately addressed.

2. Events and News

2.1 Notable visits and programmes

Minister Hipkins announces $262 million infrastructure investment

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

Chair Pat Snedden and Minister Chris Hipkins at the announcement.

The majority of the new investment will be used for a new central plant and service tunnel at Auckland DHB's Grafton site. The central plant provides critical infrastructure to Auckland City Hospital, Starship Hospital and other buildings on the site including electrical power, chilled/steam/domestic water, heating and cooling systems, and emergency back-up systems.

Most of the infrastructure at the Auckland City Hospital site is almost 50 years old and our remediation programme is critical to ensure our hospital facilities are fit for purpose now and in the future.

The Manaaki Fund

Launched in mid-April in partnership with the Auckland Health Foundation (the official charity of Auckland DHB's adult health services), the Manaaki Fund provides a way for our 11,000 Auckland DHB staff to support colleagues who have been financially impacted by Covid-19.

Those impacted by COVID-19 include our own people and their whānau, and the fund provides immediate relief to staff in the form of supermarket and petrol vouchers. The fund will also be used to set up an employee wellbeing centre where staff can come for karakia, career development workshops and other events. The centre will also be a place to access additional support including that provided by other services and agencies.

As of 21 July 2020, more than $24,000 had been raised for the Maanaki Fund.

2.2 COVID-19 response

The COVID-19 Response Team continues to manage the impact of COVID-19 on Auckland DHB, working closely with the Northern Region Health Coordination Centre (NRHCC) and other agencies.

The current risk to the public from COVID-19 is low. The last community case in Auckland was reported on May 22 and since that time more than 80,000 community tests have been carried out across Auckland – all negative.

The only COVID-19 cases currently in Auckland are people who have recently returned from overseas into managed isolation and quarantine facilities. Some of these people need hospital care for COVID-19 or for other reasons. We have cared for a number of patients with COVID-19 at Auckland City Hospital and have robust infection and control processes to protect staff and other patients.

Despite the current low risk, we remain ready to respond if there is a resurgence of cases. Contract tracing capacity has been significantly increased, we are part of an active testing programme managed by the NRHCC and our hospitals are prepared to manage an increase in COVID-19 cases.

2.3 Patients and community

2.3.1 Email enquiries

The Communications Team manages a generic communication email box, responding to all emails and connecting people to the correct departments. For this period, 369 emails were received. Of these emails, 43 were not communications-related and where appropriate, were referred to other departments and services at Auckland DHB.

2.3.2 Patient experience

Some examples of patient feedback we received this month:

"Having zoom appointments was excellent. This allowed me to have my pre admit appointments with the nurse and doctor in my lunch break. This was so convenient and everyone was on time. I really hope Auckland DHB will continue with these types of appointments". – Anon

"I was very impressed with the nurses and staff in ward 31 during my stay. I found them very helpful and always willing to answer any questions and to be very helpful and pleasant nothing was too much trouble, the doctors also were very helpful in explaining about the operation and what was happening which I really appreciated. Thank you" – A.V

2.4 External and internal communications

2.4.1 External

Between 9 June and 20 July we received 78 requests for information, interviews or access from media organisations. Requests continued to focus on the COVID-19 response and included enquiries about aged residential care facilities, maternal deaths during national alert levels 3 and 4, and the impact of COVID-19 on dental wait lists for children. Around 25% of the enquiries over this period sought the status of patients admitted following incidents such as road traffic accidents.

The DHB responded to 36 Official Information Act requests over this period.

2.4.2 Internal

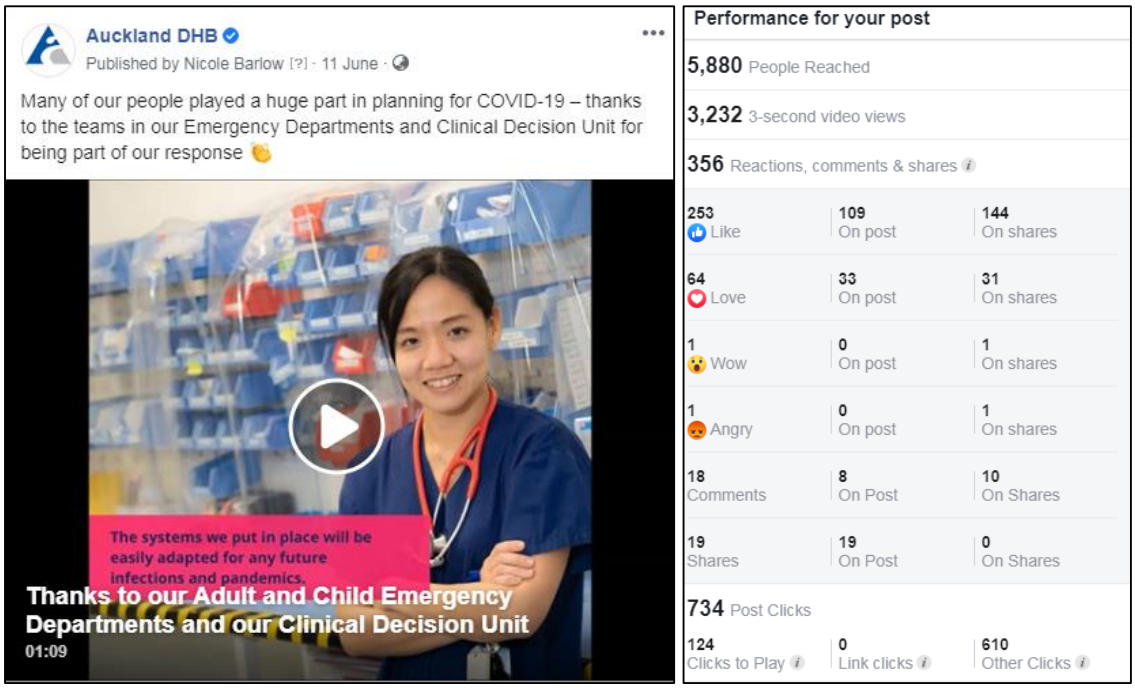
- Seven editions of Pitopito Kōrero | Our News, the weekly email newsletter for all employees, were distributed.
- Six editions of the Manager Briefing were published for all people managers.
- Three webinar sessions were held for all employees to provide updates on the organisation and COVID-19 with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

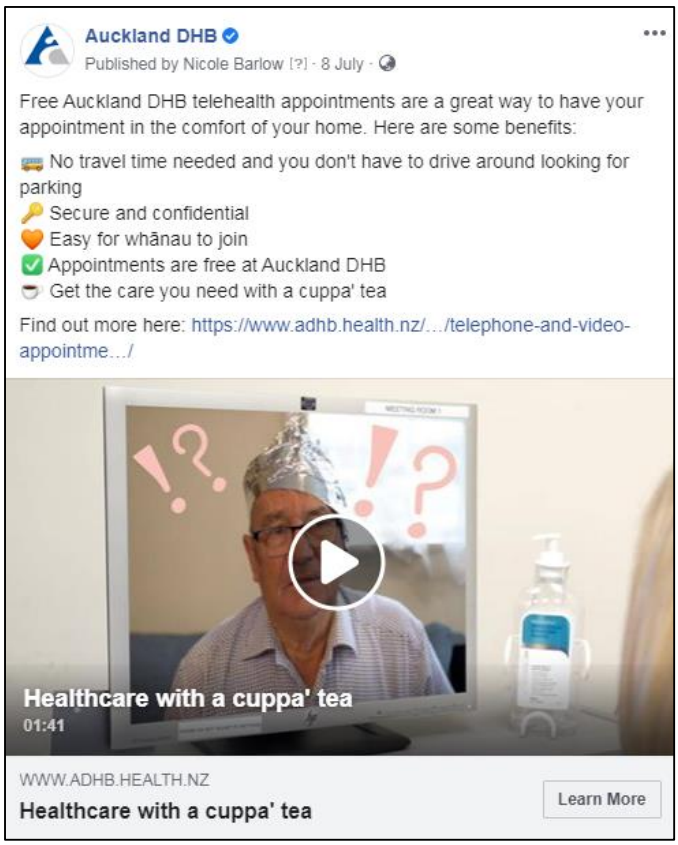
2.4.4 Social Media

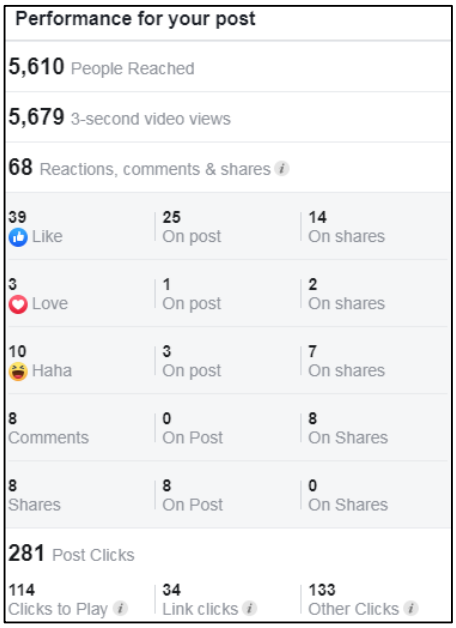
Followers
LinkedIn: 14,898
Facebook: 10,607
Twitter: 4,086

Top posts and statistics

Facebook

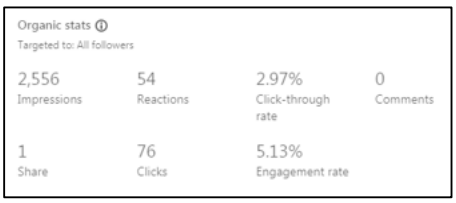


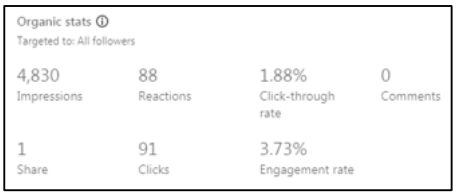

Auckland DHB
Published by Nicole Barlow [?] · 8 July ·
Free Auckland DHB telehealth appointments are a great way to have your appointment in the comfort of your home. Here are some benefits:
No travel time needed and you don't have to drive around looking for parking
Secure and confidential
Easy for whānau to join
Appointments are free at Auckland DHB
Get the care you need with a cuppa' tea
Find out more here: https://www.adhb.health.nz/.../telephone-and-video-appointme.../
Healthcare with a cuppa' tea
01:41
WWW.ADHB.HEALTH.NZ
Healthcare with a cuppa' tea
Learn More


Performance for your post
5,610 People Reached
5,679 3-second video views
68 Reactions, comments & shares
39 Like | 25 On post | 14 On shares
3 Love | 1 On post | 2 On shares
10 Haha | 3 On post | 7 On shares
8 Comments | 0 On Post | 8 On Shares
8 Shares | 8 On Post | 0 On Shares
281 Post Clicks
114 Clicks to Play | 34 Link clicks | 133 Other Clicks

LinkedIn


Auckland DHB
14,898 followers
2d •
Haere Mai to our new Partnership Leaders of the Mental Health and Addictions Directorate, Hineroa Hakiaha and Tracy Silva-Garay.
This is an exciting opportunity to continue to support our Te tiriti o Waitangi commitment and improve our mental health and addictions services.


Organic stats
Targeted to: All followers
2,556 Impressions
54 Reactions
2.97% Click-through rate
0 Comments
1 Share
76 Clicks
5.13% Engagement rate



2.5 Our People

2.5.1 Local Heroes

There were 26 people nominated as local heroes in April and May. Congratulations to our April and May Local Heroes. Here are their nominations:

April – Laura Ison
Mental Health Nurse, Buchanan Rehabilitation Centre

"Laura truly lives the values of Auckland DHB with her boundless enthusiasm and clinical expertise. She is compassionate, collaborative, fun, warm and always willing to go the extra mile. Laura shares her love of what she does amongst her workmates, and its wonderful being around Laura and watching her do what she does in the workplace. Above all else, Laura sets the standard for excellence in all aspects of her work. She's one in a million."

May – Sandy Grant

Low Vision Coordinator, Eye Clinic, Greenlane Clinical Centre

"Sandy is a compassionate person who understood how difficult it was for my husband to come to terms with being blind. She talked and encouraged him to get out of bed and gave him the confidence to move forward. She put us in touch with the appropriate people, organised a white cane and an Alexa so he could listen to books and put him on the foundation list to get a guide dog. She's passionate about what she does and without her we couldn't have coped with this huge change. Sandy goes above and beyond and we love her to bits."

2.5.2 Ka Pai – Shout Outs

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

Here are some of the recent Shout Outs:

LabPlus Admin Team

"BIG shout out to Yvonne Chan, Mariska De Wet and Florence Grimma. Working during COVID was not easy for this team especially with 2/3 being brand new to ADHB. You've all done an awesome job and have done the lab proud!!! Keep up the good work team. "

Mobility Solutions

"A big congratulations and thank you to Mobility Solutions, ADHB's Wheelchair and Seating Assessment Service. This month the service which assists 100's of Aucklander's to get moving has reached 20 years of service. This Allied Health Team work with people of all abilities across the greater Auckland region to assist them to meet their mobility goals, maximise their safety and independence and optimise their positioning and pressure management. Over 1400 clients aged between 9 months and 99 years are life-long services

users and our team cover 100's of kms per week to meet the needs of these clients. Thank you to all the past and present staff of this team for all the work you do."

Tama Davis - Deputy Chair Board of Auckland DHB, Mana Whenua

"Thanks very much to Tama for supporting our opening of our Perioperative Directorate COVID awards with respect of Te Ao Maori. All our teams especially enjoyed the hongi process done after yours and Chris Horlock's mihi. Ka nui to mihi aroha kia koe Tama Davis. On behalf of our Perioperative whānau."

2.5.3 Celebrating our people

Professor Wayne Cutfield awarded the Gluckman Medal

Congratulations to Professor Wayne Cutfield, paediatric endocrinologist at Starship Child Health who is this year's recipient of the Gluckman Medal for his outstanding contributions to research.

The Gluckman Medal is the premier acknowledgement of excellence awarded each year by the Faculty of Medical and Health Sciences at the University of Auckland.

As a researcher Professor Cutfield's major contribution has been to show the link between restricted growth, preterm birth and impaired insulin sensitivity in childhood. In turn, this impaired insulin sensitivity can lead to long-term cardiovascular and metabolic problems. His work has led to better diagnosis and management of poor metabolic control in childhood.

Professor Cutfield is also the Director of A Better Start, the National Science Challenge responsible for a national collaboration of researchers working to lift children's health and well-being outcomes.

2.5.4 Senior Leadership appointments

Haere mai to our new Mental Health and Addictions Directors

He aha te mea nui o te ao. He tāngata, he tāngata, he tāngata.
Congratulations to Hineroa Hakiaha and Tracy Silva-Garay who have been appointed as our first Partnership Leaders of the Mental Health and Addictions Directorate.
Hineroa and Tracy were outstanding applicants for the Director role with complementary strengths. As a result the interview panel proposed appointing both as a way of progressing our Tiriti o Waitangi commitment while continuing our clinical leadership model.

Both Hineroa and Tracy are appointed from within Auckland DHB; Hineroa as Manawanui and Directorate Māori Lead Service Clinical Director, Tracy as Nurse Director Mental Health and Addictions and most recently Interim Director for Mental Health and Addictions.

Welcome back to our new Director for Community and Long Term Conditions

Haere mai to Samantha Titchener, who has been appointed as the Director of Community and Long Term Conditions. Sam rejoins us from Waitematā DHB where she was Director of Surgical Services and COVID-19 response lead. She was previously General Manager Cardiovascular Services for Auckland DHB as well as an interim Director of Cardiovascular Services.

Sam is a highly experienced leader and skilled nurse with many years of clinical experience in a wide range of services in NZ and Australia, including senior roles in transplant coordination.

3. Performance of the Wider Health System

3.1 Priority Health Outcomes Summary

	Status	Comment
Acute patient flow (ED 6 hr)		Jun 93%, Target 95%
Improved access to elective surgery (YTD)		88% to plan for the year, Target 100%
Faster cancer treatment		Jun 97%, Target 90%
Better help for smokers to quit: • Hospital patients • PHO enrolled patients • Pregnant women registered with DHB-employed midwife or lead maternity	  	Jun 96%, Target 95% Mar Qtr 85%,Target 90% Dec Qtr 97%,Target 90%
Raising healthy kids		June 100%, Target 95%
Increased immunisation 8 months		Mar Qtr 94%, Target 95%

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

4. Financial Performance

The preliminary and unaudited financial result for the DHB for the year ended 30 June 2020 is a deficit of $101.9M against a budgeted deficit of $20M (81.9M unfavourable). $87.1M of this deficit is mainly due to two abnormal unbudgeted items i.e. an increase in the provision for the liability for non-compliance with the Holidays Act of $60.8M and unfunded Covid-19 impacts of $26.3M. Without these impacts, the underlying business as usual result is a deficit of $14.8M which would have been favourable to the planned deficit by $5.2M. The distribution of the full year result across the three divisions is as follows: Provider arm deficit of $168.7M (unfavourable to budget by $96.7M), partially offset by the Funder Surplus of $65M (favourable to budget by $13M) and a Governance Arm surplus of $1.8M (favourable to the planned breakeven position).

For the new financial year 2020/21, work is continuing to complete a revised budget in line with the position discussed at the last Finance Risk and Assurance Committee meeting. Board approval will be sought once this is completed.

Occupational Health and Safety Performance Report

5.2

Recommendation:

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

Prepared by: Alistair Forde, Director Occupational Health and Safety
Endorsed by: Mark Edwards, Chief Quality, Safety, and Risk Officer
Date: July 2020

Glossary

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

Board Strategic Alignment

Community, whanau and patient-centred model of care	*Supports Patient Safety, workplace safety, visitor safety, worker health and wellbeing.*
Emphasis and investment on both treatment and keeping people healthy	*This report comments on organisational health information via incidents, worker safety, health monitoring and leave information.*
Service integration and consolidation	*This report details mandatory workplace safety audit results and reports findings and updates to the Finance Risk and Assurance Committee.*

 Intelligence and insight	*The report provides information and insight into workplace incidents and what Auckland DHB is doing to respond to these and other workplace risks.*
 Consistent evidence-informed decision-making practice	*Demonstrates Integrity associated with meeting ethical and legal obligations.*
 Outward focus and flexible, service orientation	*Health, safety and wellbeing risks and programmes are inherently focused on staff, patients, visitors, students and contractors. All strategic and operational work programmes and policy decisions are discussed with relevant services such as site visits and approaches to reduce risks.*
 Emphasis on operational and financial sustainability	*Addresses Risk minimisation strategies adopted.*

Performance Summary

Lead Indicators

Description	Actual	Previous Month	3mth Trend	6mth Trend
Leadership Observations	49	196	↑	↑
Leadership Discussions (H&S Rep Meetings, Regional H&S Technical Advisory Group (TAG) ACC/Safe 365	178	107	↑	↑
Training (Inductions/PPE/Patient Handling)	132	91	↓	↓
Audits/Inspections	TBC	39	↑	↑

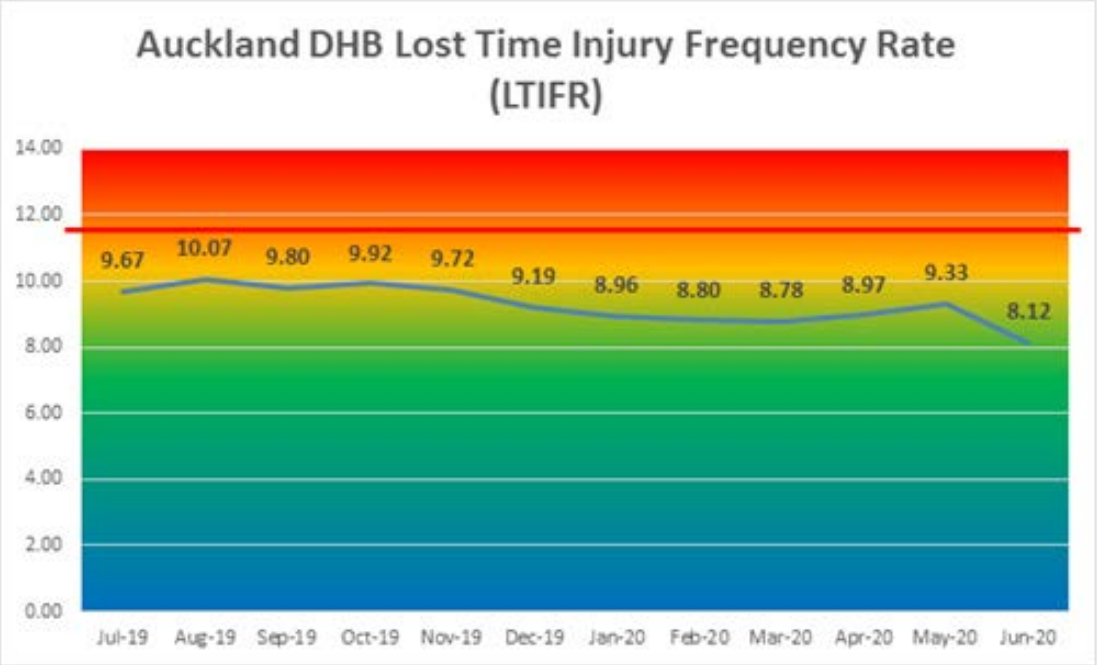
a. For the month of June 2020 we had 359 leadership activities across Auckland DHB, which decreased from the previous month.
b. In June 2020 we completed 11 site visits resulting in 49 (33 Safe, 12 At-Risk, 4 Significant At-Risk) observations. The Significant At-Risks observations were around hazardous substances not being managed correctly and fire extinguishers not being available for working in explosive atmospheres.
c. All above observations were communicated to workplace managers to rectify.
d. The number of Leadership Discussions has increased from last month. This has been enabled by the easing of COVID–19 level restrictions.
e. The focus of the leadership discussions has been on validating the controls for our key workplace risks such as Workplace Violence and Lone Worker risks. We are also emphasising the importance of continued coaching and mentoring across the Directorates.
f. Our H & S Inductions for the month of June have increased from the previous month to 44% completed but this remains below achieving above 90% consistently.

g. We know that some of the induction figures are reported late resulting in a lower than actual number being reported, but in general the Directorates are not consistently ensuring Inductions are being completed.
h. We have reported this back to all of our Directorates and asked for 100% delivery of H & S Inductions and for this to be reported in the correct month. To facilitate reporting a monthly reporting template has been introduced. This will include completed inductions versus incomplete/not completed and it will require each Directorate to provide an explanation for variance. To highlight importance, we will also raise this at the next H&S Governance meeting in August as a key concern.
i. A monthly schedule of validating our 12 key risks to ensure our control measures are working effectively has been put in place.
j. We have changed our current Board and FRAC reporting to be completed monthly in the first working week of each month to ensure the most up-to-date information can be presented in this report.

Lag Indicators

Description	Target	Actual	Prev Month	3mth Trend	6mth Trend	12mth Trend
Total Recordable Injury Frequency Rate (TRIFR)(per 1,000,000 hrs)	–	**28.19**	**28.12**	**26.22**	**25.94**	**31.31**
LTI Frequency Rate (LTIFR)(per 1,000,000 hrs)	10.00	**8.12**	**9.33**	**8.97**	**8.96**	**9.67**
All Injury Frequency Rate (AIFR)(per 1,000,000 hrs)	–	**119.60**	**128.56**	**122.11**	**106.38**	**60.39**

a. Across Auckland DHB there were 35 recordable injury claims in June 2020. These are mainly Lost Time and Medical Treatment injuries.
b. The TRIFR increased from last month, but the LTIFR and AIFR decreased.
c. We are currently formalising specific procedures to address injury prevention and management. Our expectation is that this process will take several months of review and implementation.
d. We should start seeing a decrease in all types of injuries as we embed new and improved processes during this period of change.



Lost Time Injury Frequency Rate fell compared with the previous month due to a slight decrease in Recordable injuries received from ACC claims. The injuries that were received were mainly related to manual handling, slips and falls.
It will take several months of analysis and observation to determine whether the current controls for reducing our Lost Time injuries are working.

Risk Analysis

Occupational Health and Safety (H&S) Risk Management

There are 3 significant risks (HS 04, HS 11, HS 12) with a risk rating of high, described as follows.

Workplace Violence and Aggression (HS 11)

There was a change from last month for the Heat Map (Appendix 2) where Workplace Violence has reduced in likelihood but still remains a high risk to Auckland DHB.

Our assessment of the risk controls from the Deep Dive completed in July reflected an increase in this type of incident from the previous 12 months due to increased reporting. Overall the severity of the incidents has not changed, but the overriding concern was that incidents are still occurring and the severity of Workplace Violence has not dramatically changed specifically around physical contact involving patient to staff members.

There is a comprehensive suite of controls that have been put in place over the last 12 months. We observed that the (now current) controls are not all being followed consistently and have raised this back to our Directorate Leads to ensure the uptake and implementation of these controls are consistently applied by our people.

We have put in place a monthly evidence check for Workplace Violence and Aggression to ensure there is a consistent approach to following our controls.

Remote and Lone Worker (HS 04)

The residual consequence associated with this risk remains the same as the inherent consequence, but the likelihood has reduced due to existing and new controls. To further reduce this risk

consistent knowledge and behaviour by our people in following the existing processes will reduce the likelihood further.

There was a change from last month for the Heat Map (Appendix 2) where Remote and Lone Worker risk increased from Moderate to High to fairly reflect the current severity of this risk. The previous reporting of this residual risk as moderate was incorrect due to consequence being underrated and the risk has been revised in line with our Risk Appetite and overall performance around the management of this risk.

Our observations highlighted that there is a small number of community lone worker staff who are not using the "Get Home Safe" app and there is still some inconsistent understanding towards using the app. This information has been communicated to those areas to address directly with staff.

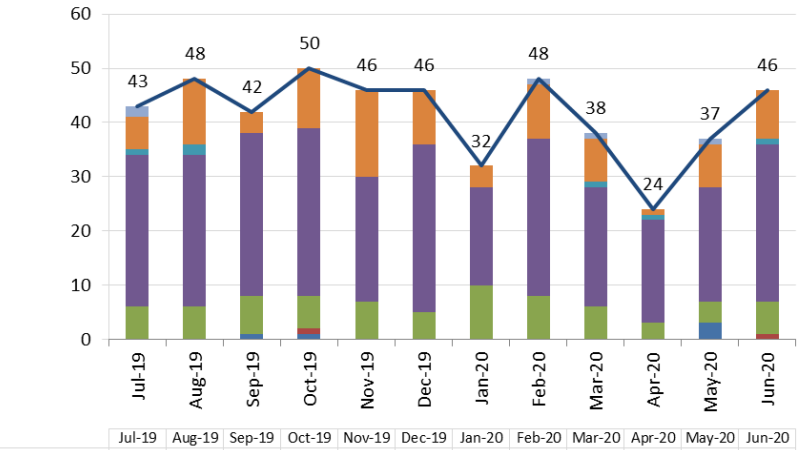
Biological Hazards (HS 12)

There was no change from last month for Biological Hazards.

We observed a number of key risk controls for COVID still in place. Events in the past month highlighted in the media have reinforced the importance of maintaining these controls consistently. We have also been working with the Ministry of Health to ensure our people operating outside of the hospital (mainly at border control) understand and are managing risk.

The consequence associated with this risk remains the same but the likelihood is low because of ongoing border controls and no community transmission.

Blood and Body Fluids Incidents



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

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

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

Vulnerable Staff and COVID-19

We are currently moving all of our Self-Assessment forms across into Medtech which is expected take several weeks of medical coding. The medical advice to our vulnerable staff is continuing but reducing due to the lower likelihood of COVID risk in our community and current Auckland DHB controls.

Information Technology

Our current ongoing improvements for Medtech 32 are on hold at present due to other priorities.

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

The 'Making Health Safer' project sponsored by ACC is nearing year 1 of completion. This opportunity has allowed Auckland DHB to better understand the health and safety maturity of 600 contractors in our supply chain. The project team are in the process of formulating an Insights Report which will highlight not just the maturity of our individual contractors but also highlight them collectively as a group in terms of their safety capability and culture with a specific focus on their strengths and weaknesses. This Insights Report will be available in the week of 10 August along with a narrative of key findings and learning to emerge from the project. Many of these findings will likely have significant implications for how Auckland DHB manages its contractors. We will outline and discuss these at the next Board meeting. It is important to note that they have significant implications for our PCBU responsibilities and obligations. Reducing DHB risk exposure will require a more systematic approach to managing our contractor supply chain. A business case for year 2 and 3 funding from ACC is currently being prepared to identify enhancements to our contractor management system and leverage the insights and data gained to date including a risk-based approach to managing contractors.

Auckland DHB Health and Safety Committee

The Auckland DHB Health and Safety Committee meet six-weekly.
Our next meeting is on 14 August 2020.
We have formed a working group to review the H&S representative roles with the development of a H&S representative procedure to help support our commitment to Worker Participation by streamlining our issue resolution and communication processes, and ensuring significant issues are being resolved, reviewed and communicated to all levels of the business. We expect both the procedure and H&S representative role description to be in place formally over the next few months.
Figures 1 and 2 describe the relationship, communication and resolution process Auckland DHB will have with its H&S representatives.

Figure 1

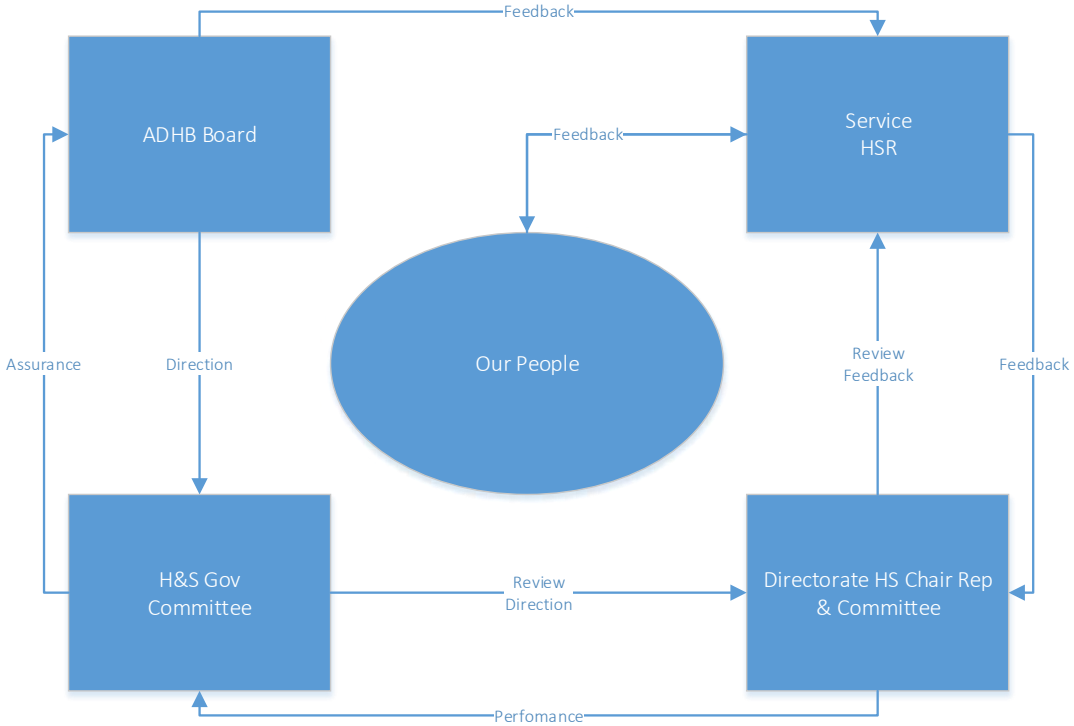
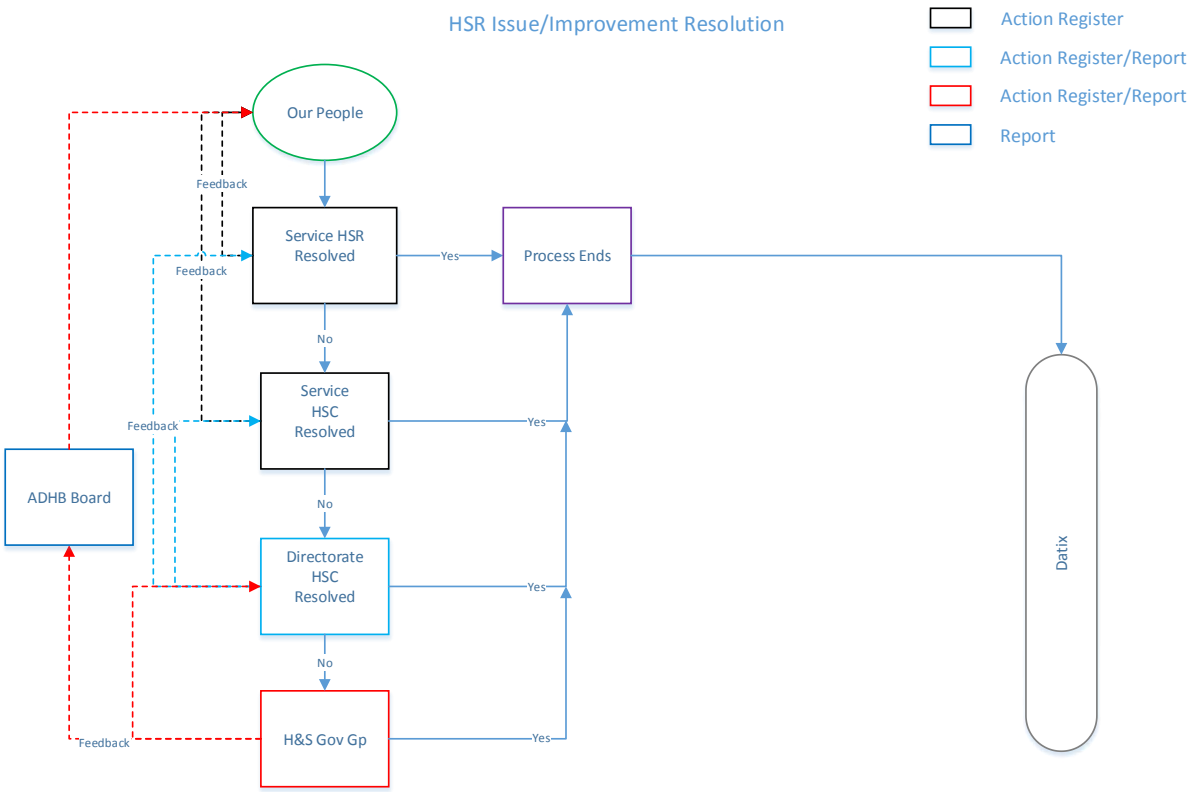


Figure 2



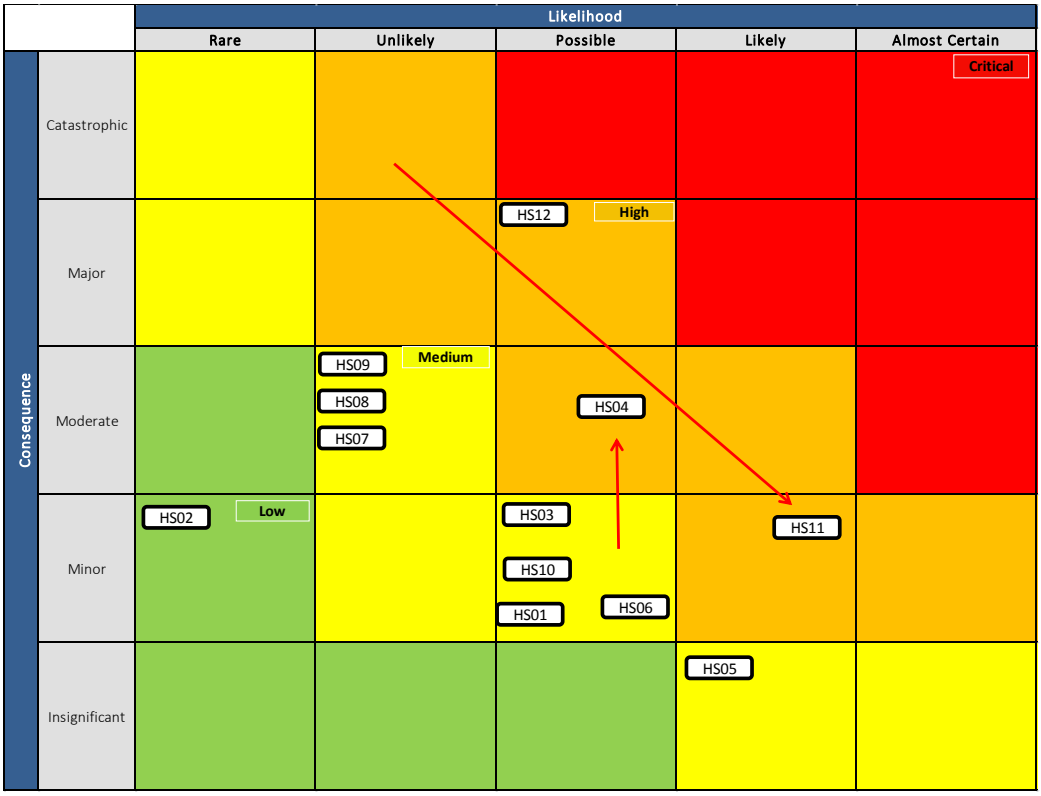
Appendix 1

% Pre-employment screening before start date	93
Training	
# local H&S Induction completed (one month lag)	44
# H&S e-learning completed (excl. RMOs & HOs, one month lag)	69
# H&S Representatives Trained	19
# MAPA training completed in high risk WV areas	0
Audits	
# of contractor audits completed	0
% compliance contractor audits	0
# of Hazardous Substance audits conducted	0
% Hazardous Substance audits compliant	0

Appendix 2

Health and Safety Risks

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



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

Financial Performance Report for the year ended 30 June 2020

Recommendation

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

Prepared by: Rosalie Percival, Chief Financial Officer
Date: 29 July 2020

1. Executive Summary

Financial performance for the full year to 30 June 2020 shows a deficit of $101.9M, which is $82M unfavourable to the budgeted deficit $20M. The significant adverse variance is driven by an increase in the provision for the Holidays Act liability and unfunded Covid-19 impacts. When these are excluded, the underlying result is favourable to the planned deficit by $5.2 M. This is summarised in the table below:

Reconciliation of 2019/20 Result	$'000s		
	Budget	Actual	Variance
Holidays Act Provision increase	0	(60,769)	(60,769)
Covid-19 Unfunded Impacts	0	(26,342)	(26,342)
Subtotal Deficit	0	(87,111)	(87,111)
BAU underlying result	(20,000)	(14,763)	5,237
Net Deficit	(20,000)	(101,874)	(81,874)

The distribution of the full year result across divisions is as follows:

Result by Division	For the year ending 30 June 2020		
	Actual	Budget	Variance
Funder	65,073	52,000	13,073 F
Provider	(168,709)	(72,000)	96,711 U
Governance	1,761	0	1,761 F
Net Surplus / (Deficit)	**(101,875)**	**(20,000)**	**81,875 U**

- The Funder arm result reflects NGO expenditure being favourable to budget mainly in demand driven services, uncommitted initiatives, one off prior year adjustments and favourable Inter District Flow (IDF) wash-ups. These offset the shortfall in funding for COVID-19 expenditure, and unfavourable Planned Care revenue.
- The unfavourable Provider arm result reflects the impact of the Holidays Act provision increase, and unfunded Covid-19 impacts and actuarial valuations.
- The favourable Governance result is mainly driven by less expenditure than budgeted infrastructure costs (mainly Professional fees).

2. Summary Result and Financial Commentary for June 2020

$000s	Month (June-2020)			For the year ending 30 June 2020			Full Year (2019/20)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Income									
Government and Crown Agency	148,024	138,009	10,015 F	1,687,379	1,657,122	30,257 F	1,679,037	1,657,122	21,915F
Non-Government and Crown Agency	10,456	8,510	1,946 F	103,060	104,022	962 U	101,114	104,022	2,908U
Inter- District Flows	59,542	56,624	2,918 F	686,267	686,196	71 F	682,047	686,196	4,148U
Inter-Provider and Internal Revenue	1,266	1,164	101 F	14,912	14,079	834 F	14,811	14,079	732F
Total Income	**219,288**	**204,306**	**14,981 F**	**2,491,618**	**2,461,418**	**30,200 F**	**2,477,009**	**2,461,418**	**15,591F**
Expenditure									
Personnel	181,364	100,870	80,494 U	1,211,108	1,115,795	95,313 U	1,171,447	1,115,795	55,652U
Outsourced Personnel	2,819	1,175	1,644 U	28,269	14,155	14,114 U	26,625	14,155	12,470U
Outsourced Clinical Services	4,655	3,716	939 U	44,315	44,636	321 F	43,497	44,636	1,139F
Outsourced Other Services	5,879	6,807	928 F	82,480	81,687	794 U	83,408	81,687	1,721U
Clinical Supplies	27,174	25,649	1,525 U	308,527	304,101	4,427 U	312,849	304,101	8,748U
Funder Payments - NGOs and IDF Outflows	62,204	59,095	3,109 U	702,165	705,213	3,048 F	706,545	705,213	1,331U
Infrastructure & Non-Clinical Supplies	18,760	18,453	307 U	216,629	215,831	799 U	207,485	215,831	8,346F
Total Expenditure	**302,855**	**215,766**	**87,090 U**	**2,593,493**	**2,481,418**	**112,077 U**	**2,551,857**	**2,481,418**	**70,439U**
Net Surplus / (Deficit)	**(83,567)**	**(11,459)**	**72,108 U**	**(101,875)**	**(20,000)**	**81,876 U**	**(74,847)**	**(20,000)**	**54,848 U**

Result by Division	Month (June-2020)			For the year ending 30 June 2020			Full Year (2019/20)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funder	9,411	3,325	6,086 F	65,073	52,000	13,073 F	52,005	52,000	5 F
Provider	(94,411)	(14,773)	79,639 U	(168,709)	(72,000)	96,711 U	(128,613)	(72,000)	56,613 U
Governance	1,433	(11)	1,445 F	1,761	0	1,761 F	1,761	0	1,761 F
Net Surplus / (Deficit)	**(83,568)**	**(11,459)**	**72,108 U**	**(101,875)**	**(20,000)**	**81,875 U**	**(74,847)**	**(20,000)**	**54,847 U**

Commentary on DHB Consolidated Financial Performance

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

Total Revenue for the month is favourable to budget by $15M (7.3%) with major variances as follows:

- $10M (7.3%) favourable Government and Crown Agency revenue, mainly due to new and additional funded initiatives funding. This includes COVID-19 funding, new Mental Health initiatives, additional capital charge funding as advised by the Ministry from March 2020 and funding for MECA (PSA and MERAS) settlement received from November 2019. These are offset by a Planned Care revenue shortfall.
- $2M (22.9%) favourable variance in Non-Government and Crown Agency is mainly driven by higher than budget income for the month from non resident patients, donations, and general rents.
- $2.9M (5.2%) favourable IDFs, mainly due to favourable IDF wash-ups as advised by the Ministry offset by an adverse revision of the Undischarged inpatients provision. The variance also includes the net favourable impact of PHO wash-ups to appropriately account for changes in GP enrolments and fee for service wash up.

Total Expenditure for the month is unfavourable to budget by $87M (-40.4%) mainly driven by:

- $82M (-80.5%) unfavourable variance in Personnel/Outsourced Personnel costs due to
  - Holidays Act provision $60.8M
  - Increase in provisions for staff related liabilities $13.7M unfavourable
  - FTE above budget by 227, with the main contributing factor being additional resources as a result of the Covid-19 response, equating to a $2.1M unfavourable variance.
  - Estimated $3.9M additional cost for reduction in annual leave taken due to Covid-19.
  - The remaining $1.7M unfavourable variance reflects a small variation in cost per FTE between budget assumption and actuals
- $1.5M (-5.9%) unfavourable variance in Clinical supplies, with the key variances being:
  - Covid-19 costs $0.6M, being PPE for $0.4M and Covid-19 test consumables $0.2M
  - PCT (cancer) drugs $0.5M
  - The balance of $0.4M represents additional costs in Perioperative and surgical specialties reflecting high activity for the month.

- $3M (-5.3%) unfavourable variance in in NGO and IDF Outflows is mainly due to new specific COVID-19 and Mental Health initiatives, partially offset by favourable National IDF (Outflows) wash-ups, favourable demand driven expenditure, funded and unfunded initiatives not committed.

Year to Date Result - Major variances to budget on a line by line basis are described below:

Revenue is favourable to budget by $30M (1.2%), mainly driven by:

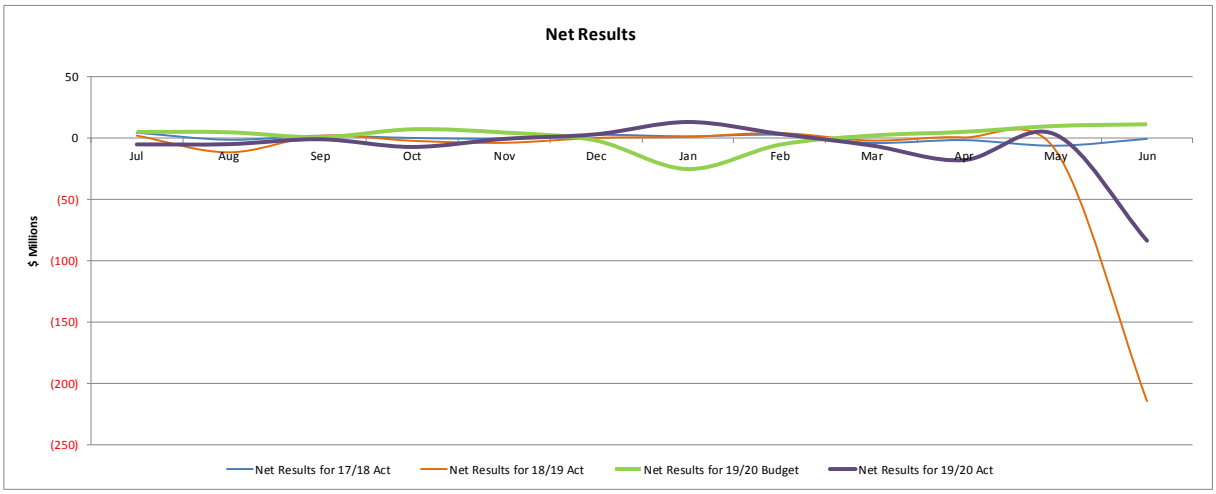
- $30M (1.8%) favourable Government and Crown Agency revenue, mainly driven by new COVID-19 funding, new Mental Health initiatives, additional capital charge received for asset revaluation, favourable prior year revenue wash-ups and additional funding for MECA (PSA and MERAS), partially offset by a shortfall in Planned Care funding.
- $1M (-0.9%) unfavourable variance in Non-Government and Crown Agency, mainly driven by Covid-19 impacts resulting in lower non resident volumes, lower financial income and reflecting additional revenue assumed for budget initiatives not received.

Total expenditure year to date is unfavourable to budget by $112M (-9.7%), mainly driven by:

- $109M (-1.7%) unfavourable variance in Personnel/Outsourced Personnel costs, reflecting:
  - Holidays Act provision $60.8M
  - Increase in provisions for staff related liabilities $13.7M unfavourable
  - Security staff $3.4M unfavourable but largely offset with favourable Outsourced security costs $2.4M favourable, reflecting transfer of security services in-house.
  - Estimated $18.8M additional Covid-19 related costs for reduction in annual leave taken, paid isolation leave and costs of additional resources.
  - After adjusting for the additional FTE for Covid-19, the remaining full year average FTE are approximately 30 (0.3%) above budget - equating to $3.4M unfavourable.
  - The balance of the variance, $7.9M, represents a variation in cost per FTE between budget assumptions and actual costs.
- $4M (-1.5%) unfavourable in Clinical supplies, mainly driven by the following key unfavourable variances:
  - Funded pharmaceutical cancer treatment (PCT) costs $4.8M over budget.
  - Haemophilia blood product $2.5M over budget – this is fully funded and will be subject to full wash up.
  - These unfavourable costs are offset by a net reduction in Clinical Supplies cost due to to the reduced patient volumes in March, April and May.
- $3M (0.4%) favourable NGO costs and IDF Outflows is due to favourable demand driven nature of expenditure, uncommitted initiatives, once off prior year adjustments, favourable National IDF outflow wash-ups, post budget service changes and PHO wash-ups. These were partially offset by new COVID-19 expenditure, new Mental Health initiatives expenditure and an increase in contribution to the National Haemophilia Management Group increased costs.

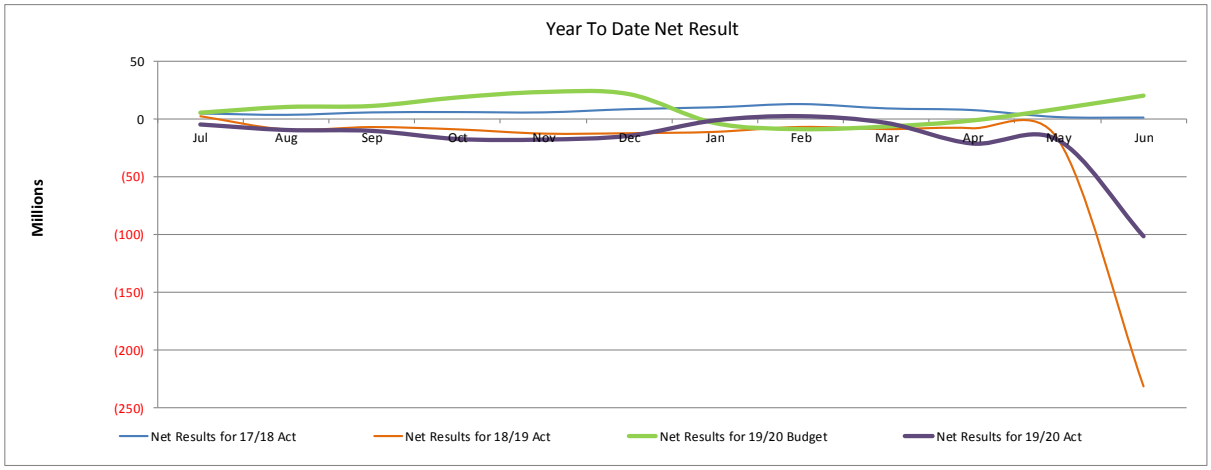
3. Performance Graphs

Figure 1: Consolidated Net Result (By Month)



$ millions	July	August	Spetember	October	November	December	January	February	March	April	May	June	Total
Net Results for 17/18 Act	4.569	(1.187)	2.114	0.283	(0.252)	2.806	1.585	2.793	(3.739)	(1.453)	(6.051)	(0.456)	1.012
Net Results for 18/19 Act	2.183	(11.446)	2.057	(2.009)	(3.665)	0.324	1.185	4.248	(1.830)	0.728	(9.280)	(214.462)	(231.967)
Net Results for 19/20 Budget	5.269	4.924	0.895	7.392	4.691	(1.834)	(25.085)	(5.260)	2.241	5.241	10.064	11.459	20.000
Net Results for 19/20 Act	(4.968)	(4.764)	(0.776)	(7.055)	(0.494)	3.289	13.310	3.679	(5.846)	(17.834)	3.151	(83.568)	(101.875)

Figure 2: Consolidated Net Result (Cumulative YTD)



$'millions	July	August	September	October	November	December	January	February	March	April	May	June
Net Results for 17/18 Act	4.569	3.382	5.497	5.779	5.527	8.333	9.919	12.712	8.972	7.520	1.468	1.012
Net Results for 18/19 Act	2.183	(9.263)	(7.207)	(9.215)	(12.880)	(12.556)	(11.371)	(7.122)	(8.953)	(8.225)	(17.505)	(231.967)
Net Results for 19/20 Budget	5.269	10.194	11.089	18.481	23.172	21.338	(3.746)	(9.006)	(6.765)	(1.524)	8.540	20.000
Net Results for 19/20 Act	(4.968)	(9.732)	(10.509)	(17.564)	(18.057)	(14.768)	(1.458)	2.221	(3.625)	(21.459)	(18.308)	(101.875)
Variance to Budget 19/20	(10.238)	(19.926)	(21.598)	(36.045)	(41.229)	(36.107)	2.289	11.227	3.140	(19.935)	(26.848)	121.875

4. Financial Position

4.1 Statement of Financial Position as at 30 June 2020

$'000	31/06/2020			31-May-20	Variance	30-Jun-19	Variance
	Actual	Budget	Variance	Actual	Last Month	Actual	Last Year
Public Equity	919,427	984,828	65,401U	913,147	6,280F	889,380	30,047F
Reserves							
Revaluation Reserve	599,151	599,151	0F	599,151	0F	599,151	0U
Accumulated Deficits from Prior Year's	(688,960)	(688,958)	1U	(688,960)	0F	(456,995)	231,965U
Current Surplus/(Deficit)	(101,873)	(19,996)	81,877U	(18,306)	83,567U	(231,965)	130,091F
	(191,682)	(109,804)	81,878U	(108,114)	83,567U	(89,808)	101,873U
Total Equity	**727,745**	**875,024**	**147,280U**	**805,032**	**77,287U**	**799,572**	**71,827U**
Non Current Assets							
Fixed Assets							
Land	347,122	347,122	0U	347,122	0F	347,122	0F
Buildings	624,109	628,168	4,059U	603,680	20,429F	631,462	7,354U
Plant & Equipment	86,655	99,875	13,220U	82,060	4,595F	86,580	75F
Work in Progress	74,834	157,874	83,041U	101,094	26,260U	52,223	22,611F
Total PPE	1,132,720	1,233,039	100,320U	1,133,955	1,235U	1,117,387	15,333F
Investments							
- Health Alliance	74,268	71,003	3,265F	70,158	4,110F	70,066	4,203F
- Health Source	271	-	271F	-	271F	-	271F
- NZHPL	5,755	6,714	959U	10,193	4,438U	6,714	959U
- ADHB Term Deposits > 12 months	-	15,000	15,000U	-	0F	15,000	15,000U
- Other Investments	518	-	518F	938	420U	937	420U
	80,812	92,717	11,905U	81,289	477U	92,717	11,905U
Intangible Assets	2,216	1,383	833F	2,194	22F	1,810	406F
Trust Funds	15,970	17,200	1,230U	15,831	139F	17,200	1,230U
	98,998	111,300	12,302U	99,314	316U	111,727	12,729U
Total Non Current Assets	**1,231,718**	**1,344,339**	**112,621U**	**1,233,269**	**1,551U**	**1,229,114**	**2,604F**
Current Assets							
Cash & Short Term Deposits	135,902	70,760	65,142F	136,133	232U	97,046	38,856F
Trust Deposits > 3months	16,394	13,300	3,094F	18,316	1,922U	13,300	3,094F
ADHB Term Deposits > 3 months	15,000	15,000	0F	15,000	0F	15,000	0F
Debtors	45,325	30,081	15,244F	22,700	22,626F	30,081	15,244F
Accrued Income	53,611	56,786	3,175U	59,126	5,515U	56,786	3,175U
Prepayments	5,729	996	4,733F	1,912	3,816F	996	4,733F
Inventory	27,511	14,357	13,154F	35,156	7,645U	14,356	13,155F
Total Current Assets	**299,472**	**201,280**	**98,192F**	**288,344**	**11,128F**	**227,566**	**71,906F**
Current Liabilities							
Borrowing	(1,828)	(3,879)	2,051F	(1,520)	308U	(1,079)	749U
Trade & Other Creditors, Provisions	(176,419)	(147,842)	28,577U	(186,227)	9,809F	(147,836)	28,583U
Employee Entitlements	(524,748)	(428,008)	96,740U	(444,493)	80,255U	(428,009)	96,739U
Funds Held in Trust	(1,384)	(1,275)	109U	(1,308)	76U	(1,308)	76U
Total Current Liabilities	**(704,378)**	**(581,004)**	**123,374U**	**(633,547)**	**70,830U**	**(578,231)**	**126,147U**
Working Capital	**(404,906)**	**(379,724)**	**25,182U**	**(345,203)**	**59,701U**	**(350,665)**	**54,240U**
Non Current Liabilities							
Borrowings	(10,136)	(19,697)	9,561F	(9,357)	779U	(8,983)	1,153U
Employee Entitlements	(88,931)	(69,894)	19,037U	(73,677)	15,254U	(69,894)	19,037U
Total Non Current Liabilities	**(99,067)**	**(89,591)**	**9,476U**	**(83,033)**	**16,034U**	**(78,877)**	**20,190U**
Net Assets	**727,745**	**875,025**	**147,280U**	**805,032**	**77,287U**	**799,572**	**71,827U**

Commentary

The major variances to budget are summarised below:

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

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

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

Employee entitlements (current and non current)
Increase in total employee entitlements is mainly due to increase in provision for Holiday Act by $60m and liabilities for long service leave and retirement gratuities by $19.8m.

Trade & Other Creditors and Provisions:

Trade & Other Creditors, Provisions:	**$000's**
Trade Creditors (including accruals)	159,650
Income in Advance	16,769
Total	176,419

4.2 Statement of Cash flows as at 30 June 2020

$000's	31/06/2020			For the year ending 30 June 2020		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Revenue Received	195,167	203,853	8,686U	2,481,987	2,455,972	26,015F
Payments						
Personnel	(85,854)	(100,255)	14,401F	(1,095,331)	(1,115,796)	20,465F
Suppliers	(32,328)	(48,042)	15,714F	(577,409)	(568,359)	9,050U
Capital Charge	(22,884)	(21,964)	920U	(45,993)	(45,986)	7U
Payments to other DHBs and Providers	(62,204)	(59,095)	3,109U	(702,165)	(705,212)	3,047F
GST	4,021	0	4,021F	3,842	0	3,842F
	(199,248)	(229,356)	30,108F	(2,417,056)	(2,435,353)	18,297F
Net Operating Cash flows	**(4,082)**	**(25,503)**	**21,421F**	**64,931**	**20,619**	**44,312F**
Investing						
Interest Income	178	454	276U	4,159	5,448	1,289U
Sale of Assets	27	0	27F	162	0	162F
Purchase Fixed Assets	(5,960)	(13,335)	7,375F	(71,962)	(160,020)	88,058F
Investments and restricted trust funds	2,057	0	2,057F	9,986	0	9,986F
Net Investing Cash flows	**(3,698)**	**(12,881)**	**9,183F**	**(57,655)**	**(154,572)**	**96,917F**
Financing						
Interest paid	(11)	(116)	105F	(562)	(1,296)	734F
New loans raised	1,308	0	1,308F	3,446	13,514	10,068U
Loans repaid	(30)	0	30U	(1,353)	0	1,353U
Other Equity Movement	6,280	7,954	1,674U	30,047	95,448	65,401U
Net Financing Cash flows	**7,547**	**7,838**	**291U**	**31,577**	**107,666**	**76,089U**
Total Net Cash flows	**(233)**	**(30,546)**	**30,313F**	**38,853**	**(26,287)**	**65,140F**
Opening Cash	136,133	101,306	34,827F	97,047	97,047	0F
Total Net Cash flows	(233)	(30,546)	30,313F	38,853	(26,287)	65,140F
Closing Cash	**135,902**	**70,760**	**65,140F**	**135,900**	**70,760**	**65,140F**
ADHB Cash				130,679	67,855	62,824F
A+ Trust Cash				4,877	2,562	2,315F
A+ Trust Deposits - Short Term < 3 months & restricted fund deposits				346	343	3F
				135,902	**70,760**	**65,140F**
ADHB Short Term Investments 3 > 12 months				15,000	15,000	0F
A+ Trust Short Term Investments 3 > 12 months				16,394	13,300	3,094F
ADHB Long Term Investments				-	15,000	15,000U
A+ Trust Long Term Investment Portfolio				15,970	17,200	1,230U
Total Cash & Deposits				**183,264**	**131,260**	**52,004F**

Planning Funding and Outcomes Update

Recommendation

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

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

Glossary

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

NHI	-	National Health Index
NIR	-	National Immunisation Register
NRA	-	Northern Region Alliance
NRHCC	-	Northern Region Health Coordination Centre
OIS	-	Outreach Immunisation Service
PCV	-	Pneumococcal virus
PFO	-	Planning, Funding and Outcomes
PHARMAC		The Pharmaceutical Management Agency
PHO	-	Primary Health Organisation
PFO	-	Planning, Funding and Outcomes
POAC	-	Primary Options for Acute Care
PPAL	-	Positive Parenting Active Lifestyle
PPE		Personal Protective Equipment
PRRT	-	Peptide Receptor Radionuclide Therapy
RhF	-	Rheumatic Fever
RFP	-	Request for Proposal
SHH	-	Sexual Health Hub
SMILE	-	Smoke and Alcohol Free, Mental wellbeing Matters, Immunise, Lie on Your Side and Eat Healthily
STI	-	Sexually Transmitted Infections
UR-CHCC		Uri Ririki - Child Health Connection Centre
WCTO	-	Well Child Tamariki Ora

1. Purpose

This report updates the Auckland District Health Board (DHB) on Planning and Funding and Outcomes (PFO) activities and areas of priority, since its last meeting on 1 July 2020.

2. Planning

2.1 Annual Plans

The second draft of the 2020/21 Annual Plan was submitted to the Ministry of Health on 10 July 2020 and feedback was received on 13 July 2020, including feedback on performance measures. Revisions and amendments were made to the Annual Plan in response to this feedback, noting that this did not include any amendments to the financial information. A further draft was submitted to the Ministry on 17 July.

Review and update of Annual Plans will continue, once further information is received from the Ministry of Health and other actions, measures and targets are finalised. The financial content and templates will continue to be updated as and when any amendments are agreed.

It should be noted, that as per the modification to the Crown Entities Act (149CA), DHBs will be required to have a final, signed 2020/21 Statement of Performance Expectations (including the financial position at that time) published to the DHB's website by 15 August 2020. Notice to take up this extension, in line with the modification to the legislation, has been published to the DHB's website, as required.

2.2 2019/20 Annual Reports

2019/20 audit has commenced, we are working with the auditors to complete initial requirements. Audit NZ, the Ministry of Health and the DHB have agreed to the production of a 'cut-down' version of the Annual Report this year, due to limited staff time because of COVID-19 response activities.

These response activities have impacted on service delivery and this, in turn, will be reflected in performance against many of the indicators/targets presented in the Annual Report. Audit NZ have requested the completion of a COVID-19 Questionnaire to get an overview of:

- Covid-19's impact on Auckland DHB (Both Financial and Service Performance); and
- What Auckland DHB has done to address Covid-19

The recently updated population estimates (from StatsNZ and the Ministry of Health) will also impact some indicators. These impacts are being discussed with the auditors.

3. COVID-19 Response

Many of the Planning Funding and Outcomes team have continued to be seconded to the Northern Region Health Coordination Centre (NRHCC), Auckland Regional Public Health Service (ARPHS) and other areas to help in the response. A particular focus for the teams are the testing approaches (symptomatic and asymptomatic testing) and the Managed Isolation and Quarantine Facilities. As a consequence, much of the 'business as usual' has remained on hold. Team members have put in an extraordinary effort as has others from the wider DHB teams in responding to a rapidly changing environment.

4. Primary Care

4.1 Response to COVID-19

The primary care team continues to be involved in the Northern Region Health Coordination Centre. The role of Community Based Assessment Centres (CBAC) remains a key priority to support both swabbing of people with symptoms and surveillance swabbing in accordance with the national guidance. The role of CBACs is likely to be needed for up to another 6 months. As a consequence the number and locations of the CBACs has been reviewed as have the mobile testing clinics. The mobile testing clinics are in the main swabbing people in the Managed Isolation Facilities.

As at July 14th, CBACs and mobile clinics have swabbed over 100,000 people and another 53,000 people have been swabbed through their general practitioner across metropolitan Auckland.

Table 1. Proportion of tests taken at CBACs and mobile testing clinics by ethnicity (Source: e-notifications)

Māori	12%
Pacific	18%
European	44%
Asian	20%
MELAA	2%
Other	3%

The government announced a $18 million support package for community pharmacy. The $18 million fund is in addition to the $15 million government funding paid to all pharmacies during Alert Level 4 Lockdown, and the various advanced payments made by DHBs to support pharmacy cash flow in April and May. Funding will be held centrally by the Ministry of Health, but the application process will be managed by DHBs. The DHBs have developed a nationally consistent approach to the allocation of these funds. There are some caveats on the use of the funds as specified by Cabinet; (i)

the fund is not universal and targets pharmacies that meet a set of eligibility criteria and, because of COVID-19, require financial support to remain viable, (ii) the DHB assesses that the pharmacy is critical based on factors including location; provision of specific services; and servicing high needs or vulnerable populations, (iii) critical pharmacies will be required to demonstrate to the DHB, through an 'open book' process, that they have exhausted all other funding avenues, including government COVID-19 business support packages and other financial supports, to remain open, i.e. there is no reduction in service provision.

During level 4, approximately 500, rough sleepers were accommodated in to motel units across metropolitan Auckland. Social housing providers are working on finding permanent housing for those temporarily placed in to motel units. It will possibly take up to six months to find permanent housing for all of these people. Many of these rough sleepers are not enrolled with a primary care provider and have untreated or poorly treated health need. The DHBs have funded an interim health service to address health need and to support enrolment and engagement with a general practice.

4.2 Flexible Funding Pool

The Flexible Funding Pool is a revenue stream within the PHO Services Agreement that allocates funding based on the demographics of the enrolled population of a PHO and is weighted for deprivation. The Auckland Waitematā Alliance and the Counties Manukau Health Alliance have worked on the development of a revised framework for the Flexible Funding Pool. The revised framework is being presented to a joint Alliance Leadership Team meeting at the end of July. The revised frame work will be presented to the DHB Boards for endorsement.

Historically the application of the Flexible Funding Pool has been determined, with some DHB input, individually by PHOs. This has led to variation in the type and range of service invested in. The new framework will provide a consistent approach for allocation while allowing some flexibility to address a particular need within any given PHO.

The next step in the development is an outcomes measurement framework so we can assess impact on health outcomes. This will enable a more exacting mechanism to identify programmes providing better outcomes compared to other similar programme. This will then enable a continuous improvement approach to be applied to maximise this investment over time.

4.3 Metro Auckland Data Sharing Framework

The Metro Auckland Data Sharing program (MADS program) is a partnership initiative between the Metro Auckland PHOs and DHBs to enable the secure sharing of health data between the stakeholders for the purpose of population health improvement.

It is supported by a Framework (suite of guidelines, policies and processes) that was setup by the Metro Auckland Data Stewardship Group and directs exchange of health data between the stakeholders in the Metro Auckland area and ensures its compliance with the requirements of the Privacy Act and the Health Information Privacy Code. The Framework was endorsed by Counties Manukau Health and Auckland Waitemata Alliance Leadership Teams (ALTs) in August and September 2015 respectively.

Examples of data sharing include data that forms the after-hours dashboard (includes urgent care clinic, emergency department and St John data) and the diabetes data set to name but two examples. Since the development of the framework the scope of data sharing has expanded and the exchange of data is now supported by a secure portal known as HealthSafe which was developed in 2018. Considering the rate of change in the effective management of data a review of the framework has been undertaken. The review and the associated recommendations are now being

considered by the Alliance Leadership Team and implementation planning is underway. Some key findings of the review were:

- The Metro Auckland Data Sharing Framework and HealthSafe are sound concepts with significant potential to support improvements in health services delivery and outcomes. Metro Auckland greatly benefits from having robust data sharing processes in place between primary and secondary care (and other users).
- This program is an important regional resource, both in its people, the range of technical infrastructure available and also the knowledge that has been attained with the operational experience over the framework.
- Technical capabilities have evolved along with sector aspirations for data sharing opportunities with potential to improve care both at the population and individual level.
- There is a growing appreciation for how data generated in primary care can be used to monitor change at a population level. Originally the focus was on data exchange whereas now the focus is far more on enabling a wide range of information sharing which involves matching datasets for various programs and situations.
- It is worth the investment of time and effort to improve and update the Framework and to consider any extensions to the HealthSafe functionality required.

This framework and the development of HealthSafe better places the DHBs and PHOs to measure performance and identify if interventions are delivering on improve health outcomes or not. Thus, enabling improved reinvestment and or new invest decision making based on metrics of outcomes.

Figure 1. Metro Auckland Clinical Governance Forum CVD and Diabetes indicators

5. Health of Older People

5.1 Aged Residential Care

The offer from DHBs to increase 2020/21 service level prices for aged residential care (ARC) by 3% was initially rejected by the sector. The main reason for the rejection was that the offer failed to adequately address the issue of pay parity for nurses working in ARC with their counterparts in DHBs. The offer was subsequently accepted when DHBs committed to working with the sector over the coming months, as a priority, to establish a clear position on pay parity with the view that this work be used to inform any budget bid considerations if indicated by government. It was acknowledged that pay equity issues extend beyond ARC and government interest is in understanding the broader picture.

It had previously been agreed that ARC providers would start publishing their minimum and maximum charges for rooms on the 1 July 2020. However, the work to prepare and reach agreement for how room charges would be notified was paused due to COVID-19. The sector has now requested that this be addressed at the same time the 'opt out' clause for premium room charging is reviewed in the national Aged Related Residential Care (ARRC) Agreement as the sector view is the clause is not always being used for cases of financial hardship. A deadline has been set to resolve these two issues by 1 October 2020. A variation to the ARRC Agreement will be issued then if required.

Maintaining ARC COVID-19 preparedness and planning for an outbreak remains a priority. The DHB quality and monitoring manager will review a facility's preparedness assessment if there is a change in manger or any other significant change at a facility. Relevant information from the COVID-19 preparedness assessments will also be provided as pre-audit feedback to the independent auditors for their site visits.

5.2 Other Health of Older People Services

Home and Community Support Service (HCSS) visiting guidelines have been updated for HCSS providers for when a client or household member: is a suspected, probable or confirmed case of COVID-19; has acute respiratory symptoms; or has been in contact with a confirmed case of COVID-19 in the last 14 days. The Northern Region DHBs' approach to supporting HCSS providers during the Alert levels 4-2 worked well and are able to be quickly re-established if required.

6. Child, Youth and Women's Health

6.1 Immunisation

6.1.1 Childhood Immunisation Schedule Vaccinations

There has been a significant primary healthcare disruption over the last two quarters due to COVID-19. The provisional results for the 8 month immunisation focus area for Quarter 4 are 94% Total, 83% Māori and 92% Pacific. The target of 95% has not been achieved. Despite concerns of COVID-19 impact, we have achieved higher coverage than the same time last year 92.8% Total, 82.1% Māori and 92.0% Pacific.

The COVID-19 impact is more likely to be felt in the first quarter of 2020/21. We are monitoring 6 month and 18 month immunisation coverage as a measure of timeliness. The 3 month rolling average coverage for children turning 6 months appears stable, however the one month rolling average, a more 'real-time' indication (although prone to fluctuation due to population size), has shown a reduction in coverage with some recovery. This is consistent with community feedback regarding reluctance to access health services. Tamariki Māori have been most affected by the drop in on-time coverage and we are working with Primary Health Organisations (PHOs) and Well Child Tamariki Ora (WCTO) colleagues on initiatives to catch up these children. The National Immunisation Register (NIR) team have identified the Māori and Pacific cohort who were due immunisation during lockdown for priority follow up by the NIR team and Outreach Immunisation Service (OIS).

Māori Immunisation Coverage as at	6m	8m	18m	24m
23/03/20	78. %	87. %	63. %	89. %
20/04/20	65. %	84. %	69. %	89. %
18/05/20	52. %	83. %	54. %	86. %
15/06/20	56. %	91. %	78. %	94. %
13/07/20	63. %	72. %	72. %	89. %

During the COVID lockdown immunisation uptake fell. Contributing factors included parental concerns around social distancing in primary care practices and various access issues such as:

- Reduction in general practice services with several large high-needs practices that do not routinely take booked appointments and closed satellite clinics resulting in some parents having to adapt rapidly,
- absence of opportunistic immunisation,
- the pause of outreach immunisation services from around 25 March -17 April (even after the provider developed protocols, accessed Personal Protective Equipment (PPE) and restarted, they reported that home visiting uptake in the community was slow). The outreach immunisation service has now resumed the drop-in aspect of their service which will have a positive impact on immunisation uptake.

As at 1 July 2020, the Immunisation Schedule has dropped the 3 month Pneumococcal virus (PCV) vaccine (PCV-10) dose (so now only given at 6 weeks and 5 months), high risk PCV schedule remains three doses and other changes are brand only. In October 2020 a 12 month event is being

introduced with the first dose of Measles, Mumps and Rubella (MMR) and a PCV vaccine. The 15 month event remains but will be three immunisations (Haemophillus influenzae b, Varicella and the second dose of MMR). The four year event will only be DTap-Polio. We are working with PHOs and the immunisation Advisory Centre to ensure primary care and other child health providers are aware of the changes.

6.1.2 Influenza vaccination

There was strong and early demand for the influenza vaccine this year which has now settled. High coverage was an important part of the COVID-19 response as reducing the impact of influenza takes pressure off the health sector. The sector is commended for responding to this high demand.

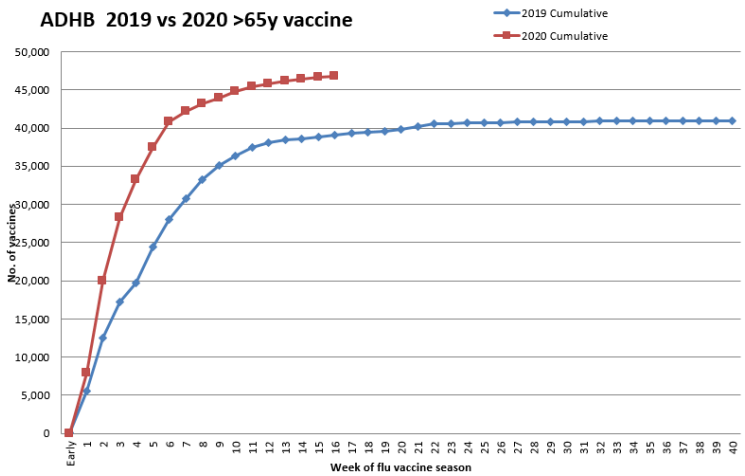


Figure 2. Number of influenza vaccines given to over 65 year olds in 2020 and 2019 (Auckland DHB) as at 6 July 2020.

Uptake for 0-4 year old Ambulatory Sensitive Hospitalisations (ASH) eligible influenza children (a Systems Level Measure) has shown a significant improvement on last year, as at 30 June 2020 31.1% of Auckland DHB's eligible 0-4 year olds had been immunised, compared to 16.6% at the same time last year. Coverage for Māori has nearly tripled at 23.6% compared to 8.8% last year. Coverage for Pacific children also more than doubled at 24.2%, from 10.5% last year.

The Auckland and Waitematā DHBs 'flu Rapid Response project ran for 6 weeks taking an intentional approach to increase access for Māori, Pacific and those living in quintile 5 areas, this included redeployment of some of the Uri Ririki Child Health Connection team to support the initiative. Throughout April and May the small team delivered in-home 'flu vaccinations and street level clinics for those unable to attend a primary care provider. A whole of whānau approach was taken so while 'flu was the entry point, people of all ages in the household were offered any immunisation they were due. This service immunised 420 people across Auckland and Waitematā DHB in a four-week period, including those eligible due to pregnancy, <5 year olds with an ASH condition, >65 year olds and those <65 eligible due to other conditions. An outreach response is now being led by the Māori Health Gain Team and the Pacific Health Gain Team.

The three current Māori flu mobile clinics are now underway working closely with primary care (see Maori Health section 8 below). As at 13 July 2020, coverage for Auckland DHB over 65 year olds for influenza is 60% for the total population, with similar coverage for the other Metro Auckland DHBs. However, coverage for Māori over 65's in Auckland DHB is recorded as the lowest in the country at 38%. We note that flu coverage is still being calculated using the old population denominators (2013 census projections). Auckland DHB has lower population numbers in the most recent census estimates which make a large difference in terms of coverage (see table below).

Northern Region Māori population influenza vaccination coverage for over 65 years

DHB	Using old population projections	Using new population projections	Difference
Auckland	38%	46%	+8%
Counties Manukau	52%	53%	+1%
Northland	55%	47%	-8%
Waitematā	47%	50%	+3%

Undertaking a data match with PHO registers and the NIR we have found that flu coverage for Māori 65+ is 60% (65% for non-Māori non-Pacific). In total there are 1,983 Maori aged 65+ that reside in the Auckland DHB region and are enrolled in a PHO; 1,190 of these individuals are able to be matched to an influenza vaccination event on the NIR. We note that not all vaccination events are registered on the NIR so coverage may be higher than is recorded. However it appears possible that the coverage gap is driven by the unenrolled population. PHO enrolment rates among 65+ Māori are 72% in Auckland, with around 760 individuals potentially not enrolled in a PHO. Therefore we have mapped the location of Māori potentially unenrolled with a PHO (see link here: https://arcg.is/0umSXW) to see whether a geographical mobile service response could assist in raising coverage. The mapping work indicates that there are pockets of unenrolled people throughout the region. Of interest in this analysis is that approximately 75% of the unenrolled are located in areas where deprivation scores are Q3 or less (the least deprived areas), therefore only 25% in Q4-5 areas (the most deprived). Alongside the mobile services work with PHO enrolled populations the mobile teams will also focus on kaumatua who are not enrolled with a PHO. Targeted activities include pop-up events in specific areas and at community events, including Matariki events

6.1.3 Measles

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

The programme will be supported by a communication strategy which will be informed by focus groups with Māori and Pacific people aged 15-29. It is likely that static media, social media (TradeMe), Dating aps, Spotify and radio advertising (Flava and Mai FM, including sponsored messages on their social media) will be used to get messaging to the target communities.

6.2 Antenatal immunisation

The DHB has now funded a revision of the antenatal reminder card to reflect the Smoke and Alcohol Free, Mental wellbeing Matters, Immunise, Lie on Your Side and Eat Healthily resource (SMILE). The SMILE resource is also in the process of being translated into Te Reo, Samoan and Tongan.

6.3 Uri Ririki – Child Health Connection Centre

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

During the COVID-19 lockdown Level 2 the teams returned to work at the Greenlane offices after having provided business as usual activities from their homes in Levels 4 & 3. The repatriation of the NIR into Uri Ririki - Child Health Connection Centre continues to have been a success, providing ongoing support to general practices and immunisation providers. The national NIR was successfully migrated to a new platform over Queen's Birthday, however the migration is still causing some issues for both the DHB administration and also for providers - The Ministry of Health (MoH) and Orion (as platform provider) are rapidly addressing the issues.

Work is underway to harness information from NIR and NCHIP to help understand the impact of Covid-19 disruptions on the uptake of childhood immunisations. Additional follow-up is being provided to General Practices (GP) regarding children who were due/overdue immunisation during the lock down period.

Linkage with the Ministry of Social Development (MSD) continues to evolve, with business processes now in place for the one-way sharing of contact details for children who are overdue immunisations and unable to be located by *any* child healthcare organisation (including home visits). This is the first quarter of operation. In summary, 134 children were identified as 'lost-to-services' and request made for MSD contact details. A total of 52 (39%) were known to MSD, of whom, new contact information was provided for 36 (27%) children, including 6 who had gone overseas or out of the DHB areas. The Uri Ririki service is working with HealthWEST OIS, to provide immunisation access for these 52 children this quarter. This new process will continue to be closely monitored to ensure privacy and security standards are maintained.

One of the objectives of NCHIP and Uri Ririki is to reduce duplication of effort in the sector and reduce complexity for parents in accessing service. An early benefit of NCHIP has been the discovery of duplicate National Health Index (NHI) numbers that were previously unknown. In these cases the same baby is being followed up and caregivers are offered duplicate services at least twice by all the different care providers. In this quarter 21 babies less than 8 months old were discovered with duplicate NHI numbers that required merging by the Ministry of Health. One infant already had 3 NHI numbers.

A new release of NCHIP this month has added features that improve identification of high needs children who may have missed several milestones. Intensive data quality work is continuing such as flagging and disabling historical records for more than 900 deceased children under 6 years of age.

Socialisation of Uri Ririki – Child Health Connection Centre continues. In the next phase, the service is starting to work via the Well Child Clinical Equity and Excellence Group with Well Child Tamariki Ora providers, PHO child health representatives and Oral Health to develop systematic pathways to re-engage those who are identified as lost-to-service. Future NCHIP enhancements are planned that will provide look up access to the child's milestone information for these providers.

The Noho Āhuru – Healthy Homes service is now able to progress most components as per usual. Ministry of Social Development have now commenced housing assessments for our whānau, after a significant delay during the COVID-19 response due to their capacity, a small backlog of assessments remains to work through. Referrals to the service have increased steadily as other health services have resumed seeing normal volumes and are now tracking above the comparable time last year.

Habitat for Humanity will continue to provide a curtain bank and curtain installation service for Noho Ahuru – Healthy Homes. Minor repairs for privately owned homes will not be available through Habitat for Humanity.

As at 30 June 2020, Auckland DHB received 1,406 referrals to Noho Āhuru – Healthy Homes. This included 5,299 family members getting access to healthier home interventions. Of the referrals received, 464 (33%) were for families with a newborn baby or hapu woman.

6.4 Well Child Tamariki Ora and B4 School Check

All the providers have resumed face to face WCTO services under COVID-19 alert level 1 and are focusing on catching up those Tamariki that could have missed their core visits during lock down. Phone screening is undertaken before undertaking home visits. Two WCTO Nurses from Ngati Whatua Orakei have completed the Provisional Vaccinator course and can immunise over 3 year olds for MMR and Influenza.

6.5 Rheumatic Fever

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

1. Identification of culturally safe ways to increase referrals to the Healthy Homes initiative
2. Piloting of whānau support worker programme
3. Piloting dental health services for adults with Acute Renal Failure / Rheumatic Heart Disease
4. Finalisation, evaluation and release of 'fight the fever' mobile app.

A new project manager starting at the beginning of August will focus on Rheumatic Fever (RhF), review initiatives previously undertaken and work with the community to implement strategies to reduce RhF.

6.6 Oral Health

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

The onset of COVID-19 has had a significant and enduring impact on the delivery of the service. On 23 March 2020, all oral health providers (including ARDS) were directed by the Ministry of Health and Dental Council to suspend all non-essential and elective dental treatments. Only essential

emergency treatment which included telephone triage and advice; electronic prescriptions of medications; and limited face to face treatment of children in severe pain were able to be provided. These limitations continued under Alert Levels 3 and 4.

As a result, ARDS was unable to offer any routine services to children between 23 March 2020 and 14 May. The service was reduced to six clinics during this time. Staff who were not providing direct clinical care were redeployed within the organisation or were working from home (undertaking quality improvement activities).

On 11 May 2020 The New Zealand (NZ) Dental Council issued direction on service provision at alert level 2. This enabled the service to recommence the provision of routine care, but required patient COVID-19 pre-screening (clinical symptoms and epidemiological risk) and enhanced infection prevention and control measures. The service experienced significant challenges with transitioning back to the provision of routine care. Specifically:

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

Many of these issues have continued into alert level 1, as the NZ Dental Council screening requirements have remained in place. The service is continuing to work on maximising the number of children that can be seen whilst adhering with the NZ Dental Council requirements.

Children with the highest need are being prioritised. The current clinical prioritisation focus is on children who have previously had an examination and are in the process of having their treatment completed, and children who are most overdue their routine examination (check-ups).

All routine and emergency dental services are continued to be delivered under Level 1 by contracted dental providers for adolescents. To ensure those who turned 18 years during COVID-19 alert levels do not miss out on their treatment under Community Dental Agreements, an extension of eligibility is allowed to complete treatment on any patient who has turned 18 years of age this year. This extension is available for six months following the commencement of Level 2. This will allow examinations and uncompleted treatment to occur for this cohort of adolescents.

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

Under Alert Level 1, all hapu māmā who were accepted into the service were contacted and offered appointments based on their clinical need.

Referrals

Fifty one referrals have been received and 48 of the 51 referrals have been accepted (94%). Of the 3 declined referrals, 2 were declined as the patients were living out of the area and 1 was declined as it was a duplicate. 48 of the 51 referrals were from Auckland DHB community midwives, two from GATEWAY coordinators and one was from a General Practitioner.

Supportive Treatment Pathway

A Supportive Treatment Pathway was designed for the service for the administrator to use if hapu māmā were non-contactable or if hapu māmā required more encouragement to attend their appointment (e.g. if they were unable to commit to an appointment date). The Supportive Treatment Pathway has been used for ten hapu māmā, two of whom attended once avenues of this Pathway were explored. Eight hapu māmā were discharged from the service once the avenues of this pathway were exhausted; their referrers have been notified of these discharges as part of the process.

Future initiatives

The steering group will look to review referral criteria to ensure all eligible hapu mama are identified. ARDS is working closely with Waitemātā DHB's Patient Experience team to seek patient feedback from the hapu māmā who are currently undergoing treatment, to identify any areas of improvement for the service.

6.8 Youth Health

6.7.1 Enhanced School Based Health Services

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

All Year 9 students having a bio-psychosocial Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety (HEEADSSS) assessment to identify unmet health needs. The Ministry of Health target for HEEADSSS assessments is 95% by the end of the school year.

By the end of Term 2, the school nurses in Auckland DHB have completed on average 34% of HEEADSSS assessments for Year 9 students. Even with the disruptions caused by COVID-19 lockdown and school closures, the completion rate for HEEADSSS assessments by school Term 2 is similar to previous years.

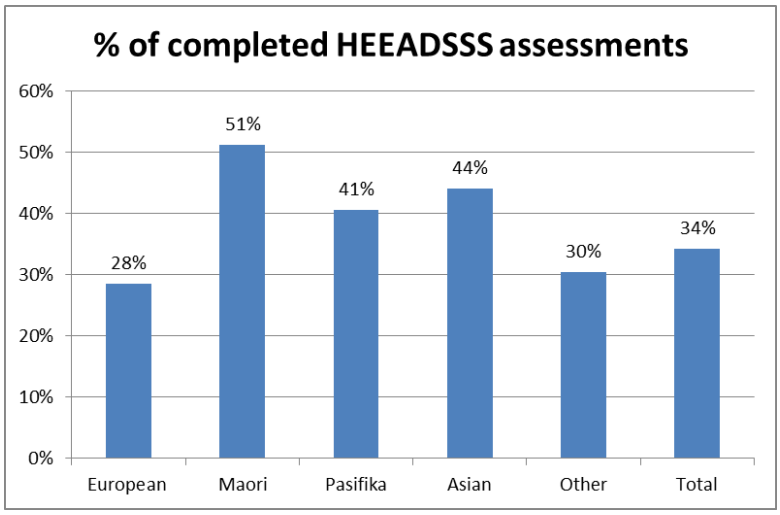


Figure 3. Percentage of completed HEEADSSS assessments in school term 2, 2020

Some factors that affected service delivery included:

- Move to alert Level 1 on 8 June - 3 weeks before the end of term 2,
- Reduced school attendance (down to about 80%),
- Teachers not wanting students to miss classes resulting in nurses finding it hard to get students out of class,
- Heightened anxiety in the Pacific community especially following Measles outbreak last year. (Students have been away for longer and parents have taken up nursing time requesting information),
- Increased demand for sexual health consults and mental health concerns and severity of the concerns.

To help nurses' complete psychosocial/wellbeing assessments for all students in Year 9, the DHB employs a roaming Registered Nurse. In the past use of the roaming nurse has increased the number of HEEADSSS assessments. In addition, to further enable nurses to complete these assessments, the DHB is implementing YouthChat, a self-completed psycho-social assessment for students in secondary schools. A face to face assessment takes around an hour to complete, YouthChat has been shown to use less nursing time, and get more accurate information across some domains (sexual health and mental well-being). The DHB has provided funding to support the provision of an iPad or tablet for each nurse which will be used by the students at the health centre for the purpose of completing YouthChat.

6.8.1 Sexual Health Hub

During Covid-19 lockdown, Family Planning (FP) were offering phone consultations only with limited services at Auckland Sexual Health services and general practices, a majority being virtual. Some sexual health services cannot be delivered via phone or virtual consults. The risks associated with young people not being able to access sexual healthcare are possible complications arising from untreated symptomatic Sexually Transmitted Infections (STI) and an increase in unintended pregnancies.

To ensure students had access to essential sexual health care (symptomatic STI testing and treatment) and essential contraceptive care (Depo Provera or Emergency Contraceptive Pill) a dedicated, temporary sexual health hub (SHH) was established during lockdown for young people enrolled at the 10 ESBHS schools. School nurses arranged appointments for students with the SHH GP. The GP was able to contact student via telephone or virtually, assess as needed and then prepare

a script for the SHH hub nurse. The student was able to attend the hub clinic at an arranged time to see the nurse for care. We will be continuing the hub model to provide sexual health services during school holidays. If funding permitted, a fully funded Youth Health Hub would be established to provide free, youth appropriate primary healthcare services for young people in a range of locations across Auckland.

6.9 Contraception

Commencement of services through the primary care agreements for contraception counselling and the provision of Long Acting Reversible Contraception (LARC) was slow during the COVID response period. An agreement to manage service claims through the Primary Options for Acute Care (POAC) administration mechanism provided by Clinical Assessments Limited is now established and promotion of the options will be ongoing to increase access.

6.10 Fertility

Fertility services are continuing to catch up patient delays from COVID closure period but most services are back on track or at most delayed from pre-COVID by a month. An analysis of fertility services demonstrates issues with timeliness, as the funded service volumes have not been increased since contracts were entered into over six years ago. Since then the population has increased 22%. Couples are now waiting around 17 months to start treatment which is outside of MoH expectations. To align with the MoH expectations of timeliness, increased funding or reduced access criteria will need to be considered.

6.11 Cervical Screening

Cervical screening coverage in Auckland district is very low (although impacted by inaccurate population denominators), particularly for Māori women. HPV self sampling as part of an HPV primary screening programme for cervical screening was recommended by the NCSP Parliamentary review 2018. Our DHB led research, and research with Massey University (Health Research Council Funded) suggests that a programme inclusive of self – sampling presents many opportunities to improve equity and women centred access to the screening pathway. PHOs have expressed their support for implementing HPV self-testing, however the National Cervical Screening Programme have not yet confirmed the implementation of primary HPV screening and a new NCSP-register which are now very delayed from the planned timeframes.

6.12 Abortion

Abortion legislation reform came into force on 24 March 2020. This changed who and where services could be provided by. Services are still centralised at Epsom Day Unit, though adjustments have been made to the service to comply with the new legal framework. A metro Auckland process regarding the configuration of services has been led by PFO. This was initiated in 2018, and anticipated law reform, as well as responding to criticism of the configuration of services made by the former Abortion Supervisory Committee. A significant criticism included the lack of access to the service for women who live outside of central Auckland.

7. Mental Health and Addictions

7.1 Mental Health and Addiction Non-Governmental Organisation Price Uplift

The DHBs have followed a national process for agreeing the increase in 2020/21 contract pricing for the Mental Health and Addiction Non-Governmental Organisations (NGOs). On the basis of that process, the DHBs will be offering an increase in pricing of 3%. The increase of 3% will apply to the contract price. There is no separate component for pay equity increase this year. The 3% increase to contract price consists of 2.84% cost uplift and 0.16% recognition of equity concerns.

7.2 NGO Partner in the Community Mental Health Centres

As a result of a review carried out in 2019, the Mental Health Directorate decided to disestablish the Auckland DHB Community Support Worker (CSW) roles based at Point Chevalier. The decision was based on an assessment that delivery of a community support work service was not a core function of specialist Mental Health services.

A co-design process was undertaken to determine how best to apply this community support work resource through the NGO sector. The model agreed was an NGO based service, co-located in each Community Mental Health Clinic, working with NGOs and Service Coordination to ensure that service users / whānau could access appropriate support quickly, easily and effectively.

The service was designed to specifically address service users' urgent or short term needs related to social determinants of mental health. The service includes brokering and navigating service users to appropriate support. For example, this would include accessing support hours delivered by the contracted NGOs for Auckland DHB.

Dispensation was granted to conduct a closed Request for Proposal (RFP) with eight NGOs with a proven track record in providing NGO Support Hours/Peer Support services to Mental Health and Addition Services. These eight NGOs were considered to be the best candidates to tender for this new service, because they had the local expertise in support hour's service delivery, held collaborative relationships across the other 7 NGOs to support cross referrals/hand-overs, and they had the existing relationships with the Community Mental Health Centres (CMHCs).

Emerge Aotearoa (NGO) were selected by the RFP panel as the preferred candidate, and a contract is now in place, for six NGO partners to be co-located across the CMHCs (2 partners in the two larger CMHCs, and 1 partner in each of the two smaller CMHCs).

8. Māori Health Gain

8.1 Māori mobile units

The Māori health gain team have received support from the MoH and Northern Regional Health Coordination Centre (NRHCC) to roll out 5 kaupapa Māori mobile units. Funding is provided by the ministry of Health's Māori Influenza Vaccination Fund giving the units a core focus on 'flu vaccinations for Māori aged 65 years and older, pregnant women, under fours with severe respiratory issues and adults with long term conditions.

The core elements of this service are:

- *A system wide prioritisation of 'flu vaccinations for eligible Māori* – Ring fencing 'flu vaccinations for eligible Māori across the region, giving priority to Māori provider requests for vaccinations and partnerships (referrals, data sharing agreements) across the region to ensure eligible Māori non-vaccinated are identified and offered care
- *Coordination and proactive outreach* – Identification of and contact with eligible Māori patients and a focus on patient booking/referral to the mobile clinics and triage/telehealth
- *Mobile clinics* – 10 mobile clinics (5 across Auckland DHB/Waitematā DHB and 5 for Counties Manukau Health) with multi-disciplinary teams offering primary health care and social support services
- Proposed mix of nurse-led and General Practitioner supported services, implemented by Māori health providers across metro-Auckland (a separate service is being implemented on Waiheke Island and in Northland)

Mobile units can operate either as house to house units, vaccinating Māori in their homes, or they can base themselves in community settings (i.e. marae, community facilities, schools and kura) to offer pop-up vaccination clinics in deprived communities. Supporting the mobile units is a coordination centre that will ensure lists of vulnerable Māori are generated to supplement the eligible Māori who are enrolled with Māori health providers, offer clinical oversight and support, book in appointments through outreach and call back, receive referrals from primary care and other care partners, inform communities and providers about the location of mobile units and coordinate mobile units on the ground.

8.2 Kaimanaaki services

In the midst of our region's COVID-19 response, the NRHCC supported the implementation of Ngā Kaimanaaki services across Auckland DHB (non-clinical welfare and care navigation support services). Three lead providers were identified to support whānau in Auckland DHB's catchment area – Orakei Health Services, Kotuku ki te Rangi (a kaupapa Māori mental health provider) and Piritahi Hauora (on Waiheke Island).

Each of these services come online in April and we have been meeting with providers on a regular basis to support these services being stood up. Reporting has not yet been received but through engagement with providers it is clear that these services have been extremely valuable to communities. Future updates will provide updates on this service and its impact in communities.

8.3 Māori Pipeline Projects

A summary of recent Māori Health Pipeline activity is below:

- Lung cancer screening – the focus groups and surveys are now complete (305 potentially eligible Māori and more than 100 whānau in the surveys). Surveys have been extended to Northland as the Iwi-DHB Partnership Board requested that Northland be included in the work. This will provide useful information on whether there are differences for rural Māori. Several grant applications are being completed for the next phase of work which is a pilot trial aiming to screen 500 eligible Māori. Additional components such as smoking cessation and optimisation of co-morbidities are being developed.
- Alternative community cardiac rehabilitation model – work on the business case was on hold during COVID-19.
- Alternative community pulmonary rehabilitation model – Dr Sandra Hotu has now completed her PhD and is supporting the prototype and feasibility development. A workshop is planned with kapa haka and physiotherapy pulmonary rehab experts to design the intervention.
- Northern region breast screening data match ('500 Māori women campaign') – interim reporting has been completed, due to COVID-19 catch-up a further 6 weeks has been allowed for final reporting.
- Māori provider and PHO data match – Data sharing agreements with the nominated Iwi representatives have been drafted and approved. A privacy impact assessment was completed and approved by DHB and regional privacy groups. The project Māori data governance group has been established and has met. Data extraction is underway in Auckland and Waitematā DHBs, meetings have been held with Counties Māori health providers and further support will be offered as a metro Auckland match process would be optimal.
- Facilitated PHO enrolment – Maternity services have been identified as the potential pilot location to identify women not enrolled in a PHO and develop an offer of service. A project team is being set up to scope the next phases of work.
- High grade cervical screening project – The Māori GP clinical lead has completed the audit tool process and offer of an intensive supported engagement at two pilot practices. A review will

now be undertaken and a report provided to the steering group on next steps for the project. Ethics approval to complete the A+ Trust funded HPV sub-study will progress in parallel.

9. Pacific Health Gain

9.1 Pacific Health Action Plan (PHAP) Priority 3 – Positive Parenting Active Lifestyle Program (PPAL)

The Pacific health team has worked with the Child health team to support the implementation of the PPAL programme. The programme focus is to improve equitable outcomes for Pacific children and their families by supporting parents of children (under 5 years) that have been identified as being overweight or obese to become physically active and eat healthy food. To date more than 120 Pacific parents have graduated from this nine week program.

9.2 Measles Mumps Rubella (MMR) Vaccination plan

The Ministry of Health has provided positive feedback to the proposed MMR vaccination catch-up plan for Auckland and Waitematā DHBs. The goal of the plan is to equitably improve measles immunity and will focus on engaging Pacific and Māori, especially those between 15-29 year olds. Removing barriers and encouraging the target group to get vaccinated will be instrumental in reducing the risk of future measles outbreaks. The Pacific Team will be actively involved in implementing the diverse range of pacific specific activities within the plan.

9.3 Pacific Regional response to COVID-19

As part of the Northern Pacific regional COVID-19 response to support Pacific peoples and communities, work is underway to establish a Pacific mobile service that will support vulnerable Pacific populations in Auckland DHB. The service will provide focused mobile capacity to ensure any COVID-19 cases are rapidly identified and managed appropriately to reduce the risk of community transmission. It will also provide surveillance swabbing if requested by the DHB, primary care assessment and care and social service support as is needed.

9.4 Pacific Health Action Plan 2020-2025

The Pacific Health team is in the process of drafting a plan to refresh the Auckland and Waitematā DHBs Pacific Health Action Plan 2020-2025. The plan will reassess current health needs, build upon the previous activities and align with Ola Manuia: Pacific Health and Wellbeing Action Plan 2020.

10. Asian, Migrant and Former Refugee Health Gain

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

An Asian, new migrant, former refugee and current asylum seeker health plan 2020-2023 has been developed and will be tabled to the Auckland DHB Board and/or joint metro Auckland Community Public Health Advisory Committee at the September meeting.

The team continue to provide support when needed to COVID-19 related cases that are referred to the ARPHS Welfare Team.

10.2 Increase access and utilisation to Health Services

Indicators:

- Increase by 2% the proportion of Asians who enrol with a Primary Health Organisation (PHO) to meet 71% (Auckland DHB) by 30 June, 2020

The Auckland DHB, Asian PHO enrolment rate for Quarter 2 2020 was 86%.

We continue to work with community stakeholders and promote the updated resources and flyers, virtual presentations on the NZ Health and Disability System.

We have reflected on the team's learnings and efforts on the Northern Region COVID-19 response for the Culturally and Linguistically Diverse Communities (CALD) Communities and have shared with our CALD community partners.

As part of the Language Assistance Services Programme (LAS), the national procurement of Face to Face interpreting services is underway with a metro Auckland regional lead response planned to coordinate and streamline processes, and identify cost savings within the delivery of interpreter services.

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

The new arrival of quota refugees has been on hold due to the COVID-19.

As part of the changes to the Quota Health Service Model (due to the increase in the annual refugee quota from 1,000 to 1,500 from 1 July 2020), the health service provided at the Mangere Refugee Resettlement Centre and how it will work with current and new resettlement regions is being currently developed.

The new service model will consist of five main components:

Offshore

1. Immigration medical examinations (visa medical assessments) to be completed outside of New Zealand during, or directly following, the quota refugee selection mission.
2. Once the visa is approved, a full health assessment is offered, including a full health screen, immunisation and treatment of any identified health needs.
3. A pre-departure health check will be offered to ensure health needs are met before leaving for New Zealand.

Onshore

4. Primary health and other health services such as mental health and urgent health needs are provided when a person arrives at the Mangere Refugee Resettlement Centre.
5. Health and other services are provided when a quota refugee resettles in their new region within New Zealand.

We are developing the New Zealand Health & Disability System and Healthcare-Where Should I go? in new minority languages for former refugee communities settling and resettling in metro Auckland. Around six families from the March 2020 intake were resettled in metro-Auckland.

The 'Improving access to general practice services for former refugees and current asylum seekers' agreement' for the PHOs is being rolled over.

11. Hospitals

11.1 Cancer target

Auckland DHB has maintained compliance with the Faster Cancer Treatment (FCT) 62 day indicator having achieved 94.6% for the rolling six month period to April 2020 and the Northern region rate for the same period is 82.8%. The 31 day indicator was also achieved by ADHB during this time period at 89.9%. The Regional rate for the same period was 85.5%

11.2 Auckland DHB Planned Care Initiative (formerly Elective Surgical Health Target)

At the end of May 2020 Auckland DHB was achieving 89.9% of planned care interventions (previously elective surgical discharges). As previously advised, COVID-19 has affected capacity from March onwards which has had a significant impact on the ability to achieve the expected volumes for 19/20. ADHB achieved over 90% planned discharges for the month of June and this ensures we achieve full payment of the planned revenue for the period March – June 2020.

11.3 Elective Services Performance Indicators (ESPI) Compliance

The ESPI compliance position for both outpatient assessment (ESPI 2) and surgical and treatment services (ESPI 5) has deteriorated as expected due to the significant reduction in planned care capacity during the COVID response. Improvement Plans have been submitted to the MOH for all ADHB services and these detail a range of measures to address the waiting times over time across all services. The rate of improvement is limited by available capacity including workforce and physical capacity, and the level of funding expected to be available to the DHB to invest in additional capacity. The MOH had previously signalled policy advice in respect of additional funding would be available by the end of July 2020 however this advice has yet to be received. In the absence of the funding advice no commitments have been made to increase the use of private surgical capacity and it should be noted that it is likely that any future use will be limited by the affordability of the cost of that capacity.

11.4 Orthopaedics

The Orthopaedic elective discharge activity prior to the impact of COVID was tracking at less than 90% of planned volumes but with some improvement in the rate of ESPI non-compliance in the July – February period, however the service is now reporting more than 50% of patients are waiting in excess of 120 days. Internal capacity within ADHB remains insufficient to meet the pre COVID planned volumes and this remains an issue in 2020/21.

11.5 2019/20 Auckland DHB provider performance

For the period to March 2020 there were higher levels of acute activity than for the same period last year. During the COVID response period there was a significant decrease in acute demand however in the May to July period weekly acute admissions are tracking at slightly less than the levels of last year.

11.6 Cardiac service demand

The ADHB provider has developed a proposal to address the regional electrophysiology (EP) waiting list that has steadily grown over the last three years in the absence of sufficient capacity to meet the demand for the service. The preferred option is to resource available physical capacity within ADHB however a decision has yet to be made about the relative priority and affordability of addressing this waiting list.

Cardiac Surgery demand declined during COVID and has not returned to levels consistent with prior months and the regional waiting list has been consistently less than 50 patients for a number of weeks, compared with a more usual range of 85 -95 patients waiting.

11.7 Ophthalmology service demand

Work has recommenced regionally to proceed with the implementation of the Ophthalmology Strategy across the Auckland region, and progress is being made towards the development of consistent access criteria and care pathways across community and secondary care settings.

11.8 Policy Priority areas

Colonoscopy Indicators

Auckland DHB has consistently been unable to meet the national waiting time indicators for P2 colonoscopy and surveillance colonoscopy over the last 24 months and in March 2020 a review identified a need to outsource 550 colonoscopy procedures to enable the waiting times to be recovered. The impact of COVID has meant the waiting time position has deteriorated further and the outsourcing will need to be supplemented by a range of activities within the provider to improve the use of internal physical capacity to ensure the DHB is able to proceed with the rollout of the Bowel Screening Programme in November.

Radiology Indicators

Auckland DHB has been unable to meet the waiting time indicator for MRI for a prolonged period of time, and the impact of lost capacity during the COVID response has meant that only 44% of patients are receiving their diagnostic within six weeks. Additional funding has been made available to the DHB in June and July for increased volumes through use of private capacity, and this will result in some improvement in the waiting time position however further investment will be needed to materially improve waiting times. Prior to COVID patients were consistently receiving CT within expected timeframes however this has reduced to 72% (compared to the target of 95%). The service has identified options to improve this waiting list however the rate of recovery will be informed by the affordability and prioritisation of the DHBs overall recovery plan and availability of additional funding.

11.9 National Services

Following restructuring and personnel changes within the Ministry of Health during 2018/19 and further changes in 2019/20 there has been little engagement with ADHB regarding the provision of National services. ADHB submitted two proposals for additional investment in Adult Congenital Health Services and Cardiac Inherited Diseases Services during 2018/19 and we have yet to receive a response.

11.10

Draft Schedule of Auckland DHB Board and Committee Meetings for 2021

Recommendation

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

Prepared by: Marlene Skelton - Corporate Business Manager
Endorsed by: Pat Snedden - Board Chair

1. Executive Summary

The Draft Schedule of Auckland DHB Board and Committee Meetings for 2021 [attached] is being submitted for Board Members information.

These meetings, for the most part, occur on a Wednesday with Board Members having agreed to reserve Wednesdays exclusively for Auckland DHB Board business. The meetings will appear as electronic invitations in a members email box for acceptance into electronic diaries.

A set schedule allows for certainty in meeting planning and the attendance of board members and staff along with outside appointees at both the home DHB meetings and as required other metropolitan DHB meetings.

2. Metropolitan Position

Meetings are on a six-weekly cycle which has been developed to accommodate possible cross over attendance at meetings by board members and staff of the three metropolitan DHBs.

[Note: A few of the Waitemata DHB Board dates have been brought forward (the first meeting of the year and the last meeting of the year) during 2021.]

Currently the Auckland DHB Board Chair, Pat Snedden is also chair of the Counties Manukau DHB Audit, Risk and Finance Committee and appointed member Norman Wong is chair of Waitemata DHB Audit and Finance Committee. There are Planning and Funding staff that are required to attend both Auckland and Waitemata DHB Finance Committee meetings.

3. Conclusion

That the Board note and receive the Draft Schedule of Auckland DHB Board and Committee Meetings for 2021.

ADHB, WDHB and CMDHB Corporate Governance Meetings Schedule – 2021

ADHB | WDHB | CMDHB | Regional

January			February			March			April			May			June			July			August			September			October			November			December		
1	Fri	New Year's Day	1	Mon	Auckland Anniversary Day	1	Mon	MCPE Advisory Group	1	Thu		1	Sat		1	Tue		1	Thu		1	Sun		1	Wed	FRAC People and Culture Sub-Com	1	Fri		1	Mon		1	Wed	HAC – Provider Equity Advisory Committee CPHAC – Commissioning Health Equity Advisory Committee CMDHD ARF
2	Sat		2	Tues		2	Tues		2	Fri	Good Friday	2	Sun		2	Wed		2	Fri		2	Mon		2	Thu		2	Sat		2	Tues		2	Thu	
3	Sun		3	Wed	HOLD Iwi Partnership board FRAC People and Culture Sub-Com	3	Wed		3	Sat		3	Mon		3	Thu		3	Sat		3	Tues		3	Fri		3	Sun		3	Wed	Board	3	Fri	
4	Mon	Day after New Year's Day	4	Thu		4	Thu		4	Sun		4	Tue		4	Fri		4	Sun		4	Wed	WDHB Audit & Risk	4	Sat		4	Mon		4	Thu		4	Sat	
5	Tue		5	Fri		5	Fri		5	Mon	Easter Monday	5	Wed	HAC – Provider Equity Advisory Committee CPHAC – Commissioning Health Equity Advisory Committee CMDHD ARF	5	Sat		5	Mon	MCPE Advisory Group	5	Thu		5	Sun		5	Tue		5	Fri		5	Sun	
6	Wed		6	Sat		6	Sat		6	Tue		6	Thu		6	Sun		6	Tue		6	Fri		6	Mon		6	Wed	WDHB Board	6	Sat		6	Mon	
7	Thu		7	Sun		7	Sun		7	Wed	Board HOLD Iwi Partnership board	7	Fri		7	Mon	Queens B/Day	7	Wed		7	Sat		7	Tues		7	Thu		7	Sun		7	Tue	
8	Fri		8	Mon	Waitangi Day observed	8	Mon		8	Thu		8	Sat		8	Tues		8	Thu		8	Sun		8	Wed	HAC – Provider Equity Advisory Committee CPHAC – Commissioning Health Equity Advisory Committee CMDHD ARF	8	Fri		8	Mon	MCPE Advisory Group	8	Wed	WDHB Audit & Risk
9	Sat		9	Tues		9	Tue		9	Fri		9	Sun		9	Wed	FRAC People & Culture Sub Com	9	Fri		9	Mon		9	Thu		9	Sat		9	Tue		9	Thu	
10	Sun		10	Wed	HAC – Provider Equity Advisory Committee CPHAC – Commissioning Health Equity Advisory Committee CMDHD ARF	10	Wed	WDHB Board	10	Sat		10	Mon		10	Thu		10	Sat		10	Tues		10	Fri		10	Sun		10	Wed		10	Fri	
11	Mon		11	Thu		11	Thu		11	Sun		11	Tue		11	Fri		11	Sun		11	Wed	Board	11	Sat		11	Mon		11	Thu		11	Sat	
12	Tues		12	Fri		12	Fri		12	Mon	MCPE Advisory Group	12	Wed	WDHB Audit	12	Sat		12	Mon		12	Thu		12	Sun		12	Tue		12	Fri		12	Sun	
13	Wed		13	Sat		13	Sat		13	Tue		13	Thu		13	Sun		13	Tue		13	Fri		13	Mon		13	Wed	FRAC People & Culture Sub Com	13	Sat		13	Mon	
14	Thu		14	Sun		14	Sun		14	Wed		14	Fri		14	Mon		14	Wed	WDHB Board	14	Sat		14	Tues		14	Thu		14	Sun		14	Tue	
15	Fri		15	Mon		15	Mon		15	Thu		15	Sat		15	Tue		15	Thu		15	Sun		15	Wed	WDHB Audit & Risk	15	Fri		15	Mon		15	Wed	Board WDHB Board
16	Sat		16	Tues		16	Tue		16	Fri		16	Sun		16	Wed	HAC – Provider Equity Advisory Committee/DiSAC CMDHD ARF	16	Fri		16	Mon	MCPE Advisory Group	16	Thu		16	Sat		16	Tues		16	Thur	
17	Sun		17	Wed	WDHB Audit	17	Wed	FRAC People & Culture Sub Com	17	Sat		17	Mon		17	Thu		17	Sat		17	Tue		17	Fri		17	Sun		17	Wed	WDHB Board	17	Fri	
18	Mon	Major Capital Expert Advisory Group	18	Thu		18	Thu		18	Sun		18	Tues		18	Fri		18	Sun		18	Wed		18	Sat		18	Mon		18	Thu		18	Sat	
19	Tues		19	Fri		19	Fri		19	Mon		19	Wed	Board	19	Sat		19	Mon		19	Thu		19	Sun		19	Tue		19	Fri		19	Sun	
20	Wed		20	Sat		20	Sat		20	Tues		20	Thu		20	Sun		20	Tue		20	Fri		20	Mon		20	Wed	HAC – Provider Equity Advisory Committee/DiSAC CMDHD ARF	20	Sat		20	Mon	
21	Thu		21	Sun		21	Sun		21	Wed	WDHB Board	21	Fri		21	Mon		21	Wed	FRAC People & Culture Sub Com	21	Sat		21	Tue		21	Thu		21	Sun		21	Tue	
22	Fri		22	Mon		22	Mon		22	Thu		22	Sat		22	Tue		22	Thu		22	Sun		22	Wed	Board HOLD Iwi Partnership board	22	Fri		22	Mon		22	Wed	
23	Sat		23	Tues		23	Tues		23	Fri		23	Sun		23	Wed	WDHB Audit & Risk	23	Fri		23	Mon		23	Thu		23	Sat		23	Tue		23	Thur	
24	Sun		24	Wed	Board	24	Wed	HAC – Provider Equity Advisory Committee/ DiSAC CMDHD ARF	24	Sat		24	Mon	MCPE Advisory Group	24	Thu		24	Sat		24	Tue		24	Fri		24	Sun		24	Wed	FRAC People & Culture Sub Com	24	Fri	
25	Mon		25	Thu		25	Thu		25	Sun		25	Tues		25	Fri		25	Sun		25	Wed		25	Sat		25	Mon	Labour Day	25	Thu		25	Sat	Christmas Day
26	Tue		26	Fri		26	Fri		26	Mon	ANZAC DAY	26	Wed		26	Sat		26	Mon		26	Thu		26	Sun		26	Tue		26	Fri		26	Sun	
27	Wed		27	Sat		27	Sat		27	Tue		27	Thu		27	Sun		27	Tue		27	Fri		27	Mon	MCPE Advisory Group	27	Wed	WDHB Audit & Risk	27	Sat		27	Mon	Xmas Day
28	Thu		28	Sun		28	Sun		28	Wed	FRAC People & Culture Sub Com	28	Fri		28	Mon		28	Wed	HAC – Provider Equity Advisory Committee CMDHD ARF	28	Sat		28	Tues		28	Thu		28	Sun		28	Tue	Boxing Day
29	Fri					29	Mon		29	Thu		29	Sat		29	Tues		29	Thu		29	Sun		29	Wed		29	Fri		29	Mon		29	Wed	
30	Sat					30	Tues		30	Fri		30	Sun		30	Wed	Board	30	Fri		30	Mon		30	Thu		30	Sat		30	Tue		30	Thu	
31	Sun					31	Wed	WDHB Audit				31	Mon					31	Sat		31	Tue					31	Sun					31	Fri	

Resolution to exclude the public from the meeting

Recommendation

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Apologies	N/A	N/A
2. Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Confidential Minutes 8 July 2020	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3.1 Circulated Resolution - Draft Annual Plan 2020/21	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Action Points	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Risk Management	**Commercial Activities** Information contained in this report is	That the public conduct of the whole or the relevant part of the meeting would

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

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

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