AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Open Board Meeting

Wednesday, 16 December 2020

10:00am

Note:

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

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

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

Published 10 December 2020

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

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

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

Well Being to All.

Agenda
Meeting of the Board
16 December 2020

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

Time: 10.00am

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

Agenda

Please note that agenda times are estimates only

0. KARAKIA

10.00am **1. ATTENDANCE AND APOLOGIES**

Mark Edwards, Shayne Tong

10.05am **2. REGISTER OF INTEREST AND CONFLICTS OF INTEREST**

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

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

10.07am **3. CONFIRMATION OF MINUTES 4 November 2020**

10.10am **4. PASIFIKA FUTURES (PMA) MOU SIGNING AND BOARD TO BOARD ENGAGEMENT**

Dr Maoate (*the President of Pasifika Medical Association and Chair of Pasifika Futures*) highlighting the work of PMA and PFL and presenting the MOU for formal signing.

A detailed run sheet governing this hour will be released closer to the meeting time.

11.15am		**BREAK TO TAKE MORNING TEA WITH PASIFIKA FUTURES DELEGATION**
11.30am	**5.**	**ACTION POINTS**
11.30am	**6.**	**EXECUTIVE REPORTS**
	6.1	Chief Executives Report
11.45am	**7.**	**PERFORMANCE REPORTS**
	7.1	Financial Performance Report
	7.2	Planning and Funding Outcomes Update
12.15 am	**8.**	**COMMITTEE REPORTS**
	8.1	Hospital Advisory Committee
	8.2	Disability Support Advisory Committee
	8.3	Community and Public Health Equity Advisory Committee
	9	**DECISION REPORTS**
	9.1	Schedule of Meetings for 2021
	9.2	Establishment of Executive Committee of the Board
	10.	**INFORMATION REPORTS - Nil**
	11.	**GENERAL BUSINESS**
12.45am	**12.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Next Meeting:	27 January 2021 at 10.00am A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

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Attendance at Board Meetings

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

2020/2021

Members	26 Feb 20	08 Apr. 20	20 May. 20	18 June 20	8 July 20	12 Aug 20	23 Sept 20	4 Nov 20	16 Dec 20
Pat Snedden (Board Chair)	1	c	1	1	1	1	1	1	
Joanne Agnew	1	c	x	1	1	1	1	1	
Doug Armstrong	1	c	1	1	1	1	1	1	
Michelle Atkinson	1	c	1	1	1	1	1	1	
Zoe Brownlie	1	c	1	1	1	1	1	1	
Peter Davis	1	c	1	1	1	1	1	1	
Tama Davis	1	c	1	1	x	1	1	1	
Fiona Lai	1	c	1	1	1	1	1	1	
Bernie O'Donnell	1	c	1	1	1	1	1	1	
Michael Quirke	1	c	1	1	1	1	1	1	
Ian Ward	x	c	1	x	1	1	1	1	

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

Register of Interests – Board

Member	Interest	Latest Disclosure
Pat SNEDDEN	Director and Shareholder – Snedden Publishing & Management Consultants Limited Director and Shareholder – Ayers Contracting Services Limited Director and Shareholder – Data Publishing Limited Trustee - Recovery Solutions Trust Director – Recovery Solutions Services Limited Director – Emerge Aotearoa Limited and Subsidiaries Director – Mind and Body consultants Ltd Director – Mind and Body Learning & Development Ltd Shareholder – Ayers Snedden Consultants Ltd Executive Chair – Manaiakalani Education Trust Director – Te Urungi o Ngati Kuri Ltd Director – Wharekapua Ltd Director – Te Paki Ltd Director – Ngati Kuri Tourism Ltd Director – Waimarama Orchards Ltd Chair – Auckland District Health Board Director – Ports of Auckland Ltd Chair – Counties Manukau Audit, Risk and Finance Committee	23.11.2020
Jo AGNEW	Professional Teaching Fellow – School of Nursing, Auckland University Casual Staff Nurse – Auckland District Health Board Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Shareholder – Karma Management NZ Ltd (non-Director, majority shareholder) Member – New Zealand Nurses Organisation [NZNO] Member – Tertiary Education Union [TEU]	30.07.2019
Michelle ATKINSON	Director – Stripey Limited Trustee - Starship Foundation Contracting in the sector Chargenet, Director & CEO – Partner	21.05.2020
Doug ARMSTRONG	Trustee – Woolf Fisher Trust *(both trusts are solely charitable and own shares in a large number of companies some health related. I have no beneficial or financial interest* Trustee- Sir Woolf Fisher Charitable Trust *(both trusts are solely charitable and own shares in a large number of companies some health related. I have no beneficial or financial interest* Member – Trans-Tasman Occupations Tribunal Daughter – *(daughter practices as a Barrister and may engage in health related work from time to time)* Meta – Moto Consulting Firm – (*friend and former colleague of the principal, Mr Richard Simpson)*	20.08.2020
Zoe BROWNLIE	Co-Director – AllHuman Board Member – Waitakere Health and Education Trust Partner – Team Leader, Community Action on Youth and Drugs	02.12.2020
Peter DAVIS	Retirement portfolio – Fisher and Paykel Retirement portfolio – Ryman Healthcare Retirement portfolio – Arvida, Metlifecare, Oceania Healthcare, Summerset, Vital Healthcare Properties	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	23.11.2020

	Director – Comprehensive Care PHO Board Board Member – Supporting Families Auckland Board Member – Freemans Bay School Board Member – District Maori Leadership Board Iwi Affiliations – Ngati Whatua, Ngati Haua and Ngati Tuwharetoa Director - - Board of New Zealand Health Partnerships	
Fiona LAI	Member – Pharmaceutical Society NZ Casual Pharmacist – Auckland DHB Member – PSA Union Puketapapa Local Board Member – Auckland Council Member – NZ Hospital Pharmacists' Association	26.08.2020
Bernie O'DONNELL	Chairman Manukau Urban Māori Authority(MUMA) Chairman UMA Broadcasting Limited Board Member National Urban Māori Authority (NUMA) Board Member Whānau Ora Commissioning Agency National Board-Urban Maori Representative – Te Matawai Board Member - Te Mātāwai. National Māori language board Owner/Operator– Mokokoko Limited	26.11.2020
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
04 November 2020

Minutes of the Auckland District Health Board meeting held on Wednesday, 04 November 2020 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 10:00am

Board Members Present	**Auckland DHB Executive Leadership Team Present**	
Pat Snedden (Board Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Dr Karen Bartholomew	Director, Health Outcomes for ADHB/WDHB
Doug Armstrong	Mel Dooney	Chief People Officer
Michelle Atkinson	Margaret Dotchin	Chief Nursing Officer
Zoe Brownlie	Mark Edwards	Chief Quality, Safety and Risk Officer
Peter Davis	Joanne Gibbs	Director Provider Services
Tama Davis	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Fiona Lai	Meg Poutasi	Chief of Strategy, Participation and Improvement
Bernie O'Donnell	Shayne Tong	Chief Digital Officer
Michael Quirke	Sue Waters	Chief Health Professions Officer
Ian Ward	Justine White	Chief Financial Officer
	Dr Margaret Wilsher	Chief Medical Officer
	Auckland DHB Senior Staff Present	
	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

The Karakia was led by Tama Davis.

Acknowledgement and Presentation to Margaret Dotchin

Announced this week were the Te Tohu Ratonga Tūmatanui, NZ Public Service Medal awards. Margaret Dotchin was accorded the merit of the highest order.

Ailsa and Pat attended the ceremony with Margaret her husband and Margaret's parents. .

As articulated by Peter Hughes this award represented a shift in the emphasis placed on the work that those of us do that operate in the public service as the glue that holds society together.

Many people had spoken in support of Margaret's nomination and to the magnificent contribution made to her colleagues, to the system she operates and to the wholesale support for doing good at a very high level. This is a brilliant recognition of someone in our system and in our leadership team who exemplifies the grace, the intelligence, the competence, the moral purpose and who has the breadth of skill set necessary to inspire her colleagues to do great work.

Board Chair, Pat Snedden read to the meeting an excerpt from the recognition accorded Margaret at the award ceremony which captures Margaret's dedication to nursing and her desire to make a difference.

"Margaret is an outstanding nurse and health leader, and an inclusive practitioner. She is passionate about nursing and delivering vital services to patients, which she has been doing for 30 years as a senior leader in her field. People trust her because she does what she says she will do and never walks away from a challenge.

Margaret has led innovative nursing approaches that improve the patient experience and is an outstanding role model for nurses. She led the development of Auckland District Health Board's nursing strategy, a blueprint for nurses that underpins their professional development. She has been fundamental in creating nursing scholarships for Māori and Pasifika students to ensure they are better represented in the workforce.

Margaret is driven by a spirit of service to the community she serves and is a worthy recipient of the New Zealand Public Service Medal."

The Board Chair, Pat Snedden on behalf of the Board thanked Margaret for her leadership for the singular niceness she brought to the role. She has made the organisation better by her contribution and as only one of 10 to receive this award in the Public Service it was worth a round of applause.

Margaret Dotchin responded that she felt a huge level of pride, overlaid by a sense of humility and said that she was privileged to be able to do what she had done for the last 30 years. Her achievement would not be possible without the support of the leaders she had worked alongside, the Boards that she had worked with and the nurses and other health professionals themselves. Margaret said that she loved her job, loved coming to work and the difference that she could make. Providing the best place for these people to work enables them to provide the best care to the people that we serve. This award is not just for me but for all at Auckland DHB but in particular for the nearly 5,000 nurses who work here putting their heart and soul into providing care for people, often when those people are very vulnerable or when they are in tragic circumstances.

Margaret acknowledged Pat and Ailsa for their leadership and support and for providing the platform that allowed this situation to occur.

1. ATTENDANCE AND APOLOGIES

There were no apologies.

2. REGISTER AND CONFLICTS OF INTEREST

Bernie O'Donnell advised that he had been appointed to Te Mātāwai as National Board - Urban Māori representative. This was a national funding body and lead for te reo Māori strategy.

Tama Davis advised that he had been appointed as a Director on the Board of New Zealand Health Partnerships.

Pat Snedden advised that he had stood down from the Board of New Zealand Health Partnerships and this could be deleted from his interest register.

3. CONFIRMATION OF MINUTES 23 September 2020 (*Pages 9-48)*

Resolution: Moved Fiona Lai / Seconded Ian Ward

That the minutes of the Board meeting held on 23 September 2020 be confirmed as a true and accurate record.

Carried

4. ACTION POINTS *(Page 49)*

4.1 Patients effectively connecting with the hospital system *(Pages 50-52)*

Jo Gibbs, Director Provider Services asked that the report be taken as read.

The following was covered during discussion of the report:

Doug Armstrong commented that the reason that he originally brought this issue up was to address the way in which the Board did business with its stakeholders and patients. What he wanted to see was a digital dialogue entered into that resulted in a real conversation occurring with a patient which was more efficient and resulted in a more effective outcome.

While he acknowledged that some progress had been made he wanted a recommendation added to read, "That the Board wished to see progress in respect of this matter and that a report be made back on six months on progress made."

The Board Chair, Pat Snedden summarised that Doug Armstrong's point in particular did not refer to those that had to be communicated with via post, but to the majority of patients that the hospital had the opportunity to communicate with via digital means.

Ailsa Claire advised that progress could not be made until the HARP project was progressed as that platform was required to enable more digital solutions to be employed.

Doug felt there was not a need to be too complex in the solution employed referring to what was done at Mercy Hospital to advise patients of appointments and results. Michael Quirke advised that Mercy Hospital had just implemented a new PAS and was following quite an aggressive but connected agenda and as a relatively small enterprise were able to do that. It was an unknown whether what had been implemented was able to be scaled up for a larger organisation.

Peter Davis considered that while a PAS was necessary to reduce the current level of manual intervention there were some good ideas that could be followed up on now to get some interim improvement.

It was agreed that the six-monthly report back could provide an update on gains made with Telehealth and other initiatives currently being undertaken.

Resolution: Moved Doug Armstrong / Seconded Pat Snedden

That the Board:

1. Receives the Patients Effectively Connecting report

2. Notes that this is in response to an Action Point from 23 September 2020 Board

Meeting - Item 6.1

3. **Receive a six monthly update report (May 2021) detailing gains made with Telehealth and other initiatives undertaken in that period.**

Carried

5. EXECUTIVE REPORTS *(Pages 53-83)*

5.1 CHIEF EXECUTIVE'S REPORT

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

Notable Programmes

Attention was drawn to videos that had been produced that were fun but also a different way of engaging with people and increasing awareness.

Healthy Workplace

Mel Dooney advised that a large amount of work had been done in February and March of this year that had revealed some very detailed insights around a healthy workplace. The artwork attached to the item was a visual recorder of the outcomes of those workshops at the time. Those insights and knowledge gained during COVID 19 through Occupational Health about the organisations vulnerable workers have been brought together to form the framework and six action areas. What was heard was that the organisation needs to support leaders to have conversations with their teams around wellbeing.

There has been some work done with Kaui Oranga which is a national collaboration between the Unions, the MoH and the DHBs. We have led a series of webinars around wellbeing topics from health and safety through to compassionate leadership. The Auckland DHB team have been heavily involved with sourcing the content for those webinars.

The Board Chair, Pat Snedden asked whether there had been a strong sense that people had reflected on the impact of COVID 19 on their practise and sense of personal wellbeing. And was advised that this was the case. During COVID a series of seminars have been held to allow leaders to check in and then how to facilitate that process with their teams.

COVID Barometer

The barometer is a reflection of what is required to be done to meet the requirements of COVID 19 at any particular time and dictates the actions that staff must take. Currently the barometer sits at "low".

Our People

Celebrations our people and Local Hero acknowledgements have continued.

It is particularly pleasing to see Dr Alison Levershea winning an award for her report dealing with reducing inequalities in Well Child Tamariki Ora development surveillance.

Performance of the Wider Health System

The organisation remains challenged in moving forward.

Resolution:

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

Carried

5.2 Health and Safety Report

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

The health and safety work being undertaken by all 20 DHBs is progressing well. One national meeting has been held recently with another next week and good progress is being made in prioritising and aligning work across all DHBs.

There has been a visit from WorkSafe. Ailsa Claire, Mel Dooney and Mark Edwards have met with their CEO and the senior staff member who specifically focuses on the health sector for a relatively informal discussion. This was with the aim of starting a constructive on-going dialogue.

Progress has been made toward developing a health and safety work plan which will be taken to Finance, Risk and Assurance Committee and then to Board.

The following was covered during discussion of the report

Mark Edwards advised that the key thing that required the most work was engaging with staff to ensure that health and safety was integrated into everything that they did every day. What will make the difference in achieving this is how people managers conduct their work and how we as an Executive leadership Team and Board seek to encourage and model that behaviour. Mark felt that more could be done by the Board in providing inspiration and motivation in this area. Some less formal "walk arounds" and being seen out and about a little more frequently would be advantageous. The Board Chair, Pat Snedden agreed that this was a fundamental part of the Boards due diligence responsibilities.

Doug Armstrong felt that the greatest risk for the organisation currently was related to COVID 19 and asked what the public expected to experience when visiting the hospital and whether there was adequate mask wearing, available hand sanitiser and contact tracing mechanisms. He was concerned that, with the lowering of the levels, the hospital might become a bit too relaxed. Ailsa Claire advised that the "Barometer" describes the state of the hospital's alertness and the assessment of risk of COVID within the community and the impact that COVID would have including how staff would be redeployed.

When the hospital moves up and down levels there are a range of activities that people need to undertake including the wearing of masks, hand sanitising and other processes related to contact tracing. That assessment is based on an in-depth assessment of where there is a presence of COVID-19 within the community and what the risk associated with that is. The risk at level 2 during the second wave of COVID 19 was of a nature that prompted protection

of the hospital and the stringent signing in procedures and mask wearing. During the recent cluster of four community cases the hospital was aware of how well controlled that outbreak was and were comfortable that the level remain at "Very Low". Assessments are made in relation to the activity that the hospital and its staff must perform at any one time. Some services such as the ED department are more vulnerable and there are different requirements there than in other services or places within the organisation.

The Board Chair, Pat Snedden drew attention to the barometer shown on page 55 of the agenda and advised that the hospital made its own assessment separately from that made nationally and they tended to be on the very conservative side to protect the hospital.

Mark Edwards advised that there was a detailed escalation plan that was reviewed weekly which enables management to map out any triggers that are considered important and then the associated actions that need to follow. It provides an overall picture of what is occurring and the sensible actions that are required to be taken at each stage.

Jo Gibbs advised that masks and hand sanitiser are available at all hospital entrances and hand sanitiser is available throughout the hospital.

Zoe Brownlie drew attention to page 64 of the agenda and mention of training for induction including patient handling commenting that she was aware that over the last couple of years there has been issues around reporting relating to training due to recording issues rather than training not being undertaken and wanted to know whether anything had been done to remediate this. Mark Edwards advised that the system used to track training had been changed and that he would need to follow up to ascertain what the level of recording looked like now to answer the question.

Resolution:

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

Carried

5.3 Auckland DHB Pūmanawa Tāngata Update November 2020

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

This is a status update in relation to the 6 KRAs under Pūmanawa Tāngata. The report details the work which has been performed since the Plan was approved at last meeting.

With the strategy now approved it is a matter of preparing the detailed plans and engaging with the organisation in that work, without overwhelming staff at this time given COVID 19 commitments. There has been significant work done, particularly with respect to KRA 2 and KRA3, where good progress is being made.

Resolution:

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

Carried

5.4 Auckland DHB People Dashboard – Quarter 1 2020/21

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

The analytics dashboard is presented in a slightly different format this report, to accommodate the request at the last meeting for a deeper review on a particular aspect to build familiarity by the Board members with the new data as presented. To this end a deep dive into talent sourcing metrics has been presented. The three key points to note around those metrics. Firstly, that there is increasing interest through the career sites and social media which indicates the Health Sectors attractiveness as a secure workplace. This also reflects what is happening in the wider national employment landscape. Secondly, that there is work to be done in employment brand to ensure consistency, and ensure we are telling our story as an employer to best effect. And lastly, that there is also a lot of work to do, and commitment to doing so, with respect to developing the Maori and Pacific workforce in the areas of both attraction and ensuring hiring managers are equipped to properly assess those applications.

It was noted that the dashboard reflected the fact that people were staying in their positions and not moving. That fact is also reflected in the paper on personnel costs and what this phenomenon has meant in financial terms for the organisation.

The following was covered during discussion of the report:

Bernie O'Donnell asked whether a kura kaupapa, kohunga reo, wharekura, wānanga pathway had been considered to attract a Māori cohort. These are speakers of te reo Māori who are looking to see how they can continue to develop in various work sectors. Mel Dooney advised that work is being done with rangatahi in schools where the DHB has relationships via nursing and other clinical professions, but it acknowledged that there is a desire to do more in this area.

Resolution:

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

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

Carried

6 PERFORMANCE REPORTS *(Pages 84-107)*

6.1 Financial Performance Report

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

In terms of the Annual Report for 19/20 year there has been a change in central requirements which allows the DHB to have until 18 December to submit. The Annual Report will come back to the Board but, as it was deferred from the last Finance, Risk and Assurance Committee meeting, it is being suggested that the Chair and Deputy Chair sign the

final report based on the recommendation of the Finance, Risk and Assurance Committee as the statutory deadlines do not work timing wise with Board meetings. Ian Ward commented that the Board should not delegate its responsibilities and that due process needed to be followed. It was agreed that FRAC needed to consider the Annual Report and that they recommend that it is in order for the Board to approve but that it was the Board itself that needed to delegate authority to the Board Chair and Deputy Board Chair to sign the final Annual Report preserving the Boards accountability.

The Annual Plan for 2021 still awaits ministerial approval and sign off and in the meantime the Board is still working toward its $45M deficit budget.

The year to date performance has the Board is on track if the net COVID 19 impact of $17M was removed. There are some significant pressures in terms of revenue and non-resident volume related to IDF and in terms of people cost; both COVID 19 related costs being the backfill and overtime component and the holidays and vacancy issues. There are a number of initiatives in play to reduce that deficit. The year-end forecast allows for a deficit of $61M; which is the $45M as per the plan and the COVID 19 related impacts that have been seen year to date. It is being forecast at this stage that the Board can manage those pressure points but not recover the direct COVID 19 cost impact already felt.

The only other point to note is that the balance sheet cash balance reflects the delay of capex programme and a fixed term investment that has rolled off but which has yet to be reinvested.

The following was covered during discussion of the report:

There was a discussion around what public equity was with advice given that it referred to the investment by the Crown in the DHB over time. The extent to which equity rises and falls each year is determined by the outcome of the DHBs operating position process.

Resolution:

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

Carried

6.2 Planning and Funding Outcomes Update

COVID clearly remains a significant impact on both staffing and team workloads.

The scale of community testing has been significant in terms of staff and cost and a process has been embarked on, recognising that this is now part of “business as usual”, as to how surge capacity is managed and funded.

The Community Services Team have adopted a new model of care relating to where virtual assessments can be conducted. The biggest impact has been on oral health where there are on-going refinements on the part of the Dental Council which have impacted productivity.

During COVID 19 Alert Level 4 approximately 500 rough sleepers were accommodated in

motel units (managed accommodation) across metropolitan Auckland. Mobile Outreach Health Clinics were successfully implemented to provide health services to those people who it had not been possible to reach in the past. The funding for housing of rough sleepers is still being funded up until March 2021. The challenge moving forward will be in that there is not a permanent outcome for rough sleepers past this point.

The Pacific AAA pilot has successfully completed a pilot for Tongan men. Out of 150 Tongan men 50% were diabetic and a quarter are current smokers. Seven AAA were found, five new atrial fibrillation cases were identified, 12 that were known but who were not on optimal medications who are now being followed up along with four men with very high blood pressure readings who have been referred back to their GPs.

Critical success factors involve having a Tongan Champion who is well known and can undertake community awareness raising, language translation and particularly continuing the robust high quality screening systems and processes that are already in place. Using learning's around accessible community locations from the previous Māori-specific AAA programme is important along with trusting relationships with primary care where the team could work closely with the PHOs and practices.

The results have been comparable with the Māori programme and work is being done to assess how the programme can be continued with other Pacific groups.

An explanation was given of what AAA involved being a one off abdominal aortic ultrasound (scan of the tummy). It looks for nothing else other than the aorta, checking for ballooning of the aorta (large blood vessel from the heart to the legs). If a ballooning (AAA) is caught early the outcomes are very good, if not caught early the chances of rupture for large AAA are high and likely to result in a fatality.

There had been very good media pickup in relation to the Māori lung cancer screening programme. A very positive first consumer advisory group meeting had taken place. Those consumers have agreed to walk alongside the team to build the programme. In particular they wish to focus on communication and pathways for the pilot. A case is being worked on for funding of a mobile CT for the programme.

There has been a dramatic reduction in rheumatic fever seen in the latest surveillance report, rather than the potential concern that rheumatic fever might increase over lockdown. The reduction was seen most clearly in Counties Manukau DHB and also Auckland DHB.

The following was covered during discussion of the report:

The Board Chair, Pat Snedden commented that with the restriction applied by the Dental Council to access to services based on health and safety issues and money is not being spent on children's dental heath recovery what is being done with the money allocated to that process. It was advised that staff were still engaged and work did continue but that it required an updated screening assessment process that was quite rigorous. Telehealth in this instance, for direct dental activity, had not been of any benefit but had been used in the dental promotion space.

Bernie O'Donnell applauded the early engagement with Maori in relation to the AAA programme and making a shift to being more proactive to provide early detection resulting

in less invasive treatment.

Fiona Lai was advised that engagement for AAA was via Primary Care where a person in the age group that the team were interested in is invited to come in for a one off ultrasound scan visit and a series of other assessments. The team works very closely with the primary care practice to locate the right sites close to where these people live or very close to their GP. The team works on a co-benefit model. A holistic approach to health is taken using the opportunity to maximise the benefit out of that one visit (eg CVD risk assessment, smoking cessation, blood pressure check).

The Board Chair, Pat Snedden noted the ebb and flow associated with immunisation throughout the COVID periods, and particularly the parental consent required around immunisation noting that he had been made aware that some parents had expressly said no to this process. It was advised that there had been some vaccine hesitancy but there had also been hesitancy related to COVID in terms of stepping outside of the home into the community and allowing outreach services into their homes. However, accurate data is available and historic gaps have been identified and are being closed with a marked decrease in patients being recalled.

Peter Davis queried how many parallel nursing services were required to manage rheumatic fever and was advised that this was not a new nursing service but was the Kāinga Ora service associated with the healthy homes initiative. Adding a nurse to the team increased the value of what that potential intervention could deliver.

Advice was given that the cervical screening data referred to on page 100 of the agenda related to cervical screening register data held by the Ministry of Health for the Auckland population (coverage is calculated by the number of screening tests over the population projections for the DHB, adjusted for estimated hysterectomy rates). The data reflects a number of things among those a general programme failure over the last couple of years where there is declining cervical screening in primary care and perhaps that reflects people anticipating a move in the programme from a screen every three years to five years and that decline is now disproportionately affecting Maori women. There is also a COVID impact with 59,000 deferred screens.

It was advised that a limitation existed as there is no population register for cervical screening. What does exist are PHO enrolment registers with primary care being responsible for the delivery of the cervical screening programme. Data matched lists between primary care and the cervical register were available routinely for primary care practices. This is an on-going task for cervical screening coordinators and practice champions.

Michelle Atkinson advised that this is similar to other inequities seen in health care. Not all women are approached or enrolled in health care or Maori women are not comfortable accessing the service or can't access it for the same reasons that they cannot access other health services or PHOs are not necessarily prioritising this as important right now. It is also the only screening programme that people have to pay for.

Resolution:

That the Board note the key activities within the Planning, Funding and Outcomes Unit

since the last update provided on 23 September 2020.

Carried

7 COMMITTEE REPORTS *(Pages 108-118)*

7.1 Hospital Advisory Committee

Tama Davis, the Committee Chair, presented the unconfirmed Hospital Advisory Committee minutes for information advising as follows:

There was robust discussion at the meeting. There were two presentations made to the Committee by Navigators for both Māori and Pacifika people informing members about the KRAs being put in place to make the Division tangible and the provision of clear pathways for patients accessing hospital planned care services. There was also a presentation from the Patient Whānau Centre to inform members of the work being done within the hospital to bring patients to us. This provided much information and experience which will enable leadership to enable them to implement new ideas into service delivery. There was a lot of input from the Board members and management.

Bernie O'Donnell clarified that the Board had Ti Tiriti obligations and then equity obligations. Urban Māori (Maata Waka) who do not have whakapapa affiliations to Tāmaki Makaurau and are still being failed by the system fall under the Boards equity obligation. The Treaty dynamics is a different dynamic and conversation altogether.

Meg Poutasi advised that the Navigators were part of her team and were part of the equity improvement work. They have two objectives the first being to ensure whānau and families receive fast care through the hospital services and systems and the second is to assist services with their equity approach and design change.

The Navigators take the waiting list and reach out to the long waiters first and offer all forms of assistance. The Services have themselves started to refer highly complicated and complex patients to them for management. There are two cohorts of people being managed. Those that have highly complicated and complex needs with the outcome being that they get an outcome in that they get their planned care event. Then there are those who just need someone to help them understand their planned care event and get through the event. They take all Māori and Pacifika people and are now taking those referred to them by the Services.

Ailsa Claire advised that this is a different way of working where Navigators work alongside Services to create the change that make those Services more available, accessible and acceptable to Māori and Pacifika people. This is not an initiative where the gains will reverse as it is an objective for Navigators to imbed this change within the Services that they are working with.

Bernie O'Donnell commented that he felt what was being talked about was the framework for Whānau Ora which was about navigating with multiple navigators with eyes on whānau and the community. Care needed to be taken not to use the DHBs structural muscle to intervene or put itself between the Whānau Ora Commissioning Agency and the people.

There is a need have a relationship with and to work alongside the Whānau Ora Commissioning Agency to make the gains the DHB wants to see.

The Board Chair, Pat Snedden reflected that in effect the Whānau Ora Commissioning Agency has in within its kaupapa the provision to enable people to obtain the best care for themselves. Bernie O'Donnell agreed saying that the situation needed to be looked at from the Māori perspective through a Māori lens. The DHB needed to question the core values that it was trying to develop as an organisation or it was in danger of simply taking over what the Whānau Ora Commissioning Agency was already doing.

Meg Poutasi added that it was the intention of this programme to start with GP referral and engage very early when people are first told that an intervention needs to occur. The DHB hasn't been able to achieve that yet due to level of change required with some services. Navigators do receive referrals from Whānau Ora Navigators, largely from Counties and other places where they are aware of the pathways of care at Auckland DHB. These Navigators are highly skilled clinicians and that has been hugely beneficial when talking about the complex nature of some surgeries and providing support to SMOs. They are advising at a very senior level and advocating change which is a very different type of approach. It would be wonderful to have Whānau Ora Navigators who effectively help the family with their goals in planned care to additionally helping them with their goals in the Whānau Ora framework.

Advice was given that the $11M referred to on page 113 of the agenda was loss of income because of work that was not able to be undertaken. That situation is different to the one recently introduced by the Ministry with incentive payments aligned to the ability of a DHB to recover the planned care targets post COVID19 lock down. Penalties have now been removed.

Jo Gibbs advised that DHB had bid and been successful with a number of planned care initiatives which were designed to primarily cover the activity loss during COVID. The payments for those are made on a quarterly basis at 80% with final 20% being paid on delivery aligned to a range of performance points.

Resolution: Moved Tama Davis / Seconded Fiona Lai

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

Carried

8 DECISION REPORTS *(Pages 119-120)*

8.1 Te Toka Tumai – Auckland DHB Strategy 2020-2023

Meg Poutasi, Chief of Strategy, Participation and Improvement asked that the report be taken as read advising that approval is being sought for the Auckland DHB strategy so that a quarterly conversation can be published about the strategic priorities throughout the wider organisation. Meg drew attention to an amendment to be made under the organisational

pillars in the "People, Culture and Values" stream where the six key results areas from the People Strategy should now be added since they had been approved by the Board.

Meg Poutasi advised that the "eliminate inequity" priority is based on the IHI improvement framework ("Achieving Health Equity") that addresses five key elements to reduce health disparities related to race. For the DHB to be effective in eliminating inequity in the first two strategic pillars, or in eliminating inequity for Maori or Pacific, a targeted approach needed to be taken or the DHB would not be successful. People are not excluded in lower socio economic areas, in fact when you look at what is invested in the community space, and in primary care, the majority of our localities work is in the high quintile or high deprivation areas. When you look at where DHB investment is concentrated it is in areas of high deprivation. The inequity targeted over the next three years is racial inequity.

The IHI framework suggests that ethnic inequity needs to be a strategic priority if our DHB wishes to eliminate this. It should be explicit and form part of the inequity strategic programme that sits underneath the framework. It is about making ethnicity and the disparity transparent within the organisation's data and approaches, so that clinicians can take action. If inequity is considered too broadly then you remove the targeted nature of the approach and the organisation will not be effective in its actual strategic objective, which is firstly, eliminating for inequity for Māori as a Treaty and system issue and then secondly, considering Pacific based on the current health outcomes of those groups.

The Board Chair, Pat Snedden commented that no one is actually excluded from obtaining care. What is being discussed is how to turn a problem that has been afflicting health care for such a long time; poor outcomes for Maori and Pacific. This situation is so predominantly clear in all evidence that something specific has to be done now to deal with it. It is being done because it is a constitutional requirement of Ti Tiriti for Māori and it is being done for Pacifika because their health outcomes are so very poor.

Doug Armstrong raised again the regional set of statements that he would have liked to have seen included in the Te Toka Tumai – Auckland DHB Strategy 2020-2023 purely for its clear aspirational sense. The Board Chair Pat Snedden agreed that that piece of narrative did outline what would be great experience for a person engaging with our health system but what was being talked about in this strategy was a macro commitment to a shift in outcomes for the whole of population with a particular focus on Ti Tiriti obligations and equity. That is very difficult to express on one page.

Ailsa Claire advised that the document Doug Armstrong referred to was referenced in work supporting this one page high level summary. When it comes to developing the programmes there will be an opportunity to utilise that narrative.

The Board Chair, Pat Snedden summarised that the Board broadly supported the Te Toka Tumai – Auckland DHB Strategy 2020-2023 and asked that in the design of one page document there might be a reference to the narrative piece favoured by Doug Armstrong and that more attention be paid to how those who are in the same circumstances as Māori and Pacific might also be accommodated.

Resolution: Moved Pat Snedden / Seconded Jo Agnew

1. **That the Board broadly endorses the strategic priorities and organisational pillars supporting the Te Toka Tumai – Auckland DHB Strategy 2020-2023 and requests that in the design of the one page document there might be a reference to the narrative piece favoured by Doug Armstrong and that more attention be paid to how those who are in the same circumstances as Māori and Pacific might also be accommodated.**
2. **That the Pūmanawa Tāngata KRAs be included under the organisational pillars in the "People, Culture and Values" stream.**

Carried

9 INFORMATION REPORTS *(Pages 121-199)*

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

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

The quarter four report reflects the bulk of the COVID 19 impact on the hospital and the spectrum of primary community care.

The following was covered during discussion of the report:

The Board Chair, Pat Snedden was advised that during the pandemic positive outcomes had been experienced. There had been clear impacts right across the system. Primary and community care have distinct flow on effects into the hospital. Obviously Telehealth has been a positive outcome. However, the on-going waves of impact from COVID are going to take some time to work their way right through the system and there were still things to learn.

There are benefits emanating particularly from the social distancing approach taken during COVID for respiratory disease which appears to be a world-wide phenomenon with significantly reduced impacts showing in the hospital. Recent analysis shows that far fewer cardiovascular events are presenting to hospital and there is a reduction in strokes. I t has been speculated that the early and high uptake of flu vaccination (community and healthcare workers) has had some effect.

The Board Chair, Pat Snedden commented that an observation made by the Minister for Health was that having an early flu vaccination early in the new year could be used as a preparatory campaign for the later roll out of a COVID vaccination. It would demonstrate the capacity of the system to vaccinate a large number of people.

It was advised that there had been a phenomenal uptake of the flu vaccination this year. Auckland DHB itself has an extremely high uptake for healthcare workers and is an exemplar. COVID vaccine requires a different programme for how it would be administered. The central planning and coordination and logistical challenges with that vaccine will mean that it will need to be run in a different way, although the lessons from the measles campaign, healthcare worker flu campaigns and childhood immunisations will be applied. The Ministry

of Health are planning for that now and the DHB has had various interactions with them around early thinking and it is hoped to see a comprehensive plan being released soon. The biggest challenge with the COVID vaccine will be the determination of eligibility and how that will be managed and communicated.

Michael Quirke commented that the planned care interventions within the scorecards came to the fore because the other two metro DHBs remained on target while the Auckland DHB didn't and asked whether that was a reflection of the heavier clinical and operational response that Auckland DHB took. Advice was given that there was no doubt that in terms of fit testing and in provision of staff assistance to ARPHS for the border response Auckland DHB had a higher involvement in the COVID response that reduced planned care able to be undertaken. There were other smaller issues that would have had a peripheral impact such as different visitor screening processes and policies and then there was the dental care issue. Auckland DHB provides the regional service for secondary care and the Dental Council had very specific requirements which meant the DHB could not provide planned care during COVID.

Michael Quirke commented that when looking at the scorecards and considering the COVID impacts there is a concern that anomalies are being placed at the door of COVID and that there is a risk that something important will be missed that should have been seen as a trigger for action. COVID has given skewed data and being able to distil that for the Board will be important. This was acknowledged with comment that one of those areas could be oral health which has quite complex COVID related issues along with pre-existing issues and this will be reported back to CPHAC so that a more in depth discussion can be had.

Ailsa Claire advised that these types of issues were already known pre COVID and work continues on them. For example, the Māori and Pacifika outcomes which have existed for a very long time. These have been affected by COVID but sometimes in a positive way too because different ways of working and relating to communities had to be found. COVID most definitely cannot be blamed for all results. What is being seen is that the quarter four report falls squarely into the timeframe of the Level Four lockdown where planned care was shut down.

Resolution:

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

Carried

9.2 Northern Region Service Annual Plan 2020/21

The Board Chair, Pat Snedden drew attention to page 152 of the agenda commenting that this was the document that Doug Armstrong referred to which is a very clear unambiguous explanation of what a person might expect from a good health system.

The Northern Regional Service Annual Plan explains what is being done across the region and is a good communication document of what DHBs are trying to achieve.

Ailsa Claire advised that one of the positive things arising from COVID is the shared

recognition that the region has vulnerable services. Although shared work has been done for some time the different way of working during COVID has created a greater awareness making this regional plan much more significant than it has been in the past. The summary of regional programmes and activities is a really good description of what is being attempted regionally and the DHBs need to be held to account to each other for this. One cannot achieve this without the other.

Tama Davis commented that he liked the fact that this plan had fostered many different conversations at many different levels both in the community and at Provider Arm level.

Peter Davis commented that he liked the graphic on page 150 of the agenda and was reassured by the strategies articulated within it.

Zoe Brownlie questioned the use of the word "I" instead of the use of "we" in the narrative relating to "what can I expect from future health services". The general consensus was that this was acceptable as it was referring to what an individual could expect from the health service and didn't change the general thrust of the document. The individual experience and the individual's knowledge and understanding of their own health are hugely important and in this context the use of "I" was acceptable.

Resolution: Moved Pat Snedden / Seconded Tama Davis

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

Carried

[Secretarial Note: An adjournment was taken to allow a lunch break with the meeting resuming at 1.00pm.]

9.3 Maternity Services Data Update

Jo Gibbs, Director Provider Services asked that the report be taken as read.

The Board Chair, Pat Snedden advised that this was factual data demonstrating what was occurring and the Board needed to consider whether this was something that they wished to continue doing and if it was not, then how could a change be effected that was respectful but clear in its intent.

Ailsa Claire drew attention to table 2 on page 195 of the agenda which provided a clear indication of the issues that are being seen. The spontaneous vaginal birth rate comparison for Auckland DHB employed midwives as opposed to private obstetricians and self-employed midwives is quite different. This is also true for C-Section rates and inductions of labour. A woman under the care of a private obstetrician is much more likely to have a C-section or an induction of labour. There is no indication that the private obstetricians have a different case mix of women, as this data has been adjusted and includes only standard primip data. Self-employed midwives had a higher rate of intervention than Auckland DHB midwives.

It was advised that while women have the right to determine where to have a primary birth they do not have the right to determine whether they can have a C-section or induction; this should be decided on the basis only of clinical need.

Jo Gibbs drew attention to figure two depicting ethnicity data which shows the significant difference by ethnicity of women who are paying for a private obstetrician compared to those using a LMC, self-employed LMC or an Auckland DHB midwife.

In response to a question, it was advised that Birthcare does not have private operating facilities and that private obstetricians choosing to deliver women by caesarean section would not be able currently to do that at Birthcare or at any of the other private hospitals in Auckland. Auckland DHB was the only facility with a delivery suite that could be used for planned C-sections. For historical reasons Auckland DHB is the only provider across the region that offers access agreements to private obstetricians which is why there is a high proportion of non-domiciled women coming to Auckland DHB for private birth care.

The Board Chair, Pat Snedden commented that if the Board were to change this situation it would cause contention within the market place and perhaps some alarm. There would no doubt be arguments about a woman's choice along with noise about preferential care.

Ailsa Claire advised that what is before the Board is an argument about quality of care and fairness.

Women who choose to have a private care package pay their clinician privately at a fee agreed between them but they do not pay Auckland DHB for the privilege of accessing private care. The private obstetrician has an agreement with Auckland DHB allowing them to access ADHB facilities for the delivery of healthcare. The woman does not pay anything to Auckland DHB with the only payment being through the IDF mechanism.

The issue is that these women are receiving high cost health care when there is no clinical reason for it. This is probably not optimal for them or the baby. Ailsa Claire advised that if the intervention rate was a reasonable one private obstetrician rates would the approximately the same as the rates for NZ as a whole.

Margaret Wilsher added that the facts are that the intervention rates are inexplicably high for private obstetricians and that is extremely worrying given the morbidity rate that is associated with these interventions. The data simply speaks for itself.

Peter Davis commented that the argument would be strengthened by the inclusion of WHO data which spoke of an acceptable intervention rate of around 15%.

Tama Davis added that the argument was around fairness of use of resource. These private planned interventions are using the resource of a public system which should be applied to those in greatest need. There is an equity aspect to this situation.

Ailsa Claire agreed that it was an opportunity cost. The DHB has limited resources and Auckland DHB provides the majority of services to people who cannot afford a private obstetrician. That means when the private obstetrician comes in and uses theatre capacity that theatre becomes unavailable to the rest of the Auckland population. Because private obstetrician's rooms are mainly in Auckland they find it convenient to birth these women in

Auckland DHB and not their own home DHB.

The Board Chair, Pat Snedden commented that this is a clear situation where capacity is being constrained by the activity of the private obstetrician. He questioned Doug Armstrong's opinion that this should be left to Government to decide. What would get in the way of the Board dealing with this? This is not news to the private obstetrician as they are confronted with the data each year at the Annual Report Day. Why would it be Government policy when the Board is prepared to make decisions in other areas of care allocation without necessarily reverting to the Government for support? This is highly sensitive but Management is saying the evidence exists and therefore a change needs to be considered.

Michelle Atkinson commented that any action taken should be done so with care and respect but this issue has been known of for several years and it is one of the clearest and most easily traceable examples of inequity. It is something that affects the safety of the services that Auckland DHB provides to women. It is something a more affluent woman can purchase that allows them more choice. Our first responsibility is to provide safe and timely care and in this situation that is not being done.

Advice was given that no new access agreements had been granted to private obstetricians or anaesthetists. The agreement with the Unions places no obligation on Auckland DHB to grant a right to private practice but nor would it unreasonably be withheld. However, there is a capacity issue so therefore no new access agreements can be issued.

In respect of Bernie O'Donnell's concern about the interpretation of the data, Margaret Wilsher agreed that the interpretation did need to be finessed. Jo Gibbs advised that if more qualitative and quantative data was required that could be found in the Annual Clinical Report.

Ailsa Claire advised that it needed to be kept in mind that the data only related to uncomplicated standard births and excluded those women with other co-morbidities or other issues who were high risk and might require a private obstetrician.

The Auckland DHB policy states that a woman cannot choose to have a C-section or induction of labour it must be done for clinical reasons. These policies and standards are national standards and have been approved by all the relevant bodies. If the policies were being applied there would be approximately the same outcomes for private obstetricians, self-employed midwives and Auckland DHB midwives. It is also the responsibility of the private obstetrician to advise their client of the pros and cons of the interventions they are recommending.

Michael Quirke commented that it would be good to get a view from the College around private obstetricians not adhering to these policies and standards and a review of what could be done. Michael was reminded that the statistical data was very strong and even through this report doesn't contain the qualitative data it did exist in the Annual Clinical Report. These concerns did need to be presented more formally to the private clinicians and there is a need to move forward and so a quality based argument is the best way of achieving that. This situation is inequitable, unfair and not sustainable.

In response to a question from the Board Chair as to how to progress this matter Jo Gibbs advised that discussion be continued through the Hospital Advisory Committee which would

continue to receive the reports around maternal deaths and any systemic recommendations and issues that arose from those reviews. Further, that an engagement plan that takes account of that process and the data in this report be brought back to the Board and that approval be sought to engage with the whole of the Women's Health Team to develop a strategy.

The Board Chair agreed that this would accommodate all Board members concerns and would mean that all clinicians to be part of the discussion and solution.

Doug Armstrong disagreed saying he favoured a well worded letter to the College signed by Ailsa Claire or Margaret Wilsher inviting the College to comment on the report and the additional issues that the Chief Executive had raised. He would like to see a College representative coming to the Hospital Advisory Committee or Board to address the issues outlined in that letter.

The Board Chair, Pat Snedden said that he leaned more toward the course of action outlined by Jo Gibbs as it provided the ability to engage the whole service in this conversation and gave the most potential for a positive outcome for reframing the situation. The College could be included in this conversation also.

Resolution: Moved Pat Snedden / Seconded Tama Davis

1. **That the Board receives this maternity services data update paper.**
2. **That discussion be continued through the Hospital Advisory Committee which would continue to receive the reports around maternal deaths and any systemic recommendations and issues that arose from those reviews.**
3. **That an engagement plan be developed that takes account of the process to date, and the plan to be brought back to the Board seeking approval to engage with the whole of the Women's Health Team to develop a strategy**

Carried

10 GENERAL BUSINESS

There was none.

11 RESOLUTION TO EXCLUDE THE PUBLIC *(Pages 200-204)*

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 23 September 2020	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Action Points	**N/A**	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4.1 Personnel costs including Annual Leave Accruals	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Risk Management 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	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]

	could be used for improper gain or advantage if it is made public at this time.	
6.1 Chief Executives Confidential Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 Human Resources Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.1 People and Culture Sub-Committee Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.2 Finance, Risk and Assurance Committee Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.1 Annual Report 2021	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or	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

	disadvantaged if that information was made public. **Obligation of Confidence** Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report.	withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.2 COVID 19 Governance Arrangements	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time. **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.3 Three Year Planned Care Update	**Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
10.0 Discussion Reports - Nil	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11.1 Auckland DHB Violence and Abuse Prevention Governance Group –	**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

Update	**Obligation of Confidence** Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report. **Protect Health or Safety** Information relating to the health and safety of the public is enclosed in the report.	1982 [NZPH&D Act 2000]
11.2 heathAlliance Key Highlights Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11.3 HealthSource Key Highlights report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11.4 On-going Work and Arrangements for the IMT/ NRHCC Regional COVID response	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
12.0 General Business	**N/A** N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

The meeting closed at 3.55pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 04 November 2020

Chair: _____ Date: _____

Pat Snedden

Action Points from 4 November 2020 Open Board Meeting

5

As at Wednesday, 16 December 2020

Meeting and Item	Detail of Action	Designated to	Action by
4 November 2020 Item 9.3	**Maternity Services Data Update** That an engagement plan be developed that takes account of the process to date, and the plan to be brought back to the Board seeking approval to engage with the whole of the Women's Health Team to develop a strategy	Jo Gibbs	TBA

Chief Executive's Report

TE TOKA TUMAI
Auckland DHB

Recommendation

That the Chief Executives report for 13 October 2020 – 23 November 2020 be received.

6.1

Prepared by: Ailsa Claire (Chief Executive)

1. Introduction

This report covers the period from 13 October 2020 to 23 November 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

2020-23 Strategy

In November we launched our strategy to our employees. The strategy will guide our work until 2023.

There are five strategic priorities in our strategy:

- Te Tiriti o Waitangi in action
- Eliminate inequity
- People, patients and whānau at the centre
- Digital transformation
- Resilient services

These are underpinned by:

- **Pūmanawa Tāngata**, our people plan. It aims to continue to strengthen our culture and build people's capability to deliver our strategy.
- **Quality, Safety and Risk** - making quality, safety and

risk part of what we do all the time.
- **Commissioning services** to achieve the best outcomes for our population.

Taiao Ora | Ward 51 opens

In November the first patients were admitted to Taiao Ora | Ward 51 at Auckland City Hospital.

The name Taiao Ora, meaning wellness environment, was gifted by Chief Advisor Tikanga, Dame Rangimārie Naida Glavish.

Taiao Ora integrates hyper-acute stroke, acute stroke, neurology, inpatient stroke rehabilitation and adult rehabilitation (for under 65-years-old) together on one ward.

Patients with stroke, neurologic disorders and rehabilitation needs now will get seamless hospital care in a purpose-built facility. Previously, our patients had a stop-go experience as they worked their way through the acute admission and rehabilitation steps of their hospital journey.

Bringing health staff from Ward 61, Rangitoto Ward and some of the Allied Health team together in Taiao Ora means they all continue to use their existing skills, as well as learning new ones as they integrate these services together.

The new ward has been designed with Taiao Ora in mind. The colours, textures, lighting and flooring have been chosen to bring a sense of wellbeing and healing. Natural elements such as harakeke, kawakawa, tui, pōhatu and awa are included in large murals throughout the ward.

It provides a safe, healing space to support patients on their journey to improved health and wellbeing. It also features a number of shared spaces to encourage whānau involvement along this journey.

Āhua Tohu Pokāngia Tika Rōpū – Equity Committee

As part of our commitment to equity Perioperative Services held a hui for Māori kaimahi. This was an opportunity to better understand how we could make the directorate a culturally safer place for everyone and make the environment be more meaningful for Māori kaimahi. This in turn creates a flow on effect to our tangata i te whai ora."

Te Āhua Tohu Pokāngia Tika Rōpū – Equity Committee was created in Perioperative Services to tautoko ōku hoamahi, establish whakawhanaungatanga, and initiate kawa within hui.

The Kaupapa of our Rōpū, is to:

- Achieve equity within our daily mahi and our perioperative whānau.
- Deliver our responsibilities outlined in Te Tiriti o Waitangi.
- Move towards a shared vision of improving partnerships with our Māori and Pacific people and increasing our Māori kaimahi and Pacific workforce.
- Embrace Māori culture and tikanga and embed it in our service delivery and day to day activities.

Glossary

- Kaimahi / staff
- Kaupapa / purpose
- Kawa / protocol
- Ōku hoamahi / colleagues
- Rōpū / committee
- Tangata i te whai ora / patients
- Tautoko / support
- Whakaaro / opinions
- Whakawhanaungatanga / connections.

Starship Hospital Tūpāpaku lift

We have a designated pathway for Tūpāpaku (deceased) to travel. It ensures the tapu (sacredness) of the deceased and the grieving whānau is not violated. One of those areas is the Tūpāpaku Lifts which is considered tapu (sacred). As it is tapu, food, drink, dirty linen and instruments cannot be taken in the lift at any time.

This pathway is very important and has seen the lifts receive a makeover first at Auckland City Hospital, and now at Starship Hospital to ensure the message to respect these lifts is really clear.

Illustrated by Toby Morris, the design on the Tūpāpaku lifts features manu (birds). Manu are regarded as spiritual messengers. Each of the birds in the illustration has significance and can be found in the Auckland DHB region.

Patient Safety Day

Aotearoa Patient Safety Day on 17 November this year was a reminder that caring for our patients means caring for our wellbeing too. It was also an opportunity to say thank you to health care workers for their dedication and commitment during a tough year.

Meg Poutasi serving morning tea

At Auckland DHB four 'thank you' morning and afternoon teas for staff were held at Auckland City Hospital and Greenlane Clinical Centre, hosted by the Executive Team and senior leaders. The idea was for senior leaders to demonstrate a spirit of service to those staff who express this every day through the work they do. We estimate that around 150 staff attended these events, interacting with leaders and one another. Feedback indicates that the events were positively received with attendees mentioning that 'it made me feel that I mattered.'

Communications through the week reinforced the message. A wellbeing discussion board was activated on Hippo encouraging individuals and teams to share how they were looking after wellbeing. Patient Safety Day videos produced by Health Quality Safety Commission (HQSC) were made available on the staff intranet and hospital video wall along with posts on Auckland DHB social media channels.

Mel Dooney serving treats

2. 2 COVID-19 response

Our planning continues to ensure we remain flexible to the COVID-19 pandemic. An escalation tool has been developed. This looks at internal and external triggers, such as number of cases of COVID in the community. Following this the plan looks across all settings, for example visitors, patient screening and planned care so we can adjust our settings to continue delivering our services, safely.

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, 363 emails were received. Of these emails, 333 were not communications-related and where appropriate, were referred to other departments and services at Auckland DHB.

2. 3. 2 Patient experience

Some examples of patient feedback we received this month:

Greenlane Surgical Unit

"Amazing communication and support from the get go, main reception desk staff were lovely, paediatric team were amazing, play specialist was soft and gentle which made for easy communication and a calm play space. The anaesthetist was very skilled and had clear communication and an ability to make you feel calm and safe. The theatre nurses were very helpful and ensured I was feeling okay after leaving my child in theatre. The surgeon did an amazing job and gave us all the information we needed both before and after surgery while we waited for our child to wake up." – Anon.

Emergency Department and the Transition Lounge

“My symptoms weren't dismissed, I felt listened to, I was spoken to with kindness (not patronised), nurses were able to smile and joke around with me - laughter makes a hospital stay THAT MUCH better and I was taken seriously.” – Anon.

2. 4 External and internal communications

2. 4. 1 External

Between 13 October and 23 November we received 59 requests for information, interviews or access from media organisations. This included requests for information or to interview clinicians regarding the temporary relocation of our Haematology Service, a pilot lung cancer screening programme and cataract surgery. Around 8 per cent of the enquiries over this period sought the status of patients admitted following incidents such as road traffic accidents.

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

Auckland DHB responded to 26 Official Information Act requests over this period.

2. 4. 2 Internal

- Six editions of Pitopito Kōrero | Our News, the weekly email newsletter for all employees, were distributed.
- Six editions of the Manager Briefing were published for all people managers.
- Eight COVID-19 update emails were sent out to all employees.

2. 5 Our People

2.5.1 Local Heroes

There were 39 people nominated as local heroes in September, October and November. Congratulations to our September local hero, Katherine Arnold, Cultural Community Support Worker. Here is Katherine's nomination:

Katherine with her local hero award at Manawanui Marae.

"Earlier this year a tangata whai i te ora was diagnosed with cancer. This 59 year-old woman had been under the care of Manawanui Oranga Hinengaro since 2006.

Previous key workers had made many attempts to locate her whānau members – but to no avail.

Katherine recognised the tangata whai i te ora's condition was starting to deteriorate. So Katherine quickly went back to the drawing board to search for the whānau – reading old notes and going through cultural assessments to try and find a name and phone number that could link her to someone who knew where the tangata whai i te ora's whānau lived.

Katherine began ringing Marae and Māori Trust Boards – but again to no avail. The most solid information that Katherine had was the tangata whai i te ora's Iwi – Ngāti Porou from Gisborne.

Katherine rang the local Ngāti Porou radio station and asked for whānau to make contact with her. In May the whānau made contact and came to visit their beloved whānau member. Thank you Katherine for re-uniting this whānau after 23 years of no contact. Thank you for bringing joy to our tangata whai i te ora in her final days."

2.5.2 Celebrating our people

New Zealand Public Service accolade for Margaret Dotchin

Congratulations to Margaret Dotchin, our Chief Nursing Officer, who has been awarded Te Tohu Ratonga Tūmatanui | The New Zealand Public Service Medal for 2020.

Part of the New Zealand Royal Honours, the medal recognises public service employees who demonstrate exceptional commitment to their work, the highest standard of integrity, and a spirit of service to New Zealanders.

Margaret Dotchin is an outstanding nurse and health leader. She is passionate about nursing and delivering vital services to patients, which she has been doing for 30 years as a senior leader in her field. She has led innovative nursing approaches that improve the patient experience and is an outstanding role model for nurses. She led the development of Auckland DHB's nursing strategy, a blueprint for nurses that underpins their professional development.

She has been fundamental in creating nursing scholarships for Māori and Pacific students and facilitates the development of the nursing pipeline to ensure it is robust and equipped for New Zealand's future.

Chief Digital Officer Shayne Tong – Top 10 in CIO50 List

Congratulations to our Chief Digital Officer Shayne Tong who is placed 10 in CIO50 list. The list highlights the top 50 senior technology executives in Aotearoa who are driving innovation and influencing rapid change across their organisations.

Shayne and the Te Toka Tumai Digital team are on a journey to strengthen the DHB's capabilities around digital acceleration, advanced analytics and data science.

2.5.3 Senior Leadership changes

Farewell to Michael Stewart – Director of Cardiovascular Services.

Michael is leaving to take up a new post as Chief Medical Officer, an Executive Director role, at South Tees Hospitals NHS Foundation Trust in Middlesbrough, North Yorkshire, UK, where he worked previously from 1996-2018.

Michael has made an extremely valuable contribution to our services here, in leading our Cardiovascular Directorate, which he has done with immense skill and experience over the

last 2 years. He has also shown great leadership across the organisation, most recently as part of our COVID-19 response

Michael will be leaving Te Toka Tumai in January.

Congratulations to Ian Dittmer – Medical Director, Adult Community and Long Term Conditions.

Ian Dittmer has been appointed in the role of Medical Director, Adult Community and Long Term Conditions. Ian expertly led the Renal team from 2008 till March 2020 and has made a substantial contribution to the development of the Renal Service. More recently he has been working with the Te Toka Tumai COVID-19 response team.
Ian brings a wealth of clinical and leadership experience and is well known and respected throughout the organisation.

3. Performance of the Wider Health System

3. 1 Priority Health Outcomes Summary

	Status	Comment
Acute patient flow (ED 6 hr)		Oct 90%, Target 95%
Improved access to elective surgery (YTD)		91% to plan for the year, Target 100%
Faster cancer treatment		Oct 96%, Target 90%
Better help for smokers to quit: • Hospital patients • PHO enrolled patients • Pregnant women registered with DHB-employed midwife or lead maternity	  	Oct 95%, Target 95% Sep Qtr 80%,Target 90% Sep Qtr 100%,Target 90%
Raising healthy kids		October 100%, Target 95%
Increased immunisation 8 months		Sep Qtr 94%, Target 95%

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

4. Financial Performance

The Auckland DHB Board approved 2020/21 Annual Plan financial budget is a deficit of $45M. Financial performance against the budget for the four months ending 31 October 2020 is a deficit of $28.4M, against a budgeted deficit of $6.2M, thus unfavourable by $22.2M. This unfavourable variance is entirely attributed to net Covid impacts and includes a provision for IDFs and Planned Care revenue adverse wash-ups of $14M as volume delivery was impacted by Covid. The consolidated Business as Usual (BAU) operational result (excluding Covid impacts) is favourable to budget for the year to date by $206K.

At a divisional level, the Provider Arm result is $22.7M unfavourable to budget (mainly due to unfunded Covid impacts). The Funder Arm result is similar to budget ($17k favourable) and the Governance and Admin Arm result is favourable to budget by $492K.

Financial Performance Report for the period ending 31 October 2020

Recommendation

That the Board Receives this Financial Report for the four months ending 31 October 2020

Prepared by: Auxilia Nyangoni, Deputy Chief Financial Officer
Endorsed by: Justine White, Chief Financial Officer
Date: 1 December 2020

1. Executive Summary

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

For the year to date period ending 31 October 2020, the DHB realised a deficit of $28M, which was $22M unfavourable to the budgeted deficit of $6M. The result by division and showing the Covid impacts is as follows:

Result by Division	**For the four months ending 31 Oct 2020**		
	Actual	**Budget**	**Variance**
Funder	6,317	6,300	17 F
Provider	(35,114)	(12,400)	22,716 U
Governance	422	(70)	492 F
Net Surplus / (Deficit)	**(28,375)**	**(6,170)**	**22,206 U**
COVID-19 Net impact on bottom-line	(22,412)	0	**22,412 U**
BAU Net impact on bottom-line	(5,963)	(6,170)	**206 F**

The $22M unfavourable variance is realised in the Provider Arm and is mainly due to Covid impacts, as the underlying Business as Usual (BAU) operations' result was overall favourable to budget by $206K as shown above.

Covid impacts include a provision for adverse IDF and Planned Care revenue wash-ups of $14M reflecting continuing lower than planned volumes delivered during the level 3 Covid lockdown period. The balance of the variance is due to net unfunded Covid costs.

2. Summary Result and Financial Commentary for October 2020

$000s	Month (Oct-2020)			For the four months ending 31 Oct 2020			Full Year (2020/21)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Income									
Government and Crown Agency	148,344	145,136	3,208 F	598,273	581,751	16,522 F	1,713,509	1,742,995	29,487U
Non-Government and Crown Agency	7,861	8,750	889 U	32,834	35,510	2,676 U	151,051	105,660	45,390F
Inter- District Flows	59,746	60,598	852 U	233,557	242,392	8,835 U	727,840	727,176	664F
Inter-Provider and Internal Revenue	1,444	1,565	121 U	6,049	5,721	328 F	18,570	18,242	328F
Total Income	**217,395**	**216,049**	**1,347 F**	**870,712**	**865,374**	**5,338 F**	**2,610,970**	**2,594,073**	**16,896F**
Expenditure									
Personnel	95,578	96,015	437 F	390,709	384,485	6,224 U	1,195,026	1,184,077	10,949U
Outsourced Personnel	2,814	1,605	1,210 U	10,933	6,418	4,514 U	22,559	19,254	3,305U
Outsourced Clinical Services	3,933	3,720	213 U	16,051	14,475	1,576 U	46,329	45,976	353U
Outsourced Other Services	8,199	7,395	805 U	29,285	29,579	294 F	94,210	88,737	5,473U
Clinical Supplies	28,879	27,483	1,395 U	112,798	111,993	805 U	329,352	326,698	2,654U
Funder Payments - NGOs and IDF Outflows	65,923	62,490	3,433 U	262,652	249,960	12,692 U	773,741	749,879	23,862U
Infrastructure & Non-Clinical Supplies	18,242	18,631	389 F	76,659	74,633	2,027 U	234,684	224,496	10,188U
Total Expenditure	**223,569**	**217,338**	**6,230 U**	**899,087**	**871,543**	**27,544 U**	**2,695,901**	**2,639,117**	**56,784U**
Net Surplus / (Deficit)	**(6,173)**	**(1,290)**	**4,884 U**	**(28,375)**	**(6,170)**	**22,206 U**	**(84,932)**	**(45,044)**	**39,888 U**

Result by Division	Month (Oct-2020)			For the four months ending 31 Oct 2020			Full Year (2020/21)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funder	1,133	1,575	442 U	6,317	6,300	17 F	13,843	18,900	5,057 U
Provider	(7,277)	(2,858)	4,418 U	(35,114)	(12,400)	22,716 U	(99,229)	(63,882)	35,347 U
Governance	(30)	(6)	23 U	422	(70)	492 F	454	(61)	515 F
Net Surplus / (Deficit)	**(6,173)**	**(1,290)**	**4,884 U**	**(28,375)**	**(6,170)**	**22,206 U**	**(84,932)**	**(45,044)**	**39,888 U**
COVID-19 Net impact on bottom-line	(5,505)	(575)	**4,930 U**	(22,412)	0	**22,412 U**	**(39,676)**	0	**39,676 U**
BAU Net impact on bottom-line	(668)	(715)	**46 F**	(5,963)	(6,170)	**206 F**	**(45,255)**	(45,044)	**211 U**

Commentary on DHB Consolidated Financial Performance

Result for the Month of October 2020

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

Revenue for the month of October 2020 is favourable to budget by $1.3M (0.6%). This variance reflects $5M additional Covid income realised which fully offset BAU revenue that was $3.8M unfavourable, mainly in Non-Government and Crown Agency revenue and including provisions for Inter-District Flow (IDF) wash-ups.

Expenditure for the month of October 2020 is unfavourable to budget by $6.2M (-2.9%). $10M of this variance is due to unbudgeted costs arising from Covid-19 and this is partially offset by $3.8M favourable cost movements in BAU operations. Significant variances include:

- $773K (-0.8%) unfavourable variance in combined Personnel and Outsourced Staff costs reflecting Covid impact ($3.1M unfavourable), offset by a favourable BAU variance of $2.3M.
- $1.3M (-5.1%) unfavourable Clinical supplies, reflecting $0.9M Covid-19 cost impacts mainly in Laboratory consumable costs and driven by high volume of Covid tests processed during the month.
- $3.4M (-5.5%) unfavourable variance in Funder NGOs expenditure is mainly driven by unbudgeted Covid costs which are offset by additional Covid funding from MoH.

Result for the Year to Date

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

Total Revenue is favourable to budget YTD by $5.3M (0.6%), mainly driven by a net favourable Covid impact of $6.5M, with BAU revenue being $1.2M unfavourable. Significant variances in revenue categories include:

- $16.5M (2.8%) favourable Government and Crown Agency revenue. This includes additional revenue of $11.3M realised for Covid for community testing and for an increase in Laboratory services. The balance

reflects favourable revenue in BAU operations mainly MoH devolved contract revenue with associated costs.

- $2.7M (-7.5%) unfavourable Non-Government and Crown Agency revenue, mainly reflecting:
  - $3.4M unfavourable Non-Resident revenue due to reduced Pacific contract cases as a result of Covid.
  - $1.9M unfavourable Other Income reflecting additional revenue assumed for budget initiatives not realised.
  - $1.3M unfavourable Donations - this income fluctuates from month to month depending on timing of larger donations for key projects.
  - These were offset by $2M favourable Retail Pharmacy revenue (with corresponding costs of goods sold), Research Income $1.2M favourable (offset by additional research costs so bottom line neutral) and ACC income $0.6M favourable reflecting additional volumes in services such as Reablement and the Regional Pain Service.
- $8.8M (-3.6%) unfavourable Inter-District Flows, mainly from revenue wash-up provisions for under delivery of inpatient services.

The year to date expenditure variance of $27.5M (-3.2%) includes an overall adverse Covid impact of $28.9M and the balance is due to $1.4M favourable impact from BAU operations. Significant variances are:

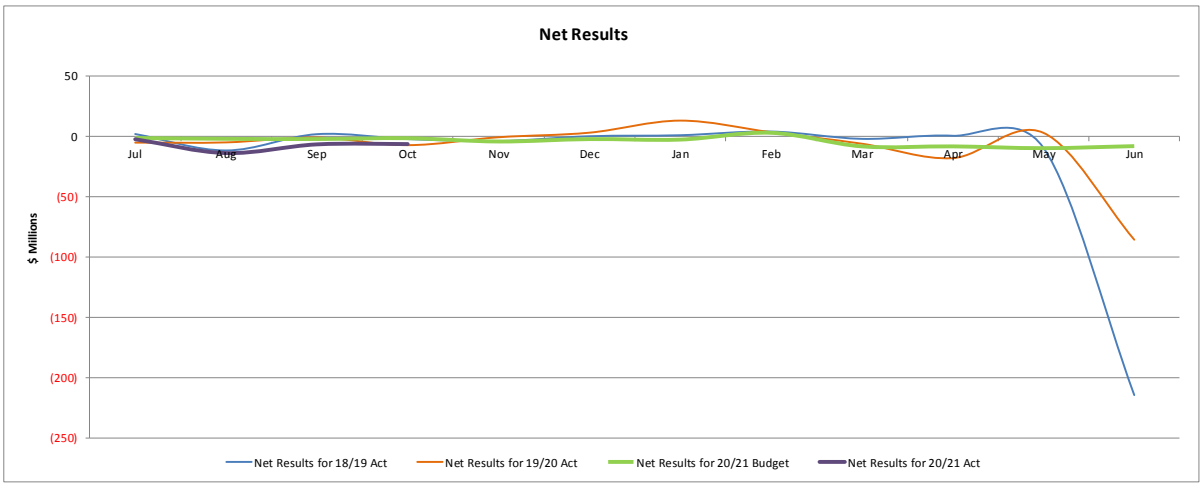
- $10.7M (-2.7%) unfavourable variance in Personnel/Outsourced Personnel costs, driven by the following:
  - Unbudgeted Covid-19 related expenditure of $10.3M, with unbudgeted Covid FTEs at 129 YTD.
  - Budget Personnel vacancy and cost per FTE assumptions not fully achieved for year to date $0.5M unfavourable.
- $1.6M (-10.9%) unfavourable in Outsourced Clinical Services, with the key variances as follows:
  - Unbudgeted Covid-19 related expenditure of $0.3M (for laboratory send-away tests).
  - Diagnostic genetics $0.4M unfavourable due to delay in repatriation of tests previously not done in house – this variance will reduce once repatriation is complete.
  - Planned outsourcing for colonoscopy has been completed earlier than budget phasing resulting in a $0.4M unfavourable variance which will correct during the year.
  - Additional MRI outsourcing $0.3M unfavourable for which additional one off MOH funding has been received.
  - Additional outsourcing in Ophthalmology in order to meet planned volumes, $0.5M unfavourable.
- $12.7M (-5.1%) unfavourable variance in Funder NGOs expenditure & IDF outflows, mainly reflecting unbudgeted Covid cost impact of $13.7M, offset by additional Covid revenue and net favourable variances across the other funded Initiatives within Funder NGO and, favourable prior year adjustments in Other Personal Health expenditure.
- $2M (-2.7%) unfavourable variance in Infrastructure & Non Clinical Supplies costs mainly driven by unbudgeted Covid-19 related expenditure of $2.5M offset by various net favourable movements across the expenditure categories.

Year End Forecast Result

The high level forecast year end result is a deficit of $84.9M against the full year planned deficit of $45M, this excludes any further Holidays Act remediation provision that will be required for 2020/21 and will be subject to estimation by experts. The forecast variance to the budget is primarily due to the year to date and forecast Covid impacts.

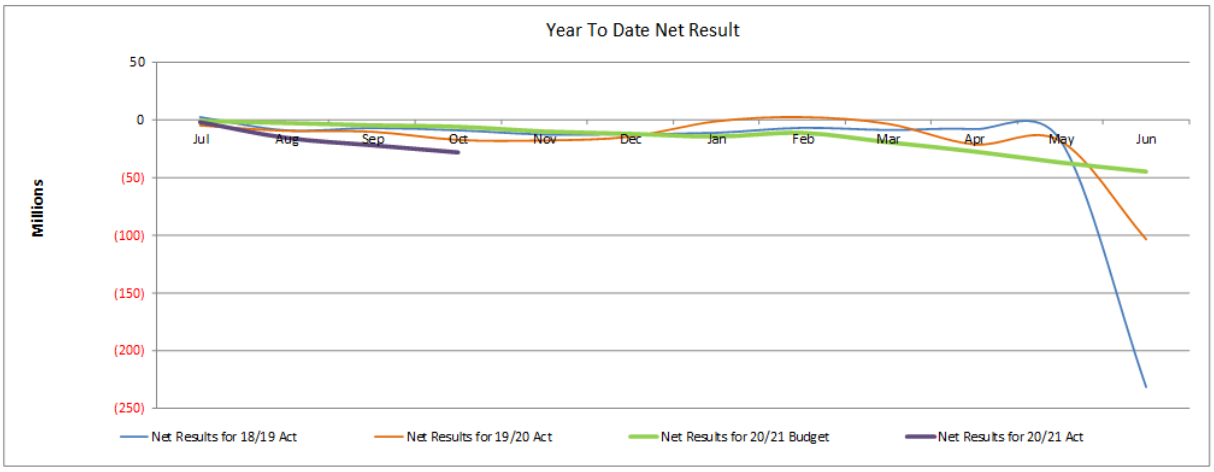
3. Performance Graphs

Figure 1: Consolidated Net Result (By Month)



$ millions	July	August	Spetember	October	November	December	January	February	March	April	May	June	Total
Net Results for 18/19 Act	2.183	(11.446)	2.057	(2.009)	(3.665)	0.324	1.185	4.248	(1.830)	0.728	(9.280)	(214.462)	(231.967)
Net Results for 19/20 Act	(4.968)	(4.764)	(0.776)	(7.055)	(0.494)	3.289	13.310	3.679	(5.846)	(17.834)	3.151	(85.513)	(103.821)
Net Results for 20/21 Budget	(1.110)	(1.795)	(1.975)	(1.290)	(4.026)	(2.028)	(2.449)	3.189	(8.065)	(8.066)	(9.566)	(7.864)	(45.043)
Net Results for 20/21 Act	(2.167)	(13.626)	(6.409)	(6.173)									(28.375)

Figure 2: Consolidated Net Result (Cumulative YTD)



$'millions	July	August	September	October	November	December	January	February	March	April	May	June
Net Results for 18/19 Act	2.183	(9.263)	(7.207)	(9.215)	(12.880)	(12.556)	(11.371)	(7.122)	(8.953)	(8.225)	(17.505)	(231.967)
Net Results for 19/20 Act	(4.968)	(9.732)	(10.509)	(17.564)	(18.057)	(14.768)	(1.458)	2.221	(3.625)	(21.459)	(18.308)	(103.821)
Net Results for 20/21 Budget	(1.110)	(2.905)	(4.880)	(6.169)	(10.195)	(12.223)	(14.672)	(11.483)	(19.548)	(27.614)	(37.179)	(45.043)
Net Results for 20/21 Act	(2.167)	(15.793)	(22.202)	(28.375)								
Variance to Budget 20/21	(1.057)	(12.888)	(17.322)	(22.206)								

4. Financial Position

4.1 Statement of Financial Position as at 31 October 2020

$'000	31-Oct-20			30-Sep-20	Variance	30-Jun-20	Variance
	Actual	Budget	Variance	Actual	Last Month	Actual	Last Year
Public Equity	931,503	950,352	18,849U	928,574	2,930F	919,427	12,077F
Reserves							
Revaluation Reserve	599,151	599,151	0F	599,151	0F	599,151	0F
Accumulated Deficits from Prior Year's	(792,779)	(790,846)	1,933U	(792,779)	0F	(688,960)	103,819U
Current Surplus/(Deficit)	(28,375)	(6,169)	22,205U	(22,201)	6,173U	(103,819)	75,445F
	(222,002)	(197,864)	24,138U	(215,829)	6,173U	(193,628)	28,375U
Total Equity	**709,501**	**752,488**	**42,987U**	**712,745**	**3,243U**	**725,799**	**16,298U**
Non Current Assets							
Fixed Assets							
Land	347,122	347,122	0F	347,122	0F	347,122	0F
Buildings	613,523	627,496	13,973U	616,262	2,739U	624,109	10,586U
Plant & Equipment	82,423	92,548	10,124U	84,007	1,583U	86,655	4,232U
Work in Progress	94,271	104,511	10,240U	87,482	6,789F	73,193	21,078F
Total PPE	1,137,339	1,171,677	34,338U	1,134,873	2,466F	1,131,079	6,259F
Investments							
- Health Alliance	74,268	75,057	789U	74,268	0F	74,268	0F
- Health Source	271	-	271F	271	0F	271	0F
- NZHPL	6,791	5,511	1,281F	6,846	55U	7,084	293U
- Other Investments	518	-	518F	518	0F	518	0F
	81,848	80,568	1,281F	81,903	55U	82,141	293U
Intangible Assets	2,165	6,034	3,869U	2,237	72U	2,216	51U
Trust Funds	16,883	15,970	913F	16,386	497F	15,970	913F
	100,896	102,572	1,675U	100,526	370F	100,327	569F
Total Non Current Assets	**1,238,235**	**1,274,248**	**36,013U**	**1,235,399**	**2,837F**	**1,231,407**	**6,829F**
Current Assets							
Cash & Short Term Deposits	170,419	112,742	57,677F	151,504	18,915F	135,902	34,517F
Trust Deposits > 3months	18,392	16,394	1,998F	15,892	2,500F	16,394	1,998F
ADHB Term Deposits > 3 months	5,000	15,000	10,000U	5,000	0F	15,000	10,000U
Debtors	33,201	45,325	12,125U	28,663	4,538F	45,325	12,125U
Accrued Income	64,404	53,611	10,793F	89,912	25,507U	66,672	2,268U
Prepayments	9,869	6,466	3,402F	9,447	422F	4,622	5,247F
Inventory	15,369	27,511	12,142U	15,449	80U	15,396	27U
Total Current Assets	**316,654**	**277,050**	**39,604F**	**315,866**	**788F**	**299,311**	**17,343F**
Current Liabilities							
Borrowing	(2,047)	(1,925)	122U	(1,985)	63U	(1,828)	220U
Trade & Other Creditors, Provisions	(217,517)	(167,122)	50,395U	(210,089)	7,426U	(177,892)	39,625U
Employee Entitlements	(524,452)	(524,748)	296F	(525,058)	606F	(524,748)	296F
Funds Held in Trust	(1,384)	(1,376)	8U	(1,384)	0U	(1,384)	0U
Total Current Liabilities	**(745,400)**	**(695,170)**	**50,230U**	**(738,516)**	**6,883U**	**(705,851)**	**39,549U**
Working Capital	**(428,746)**	**(418,120)**	**10,626U**	**(422,650)**	**6,095U**	**(406,541)**	**22,206U**
Non Current Liabilities							
Borrowings	(11,057)	(14,546)	3,489F	(11,072)	16F	(10,136)	920U
Employee Entitlements	(88,931)	(89,094)	162F	(88,931)	0F	(88,931)	0F
Total Non Current Liabilities	**(99,988)**	**(103,639)**	**3,652F**	**(100,003)**	**16F**	**(99,067)**	**920U**
Net Assets	**709,501**	**752,488**	**42,987U**	**712,745**	**3,243U**	**725,799**	**16,297U**

Commentary

The major variances to budget are summarised below:

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

Cash and Short Term Deposits:
The higher than budgeted balance mainly reflects the impact of the delay in the capital program on cash and timing of receipts and payments. The cash balances include $25m investment matured and not yet reinvested.

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

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

Trade & Other Creditors and Provisions:

Trade & Other Creditors, Provisions:	**$000's**
Trade Creditors (including accruals)	190,547
Income in Advance	26,970
Total	217,517

4.2 Statement of Cash flows as at 31 October 2020

$000's	31-Oct-20			For the four months ending 31 Oct 2020		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Revenue Received	242,345	215,822	26,524F	894,143	864,050	30,093F
Payments						
Personnel	(96,184)	(96,015)	169U	(391,005)	(385,072)	5,933U
Suppliers	(54,920)	(50,517)	4,402U	(200,547)	(203,503)	2,955F
Capital Charge	(700)	(3,807)	3,107F	- 700	(15,229)	14,529F
Payments to other DHBs and Providers	(65,923)	(62,490)	3,433U	(262,652)	(249,960)	12,692U
GST	2,508	0	2,508F	401	0	401F
	(215,219)	(212,830)	2,390U	(854,503)	(853,763)	740U
Net Operating Cash flows	**27,126**	**2,992**	**24,134F**	**39,640**	**10,287**	**29,353F**
Investing						
Interest Income	212	227	15U	842	908	66U
Sale of Assets	16	0	16F	22	0	22F
Purchase Fixed Assets	(8,358)	(15,363)	7,005F	(26,745)	(69,458)	42,713F
Investments and restricted trust funds	(2,945)	0	2,945U	7,793	0	7,793F
Net Investing Cash flows	**(11,075)**	**(15,136)**	**4,061F**	**(18,088)**	**(68,550)**	**50,462F**
Financing						
Interest paid	(109)	(99)	10U	(253)	(395)	141F
New loans raised	342	2,146	1,804U	1,887	5,357	3,470U
Loans repaid	(295)	(218)	77U	(747)	(785)	38F
Other Equity Movement	2,930	8,477	5,547U	12,077	30,926	18,849U
Net Financing Cash flows	**2,868**	**10,306**	**7,438U**	**12,964**	**35,104**	**22,140U**
Total Net Cash flows	**18,919**	**(1,838)**	**20,756F**	**34,515**	**(23,160)**	**57,675F**
Opening Cash	151,504	114,580	36,924F	135,902	135,902	0F
Total Net Cash flows	18,919	(1,838)	20,756F	34,515	(23,160)	57,675F
Closing Cash	**170,419**	**112,742**	**57,677F**	**170,419**	**112,742**	**57,677F**
ADHB Cash				166,751	106,539	60,212F
A+ Trust Cash				3,322	5,857	2,535U
A+ Trust Deposits - Short Term < 3 months & restricted fund deposits				346	346	0F
				170,419	**112,742**	**57,677F**
ADHB Short Term Investments 3 > 12 months				5,000	15,000	10,000U
A+ Trust Short Term Investments 3 > 12 months				18,392	16,394	1,998F
ADHB Long Term Investments				-	-	0F
A+ Trust Long Term Investment Portfolio				16,883	15,970	913F
Total Cash & Deposits				**210,694**	**160,106**	**50,589F**

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 4 November 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), Jesse Solomon (Senior Programme Manager Women's Health), 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)

Tawhiti rawa tō tātou haerenga te kore haere tonu,
maha rawa wā tātou mahi te kore mahi tonu.
We have come too far to not go further
and we have done too much to not do more
. – Sir James Henare

Kuputaka/Glossary

ACC		Accident Compensation Corporation
AH+		Alliance Health Plus PHO
ARC	-	Aged Residential Care
ARDS	-	Auckland Regional Dental Service
ASH	-	Ambulatory Sensitive Hospitalisations
B4SC		B4 School Check
CT	-	Computed Tomography
DHB	-	District Health Board
ESBHS	-	Enhanced School Based Health Services
ESPI	-	Elective Services Performance Indicators
FPA		Family Planning Association
GP	-	General Practitioner/General Practice
HC		Health Coach
HDSR		Health and Disability Sector Review
HEEADSSS		Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety
HIP		Health Improvement Practitioner
HPV	-	Human Papilloma Virus
IDF	-	Inter District Flow
IPC		Infection Prevention and Control
IPMHAS		Integrated Primary Mental Health and Addiction Services
LARC	-	Long Acting Reversible Contraception
MHAS		Mental Health and Addiction Services
MMR	-	Mumps, Measles and Rubella
MoH	-	Ministry of Health
MRI	-	Magnetic Resonance Imaging
MSD	-	Ministry of Social Development
NAHH		Noho Āhuru – Healthy Homes

NCHIP	-	National Child Health Information Platform
NCSP	-	National Cervical Screening Programme
NGO	-	Non-Governmental Organisation
NHI	-	National Health Index
NIR	-	National Immunisation Register
NRA	-	Northern Region Alliance
NRHCC		Northern Region Health Coordination Centre
NSU		National Screening Unit
NZ	-	New Zealand
PCV	-	Pneumococcal virus
PFO	-	Planning, Funding and Outcomes
PHO	-	Primary Health Organisation
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
SPE		Statement of Performance Expectations
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 4 November 2020.

2. Planning

2.1 2020/21 Annual Plans

The final, Board approved and signed 2020/21 Annual Plan was submitted to the Ministry of Health (MoH) on 19 October 2020. We are still awaiting Ministerial approval and signatures on the Plan. Updates to the Annual Plan mean that the Statement of Performance Expectations (SPE) published to the DHB's website on 18th August to meet Crown Entities Act legislative obligations, is now misaligned to the finalised Annual Plan. We will need to work through a process with the MoH to republish the SPE and table either the SPE or the full Annual Plan in parliament in line with Crown Entities Act requirements.

2.2 2019/20 Annual Reports

The 2019/20 audit is now complete and the Annual Report has been finalised. We are awaiting final Audit New Zealand clearance and audit report. The Annual Report is due to the MoH on or before 18th December 2020 after which it will be tabled in parliament along with the SPE or Annual Plan.

3. Primary Care

The PFO Primary Care team continue to have staff working within both the DHB and the Northern Region Health Coordination Centre (NRHCC) on the regional COVID-19 response. Included within the activity is supporting a procurement process for surge COVID-19 swabbing capacity and the Christmas New Year primary care plans. The COVID-19 surge capacity procurement is to identify

providers who are willing and able to step up at short notice additional swabbing as when required to response to any community cases. The Christmas and New Year planning is more difficult than usual. Many primary care clinical teams are more tired than usual due to their response to COVID-19 and want longer leave breaks. In addition, there is a need to main access to COVID-19 swabbing.

A consequence of COVID-19 response is that less people went to see their general practice team as frequently as they usually would. Thus, there is a decline in a number of areas in the management of chronic conditions and prevention. Primary Health Organisations (PHO) report that both Māori and Pacific people are accessing primary care at low frequency rates than that seen prior to the COVID-19 lock downs. The three metropolitan Auckland DHBs and the seven PHOs are undertaking work to look at the resilience and well-being of the primary care team while endeavouring to get care levels back to normal.

Your Health Summary

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

Equivalent systems of patient summary record sharing are already in place for the whole of the South Island, and much of the lower North Island.

Your Health Summary utilises the Valentia shared electronic health record platform. Once this is installed in the general practice information system it will extract summary information for each patient on a daily basis, uploading this to a central database located in Auckland. The system has been thoroughly security tested and approved by an independent assessor.

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

Uptake of the system by general practices is slower than expected. One reason for this is that Valencia is a competitor to other practice management systems used by general practices. Vendors of these other systems have required certification before allowing Your Health Summary to be activated. The certification process is nearing completion.

Further Your Health Summary is seen as low priority for some general practices who have limited capacity for change, have high workloads associated with on-going COVID-19 swabbing and catching up on patient care and the need to prioritise their activity.

PHOs have agreed to make this a priority area to improve the rate of uptake.

Primary and Community Care Deep Dive

The Primary and Community Care Deep Dive sets out the long-term strategic direction for primary and community services in the Northern Region. It covers the broad range of services in the community referred to in the Health and Disability Sector Review (HDSR) report as tier 1 services. Equity is a key focus of the report particularly for Māori populations and Pacific people. The deep

dive has been undertaken as part of the second phase of the Northern Region Long Term Investment plan and is one of a number of deep dives that have been undertaken.

The report is now nearing finalisation for approval through regional forums and DHB Governance. The development of the report has involved the input of service users and many stakeholders in the system.

4. Health of Older People

4.1 Aged Residential Care

The annual review of the national Aged Related Residential Care Agreement (A21 Review) is underway; currently DHBs and the Aged Residential Care (ARC) sector are submitting issues to consider through this process. The Northern Region has submitted a request for increased clarity on temporary leave of absence from a facility so there is a consistent approach to how this managed, and further clarity on some aspects of accommodation premium charges. Starting in October, all ARC facilities are now required to publish their minimum and maximum accommodation premium charges.

The metro Auckland DHBs have completed their five-week programme on supporting ARC facilities to maintain their vigilance and COVID-19 preparedness long term. An evaluation of this programme is underway to help determine the most useful ongoing support for the Sector. A COVID-19 scenario workshop was held on the 30 November with representatives from the Northern Region DHBs, ARPHS, ARC facilities and Unions and will use tabletop exercises to test assumptions and planning for a COVID-19 outbreak in an ARC facility. The aim is to improve operational readiness.

4.2 Falls and Fracture Prevention Services

There has been a period of uncertainty around ongoing Accident Compensation Corporation (ACC) funding for the In Home Strength and Balance Programme and the Fracture Liaison Service; Auckland DHB and ACC currently jointly fund both services but ACC funding was due to end on 31 December. ACC has recently announced ongoing investment in its Live Stronger for Longer suite of activities. This means ACC will continue to contribute funding to the In Home Strength and Balance programme until 30 June 2021. Whilst it will have a longer-term commitment to funding the Fracture Liaison Service up to 30 June 2024; a focus will be on achieving International Osteoporosis Foundation accreditation for this service.

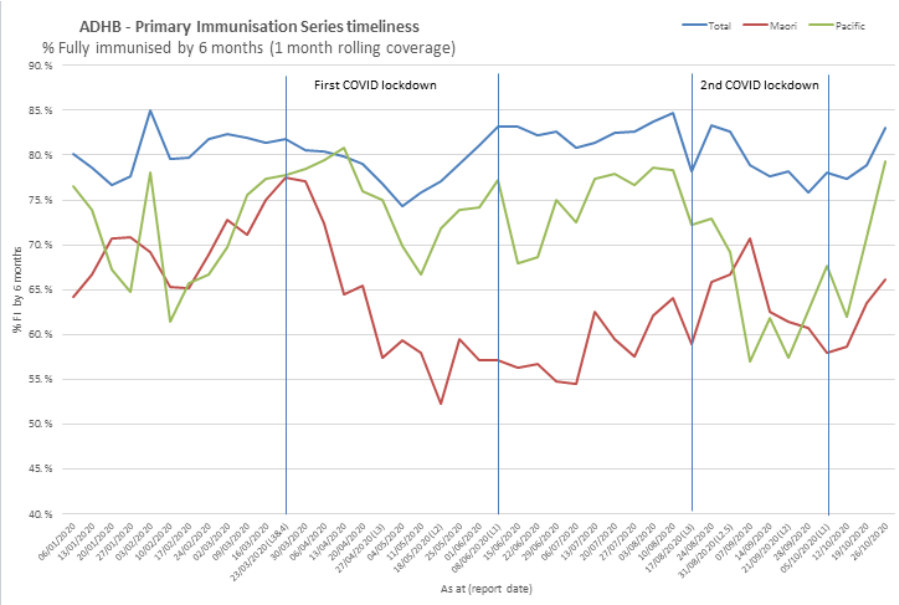
5. Child, Youth and Women's Health

5.1 Immunisation

5.1.1 Childhood Immunisation Schedule Vaccinations

As previously indicated, COVID-19 will have an impact on immunisation coverage. Auckland DHB is currently not achieving the 95% target, with 94% for the total population and 84% for tamariki Māori – at the same time last year, coverage was 95% for the total population and 87% for tamariki Māori. We have highlighted a measurement issue to the Ministry (coverage continued to include the discontinued 3 month PCV dose in coverage calculations) which has now been resolved.

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



We are working with our Māori Health Gain team colleagues on an analysis of the factors impacting immunisation coverage. The MoH has moved to the Qlik reporting platform for immunisation coverage which enables us to view vaccine hesitancy by ethnicity for the first time. As at 16th November vaccine hesitancy (decline of some or all vaccines and opt-off the National Immunisation Register (NIR) is 5.3% for Auckland DHB domiciled tamariki Māori at 8 months, compared to 1.9% for the total population. Review of other DHBs reflects that we are not alone with high Māori decline rates, with other DHBs experiencing rates as high as 17%. Reports from the sector reflect the impact of a viral video by a Māori social media influencer, as well as rhetoric from some church groups and political candidates against immunisation having an impact. We have requested assistance from the MoH at a National level to promote immunisation and will also be working with our Primary Care providers to devise some local strategies to support immunisation.

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

5.1.2 Measles

In February 2020, the MoH announced funding for a national measles campaign, with a focus on 15 to 30 year olds, particularly Māori and Pacific. The primary strategies for Auckland DHB and Waitematā DHB are increasing awareness of the need to be immunised and increasing access to the vaccine. The plan includes utilising the relationships with schools through the Enhanced School Based Health Service (ESBHS) (as per the successful MMR catch up during the mumps outbreak), tertiary institutes, workplaces (alongside 'flu vaccination in 2021), sexual health and Family Planning clinics, community pharmacies and other community settings such as marae and Pacific churches.

The Ministry has now released the complete resource suite to support this programme. Radio advertisements are now being played on Mai FM, ZM etc, with a video set to stream in early 2021. We will be distributing posters and leaflets to primary care practices and pharmacies in the coming weeks

We have undertaken focus groups with rangatahi Māori and Pacific people aged 15-30, supported by the Māori Health Gain and Pacific Health Gain teams. These groups have confirmed our strategy of taking immunisations to where people are, as well as identifying some additional opportunities such as libraries and community centres. Discussions are underway with tertiary institutes in regards to pop-up clinics on campus and within residential halls. There have also been positive meetings with a number of private occupational health providers about offering MMR within targeted workplaces. We are planning to host a pop-up clinic with support from Ngāti Whātua o Orakei in early December.

5.2 Uri Ririki – Child Health Connection Centre

The Uri Ririki - Child Health Connection Centre (UR-CHCC) and NCHIP is starting to deliver real and tangible results. A total of 84 Auckland and Waitematā babies previously missing from the NIR were identified via NCHIP and linked in with GPs or outreach for immunisation follow up in Q1 20/21. In the same quarter, the Ministry of Social Development (MSD) shared new contact details for 22/69 (32%) of babies who were previously unable to be located by any of the child health service providers.

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

As at 31 October 2020, Auckland DHB received 1,541 referrals to Noho Āhuru – Health Homes (NA-HH). This included 5,779 family members getting access to healthier home interventions. Of the referrals received, 531 (34%) were for families with a newborn baby or hapu woman.

The service has developed some new promotional resources and will commence promoting these to referrers and community agencies over the coming months.

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

5.3 Well Child Tamariki Ora (WCTO) and B4 School Check

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

Recent data as shown in the table below shows that providers have managed to catch up those tamariki that had missed their core checks during the lock downs with the exception of the Asian population. Overall, for the period (October – November) of 2020, the Auckland DHB WCTO services delivered a total of 1,285 core checks compared to 1,040 for the same period of 2019.

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

	Asian	European	Māori	Pacific	Other	Unknown	Total
Oct-Nov 2020	131	208	429	444	54	19	1,285
Oct-Nov 2019	152	164	350	339	30	5	1,040

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

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

The table below shows that the B4SC coverage is not tracking on target for November 2020. The provider continues to prioritise tamariki as above. It is positive to note that despite COVID lockdowns, coverage for children in high deprivation areas is higher in 2020 YTD compared with 2019 YTD. We are in in discussion with the B4SC provider and the MoH regarding strategies to address the gap.

B4SC Comparison Auckland DHB November 2019 and November 2020

Percentage of eligible population checked	High deprivation	Māori coverage	Pacific coverage	Overall coverage
November 2019	29.8	33.9	28.6	30.1
November 2020	31.3	29.8	29.8	28.1

Auckland DHB has continued to achieve the Health Target with 100% of obese children identified in the B4SC programme being offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions in October 2020.

5.4 Rheumatic Fever

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

- *Identification of culturally safe ways to increase referrals to the Noho Āhuru - Healthy Homes initiative.* A procurement process has been completed to recruit both kaupapa Māori and Pacific researchers who will use guidance from families to develop resources. Planning is underway to gather insights from health workers who will be 'end users' of the resources
- *Piloting of whānau support worker programme*. Work is underway to develop a service specification for this programme alongside the nursing service which will partner with the social workers in NA-HH, as there are synergies between the two programmes.

- *Piloting dental health services for adults with Acute RhF / Rheumatic Heart Disease*. Early costings and pathways are being developed for hospital-based clinics and community based clinics.
- *Finalisation, evaluation and release of 'fight the fever' mobile app.* The app has been launched and young people on monthly bicillin injections are now being recruited to the evaluation.

The project manager is working with a Public Health Physician Registrar on opportunities for increasing awareness, which may include schools and pharmacy settings.

5.5 Oral Health

Recent changes in oral health practice and service disruption due to COVID-19 restrictions have exacerbated existing inequities in oral health outcomes. An information paper describing the status of oral health in the Auckland Region was presented to Auckland DHB's Community and Public Health Advisory Committee. An urgent review will be undertaken within Regional Services Framework to look at oral health end-to-end service improvement from 0 to 18 years in the Auckland region.

Auckland Regional Dental Service is currently prioritising appointments for children who are under treatment and those waiting the longest for their routine examination. In addition, there is a focus on children living in the highest need communities by prioritising schools that are low decile (1-4) and/or rural locations, and have:

- both high Māori and high Pacific enrolments
- high number of children under treatment
- most delayed service

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

There were 27 additional referrals accepted into the service in October 2020, bringing the total number of wahine whose referrals have been accepted to 109. Of these, 12% have completed their episode of care, 68% are currently undergoing their episode of care, 28% have their initial appointment booked, and 17% have not yet been examined. Of those enrolled with the service, 60% are Pacific, 25% are Māori, 3% are New Zealand European, 1% is Asian and 2% are Other ethnicities.

5.6 Contraception

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

The MoH has commissioned the preparation of National Contraception Guidelines, these have now been shared to professional colleges for endorsement and we understand they are close to release. The guidance will be released on the MoH website and integrated into Health Pathways platform. Once the guidelines are complete, a training package will be released by Family Planning Association (FPA). This training, which has been commissioned by MoH, will provide some free training for health practitioners to access LARCs training. Training has been a gap to date and remains an issue in achieving a robust network of providers who can offer all types of contraceptive options. We are working with Family Planning to confirm the offering for our DHB and prioritise recipients of training as well as work towards a sustainable training programme going forward. We have signalled this may include additional training, as concern remains that FPA programme will not be sufficient to meet the demand and need to significantly improve coverage of service provision and address access barriers.

5.7 Cervical Screening

Cervical Screening coverage for Auckland DHB remains significantly below the coverage target 80%, updated coverage based on the revised population forecast shows an 8.7% increase in coverage for the total population with coverage now reported at 69.2%. The coverage rate remains inequitable for Māori, while the revised population forecast has increased coverage for Māori (now 57.8%), there is a 22% difference in coverage between Māori and 'Other' women who are meeting 80% coverage. Coverage for Pacific and Asian women also remains inequitable at 61.7% and 58.7% respectively (noting that there is currently no outcome inequity for Asian women, however this remains for both Māori women and Pacific women).

Coverage among Māori Pacific and Asian women has declined over the last three years while coverage for Other women has increased slightly. Cervical Screening coverage has been declining over the past 3 years nationally and locally. The recent COVID restrictions had a significant impact on completion of cervical screens which are largely provided in primary care. Of greatest concern however are the women who have never been screened, or have not been screened for 5 years or more. The National Screening Unit (NSU) are moving toward implementation of the HPV Primary Screening Programme, which offers some significant advantages for improving equity and coverage. One of these is the implementation of HPV self testing which the NSU have recently confirmed will be included in the HPV Primary Screening Programme. An implementation timeline remains unclear. The HPV self-testing research continues in the Māori Health Pipeline.

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

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

6. Mental Health and Addictions

6.1 Integrated Primary Mental Health and Addiction Services (IPMHAS)

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

IPMHAS is now being rolled out across the metro Auckland region. As at the end of October 2020, 27 practices across Metro Auckland have a Health Improvement Practitioner (HIP) and 25 have a Health Coach (HC) and 22 practices with a linked Awhi Ora provider as part of this contract.

With Auckland DHB, there are 11 practices with IPMHAS services (out of a proposed 18 practices or 61% of practices proposed in this rollout phase to June 2021).[1]

The increase in practice rollout for practices in the Auckland DHB area has occurred primarily between August 2020 and end of October 2020. During this period, six new practices started IPMHAS. Awhi Ora provision is linked to 12 GP practices in the current roll out schedule. A further 15 practices have Awhi Ora provision linked them as part of historical ADHB provision.

Implementation of IPMHAS continued through both COVID-19 alert level restrictions. Following the second Auckland cluster in August/September, there was a slow return of people seeking support via GP practices. Virtual support is available during COVID alert level restrictions. From 1st March – 30th October just over 11,000 unique people have accessed one or more components of the model (including wellness support) across Metro Auckland. For the Auckland DHB area this was 3,719 people with significant increase in access during October. A similar increase is anticipated during November.

Table 2. Number of clients seen by ethnicity- Auckland DHB

Role	Māori	Pacific	European	Asian	MELAA	Other
Health Coach	8.4%	51.4%	10.7%	21.2%	3.4%	5.0%
Health Imp Practitioner	16.5%	13.8%	34.1%	28.4%	3.1%	4.2%
Comm Support Worker/ Awhi Ora	18.0%	14.6%	34.7%	17.5%	8.1%	7.1%
Total	**14.2%**	**25.5%**	**27.0%**	**24.7%**	**3.9%**	**16.3%**

6.2 Primary Mental Health Investment Review

In addition to IPMHAS funding, there is additional funding for primary mental health in Auckland DHB. Primary Mental Health Initiatives funding has been in place for over a decade, and the existing services contracted have been specified in line with Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017. This plan articulated Government expectations at that time about the changes needed in the delivery of mental health and addiction services.

The Auckland DHB and Waitematā DHB Mental Health and Addictions Funding team has an opportunity to review and increase clarity around existing primary mental health investment and service delivery in both DHB areas, with a view to making recommendations about the current state and possible future state.

Primary mental health initiative investment is being reviewed now in the context of *He Ara Oranga* (2018), IPMHAS and with health equity for Māori and Pacific people front of mind.

An existing review took place in 2016/2017 and we will review learnings from that time.

6.3 Suicide Prevention and Postvention

A review of our current postvention response to family and whānau bereaved by suicides is being undertaken. A working group has been set up to progress this work, and will report to the suicide prevention and postvention governance group. We recently appointed a full time whānau support coordinator to provide support services to whānau bereaved by suicides, which is a welcoming addition to our effort in trying to reduce our number of suicides for Auckland DHB.

[1] WDHB has five live practices out of a proposed 10 or 50% of practices proposed in this rollout phase to June 2021. CMDHB has 13 live practices out of a proposed 26 or 50% of practices proposed in this rollout phase to June 2021.

7. Māori Health Gain

7.1 Māori health COVID-19 response

The Māori Health Gain Team continues to support the establishment of a permanent Māori health team within the NRHCC. Once completed in December, our team will support the Māori COVID-19 response team by providing contract management (for on-going funded services like Māori Mobile Clinics) and engagement support with Māori providers and our iwi partners.

Three programmes of work remain underway:

- Māori mobile clinics were set up across the region with Ministry of health funding to focus efforts on flu vaccinations for eligible Māori. The model that our region presented to the Ministry and eventually implemented was much broader than flu vaccinations. It included an emphasis on mental health and wellbeing assessments, social support and referral to/engagement with other supporting social and health services. Unfortunately, these services went live in early August and were soon redeployed to COVID-19 testing throughout Auckland (except Northland providers who continued to provide mobile care). The several weeks of redeployment by these providers has seriously impacted flu vaccination efforts with a high number of whānau declining flu vaccinations as they felt these were no longer necessary. Despite this, the units have engaged whānau in other care. Orakei Health Services who operate a mobile unit in central and east Auckland saw almost 120 kaumātua and whānau members over 6 weeks. This resulted in several new primary care enrolments, in home healthcare provided and multiple referrals to specialist care providers.
- Kaimanaaki services have concluded. In our previous report to the Board we presented data from the first and second phase of this initiative. A proposal to maintain these services is currently being presented to DHB executives for support. If successful, Kaimanaaki services will be in place until 2022.
- Māori testing sites and services are still operating in West and South Auckland. Our input into these is minimal at this point with the appointment of a Māori Testing Lead within the NRHCC.

7.2 Orakei Health Services – Whai Maia

The Māori Health Gain Team and the Outcomes Team within PFO unit are supporting Whai Maia to develop and implement a programme they have developed based on annual checks for Iwi members, developed across the life course. The team are supporting an evaluation framework and pilot approach to test the processes and experience of this as a new service.

7.3 Māori workforce development

The Māori health provider network and their clinical workforce have become essential in COVID-19 response and recovery efforts. Their ability to stand up testing sites in vulnerable communities, access homes to undertake wellbeing assessments, provide essential items to whānau, and provide in-home care were and are important in the health sector's response to COVID-19. However, a number of issues exist within this workforce including pay equity, clinical leadership and guidance, varying levels of orientation into community nursing roles, access to training and development, and cultural support. This has a considerable impact on the recruitment and retention of Māori clinicians by Māori health providers.

A project is being implemented in partnership between the DHBs' Māori Nursing Director, He Kamaka Waiora, Māori Health Gain and Primary Care Nursing Development Team within the PFO unit to strengthen support for the Māori provider clinical workforce (it has potentially to be expanded to all Māori clinicians working in community providers/settings). The first milestone of this project is to determine a core set of professional skills for Māori health provider based nursing roles that includes

independent vaccination and COVID-19 testing amongst other skills, but also seeks to capture personal and cultural skills and abilities, as a means for prioritising development support needed amongst this workforce. At the recent Māori provider forum for Auckland DHB and Waitematā DHB Māori providers, this project was supported by the provider leadership.

7.4 Māori Pipeline Projects

The Māori Health Pipeline has been recently reviewed and refreshed, with endorsement from the December meeting of Te Kōtui Hauora.

The Breast screening project will be closed off (complete, achieving the enrolment of 730 Māori in breast screening across the Northern region).

Additional projects will be added to the Pipeline:

- Hepatitis C – Equity focused primary care re-offer of treatment to people with known Hepatitis C enrolled in primary care via a central hub (nurse and pharmacy led with engagement coordinators).
- HPV self-testing – development of a programme of implementation science research via a nurse-led central hub, enabled by telehealth. Development of a new datamatch to identify Māori women not enrolled in primary care, who have never been screened or who are overdue, and offer service. The high-grade project has been re-scoped and will be included in this programme.
- H. pylori – support for a University of Otago prevalence study for H. pylori, the causative organism for non-genetic stomach cancer (incidence of stomach cancer is 3-6 times higher for Māori than non-Māori).
- Bowel screening age extension for Māori – DHBs across the Northern Region are undertaking scoping to implement this change locally.

Progress on current projects:

- Lung cancer screening – the second Consumer Advisory Group met in mid-October, and have proposed their group name (Te Hā Kōtahi) and a name for the broader programme. These are being provided to Dame Naida for consideration. The group examined a range of information material and provided valuable feedback with materials being revised. A readiness assessment process with hospital services has now been agreed, with an establishment meeting set for January. The team presented the Cost-Effectiveness work and the broader programme to the National Screening Advisory Committee (NSAC) in November which was well received. Grant funding decisions are awaited.
- Alternative community cardiac rehabilitation model – this has been paused after the refresh, with a review to be undertaken with the Waitematā DHB Funder and Provider and assessment of options for community delivery and elements of the model that can be initiated.
- Alternative community kapa haka based pulmonary rehabilitation model –a very successful meeting between kapa haka expert Vicki Wright (leads the kaumatua and kuia kapa haka group at Orakei) and participating physiotherapists was undertaken in November. Agreement on a prototype approach was agreed and a protocol is being finalised.
- Northern region breast screening datamatch ('500 Māori women campaign') – this project is now complete and a report will be shared with providers and key stakeholders. The project is now closed off.
- Māori provider and PHO datamatch – the first phase of this project is now complete, with the datamatch[2] demonstrating sufficient quantum of Māori provider whānau not being enrolled in

[2] Noting that not all providers participated, despite multiple offers, project coordination and analyst in-person support was also offered, and a further final offer extended by the project Iwi and MoU-partner leads.

primary care to progress to phase two. Phase two involves working with Māori providers to develop service options which may include facilitated enrolment, health service delivery or other options.

- High grade cervical screening project – a final progress report will be presented to the steering group with the project now incorporated it into a HPV self-testing programme.

8. Pacific Health Gain

8.1 Pacific Regional response to COVID-19

The Pacific team continues to provide advice and support to NRHCC as it further develops its COVID-19 response plan for the Auckland region. Pacific providers involved in setting up pop up mobile community COVID-19 testing centres across Auckland have resumed their business as usual activities. The providers have reported some families requiring access to financial assistance and help upon returning to Alert 1.

8.2 Pacific Mobile service

The Tongan Health Society Pacific Mobile service continues to work with individuals and families to ensure they can access primary care services during this period while Auckland remains at Alert level 1. The service has identified a lot of pacific individuals and families with a complexity of social and health issues requiring support. The provider has continued to actively promote its service within the community and flyers have been distributed in both English and Tongan.

Plans are underway to develop an evaluation of the Pacific mobile services across both Auckland DHB and Waitematā DHB.

8.3 Measles Mumps Rubella (MMR) Vaccination plan

The MMR team have met with Pacific providers of the Healthy Village Action Zones and Enua Ola programmes and presented the MMR catch-up campaign for 15-29 year olds. The discussions included opportunities to connect with pacific communities to raise awareness and vaccinate those within the target population. The Pacific providers were invited to provide suggestions and feedback about the MMR vaccination plan and how to implement it.

Focus groups held in November with Pacific young people provided information on what is important to youth, how and where to promote messages to young people, as well as barriers they faced in accessing health services. These findings will be utilised as part of MMR vaccination plan.

8.4 Rheumatic fever

As part of the RhF working group, the Pacific Team continues to work with the Child Health team to provide appropriate advice and information about approaches to reach, engage and connect with Pacific people. A workshop is planned for Parish Community nurses as part of the Healthy Village Action zones programme to receive additional training on RhF and the swabbing process in the community.

8.5 Community based Pulmonary Rehabilitation Request For Proposal

The Community based Pulmonary Rehabilitation RFP process is underway to find a Community based Pulmonary Rehabilitation provider to improve health and wellbeing of COPD patients (primarily Māori and Pacific patients), through the use of individualised and disease-specific exercise prescription and education sessions. The evaluation panel membership includes Pacific health representation.

8.6 Fanau ola Integrated services

Auckland DHB contracts with Alliance Health Plus PHO (AH+) to deliver integrated services to Pacific families and households experiencing severe and complex health and social needs. AH+ has agreements with The Tongan Health Society, Baderdrive Doctors and South Seas Healthcare to deliver the Fanau Ola Integrated services. During the recent Auckland August cluster of COVID-19 the integrated service providers experienced an increase in requests by families and households for access to food and financial assistance to pay for electricity and other services. The providers have continued to implement and monitor family or household action plans which includes COVID-19 education, health education, self-management education, medication adherence support, referrals to other specialised services for example Diabetic Nurse. The number of new enrolments of families or households has been steadily increasing in Q1.

9. Asian, Migrant and Former Refugee Health Gain

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

The Asian, new migrant, former refugee and current asylum seeker health plan 2020-2023 has been endorsed by Auckland DHB CPHAC (18 Nov).

The Asian, new migrant and former refugee health gain team continues to contribute significant resource to provide culturally appropriate support to the Northern Region Health Coordination Centre (NRHCC)'s COVID-19 response. An Asian campaign (print, online and social media) has been launched to Chinese, Indian, Filipino, Japanese and Korean communities in response to the Asian AUT student case and public response. The Campaign tagline is:
We're all in this together: Find out how to protect you and your family. The two key messages are:

- Where you can get a COVID-19 test if you have any cold or flu-like symptoms
- Where you can find support if you need to talk

9.2 Increase access and utilisation to Health Services

Indicators:

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

The Auckland DHB, Asian PHO enrolment rate for Quarter 4 2020 has decreased by 1% to 85%. This decrease is partially due to rounding rather than a solid 1% decreased change. Between Quarter 3 and Quarter 4 2020, there were only 781 new enrolees.

The team are refreshing and/or developing multilingual podcast videos on the New Zealand Health & Disability System to increase awareness to Asian and migrant communities in English, Mandarin, Arabic, Korean and Hindi. New content including pregnancy messaging will be added in response to feedback from Auckland DHB CPHAC.

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

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

A *Former Refugee & Asylum Seeker Health & Wellbeing* forum/webinar was held on 26 November on the topic 'New National Quota Refugee Health Model, Pilot Study and COVID-19.'

10. Hospitals

10.1 2020/21 Planned Care Services

10.1.1 Planned Care

As part of the Ministry of Health requirement to increase access to planned care services each year, Auckland DHB provider needs to deliver 12,626 elective surgical discharges in 2020/21. For the period to end of October 2020, Auckland DHB has completed 97% of planned elective surgical discharges, with a shortfall of 245 discharges. This is influenced by internal capacity constraints and reduced activity in August and September with 72% and 94% of planned discharges being completed in each of those months. There has been increased activity in October but the impact of the lower level of services being delivered has put at risk approximately $3.4m of additional revenue from the Ministry of Health. The provider is putting in place a range of measures to increase internal production to address shortfalls in capacity going forward including extending hours of operating in some elective operating rooms and resourcing additional acute operating room capacity on weekends to reduce the need to cancel elective surgery to meet acute demand.

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

The Ministry of Health has allocated additional funding of $6.4M to Auckland DHB to enable increased planned care delivery across a range of services to support clearing waiting list backlogs. Auckland DHB has prioritised this additional funding to the delivery of more colonoscopy procedures, increased outpatient Ophthalmology specialist assessments and follow-ups, additional MRI and CT scans and increased spinal Orthopaedic surgery. The Ministry of Health has approved this plan and we are in the final stages of completing the funding agreement. Note that 80% of the funding will be paid on actual activity performed with 20% of this funding to be paid in arrears after the DHB has demonstrated compliance with forecast national indicator improvement trajectories.

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

Capital funding of $50M has been made available nationally for DHBs to support optimising capacity across the system to improve access to planned care. The Northern region submitted proposals to the Ministry of Health in mid-September with an expectation that funding allocations would be confirmed early November. The Ministry of Health subsequently established a requirement for DHBs to additionally submit business case proposals to support these bids and we have yet to have formal advice that these proposals have been accepted.

10.1.2 Planned Care services - Regional Vulnerable services workplan

The regional Vulnerable services workplan was developed following the first COVID wave to support the prioritisation of actions to address sustainability issues in a number of identified services including Vascular, Ophthalmology, Oral Health, ORL and Sarcoma services. This work has been supported by a different regional planning approach with an identified Executive operational or clinical lead, support from the Auckland/Waitematā DHB funder and the Northern Region Alliance (NRA) and leadership and oversight provided by the Auckland DHB Chief Executive and a Regional Planned Care Service Improvement Steering Group. Progress is being made across all identified services with early direction establishing improved regional service integration and coordination, increased regional cooperation in the employment and deployment of specialist workforce across the region, consolidation of regional waiting lists to support more equitable care and increased local service delivery. Regional Ophthalmology planning as progressed to a point of implementing regionally consistent access thresholds, and the appointment of a regional Clinical Leader, Regional project manager and Regional Oversight group to support progress of the implementation plan which will support increased regional consistency in patient pathways and development of additional capacity. There has been Regional Chief Executive approval to establish an integrated Regional Vascular service with consolidation of complex surgery at Auckland DHB and the development of enhanced local delivery of vascular services at Waitematā and Northland DHBs. Progress is being made towards developing regional recommendations for all other Vulnerable services work streams.

10.2 National Planned Care Performance Indicators

10.2.1 Elective Services Performance Indicators (ESPI) Performance

The ESPI compliance position for all DHBs deteriorated as a result of the March COVID-19 outbreak. In spite of the subsequent community outbreak in Auckland during August resulting in some reduced delivery of planned care services, there has been incremental progress in the Auckland DHB ESPI performance. ESPI 2 remains static with 7.6% of patients (n = 1052) on the outpatient waiting list waiting longer than 120 days in September; compared to 12.2% in July., ESPI 5 performance has improved further with 13.6% of patients (n = 920) waiting longer than 120 days for treatment compared with 15.4% in August.

Both the additional activity based funding and the service improvement funding is expected to support further improvement in ESPI performance. Auckland DHB has submitted improvement forecasts for ESPI indicators with the expectation that all ADHB services will be ESPI 2 compliant (100% patients being assessed within 120 days) by September 2021, and ESPI 5 compliant (100% patients being treated within 120 days) by December 2021, except for Orthopaedic services which will be ESPI 5 compliant by June 2022.

10.2.2 Colonoscopy national indicators

Auckland DHB has been unable to achieve compliance with national waiting time indicators for symptomatic and surveillance colonoscopy for some time. Additional funding and resources have been prioritised to complete additional volumes to improve waiting time performance ahead of the planned Bowel Screening roll out for the Auckland DHB population. There has been consistent in the waiting time indicators over the last three months however the service is not yet compliant with the national indicators. The provider is forecasting compliance with the national indicators by the end of December. The Auckland DHB Bowel Screening programme was launched on the 4th December and further improvement work is underway within the Auckland provider to maintain timely access to symptomatic and surveillance colonoscopy and meet the obligations to deliver the increased colonoscopy demand associated with bowel screening, with additional capacity in place for the next six months to enable this to occur.

10.2.3 Radiology national indicators

As a result of the March COVID-19 outbreak, capacity for delivering Radiology services was affected which impacted waiting time performance for access to CT and MRI. Additional funding has been allocated to support ongoing improvement in the level of compliance with the national indicators for CT (95% within six weeks) and MRI (90% within six weeks) and the provider is forecast to achieve compliance with these indicators by June 2021. September performance against the national indicators was 68.4% compliance for CT and 64.3% compliance for MRI.

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10.3 National Services

10.3.1 PRRT (Peptide Receptor Radionuclide Therapy)

The Ministry of Health has now confirmed funding support for ADHB to provide an interim service for PRRT treatment for neuro endocrine tumours, and we are in the process of finalising the funding agreement for this interim service. Auckland DHB has submitted a business case proposal to the Ministry of Health for the permanent service to be delivered nationally by Auckland DHB. As yet the funding arrangement for this service has yet to be established.

There have been a number of changes of personnel within the Ministry of Health and this has delayed decision making on a number of national service arrangements delivered by Auckland DHB. The Ministry of Health has recently confirmed the senior management accountability for National Services oversight and discussions are being reinitiated with the Ministry of Health to get progress on a range of outstanding matters.

Hospital Advisory Committee Meeting 18 November 2020 – Draft Unconfirmed Minutes

Prepared by: Marlene Skelton, Corporate Business Manager

Recommendation

That the unconfirmed minutes from the Hospital Advisory Committee meeting held on 18 November 2020 be received.

Minutes
Hospital Advisory Committee – Provider Equity Meeting
18 November 2020

Minutes of the Hospital Advisory Committee – Provider Equity meeting held on Wednesday, 18 November 2020 in the Marion Davis Library, Building 43, Auckland City Hospital, Grafton commencing at 8:30am

Committee Members Present	**Auckland DHB Executive Leadership Team Present**	
William (Tama) Davis (Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew (Deputy Chair)	Joanne Gibbs	Director Provider Services
Doug Armstrong	Justine White	Chief Financial Officer
Fiona Lai	Dr Mark Edwards	Chief Quality, Safety and Risk Officer
Michael Quirke	Sue Waters	Chief Health Professions Officer
Michelle Atkinson	**Auckland DHB Senior Staff Present**	
Peter Davis	Jo Brown	Funding and Development Manager Hospitals
Zoe Brownlie	Nigel Robertson	Interim Director, Perioperative Services
	Marlene Skelton	Corporate Business Manager
	Kay Sevillano	EA to Board Chair and Governance Administration
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

Karakia

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

1. APOLOGIES

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

The following apologies were received from members of the Executive Leadership team: Dame Naida Glavish, Chief Advisor Tikanga ADHB/WDHB, Dr Margaret Wilsher, Chief Medical Officer, Margaret Dotchin, Chief Nursing Officer, Meg Poutasi, Chief of Strategy, Mel Dooney, Chief People Officer, Shayne Tong, Chief of Informatics, Dr Debbie Holdsworth, Director of Funding Auckland and Waitemata DHBs, and Karen Bartholomew, Director of Health Outcomes Auckland and Waitemata DHBs.

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

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

3. CONFIRMATION OF MINUTES 7 OCTOBER 2020 *(Pages 9-18)*

Resolution: Moved Jo Agnew / Seconded Fiona Lai

That the minutes of the HAC meeting held on 7 October 2020 be approved.

Carried

4. ACTION POINTS

There were no action points to review.

5. PERFORMANCE REPORTS

5.1 Provider Arm Operational Update *(page 19-22)*

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

The work carried out by Emma Wiley, Consultation and Co-Design Manager and Vanessa Duthie, Māori Patient and Whānau Experience Lead, in the Adult Medicine Directorate was acknowledged. Their analysis contains a number of themes that will be carried across other directorates. A number of these themes will also be brought forward as work on the development of Key Result Areas (KRAs) continues for both the People Plan and the Business Plan, with the Board having approved the strategy.

The work currently undertaken by Kāiarahi Nāhi rōpū and the Pacific Care Navigation team will be audited after 6 months. The teams are 4 months into their work with significant improvements evident in the different specialities they are working in, particularly in the 3 large clinical areas, General Surgery, Orthopaedics and Ophthalmology. The Auckland DHB is making significant progress towards equivalent waiting times regardless of ethnicity.

The Ministry of Health has yet to confirm the go-live date for Bowel Screening services at the Auckland DHB. The Ministry were seeking clarification around recruitment of staff into key posts for this service, for which the Auckland DHB has provided relevant information.

Taiao Ora, Ward 51 officially opened on 16 November 2020. Patients have since been admitted to the ward.

There were no transplants during the level 4 COVID-19 lockdown However ,Transplants numbers have now recovered with kidney transplants in particular, having hit record high numbers.

COVID-19 work continues across the region and the 2 major risks faced by the Auckland DHB are around staffing deployments to border work and ARPHS (providing surge staffing while maintaining optimal hospital services for patients), and ongoing supply issues (international deliveries and logistics).

This year's Summer Plan will be a challenge due to the unpredictable nature of numerous events (e.g. internal movements, resurgence of COVID-19, etc).

Performance has slowly improved in terms of waiting times and details of this have been

noted in the September figures for ESPI-2 and ESPI-5. The Orthopaedic department waiting times have improved when compared to the position over the last 5 years. Although the Orthopaedic department's waiting list has room for improvement, activity numbers for September and October 2020 have exceeded that from the same time last year. However, activity overall still falls behind plan, which will be discussed further in the Financial Update.

The following was raised in discussion:

Stuart McGowan, Clinical Director, and the new Operations Manager of the Orthopaedics department were credited with leading the team's performance improvement. The Orthopaedics leadership team introduced important changes to the directorate such as an improved pooling of lists, better management of outsourcing of volumes, and tracking of short notice patients to fill waiting lists. Stuart McGowan is retiring in December 2020 and recruitment for his replacement is ongoing.

The Kāiarahi Nāhi rōpū and the Pacific Care Navigation team have reached out to 500 Māori and 700 Pasifika patients on waiting lists to date. The navigators continue to reach out to all Māori and Pasifika patients, many of whom are complex cases and have experienced issues accessing hospital services.

In 6 months, the size and skills mix of the navigation team will be evaluated. It was recognised that input from other allied health specialists, especially social workers, might be of benefit to the team going forward. At present, there are 20 navigators, 10 of whom are with Kāiarahi Nāhi and the other 10 are with the Pacific Care Navigation team.

The navigation team is comprised of senior nurses and their role is to challenge the existing system. If they are successful in working with clinicians, this will result in broader and more sustainable changes to the delivery of healthcare across the directorates.

Under the current Ministry of Health guidelines, the Auckland DHB receives funding for electives that have been carried out, and does not receive payment if electives are not delivered. There is no longer a system of fines when the DHB is unable to meet elective targets.

There is significant fixed cost needed to drive all acute work. In order to utilise this resource efficiently, the Auckland DHB needs to deliver as much planned care work as possible. The revenue from planned work and acute work makes up total cost. The Audit Committee is preparing a paper on the financial advantages of contracting with other providers through the funder, which will be shared.

That the Hospital Advisory Committee receives the Provider Arm Operational Exceptions Report for November 2020.

Carried

5.2 Financial Update *(Pages 23-32)*

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

The budget is on track year to date (YTD) with minimal variance, if COVID-related expenses are excluded. The impact of COVID is significant during the month of September. There was an unfavourable result of $5.6m, of which $5m is attributed to COVID-related expenses. This has created an unfavourable variance of approximately $530K, which sits at approximately $710K year-to-date.

At the Committee's request, financial reports now include columns that reflect forecast figures. Auckland DHB's financial forecast is on track until the end of the year, excluding any possible further impacts of COVID.

There are FTE pressures around staff not taking annual leave and reduced staff turnover, which has resulted in a residual of 42 unfavourable FTE. Measures to manage these risks are being undertaken.

The Auckland DHB is sitting at approximately 94% of volume expectations, which creates financial risk in terms of revenue for IDF and planned care. Further, there is risk around Pacific contracts for non-resident work.

It was noted that a correction be made on page 26 of the Financial Report submitted to the committee. Where it states that, "The Provider Arm resulted for the year to date is $18.3m unfavourable", the figure should be $12.5 not $18.3m.

The following was raised in discussion:

Due to COVID activity, a number of FTEs for ARPHS response work have been coded as management and corporate costs to separate these from expenses that are sitting in provisional services (where COVID expenses are charged).

The Auckland DHB has received payments from the Ministry of Health for COVID-related expenses and the appropriation of funds is underway. Estimates from November until the end of the year are also being prepared.

Under the multi-collective employment agreement, staff can accrue up to 2 years of annual leave. Those with over 2 year's annual leave are asked to prepare a leave plan. Staff are being encouraged to take leave and refresh after a challenging year. Leave is built into the nurses' rosters as part of CCDM requirements. However, leave management differs according to clinical area due to varying circumstances and to ensure planned care work continues. Clinical Directors are working with their specialty leads to establish an appropriate leave plan suited to their directorate. Junior doctors adhere to specific leave provisions through MECA. The Medirota system is also being utilised, which provides notification when staff are surplus to roster, enabling them to take leave.

That the Hospital Advisory Committee:

1) **Note the correction on page 26 of the HAC report. Where it states, "The Provider Arm resulted for the year to date is $18.3m unfavourable", the figure should be $12.5m not $18.3m**
2) **Receives the Financial Update for November 2020.**

Carried

5.3 Director Equity Update – Cancer and Blood *(pages 33-39)*

Dr George Laking, Te Whakatōhea, Medical Oncologist, Kaihautū – Pou Ārahi, Dr Richard Sullivan, Director Cancer & Blood, Dr Ingo Lambrecht, Ngāi Tiamani, whāngai nā Ngāti Whātua and Troydyn Raturaga, (Ngāti Whātua, Ngāpuhi) Business Manager Provider Services and HR, were present to provide an update on Māori wellbeing in the Cancer and Blood directorate. This is in line with the Auckland DHB's commitment to Te Tiriti o Waitangi and health equity.

Dr Laking asked that the report be taken as read outlining as follows:

The report (Te Pou Ārahi) outlines the establishment of a structure in the Cancer and Blood directorate. The purpose is to advance the transformation of services by developing the capability and skills to work with Māori. The report also outlines work undertaken to develop capability in line with the Key Result Area 2 (KRA2) of the Pūmanawa Tāngata (the People Plan), which is to "Uphold Te Tiriti o Waitangi as our framework to eliminate racism, build culturally safe practice and achieve health equity".

Dr Laking discussed the membership, noting the absences of Tame Hauraki (Ngāti Whātua, Ngāpuhi, Ngāti Whānaunga), the newly appointed Kaumātua for Te Pūriri O Te Ora, and Kadin Latham (Ngāi Tahu) Project Coordinator.

The directorate is also involved in work relating to the Key Result Area 3 (KRA3) of the People Plan. This is around growing and developing Kaimahi Māori, by expanding the Māori workforce and promoting staff education. Their efforts in Tino Rangatiratanga, Ōritetanga and Te Ritenga were mentioned, including the intention to practice mihi whakatau and pōwhiri in the directorate to welcome new staff and whānau.

The following was raised in discussion:

The cultural changes being introduced to the Cancer and Blood directorate have had positive feedback. There is strong support and engagement from the directorate leadership team, branch staff and SLT. Kaimahi Māori (Māori workforce) have been brought into the directorate for the first time, resulting in Maori comprising about 4% of the workforce. The suggested optimum number of Māori in the directorate should be between 16% to 20% to match the directorate's workforce with the needs of the community.

It is important to address significant gaps in patient health outcomes for Māori and Pasifika groups to be able to provide world-class healthcare services. This is made possible when the practice of medicine reflects the diverse and unique requirements of the community that the Auckland DHB serves. The drive to change the way healthcare is provided does not pose as a risk at this time, but instead there is growing momentum and engagement from the wider organisation for this to happen.

Aspergillus/Fungal spore mitigation measures are being undertaken to ensure the safety of immune-compromised patients. There is a risk that spore counts will increase as the demolition of Building 13 commences. The Haematology service will relocate from Building

8 to the Rangitoto ward to mitigate the risk of infection. The move is a short-term solution until February/March 2021. It is uncertain when the Haematology services will be able to return to Building 8, and there is also concern that the Rangitoto ward may be needed for other purposes after March. The date for the demolition of Building 7 in 2021 is yet to be confirmed, which is another risk to be managed. Patients and whānau passing through the cut and cover tunnel during demolition is also a health risk so instructions will be provided to ensure they use a particular path to avoid the demolition area. A risk matrix is in place to manage the directorate's responsibility as a provider. This move has drawn a fair amount of media attention that is being managed.

Tama Davis, Committee Chair concluded the discussion by referring to the quote of Tā Apirana Ngata mentioned in the report and reflected as follows:

"It (change) speaks to the mention of springtime but also tapping into skillset regardless of where it exists within our community, to get the best outcomes for those who are most in need. Apirana's toki was a call to the changing environment within the Māori and pakeha development of our communities, and it was about thriving in the days destined for you. Taking a hold of new technologies (which at that time was pakeha technologies), understanding what that is, how we bring that into the world of oneness that we share, and moving forward as one people, elevating the uniqueness of us a New Zealand nation here in Aotearoa, while understanding that the many lenses and many perspectives allow us to drive with a colourful vision to the future."

That the Hospital Advisory Committee receives the Director Equity Update – Cancer and Blood for November 2020.

Carried

5.4 Director Equity Update – Surgical Services *(pages 40-47)*

Dr Rob Sherwin, Director Women's Health (presenting on behalf of Duncan Bliss, General Manager Surgical and Perioperative Services) and Rebecca Stevenson, General Manager Surgical Services were present. Dr Sherwin asked that the report be taken as read highlighting as follows:

The work of the navigators has delivered significant benefits given the reduction in waiting times for Māori and Pasifika patients. There is positive change around employment and retention of Māori staff, and a commitment from the directorate has been made to embed the gold standard of Māori patient and whānau experience and care.

Planned care volumes for Auckland DHB domicile patients are approximately 100% for adult surgery. The acute volumes have been impacted since COVID as reflected in ED attendances. There was 106% expected acute activity before COVID. The numbers have since decreased, and activity going forward is being monitored.

Planned care recovery funding targeted for specific services will be operationalised in due course. Plans for recruitment to make this possible are underway.

The leadership structure is under review and there is ongoing consultation and engagement with perioperative and surgical staff. A review group will consolidate staff

feedback after which results and recommendations will be submitted to the leadership team.

DNA rates have also reduced for Māori and Pacific patients due to the provision of Telehealth services and assistance from the navigators. ESPI-2 and ESPI-5 compliance (see page 46) also shows a reduction in long waiters.

The following was raised in discussion:

ESPI-5 performance has remained static due to increased referral volumes following the first COVID lockdown. Referrals had decreased significantly during the lockdown. The directorate has increased delivery of services to address the 4-month backlog.

The different clinical areas have had a positive experience utilising the equity adjuster waiting tool. This has resulted in very little disparity between Māori, Pasifika and patients of other ethnicities. There is staff confidence in the tool as longest waiting patients who are most at risk can now be prioritised, resulting in positive patient outcomes.

That the Hospital Advisory Committee receives the Director Equity Update – Surgical Services for November 2020.

Carried

5.5 Director Equity Update – Perioperative *(pages 48-58)*

Dr Nigel Robertson, Interim Director Perioperative Services asked the report be taken as read highlighting the following:

The work undertaken by Kāiarahi Nāhi rōpū is significant as patients are now receiving the appropriate attention and care they require.

Language is important to culture. The use of Te Reo Māori at the Auckland DHB is significant as it marks the ability for a culture to express itself.

The directorate has taken initiative to reach out to iwi-based primary care providers to foster the development of the front-end perioperative pathway, as the Directorate is aware there are systemic issues, especially for Māori. This is in tandem with the development of perioperative medicine as a speciality in itself, and has resulted in an integrated view of the patient journey from referral from primary care, and back to primary care after treatment.

Incidences of change in Tikanga Māori are as follows:

1) The use of forensic instruments processed through CSSD that was identified as inappropriate has now been changed.
2) There have been challenges in dealing with COVID patients in the operating rooms (OR) while ensuring the safety of both patients and staff. However, there has also been an uptake in OR productivity.

The following was raised in discussion:

There are no unusual workforce drivers in CSSD at present. An operations manager was

appointed this year to assist the leadership in the service. Operating rooms (OR) have a large number of overseas trained nurses and has been significantly impacted during the year. This has since been offset by a great reduction in staff resignations resulting in a slight under recruitment of nursing staff. Anaesthetic technician FTE figures are the best it has been in many years.

The directorate is embarking on a project to improve workforce flexibility and increase the scope of practice of nursing and allied staff in ORs. This will result in having registered nurses who are also fully trained anaesthetic assistants, and anaesthesia technicians capable of scrubbing for surgery and looking after patients. The last intake for the diploma course at AUT commences on semester 2 next year. Staff will gain level 7 qualification, which is beneficial for both the hospital's workforce and individual professional development.

There has been an increase in incidents reported in CSSD. (CSSD processes 466,000 instruments per month, 41,000 of which are trays or packs of instruments). There were 15 Datix reports in October, 10 of which were related to trays from external sources. Two-thirds of reports were around instruments from outside the hospital facility. There were 5 "near misses" of staff-related incidents reported but no one was harmed.

Implants removed from patients are returned directly to the patient (should they so wish) in a suitable, sealed receptacle.

That the Hospital Advisory Committee receives the Director Equity Update – Perioperative Services for November 2020

Carried

5.6 Patient and Whānau Voice – Report *(pages 59-62)*

Dr Mark Edwards explained that this is the second presentation made by the Patient and Whānau Centered Care Council (PWCCC) to the committee, to further explain the general structure and function of the PWCCC. The council will regularly participate at HAC meetings next year and will be reporting to a work plan, which is currently in development.

Jane Drumm, Co-Chair, Patient and Whānau Centered Care Council asked that the paper be taken as read and highlighting as follows:

The focus of the paper is to illustrate the council's journey so far, what patient whānau care looks like, and how the council can work towards a Te Tiriti o Waitangi-based framework. The Terms of Reference prioritise recruitment of Māori to the Council, and work that is underway with other Councils across the country to ensure best outcomes for patients and whānau.

Iani Nemani, Patient and Whānau Advisor, Patient and Whānau Centered Care Council (PWCCC) provided a brief background on his family's journey from Tonga to New Zealand, and his hospital experience at Counties Manukau and Auckland. He expressed aspiration for equitable health services to be provided for all people, especially those who face challenges in accessing health care. The Council will strive to make this possible by being the vehicle for change, promoting diversity (not just ethnicity) in order to address equity.

The Council will also act as bridge builder between forums, boards, Māori, etc, facilitating challenging conversations as well as sharing patient stories across the organisation.

The following was raised in discussion:

Vanessa Duthie, Māori Patient and Whānau Experience Lead explained that the new Māori champions of patient and whānau experience are hosting expert speakers to enable cross-cultural sharing and learning. Speakers from cross-cultural backgrounds with interest in improved patient experience and equitable health outcomes are invited to monthly council meetings. A Pasifika speaker attended a recent session, and an Asian community representative has been invited to attend in the new year. Trans-gender and health experts will also be invited to participate.

A draft framework outlining the strategic direction of the Auckland DHB and how the Treaty of Waitangi will impact the work of the PWCCC will be presented to the committee by approximately March 2021. All ethnicities who are likely to be patients of the hospital will be included in the framework.

That the Hospital Advisory Committee:

1. **Receives the Patient and Whānau Voice report**
2. **Endorses the suggested approach to developing a framework for patient and whānau centred care.**

Resolution: Moved Jo Agnew / Seconded Zoe Brownlie

Carried

6. GENERAL BUSINESS

Nil

7. RESOLUTION TO EXCLUDE THE PUBLIC *(Pages 63-64)*

Resolution: Moved Tama Davis / 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. Karakia Attendance and Apologies	N/A	N/A
2. Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result

		in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Confidential Minutes 7 October 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** [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Confidential 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** [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Women's Health Review – Verbal Update	**Privacy of Persons** **Information relating to natural person(s) either living or deceased is enclosed in this report.** **Commercial Activities** **Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public** [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 Major Risk & Issues – Verbal Report	**Commercial Activities** Information contained in this report is related to commercial	That the public conduct of the whole or the relevant part of the meeting would be likely to result

	activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time. **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	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 Clinical Quality & Safety Report	**Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time. **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)] **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]

The meeting closed at 10.30am.

Signed as a true and correct record of the Hospital Advisory Committee meeting held on Wednesday, 18 November 2020

Chair: _____ Date: _____

Tama Davis

Disability Support Advisory Committee Meeting 12 November 2020 – Draft Unconfirmed Minutes

Prepared by: Marlene Skelton, Corporate Business Manager

Recommendation

That the unconfirmed minutes from the Disability Support Advisory Committee meeting held on 12 November 2020 be received.

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

This item is:

	Terms of Reference for DiSAC *(Was item 5.1, Pages 7-11 on the Disability Support Advisory Committee agenda for 12 November 2020)*
	That the Board: **Adopt the responsibilities of the Disability Support Advisory Committee as per the amended Terms of Reference.** [*See amended Terms of Reference attached to this report*]

Auckland District Health Board

Disability Support Advisory Committee (DiSAC)
Terms of Reference

New - November 2020

Establishment

Section 35 of the New Zealand Public Health and Disability Act 2000 (the Act) requires the Board of a DHB to have a committee to advise on disability issues called the disability support advisory committee. The committee must provide for Māori representation. The Board may amend the terms of reference for the Committee from time to time.

Purpose

As provided by section 35 of the Act, DiSAC's purpose is to advise the Board on disability issues.

Functions

As provided by clause 3 of Schedule 4 of the Act, DiSAC's functions are as follows:

(1) To provide advice on:

(a) the disability support needs of the resident population of the Auckland district; and

(b) priorities for use of the disability support funding provided.

(2) To ensure that the following promote the inclusion and participation in society, and maximise the independence, of the people with disabilities within the DHB's resident population:

(a) the kinds of disability support services the Auckland DHB has provided or funded or could provide or fund for those people:

(b) all policies the DHB has adopted or could adopt for those people.

(3) To ensure that its advice this is not inconsistent with the New Zealand disability strategy.

Responsibilities

To carry out its functions, DiSAC will develop and operate under an explicit philosophy that values diversity and self-determination for people with disabilities.

In particular, DiSAC will provide advice on:

1. The overall performance of disability support services delivered by, or through, the metro Auckland DHBs.
2. The development of strategies and policies related to disability support services, disability issues and health service provision for people with disabilities in the district, having regard to, as appropriate:
   a. the United National Convention on the Rights of Persons with Disabilities.
   b. The New Zealand Disability Strategy.
   c. The Health of Older People Strategy and the New Zealand Positive Ageing Strategy.
   d. The strategic planning processes of the DHB, including the Northern Region's Long-Term Investment Plan (LTIP), Information Systems Strategic Plan (ISSP) and Health Plan, and related consultation processes.
3. The performance of disability support services against expectations as set out in Annual Plan and other relevant accountability documents, documented standards and legislation.
4. The delivery of mainstream health services by disabled people.
5. Contributions that can be made by the DHB to the development and implementation of regional and national policies related to disability issues.
6. The development and maintenance of relationships with disability stakeholders to support regional collaboration and co-ordination.
7. The extent to which the Annual Plan demonstrates how disabled people will access health services and how the DHB will ensure that the disability support services they provide are coordinated across the DHB and with services of other providers to meet the needs of disabled people.
8. How the DHB can meet its responsibilities to deliver the Government's vision and strategies for people with disabilities
9. How to build capacity for Māori and Pasifika to participate in the health and disability sector and for the sector to meet the needs of Māori and Pasifika.
10. The criteria, priorities and systems to be used in providing, auditing and monitoring disability support services.
11. The management of risks relevant to the provision of disability support services.
12. The implications of strategic planning, prioritisation and funding decisions.

Accountabilities

DiSAC is accountable to the Auckland DHB Board.

While DiSAC's role is advisory only, the Board may delegate to DiSAC the authority to make decisions and take actions on its behalf in relation to certain matters. In this event, the Board may need to amend its delegation policies and seek the approval of the Minister of Health pursuant to clause 39 of Schedule 3 of the Act.

Any recommendations or decisions of DiSAC must be ratified by the Board (unless authority has already been delegated to DiSAC).

DiSAC may only give advice or release information to other parties under authority from the Boards.

DiSAC must comply with all relevant provisions of the Act, including requirements relating to

committee meetings.

Members of DiSAC must comply with processes and requirements of the Boards, whether or not they are Board members or external appointees.

Membership

DiSAC shall comprise:

- Up to-three Board members
- A minimum of two appointed members with lived experience of disability, one of those being Maori.
- At least one member of DiSAC shall be Māori.

Quorum
A majority of DiSAC's members must be present before a meeting can be convened.
DiSAC decisions can be reached by a simple majority of members present (whether Board members or external appointees).

Conduct and frequency of meetings
It is envisaged that DiSAC will meet quarterly, although the frequency of meetings will be a matter for the chairperson to decide. The chairperson will also decide the venue for meetings.

Conflicts of interest
As required by clause 6(3) of Schedule 3 of the Act, prospective appointees to committees are required to disclose existing and potential conflicts before they are appointed. Any subsequent conflicts must also be declared, especially when funding matters are being considered.

Review
These terms of reference will be reviewed by DiSAC and the Board after one year of operation and subsequently at least every three years.

Minutes
Disability Support Advisory Committee Meeting
12 November 2020

Minutes of the Disability Support Advisory Committee meeting held on Thursday, 12 November 2020 in the A+ Trust Board Room, Building 32, Auckland City Hospital, Grafton Auckland commencing at 1pm.

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

Karakia

The Karakia was led by Tama Davis.

1. ATTENDANCE AND APOLOGIES

That the apologies of Executive Leadership Team members Ailsa Claire Chief Executive Officer Auckland DHB and Debbie Holdsworth, Director of Planning and Funding be received.

2. CONFLICTS OF INTEREST (Pages 5-6)

There were no new interests to record nor were there any conflicts of interest with any item on the open agenda.

3. CONFIRMATION OF MINUTES - NIL

There were no minutes to confirm.

4. ACTION POINTS -NIL

There were no actions to consider.

5. GOVERNANCE ITEMS

5.1 Terms of Reference for DiSAC *(Pages 7-11)*

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

as follows:

For a number of years Auckland DHB has operated a joint DiSAC committee with Waitematā DHB. With the new term of Board a decision was made to hold four separate meetings per year with the potential to hold a further two joint meetings.

The Executive Leadership Team and Planning and Funding staff from each of the DHBs are continuing to work together, sharing and continuing with the prior approach of partnership, collaboration and alignment wherever possible across metro Auckland.

Reports to both committees are aligned so that the two DHBs remain as consistent as possible but noting that there will be times when some individualistic differences.

The Terms of Reference are those for an individual DiSAC for Auckland DHB.

The following was covered during discussion of the report:

The idea of continuing regional alignment but also having a locality based approach to solutions was supported.

It was asked how, as an Auckland DHB DiSAC committee, it could be ensured that Auckland knew what was going on across the wider metropolitan Auckland region. Advice was given that currently an informal arrangement exists where there is a Metro Auckland meeting which is linked into. There is also a regional resourced based at the NRA undertaking a piece of work around disability. This meeting occurs once a month where consideration is given to any matters which have arisen, new issues and agreement is obtained on how those will be managed. That information is then reflected in the work papers that are submitted to each DHBs DiSAC.

It was asked that a permanent item be placed on the agenda covering previous and on-going work by way of a brief summary of what is occurring. It would be a Standing Item.

Māori membership was discussed noting that the Terms of Reference stipulated that there be a minimum of one member. It was asked whether Pacifika membership had been considered.

It was advised that there were specific programmes that have an intersect with Māori and Pacifika as part of the accessibility work stream. As part of the organisational development work plan there is the Strategic Plan and People Plan that touch on these areas too. While disability is the focus of this committee it is also picked up in other committee's activities and processes.

It was considered that the Terms of Reference, in stating that there should be two members identifying as having a disability, was setting a very low bar.

It was generally considered by members that the Patient and Whanau Centred Care Council (PWCC) could be better utilised for particular discussions that DiSAC would need to have to provide further depth of information and knowledge.

Advice was given that a paper was to be taken to the PWCC at the end of November asking them to focus on disability across four particular areas (see item 6.4 on the agenda). That largely aligns to the approach that Waitematā DHB has taken. The Council could be asked to act on behalf of the community when particular advice is required.

The difficulty that DiSAC has found itself in previously was that in co-opting members identifying as having a disability directly onto the Committee offered a very representative view of "my individual circumstance".

There was discussion around stating directly in the Terms of Reference, as had been done for Māori representation, that there be two appointed members with lived experience of

disability.

A reference was made to a recent Paerangi presentation. It was noted that this group engaged with numerous people and organisations and that they had discussed representation in the context of lived disability. The presentation was given by six people and five would have had lived experience of disability.

Members felt that while the Terms of Reference stated that one member of DiSAC be Māori that it would be good that another Māori representative with a lived experience of disability be appointed. It was known that the experience of Māori in general in the health system and society was different to that of European and other ethnicities. This factor would be no different for Māori with a disability.

Tama Davis commented that having disabled Māori on any committee contributing to the general intelligence of hauora is beneficial for all people.

Advice was given that there were a number of organisations that could be approached to source representation and the focus at this point should not be on how this was to be achieved. It would be better to identify organisations rather than people at this point.

There is a regional piece of work that is being done regionally across disability by Kal Lalit and as there are numerous points of difference to take into consideration it would useful to have that information when making a decision on how to move forward.

Action

1. **That a Standing Item be placed on the agenda covering previous and on-going metropolitan wide DiSAC work.**
2. **That the Terms of Reference be amended to reflect that there be a minimum of two appointed members with lived experience of disability, one of those being Māori.**

Resolution: Moved Jo Agnew / Seconded Tama Davis

Recommendation

That the Disability Support Advisory Committee recommend to the Board that it:

1. **Adopt the responsibilities of the Disability Support Advisory Committee as per the amended Terms of Reference.**

Carried

6. STANDING ITEMS

6.1 Disability Strategy Implementation Plan 2016-2026 *(Pages 12-21)*

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

This Strategy goes through from 2016 to 2026 and a review was proposed for 2020. The Strategy is actively under review now and any comment and identified priorities would be welcomed.

The following was covered during discussion of the report

Tama Davis supported the slant toward the Māori and Pacifika models of care and

understanding disability through that cultural lens of wellbeing. He felt that a review at this point, in light of the recent Heather Simpson report, was prudent.

It was advised that it was worth noting that the second stage of Wai 2575 is starting later this year and has a focus on disability. Discussions with Te Roopu Waiora have made it clear that the DHB should not wait for the findings of the Tribunal to be released to act on some of the obvious recommendations that will be made. These can be identified by questions made by claimants. This can be used as the basis for informing actions moving forward. When the Tribunal does report the DHB can say that it knew these would be issues and work has already begun to address them.

Sue Waters advised that she and Nigel Chee would undertake to complete a gap analysis against the questions to identify what may fall within the disability portfolio and had not yet been addressed in the work plan.

Members commented that the funding for disability was of concern as DHBs did not have direct control of funding. There is a need to be mindful of that while not letting it limit aspirations.

It was advised that there may be an opportunity for the DHB to consider influencing the implementation of the Simpson review. A transition team exists with one of its core functions being to establish the Māori Health Authority which will have a commissioning function. Some of the commissioning functions are going to be moved from population health, mental health and Māori health into that agency. It may be the time to advocate for the disability funding to move to that agency which would potentially provide opportunity for more influence over it.

It was advised that the report that Lalit Kalra is finalising could be tabled at the next meeting of this committee.

It was confirmed that while there was no combined regional executive team with responsibility for disability there was a meeting of like-minded staff who had agreed that the DHBs had come so far with the Strategy and that the Strategy was still applicable, notwithstanding the changes that were likely to come through the Health and Disability system, that we would continue being aligned and include all who were willing to be involved and then it was up to staff to take issues back in the manner most appropriate to their DHBs.

It was explained that the relationship with Northland DHB was one where information was shared but that they are not as involved in the same way as other metro Auckland DHBs. The across metro Auckland relationship came about as a result of patients and families who moved across the metro DHBS providing feedback about differences and preferences that needed to be recognised.

Nigel Chee advised that in terms of the Māori population further conversation could be had with Northland DHB because that population tends to move along whanaungatanga lines rather than DHB boundaries. COVID had shown that and how Northland DHB could get left out of the loop.

It was advised that Amanda Bleckmann from the Ministry of Health in the past joined all DiSAC meetings to provide a Ministry viewpoint on what was happening in the Northern Region and that it would be good to have her attend again.

Resolution:

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

Carried

6.2 Auckland DHB Accessibility - Update November 2020 *(Pages 22-27)*

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

That this report provided an overview and outline of work that was planned moving forward. It had been unfortunate that this year not as much had been able to be achieved as planned due to COVID 19.

Two of the things being concentrated on as part of the Disability Strategy are related to outcome two around employment and economic security by trying to engage and support people into roles at the DHB and to change attitudes. Workshops have been done with the Recruitment Team to ensure supportive processes are in place. There has been some disability confidence training done with people managers but there is much more to do in this space.

It was advised that disability training was not mandatory. There is a programme of training for a new staff member to complete in 30, 60 and 90 days. There are a considerable number of modules of training to be completed. There is much that is mandatory already that it has to be split between what is mandatory and what is important otherwise staff cannot complete it and be fully functional. Disability training is completed in the first 30 days.

It was suggested that disability awareness could be raised by having a Disability Awareness Week at the DHB and some targeted communications throughout the year.

It was advised that where perhaps disability awareness and competence were not so well developed would be within outpatient services where people were fronting up for services that were more transactional and short term in nature. Some of the accessibility work is centred around improving this.

There are areas to be concentrated on. One being improving health literacy and using multimedia that meets a required standard so that people have an opportunity to engage in a way that is relevant to them. However, not everything can be done at once, there is no dedicated resource and reliance is placed on Disability Champions within Directorates to make sure that people are trained in the correct approach.

It was asked whether it was considered that a dedicated resource was required with advice being given that such a resource could start to lead some of these programmes of work but they cannot do the actual work at ground level. This needs to be filtered down to the functional groups that are directly involved. It could be something to consider in the future should anything change with the current situation.

Attention was drawn to page 23 of the agenda and mention of employees with a disability. It was asked what was known of employees that had an impairment. It was stated that people do not have a disability, they have an impairment and that only becomes a disability when the environment they are in does not adapt to accommodate their impairment. You cannot ask an employee, “what is your disability” because they will immediately feel that they have something to hide. The conversation becomes a different one if they are asked whether they have an impairment.

It was advised that on staff there were 34 people who had self-identified that they had an impairment and that for an organisation of the size of the Auckland DHB there should be more than that. Statistics show that one in five people have an impairment of some description. Auckland DHB was under represented and that was a result of not having yet done enough work in the awareness area. Fear of stigma and professional repercussions will prevent staff from opening up. There is much more to do for both employees and patients in this area.

Resolution: Moved Michelle Atkinson/ Seconded Tama Davis

That the Disability Support Advisory Committee

1. **Receives the Auckland DHB Accessibility - Update November 2020**
2. **Endorses the Accessibility Tick Action Plan**

Carried

6.3 Letter – Disability Data and Alerts *(Pages 28-30)*

Sue Waters, Chief Health Professions Officer asked that the report be taken as read advising that this presented to the Committee for information. there is a piece of work being led by Capital and Coast DHB nationally across the 20 DHBs around focusing coordinated effort across the DHBs to improve data collection and use and the use of an alert.

Capital and Coast DHB have quite a significant disability team coming from a variety of background and offering a variety of skills. They have done a lot of work integrating the Health Passport. Because it is a paper based booklet that patients have to carry with them it invariably gets misplaced. Based on feedback from the disabled community it is not portable or accessible. An e-passport initiative is also being pursued with Wellington.

Wellington tried to introduce a disability alert system based on the alert system within their PAS. Unfortunately, the evaluation of it showed it was not fit for purpose and would never achieve its objectives.

The 20 DHBs now wish to attempt to develop a system that will meet requirements.

The other issue is around data and work being done with the Disability Directorate at the MoH looking at how data might be shared. It is a national piece of work.

Debbie Holdsworth, Director Planning and Funding has approached Disability Support Services asking for NHI level data. It has been agreed that there is no reason why DHBs cannot have this data. It has not been forthcoming and the 20 DHBs are following this up nationally through the work that Wellington is leading.

The following was covered during discussion:

It was advised that the way the passport is devised is that the impaired person holds the information and it is then made available to anyone at the point where they present it. Whether that will change in the development of the App and how that works is unknown at this point.

The alert sits on the system and where ever a patient goes signals that the patient has particular needs to be considered.

Resolution:

That the information in the letter from Capital and Coast DHB dealing with Disability Data and Alerts be received.

Carried

6.4 Disability – Proposed Discussion Paper to be presented to the PWCC at its November 2020 Meeting (Pages 31-33)

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

that it was her intention to go to the PWCC in November and ask them to consider prioritising disability as a work stream focus over the next three years. In particular:

- Staff training
- Unconscious bias
- Reading platforms to ensure documents/website are accessible to those with vision impairments
- Access to buildings/facilities.

A particular focus would be in relation to staff training around attitudes and beliefs.

Reading platforms to ensure documents on websites are accessible for those visually impaired will probably sit within the accessibility areas. Therefore, we are trying not to duplicate effort but to streamline areas that are important in accessibility and disability. Access to buildings and facilities is also important on a geographically challenged site such as ACH. There is opportunity to look further at this issue while the FIRP and BFTF programmes of work are currently underway.

This approach aligns with the approach agreed at Waitematā DHB DiSAC and builds on the integrated work in Disability across metro Auckland.

The following was covered during discussion:

Attention was drawn to page 32 of the agenda and a question asked as to who the disability champions in each directorate actually were. It was advised that these people were the Allied Health Directors. These are the people that look at all the issues, incidents or complaints around disability related areas; accessibility, access to information or not being treated in the right way.

These people are part of the directorate leadership teams and have the ability to advise and influence. They work together to make sure that everyone is thinking about need to consider elements within a disability landscape.

Tama Davis asked that note be taken of work being done around Age-friendly Cities and how that could be supported within the community.

Direction of Travel for DiSAC

Agreement was given by the Committee that it would be action oriented.

Tama Davis asked that the United Nations Declaration of Indigenous Rights be added to the below list. He also asked that a paper be presented detailing the investment required to gain momentum in the disability space. He was advised that the work being done by Lalit Kalra would provide clarity around what areas the DHB has some control over and what it does not. There were opportunities too from the Health and Disability system review for potential change.

If the needs are made clear these can then be mapped against what the MoH funded allowing identification of the gap that exists and the ability to advocate collectively in the right places to fund that gap. Consideration can then be given to whether work is done by the DHB at a local level, whether the DHB advocates to the MoH as the primary funder or whether the DHB looks to the new model that the Government is moving toward.

Resolved: Moved Jo Agnew/ Seconded Michelle Atkinson

That DiSAC would be involved with:

- **Te Roopu Waiora**
- **Employment**
- **Capital and Coast collaboration**

- **Data and Alerts**
- **The work done by Lalit Kalra – strategic context of disability and accessibility, inclusion, improved outcomes, cultural responsiveness, rehab, locational rehab equipment, transition from child to adult, independent living including funding and NASC, the enabling good life initiative and international models of disability.**
- **United Nations Declaration of Indigenous Rights**

Carried

7. GENERAL BUSINESS

Position of Chair

Jo Agnew advised that there had been a discussion between herself and the Board Chair with regard to how DiSAC was run and the potential in the future for an independent chair. Jo Agnew indicated that she would prefer the issue be taken to the board for discussion but would be happy to step down should an independent chair be appointed.

The meeting closed at 2.15pm with a Karakia from Tama Davis.

Signed as a true and correct record of the Disability Support Advisory Committee meeting held on Thursday, 12 November 2020

Chair: _____ Date: _____

Jo Agnew

Community and Public Health Equity Advisory Committee Meeting 18 November 2020 – Draft Unconfirmed Minutes

Prepared by: Marlene Skelton, Corporate Business Manager

Recommendation

That the draft unconfirmed minutes from the Community and Public Health Equity Advisory Committee meeting held on 18 November 2020 be received.

Recommendation

The following item from within the draft minutes are submitted by the Community and Public Health Equity Advisory Committee for consideration and approval by the Board**.**

This item is:

	Asian, New Migrant, Former Refugee and Current Asylum Seeker Health Plan 2020-2023 *(Was item 6, Pages 71-125 on the Community and Public Health Equity Advisory Committee agenda for 18 November 2020)*
	That the Board: **Endorse the Asian, New Migrant, Former Refugee and Current Asylum Seeker Health Plan 2020-2023.** [*Secretarial Note*] See amended plan attached to the back of this report. It was agreed that the areas around Te Tiriti be flagged in the Plan for consideration when the Plan went before the Board for final endorsement. Samantha Bennett, Asian, Migrant and Former Refugee Health Gain Manager provides assurance that this has been undertaken. • The Treaty principles in this Asian, New Migrant, Former Refugee and Current Asylum Seeker Health Plan 2020-2023 are consistent with the Treaty statement in our current Auckland DHB Annual Plan. The Treaty statement has undergone extensive annual review and refinement by our MoU partners undertaken by the Māori Health Gain Team and Kahurangi Dame Naida through the Planning, Funding and Outcomes Team process. • The Asian, New Migrant and Former Refugee Health Gain Manager has consulted Dame Naida Glavish in regards to correct use of te reo Māori for Plans prepared by the team. • The Treaty principles and articles have utility across the sector. They are included in the Treaty statement here to reaffirm the DHB's commitment to the Treaty of Waitangi and also to provide a framework for which other targeted ethnic groups who experience health disparities (and discrimination) can draw inspiration and action from. The principles of partnership, equity, self-determination, and acceptance and celebration of our uniqueness are principles that resonate with all

		cultures particularly our Asian and new migrant communities that are socially, culturally, linguistically, and faith diverse. In this respect, we show solidarity with manawhenua and the Treaty as our country's founding document.

Minutes
Community and Public Health Advisory Committee – Commissioning Health Equity Advisory Meeting 18 November 2020

Minutes of the Community and Public Health Advisory Committee – Commissioning Health Equity Advisory meeting held on Wednesday, 18 November 2020 in the Marion Davis Library, Building 43, Auckland City Hospital commencing at 1:30pm

Board Members Present	**Auckland DHB Executive Leadership Team Present**	
Dr Teuila Percival (Chair)	Dr Karen Bartholomew	Director of Health Outcomes – ADHB/WDHB
Michelle Atkinson (Deputy Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Margaret Dotchin	Chief Nursing Officer
Zoe Brownlie	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Tama Davis	Meg Poutasi	Chief of Strategy, Participation and Improvement
Fiona Lai	**Auckland DHB Senior Staff Present**	
Bernie O'Donnell	Samantha Bennett	Manager Asian Migrant and Refugee Health Gain
Michael Quirke	Ruth Bijl	Funding and Development Manager Women's /Child and Youth Health
Heather Came	Nigel Chee	Interim General Manager Māori Health
Michael Steedman	Meenal Dugal	Funding and Development Manager – Mental
	Deepa Hughes	Youth and Oral Health Portfolio Manager
	Leani Sandford	Pacific Health Portfolio Manager
	Raj Singh	Project Manager Asian Migrant & Refugee Health Gain
	Marlene Skelton	Corporate Business Manager
	Kate Sladden	Funding and Development Manager – Health of Older People
	Shayne Wijohn	Manager Māori Health Gains
	Tim Wood	Funding and Development Manager Primary Care
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

Karakia

Tama Davis led the Karakia for the meeting.

Chairs Introduction

Dr Teuila Percival gave a brief introduction and outline of her professional background advising that she was of Samoan descent and a Consultant Paediatrician at KidzFirst Children's Hospital, at Middlemore. Dr Percival holds a number of leadership positions in the Pacific health sector and academia. She is Head of Pacific Health and Senior Lecturer at the School of Population Health at the University of Auckland, Vice-President of the Pasifika Medical Association (PMA), a trustee of TaPasefika Primary Health Organisation and serves on a number of government health advisory

groups. Dr Percival has a specific interest in Pacific people's health and a passion for the community, service and equity.

1. ATTENDANCE AND APOLOGIES *(Page 5)*

That the apologies of Peter Davis and Bernie O'Donnell (both for late arrival) be received.

The apologies of Executive Leadership Team members, Sue Waters, Chief Health Professions Officer and Dr Margaret Wilsher, Chief Medical Officer be received.

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

There were no changes to the Interest Register and no conflicts with any items on the open agenda.

3. CONFIRMATION OF MINUTES – NIL

There were no minutes to confirm.

4. ACTION POINTS -NIL

There were no action points to review.

5. INDUCTION AND OVERVIEW

Karen Bartholomew, Director of Health Outcomes – Auckland and Waitematā DHBs tabled a slide presentation providing an overview of the previous CPHAC approaches to equity and spoke to the points raised therein. [Attachment 5.1.1]

This information was provided to assist in informing where members may like to direct work from this point forward.

The following points were made during discussion of the overview presentation:

- Tama Davis commented that this overview had provided him with a good understanding of what the critical success factors might be for moving forward. He would like to know how Auckland DHB could be more involved particularly with Kōtui Hauora around the devolvement of services back to regional Iwi. It would be good to see how that has been progressed and how the DHB is looking at supporting that and how it can be provided with the necessary weight and authority. It was advised that the December meeting would provide direction for these issues.
- Dr Teuila Percival commented that it was good to see the emphasis on the use of evidence and developing evidence when it is missing. She asked that with the equity focus being on Māori and Pasifika how much time was spent looking at Māori and Pasifika research and how much of that research was utilised. It was advised that this could be addressed during discussion of items 5.1 and 5.2

5.1 Planning Funding and Outcomes: Approach to Commissioning *(Pages 9-49)*

5.2 Planning, Funding and Outcomes: Summary of community investment and areas of focus *(Pages 50-70)*

Dr Debbie Holdsworth, Director of Funding – Auckland and Waitematā DHBs asked that the reports be taken as read and considered together.

The advantage of working as a joint Auckland and Waitematā DHB team is that some scale has been able to be developed and a lot of the work undertaken informs programmes that are subsequently rolled out nationally.

The team adhere to a number of key traits, including impartiality, and apply a consistent set of principles that drive our approach. These principles are:

- Elimination of gaps in equity of outcome
- Population health focus and needs assessment
- Evidence based or developing an evidence base
- Deep understanding of the data
- Continuous quality and equity improvement
- Partnership with people with lived experience, communities and providers of services

In terms of the earlier question in relation to utilisation of Māori and Pasifika research Dr Matire Harwood sat on the joint CPHAC. The team are very much aware of her research and have utilised it within their work, also a number of key clinical and academic Māori and Pasifika leaders are involved in some of the programmes outlined.

The following points were made during discussion:

An explanation was given as to how the team engaged with Te Tiriti in a number of ways. A memorandum of understanding exists with Ngāti Whātua as manuwhenua. The Māori Health Gain team have responsibility for the relationship with our Te Tiriti partner. The Waitematā DHB also has a memorandum of understanding with Te Whānau o Waipareira Trust. Both of these MOU partners are partners on the District Alliance in Primary Care.

Shayne Wijohn advised that the MOU partners were involved in any funding decisions that were being made. The DHBs engage through them with Māori communities to understand the issues and needs of communities.

Nigel Chee added that Kōtui Hauora which is the Iwi Partnership Board is the most visible manifestation of Te Tiriti in terms of the way in which the partners work together.

It was acknowledged that there were a number of pilot programmes were clearly showing good results with the AAA programme of work being seen as an exemplar. It was asked whether these could be moved from a pilot phase and kept going. Karen Bartholomew commented that the AAA Screening was seen as a programme of work intentionally taking action on a small but important gap in life expectancy. International evidence was used to inform that but the approach was to generate local evidence. There was a view that Māori had lower coverage in screening programmes but that if you design a programme by Māori for Māori that does not have to be the case. This was demonstrated by this

programme, it had high participation and it was cost effective. The extension is now to take the same approach to Pasifika particularly around language needs. The intention is to be able to provide back to the Board an effective model for AAA screening that is focussed on addressing inequities and what that would look like for the DHB, across the region and ideally nationally.

Introduction of Planning and Funding Team

Members of the team introduced themselves.
Meenal Duggal – Mental Health Care
Tim Wood – Primary Care and Pharmacy
Ruth Bijl – Child and Women's Health
Shayne Wijohn – Māori Health Gains
Kate Sladden – Health of Older People Services
Leani Sandford – Pacific Health
Samantha Bennett – Asian Health
Raj Singh – Asian Health

The following points were made during resumption of discussion:

Tama Davis directed a question to Tim Wood in relation to understanding patient/whānau voice in terms of the PHO. How is that community voice captured? Tim Wood gave an example of the work undertaken for the Diabetes Programme where both patient and whānau are brought into the room with the GP to discuss diabetic care. This work started with the use of social media to engage with Māori and Pasifika people in the community who had poor diabetes control and did not go and see their GP in order to understand what the issues were for those people. This information was presented to the PHOs and General Practice teams and is being used to get all parties in the room together to talk about the experiences Māori have had and the barriers they have around effectively managing their diabetes care. There are whānau, cultural and social issues that need to be taken account of. It is hoped that this will raise awareness with the General Practise teams around what they can do to at their level to respond in a better way. The challenge will be replicating this across all General Practises as this is a cultural shift for them too.

Tama Davis commented that he acknowledged that a focus had to be on GPs to get intelligence and change at a grass roots level; however it was the PHOs that applied for funding to support practise members to deliver in areas the DHB requires them to deliver to. PHOs were an area that required more work to get better information so that informed decisions could be made as to what service could be devolved and where community investment should be made.

Tim Wood referred to the Kare Programme which was only able to be worked through and have a funding model applied by actually working directly with the GPs to understand how that programme would work with their business models. The problem a funder or commissioner has is that people want to talk about money before talking about service and outcomes. There is effort being made to shift conversations to deal with outcomes and service models before talking about funding models. Ailsa Claire advised that in terms

of the diabetes programme a commitment was made to identify the full expenditure, including that funding which sat within the DHB so that all of that money could be placed in one collective pot. This allowed more freedom for decisions to be made around how to do things differently. However, trying to get PHOs to identify and itemise what they were spending on diabetes was problematic.

Michelle Atkinson acknowledged that the DHB had some serious problems to deal with in terms of equity and if the DHB was looking to change outcomes then some of these small but well-designed projects mentioned in the reports, for a small investment, make a very big difference. Michelle referred to rheumatic fever and healthy homes. Investing a small sum in a healthy home now provides an immediate benefit for children not to mention the wider household and the health outcomes of that child in the future. Therefore, it was important to prioritise these small projects because they were easy to lose sight of and to be the first to be cut in the face of what might be perceived as bigger problems to fund.

Tama Davis commented that in terms of Māori Health Gains he would like to see how the networking and on-going relationship building will enable the DHB to place itself in a good position to take on implementation of Wai 2575 in a meaningful way along with supporting the entry of the Māori Health Authority into the funding arena. Advice was given that there were several local and regional networks with providers directly placed in communities. While the relationships are important, they have to provide a good understanding of what the Māori health providers needs are along with the needs of the communities that they serve for the DHB as a funder to increase its investment.

Bernie O'Donnell asked whether a discussion had ever been had with the partners around what wellbeing looked like so that something could be co-designed that speaks to the partnership and starts to provide an understanding of what is meant by "Hauora" as opposed to a merely clinical Kaupapa. Bernie also raised the issue of socialising the concept of Manu Motuhake and working on getting that to resonate with the partnerships. It was advised that there is clear good will and intent across the DHBs and that there is a structure in place in terms of Kōtui Hauora with opportunity in terms of outcome, health gain and priorities for Māori. What does not exist is the right process which has been delayed due to the challenging year that 2020 has been. Given that the planning cycle for 2021/2022 is about to begin the time is right for these conversations to be had to bring all threads together from the perspective of the partners and the Crown through the DHBs. Kōtui Hauora is the beginning of the process and it is hoped that as a result of this process an agreed plan that the Crown and Māori through Kōtui Hauora can agree to results.

Energy needs to be focussed on those things that will bring the biggest and greatest gains given that resource is constrained.

Resolution:

That the Community and Public Health Advisory Committee note:

1. **The focus of Planning, Funding and Outcomes on equity and evidence informed commissioning initiatives.**

2. **The exemplar case studies provided to illustrate the commissioning approach.**
3. **The need for continued investment in primary and community services to achieve equity and address the continuum of prevention, early detection and service needs including the impact on secondary care.**
4. **The range, value and breadth of community investment and areas of focus.**
5. **The constraints on funding and contracting arrangements, with limited discretionary funding opportunities.**

Carried

6. ASIAN, NEW MIGRANT, FORMER REFUGEE & CURRENT ASYLUM SEEKER HEALTH PLAN 2020-2023 *(Pages 71-125)*

Samantha Bennett, Manager Asian Migrant & Refugee Health Gain – Asian Health and Raj Singh – Asian Health Gain

Advising that the Plan is a collection and collation of all the effort in the Planning and Funding outcomes space across the two DHBs. It has been guided by the health needs assessment completed in 2017. This information highlighted that overall Asian populations do experience very good health outcomes and life expectancy. The recommendations from the report highlighted some nuanced disparities that some of the target population experience. It was decided as a result to create a new plan that addressed these disparities for select groups. The plan tabled today does not specifically outline everything done for all the Asian population but it specifically addresses where health gains and improved health outcomes can be made.

There are three key areas around capability and capacity building. If granularity can be obtained in data and an understanding gained of level four data for ethnicity, then a more nuanced view of the Asian population can be formulated.

Another key area is around access to health services with a focus on primary care for Asian, new migrant and former refugee and current asylum seeker groups. This opens the door for those communities in accessing language via an interpreter at primary care level in particular to access wrap-around support.

The last area is around partnerships. Work has been done with the Northern Region Health Coordination Centre during the two outbreaks of COVID 19. The learnings from these outbreaks in relation to communication and welfare support has shown that there is a need to ensure strong relationships and partnerships with ethnic and religious leaders and ethnic associations. These relationships will assist in supporting the effort required to deliver this new plan over the next three years.

There is an Asian and MELAA Governance Group who are members of the Planning and Funding Outcomes Team across the two DHBs for the portfolios that were highlighted. It Quarterly progress is monitored via a scorecard. The Governance Group feeds information through to Committee Funder Updates and CPHAC reports.

The following points were made during discussion:

Dr Percival agreed with the points made in the introduction noting that this was such a diverse group making it very important to disaggregate and collect the right data as needs are going to be so different. There are some concerning issues around diabetes in some subpopulations and asylum seekers must have mental health issues which are not being addressed.

It was asked how much of the greater Auckland population fits within the category of new Asian, migrant and former refugee and current asylum seekers. Advice was given that 70% of this population lives within the Auckland region. Auckland DHB has 35% of the Asian population and significantly what is seen with this population is a growing Filipino, south East Asian demographic. Chinese and Indian are still the biggest demographic.

The other area of focus would be the Middle Eastern group. That became obvious was seen during COVID 19 with the Botany cluster where, even though the population was within the Counties Manukau DHB area, the ripple effect from the cluster cascaded into Auckland DHB. A lot of effort went into ring fencing this cluster so that the Auckland DHB Middle Eastern communities weren't impacted.

The Asylum Seeker population typically lives within the Auckland DHB boundaries and they do so because they need to be close to the INZ Building in the central city. A lot of these communities are living in the fringe suburbs around the city or living in the Asylum Seeker Trust Hostel.

It was commented that this appeared to be a large work programme for a small team. In terms of what is laid out in the Plan is it thought that the actions are achievable with collective effort across the Planning and Funding and Outcomes and partner organisations. While Samantha and Raj led the Plan a lot of effort goes into influencing peer portfolio groups to assist. This Plan may be ambitious but at the core of it is a focus on Primary Care, Mental Health and Oral Health as this is where the greatest disparity lies for new Asian, migrant and former refugee and current asylum seekers.

It was asked that in terms of the network spoken of, whether schools are part of that as many have students where English is a second language. It was advised that the Child and Women's Health Team were utilised to identify, particularly former refugee students, in the school-based health network. GP access for Asians has improved due to awareness raising around the role of a GP. There are areas of improvement for Asian youth who may not understand the role of a practise nurse or primary care or seeing a nurse at school. There are issues around confidentiality as communities worry that someone else within their community may find out about their personal details. There is more work to do to understand how this fear can be addressed.

It was commented that for a number of these communities' midwifery is not part of their cultural norm. Is this something that is being addressed? It was advised that a NZ Health System video has just been developed to increase awareness to new migrants and it has been translated into Mandarin, Korean with Arabic the next translation to be provided. There is a newly crafted message to be inserted into the video around, "When you are pregnant what do you do?" While people do go to their GP it is the other things that you

are required to do like finding a midwife.

It was noted by Fiona Lai that different cultures will accept different types of health promotion and that needs to be clearly understood. Accessibility and navigating the health system are very important so data is important to know where to focus effort. Fiona asked whether the Team felt that they had tapped into all the different partners within the Asian community or more work was required in this area.

It was advised that an Asian campaign is being launched this week as a result of the recent COVID cases within the CBD with a focus on traditional Chinese language. It will be aimed at the Hongkongese, Taiwanese and other communities that prefer to read information in traditional Chinese. Nuance around language is very important. It was noted that even though Filipinos in general speak very good English they themselves had asked for material that was important to them to be provided in Tagalog.

It was advised that there are only a few key core key players within the Asian community that have the required reach into their communities. The safe guard is dealing directly with these key leaders and agencies that it is known can get the message across.

The inclusion of the statements (transferred from the Annual Plan) including reference to Article 4 [guarantee around customs and beliefs] of Te Tiriti was commented upon. It was noted that reference needs to be discussed with manuwhenua and kaurangi around what that might mean for them.

Action

It was agreed that the areas around Te Tiriti be flagged in the Plan for consideration when the Plan goes to Board for final endorsement.

Resolution: Moved Zoe Brownlie / Seconded Tama Davis

That the Community and Public Health Advisory Committee recommend to the Board that it:

Endorse the Asian, New Migrant, Former Refugee and Current Asylum Seeker Health Plan 2020-2023

Carried

7. ORAL HEALTH - UPDATE *(Pages 126-151)*

Ruth Bijl, Funding and Development Manager Women's /Child and Youth Health asked that the report be taken as read, highlighting as follows:

There are fundamental challenges to be addressed in the oral health space. The system has been in place for more than 20 years and it is time that it be reviewed and redesigned.

Dr Percival commented that it was a very concerning situation. Ailsa Claire advised that there was a programme of work being undertaken to address the waiting list however the critical action lies with the future redesign of the system. She made mention of the Regional Vulnerable Services Framework which is work being undertaken on a number services where rapid change is absolutely required. The oral health issue will become part

of that framework.

It was asked whether the waiting list of 2000 were children who had been seen and were waiting for a general anaesthetic or that they simply had not been seen or a combination of both. It was advised that these were children waiting to be seen. There were some children who absolutely needed to be seen because they had congenital abnormalities as opposed to those that were well but had bad teeth requiring removal under anaesthesia.

There was a need to work through the process with those people accessing the service to fully understand what the solutions might be that work for them. There is also the school age to 18-year-old youth cohort to consider, wherein only 50% of Māori youth are being seen by a dentist under the combined dental agreement arrangement. In terms of the highest impact however Ailsa Claire advised that a significant number of the children referred to the specialist dental service are under five years of age.

It was asked how the COVID19 investment referred to would help address the backlog. It was advised that it would allow referrals to be dealt with as they came in so that no new waiting list was being built up.

It was acknowledged that the pre-school cohort was critical as preventative health education was required to halt dental disease. Part of what the Auckland Regional Dental Service (ARDS) does is visit early childhood and kōhanga reo settings to provide fluoride varnish, dental health promotion and other dental work. It is known that there are cohorts of children who are missing out on being seen. Stakeholder research has shown that people do not have a good awareness of healthy teeth messages and of the services.

There is one piece of work specific to Auckland DHB around maternal oral health which it was hoped to progress further when the evaluation of its efficacy was received.

Bernie O'Donnell commented he was not sure whether oral health had been prioritised correctly. He asked that over the next months the Committee be informed of what was being done to engage with Māori and Pasifika to reverse these statistics. He asked whether the capacity existed for the DHB to develop its own programmes or did it wait for someone else to develop something. It looks like once again the DHB is the ambulance at the bottom of the cliff which is frustrating.

Ruth Bijl acknowledged that it was a difficult situation made worse by COVID 19. A clear view had prevailed that dental procedures were a high risk and should not be performed during certain COVID alert levels which had placed providers in a situation of not being permitted to provide a service. Ailsa Claire agreed noting that a number of the dental vans had been reassigned to deal with COVID testing.

The use of the mobile units led by Māori and Pasifika during COVID 19 demonstrated that there were different ways of engaging and that in some instances you simply had to have a go and try something different rather than waiting.

It was acknowledged that while there were certain aspects during COVID 19 that prevented care being offered and which had dismantled any gains made, the situation did exist pre COVID 19. What COVID 19 had provided was seed funding which provided a platform to move forward on. The funding is sufficient to deal with the combined

Auckland DHB children currently on the waiting list. There is an inclusive common goal across all four regional DHBs to address this situation.

Advice was given that the Auckland metro region has the highest number (310) combined dental providers. In addition to that there were three mobile dental units which cover the low decile 1-5 schools. Statistics show that there are a high number of Māori and Pasifika teenagers engaging with this service. The model of taking the service to them works. The inequity is seen in the higher decile schools. There is also a cultural aspect to be aware of as some teenagers find it difficult to walk into a high-end dental practise which is very different from what they are used to in a school dental service. Work is being done with these providers to get them to understand how best to provide a service to and engage with this cohort.

Tama Davis, like Bernie O'Donnell wanted the team to provide guidance around where the service should be heading and what it should look like. It might be that divestment of some parts of the service is required and reinvestment in others. Ruth Bijl responded that something could be designed for the vast majority and they would use that service. However, it does not work for all and that is where the effort has to be made to ask those families what they require to make it work for them.

It was asked what the plan was, outside of co-creating with the community, as something has to be in place in the short term to turn this situation around. Advice was given that the key concern was around dental disease starting and progressing so preventative health education was critical.

Bernie O'Donnell suggested that a visit be paid to Takaparawhā to see what was being done in terms of working with other organisations in the area of wellbeing. They are working with these agencies in shared space and are able to stipulate what is required. This arrangement allows very good access to the people. There is a level of trust being the people are interacting with trusted voices and trusted faces. This situation requires outreach with the genuine intention to do things differently.

Concern was expressed again that money itself was not going to address these issues and Ailsa Claire was asked what political landscape existed that would allow the situation to be thoroughly reviewed. Ailsa Claire advised that the money would reduce the waiting list for people who had been referred for secondary care but not solve the core issue. The DHB needed to get itself in a position where outcomes could be determined and different things tried. The money would not need to be spent in the secondary service if the core of the problem at the pre-school level was addressed. How do we all collectively stop this issue which relies on a cultural change being made? It is largely sugar laden drinks that are causing this problem.

Working with the region specific funding has been allocated to Waitematā DHB to address the redesign of the children's school service and specific funding allocated to Auckland DHB to address the waiting list in the secondary service. That is a real opportunity to undertake a total rethink around service delivery but with the assistance of those using the services.

Assurance was provided that the waiting list was being addressed now and in terms of the

service redesign under the Vulnerable Services Framework that would enter a "rapid process" which would take six weeks to provide a pathway for what should be done next.

In reply to a question asked about what opportunities were being explored for Pasifika children Meg Poutasi advised that this why a regional approach was so very important as a large number on the list were Pasifika children based in the Counties Manukau DHB. The solutions must be designed together to be effective.

Resolution:

That the Community and Public Health Advisory Committee:

1. **Notes that oral health is a vital component of general health and that there are persistent inequities for Pacific and Māori children.**
2. **Notes that some good progress had been made against the equity focused 2017 Preschool Oral Health Action Plan, but gains have been lost due to COVID-19 outbreaks and on-going requirements placed by the Dental Council of New Zealand.**
3. **Notes that there are significant delays in time to treatment for hospital-based (secondary) dental care that have led this to be identified as a vulnerable service in the regional services plan.**
4. **Notes that Auckland DHB has used $650k of the Ministry of Health Planned Care COVID-19 catch up activity funding to fund additional secondary dental capacity to address these delays in three above.**
5. **Notes the need for urgent additional targeted approaches to improve access to oral health services for Māori and Pacific children and adolescents, cognisant of the on-going risk of COVID-19 and Dental Council of New Zealand requirements. Further work will be undertaken within the Regional Vulnerable Services Framework.**

Carried

8. ARPHS - UPDATE *(Pages 152-176)*

Dr William Rainger, Director and Jane McEntee, General Manager were in attendance to answer questions relating to the report.

The service has primarily been focused on the COVID response since late January. Following the first wave June and July was spent building capacity to deal with future community outbreaks. In particular, with the support of the DHB and the region capacity was built to respond to community outbreaks in vulnerable communities; Pasifika and Māori. In August the second wave came which disproportionately affected the Pasifika community. The service was relatively well placed to respond to that with the assistance of the DHB.

Systems, capacity and resource are again being reviewed and rebuilt to respond to future outbreaks while managing smaller outbreaks as they occur such as the Maritime Technology Worker and recently the November Quarantine outbreak. It is hoped that the combined health sector and multi-agency approach will enable cases to be identified very early on and therefore allowing a strong response to be mounted across the health sector to manage these situations.

The service does have other responsibilities and while 60%-80% of capacity is deployed to dealing with COVID 19 it is important that other critical public health functions are continued. Particularly important is the area of communicable diseases, notable being tuberculosis as the last thing required is multi drug resistant TB emerging because of the focus on COVID.

The population health improvement work is important and some work has managed to be continued in the areas of tobacco, alcohol and "Healthy Auckland Together".

Looking forward the Government has signalled its intention to move forward with changes in how Public Health Services are configured and delivered and ARPHS is keen to work with the DHBs on a regional basis to ensure that whatever emanates from that review will work best for the Auckland population.

The following points were made during discussion:

The good work being done in the areas of drinking water, smoke-free and alcohol pre COVID 19 was acknowledged with concern being expressed that with the continuation of COVID 19 outbreaks the service might not be able to get back to full capacity in those areas. It was advised that since May a COVID 19 response unit had been built within ARPHS to not just allow a COVID response but also to ring-fence ARPHS resources allowing this other work to continue. It is impossible to say when the Service would be back to normal strength but there was a commitment to deploying as much resource as possible to other work.

Jane McEntee advised that the Service also looked to see where it might participate regionally and nationally to support some of that other work and gain a wider impact. The Service participated in the Public Health Advocacy Group which is led by the NRA and endorsed by the DHB CEOs across the country.

It was advised that the Northern Regional Health Coordination Centre is an incident management response structure that is fully regional and includes Northland which has particular work streams dedicated to primary care, for testing, Māori and Pacific health and other functions and is based in Bledisloe House in the city. ARPHS is an operating unit within that wider structure. When there is an outbreak then testing and primary care is an important part of that response. ARPHS works by linking with the NRHCC to deliver that component.

In a response situation it is ARPHS responsibility to receive the notification of that case and mount the immediate response to the case and undertake the required contact tracing. The region supports the response in terms of the testing and primary care components.

Ailsa Claire advised that ARPHS have had to flex up in a way that they have never had to previously. The only way that could occur was by DHBs offering staff. When staff were first required schools were shut so school nurses were transferred to ARPHS. Staff cannot just turn up at ARPHS and begin work they must undertake training. As there was not a long enough gap between the first and second COVID waves other groups of staff could not be trained so the same pool of people were being drawn upon during the second wave and this time schools remained open. There is now a complex plan around bringing in additional staff to ARPHS which relies on core funding and a flex group that have a shadow

roster so if they are required, they can be brought in without adversely affecting the hospitals BAU. Work is also being done to look at how new graduate nurses can be brought into the hospital releasing more qualified staff to be transferred to ARPHS.

Dr Rainger added that there was another dimension to assisting ARPHS in the way that Ailsa Claire had described and that was the national network. This is through the Ministries National Investigation and Tracing Centre with the concept being that the Ministry and Public Health Units around the country should be able to work as a distributive network and share out the work. It is complicated in terms of delegations as to who does what in a safe and effective way. That is progressing and improving. In the latest outbreak Waikato has been assisting with the management of the cases from the managed isolation facilities. The more efficient that becomes the more ARPHS will be able to protect some of its core resource to undertake core business.

Meg Poutasi commented that one of the things that the pandemic had provided was an opportunity to review and learn. ARPHS were to be congratulated on how quickly they have responded and adapted their model to be more responsive to the community. In the first stand-up the Pacific team at the NRHCC was significantly larger than it was in the second and third response because functions were able to be delegated into ARPHS as a result of their review following the first wave and the design of a Pacific model which was incorporated into ARPHS structure. The second thing they did was picking up social support and moving that into a public health response model which allowed a very smooth referral process with the Whānau Ora Commissioning Agency. One of the other benefits of this model of evolution may well be the gains made in working with Pacific providers regionally and the willingness of those providers to be involved in public health conversations going forward. For instance, messages about sugary drinks and immunisation can be pushed through that network. It will be important to preserve and maintain these relationships and networks for other public health good.

Resolution:

That the Community and Public Health Advisory Committee

> **Receive this update from the Auckland Regional Public Health Service (ARPHS) on key areas of work that are underway and/or have been completed between January and September 2020.**

Carried

9. HPV SELF TESTING - UPDATE *(Pages 177-189)*

Dr Karen Bartholomew, Director of Health Outcomes – Auckland DHB and Waitematā DHB asked that the report be taken as read.

Acknowledgement was made of the women who had participated in the programme of work, the research team, providers across primary care and Māori, Pacific and Asian health advisors.

This programme of work was started to test the acceptability of self-testing in a New Zealand context. Specifically to test a new technology in addressing current long standing persistent inequities in cervical screening. It was known that new technologies could make inequities worse if a specific design for process and approach is not undertaken. It was wanted to ensure that new technology could improve the participation in cervical screening and that it was done so with a focus on Māori women first.

There was a commitment to a Kaupapa Māori evaluation of that work before it was proceeded with any other population groups and that was done with partners in the WaiHealth Waipereira Research Unit. It was hoped that the Programme would have national influence which it did attain with the Ministry this year agreeing to accept self-testing as part of the national programme when it is rolled out. The challenge when it is rolled out is that a new national register will be required. That is important for a number of reasons but particularly because the cervical screening programme is governed by its own legislation.

The following points were made during discussion:

It was commented that while universal support may have been gained the programme was still in a holding pattern awaiting a rollout date, funding and the fact that a National IT system was required for the screening programme. There are good lessons to be learned from Gisborne and the Cartwright Report when things are not done right and there is a need to be mindful of those.

It was noted that it would take a big commitment from central Government to move this forward. Karen Bartholomew agreed and acknowledged her colleague Professor Beverley Lawton from Victoria University who was a champion of self-testing and promoting it widely. She had just been awarded additional funding to undertake further work for Northland. There is a drive from a Māori health perspective to ensure that self-testing stays front and centre in discussions with the National Screening Unit.

Resolution:

That the Community and Public Health Advisory Committee note:

1. **That the two equity focused human papilloma virus (HPV) Self-Testing studies are now complete with results awaiting publication.**
2. **The HPV Self-Testing research programme has demonstrated that the approach is acceptable and will improve equity of access, including for those women who are most underserved in the current screening programme. This research aligns well with similar work undertaken by research colleagues in Northland District Health Board.**
3. **The Parliamentary Review Committee in 2018 strongly recommended that HPV Self-Testing alongside primary HPV screening is implemented with urgency in the New Zealand national cervical screening programme.**
4. **On the basis of the successful local research and the clear international evidence there is increasing support in metro Auckland for local implementation of HPV self-testing in ahead of national programme implementation to address low coverage and worsening inequities. The volume of deferred screens related to COVID-19 has provided further urgency. It is likely that the national implementation of a primary**

HPV programme will be further delayed; noting that supportive infrastructure such a new national cervical screening register is not yet in place.

Carried

10. RESOURCE CENTRE *(Pages 190-213)*

10.1 System Level Measures Improvement Plan 2020/2021

[Information material to be read in conjunction with the papers in the agenda.]

The meeting closed at 3.45pm with a Karakia led by Bernie O'Donnell.

Signed as a true and correct record of the Board meeting held on Wednesday, 18 November 2020

Chair: _____ Date: _____

Teulia Percival

Asian, New Migrant, Former Refugee & Current Asylum Seeker Health Plan 2020-2023

Waitematā and Auckland District Health Boards

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Waitematā District Health Board
Best Care for Everyone

Contents

Foreword

Auckland's population is growing and changing rapidly. More than 180 different ethnicities call this city their home with almost 40 per cent of Aucklanders born outside New Zealand.

The Asian population in particular has experienced rapid growth over the last two decades. Census 2018 data tells us that while there was an increase in the proportion of Asians living in every region in New Zealand, the biggest growth occurred in the metropolitan Auckland region. Over a quarter (28 per cent) of Auckland residents identified with an Asian ethnicity, and Auckland was home to almost two thirds (63 per cent) of all Asian peoples in New Zealand. Closer to home, Asian constitutes 23 per cent in Waitematā DHB and 35 per cent in Auckland DHB, with the greatest population increase principally first from China, India, and more recently the Philippines. Filipinos are now the third largest ethnic group in Auckland DHB and is projected to surpass the total Korean population in Waitematā DHB by the next Census.

Whilst the Asian population contributes a significant share to our districts' diversity, so to do other culturally and linguistically diverse communities such as those from Middle Eastern, Latin American, and African (MELAA) backgrounds. At the 2018 Census, there were 35,838 usual residents living in the metropolitan Auckland region, who identify within the broader MELAA category (2.3% of Auckland's population) – an increase of 10,893 people, or 43.7%, since the 2013 Census. The fastest population growth in the region was from the Latin American communities doubling in population size between 2013 and 2018 and most significantly in the Auckland DHB catchment.

As part of the many new migrants that have arrived in recent years, former refugees and current asylum seekers (and their families) have also made a significant contribution to our diversity. The New Zealand annual refugee quota programme will increase from 1,000 to 1,500 from July 2020 – we will continue to welcome and support those families who engage with our health services in both Waitematā and Auckland DHBs.

As this rapid growth of cultural and ethnic diversity has enriched our districts in a myriad of ways, it also highlights the unique health and wellbeing challenges some of our communities face. Overall the health outcomes of the Waitematā and Auckland DHBs' Asian population - when compared to New Zealand and overseas - are very good and in many areas Asian health status within the two DHBs would make us an international leader in achieving excellent health outcomes.

However, there are some ethnic groups who experience particularly specific health inequities and/or disparities that impact on their health outcomes. Such risk factors include settlement and/or resettlement determinants, equity of access to health services, early and timely access to and utilisation of culturally appropriate health services, burden of lifestyle-associated risk factors, language, and awareness of the health & disability system.

We are highly committed to achieving and maintaining equitable health outcomes for the multiple, varied population groups in Auckland as part of this three-year Health Plan, and look forward to working with our many partners who are passionate about ethnic health and wellbeing in this city.

Dr Dale Bramley,

Chief Executive Officer

Waitematā District Health Board

Introduction

New Zealand and specifically Auckland are experiencing a changing and increasing demography of our culturally and linguistically diverse (CALD) ethnic communities from Asian and Middle Eastern, Latin American and African (MELAA) backgrounds who are very diverse in language, culture, traditions and health needs. This Asian, New Migrant, Former Refugee and Current Asylum Seeker Health Plan 2020-2023 reflects the overarching Government theme 'Improving the well-being of New Zealanders and their families' and summarises collective business as usual initiatives across the "Funder" (Waitematā and Auckland District Health Boards (DHB)) and Waitematā DHB's Asian Health Services (AHS) provider arm that represents existing work specific to Asian, new migrant[1], former refugee[2], and current asylum seekers.

Although some Asian groups experience high life expectancy and overall good health status, there are health disparities experienced for priority Asian & MELAA groups that require targeted effort. The focus of the Plan aims to prioritise effort to:

- Improve health outcomes where there are health inequalities
- Increase equity of access to and utilisation of health services, and
- Continue to fund equity of access to primary healthcare services for former refugee and current asylum seeker background populations.

Our Focus

The Plan focuses on key health areas identified from: i) 2019 Health Needs Assessments (Waitematā[3] and Auckland[4] DHBs), ii) 2017 International Benchmarking of Asian Health Outcomes for Waitematā and Auckland DHBs report[5] (Appendices 1&2), iii) Asian, Migrant & Refugee Health Plan 2017-2019[6] (Waitematā and Auckland DHBs), iv) Consultation with the Metro Auckland Asian & MELAA Primary Care Service Improvement Group, v) Health service utilisation data, vi) Feedback from engagement with partners and stakeholders, and vi) Aligning to common Counties Manukau Health's population priorities for health equity. The following top four higher level areas for action in this Plan are:

i. **Capability and capacity building:** Granular data monitoring to level 4.
   - Making sure our data tells us about the subgroups we're interested in.

ii. **Access:** Equity of access and utilisation of healthcare services:
   - Awareness of the New Zealand Health & Disability System

[1] A new migrant for the purpose of this Plan is considered living in New Zealand less than 2 years.
[2] Information about refugee and protection. Accessible online from https://www.immigration.govt.nz/about-us/what-we-do/our-strategies-and-projects/supporting-refugees-and-asylum-seekers/refugee-and-protection-unit
[3] Accessible online from http://www.waitematadhb.govt.nz/assets/Documents/health-needs-assessments/Health-Needs-Assessment-Waitemata-DHB-2019.pdf
[4] Accessible online from https://adhb.health.nz/assets/Documents/About-Us/Planning-documents/ADHB-Health-Needs-Assessment-2017.pdf
[5] Accessible online from http://www.waitematadhb.govt.nz/dhb-planning/health-needs-assessments/international-benchmarking-of-asian-health-outcomes-for-waitemata-and-auckland-dhbs/
[6] Accessible online from www.waitematadhb.govt.nz/dhb-planning/health-plans/

- PHO enrolment (eligible new migrants, (**equity of access)** to former refugees, and babies at 3 months) and lower access to primary health services
- Better management of long term conditions (**equity of access**) to cardiovascular disease – Indian and South Asian; diabetes – Chinese, Indian and South East Asian (Filipino)
- Mental health and addictions (youth, (**equity of access)** to perinatal maternal mental health)
- Immunisations (HPV, 5 year event, Influenza over 65 years), and
- Preschool oral health (Chinese, Filipino and Middle Eastern).

iii. Health promotion/prevention including culturally tailored and/or targeted preventive healthy lifestyle activities.

iv. Adopting a partnerships approach to engage segments of the population i.e. students, former refugees and current asylum seekers in awareness raising of health services and health education; and collaborative work with Asian & MELAA ethnic consumers.

Strategic Approach

We will align our efforts in this Plan to national, regional and local directions (Appendix 3).

Governance

This Plan will be managed by the Asian, Migrant and Former Refugee Health Gain Manager, and overseen by the Asian & MELAA Health Governance Group (Waitematā and Auckland DHBs). Progress updates will be shared with the Community & Public Health Advisory Committee (CPHAC) and Auckland DHB Funder. A quarterly Asian scorecard (Appendix 4) will guide monitoring on progress of the key areas of focus where data is available. Successful implementation of the Plan will require collaboration across the three metropolitan DHBs (where appropriate), and the health and community sectors.

Limitations and Risks

There are limitations to this Plan largely due to the challenges when needing to plan in a fiscally constrained environment where funding must be applied to those populations with the greatest need – ie. Maori and Pacific in the first instance. This necessarily impacts on the activities chosen and the need to work innovatively and collaboratively to improve the health outcomes for 'targeted' Asian and MELAA groups and foreseeable risk factors such as a rapidly growing diverse population, ageing population, and waning 'healthy migrant effect'.

Te Tiriti o Waitangi

Waitematā and Auckland DHBs recognise and respect Te Tiriti o Waitangi as the founding document of New Zealand. Te Tiriti o Waitangi encapsulates the fundamental relationship between the Crown and Iwi. The four Articles of Te Tiriti o Waitangi provide a framework for Māori development, health and wellbeing by guaranteeing Māori a leading role in health sector decision making in a national, regional, and whānau/individual context. The New Zealand Public Health and Disability Act 2000 furthers this commitment to Māori health advancement by requiring DHBs to establish and maintain a responsiveness to Māori while developing, planning, managing and investing in services that do and could have a beneficial impact on Māori communicates.

Te Tiriti o Waitangi provides four domains under which Māori health priorities for Waitematā and Auckland DHBs can be established. The framework recognises that all activities have an obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities.

Article 1 – Kawanatanga (governance) is equated to health systems performance. That is, measures that provide some gauge of the DHBs' provision of structures and systems that are necessary to facilitate Māori health gain and reduce inequities. It provides for active partnerships with mana whenua at a governance level.

Article 2 – Tino Rangatiratanga (self-determination) is in this context concerned with opportunities for Māori leadership, engagement, and participation in relation to DHBs' activities.

Article 3 – Oritetanga (equity) is concerned with achieving health equity, and therefore with priorities that can be directly linked to reducing systematic inequities in determinants of health, health outcomes and health service utilisation.

Article 4 – Te Ritenga (right to beliefs and values) guarantees Māori the right to practice their own spiritual beliefs, rites and tikanga in any context they wish to do so. Therefore, the DHBs have a Tiriti obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities.

These guiding principles are applicable to our diverse Asian, new migrant, former refugee, current asylum seeker and international student communities as they contribute to cultural safety and in particular, their contribution to positive health outcomes and experience of care.

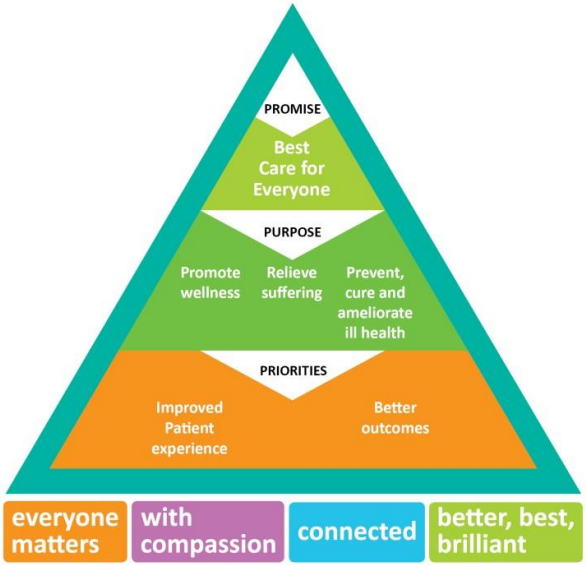
Our Decision Making Kaupapa

Waitematā DHB strategic direction

Best care for everyone

Our promise, purpose, priorities and values are the foundation for all we do as an organisation.

- Our **promise** is that we will deliver the **'best care for everyone'**. This means we strive to provide the best care possible to every single person and their family engaged with our services. We put patients first and are relentless in the pursuit of fundamental standards of care and ongoing improvements enhanced by clinical leadership.
- Our **purpose** defines what we strive to achieve, which is to:
  - Promote wellness
  - Prevent, cure and ameliorate ill health
  - Relieve suffering of those entrusted to our care.



- We have two **priorities**:
  - Better outcomes
  - Patient experience.

The way we plan and make decisions and deliver services on a daily basis is based on our **values** – **everyone matters; with compassion; better, best, brilliant** and **connected**. Our values shape our behaviour, how we measure and continue to improve.

To realise our promise of providing 'best care for everyone' we have identified seven **strategic themes** outlined below. These provide an overarching framework for the way our services will be planned, developed and delivered.

Auckland DHB strategy to 2023

Our **vision** is Kia kotahi te oranga mo te iti me te rahi o te hāpori - *Healthy Communities, World-class Healthcare, Achieved Together*. This means we are working to achieve the best outcomes for the populations we serve, people have rapid access to healthcare that is high quality and safe, and that we work as active partners across the whole system with staff, patients, whānau, iwi, communities, and other providers and agencies.

Our **purpose** is:

- Support our population to be well and healthy
- Manage within our means
- Put hauora for patients and their whānau at the heart of our transformation work
- Commission health and disability services across the whole system mai te whenua ki te whenua/ mō te katoa
- Provide specialist healthcare services to patients and whānau from the Northern Region, across districts, and New Zealand.

Our **strategic priorities** are:

- Te Tiriti o Waitangi in action
- Eliminate Inequity
- Digital transformation
- People, patients and whānau at the centre
- Resilient services.

Our **values** shape our behaviour and describe the internal culture that we strive for.

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

Our Partners

Waitematā and Auckland DHBs acknowledge that maintaining national and international leadership in Asian health requires strong collaborative partnerships. This means a committment to working with with and alongside communities, government agencies, Primary Health Organisations (PHO), Non-Governmental Organisations (NGO), health and social service providers, academia, institutes, associations, and settlement/resettlement agencies; and learning from our regional health colleagues across the Auckland region and nationally.

The Asian, migrant and former refugee health gain team are actively working with Counties Manukau Health and other regional Asian, migrant and former refugee health leaders to learn and share best practice and collaborate where we can to improve targeted disparities collectively. This includes coordinating and leading governance platforms such as the Asian & MELAA Health Governance Group (Waitematā and Auckland DHBs); Metro Auckland Asian & MELAA Primary Care Service Improvement Group; and contributions to other mainstream groups (where appropriate). We also lead and coordinate other key professional groups such as the Metro Auckland Regional Former Refugee Health Network Executive Group; and Metro Auckland PHO Former Refugee Services Operatonal Group.

The Asian Health Services (Waitematā DHB) continues to be an important local partner to support the health of Asian patients and their families within the Waitematā district provider arm services. We will work in partnership with the Asian Health Services.

A significant national service is the eCALD[7](Culturally and Linguistically Diverse) programme of courses and resources to support the health workforce to develop their cultural competence for working with CALD patients, clients, families and colleagues. We will cross-promote cultural competency courses to our health partners.

Engagement with interpreters services is key to enable access to essential language support to CALD patients who use DHB funded health services and primary health services. We will promote access to our in-house interpreter services.

Community engagement with Asian, migrant, former refugee, current asylum seeker and international student partners and communities is essential to enable them to participate in, or provide feedback on planning, policies and services is so that DHB activities are reflective of the community's ethnically and culturally diverse population. We will work with Waitematā DHB's Community Engagement Manager, and other DHB colleagues.

An overarching enabler is patient experience which aims to improve the care our population receives, engage people as partners in their care and provide services that are responsive to the individual and cultural needs of patients and their whānau. We will work with Waitematā DHB's Patient Experience Team, and support Auckland DHB's efforts for Asian and MELAA patients.

[7] Accessible online from http://www.ecald.com/

The People We Serve

‘Asian’ as defined in New Zealand

The New Zealand health and disability sector classifies ethnicity data according to the Ministry of Health protocols. The term ‘Asian’ used in the New Zealand Census and related data sets, refers to people with origins in the Asian continent, from China in the north to Indonesia in the south and from Afghanistan in the West to Japan in the East. This differs from the definition used in other countries such as the United Kingdom or the United States of America.

This definition includes over 40 sub-ethnicities and these communities have very different cultures and health needs. Reviewing health data using this broad ‘Asian’ classification is problematic if the health status of Chinese, Indian and Other Asian communities is averaged. The risk is that averaged results can appear ‘healthy’, but potentially masks true health disparities such as cardiovascular disease and diabetes in sub-ethnicity groups. Furthermore, many people classified as being ‘Asian’ do not identify with the term which may lead to under-utilisation of ‘Asian’ targeted services.

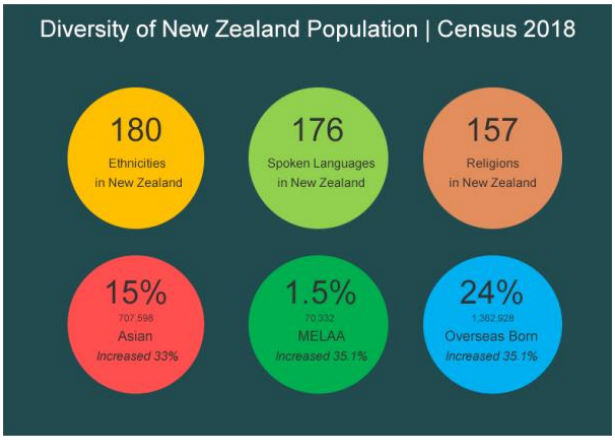
‘MELAA’ as defined in New Zealand

The Middle Eastern, Latin American and African (MELAA) populations ethnicity grouping consists of extremely diverse cultural, linguistic and religious groups. There are two key challenges for planners and funders of services to MELAA groups with respect to collecting and reporting ethnicity, 1. Reports only capture MELAA at level 1 ‘Other’ category, and 2. Reports capture MELAA as a single aggregated ethnic group output at level 2 category which is problematic to inform, plan, and monitor services that target the unique needs of the Middle Eastern, Latin American and African ethnic groups separately.

Changing Demography

Diversity of New Zealand population

Across New Zealand our diverse Asian and new migrant communities are growing faster than any other population group based on the Census 2018. The Asian population is the 3rd largest major ethnic group in New Zealand, making up 15% of the New Zealand population (707,598), which almost doubled in size since 2001.



Source: Ecald, Census 2018

Auckland and Waitematā

Asian

While there was an increase in the proportion of Asians living in every region in the Census 2018, the biggest growth occurred in the metro Auckland region. In 2018, the Asian population was made-up of 28% of the total population across the region and for Auckland and Waitematā Asian constitutes 35% (191,300) (Auckland DHB) and 23% (147,210) (Waitematā DHB)[8].

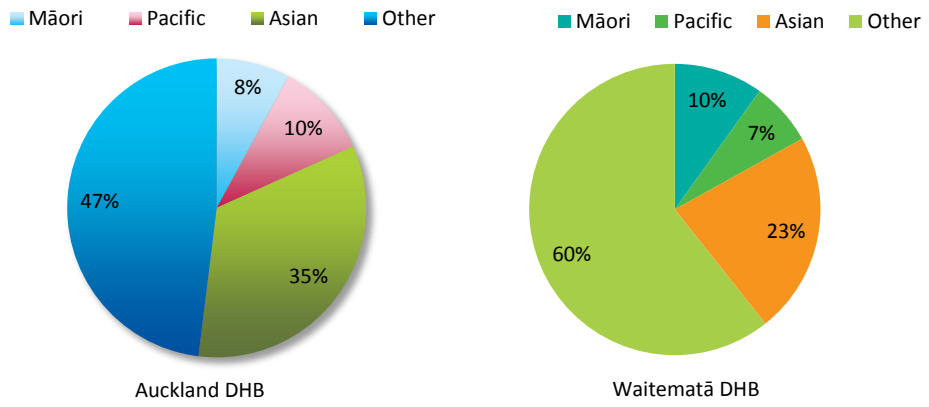


Figure 1: Ethnicity of Auckland DHB and Waitematā DHB populations, 2018/19
Source: Based on Census 2013, '2018 Update' by Stats NZ

Metro Auckland's population is growing and changing with more than 180 ethnicities living in the city, almost 40% of Aucklanders were not born in New Zealand. In the last 15 years the greatest increase of any ethnic group has been in those of Asian origin, principally first from China, India, then Korea, however more recently the Philippines with significant population growth in Waitematā DHB. Filipinos are the third largest ethnic group in Auckland DHB and will soon overtake Korean in Waitematā. The top five in-demand languages in both DHBs in 2018/19 are outlined in table 1. Access to language support and culturally appropriate information and services are key.

Table 1: Top five in-demand languages in Auckland DHB and Waitematā DHB, 2018/19

	Auckland DHB	%	Waitematā DHB	%
1	Mandarin	35	Mandarin	38
2	Cantonese	17	Korean	16
3	Tongan	8	Cantonese	10
4	Samoan	6	NZ Sign Language	5
5	Korean	5	Samoan	3

By 2025, Asian is expected to grow to make-up 38% (Auckland DHB) and 26% (Waitematā DHB) of the total population across the metro DHBs. Socio-demographic and health status information tells us that life in New Zealand is changing for these communities.

[8] Projected population by ethnicity (prioritised), 2019/20 financial year. Based on Census 2013, '2018 Update' by Stats NZ

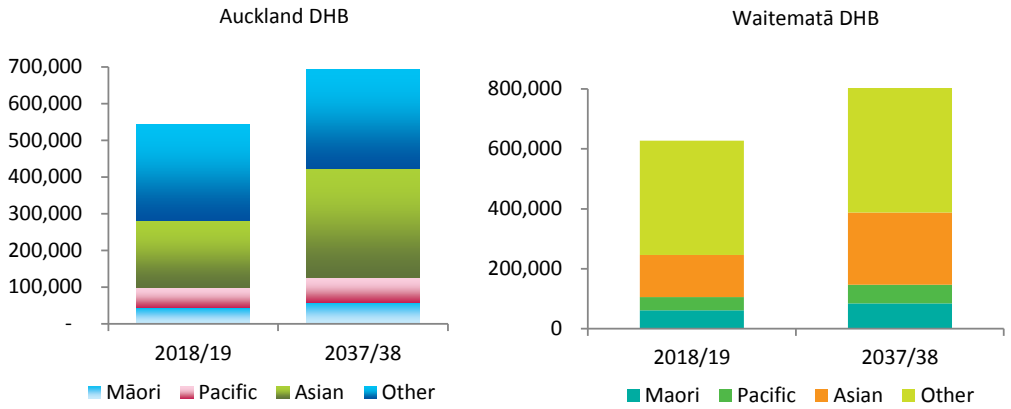


Figure 2: Projected change in Auckland DHB and Waitematā DHB populations by ethnicity, 2037/38
Source: Census 2013

Migrants

We know that New Zealand and Auckland are the destination of choice for many new migrants both permanent and temporary. Both Auckland and Waitematā DHBs have a large migrant population with Filipinos the fastest growing ethnic group. Two out of five (42%) Auckland and over a third (37%) Waitematā residents were born overseas (compared to 25% nationally). In Auckland, this includes 63,113 peoples of European/Other ethnicity, 23,486 Pacific peoples and 115,700 Asian peoples; as a percentage, 82% of Asian peoples, 45% of Pacific peoples and 27% of peoples of European/Other ethnicity. Of these migrants, 28% have lived in New Zealand less than 5 years. Census 2018 highlights that 70% of new migrants live in Auckland DHB.[9]

In Waitematā, this includes 104,077 peoples of European/Other ethnicity, 17,539 Pacific peoples and 87,356 Asian peoples; as a percentage, 81% of Asian peoples in Waitematā were born overseas, 43% of Pacific peoples and 29% of peoples of European/Other ethnicity. Of these migrants, 20% have lived in New Zealand less than 5 years.

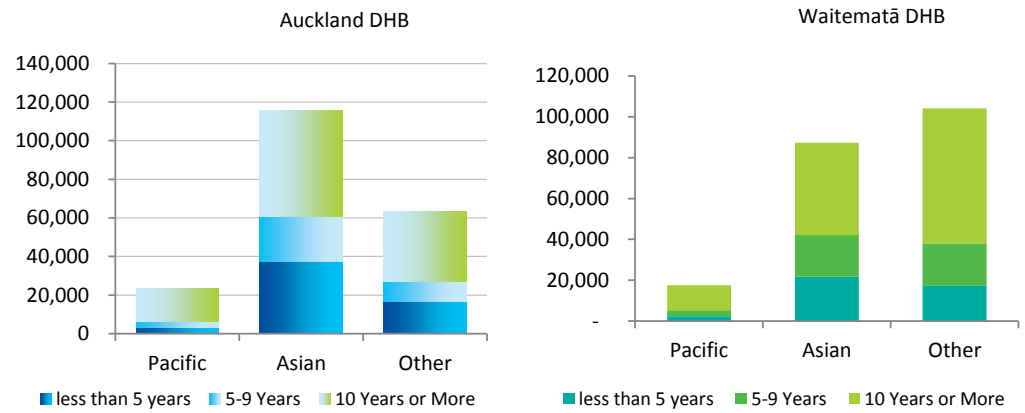


Figure 3: Number of migrants living in Auckland DHB and Waitematā DHB by duration of residence 2013
Source: Census 2013 Usually Resident population

[9] Census Usually Resident, CUR

Other than ethnic origins, the people grouped under the generic label of 'Asian' are very diverse in health status, health beliefs and practices, housing, geographical distribution, migration history, English language proficiency and socioeconomic status.[10]

These factors alongside available services and community networks impact how we monitor population health, design and deliver supporting health services. While the three metropolitan Auckland DHBs are committed to collaboration, each will need to complement these activities with a focus on specific health improvement actions that are specific to local population needs.

Former refugees and current asylum seekers

Conversely, although some ethnic groups may have arrived on these shores as a new migrant by 'choice', refugees and current asylum seekers (and their families) have come to New Zealand asking for refuge and protection.[11] Auckland has been home to former refugees from Africa, the Middle East and Asia since the 1980s. Former refugees have come from countries including Cambodia, Vietnam, Laos, Iraq, Iran, Somalia, Ethiopia, Eritrea, Rwanda, Burundi, Sudan, Sri Lanka, Congo, Afghanistan and Burma. More recently, there have been an increasing number of Quota refugees[12] who are Myanmarese (Rakhine, Chin, Kachin, Burmese, Karen, Mon, Karenni, Shan), African (Somali, Eritrean, Ethiopian) and Middle Eastern (Afghani and Persian) who have/are resettling in the Auckland region.

In September 2018, the New Zealand government announced the annual refugee quota would increase to 1,500 from July 2020. The delivery of government funded health services for quota refugees will change from 2020 as a result of this quota increase[13]. A national Quota Refugee Health Services Model will roll out across the country. Auckland and Waitematā DHBs are working closely with Immigration New Zealand (INZ) and Ministry of Health (MoH) to support the implementation of the onshore health services with a key focus on primary care as an enabling setting.

In 2018/19, there were 510 claims for refugee and/or protected person status with INZ's Refugee Status Unit - of which 153 asylum seeker[14] claims were approved largely from Asian and Middle Eastern countries (MBIE, 2019).[15]

Top five claims by nationality are:
1. China, 2. India, 3. Sri Lanka, 4. Iran, and 5. Saudi Arabia (Figure 4).[16]

[10] Suneela Mehta, *Health Needs Assessment of Asian people living in the Auckland Region* (Auckland: Northern DHB Support Agency, 2012).
[11] Lifeng Zhou and Samantha Bennett, *International Benchmarking of Asian Health Outcomes for Waitemata DHB and Auckland DHB*. (Auckland: Waitemata District Health Board, 2017).
[12] A person who has entered New Zealand under the United Nations High Commissioner for Refugees mandated quota system.
[13] The Refugee Quota Increase Programme (RQIP). Accessible online from https://www.immigration.govt.nz/about-us/what-we-do/our-strategies-and-projects/refugee-resettlement-strategy/rqip
[14] A current asylum-seeker is someone whose request for sanctuary has yet to be processed.
[15] There are over 500 claims for refugee and protected person status per year (INZ, 2019)
[16] Accessible online from https://www.immigration.govt.nz/documents/statistics/rsbrefugeeandprotectionstatpak.pdf

Top five approvals by nationality were:
1. China, 2. Iran, 3. Saudi Arabia, 4. Egypt, and 5. Russia.

Top five in-demand languages are:
1. Mandarin, 2. Arabic, 3.Spanish, 4.Dari/Farsi, and 5.Turkish.

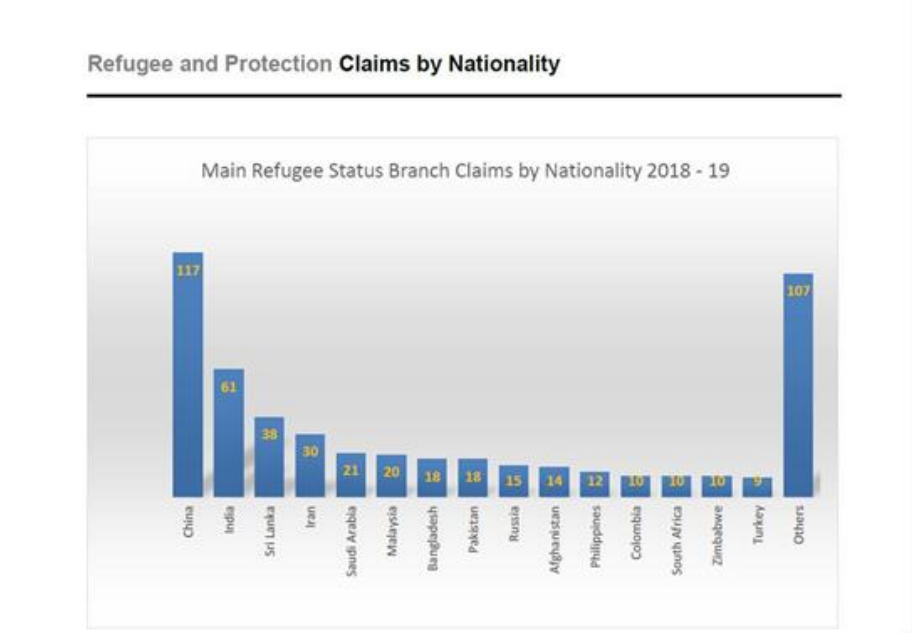


Figure 4: Main Refugee Status Branch Claims by Nationality, 2018/19
Source: Immigration New Zealand, 2019

From what is available, we know that former refugees and asylum seekers arrive with unique health care needs including: musculoskeletal and pain issues; poor oral health; longstanding undiagnosed chronic conditions; infectious diseases; neglected injuries; and mental health problems including Post-Traumatic Stress Disorder (PTSD); depression; and anxiety. Many conditions often require long term management and support at both a primary or secondary care level. Although, the health profile of an asylum seeker may vary from that of a former refugee individual, language support is a key enabler to positive health outcomes for these vulnerable groups.

Furthermore, individuals from transgender, non-binary and gender diverse backgrounds are among those who are seeking refugee and protection status, and require equitable access to primary care services in the first instance. The majority of claimants are living in the Auckland region and require early access to and utilisation of culturally appropriate health services in particular primary care, and language support.

International students

In 2018, our International student numbers reached 68,004 in Auckland (INZ & MOE, 2018). The majority of students live in the Auckland CBD and inner fringe suburbs close to city based institutes. A key outcome indicator within the New Zealand International Student Wellbeing Strategy aims to ensure that International students are aware of and can access effective and culturally appropriate healthcare.[17] Areas of concern for students include timely access to health services; mental health and wellbeing; and sexual and reproductive health.[18]

Middle Eastern, Latin American and African populations

According to Census 2018 (Census Usually Residents population, CUR) the MELAA populations was made up of 1.5% of the total population (70,332) in New Zealand, and were the fastest growing ethnic groups increasing by 35.1%. In the metro Auckland region, MELAA constitutes 2.2% of the total population[19] (Tables 2-4) and has increased 0.3% (10,950) between 2013 to 2018. The Middle Eastern population made up close to half of the MELAA group in the metro Auckland region followed by Latin American at over 30% then African over 20%, however the fastest population growth in the region was in the Latin American communities doubling in population size between 2013 (5,835) and 2018 (11,205) and most significantly in the Auckland DHB catchment.

Similar to Asians, MELAA face significant barriers to accessing health care. In addition, areas of focus to improve health outcomes are long term conditions e.g. CVD/Diabetes; oral health, women's health screening, prevention, and management programmes.

Table 2: MELAA Population by Ethnic Group, Metro Auckland Region, Census 2018 (total response ethnicity, CUR)

MELAA Ethnic Group	Total	%
Middle Eastern	17,103	47.5
African	7,794	21.6
Latin American	11,205	31.1
Total L2 MELAA Responses	35,946	100

Table 3: MELAA Population by Ethnic Group, Waitematā DHB, Census 2018 (total response ethnicity, CUR)

MELAA Ethnic Group	Total	%
Middle Eastern	6,375	48.9
African	2,706	20.7
Latin American	3,999	30.7
Total L2 MELAA Responses	13,023	100

Table 4: MELAA Population by Ethnic Group, Auckland DHB, Census 2018 (total response ethnicity, CUR)

MELAA Ethnic Group	Total	%
Middle Eastern	5,511	38.1
African	3,255	22.5
Latin American	5,763	39.8
Total L2 MELAA Responses	14,454	100

[17] Accessible online from https://education.govt.nz/assets/Documents/Ministry/Strategies-and-policies/internationlStudentWellbeingStrategyJune2017.pdf
[18] Student consultations as part of Auckland Agency Group
[19] Accessible online from https://knowledgeauckland.org.nz/media/1446/melaa-2018-census-info-sheet.pdf

Performance Expectations for 2020-2023

To identify key health inequities as a focus for health planning, we require a comparator population group that shows the **true story of inequities and inequalities**, i.e. what is the gap in health outcomes and scale of health gain we plan for? Waitematā and Auckland DHBs along with Counties Manukau Health have chosen the New Zealand 'European/Other' population as our health equity comparator group. For this reason, our baseline measures and related trend graphs in this Plan reflects this as our "local health equity target" in addition to the national targets reflecting government performance expectations. See appendix 5 for definitions of indicators/measures.

Health Priority Area	Indicators[20]	ADHB Baseline Data Total	ADHB Baseline Data European/ Other	ADHB Baseline Data Asian	WDHB Baseline Data Total	WDHB Baseline Data European/ Other	WDHB Baseline Data Asian	Target 2020-2023 Results
Mātua, Pēpi me Tamariki								
Immunisation	Percentage of babies are fully or exclusively breastfed at 3 months[21]	59%	69% (European)	62%	59%	69% (European)	61%	70%
	Percentage of pregnant women receiving pertussis vaccination in pregnancy	58%	61%	68%	54%	53%	66%	50%
	Percentage of five year olds will have their primary course of immunisation on time	88%	88%	90%	86%	83%	91%	95%
	Percentage of two year olds will have their primary course of immunisation on time	93%	92%	97%	91%	89%	96%	95%
	Percentage of eight month olds will have their primary course of immunisation on time	95%	96%	97%	93%	90%	98%	95%
	Percentage of eligible girls fully immunised with HPV vaccine	75%	83%	63%	57%	54%	63%	75%
Oral Health	Percentage of children aged birth – 4 years enrolled in DHB-funded Community Oral Health Services[21]	91%	111%	82%	95%	106%	95%	95%

[20] Data is Q1 2019/20 unless otherwise stated.
[21] June 2019.

Health Priority Area	Indicators[20]	ADHB Baseline Data Total	ADHB Baseline Data European/ Other	ADHB Baseline Data Asian	WDHB Baseline Data Total	WDHB Baseline Data European/ Other	WDHB Baseline Data Asian	Target 2020-2023 Results
	Percentage of children aged 5 years who are caries free – Asian Ethnicity[22]	58%	81% (European) 45% (MELAA) 55% (African) 65% (Latin American) 44% (Mid-Eastern)	55% (Asian Overall) 52% (Chinese) 61% (Indian) 54% (SE Asian) 59% (Other Asian)	58%	77% (European) 63% (MELAA) 62% (African) 58% (Latin American) 29% (Mid-Eastern)	47% (Asian Overall) 44% (Chinese) 59% (Indian) 38% (SE Asian) 46% (Other Asian)	ADHB 61% WDHB 67%
	Average number of DMFT at year 8 – L1 and L2 Asian and MELAA Ethnicity	0.63	0.36 (European) 0.80 (MELAA Overall) 0.69 (African) 0.74 (Latin American) 0.93 (Mid-Eastern)	0.59 (Asian Overall) 0.58 (Chinese) 0.50 (Indian) 1.08 (Southeast Asian) 0.52 (Other Asian)	0.61	0.49 (European) 1.09 (MELAA Overall) 1.12 (African) 0.39 (Latin American) 1.33 (Mid-Eastern)	0.63 (Asian Overall) 0.67 (Chinese) 0.5 (Indian) 0.83 (Southeast Asian) 0.57 (Other Asian)	ADHB <0.65 WDHB <0.59 at year 8
Rangatahi								
Youth Health	Chlamydia test rate of the youth aged 15-24 years[23]	11.3%	27.4 (Females) 7.7 (Males)	8.1 (Females 1.6 (Males)%	12.4%	25.1% (Females) 5.8% (Males)	10.7% (Females) 1.7% (Males)	6%
	Baseline self-harm hospitalisations (10-24 years) (Rate per 100,000 population)	412	448	202	493	553	158	-
Mātua me Whānau								
Cardiovascular Disease[24][25]	Percentage of eligible population who have had their cardiovascular risk assessed in the last five years	93%	94%	92% (Asian) 92% (Indian)	84%	87%	64% (Asian) 90% (Indian)	90%

[22] Dec 2019. Results for this measure will likely continue to deteriorate as ARDS recently changed their recall timeframe for children with caries, who will be seen more often (6-monthly) than those who are caries free (18-monthly).
[23] Q2 2019.
[24] No data going forward.
[25] To align with 2018 Ministry of Health Cardiovascular Disease Risk Assessment and Management for Primary Care Guidelines, South-Asians include: Indian, including Fijian Indian, Sri Lankan, Afghani, Bangladeshi, Nepalese, Pakistani and Tibetan.

Health Priority Area	Indicators[20]	ADHB Baseline Data Total	ADHB Baseline Data European/ Other	ADHB Baseline Data Asian	WDHB Baseline Data Total	WDHB Baseline Data European/ Other	WDHB Baseline Data Asian	Target 2020-2023 Results
	CVD Secondary Prevention: Percentage of enrolled patients with known cardiovascular disease who are on triple therapy (Statin + BP lowering agent + Antiplatelet/Anticoagulant)[26]	62%	61%	62% (Asian NFD) 57% (Chinese) 70% (Indian) 62% (Other Asian) 56% (South East Asian)	61%	61%	59% (Asian NFD) 55% (Chinese) 65% (Indian) 57% (Other Asian) 64% (South East Asian)	70%
	CVD Primary Prevention: Percentage of enrolled patients with cardiovascular risk ever recorded >20%, (aged 35 to 74 years, excluding those with a previous CVD event) who are on dual therapy (statin + BP Lowering agent)[26]	48%	44%	39% (Asian NFD) 43% (Chinese) 54% (Indian) 50% (Other Asian) 68% (South East Asian)	46%	45%	44% (Asian NFD) 34% (Chinese) 48% (Indian) 33% (Other Asian) 55% (South East Asian)	70%
Diabetes	HbA1c Glycaemic control: Percentage of eligible population with HbA1c ≤ 64mmol/mol recorded in the last 15 months (based on PHO enrolled numerator and denominator)[26]	60%	65%	75% (Asian NFD) 75% (Chinese) 67% (Indian) 69% (Other Asian) 67% (South East Asian)	61%	64%	58% (Asian NFD) 73% (Chinese) 65% (Indian) 68% (Other Asian) 65% (South East Asian)	80%
	Blood pressure control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) whose latest systolic blood pressure recorded in the last 15 months is <140mmHg[26]	65%	64%	73% (Asian NFD) 71% (Chinese) 68% (Indian) 68% (Other Asian) 72% (South	62%	62%	54% (Asian NFD) 65% (Chinese) 65% (Indian) 71% (Other Asian) 78% (South	80%

[26] July 2019 (Metro Auckland data).

Health Priority Area	Indicators[20]	ADHB Baseline Data Total	ADHB Baseline Data European/ Other	ADHB Baseline Data Asian	WDHB Baseline Data Total	WDHB Baseline Data European/ Other	WDHB Baseline Data Asian	Target 2020-2023 Results
				East Asian)			East Asian)	
	Management of Microalbuminuria: Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have microalbuminuria in the last 18 months and are on an ACE inhibitor or Angiotensin Receptor Blocker [26]	72%	75%	74% (Asian NFD) 55% (Chinese) 71% (Indian) 71% (Other Asian) 77% (South East Asian)	76%	78%	85% (Asian NFD) 61% (Chinese) 77% (Indian) 71% (Other Asian) 78% (South East Asian)	90%
Cancer	Percentage of women aged 25–69 years who have had a cervical screening event in the past 36 months (Statistics NZ Census projection adjusted for prevalence of hysterectomies)[27]	62%	74%	50%	70%	72%	69%	80%
Immunisation	Percentage of people aged over 65 years receive free flu vaccinations	52%	51%	58%	51%	51%	53%	75%
	Respiratory infection hospitalisation rate, over 65 years (Rate per 100,000)[28]	1,897	1,665	1,364	12,072	1,994	942	-
Self harm and suicide	Decrease in Asian deaths coded as suicides (Ministry of Health) and provisional suicides (Ministry of Justice), by age[29]	40	23	7	51	36	6	-
	Self-harm hospitalisations 65 years and over by ethnicity (Rate per 100,000 population)	89	88	69	67	68	70	-

8.3

[27] Sep 2019.

[28] Respiratory infection hospitalisation rate (per 100,000) by prioritised ethnicity, 65+ yrs, combined females and males, Waitematā and Auckland DHBs, 2018/19.

[29] Annual data from the National Mortality Collection 2016. Numbers may differ from preliminary Coroner reports.

Health Priority Area	Indicators[20]	ADHB Baseline Data Total	ADHB Baseline Data European/ Other	ADHB Baseline Data Asian	WDHB Baseline Data Total	WDHB Baseline Data European/ Other	WDHB Baseline Data Asian	Target 2020-2023 Results
Rōhe o Waitematā me Auckland								
Access To Care	Percentage of the population enrolled in a PHO[30]	83%	90%	71%	92%	93%	94%	95%
	98% of newborns are enrolled with a PHO, general practice by 3 months of age	93%	100%	93%	92%	100%	94%	98%
Patient Experience	Percentage of Asians and MELAA[31] rating overall care as 'Very Good' or 'Excellent' in the ADHB Inpatient and Outpatient surveys	**Inpatient** 85%	**Inpatient** 86% (European /Other)	**Inpatient** 82% (Asian) 84% (Chinese) 78% (Indian)	-	-	-	90%
	Net promoter score on WDHB Friends and Family Test for Asians rating 'extremely likely' to 'recommend our ward to friends and family if they need similar care or treatment'[31]	-	-	-	77	79	85 (Asian) 83 (Chinese) 87 (Indian)	65

[30] Sep 2019.
[31] Annual data 2018/19.

Mātua, Pēpi me Tamariki - Parents, Infants and Children

Good child health is important not only for children and family now, but also for good health later in adulthood. A number of the risk factors for many adult diseases such as diabetes, heart disease and some mental health conditions such as depression arise in childhood. In addition, child health, development and wellbeing have broader effects on educational achievement, violence, crime and unemployment. In 2020-2023, our action focus for Asian & MELAA infants, children and family is on **breast feeding, immunisation (human papillomavirus), healthy weight and good oral health.**

Breastfeeding

Why is this a priority?

Research shows that children who are exclusively breastfed for the early months of life are less likely to suffer adverse effects from childhood illnesses such as respiratory tract infections, gastroenteritis, otitis media, etc. Breastfeeding benefits the health of mother and baby, as well as reducing the risk of Sudden Unexpected Death in Infancy (SUDI), asthma, diabetes and obesity.

Where do we want to get to?

- 70% of Asian babies are fully or exclusively breastfed at 3 months.

DHB	European/Other	Asian*	Target
ADHB	69%	62%	70%
WDHB	69%	61%	70%

**Q4 2018/19. Plunket data only.*

What are we trying to do?

Maintain the number of exclusively or fully breastfed Asian & MELAA babies at 3 months of age.

To achieve this we will focus on:

Continue to promote breastfeeding information and support for Asian & MELAA women.

Who will we work with?

Women, Child and Youth team, Well Child Tamariki Ora (WCTO) Providers, Health Babies Healthy Futures (Asian providers), Asian NGOs, midwives, and ethnic partners/communities.

DHB	What are we going to do?	Measures
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Continue to support the Healthy Babies Healthy Futures programme which targets Asian mothers to support them to exclusively breastfeed their babies for the first six months: - Promote the benefits of breastfeeding to 6 months and beyond.	70% of babies are fully or exclusively breastfed at 3 months. Coverage rates for Asian equal to European/Other. 95% of Asian and MELAA infants receive all core WCTO contacts in the first year of life.
	YR 1-YR 3 (Q1-Q4): Support the Metro-Auckland Healthy Weight Action Plan for Children 2017-2020.	
	YR 1-YR 3 (Q1-Q4): Support the development and promotion of breast feeding resources to Asian and MELAA communities.	
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.	

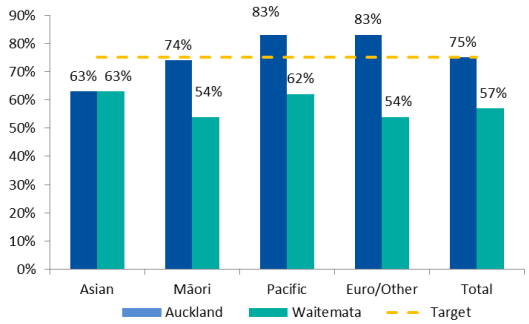
Immunisation - Children

What are we trying to do?

We want up-to-date immunisations for pregnant women and children up to five years. We want MELAA (and Asian) girls and women to be protected against cervical cancer. Screening and immunisation together will offer the most effective protection.

Where are we at and where do we want to get to?

75% of eligible Asian girls are fully immunised with HPV vaccine



** All coverage as at Sep 2019*

Source: MoH Quarterly NIR Report.

Why is this a priority?

Cervical cancer is caused by certain types of HPV.[32] There is no treatment for persistent HPV infections but immunisation is now available to help protect young women against the two common types of high-risk HPV that cause up to 70 percent of cervical cancer.

To achieve this we will focus on:

Ensure MELAA (and Asian) girls and boys (and their families) are aware of availability of the HPV vaccine to support improved uptake of the vaccine.

Who will we work with?

Women, Child and Youth teams, Metro Auckland Asian & MELAA Primary Care Service Improvement Group, WCTO Providers, schools, Asian NGOs, and ethnic partners/communities.

DHB	What are we going to do?	Measures
Auckland/ Waitematā/ Counties Manukau	YR 1-YR 3 (Q1-Q4): Develop and implement the Metro Auckland Asian & MELAA Primary Care Health Action Plan 2020-2023 to engage PHOs and institutes in opportunistic promotion of the HPV vaccination with focus on 'Other' – MELAA groups.	75% of eligible Asian & 'Other' girls are fully immunised with HPV vaccine
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Ensure promotional materials (in priority Asian & MELAA languages) developed by the Ministry of Health are available for the Asian & MELAA communities and promoted in localities where high number of MELAA (and Asian) peoples live.	
	YR 1-YR 2 (Q1-Q4): Explore parent attitudes towards the HPV vaccination for boys and girls amongst African and Middle Eastern groups.	1 report
	YR 1-YR 3 (Q1-Q4): Promote immunisations including five year old event and the pertussis vaccination in pregnancy to Asian & MELAA partners and communities: • Active promotion of culturally appropriate messaging within high enrolled Asian and former refugee general practices • Leveraging on ethnic partner's cultural events, outreach and communication platforms to promote culturally appropriate messaging.	50% of pregnant women receiving pertussis vaccination in pregnancy 95% of eight month olds, two year olds and five year olds will have their

[32] HPV stands for human papillomavirus, a group of very common viruses that infect about four out of five people at some time in their lives. HPV causes cells to grow abnormally, and over time, these abnormalities can lead to cancer.

		primary course of immunisation on time
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.	

Oral Health

Why is this a priority?

Good oral health practices in the first five years of a child's life are critical for lifelong oral health. Early childhood caries or dental decay remains the most prevalent chronic and irreversible disease in the western world.

In New Zealand, disparities still exist in oral health by ethnicity, deprivation level, and age group. This is evident where South East Asian e.g. Filipino and Chinese children have higher rates of caries and decayed, missing and filled teeth (dmft) at age of 8 years among Asian in both districts. Indian had the best oral health outcomes of all the Asian subgroups in both districts.

For MELAA groups, Latin American have the best oral health outcomes for both dmft and caries free as compared to African and Middle Eastern groups across both districts.

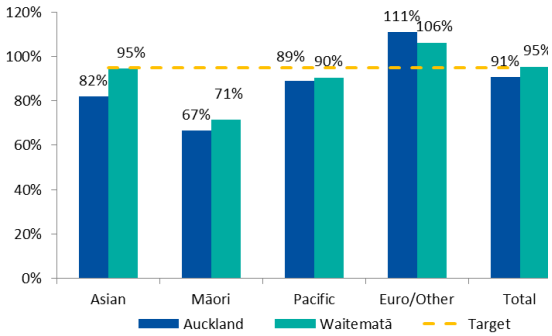
Prevention of oral disease in infants and pre-schoolers reduces the risk of dental, gingival and periodontal disease in permanent teeth and will have positive impact on their long term oral health, general health and well-being.

What are we trying to do?

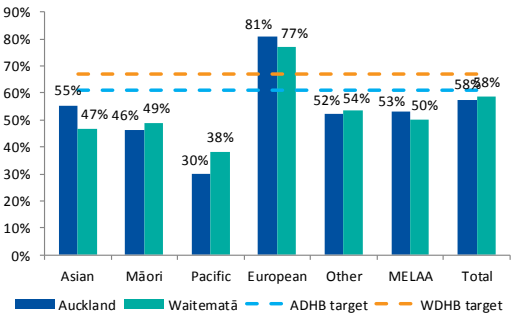
Enable access to health care to reduce inequalities in oral health status for Filipino, Chinese, and Middle Eastern children. This work will also contribute to the Metro-Auckland Healthy Weight Action Plan for Children 2017-2020.

Where are we at and where do we want to get to?

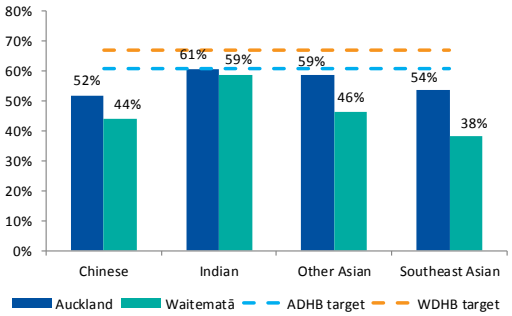
95% of 0-4 year old Asian children enrolled with pre-school oral health services



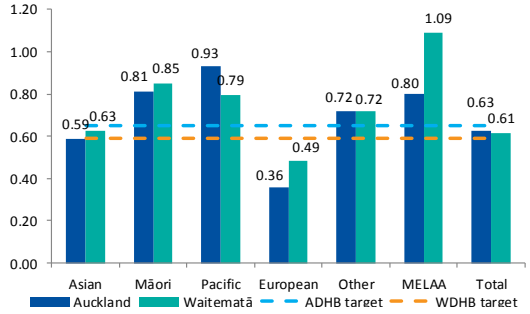
Children caries free at age of 5 years, 2019 – L1 Ethnicity



Children caries free at age of 5 years, 2019 – L2 Asian Ethnicity



Average number of dmft at year 8, 2019 – L1 Ethnicity



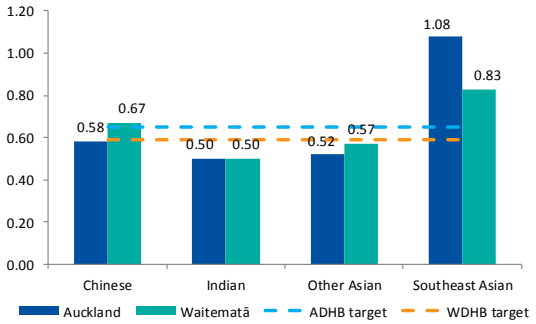
To achieve this we will focus on:

Support the implementation of the Preschool Oral Health Action Plan for Metropolitan Auckland region, and promote oral health messaging to targeted ethnic communities.

Who will we work with?

Auckland Regional Dental Services (ARDS), Women, Child and Youth team, WCTO providers, midwives, Asian NGOs, and ethnic partners/communities.

Average number of dmft at year 8, 2019 – L2 Asian Ethnicity



**All coverage as at June 2019*

DHB	What are we going to do?	Measures
Auckland/ Waitematā	YR 1-YR 3 (Q1-4): Support Asian & MELAA implementation of the: • Preschool Oral Health Action Plan for Metropolitan Auckland region • Metro-Auckland Healthy Weight Action Plan for Children 2017-2020	95% of pre-schoolers enrolled in DHB oral health services 61% (ADHB) and 67% (WDHB) children caries free at the age of 5 years – L2 Asian and Other Ethnicity Average number of dmft at year 8 <0.65 ADHB and <0.59 WDHB – L2 Asian and Other Ethnicity
	YR 1 (Q1-Q4): Publish the study findings from the *Investigating Chinese, Indian, Filipino and Middle Eastern parents' and caregivers' knowledge, attitudes and behaviours towards their child's healthy eating and oral health*	
Auckland/ Waitematā /Counties Manukau	YR 1-3 (Q1-Q4): Work with ARDS to develop or redesign culturally tailored oral health and healthy eating information for Filipino, Chinese and Middle Eastern groups.	
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Engage with ethnic partners and communities to promote culturally appropriate oral health messaging to Indian, Filipino, Chinese and Middle Eastern parents/caregivers and children.	
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.	

Rangatahi – Young People

Good health enables young people to succeed in their studies, opportunities to achieve their dreams and aspirations, and to make meaningful contributions to their families and communities. We are committed to supporting young people living in Waitematā and Auckland DHBs to be healthy, feeling safe and supported. In 2020-2023, our action focus for Asian, new migrant and former refugee young people is on **supporting youth access to - and utilisation of - youth appropriate health services** as part of the System Level Measures Improvement Plan, and other initiatives.

Mental Health & Addictions

Why is this priority?

Findings from the Suicide Mortality Review Committee's *Understanding deaths by suicide in the Asian population of Aotearoa New Zealand report* highlights that suicide is increasing for Asian peoples in Aotearoa New Zealand combined with challenges of their integration and settlement in this country, has implications for social services and the mental health system. The rate of Asian suicide fluctuates but has been slowly rising, from 5.93 per 100,000 in 2007/08 to a high of 8.69 in 2017/18; in 2018/19 the rate was 7.63[33]. Asian self-harm hospitalisations rates (10-24 years) have increased in 2017 (168) and 2018 (202) in Auckland DHB.

Table 5: Self-harm hospitalisations (10-24 years) (Rate per 100,000 population), Auckland and Waitematā DHBs, 2018

Self-harm hospitalisations (10-24 years) (Rate per 100,000 population)						
	ADHB Total	**ADHB Eur/Other**	**ADHB Asian**	**WDHB Total**	**WDHB Eur/Other**	**WDHB Asian**
Rate	412	448	202	493	553	158
Events Number	466	213	77	599	370	39

Those Asian youth are experiencing high rates of mental distress and late presentation for treatment due to a number of factors[3435] such as:

- socio-cultural and familial factors
- stigma and shame to ask for help
- ability to recognise the signs or symptoms of mental distress
- lack of awareness of the health and disability system and not knowing how to access services
- cultural barriers and the need for culturally appropriate services, and
- institutional racism and discrimination, and mental health.

We know that accessing services later can be attributed to level of acculturation and years lived in New Zealand.[36] Edgewalking, substance abuse, discrimination, family pressures about education/study are cited by former refugee youth as reasons for their mental health concerns.

[33] Accessible online from https://www.hqsc.govt.nz/assets/SUMRC/PR/Understanding-deaths-by-suicide-Asian-population.pdf

[34] Accessible online from https://www.asianfamilyservices.nz/uploads/7/5/0/8/75085209/korean_suicide_prevention_resources_development_v8_final_2.pdf

[35] Waitematā DHB, 2019. Asian Youth Suicide Prevention Project #WannaTalk- Asian Youth Life Skills Workshop Evaluation Report.

What are we trying to do?
Reduce self-harm and interpersonal violence amongst Asian & former refugee youth (15-24 years old), and improve their wellbeing through earlier intervention and access to integrated culturally appropriate mental health and additions (MH&A) care.

To achieve this we will focus on:
Support the roll out of the Integrated primary mental health and addiction service, System Level Measures Improvement Plan, and other ethnic targeted initiatives so that young people experience less mental distress and disorder, and are supported in times of need.

Who will we work with?
Northern Regional Alliance, Mental Health & Addictions team, Primary Care team, Asian Health Services (Waitematā DHB), Asian Mental Health Services teams (Waitematā and Auckland DHBs), Metro Auckland Asian & MELAA Primary Care Service Improvement Group, NGO Mental Health Providers, Refugees As Survivors New Zealand, Asylum Seeker Service Trust, Asian NGOs, Auckland Agency Group, Rainbow health services/partners, institutes, student associations, youth agencies, and ethnic partners/communities.

<table>
<tr><th>DHB</th><th>What are we going to do?</th><th>Measures</th></tr>
<tr><td>Auckland/
Waitematā/
Counties Manukau</td><td>YR 1-YR 3 (Q1-Q4): Work with the Metro Auckland Asian & MELAA Primary Care Service Improvement Group to support the:
Roll out of the Integrated primary mental health and addiction service to ensure the initiatives are culturally appropriate.</td><td rowspan="2">Baseline self-harm hospitalisations (10-24 years)

Reduction in suicide rates across ‘at risk’ populations including Asian youth</td></tr>
<tr><td>Auckland/
Waitematā</td><td>YR 1-YR 3 (Q1-Q4): Support the youth-specific actions of the:
Every Life Matters - He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029
Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand
Waitematā and Auckland DHB Suicide Prevention and Postvention Action Plan 2020-2023.
Raise awareness of the cultural barriers and nuances that influence low uptake of youth-based mental health services.</td></tr>
<tr><td>Auckland/
Waitematā/
Counties Manukau</td><td>YR 1-YR 3 (Q1-Q4): Support the Auckland Agency Group to provide guidance, from an Auckland perspective, for health initiatives which support achievement of the outcomes of the International Education Strategy regarding international student experience and wellbeing.</td><td></td></tr>
<tr><td>Auckland/
Waitematā</td><td colspan="2">Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.</td></tr>
</table>

[36] Accessible online from https://www.hqsc.govt.nz/assets/SUMRC/PR/Understanding-deaths-by-suicide-Asian-population.pdf

Sexual and Reproductive Health

Why is this priority?
Sexual and reproductive health is a taboo subject among many Asian cultures. Religious, cultural, financial, language, embarrassment, stigma, shame, confidentiality issues and lack of health education are often barriers preventing Asian young peoples accessing sexual and reproductive health services. These issues extend out to gender identity and transgender needs for young people who are more likely to have limited family understanding and support for their needs.

In relation to international students, host countries have a degree of pastoral responsibility to their students. It is well documented that international students have a higher need for mental health and sexual health due to the change in environment and the limited exposure some students have to sex and relationship education in their country of origin. To compound this issue, travel and medical insurance products to international students - in relation to coverage for sexually transmitted infections (STI) testing and treatment in general practice - is limited. This results in the underutilisation and late access to treatment.[37]

What are we trying to do?
Young people are less likely to see a family doctor (GP) each year than older adults. Promote opportunistic preventive care at every family doctor (GP) visit and STI testing in sexually active young people, irrespective of symptoms in settings such as universities.

To achieve this we will focus on:
Support monitoring of trends in STIs such as chlamydia, gonorrhoea, syphilis and HIV. Work with partners to support gender diverse youth and families through a Community Engagement approach. We hope to increase understanding within these communities of the needs of young people and to reduce the social stigma and isolation experienced by them.

Who will we work with?
Auckland DHB's Transgender Health Worker, Primary Care team, Auckland Sexual health Services Metro Auckland Asian & MELAA Primary Care Service Improvement Group, Auckland Agency Group, Asian NGOs, Body Positive, NZ Aids Foundation, Rainbow Youth, Transgender groups and networks, student associations, institutes, youth agencies, and ethnic partners/communities.

DHB	What are we going to do?
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Monitor STI trends for Asian (and if possible by visa/immigration status) via: • Syphilis Weekly IMT Report • ESR STI Surveillance Dashboard[38]
	YR 1-YR 3 (Q1-Q4): Support engagement with Auckland DHB's Transgender Health Worker, and Transgender groups and

[37] Accessible online from https://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services/guide-eligibility-publicly-funded-health-services/eligibility-limited-range-publicly-funded-health-services-0/people-receiving-treatment-infectious-diseases
[38] Accessible online from https://www.esr.cri.nz/our-services/consultancy/public-health/sti/

DHB	What are we going to do?
	networks.
	YR 1-YR 3 (Q1-Q4): Support the Auckland Agency Group to provide guidance, from an Auckland perspective, for health initiatives which support achievement of the outcomes of the International Education Strategy regarding international student experience and wellbeing.
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.

Mātua me Whānau– Adults and Family Group

Adults and older people face different health issues than younger people. Diabetes, heart disease, cancer, and mental health and addictions are some of the conditions adults experienced. We are committed to supporting adults and older people living in our districts to be healthy, and managing their health conditions well. This supports them to look after their loved ones, enjoy lives with them, succeed in careers, and see their grandchildren grow up. In 2020-2023, our action focus for Asian & MELAA adults and their families is on **cardiovascular disease management, diabetes management, mental health and addictions, health of older people and immunisation (over 65 years).**

Long Term Conditions – Cardiovascular Disease and Diabetes

Why is this a priority?

Equity of health outcomes and improved health outcomes for people with diabetes including Asian is a priority for the Diabetes Service Level Alliance.

Cardiovascular disease is one of the leading causes of death among Asian peoples. In particular, Indian people have a higher prevalence of risk factors associated with CVD, and Indian aged 35 to 74 years had higher CVD hospitalisation rates as compared to the European/Other group in Auckland and Waitematā DHBs.[39]

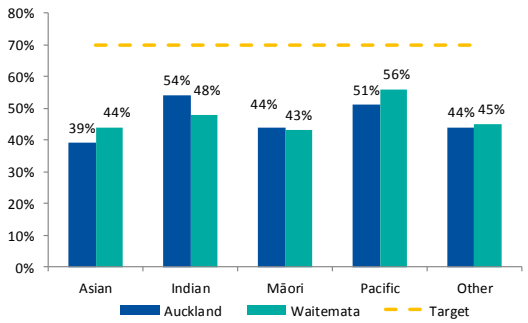
Maintaining the number of eligible Indians who receive a CVDRA, improving management for Indian with CVD and diabetes management for Other Asian and South East Asian are areas of focus in this Plan.

What are we trying to do?

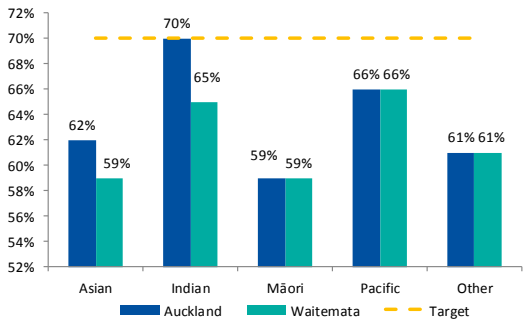
Reduce cardiovascular disease related morbidity and mortality among Indian people via improved access to quality cardiovascular and diabetes care. Improve diabetes management for Other Asian and South East Asian.

Where are we at and where do we want to get to?

CVD Primary Prevention: Percentage of enrolled patients with cardiovascular risk ever recorded >20%, (aged 35 to 74 years, excluding those with a previous CVD event) who are on dual therapy (statin + BP Lowering agent)



CVD Secondary Prevention: Percentage of enrolled patients with known cardiovascular disease who are on triple therapy (Statin + BP lowering agent + Antiplatelet/Anticoagulant)



**All coverage as at July 2019 (prescribed)*

[39] Mehta S, Health needs assessment of Asian people living in the Auckland region. Auckland: Northern DHB Support Agency, 2012.

To achieve this we will focus on:

The Auckland and Waitematā DHBs have an established Alliance agreement with the PHOs across both districts and the two Memorandum of Understanding partners. Diabetes and cardiovascular disease have been identified by the Alliance Leadership Team as the priority areas in the Alliance Work Plan.

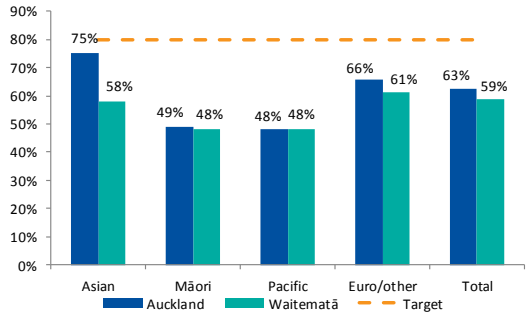
Cardiovascular disease management includes both secondary prevention (active triple therapy prescription in the past 6 months to patients who have had a CVD event – excluding haemorrhagic stroke) and primary prevention (prescribed dual therapy in the past 6 months to patients aged 35 – 74 years with a CVD risk score > 20%). Supporting the Transforming Diabetes Care Roadmap 2018 with the aim of equity of health outcomes and improved health outcomes for people with diabetes.

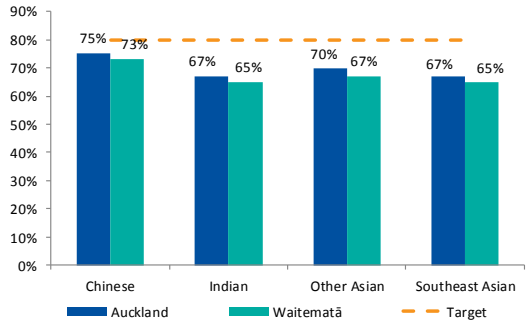
Who will we work with?

Northern Regional Alliance, Primary Care team, Metro Auckland Asian & MELAA Primary Care Service Improvement Group, Asian Health Services (Waitematā DHB), Asian NGOs, Green Prescription providers, and ethnic partners/communities.

Where are we at and where do we want to get to?

HbA1c Glycaemic control: Percentage of eligible population with HbA1c ⩽ 64mmol/mol recorded in the last 15 months (based on PHO enrolled numerator and denominator) 29





All coverage as at July 2019 (prescribed)

DHB	What are we going to do?	Measures
Auckland/ Waitematā	YR 1-YR 3 (Q1-4): Improve Heart Health: • Continue to perform CVDRA checks with eligible South-Asian[40] and Asian groups. • Implementation of updated CVDRA guidelines to ensure best practice, including lifestyle and exercise guidance.	90% CVDRA coverage for South-Asian and Asian 70% of CVD patients on triple therapy 70% of CVD risk patients on dual therapy
	YR 1-YR 3 (Q1-4): Support the Transforming Diabetes Care Roadmap 2018:	1 report

[40] To align with 2018 Ministry of Health Cardiovascular Disease Risk Assessment and Management for Primary Care Guidelines, South-Asians include: Indian, including Fijian Indian, Sri Lankan, Afghani, Bangladeshi, Nepalese, Pakistani and Tibetan. -Eligible age range change for Maori, Pacific or South Asian peoples: Men - Age 30 yrs (previously 35 yrs); Women – Age 40 yrs (previously 45 yrs)

DHB	What are we going to do?	Measures
	• Coordinate and facilitate one Asian focus group to better understand the experiences of people who live with Type 2 Diabetes.	80% of diabetes patients have good HbA1c glycaemic control 80% of diabetes patients have good blood pressure control 90% of diabetes patients with microalbuminuria are under management
	YR 1-YR 3 (Q1-4): Support the recommendations from the retinal screening review consistently across Auckland and Waitemata DHBs.	
	YR 1-YR 3 (Q1-4): Support the implementation of the Metro Auckland Foot Screening and Community Foot Protection Service Standards- 2019 across Auckland and Waitemata DHBs	
	YR 1-YR 3 (Q1-4): Ensure Asian peoples are accessing podiatry, dietetics and health psychology at the same rates as other ethnicities by providing these services in community based settings.	% of Asian peoples accessing podiatry, dietetics and health psychology* **Waitematā only*
	YR 1-YR 3 (Q1-4): Increase the proportion of South Asian participants enrolled with Green Prescription services.	2% of clients engaged with Green[41] Prescriptions - 9% Waitematā - 18% Auckland
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.	

8.3

[41] As at June, 2019, Auckland (17.2%, 758 people); Waitematā (6%, 332 people).

Mental Health & Addictions

Why is this a priority?

Asian peoples in Auckland have significantly lower rates of access to Perinatal Maternal Mental Health services (PMMH), and Mental Health & Addiction services compared to other ethnic groups, despite a high and increasing burden of mental health issues.

What are we trying to do?

Improve early access rates to PMMH services, and MH&A services.

In Waitematā DHB, there is an Asian Mental Health Work Stream Plan 2017-2020 which has been developed in alignment to the Waitematā Stakeholder Network Mental Health and Addiction Strategic Plan 2015-2020.

The Asian Mental Health Work Stream Plan includes initiatives that enable Waitematā DHB mental health services to demonstrate cultural capability and improve the equity and wellbeing of Asian peoples through better access to MH&A Services.

To achieve this we will focus on

Support the Regional Perinatal and Infant Mental Health Clinical Governance Group, Collaborative Primary Mental Health and Addictions Nurse Credentialing Programme Governance Group, Waitematā Stakeholder Network Mental Health and Addiction Strategic Plan, and Auckland DHB's Mental Health and Addictions Commissioning Board.

Who will we work with?

Northern Regional Alliance, DHBs, Mental Health & Addictions team, Primary Care team, Asian Health Services (Waitematā DHB), Asian Mental Health Services teams (Waitematā and Auckland DHBs), Metro Auckland Asian & MELAA Primary Care Service Improvement Group, Metro Auckland Collaborative Group, NGO Mental Health Providers, Refugee As Survivors New Zealand, Asian NGOs, eCALD services, and ethnic partners/communities.

DHB	What are we going to do?	Measures
Auckland/ Waitematā / Counties Manukau	YR 1-YR 3 (Q1-Q4): Develop an action plan to include activities to promote wellbeing, respond to suicide distress, respond to suicidal behaviour and support people after a suicide.	Decrease in Asian deaths coded as suicides (Ministry of Health) and provisional suicides (Ministry of Justice), by age
	YR 1-YR 3 (Q1-Q4): Work with the Metro Auckland Asian & MELAA Primary Care Service Improvement Group to: • Support the roll out of the Integrated primary mental health and addiction service to ensure the initiatives are culturally appropriate. • Link with the Metro Auckland Collaborative Group on the implementation of the Integrated primary mental health and addiction service.	
	YR 1-YR 3 (Q1-Q4): Support the Regional Perinatal and Infant Mental Health Clinical Governance Group:	

DHB	What are we going to do?	Measures
	• Research on *'Supporting Equitable Perinatal Mental Health Outcomes (Asian communities)'.*	
	YR 1-YR 3 (Q1-Q4): Support the Collaborative Primary Mental Health and Addiction Nurse Credentialing Programme Governance Group.	
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Support the: • Every Life Matters – He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand. • Waitematā and Auckland DHB Suicide Prevention and Postvention Action Plan 2020-2023 ○ Raise awareness of the cultural barriers and nuances that influence low uptake of mental health services.	
Waitematā	YR 1-YR 3 (Q1-Q4): Implement the [Asian Mental Health] Work Stream Plan 2017-2020.	
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Support early engagement with mental health services for current asylum seeker claimants.	
Auckland/ Waitematā	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group; and Asian Mental Health & Addictions Stakeholder Network Group (Waitematā DHB).	

Sexual and Reproductive Health

Why is this priority?

Reported cases of infectious syphilis have steadily increased in New Zealand since 2013, with most cases reported from areas with large cities. This is reflective of the global increase in reported syphilis cases. There is an increasing proportion of syphilis cases reported in heterosexual males and females, and the rise in cases of congenital syphilis, suggest increasing transmission in groups not considered as high risk in recent years.[42] 'Based on surveillance data from the Syphilis outbreak, we see high numbers from the Asian community and when broken down by specific Asian communities such as the Indian community, the rates are even higher. At least two thirds of the Indian community affected by Syphilis were from men who have sex with men (MSM) background and some from quite complex social environments (Appendix 6).

The Ministry of Health has confirmed that testing costs as well as treatment costs for HIV, syphilis and gonorrhoea (section C diseases) are covered by the public health act for non-eligible individuals including those who get tested and the result is not positive.[43]

Two Long Acting Reversible Contraceptions (LARC) - Mirena® and Jaydess® intrauterine systems (IUS) are now fully funded for eligible publically funded women who are seeking long-term contraception.

[42] ESR Dec 19 data

[43] Accessible online from https://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services/guide-eligibility-publicly-funded-health-services/eligibility-limited-range-publicly-funded-health-services-0/people-receiving-treatment-infectious-diseases

What are we trying to do?

Gain insight into the needs of the Asian communities in areas such as Syphilis (which can be different to that of the general population) to guide culturally appropriate planning and delivery of sexual health services.

To achieve this we will focus on:

Support monitoring of trends in Syphilis. Provide culturally appropriate information to women about DHB women's health services.

Who will we work with?

Primary Care, sexual health services, Metro Auckland Asian & MELAA Primary Care Service Improvement Group, Gynaecology Day Stay Clinics, Asian NGOs, Body Positive, NZ Aids Foundation, Auckland Sexual Health Services, Transgender groups and networks, and ethnic partners/communities.

DHB	What are we going to do?	Measures
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Monitor STI trends for Asian (and if possible by visa/immigration status) via: • Syphilis Weekly IMT Report • ESR STI Surveillance Dashboard[44]	
	YR 1-YR 3 (Q1-Q4): Promote culturally appropriate information about Epsom Day Unit and LARC information to ethnic women.	
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.	

Health of Older People

Why is this a priority?

The Healthy Ageing Strategy recognises that inequities in health status need to be reduced, in particular for Māori, Pacific peoples, migrant and refugee communities, and people with disabilities. People age in different ways, and our population is diverse. We must recognise and respect the range of ways older people access and interact with services for Asian and MELAA populations. The foreseeable risk to migrant Asian groups is the waning 'healthy migrant effect', intergenerational issues, language, financial and the significant population size living in metro Auckland that is ageing (7.8%, Auckland; 9.0% ,Waitematā).[45] Older people interacting in our health system should experience culturally appropriate care that meets the health and support needs of an increasingly ethnically diverse population.

What are we trying to do?

Improve the health outcomes and independence of older Asian & MELAA peoples by supporting the national Healthy Ageing Strategy's vision that Older people live well, age well and have a respectful end of life in age-friendly communities, and key strategic themes.

[44] Accessible online from https://www.esr.cri.nz/our-services/consultancy/public-health/sti/

[45] Population projections based on '2018 Update' based on Census 2013

To achieve this we will focus on:

Activities that include Asian and MELAA older peoples' health and support needs and voice in the planning, implementation and monitoring of projects and/or groups .

Who will we work with?

Health of Older People's team, Disability Advisor, NGOs e.g Age Concern, Aged Care providers, Asian DHB geriatricians.

DHB	What are we going to do?	Measures
Auckland/ Waitematā	YR 1 (Q1-Q4): Supporting the work on models of care and services for people with dementia and their carers.	
	YR 1 (Q1-Q4): Review current resources available to older adults and families about aged residential care services.	1 report
	YR 1-YR 3 (Q1-Q4): Increase the quality of service provision to Asian residents in Aged Residential Care: • Coordinate the Facility Owners Group meeting (including Chinese and Korean) run bi-monthly (6).	
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.	

Immunisation against Influenza

Why is this a priority?

Asian & MELAA peoples 65 years and over may not be aware they are eligible for free Seasonal Influenza vaccines. They often are staying at home looking after infants and children, thus may increase the chances of spreading the flu with family members.

What are we trying to do?

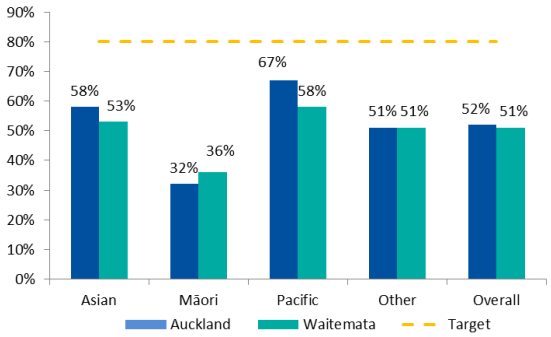
Increase the number of Asian & MELAA older peoples who received Seasonal Influenza vaccines.

To achieve this we will focus on:

Promotion of Seasonal Influenza vaccines through culturally appropriate activities and communication.

Where are we at and where do we want to get to?

Rate of seasonal influenza immunisation of eligible 65+ years population, Auckland and Waitematā DHBs (January - September 2019)



**Jan-Sep 2019*

Who will we work with?

Primary Care team, Metro Auckland Asian & MELAA Primary Care Service Improvement Group, WCTO providers, Asian NGOs, and ethnic partners/communities.

DHB	What are we going to do?	Measures
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Work with PHO Immunisation Coordinators to ensure general practices are recalling and providing the Influenza vaccine for those eligible.	75% of people aged over 65 receive a flu vaccine Respiratory infection hospitalisation rate, over 65 years (per 100,000)
Auckland/ Waitematā /Counties Manukau	YR 1-YR 3 (Q1-Q4): Starting 1 April 2020: • Targeted activities as part of CMH's Community Flu Fighters programme in Asian communities • Active promotion of culturally appropriate messaging within high enrolled Asian and former refugee general practices • Leveraging on Asian and migrant partner's cultural events, outreach and communication platforms to promote culturally appropriate messaging • Leveraging on mainstream services/activities e.g. community pharmacies to promote culturally appropriate messaging.	
Auckland/ Waitematā	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.	

Rōhe o Waitematā me Auckland

There are health systems that are potential barriers to health gain for Asian and MELAA peoples in our districts. In 2020-2023, our action focus is on regional planning and reporting, data quality, primary care enrolment, former refugee and current asylum seeker health.

Regional Asian Health Gain Planning and Reporting

Why is this a priority?
In order to maintain or improve Asian health status we must address the disparities within Asian 'high-risk' subgroups associated with access to and utilisation of health and disability services for newcomers, distribution of health determinants and risk factors, and a diminishing protective 'healthy migrant effect'.

Former refugee communities continue to resettle across the metropolitan districts under the Refugee Quota Programme; Family Reunion Refugees; Convention Refugee or Protected Person (Asylum Seeker),

A regional response is necessary to achieve best value from available resources, experience and skills by working collaboratively (where possible) to make a positive change in health outcomes for Asian, migrant, former refugee and current asylum seeker populations.

What are we trying to do?
The metropolitan Auckland DHBs have a common goal to improve or maintain health gain in their respective Asian populations. Together, we aim to review and learn from our health gain activities, insights and outcomes so we can benefit from our collective knowledge and relationships with community and health leaders.

What will we focus on?
Collectively work towards the areas of focus in the Metropolitan Auckland Asian & MELAA Primary Care Action Plan 2020-2023, share available Asian health status data, and leverage respective Asian health oversight, advisory and governance forums.

Where do we want to get to?
We will aim to develop a Metropolitan Auckland Asian & MELAA Primary Care Action Plan 2020-2023.

Who will we work with?
Northern Regional Alliance, PHOs, and Counties Manukau Health.

DHB	What are we going to do?	Measures
Auckland/ Waitematā/	YR 1-YR 3 (Q1-Q4): Support coordination of a Northern Region COVID-19 cultural response for our diverse ethnic communities across key functions	

DHB	What are we going to do?	Measures
Counties Manukau	(when needed): • Communications: Develop and promote translated COVID-19 resources to communities, and content for the ARPHS communities webpage[46] • Intelligence: Provide cultural advice and planning to the Intelligence team • Welfare: Provide advice and support to Welfare case management.	
	YR 1-YR 3 (Q1-Q4): Develop and implement a Metro Auckland Asian & MELAA Primary Care Action Plan 2020-2023.	1 Plan
	YR 1-YR 3 (Q1-Q4): Explore potential opportunities to work regionally to raise Asian and former refugee health equity awareness: • Input into the planning of Counties Manukau Health Asian initiatives to avoid duplication of effort and streamline resources (where possible).	
	YR 1-YR 3 (Q1-Q4): Continue to streamline the '*Improving Access to General Practice for Former Refugees and Current Asylum Seekers Agreements'* across the metropolitan Auckland region: • PHO Refugee Services Operational Group.	
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group; Metro Auckland Asian & MELAA Primary Care Service Improvement Group; Metro Auckland PHO Refugee Services Operational Group; and Counties Manukau's Asian Advisor.	

Data Quality

Why is this a priority?
Accurate data is imperative for policy, planning and monitoring of many indicators important for Asian Health. A key area of interest is to establish complete and accurate breakdown data on level 2 Asian subgroups to identify 'at risk' subgroup population health outcomes.

What are we trying to do?
Advocate to improve the quality of ethnicity data collected by Auckland and Waitematā DHBs.

To achieve this we will focus on:
Implement the Standard of Ethnicity Data Protocols and action plans to improve ethnicity data collection.

Who will we work with?
Primary Care team, Health Intelligence team, Metro Auckland Asian & MELAA Primary Care Service Improvement Group, and Waitematā and Auckland DHBs provider arm services.

DHB	What are we going to do?	Measures
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Continue to develop a quarterly Asian performance scorecard to monitor trends in health outcomes	Asian Scorecard (4)
	YR 1-YR 3 (Q1-Q4):Promote via the Metro Auckland Asian & MELAA Primary Care Service Improvement Group accuracy of ethnicity reporting	Standard of Ethnicity Data Protocols[47]

[46] Accessible at https://www.arphs.health.nz/public-health-topics/covid-19/covid-19-information-for-our-communities/

DHB	What are we going to do?	Measures
	in PHO registers as measured by Primary Care Ethnicity Data Audit Toolkit.	implemented.
	YR 1-YR 3 (Q1-Q4): Identify services where there are gaps in collecting and reporting of level 1 'Asian' and 'Other' and level 2 categories subgroups ('Other Asian', 'Chinese', 'Indian', 'South East Asian' and 'Asian NFD').	
	YR 1-YR 2 (Q1-Q4): Work with identified services to ensure accurate collecting and reporting of level 2 'Asian' ethnicity subgroups (at a minimum).	
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.	

Primary Healthcare Enrolment

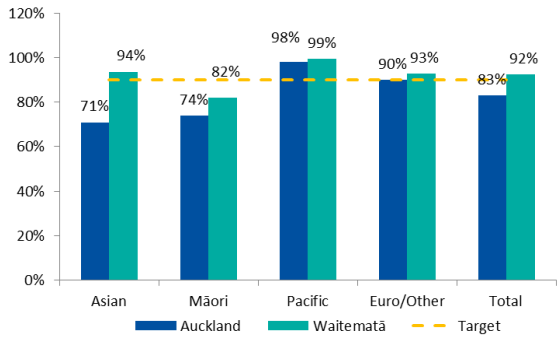
Why is this a priority?

Asian peoples have disproportionately lower PHO enrolment rates compared to European/Other in Auckland DHB (71% (Asian), 90% (European/Other).

The Auckland DHB's Asian PHO enrolment rate continues to remain significantly lower than the other Metro Auckland DHBs largely due to the high number of international students and transient temporary migrant population living in the Auckland district. [48]

Where are we at and where do we want to get to?

90% of patients are enrolled with a PHO



**Sep 2019*

Awareness of the New Zealand Health & Disability System is a key enabler to timely access and appropriate use of health services. The National Migrant Consultations 2018 report[49] highlighted that for new migrants -particularly those on working visas and skilled migrant visas - understanding how the health system works and addressing misconceptions is imperative to settlement experiences. Similarly, ethnicities from Chinese, Indian, Filipino and Middle Eastern backgrounds also expressed a lower level of awareness of the health system as part of the oral health study findings conducted in 2018.

Equitable access to timely primary care services and language support for newly arrived migrants, former refugee and current asylum seekers in general practice is essential. The role of primary care and access to a family doctor (GP) is critical to resettlement experiences for former refugees and current asylum seekers. The new national Quota Refugee Health Services Model will require greater engagement and support at the general practice level, and increasingly, the majority of current

[47] Accessible online from http://www.health.govt.nz/publication/hiso-100012017-ethnicity-data-protocols

[48] International students and temporary migrants domiciled in a district for 1 year are included in the denominator when calculating a DHB's PHO enrolment rate even though they are ineligible to enrol with a PHO. The Auckland DHB's PHO enrolment rate appears to be diluted as a result of a high ineligible healthcare population unable to enrol with a family doctor (PHO) yet included in the denominator.

[49] Accessible online from https://www.immigration.govt.nz/documents/about-us/national-migrant-consultations-2018.pdf

asylum seeker claimants live in Auckland during their claim process and require ongoing mental health support as part of their determination process.

What are we trying to do?
Deliver a suite of initiatives to increase newcomers' awareness of the New Zealand health & disability system; role and commensurate benefits of enrolling with or seeing a regular family doctor (GP) for holistic care including timely health checks, immunisations, family health services, integrated wrap around services; and knowing where to go for healthcare to get help when you're fee – for urgent, less serious conditions, injury and when it's an emergency.

To achieve this we will focus on:
Implement the Metropolitan Auckland Asian & MELAA Primary Care Action Plan 2020-2023, and support the health & wellbeing outcome areas for the: New Zealand Refugee Resettlement Strategy; New Zealand Migrant Settlement and Integration Strategy; and New Zealand International Student Wellbeing Strategy.

Who will we work with?
Uri Ririki - Child Health Connection Centre Service, Women, Child and Youth team, Primary Care team midwives, Ministry of Health, Ministry of Business, Innovation and Employment, , Metro Auckland Asian & MELAA Primary Care Service Improvement Group, Auckland Agency Group, New Zealand Red Cross, WCTO Providers, ARDS, institutes, settlement agencies, student associations, and ethnic partners/communities.

DHB	What are we going to do?	Measures
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Work with the Metro Auckland Asian & MELAA Primary Care Service Improvement Group and Primary Care to implement the Action Plan 2020-2023.	95% of the population enrolled in a PHO

	YR 1-YR 3 (Q1-Q4): Promote the suite of multilingual interventions, such as podcast videos, Healthcare – where should I go?, health literate materials, and the Your Local Doctor websites (English, Chinese and Korean):
	• NZ health system podcast videos:
	  ○ Refresh English and Mandarin videos
	  ○ Develop Korean video
	• Develop online New Zealand Health & Disability System materials for Rohingya, Karen, Kayah, Amharic, Cambodian/Khmer, Farsi, Punjabi, Somali, Swahili, Tamil, Thai, Tigrinya, and Urdu.
	• Develop online Healthcare – where should I go? flyer for Rohingya, Karen, Kayah, Amharic, Cambodian/Khmer, Farsi, Punjabi, Somali, Swahili, Tamil, Thai, Tigrinya, and Urdu.
	• Deliver the NZ Health & Disability System presentations to universities, Private Training Establishments (PTE), settlement partners, ethnic associations/communities and libraries.	

	YR 1-YR 3 (Q1-Q4): Increase the proportion of Asian & MELAA newborn infants enrolled with a PHO at 3 months of age: • Work with the Uri Ririki - Child Health Connection Centre (CHCC) service to identify gaps and trends to late PHO enrolment, and identify solutions in partnership with the Service and Sector to increase early enrolment • Promote culturally appropriate PHO enrolment messaging to	98% of newborns are enrolled with a PHO, general practice at 3 mths of age

DHB	What are we going to do?	Measures
	Asian & MELAA newcomers • Work with the PHO Newborn Enrolment Coordinators to support access to Under 5 services and culturally responsive service provision.	
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group.	

Former Refugee & Current Asylum Seeker Health

Why is this a priority?

Available evidence suggest that both former refugee and current asylum seekers including those from transgender, non-binary and gender diverse backgrounds face significant barriers to accessing primary care, mental health and addiction, pharmacy, oral health and maternity services. Key barriers to accessing health services (including maternity services), include varied levels of resettlement support, difficulty accessing language services, financial and transport stressors, lack of knowledge of the health system, cultural competence of the health workforce, discrimination and lack of awareness within health services of refugee and current asylum seeker unique needs and experiences. Financial constraints mean individuals are generally not able to access private services and depend on public or community-based services.[50]

Former refugee and/or current asylum seeker families have low access to and utilisation of primary health services in New Zealand and thus require equity of access to general practice.[51]

What are we trying to do?

Enable equitable access to mainstream primary care (affordable or no-cost options) for former refugee and current asylum seeker patients in general practice; monitor health service access and utilisation (and long-term outcomes); and support the national Quota Refugee Health Services Model implementation and monitoring.

To achieve this we will focus on:

Fund the PHOs to manage the delivery of the '*Improving Access to General Practice for Former Refugees and Current Asylum Seekers Agreements'* with their participating general practices in the metropolitan Auckland region, promote the Service among former refugee and/or current asylum seeker communities, improve cultural competency among primary care practices, promote the use of language support, and deliver professional development to the primary health workforce.

Who will we work with?

Primary Care team, DHBs, Metro Auckland PHO Refugee Services Operational Group, Metro Auckland Asian & MELAA Primary Care Service Improvement Group, PHOs, community health workers, New Zealand Red Cross, Mangere Refugee Resettlement Centre, Immigration New Zealand, Asylum Seeker Support Trust, asylum seeker lawyers/barristers, settlement agencies, Rainbow health services/partners, and ethnic partners/communities.

[50] Accessible online from https://www.racp.edu.au/docs/default-source/default-document-library/refugee-and-asylum-seeker-health-position-statement.pdf?sfvrsn=2

[51] Accessible online from https://www.ncbi.nlm.nih.gov/pubmed/28379739

DHB	What are we going to do?	Measures
Auckland/ Waitematā/ Counties Manukau	YR 1-YR 3 (Q1-Q4): Fund and manage the Improving Access to General Practice for Former Refugees and Current Asylum Seekers Agreements	Increase in number of former refugees enrolled with the Refugee Primary Care Services[52]
	YR 1-YR 3 (Q1-Q4): Strengthen pathways to PHO enrolment for former refugees: • Support the roll out of the Quota Refugee Health Services Model in primary care. • Promote pathways to primary care for Family Reunion Refugees (Refugee Quota Family Reunification Category and Refugee Family Support Category), and Convention Refugee or Protected Persons	
	YR 1-YR 3 (Q1-Q4): Coordinate bimonthly meetings with the Metro Auckland PHO Refugee Services Operational Group: • Minimum data sets to enable monitoring of service access and health outcomes.	
	YR 1-YR 3 (Q1-Q4): Raise awareness within former refugee and current asylum seeker communities of Service availability: • Work with our stakeholders, outreach services and community leaders to increase awareness, access to and uptake of the Services.	
Auckland/ Waitematā	YR 1-YR 3 (Q1-Q4): Q4: Lead and coordinate professional development to the primary health workforce: • Metro Auckland Refugee Health Network Executive Group • Metro Auckland Refugee Health Network (ARRHN) Forums • Cross Cultural Frontline Training.	
Auckland/ Waitematā / Counties Manukau	YR 1-YR 3 (Q1-Q4): Encourage and promote CALD training with the participating practices of this Service.	
	YR 1-YR 3 (Q1-Q4): Encourage and promote the use of interpreting services such as the DHBs' Primary Health Interpreting services in participating general practices of this Service.	
	Quarterly: Progress of activities and performance against health targets will be monitored and reported to the Asian & MELAA Health Governance Group; and Metro Auckland PHO Refugee Services Operational Group.	

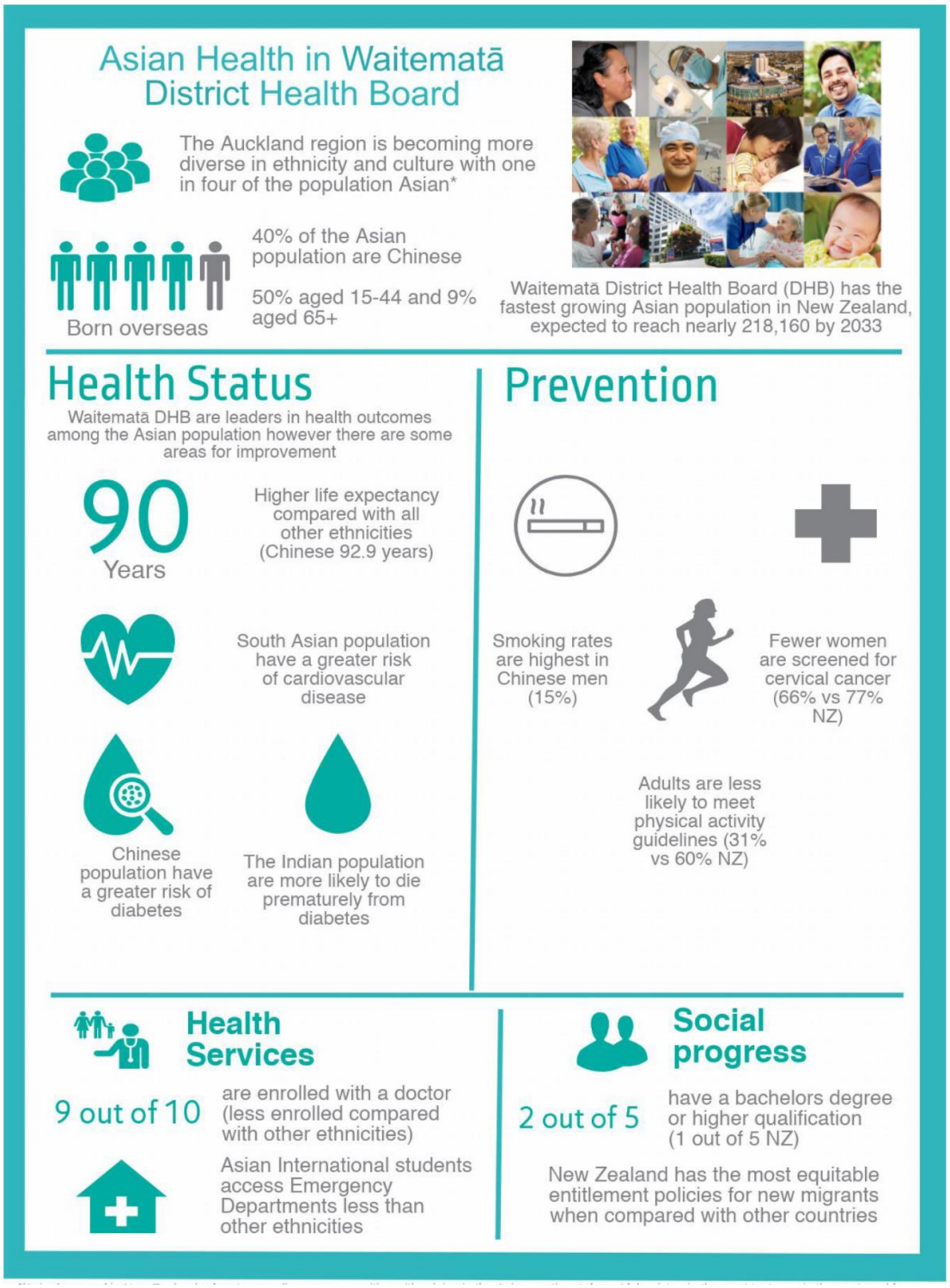
[52] As at 1 March, 68 practices participating

Glossary

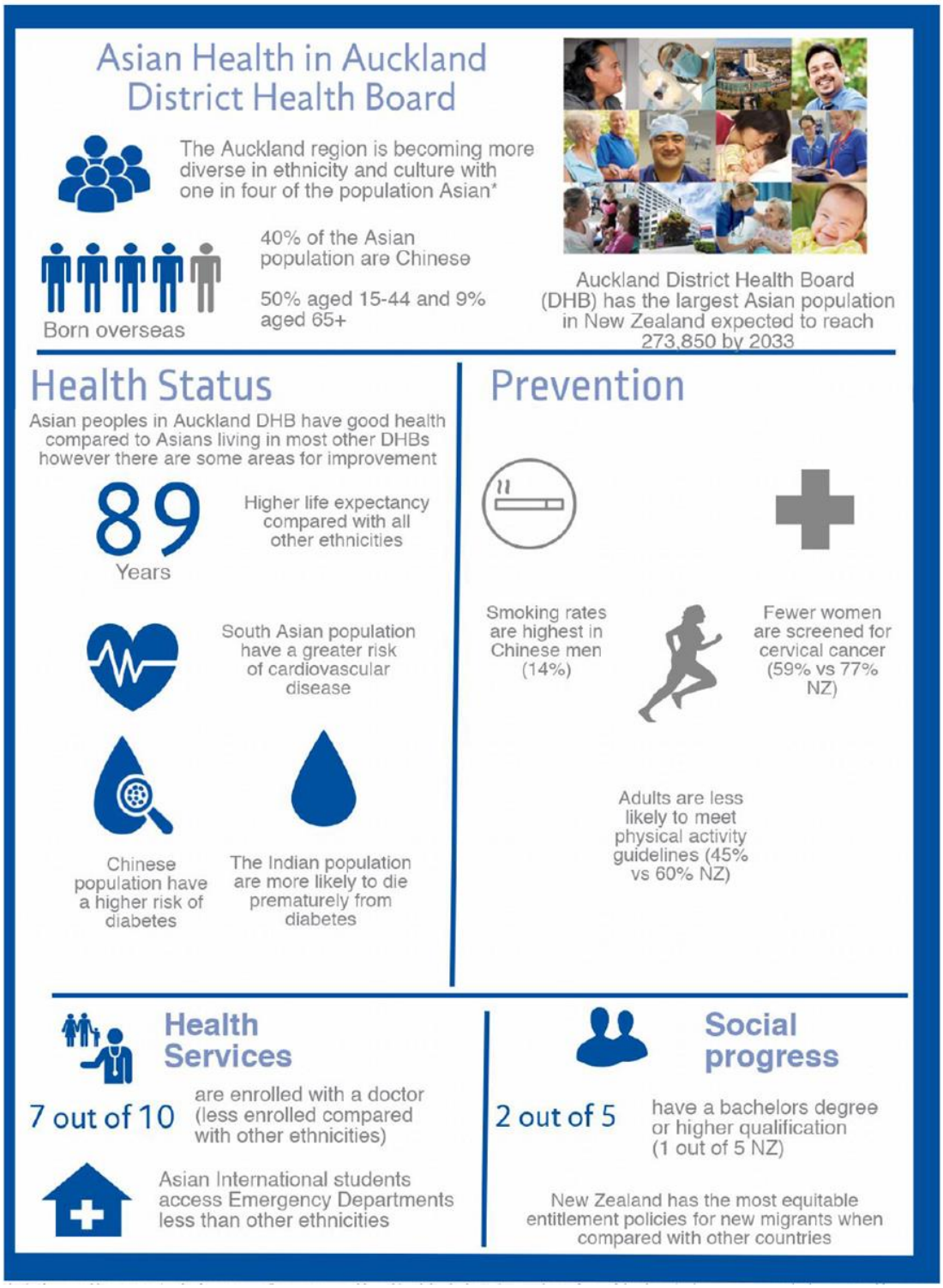
ASH	Ambulatory sensitive hospitalisations
CALD	Culturally and linguistically diverse
CBD	Central business district
CHCC	Child Health Connection Centre
CPHAC	Community & Public Health Advisory Committee
CUR	Census Usually Residents population
CVD	Cardiovascular disease
CVDRA	Cardiovascular disease/cardiovascular disease risk assessment
DHB	District health board
dmft	Measure of children's oral health (Decayed/Missing/Filled/Teeth)
GP	General practitioner
HPV	Human papilloma virus
INZ	Immigration New Zealand
IUS	Intra uterine system
LARC	Long acting reversible contraceptions
MELAA	Middle Eastern, Latin American or African
MH&A	Mental health and addictions services
MoH	Ministry of Health
MSM	Men who have sex with men
NGO	Non-government organisation
PHIS	Primary health interpreting services
PHO	Primary health organisation
PMMH	Perinatal maternal mental health
PTE	Private training establishment
SLM	System level measure (national set of six health indicators)

Appendices

Appendix 1: Asian Health Benchmarking in Waitematā District Health Board, 2017



Appendix 2: Asian Health Benchmarking in Auckland District Health Board



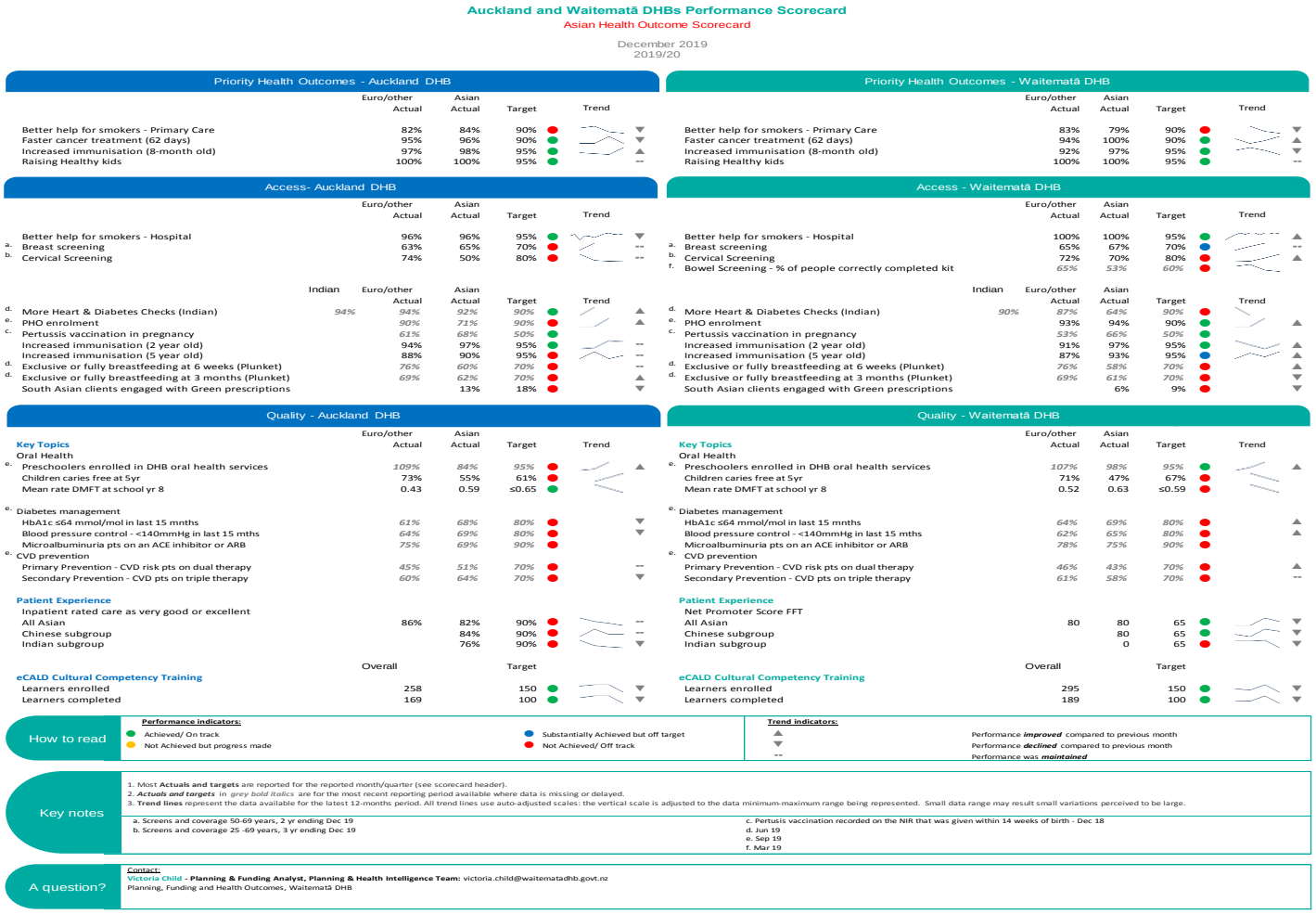
Appendix 3: Strategic Directions

- New Zealand Health Strategy: Future direction[53]
- New Zealand Migrant Settlement and Integration Strategy's - Outcome 5: Health and Wellbeing[54]
- New Zealand Refugee Resettlement Strategy - Health Outcome[55]
- New Zealand Community Engagement Framework[56]
- New Zealand International Student Wellbeing Strategy Outcomes Framework - Outcome 3: Health & Wellbeing[57]
- Plunket Asian Peoples Strategy
- All of Government (AoG) contracting
- Northern Region Health Plan
- Waitematā DHB Health Services Plan 2015-2025
- Waitematā DHB Primary and Community Care Plan
- Waitematā DHB Asian Mental Health & Addiction Governance Group's Asian Mental Health Work Stream Plans 2015-2020
- Auckland DHB Strategy
- Auckland Regional Public Health Service Strategic Plan 2017-2022
- Counties Manukau Health 2018/19-2019/20 Asian Health Outcome Priorities
- Counties Manukau Health 2018/19-2019/20 Asian Health Action Roadmap
- Auckland Metro Regional System Level Measures Improvement Plan.

Note, within the timeframe of this Plan, these Strategies/Plans below may be refreshed.

[53] Accessible online from https://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-futuredirection-2016-apr16.pdf
[54] Accessible online from https://www.immigration.govt.nz/about-us/what-we-do/our-strategies-and-projects/how-we-support-migrants
[55] Accessible online from https://www.immigration.govt.nz/about-us/what-we-do/our-strategies-and-projects/refugee-resettlement-strategy
[56] Accessible online from https://www.immigration.govt.nz/about-us/what-we-do/our-strategies-and-projects/refugee-resettlement-strategy/rqip
[57] Accessible online from https://www.education.govt.nz/our-work/overall-strategies-and-policies/international-student-wellbeing-strategy/

Appendix 4: Auckland and Waitematā DHBs Asian Performance Scorecard (Dec 2019)



Auckland and Waitematā DHBs Performance Scorecard

Asian Health Outcome Scorecard

December 2019
2019/20

Priority Health Outcomes - Auckland DHB

	Euro/other Actual	Asian Actual	Target	Trend
Better help for smokers - Primary Care	82%	84%	90%	
Faster cancer treatment (62 days)	95%	96%	90%	
Increased immunisation (8-month old)	97%	98%	95%	
Raising Healthy kids	100%	100%	95%	

Priority Health Outcomes - Waitematā DHB

	Euro/other Actual	Asian Actual	Target	Trend
Better help for smokers - Primary Care	83%	79%	90%	
Faster cancer treatment (62 days)	94%	100%	90%	
Increased immunisation (8-month old)	92%	97%	95%	
Raising Healthy kids	100%	100%	95%	

Access- Auckland DHB

	Euro/other Actual	Asian Actual	Target	Trend
Better help for smokers - Hospital	96%	96%	95%	
a. Breast screening	63%	65%	70%	
b. Cervical Screening	74%	50%	80%	

Indian		Euro/other Actual	Asian Actual	Target	Trend
d. More Heart & Diabetes Checks (Indian)	*94%*	*94%*	*92%*	*90%*	
e. PHO enrolment		*90%*	*71%*	*90%*	
c. Pertussis vaccination in pregnancy		*61%*	*68%*	*50%*	
Increased immunisation (2 year old)		94%	97%	95%	
Increased immunisation (5 year old)		88%	90%	95%	
d. Exclusive or fully breastfeeding at 6 weeks (Plunket)		*76%*	*60%*	*70%*	
d. Exclusive or fully breastfeeding at 3 months (Plunket)		*69%*	*62%*	*70%*	
South Asian clients engaged with Green prescriptions			13%	18%	

Access - Waitematā DHB

	Euro/other Actual	Asian Actual	Target	Trend
Better help for smokers - Hospital	100%	100%	95%	
a. Breast screening	65%	67%	70%	
b. Cervical Screening	72%	70%	80%	
f. Bowel Screening - % of people correctly completed kit	*65%*	*53%*	*60%*	

Indian		Euro/other Actual	Asian Actual	Target	Trend
d. More Heart & Diabetes Checks (Indian)	*90%*	*87%*	*64%*	*90%*	
e. PHO enrolment		93%	94%	90%	
c. Pertussis vaccination in pregnancy		*53%*	*66%*	*50%*	
Increased immunisation (2 year old)		91%	97%	95%	
Increased immunisation (5 year old)		87%	93%	95%	
d. Exclusive or fully breastfeeding at 6 weeks (Plunket)		*76%*	*58%*	*70%*	
d. Exclusive or fully breastfeeding at 3 months (Plunket)		*69%*	*61%*	*70%*	
South Asian clients engaged with Green prescriptions			6%	9%	

Quality - Auckland DHB

Key Topics	Euro/other Actual	Asian Actual	Target	Trend
Oral Health				
e. Preschoolers enrolled in DHB oral health services	*109%*	*84%*	*95%*	
Children caries free at 5yr	73%	55%	61%	
Mean rate DMFT at school yr 8	0.43	0.59	≤0.65	
e. Diabetes management				
HbA1c ≤64 mmol/mol in last 15 mnths	*61%*	*68%*	*80%*	
Blood pressure control - <140mmHg in last 15 mths	*64%*	*69%*	*80%*	
Microalbuminuria pts on an ACE inhibitor or ARB	*75%*	*69%*	*90%*	
e. CVD prevention				
Primary Prevention - CVD risk pts on dual therapy	*45%*	*51%*	*70%*	
Secondary Prevention - CVD pts on triple therapy	*60%*	*64%*	*70%*	
Patient Experience				
Inpatient rated care as very good or excellent				
All Asian	86%	82%	90%	
Chinese subgroup		84%	90%	
Indian subgroup		76%	90%	
	Overall		**Target**	
eCALD Cultural Competency Training				
Learners enrolled	258		150	
Learners completed	169		100	

Quality - Waitematā DHB

Key Topics	Euro/other Actual	Asian Actual	Target	Trend
Oral Health				
e. Preschoolers enrolled in DHB oral health services	*107%*	*98%*	*95%*	
Children caries free at 5yr	71%	47%	67%	
Mean rate DMFT at school yr 8	0.52	0.63	≤0.59	
e. Diabetes management				
HbA1c ≤64 mmol/mol in last 15 mnths	*64%*	*69%*	*80%*	
Blood pressure control - <140mmHg in last 15 mths	*62%*	*65%*	*80%*	
Microalbuminuria pts on an ACE inhibitor or ARB	*78%*	*75%*	*90%*	
e. CVD prevention				
Primary Prevention - CVD risk pts on dual therapy	*46%*	*43%*	*70%*	
Secondary Prevention - CVD pts on triple therapy	*61%*	*58%*	*70%*	
Patient Experience				
Net Promoter Score FFT				
All Asian	80	80	65	
Chinese subgroup		80	65	
Indian subgroup		0	65	
	Overall		**Target**	
eCALD Cultural Competency Training				
Learners enrolled	295		150	
Learners completed	189		100	

How to read

Performance indicators:
- Achieved/ On track
- Not Achieved but progress made
- Substantially Achieved but off target
- Not Achieved/ Off track

Trend indicators:
- Performance ***improved*** compared to previous month
- Performance ***declined*** compared to previous month
- Performance was ***maintained***

Key notes

1. Most **Actuals and targets** are reported for the reported month/quarter (see scorecard header).
2. ***Actuals and targets*** *in grey bold italics* are for the most recent reporting period available where data is missing or delayed.
3. **Trend lines** represent the data available for the latest 12-months period. All trend lines use auto-adjusted scales: the vertical scale is adjusted to the data minimum-maximum range being represented. Small data range may result small variations perceived to be large.

a. Screens and coverage 50-69 years, 2 yr ending Dec 19
b. Screens and coverage 25 -69 years, 3 yr ending Dec 19
c. Pertusis vaccination recorded on the NIR that was given within 14 weeks of birth - Dec 18
d. Jun 19
e. Sep 19
f. Mar 19

A question?

Contact:
Victoria Child - **Planning & Funding Analyst, Planning & Health Intelligence Team:** victoria.child@waitematadhb.govt.nz
Planning, Funding and Health Outcomes, Waitematā DHB

8.3

Appendix 5: Definitions of scorecard indicators/performance measures

Better help for smokers – Primary Care - % of PHO enrolled patients who smoke and are seen by a health practitioner in General Practice are offered brief advice and support to quit smoking. Quarterly report from MOH.

Faster Cancer treatment - % of patients referred urgently with a high suspicion of cancer whose first treatment (or other management) occurred within the last 6 months and the treatment was within 62 days of the referral being received by the hospital.
Quarterly report from NRA.

Immunisation (8-month old, 2, 5-year old) – % of children who turned the milestone age in the reporting quarter who have completed their age appropriate immunisations by the time they turn the milestone age. Quarterly report from MOH.

Raising Healthy kids - % of children who had a B4 School Check and were identified as obese (BMI>98th percentile) and were referred to a registered health professional and acknowledged within 30 days or were already under care or declined the referral. Quarterly report from MOH.

Better help for smokers – Hospital – % of hospitalised smokers provided with advice and help to quit. Reported monthly from internal reporting.

Breast screening - Breast screen Aotearoa coverage (%) 50-69 years, 2 years ending at current quarter. Quarterly report from NSU website.

Cervical screening - National Cervical Screening Programme coverage (%) 25 -69 years, 3 years ending at current quarter. Based on statistics NZ census population projection adjusted for prevalence of hysterectomies. Quarterly report from NSU website.

Bowel Screening - % 60-74 year olds, 2 years ending at reported quarter who return correctly completed kits.

More Heart and Diabetes Checks/Cardiovascular Disease (CVD) risk assessment - % of the eligible PHO enrolled population who have had their cardiovascular risk assessed in the last five years. Quarterly report from MOH.

CVD Primary Prevention: Percentage of enrolled patients with cardio-vascular risk ever recorded >20%, (aged 35 to 74 years, excluding those with a previous CVD event) who are on dual therapy (statin + BP Lowering agent).

CVD Secondary Prevention - Percentage of enrolled patients with known cardio-vascular disease who are on triple therapy (Statin + BP lowering agent + Antiplatelet/ Anticoagulant).

PHO enrolment – % of population (latest census based projections) who are enrolled with a PHO. Quarterly enrolment figures from MOH and latest census population projections.

Pertussis vaccination in pregnancy - % of pregnant women receiving pertussis vaccination in pregnancy. Pertussis vaccination recorded on the NIR that was given within 14 weeks of birth. Reported quarterly from NIR and NMDS records.

HPV vaccination - Percentage of eligible girls fully immunised with HPV vaccine. Final dose: The dose that completes HPV immunisation. For people aged under 15 years of age, two HPV vaccine doses are required to complete immunisation provided that the second dose is given more than 21 weeks after the first dose. For those aged 15 years and older, or those in whom the second dose was given less than 21 weeks after the first dose, three HPV vaccine doses are required to completeimmunisation.* Estimated HPV eligible population includes 12yrs female, male and total (includes female,male and indeterminate) on each tab and is based on the selected denominator. 2018/19, the national target is 75% of girls born in 2005 are fully immunised for HPV.

Flu vaccination – Percentage of individuals within the age band 65+yrs at the date of the report run date who have completed their annual influenza immunisation using Census estimated population projection denominator for the given vaccination year. MOH annual report.

Respiratory infection hospitalisation rate – Rate per 100 000 population of male and female 65+ year olds hospitalised for respiratory infections . Conditions include acute upper respiratory infections, influenza and pneumonia, and other acute lower respiratory infections.

Breastfeeding at 6 weeks, 3 months – % of newborn babies who are exclusively or fully breastfed at 6 weeks or 3 months as determined at WCTO contact. Quarterly data from Plunket report.

Clients engaged with Green prescriptions – Number of adults engaged in Green prescriptions. Data provided by Harbour Sport for WDHB, Sport Auckland for ADHB. South Asian data only available currently.

Oral Health

Pre-schoolers enrolled in DHB oral health services – % of 0-4 year olds enrolled with ARDS (Auckland regional dental service). Reported quarterly from ARDS enrolment data and Census population projections. High enrolment figures for the "other" ethnicity group is due to the mismatch of the census population projection and ARDS database ethnicity categorisations and the nature of projections based on census data from 2013.

Children caries free at 5 yr – % of children examined that are caries free at five years of age. Reported quarterly from ARDS data. Asian subgroup information not regularly available, masking trends in these subgroups..

Mean rate DMFT at school year 8 – Ratio of mean decayed, missing, filled teeth (DMFT) of children examined at year 8. Reported quarterly from ARDS data. Asian subgroup information not regularly available, masking trends in these subgroups.

Diabetes Glycaemic control: Percentage of eligible population with HbA1c ≤ 64mmol/mol recorded in the last 15 months (based on PHO enrolled numerator and denominator).

Diabetes Blood pressure control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) whose latest systolic blood pressure recorded in the last 15 months is <140mmHg.

Diabetes Management of Microalbuminuria: Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have microalbuminuria in the last 18 months and are on an ACE inhibitor or Angiotensin Receptor Blocker.

Inpatient rated care ADHB KPI = Patient Experience survey results ADHB - quarterly results for the % of patients who rate their overall stay in hospital as excellent or very good. Quarterly results calculated from monthly internal reports.

WDHB Net promoter score – The friends and family test is a patient feedback survey that produces the Net Promoter Score. The proportion of responses that are promoters and the proportion that are detractors are calculated and the proportion of detractors is then subtracted from the proportion of promoters to provide an overall 'net promoter' score. Those that say they are 'extremely likely' are counted as promoters. 'Likely' is neutral, 'neither unlikely nor likely', 'unlikely' and 'extremely unlikely' are all counted as detractors. Quarterly results from monthly internal reporting.

eCALD cultural competency training - Number of learners enrolled and learners that have completed eCALD cultural competency training in the previous quarter (online course participants are given 6 weeks to complete the course).
Quarterly report provided by Sue Lim (WDHB).

Deaths coded as suicides - Annual data from the National Mortality Collection 2016. Numbers may differ from preliminary Coroner reports

Traffic light criteria as per the Hospital Advisory Committee (HAC) report methodology:

Variance from target		Interpretation	Traffic light
On target or better		Achieved	
95-99.9%	0.1% - 5% away from target	Substantially Achieved	
90-94.9%*	5.1% - 10% away from target AND improvement from last month NB. The trend indicator in this case should always be ▲	Not achieved, but progress made	
<94.9%	5.1% - 10% away from target, AND no improvement, OR >10% away from target	Not Achieved	

Appendix 6: Ethnic groups with 10 or more Syphilis cases (2017-2020), as at 28 February, 2020

Ethnicity	2017	2018	2019	2020*	Total	Rank
New Zealand European	97	112	98	15	322	1
Maori	65	59	52	9	185	2
Indian	24	27	25	5	81	3
Latin American	13	22	16	3	54	4
Other European	26	22	25	4	77	5
Southeast Asian	10	14	19	1	44	6
Other Asian	7	12	8	2	29	7
Samoan	13	12	17	4	46	8
Cook Island Maori	2	10	7	1	20	9
Fijian	8	9	13	4	34	10
Chinese	8	8	16	2	34	11
European NFD	1	6	3	2	12	12
Middle Eastern	2	5	6	0	13	13
Tongan	1	4	8	2	15	14
African	4	3	4	1	12	15
Niuean	1	3	5	1	10	16

* *year in progress*

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Waitematā District Health Board
Best Care for Everyone

Board Meeting Schedule for 2021

Recommendation

That the Board approve the amended meeting schedule for 2021

Submitted by: Marlene Skelton (Corporate Business Manager)
Endorsed by: Pat Snedden (Board Chair)

Background

Historically, Auckland, Waitemata and Counties Manukau DHBs have collaborated to produce a meeting schedule that follows a six weekly meeting cycle.

At the start of this new term of Board an ambitious meeting schedule protecting the 6 weekly meeting cycle was set to support an enhanced Committee structure designed to allow Board Members to have a focus on strategy, system wide issues and overall performance management.

This meeting structure was never fully tested due to the effect of COVID 19 on business as usual. In the last few months, post the second COVID 19 lockdown, it has been found that it was overly ambitious.

The Board Chair and Chief Executive would like consideration given to a reduced meeting structure for the following reasons:

1. Report writers are in the main common for many of the committees and are spending a large amount of time preparing reports and being required to attend the meetings.
2. A significant amount of Executive Leadership Team time is spent in meetings and these are people who are currently also carrying dual roles in support of continuing COVID 19 arrangements.
3. The threat of further COVID 19 outbreaks remains and at any time the hospital could revert to a higher alert level again affecting the availability of senior staff.

Meeting Considerations

Meeting Days
In general, Board Members should be prepared to commit the equivalent of about 30 days a year to board business.

This includes preparation time, as board members are required to read a number of papers and reports before each meeting. Time also needs to be set aside to attend board meetings, committee meetings and community liaison activities.

In acknowledging that being a member of Auckland DHB Board is not a fulltime occupation and to provide some certainty around commitments; Wednesdays have been set aside as the primary day for Auckland DHB Board business to be conducted with Tuesdays being reserved for those who

currently sit on the Finance, Risk and Assurance committee and the Major Capital Expert Advisory Group.

Support for Meetings

In general Executive Leadership Team members would be setting aside on average 60 days per year each for direct support of Board meetings.
There are then other report writers from clinical areas writing reports and business cases for Board meetings which removes them from clinical engagement.
The Corporate Business Manager currently spends on average three weeks out of every four supporting Board meetings. Meeting support is not the only primary function of this role.
There are KPIs applied to these meetings such as getting agendas out four working days prior to a meeting and having the minutes with the lead Executive Leadership Team member two working days after the meeting and to the Board or Committee Chair within 10 working days of the meeting.

Proposed New Meeting Structure

In order to remove some stress from the meeting support structure and to address the concerns outlined earlier in the background section of this report, it is being proposed that the meeting structure be reduced as follows:

Committee	Current Number	Proposed Number	Comment
Board	8	6	
Finance, risk and Assurance Committee	8	6	
Hospital Advisory Committee	8	5	
Community Health Equity Advisory Committee	4+2	4+2	Up to two regional meetings
Disability Support Advisory Committee	4+2	4+2	Up to two regional meetings
Major Capital Expert Advisory Group	8	5	
People and Culture Sub-Committee	8	6	Where possible to follow the FRAC meeting

See Appendix One for proposed meeting dates.

Concerns/Risks

An alternate meeting schedule has been difficult to produce due to its production late in the year when key Board Members and senior management already have set diaries for 2021.

This has necessitated Finance, Risk and Assurance Committee meetings being held on a Tuesday morning and Major, Capital and Expert Advisory Group meetings on a Tuesday afternoon.

Care has also had to be taken in managing the diary of the Board Chair who is also the Chair of the Counties Manukau DHB Finance Committee and that of the Deputy Chair of Finance, Risk and Assurance Committee as he is also the Chair of the Waitemata DHB Finance Committee. All these other regional DHB committees continue to meet on a Wednesday.

Consideration was given to the Planning and Funding team and RIA personnel who have to support both Waitemata and Auckland DHBs Finance committees.

It is acknowledged that Tuesdays have traditionally been reserved for Executive Management Team and used for corporate meetings which generally occur later in the afternoon.

The meeting schedule was also affected by a number of statutory holidays that are now observed on the following Monday.

Conclusion

In order to provide certainty around meeting times, the level of DHB work commitment, to support the potential of further COVID 19 outbreaks and to assist with good decision making, it is asked that the proposed meeting schedule in attachment one be approved.

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Proposed Public Auckland DHB Board and Committee Meeting Dates 2021

Option 1 – Current Meeting Schedule

Committee	Frequency	January	February	March	April	May	June	July	August	September	October	November	December
BOARD Open and Confidential	8 per year		Wed 24 Feb		Wed 7 Apr	Wed 19 May	Wed 30 Jun		Wed 11 Aug	Wed 22 Sep		Wed 3 Nov	Wed 15 Dec
Finance, Risk & Assurance Committee (FRAC)	8 per year		Wed 3 Feb	Wed 17 Mar	Wed 28 Apr *26 Apr Anzac*		Wed 9 Jun *7 Jun Queens Bday*	Wed 21 Jul		Wed 1 Sep	Wed 13 Oct	Wed 24 Nov	
Hospital Advisory Committee (HAC) – Provider Equity Committee Open and Confidential	8 per year		Wed 10 Feb *8 Feb Waitangi*	Wed 24 Mar		Wed 5 May	Wed 16 Jun		Wed 25 Aug	Wed 8 Sep	Wed 20 Oct		Wed 1 Dec
Commissioning Health Equity Advisory Committee (CPHAC)	Quarterly +2 DHBs		Wed 10 Feb *8 Feb Waitangi*			Wed 5 May				Wed 8 Sep			Wed 1 Dec
Disability Support Advisory Committee (DiSAC)	Quarterly + 2 DHBs												
Major Capital & Expert Advisory Group (MCPE)	8 per year	Mon 18 Jan		Mon 1 Mar	Mon 12 Apr	Mon 24 May		Mon 5 Jul	Mon 16 Aug	Mon 27 Sep		Mon 8 Nov	

Option 2 – Proposed Meeting Schedule

Committee	Frequency	January	February	March	April	May	June	July	August	September	October	November	December
BOARD Open and Confidential	6 per year	Wed 27 Jan		Wed 31 Mar *School holidays 28/3 – 14/4*		Wed 26 May		Wed 28 Jul *School holidays 4-19/7*		Wed 29 Sep *School holidays 26/9 – 11/10*			Wed 15 Dec
Finance, Risk & Assurance Committee (FRAC)	6 per year		Tues 23 Feb		Tues 27 Apr *26 Apr Anzac*		Wed 30 Jun		Tues 24 Aug		Thurs 21 Oct *25 Oct Labour*	Tues 30 Nov	
Hospital Advisory Committee (HAC) – Provider Equity Committee Open and Confidential	5 per year		Wed 17 Feb		Wed 21 Apr		Wed 23 Jun		Wed 18 Aug		Wed 20 Oct		
Commissioning Health Equity Advisory Committee (CPHAC)	Quarterly +2 DHBs			Wed 17 Mar			Wed 16 Jun			Wed 15 Sep		Wed 17 Nov	
Disability Support Advisory Committee (DiSAC)	Quarterly + 2 DHBs		Wed 10 Feb *8 Feb Waitangi*			Wed 19 May			Wed 11 Aug			Wed 17 Nov	
Major Capital Expert Advisory Group	5 per year		Tues 2 Feb		Tues 6 Apr		Tues 8 Jun		Mon 2 Aug		Mon 4 Oct		

Establishment of Executive Committee of the Board

Recommendation

That the Board:

1. **That the Board approve the establishment of an Executive Committee (under schedule 3 clause 38 of the New Zealand Public Health and Disability Act 2000) to consider any matters that require the urgent attention of the Board during the Christmas/ New Year Board recess.**
2. **That membership of the Committee is to comprise the Board Chair, Pat Snedden, the Deputy Board Chair, Tama Davis, Michael Quirke, Zoe Brownlie and Doug Armstrong, with a quorum of three members (the Deputy Board Chair needs to be one of the three members).**
3. **That the Executive Committee be given delegated authority to make decisions on the Board's behalf relating to the urgent approval of business cases, leases and the awarding of contracts for facilities development, services and supplies and information services and on any other urgent recommendations from the Chief Executive.**
4. **That all decisions made by the Executive Committee be reported back to the Board at its meeting on 27 January 2021.**
5. **That the Executive Committee be dissolved as at 27 January 2021.**

Prepared by: Marlene Skelton (Corporate Business Manager) for Pat Snedden (Board Chairman)

Glossary

NZPH&D Act - New Zealand Public Health and Disability Act 2000

1. Purpose

To seek the Board's approval to establish a committee to conduct pressing Board business during the Christmas/New Year recess.

2. Background

The final normal scheduled meeting of the Board for the year is on 16 December 2020. The next meeting is on 27 January 2021. There may be some items of business requiring approval at Board level that need to be processed during this period.

Under the NZPH&D Act (Schedule 3 Clause 38) there is provision for the Board to establish one or more committees for a particular purpose or purposes.

3. Proposal

As in recent years, it is proposed that the Executive Committee should have a relatively small membership so that it can be convened at short notice, should this be necessary. The proposed membership is the Board Chair, Pat Snedden, the Deputy Board Chair, Tama Davis, Michael Quirke, Zoe Brownlie and Doug Armstrong, with a quorum of three members (the Deputy Board Chair needs to be one of the three members).

It is expected that, by their nature, any items referred to this Committee are likely to need to be taken in public excluded session. The date and agenda items of any meeting(s) would, as soon as confirmed, be advised to all Board members and meeting(s) publicly notified if they involve any open meeting agenda reports.

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 4 November 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 Circular Resolution – Annual Report 2019-2020	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Action Points	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
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 - 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]
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 Health and Safety Report	**Confidence** Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report [Official Information Act 1982 s9(2)(ba)] **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report, and those measures would be prejudiced by publication at this time [Official Information Act 1982 s9(2)(c)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.1 Finance, Risk and Assurance Committee Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section

	made public.	9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.2 Hospital Advisory Committee Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was 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 Pump Fleet Replacement Programme	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.2 Service Level Agreement - ODNZ	**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. **Privacy of Persons** Information relating to natural person(s) either living or deceased is enclosed in this report.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.3 Peptide Receptor Radionuclide Therapy for Patients with Neuroendocrine Tumours (PRRT): National Service Provision	**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. **Obligation of Confidence** Information which is subject to an express obligation of confidence or	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]

	which was supplied under compulsion is enclosed in this report.	
9.4 EP Lab Radiographic Equipment - Capex Variation Approval	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.5 Building for the Future: Ward 51 – additional infection prevention capacity	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.6 Security for Safety programme capex variation	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report, and those measures would be prejudiced by publication at this time [Official Information Act 1982 s9(2)(c)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.7 Purchase 99 Grafton Road	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
10.0 Discussion Reports - Nil	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

11,0 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]
12.0 General Business	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]