Waitematā
District Health Board

Best Care for Everyone

BOARD MEETING

Wednesday 15 December 2021

9.00am

AGENDA

Items to be considered in public meeting

VENUE

Zoom: https://waitematadhb.zoom.us/j/98292832829

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.

Waitematā District Health Board
Best Care for Everyone

MEETING OF THE BOARD
15 December 2021

Zoom: https://waitematadhb.zoom.us/j/98292832829

Time: 9.00am

WDHB BOARD MEMBERS	WDHB MANAGEMENT
Judy McGregor - WDHB Board Chair Edward Benson-Cooper - WDHB Board Member John Bottomley – WDHB Board Member Chris Carter – WDHB Board Member Kylie Clegg - WDHB Board Deputy Chair Sandra Coney - WDHB Board Member Warren Flaunty - WDHB Board Member David Lui - WDHB Board Member Eru Lyndon - WDHB Board Member Allison Roe - WDHB Board Member Renata Watene - WDHB Board Member BOARD OBSERVERS Wesley Pigg Amber-Paige Ngatai	Dale Bramley - Chief Executive Officer Robert Paine – Executive Director, Finance People and Planning Peta Molloy - Board Secretary

APOLOGIES:

REGISTER OF INTERESTS

- 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?

PART 1 – Items to be considered in public meeting

AGENDA

9.00am	1.	**AGENDA ORDER AND TIMING**
	2.	**BOARD & COMMITTEE MINUTES**
9.05am	2.1	Minutes of the Meeting of the Board (17/11/21) Actions arising from previous meetings
	3	**EXECUTIVE REPORTS**
9.10am	3.1	Chief Executive Update
9.30am	3.2	Health, Safety and Wellbeing Performance Report
	4.	**DECISION ITEMS**
9.40am	4.1	Memorandum of Understanding with Midwifery Council of New Zealand
9.50am	4.2	Childhood Immunisation
10.05am	4.3	Director Appointment to healthAlliance NZ Limited Board
	5.	**PERFORMANCE REPORT**
10.10am	5.1	Financial Performance Report
	6.	**INFORMATION ITEMS**
10.20am	6.1	NZ health Survey Update 2017-2020: How Waitematā DHB Compares
10.30am	6.2	Update on the Health (Fluoridation of Drinking Water) Amendment Bill
10.40am	**7.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Waitematā District Health Board

Board Member Attendance Schedule 2021

NAME	Feb	Mar	Apr	Jun	Jul	Aug	Oct	Nov	Dec
Judy McGregor (Board Chair)	✓	✓	✓	✓	✓	✓	✓	✓	
Kylie Clegg (Deputy Chair)	✓	✓	✓	✓	✓	✓	✓	✓	
Edward Benson-Cooper	✓	×	✓	✓	✓	✓	✓	✓	
John Bottomley	✓	✓	✓	✓	✓	✓	✓	✓	
Chris Carter	✓	✓	✓	✓	✓	✓	✓	✓	
Sandra Coney	✓	✓	✓	✓	✓	✓	✓	✓	
Warren Flaunty	✓	✓	✓	✓	✓	✓	✓	✓	
Eru Lyndon	n/a	n/a	✓	✓	×	✓	✓	*	
David Lui	n/a	n/a	✓	✓	✓	✓	✓	✓	
Allison Roe	✓	✓	✓	✓	✓	✓	✓	✓	
Renata Watene	✓	✓	✓	✓	✓	✓	✓	✓	

✓ *Present*
× *Apologies given*
* *Attended part of the meeting only*
\# *Absent on Board business*
^ *Leave of Absence*

REGISTER OF INTERESTS

Board Member/Observer	Involvements with other organisations	Last Updated
Judy McGregor (Board Chair)	Chair – Health Workforce Advisory Board Chair – Mental Health and Addiction Assurance Group Minor Shareholder – Sky TV New Zealand Law Foundation Fund Recipient Consultant – Asia Pacific Forum of National Human Rights Institutions Media Commentator – NZ Herald Patron – Auckland Women's Centre Life Member – Hauturu Little Barrier Island Supporters' Trust	25/08/21
Kylie Clegg (Deputy Board Chair)	Contract with Ministry of Health for services relating to Seat at the Table DHB Governance Development Programme Trustee – Well Foundation Director – Auckland Transport Trustee and Beneficiary – Mickyla Trust Trustee and Beneficiary, M&K Investments Trust (includes shareholdings in a number of listed companies, but less than 1% of shares of these companies, includes shareholdings in MC Capital Limited, HSCP1 Limited, MC Securities Limited, HSCP2 Limited, Next Minute Holdings Limited). Orion Health has commercial contracts with Waitematā District Health Board and healthAlliance.	11/08/21
Edward Benson-Cooper	Director – Harbourside Chiropractic Ltd with private practice commitments Board Member – New Zealand Chiropractic Board (NZCB) Member – Professional Conduct Committee (PCC) for the NZCB Trustee – Supported Lifestyle Hauraki Trust Member – Three Harbours Health Foundation Edward has numerous (different) family members with positions across the Auckland DHB regions including; Chairman for Intra Limited, Director of Mercy Radiology Group, Director of Mercy Breast Clinic, Intensive Care Specialist at the Department of Critical Care Medicine & Anaesthetist at Mercy Hospital	14/11/21
John Bottomley	Consultant Interventional Radiologist – Waitematā District Health Board	17/12/19
Chris Carter	Chairperson – Henderson-Massey Local Board, Auckland Council Trustee – Lazarus Trust	18/12/19
Sandra Coney	Member – Waitakere Ranges Local Board, Auckland Council Patron – Women's Health Action Trust Member – Cartwright Collective	16/12/20
Warren Flaunty	Chair – Trust Community Foundation Trustee (Vice President) – Waitakere Licensing Trust Shareholder – EBOS Group Shareholder – Green Cross Health Shareholder - Third Aged Health Director – Life Pharmacy Northwest Chair – Three Harbours Health Foundation Member – Henderson Rotary Club Trustee – Hospice West Auckland (past role)	25/10/21
David Lui	Director – Focus on Pacific Limited Board Member – Walsh Trust (MH provider in West Auckland that has contracts with WDHB) Chairman – Henderson High School BOT Executive Member – Waitakere Health Link (holds a contract with WDHB)	22/05/21
Eru Lyndon	Regional Commissioner (employee) - Ministry of Social Development Board member - Advisory Board, University of Auckland Business School Chair - Waitangi Ltd Director - National Hauora Coalition	23/06/21

REGISTER OF INTERESTS

Board Member/Observer	Involvements with other organisations	Last Updated
	Independent Advisor, Investment Advisory Committee, Sport New Zealand Trustee - The Lyndon Family Trust	
Allison Roe	Acting Chairperson and Deputy Chair Matakana Coast Trail Trust Member, Wilson Home Committee of Management (past role)	07/04/21
Renata Watene	Owner – Occhiali Optometrist Board Member – OCANZ Strategic Indigenous Task Force Council Member - NZAO Member- Te Pae Reretahi (previously Toi Ora Advisory Board) Professional Teaching Fellow, University of Auckland Optometry Department	17/02/21
Wesley Pigg (Board Observer)	Employee (physiotherapist) – Waitematā DHB	14/10/20
Amber-Paige Ngatai (Board Observer)	Employee (nurse) – Waitematā DHB	14/10/20

Conflicts of Interest Quick Reference Guide

Under the NZ Public Health and Disability Act 2000, a member of a DHB Board who is interested in a transaction of the DHB must, as soon as practicable after the relevant facts have come to the member's knowledge, disclose the nature of the interest to the Board.

A Board member is interested in a transaction of a DHB if the member is:

- a party to, or will derive a financial benefit from, the transaction; or
- has a financial interest in another party to the transaction; or
- is a director, member, official, partner, or trustee of another party to, or person who will or may derive a financial benefit from, the transaction, not being a party that is (i) the Crown; or (ii) a publicly-owned health and disability organisation; or (iii) a body that is wholly owned by 1 or more publicly-owned health and disability organisations; or
- is the parent, child, spouse or partner of another party to, or person who will or may derive a financial benefit from, the transaction; or
- is 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 responsibilities, then he or she may not be "interested in the transaction". The Board should generally make this decision, not the individual concerned.

A board member who makes a disclosure as outlined above must not:

- take part in any deliberation or decision of the Board relating to the transaction; or
- be included in the quorum required for any such deliberation or decision; or
- sign any document relating to the entry into a transaction or the initiation of the transaction.

The disclosure must be recorded in the minutes of the next meeting and entered into the interest register.

The member can take part in deliberations (but not any decision) of the Board in relation to the transaction if a 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.

Board members are expected to avoid using their official positions for personal gain, or solicit or accept gifts, rewards or benefits which might be perceived as inducement and which could compromise the Board's integrity.

IMPORTANT

Note that the best course, when there is any doubt, is to raise such matters of interest in the first instance with the Chair who will determine an appropriate course of action.

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

Note: This sheet provides summary information only.

2.1 Confirmation of Minutes of the Board meeting held on 17 November 2021

Recommendation:

That the draft Minutes of the Board meeting held on 17 November 2021 be approved.

DRAFT Minutes of the meeting of the Waitematā District Health Board

Wednesday, 17 November 2021

held by video conference
commencing at 9.52am

PART I – Items considered in public meeting

BOARD MEMBERS PRESENT:

Judy McGregor (Board Chair)
Edward Benson-Cooper
John Bottomley
Chris Carter
Kylie Clegg (Deputy Chair)
Sandra Coney
Warren Flaunty
David Lui
Eru Lyndon
Allison Roe
Renata Watene

ALSO PRESENT:

Dale Bramley (Chief Executive)
Robert Paine (Executive Director, Finance People and Planning)
Deanne Manuel (Committee Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

Rowan Quinn (Radio New Zealand)

WELCOME:

The Board Chair welcomed everyone in the meeting.

APOLOGIES:

There was no apology received.

DISCLOSURE OF INTERESTS

There were no additions or amendments to the Interests Register.

There were no disclosures of interest for items on this agenda.

1 AGENDA ORDER AND TIMING

For the open meeting, items were taken in same order as listed in the agenda except

2 BOARD AND COMMITTEE MINUTES

2.1 Confirmation of Minutes of the Board Meeting held on 6 October 2021 (Agenda pages 8-18)

Resolution (Moved Chris Carter/Seconded Eru Lyndon)

That the draft Minutes of the Board meeting held on 6 October 2021 be approved.

Carried

Actions arising from previous meetings (Agenda page 19)

There were no issues raised and the updates were noted.

2.2 Minutes of the Meeting of the Hospital Advisory Committee (27/10/21) (Agenda pages 20-25)

Resolution (Moved Edward Benson-Cooper/Seconded Warren Flaunty)

That the draft Minutes of the Hospital Advisory Committee meeting held on 27 October 2021 be received.

Carried

3 EXECUTIVE REPORTS

3.1 Chief Executive Update (Agenda pages 26-46)

Dr Dale Bramley (Chief Executive) summarised the report. He highlighted the progress of the metro Auckland DHBs to reach the 90% COVID-19 vaccination target while acknowledging the efforts of community partners and providers; noted the opening of pop-up testing centres and events to promote vaccination across the region; recognised the Minister of Health Volunteer award received by the Westlake Boys and Girls who volunteer their time to support North Shore Hospital; and noted the completion of the demolition of the Raeburn House to make way for Māori Health Centre and the whānau accommodation.

Matters covered in discussion and response to questions included:

- Noted the sustained pressure in emergency departments within metro Auckland impacted by COVID-19 screening; there is a regional process employed by the three DHBs around capacity.
- Acknowledged the generosity of Rita and Filitoga Fepulea'I in providing staff lunches
- Noting the process of health checks for COVID-19 positive patients isolating at home.
- Noted that colonoscopy procedures have been catching up before the August lockdown restrictions; urgent cases are prioritised and continue to be within

timeframes, however, outsourced capacity has reduced during the alert level restrictions.
- Noted the continuing effort to balance capacity during a public health emergency; despite challenges, planned care performance is steadily rising. The impact of COVID-19 on waiting lists and cancer services are being looked into by the Health Quality and Safety Commission and the National Cancer Agency.
- Noted the process of securing an exemption from the COVID-19 Public Health Response (Required Testing and Vaccinations) Amendment Order 2021; the DHB's policy is aligned with this process

The Board acknowledged the work of the staff in the on-going response.

The report was received.

3.2 Health, Safety and Wellbeing Performance Report (Agenda pages 47-61)

Fiona McCarthy (Director, People and Culture) and Michael Field (Group Manager, Occupational Health and Safety Service) joined by video conference for the item.

Fiona McCarthy took the report as read. She acknowledged the work of the staff during the completion of the ACC audit.

In response to a query, a more detailed narrative on physical aggression incidents will be indicated in future report.

The Board acknowledged the work of the DHB in achieving the ACC tertiary provider status and received the report.

4 DECISION ITEMS - nil

5 PERFORMANCE REPORT

5.1 Financial Performance Report (September) (Agenda pages 62-78)

Robert Paine (Executive Director, Finance People and Planning) took the report as read.

Matters covered in discussion and response to questions included:
- Noting the financial performance for the first quarter up to October is tracking well and favourable against budget, it was clarified that the financial result is not a consequence of under delivery particularly of planned care services.
- Noted the on-going recruitment including when the international borders open; some ICU staff positions have been recruited into.
- Noted that some cost recorded under COVID-19 extra-ordinary cost are 'indirect' expenditures (such as annual leaves) and are not likely to be reimbursed.

The report was received.

6 INFORMATION ITEMS - nil

GENERAL BUSINESS

No matter of general business was raised.

7 RESOLUTION TO EXCLUDE THE PUBLIC (agenda pages 79-82)

Resolution (Moved Kylie Clegg/Seconded Warren Flaunty)

That, in accordance with the provisions of Schedule 3, Sections 32 and 33, of the NZ 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 items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1.	**Minutes of Meeting of the Board - Public Excluded (06/10/21)**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.
2.	**Minutes of the Audit and Finance Committee – Public Excluded (27/10/21)**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
3.	**Minutes of the Hospital Advisory Committee – Public Excluded (27/10/21)**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.
4.	**Chair's Report**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]
5.	**COVID 19 Staffing Update**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]
6.	**Digital Workspace Programme**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
7.	**Infrastructure Services Programme T1A Additional Infrastructure Enhancements Works**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
8.	**Mason Clinic Interior Remediation**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
9.	**Mental Health Services**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
10.	**Legal Update**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)] **Legal Professional Privilege** The withholding of the information is necessary to maintain legal professional privilege. [Official Information Act 1982 S.9 (2) (h)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]

Carried

The open meeting concluded at 10.32am.

SIGNED AS A CORRECT RECORD OF THE MEETING OF THE WAITEMATĀ DISTRICT HEALTH BOARD - BOARD MEETING HELD ON 17 NOVEMBER 2021.

_____BOARD CHAIR

Actions Arising and Carried Forward from Previous Board Meetings as at 10 December 2021

Meeting Date	Agenda Ref	Topic	Person Responsible	Expected Report back	Comment
03/03/21 CPHAC	4.2	Home and Community Support Services Update on transition to the case-mix model for Home and Community Support Services (HCSS) to be presented to the Board		TBA	Transferred from CPHAC. Re-scheduled due to COVIID-19 response requirements
14/07/21	3.2	Health, Safety and Wellbeing Performance Report Board workshop with workshop with the Employers and Manufacturers Association will be scheduled	Fiona McCarthy	TBA	Re-scheduled due to COVIID-19 response requirements
06/10/21	3.2	Health, Safety and Wellbeing Performance Report Detailed update on i3 and the digital governance to be presented to a future Board meeting	Fiona McCarthy/ Penny Andews	TBA	TBA due to COVIID-19 response requirements

3.1 Chief Executive's Report

Recommendation:

That the Chief Executive's report be received.

Prepared by: Dr Dale Bramley (Chief Executive Officer)

1. News and events summary

A number of events of significance took place across the DHB over the past eight weeks:

Rest in peace: Matua Pio Jacobs

Pio and Chrissy Jacobs *at Waitakere Hospital in 2019.*

The passing of Matua Pio Jacobs in November marked the end of an era for Waitematā DHB. Matua Pio and his late wife Chrissie were well-known advocates and teachers of tikanga and te reo Māori. They worked closely with various health organisations - including Waitematā DHB - as cultural advisors for many years before their retirement in 2017.

Both were particularly well-known as kaumatua at Waitakere Hospital after starting work for the DHB in 2002 – not far from their long-time home in Henderson. There, they supported staff, patients and visitors – ensuring Māori protocol was understood and observed wherever appropriate as part of everyday hospital life. They provided additional cultural support at multiple openings and special events and were special guests during the opening of Wairua Tapu, Chapel of the Holy Spirit, in 2019.

Matua Jacobs , who was of Te Aupōuri and Te Rarawa descent, was born in Pawarenga and moved to Auckland as a teenager. The father-of-10 was 89.

New Waitakere Hospital Intensive Care Unit

The go-ahead for a six-bed Intensive Care Unit at Waitakere Hospital at a cost of $20 million has just been announced by the Government.

This represents a historic moment in the evolution of health care for the people of West Auckland and recognises a long-running grass roots campaign by the local community to have more services based at Waitakere Hospital.

Waitematā DHB has always been a significant part of that movement and we have pressed the case at every opportunity. This news is a cause for celebration for our community and the many people and groups who have supported the cause and added their voice to the campaign.

The ICU will be on the ground floor of a new ward block, that new ward having already been announced in April this year. This will be the biggest development on the Waitakere campus since major developments that occurred in 2003, which included the opening of the expanded hospital block, the Waiatarau mental health inpatient unit, renal haemodialysis building, ED and Woodford Gardens.

The announcement means fewer transfers for people who need high-level ICU care to North Shore or Auckland City hospitals where there are already dedicated ICU facilities. People who are sicker and needing a higher level of care will be able to stay in their local community in West Auckland. The burden of travel will also be removed for families visiting them and it will help keep loved ones together to reduce a little bit of the stress associated with having a whānau member in-need of ICU-level care. The development of an ICU will be the building block for a wider range of inpatient services and more complex care that requires an ICU on-site. Once the ICU is in place, a range of other services can then be developed.

With the additional ward, ICU and expanded Special Care Baby Unit due to open in 2022, we are now seeing a very significant amount of investment in the Waitakere Hospital site. We hope this investment continues into the future as West Auckland is one of the fastest-growing areas of New Zealand with a population greater than the entire Bay of Plenty district. The area has a large Māori and Pacific population and we need to continue developing more local services at Waitakere Hospital to assist our ongoing drive to address health inequities.

The Government has also just announced $5.58 million for further developments at North Shore Hospital that will assist the DHB in managing the care needs of COVID-positive patients.
This will include the creation of eight isolation rooms, all with negative pressure capability, at the Elective Surgery Centre.

In the main North Shore Hospital tower block, there will also be two additional isolation rooms created in the High Dependency Unit (HDU) with negative pressure capability. A negative pressure environment will also be created in an open area within the North Shore ICU/HDU facility.

These investments will enable our DHB to quickly increase capacity to care for COVID-positive patients, with the North Shore works scheduled to be completed by mid-2022.

Ministerial visit
North Shore Hospital received a visit from the Minister of Health, Hon Andrew Little, on 25 November to discuss our Covid-19 response and to see the work that has gone into caring for our Covid-19-positive patients.

The Minister took the time to encourage and support our staff for the work they've done to keep our patients, staff and communities safe and was particularly interested in the work we've put into caring for our patients who are recovering from the illness at home.

While he was here, he took a tour of the building site for our new hospital facility, Tōtara Haumaru - things were looking very different to when he was here last!

Minister, Dr Kate Allan, Dr Willem Landman

Dr Judy McGregor, the Minister and Dr Bramley inspecting the foundations

Waitakere ICU Ahead Announcement

Having a COVID-19 household plan

With COVID-19 circulating widely in the community, Waitematā DHB is encouraging families to have a plan in place to help them get through in the event that a member of their whānau bubble becomes infected. The DHB is encouraging people in the Waitematā district to consider the needs of their whānau if they were to test COVID-positive, including not just healthcare needs but also daily living necessities. https://www.waitematadhb.govt.nz/news/posts/have-a-household-plan-ready-as-auckland-opens-up/

Robotic surgery

Our DHB became the first in New Zealand to offer robot-assisted prostate cancer surgery in the public sector when it launched a two-year pilot of the da Vinci robotic surgical system at North Shore Hospital in November. The less-invasive high-tech option is available at a small number of private practices, though high costs can make it unviable for patients without health insurance. The first operation on 19 November went well and I want to thank all those who played a part in achieving this historic national milestone.

Thanks also to the many individuals who have worked diligently behind the scenes to bring this technology to our DHB. The robot, named Toa prior to being blessed by DHB kaumatua, is being made available for no capital outlay by Australian-based Device Technologies and the trial will determine if a longer-term purchase would be cost-effective.

The availability of this service in a public hospital setting puts us a step closer to achieving the kind of equity that we continually strive for in our work to provide best care for everyone. Importantly, it also paves the way for our DHB to form a centre of excellence for minimally-invasive robotic surgery in cancer and other fields.

Above: *Toa, the new da Vinci surgical robot, pictured with staff shortly after installation at North Shore Hospital*

COVID-19 community vaccination clinics
90% doubled vaccination achieved on Friday 3 December for Waitematā DHB, we're the third in the country to meet this milestone. 90% Pacific first dose vaccination achieved for Waitematā DHB, a first in the region, and expected to hit 90% fully vaccinated on 1 January. 88% of Maori first dose vaccination achieved.

Our outreach programme delivered pop-ups across the region using our vaccination campervans, including in Birkenhead, Orewa, Te Aroha Pa Marae, Kainga Ora sites in Ranui, Henderson, Te Atatu Peninsula and Puhoi. We hare setting up at supermarkets, schools and worksites across the region to ensure everyone has access to vaccinations.

Pfizer booster shots for staff
We are now offering staff booster doses to further guard against COVID-19. Medsafe approved a booster dose of the Pfizer vaccine for people aged 18 years and older who had their second dose at least six months ago. We have begun the booster roll-out to a number of our staff here at the DHB, with the opening of staff vaccination clinics from Monday, 29 November starting with our 'blue stream' staff.

Christmas activities

We have put together a programme of activities to help staff celebrate with their colleagues in the lead-up to Christmas. Large Christmas trees have been put up in the foyers at North Shore and Waitakere hospitals and staff are decorating their areas for the Christmas decoration competition.

As well as activities at North Shore and Waitakere hospitals, we will be providing '*Christmas in a box*' to our community sites. Over the next three weeks, we will have:

- a lighting display in the healing garden at North Shore organised by the Well Foundation and local church.
- Santa, Mrs Claus and an elf visiting North Shore Hospital on 15 Dec and Waitakere on 16 Dec. They will be giving out covered sweets and available for socially-distanced photos
- gifts for the children of staff aged 4 to 8 – collected from under the tree
- a choir performing by the lake at North Shore Hospital
- a Pacific choir performing outside Waitakere Hospital
- a Christmas quiz with prizes
- Thank you trees for staff to thank their colleagues
- free ice creams for staff
- small service-based lunches
- weekly advent services
- Christmas greeting videos from Shortland Street actors

Wellbeing initiatives

It's been a challenging year for our DHB staff and we've had to quickly learn to live and work with the tension that COVID-19 brings. It is important to recognise that we all carry a degree of COVID-19-related stress, even if we think we're doing relatively well. Our DHB is rolling out a series of 'staff wellbeing' events and resources to support our whānau to recognise the strain we are under, develop strategies for managing how we are feeling and to look after ourselves and each other.

Emergency doctors perform Crowded House's *Better Be Home Soon*

It was great to see three of our own emergency department team in the ED Musos group that performed an online version of Crowded House's *Better Be Home Soon* - Kim Yates, Sarah Dunlop and Kathryn Clark. They even got a shout-out from Crowded House on their Facebook page. The ED Musos group, which is made up of emergency physicians and healthcare workers from Australia, New Zealand and the UK, formed at the start of the pandemic. More than 100 people took part in this performance.

ED Musos group

New laparoscopy towers

In November, Waitakere Hospital took delivery of new laparoscopy towers. These towers provide visualisation and documentation of procedures using high-definition video support. They are used in a variety of surgical disciplines. Surgeons can now use endoscopic/laparoscopic technology to perform many highly effective surgical and diagnostic procedures without the major incisions and long recovery inconveniences that patients once faced. With these new towers, we are bringing enhanced technology and quality-of-care to the patients and communities we serve.

White Ribbon Day – Thursday, 25 November
White Ribbon Day, held on Thursday, 25 November, is the international day where people wear a white ribbon to show that they do not condone violence towards women. Waitematā DHB is committed to White Ribbon Day and the promotion of non-violence towards our staff and within our communities. Staff supported the cause by wearing a white ribbon during the week.

Antimicrobial Awareness Week 2021
Antimicrobial Awareness Week took place between 18- 24 November. Antimicrobial resistance is a worldwide problem that compromises human and animal health. It is due to over-use and misuse of antibiotics, leading to the loss of their effectiveness. During this week, we focused on penicillin allergy and the impact this can have on antimicrobial resistance.

Transition Unit road show – the switch to Health NZ
The Transition Unit tasked with overseeing the transition of DHBs to Health NZ has started holding information session during November to help staff find out more and ask questions. A presentation for Waitemata DHB staff held on 24 November attracted more than 250 participants.

Well Foundation updates
<u>COVID-19 Staff and patient wellbeing</u>
Well Foundation continue to work with the staff wellness and patient experience teams to assist in obtaining donations to support DHB staff and vulnerable patients and the welfare packs have now been restocked with support from Countdown.

Well Foundation is also part of the Christmas committee, securing and facilitating donations for indoor and outdoor Christmas displays and items to support plans for bringing extra Christmas cheer to our staff, patients and visitors this year.

<u>COVID-19 vaccine manaakitanga</u>
Well Foundation has been working with the NRHCC and led a collaboration with Middlemore Foundation and Auckland Health Foundation, to secure retail vouchers to be used in support of the COVID vaccination drive among Maori and Pacific Island communities. NRHCC approved $500k to purchase essential retail vouchers to be used as manaakitanga for those that choose to receive either their first or second vaccination dose ($100 voucher per vaccine). Well Foundation worked with partners at Vodafone, The Warehouse, Z Energy and Countdown to facilitate the purchase of these vouchers and to put partnership agreements in place providing additional donated contributions resulting in total donated voucher value of $780,000 in addition to the $500k purchased by NRHCC.

<u>Health worker appreciation campaign</u>
Well Foundation is involved in a public campaign in collaboration with the three Auckland Foundations and DHBs; providing an easy way for the public to choose their local hospital/region and make a small donation to thank the health workforce. Donations are received by the Foundations, and through a partnership with SOS Business, vouchers for local small business are purchased and distributed to health workers as a 'thank you' gift from the community. The campaign launched with Stuff on Monday 6 December as our media partner to tell positive health worker stories.

Tōtara Haumaru fundraising campaign development

Concept designs for the atrium have been further developed and indicative costings of $2.5mil provided. A revised concept design is being developed by Jasmax based on feedback that the 'greenscape' concept could be further enhanced with design features that utilise the available height. Work is also progressing on agreeing campaign arrangements with DHB teams for the whānau rooms as well as securing donor commitments to support a future business case for purchasing an upgraded a Vinci surgical robot.

A mock-up of a proposed design

Capital programmes update

COVID-19

The programme of works in response to the COVID-19 Delta variant has included completion of projects in the emergency departments, Elective Surgery Centre and community services, such as renal and alcohol and drug services. Further projects are underway to increase the DHB's capacity and capability to manage COVID-positive patients, including additional oxygen capacity, negative pressure areas and segregation of patient areas.

The second crane has now been erected on the Tōtara Haumaru site (refer Figure 1). Detailed excavation and foundations are continuing, with pile cap and ground beam reinforcing commenced in zone 2B. Inground services below the ground beams has also been completed in zone 2B. Zone 1b and 2b are those areas closest to the Elective Surgery Centre.

Figure 1: Tōtara Haumaru site (November 2021)

Foundations of the new building being laid

Developed design for the Mason Clinic Tranche 1A/1B facility E Tū Wairua Hinengaro commenced on 20 September, with a target completion date of 2 March 2022. Once completed, this facility will enable the DHB to move all patients out of the existing facilities with known weather-tightness issues.

Detailed design for the North Shore Central Sterile Supplies Department upgrade project is now complete. In mid-November the tender for the main contractor was issued to the shortlisted suppliers and the building consent was lodged with Auckland Council. Construction is on-track to start in February 2022, subject to the outcome of the tender process.

The resource and building consents have been approved for the NSH Māori Health 'New Build'. Demolition of Raeburn House has been completed (refer Figure 2). Excavation and civil works have now commenced.

Figure 2: Raeburn House pre-demolition and post-demolition

Before and after shots of the demolition

The electric vehicle (EV) infrastructure has been ordered now that the Decarbonisation fund application is approved. We expect this to be installed in time for EV roll-out early next year.

Creating a culture of appreciation

Another 30 people have been recognised in our fortnightly CEO Awards, which were launched in mid-2014 to celebrate those staff, nominated by their colleagues and patients, who demonstrate our organisational values through their work.
Each staff member, whose nomination is considered worthy of acknowledgement, receives a personalised letter of thanks, a certificate of appreciation and a small gift. Staff acknowledged with a CEO Award since the last Board meeting are included as ***Appendix one.***

1. Upcoming events

Looking toward the upcoming months, we can expect to see:

- Christmas activities:
  - a choir performing by the lake at North Shore Hospital
  - a Pacific choir performing outside Waitakere Hospital
  - Thank you trees for staff to thank their colleagues
- Ongoing work on Whānau Ora accommodation project
- Ongoing work on Tōtara Haumaru

2. Future focus

<u>Project Accelerate</u>

Project Accelerate has been running since mid-October. It's an ELT-sponsored, DHB-wide programme accelerating our response to the current Delta outbreak and updating our planning for

living with COVID in our community and hospitals. The aim of the project is to have an endemic COVID readiness plan by Dec 24. The programme consists of 10 workstreams covering the workforce, facilities, care pathways, community services, equity and staff and whānau welfare, and data and digital innovation. Each workstream is led by an ELT member; has a multi-disciplinary steering group; and is coordinated by a project manager. The ELT meets three times weekly to track progress and provide continuous strategic oversight.

One of the IS developments has been to set up communications with patients in isolation rooms using iPads and Zoom video conferencing. This allows easy communication between staff and patients whilst reducing the number and frequency of people having to enter the room in full PPE. The system has also enabled family members to attend "family meetings" with the doctor and patient.

Thanks to the loaned monitors from WTH SCBU, ESC is now able to monitor the respiratory rate of patients electronically. This has removed another requirement to enter the room and allows staff to intervene immediately if they see this critical measure increasing.

Another initiative from Project Accelerate is the COVIDCare@Home service which is now in operation, with nurses monitoring COVID-positive patients remotely while they are self-isolating at home. This service has SMO oversight and links patients into welfare services as required. Once clinically stable, these patients are then handed over to community providers for ongoing care.

The DHB's Artificial Intelligence Governance Group (AIGG) is presenting its first review of a new AI system to the Clinical Governance Board and the service proposer.

3. Board performance priorities
The following provides a summary of the work underway to deliver on Waitematā DHB's priorities:

Relief of suffering
Progress: ✔

Patient experience
Patient Experience feedback
National Inpatient Survey

The results for the national inpatient survey conducted with patients who were discharged between the 25 October - 7 November are due for release on 11 January 2022.

Friends & family test overall results – adult survey
In October, the Net Promoter Score (NPS) was 85 with feedback from 440 people. This is our highest score since the survey questions changed in November 2020 (previous high score NPS 87). The number of responses is still lower than usual due to Covid-19. However, despite visitor restrictions, three measures achieved their highest scores to-date, 'listened to', 'involved in decision-making' and 'explained in a way I understood', achieving scores of 88, 82 and 89 respectively.

Friends & family test overall results

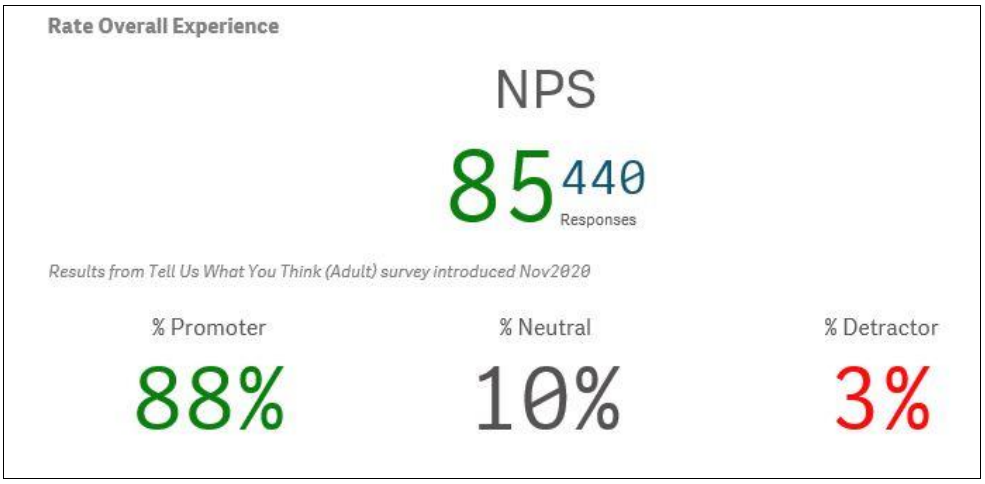
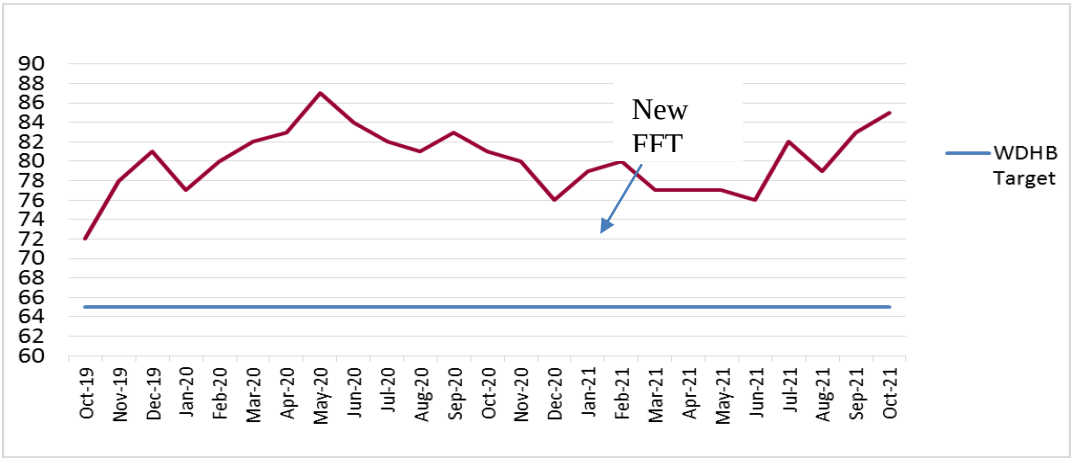


Figure 1: Waitematā DHB overall NPS

Pt Experience by Service

Month & Year	Surveys	Rate Overall Experience	Welcoming and Friendly	Listened To	Treated with Compassion	Involved in Decision Making	Explained in a Way I Understood
Totals	**440**	**85**	**91**	**88**	**89**	**82**	**89**
Oct-2021	440	85	91	88	89	82	89

Table 1: Waitematā DHB overall FFT results



Graph 2: Waitemata DHB Net Promoter Score over time

The above chart show the net promoter score over the last two years. A new Friends and Family Test was introduced in November 2020, changing the question from 'based on your experience, would you recommend' to a general question asking about their overall experience. The scale was also changed from a five-point scale to a more sensitive 11-point scale.

Patient experience highlights

- **COVID response**

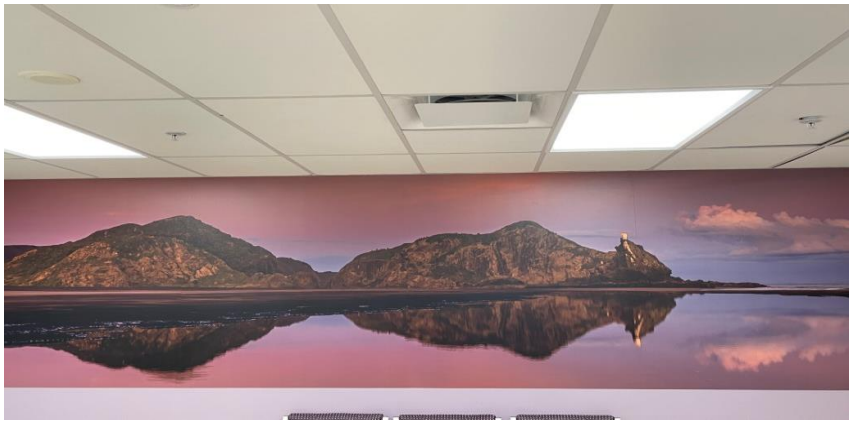
Patient Experience continues to support the COVID response by leading 'Patient Welfare' and supporting initiatives such as patient and whānau welfare support, visitor policy, emergency food parcels for patients, welfare travel letters and endemic response planning.

- **Christmas planning**

Patient Experience is working with the Well Foundation, Staff Welfare and the Communications team to safely deliver Christmas activities and bring festive joy to our staff, patients and visitors. Activities include decorating the hospital foyers, piano playing, outdoor light displays, staff Christmas day meals and individually wrapped teddy bears for our paediatric patients.

Māori patient and whānau experience update

Installations of the final set of decals have been completed at Waitākere hospital for the ADU, surgical reception, allied therapy Gym and mental health assessment rooms in ED. The decals are photographs of the local west Auckland beaches taken by one of our nurses – David Prentice. Feedback from patients and staff have all been positive about the difference they make during their time on-site in these spaces. The intent of these decals is to optimise healing opportunities by bringing images of natural elements to internal spaces without external windows. So far, we have had stories of using the art to engage with patients positively, supporting communication development, patients sharing stories and some whānau using them as photo backgrounds with their loved ones at special moments in addition to the imagery giving moments of calm and visual escape from clinical environment. A welcome addition at this time for both patients and staff.



Whatipu at sunset installed in Surgical ReceptionWaitākere to help calm anxious patients on arrival

Volunteers

Recruitment statistics

Volunteer numbers are down by two on the previous month.

Green Coats Volunteers (Front of House) (A)	Other allocated Volunteers (B)	Volunteers on boarded awaiting allocation (C)	Total volunteers available (D) (A) + (B) + (C) =(D)
50	134	11	195

Table 5:

Volunteer highlights

- Recruitment

The Patient Experience team is still receiving and processing applications steadily through our online process and word-of-mouth. However, on-boarding and induction have been put on-hold because of Covid-19 restrictions for most candidates.

- Hospital Auxiliary

The Hospital Auxiliary volunteers continue to prepare and supply orders for the North Shore and Waitakere hospitals. In October, 527 items were distributed. In addition, they have also supplied "warm packs" to dialysis unit on a regular basis. These packs consist of knee blankets, fingerless gloves, scarves and beanies.

Preparing for Christmas, 30 of the required 90 specially designed bibs (picture 1 below), and 63 knitted dolls (picture 2 below) have been prepared for SCBU and maternity packs. The home sewers are also preparing Moses baskets, which are in high demand.

Examples of the volunteer's handmade bibs and knitted dolls

Consumer council update

The Consumer Council met on 20 October 2021 and discussed the following agenda items.

- **Support for rehabilitation: self-management after COVID-19-related illness** – Patient information booklet to support people after they have had COVID-19. The booklet provides patients with guidance, support and practical suggestions on how to manage post-COVID symptoms.
- **Community Vaccination and Complaints overview (combined item) –** a verbal update on the vaccination programme and response to cultural needs in the community**.**
- **Northland DHB Consumer Council** – welcomed Lynne Tucker, Chair of Northland Consumer Council,to observe the meeting. The Chair of Waitematā DHB Consumer Council will attend the next Northland DHB Consumer Council meeting.

Achieving the priority targets – October 2021

Better outcomes

Progress: impacted by COVID-19

- Planned Care interventions – 84% (target 100%)
- Shorter waits in ED – 87% (target 95%)
- Faster cancer treatment – 90% (target 90%)
- Increased immunisation – 87% (target 95%)
- Raising healthy kids – 99% (target 95%)
- Māori percentage of overall workforce – 8.1% (target 7.5%)

Health quality and safety markers

Falls

Falls risk assessment audits that inform the Health Quality and Safety Commission data continue and are conducted monthly. Overall, Acute & Emergency Medicine completed 100% of falls risk assessments, Specialist Medicine & Health of Older People completed 100% and Surgical and Ambulatory completed 96% on admission. Of those, Acute & Emergency Medicine completed 87%, Specialist Medicine & Health of Older People completed 100% and Surgical and Ambulatory completed 82% within eight hours of admission (against a target of 90%).

Hand hygiene

Waitematā DHB's Hand Hygiene Compliance Audit result for October 2021 is 92%. This exceeds national target of 80% compliance and the DHB is consistently on of the best performing DHBs in New Zealand.

Healthcare-associated infections

The CLAB insertion bundle was used in ICU on 100% of occasions in October 2021. The insertion bundle compliance exceeds the national target of 90%.

Pacific Health

Pacific pop-up event (Tuvalu) 6 November 2021

Highlights of the month

Pacific COVID-19 outbreak response and vaccination

The Pacific Health team has focussed on promoting COVID-19 vaccination among Pacific peoples in the Waitematā area. On Monday 29 Nov, the Pacific community reached 90% vaccination coverage with the 1st dose, ahead of Pacific community coverage in the Auckland and Counties Manukau DHB. This is a major milestone which aligns with the vaccination coverage target for the DHB of > 95%.

The Waitematā DHB Pacific Community Leaders Forum meeting continues to meet weekly on Tuesdays for about an hour. The latest meeting on 30 November is the 22nd meeting. Forum members have provided advice and support to engage and mobilise Pacific peoples to get vaccinated.

Support to The Fono and other providers to deliver Pacific vaccination services

- Tuvalu Vaccination event 6 Nov Tuvalu AOG Church, Te Atatu.
- Pan-Pacific Vaccination Event, Trusts Arena, Henderson 19-20 Nov.
- Samoa AoG Community church event, Lincoln Rd, Henderson 20 Nov.

Waitematā DHB COVID-19 Pacific pastoral support

The three Pacific cultural support staff are providing daily assessments of all Pacific COVID-19 patients in hospital as well as their families, as required. This service is building towards supporting Pacific COVID-19 patients living at home.
A pool of Pacific community members is being established to provide Pacific ethnic-specific pastoral and cultural support to COVID-19 cases at North Shore Hospital and Waitakere Hospital. This service is going to be provided on a casual basis and will complement/augment the Pacific Health team. Plans are underway to extend this support to Pacific COVID-19 cases isolating at home.

Establishment of the Waitematā Pacific ethnic-specific groups

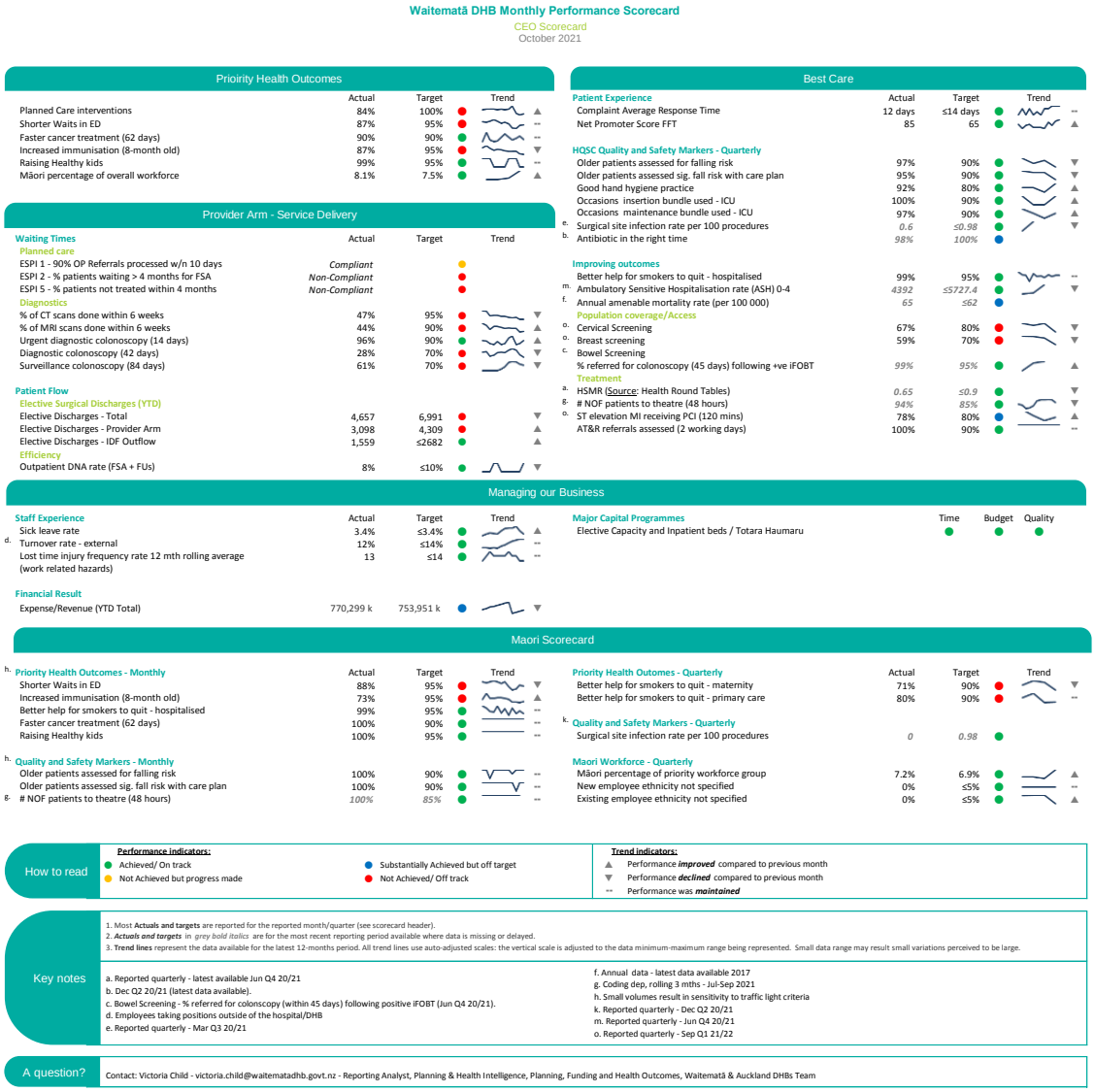
The inaugural Waitemata Pacific Community Ethnic-Specific Leaders meeting was held on Friday 26 November. Representatives of all countries and Pacific providers in the Waitematā DHB area attended. The ethnic-specific countries are Samoa, Tonga, Cook Islands, Niue, Tokelau, Tuvalu, Kiribati and Fiji, they will meet on a regular basis to consider measures to operationalise strategies that are appropriate and relevant to their respective communities. They will provide operational advice to the Pacific Community Leaders Forum to consider as a collective, noting ethnic-specific nuances will be reflected.

Pacific health cultural support/navigator team - administration

The hospital internal referral form to Pacific Health services has been published. In 2022, e-referrals to Pacific Health services will be introduced. A Pacific Health pastoral support assessment form has also been published, with plans to provide this online.

Pan-Pacific Vaccination Event 19 and 20 November 2021

CEO Scorecard



CEO Scorecard Variance Report

PRIORITY HEALTH OUTCOMES

Planned care interventions

Discharges: 78% against a target of 100%

Caseweights: 85% against a target of 100%

The resurgence of the COVID-19 pandemic in the community, the ensuing lockdown and the suspension of non-urgent elective surgery had an immediate impact on the planned care discharge volumes. This is disappointing after an excellent July, which saw elective planned care volumes exceed target. This strong trend continued to mid-August and then stopped abruptly due to COVID-19 alert level restrictions.

Shorter waits in ED – 87% against a target of 95%

The overall performance against the Shorter Waits in ED target has fallen, with Waitematā DHB performance of 87% in September and October. In August, there was a significant exposure event which impacted on NSH ED. In September, changes to the PPE worn in both departments has significantly reduced the impact of exposure events.

September and October have been challenging months for North Shore ED despite a drop in presentations. During the current COVID-19 outbreak, the processing of 'Blue' patients is more time-consuming than that of non-COVID-19 patients. Some of the delays include time to swab results, time to diagnostics, appropriate bed availability in ADU and Wards and the time taken to physically move positive and probable cases out of the ED. Work has been ongoing to improve these processes.

The North Shore Hospital Emergency Department has transformed the four-bed Paediatric area into an 11-bed Blue corridor by converting treatment rooms and office space into additional capacity (5 rooms) and allocating the two negative pressure rooms to this zone. The staffing model depends on nurses from other areas of the department being redeployed to this area, including the flow nurse and other key roles. This has led to delays in patients being seen and processed in a timely manner.

Waitākere ED has also made significant changes to the department in order to cope with the streaming of Blue patients and to ensure the safety of staff and patients. The changes saw Paediatrics reassigned to a Blue area and Observations assigned to Paediatrics. Similar to North Shore, there has been a reduction in presentations. Patients identified with COVID-19 requiring admission are then transferred to NSH.

PROVIDER ARM - SERVICE DELIVERY

Waiting times, ESPI 2 and ESPI 5 non-compliance

While surgical services were slowly reducing their planned care non-compliant volumes across both ESPI 2 and 5, with the return to Level 4 and 3 lockdown some of these gains have been lost. Where clinically appropriate, services have moved to telehealth to reduce the impact on non-compliant volumes. Services are working to accommodate the impact of lockdown on service-delivery prioritising urgent patients and reformulating recovery strategies and plans. Mitigation strategies in most instances are unable to be instigated while we remain in lockdown due to the associated constraints this imposes. Medical services have transferred to telehealth and, although they have seen a slight rise in non-compliant volumes, most services remain on-track with ESPI compliance.

% CT scans done in six weeks – 49% against a target of 95%

Performance reflects both the number of MIT/Radiographer vacancies, as well as the impact of the Level 4 and 3 lockdowns throughout September. Since mid-August, the only outsourcing has been for urgent scans within one or two weeks. Performance will continue to trend downwards as outsourcing remains on-hold, as internal capacity cannot be increased further due to staffing shortages. Acute demand has remained high throughout Level 4 and 3, which has further impacted planned care capacity.

% MRI scans done in six weeks – 42% against a target of 95%

Performance is reflective of the impacts of National Level 4 and 3 lockdowns and the hold on outsourcing. With no outsourcing available for MRI, there is an inability to meet demand, which has further impacted our backlog of patients waiting for their scan. As Auckland moved to Level 3, internal planned care was able to be increased to include routine within six week referrals and additional weekend sessions were resumed. Demand for acute imaging has remained high throughout both levels, which has impacted on planned care capacity.

Diagnostic colonoscopy within 42 days – 37% against a target of 70%
Gastroenterology service is compliant against the P1 (urgent diagnostic) indicator but not the P2 (normal diagnostic) and P3 (surveillance) indicators. The results for endoscopy were negatively impacted by the COVID-19 alert level restrictions. Internal production was reduced as per regional guidelines and outsourced procedures were stopped during alert level 4 and resumed at 50% capacity under alert level 3 due to social distancing requirements. The service continues to prioritise P1, P2 urgent, Māori and Pacific patients in line with the Northern Region endoscopy recovery plan.

Planned care discharges – Total 4,657 against a target of 6,991 (66.6%)
This value is the combined Provider and IDF-out volume of planned care discharges (includes the procedures done by ADHB and CMDHB for our community).
The COVID-19 level 4 lockdown, implemented on August 17, led to an immediate suspension of non-urgent elective surgery/planned care – as per Government guidelines. The ESC stopped operations at this point, which led to a material shortfall of planned care elective discharges against target for the provider during the remaining weeks of August and throughout both September and October.

Planned care discharges - provider arm – 3,779 against a target of 4,491 (84.1%)
Please see Planned Care Discharges – Total explanation above.
Note that planned care discharges include acute arranged discharges. When looking at purely elective discharges (Surgical Health Target), the Provider has delivered 3,105 against a target of 3,927 (79.0%) October YTD.

MANAGING OUR BUSINESS

Sick leave rate – 2.4% against a target of 3.4%
Target achieved.

MĀORI

He Kāmaka Waiora - Māori Health

He Kāmaka Waiora Priorities

He Kāmaka Waiora continues to contribute to:

- Leading the regional response to Covid-19 for Mori
- Supporting the implementation of the Waitematā DHB COVID Vaccination Plan
- Proactively contributing to the DPMC-led implementation of the HDSR
- Ongoing development of Kōtui Hauora (Iwi Partnership Board)
- Developing an equity approach for WDHB
- Improving the effectiveness and efficiency of He Kamaka Waiora
- Supporting the implementation of the WDHB building projects

BEST CARE

Cervical screening – 70% against a target of 80%
A national trend of reduction in coverage has been noted over several years and COVID-19 has contributed to this in the past 18 months. The current COVID-19 alert levels in Auckland will further contribute to this. Work continues to address inequities in cervical screening, including additional equity gap as a consequence of COVID-19.

Breast screening – 58% against a target of 70%
Coverage recovery was adversely affected by the COVID-19 level alerts in Auckland when there is no screening and subsequently COVID-19 level 3 alerts where capacity is reduced by at least a third to accommodate IPC precautions.

APPENDIX ONE – CEO RECOGNITION

Nadia Matthews - Rotational Physiotherapist, Inpatient North Therapies, Allied Health.
Nominated by May Cheng.
"Nadia organised excellent interactive activities such as 'Kupu of the Day' and quizzes for the acute inpatient north physiotherapy team during Te Wiki o Te Reo Māori. She has supported and encouraged us all to become more confident using Te Reo Māori in our mahi. Ka pai tō mahi Nadia!"

John Stewart - Orderly, Clinical Support Services, Hospital Operations.
Nominated by Sophie Sinclair.
"John is an amazing team member - friendly and forms an instant rapport with patients and staff. He is a credit to this DHB and a genuinely great person to work with. He goes above and beyond to support patients and colleagues. Thank you for your care, smiles, hard-work and friendly chats."

Amanda Wattie - Team Leader - General Surgery, Patient Service Centre, Surgical & Ambulatory Services.
Nominated by Milrose Delos Reyes-Cadelina.
"Amanda is doing a great job behind the scenes to keep our service running as smoothly and efficiently as possible. She is managing clinic slots and PAC appointments very well. Thank you Amanda for what you are doing!"

Melodi (Jam) Libre - Registered Nurse, Maternal Mental Health, Specialist Mental Health & Addiction Services.
Nominated by Nurith Divekar.
"For her dedication and commitment to caring for some of our vulnerable new parents and pregnant people. Jam supports her clients 'with compassion' and kindness while advocating for their voices to be heard as part of their treatment plan. Jam communicated effectively with a large multi-disciplinary team to ensure a baby and mum's well-being, while navigating a complex and constantly evolving situation."

Lev Zhuravsky - Operations Manager, Patient Care & Access, Waitemata Central.
Emma Farmer - Head of Division Midwifery, NSH Maternity, Child, Women & Family.
Paula Seymour - General Manager, Corporate, Corporate Services.
Aumea Josephine Herman - Director of Pacific Health, Pacific Health, Corporate Services.
Nominated by David Resoli.
"For representing the best of Waitematā, this time on an international level!! Lev, Emma, Paula and Aumea supported the emergency international transfer of a patient overseas. Representing our value of 'better, best, brilliant', through skilled teamwork they organised a repatriation into Waitematā in under 100hrs from referral to arrival. No mean feat! Subsequently, demonstrating our value of 'compassion' together, they advocated for the very best for the patient and the patient's family member and continually raised the plight of the family member in MIQ. Showing truly 'everyone matters' and here at Waitematā we are 'connected' to all of our community, not just the patient in front of us. Well done Lev, Aumea, Paula and Emma - it was an amazing effort. Very few people will truly know the sheer volume of complex work involved in this case. I'm proud to call each of you a colleague."

Susan Rae - Lead Peri-Operative Nurse Coordinator, Urology, Surgical & Ambulatory Services.
Nominated by David Resoli.
"For continued determination and perseverance and being prepared to step-up and lead! Over the last two months Susan has led the introduction of a new flexible cystoscopy service at Waitakere. This service represents a huge quality improvement for patients at Waitakere. Susan continually

displays our value of 'better, best, brilliant'. She went above and beyond and led this change, overcame obstacles, navigated challenges and all-the-while continually stayed positive, engaged and linked with others across DHB departments and services to ensure a launch of this service in October, 2021. Susan - thank you very much for all of your hard work. It has been great working with you!"

Amanda Wattie - Team Leader - General Surgery, Patient Service Centre, Surgical & Ambulatory Services.
Patricia Heavey - General Surgery Perioperative Nurse Coordinator (PNC) Lead, General Surgery, Surgical & Ambulatory Services.
Nominated by David Resoli.
"All too often it is easier to say nothing when you are unsure about a change being made. At times, colleagues don't speak up when they have ideas on how to improve things. Both Amanda and Patricia reached out me to discuss their thoughts on proposed changes within surgery and shared their ideas on how to do things differently and better for patients and staff. They represented our DHB value of 'everyone matters', put their hands up and advocated on behalf of patients to improve the service we provide to them. Thank you, Amanda and Patricia for your professionalism and dedication and for reminding me of the real meaning of our DHB promise – 'Regardless of whether we work directly with patients/clients or support the work of the organisation in other ways, each of us makes an essential contribution to ensuring Waitematā DHB delivers the best care for every single patient/client using our services.' Amanda, Patricia - keep doing what you're doing! It's exactly what SAS needs!"

Stefanie Smith - Speciality Nurse, SCBU West, Child, Women & Family.
Nominated by Rebecca Corry.
"Stefanie was recently working as the nurse in charge for the evening/night shift. The normal SCBU capacity is 12 babies, however during that evening we admitted several babies taking the total to 18 at one point! This included a very unwell baby being transferred to NICU amidst four other admissions to SCBU. Stefanie was so fantastically cool, calm and collected despite the incredible workload and stressful environment. Her calm attitude really helped to guide her colleagues, meaning that our babies received the best care. Nothing was too much trouble even when we just kept needing to admit babies. She was quick to rearrange workloads so that her colleagues were working safely and more junior colleagues were supported. Stefanie was fantastic at delegating work and was still able to offer management advice to us doctors despite all the pressure on her! I don't think I have seen anyone work so efficiently, compassionately and with such an on-going high level-of-care before. Thank you Stef for holding the unit and all of us together."

Andrew Cave - Health Informatics Manager, Information Management, Decision Support Services.
Nominated by Josie McCabe.
"For his help in setting up new systems on Ward 11 to be COVID-19-ready. Andrew has gone above and beyond to help us get systems running as we need. He has always responded promptly to our queries and takes adversity in his stride! He has been an incredibly helpful team player. Thank you, Andrew."

Grant Dolan - Clinical Support Coordinator, Clinical Support Services (NSH), Hospital Operations.
Patricia Humphreys-Grey - Clinical Support Coordinator, Clinical Support Services (WTH), Hospital Operations.
Nominated by Nicola Doyle.
"Grant and Trish consistently demonstrate the values 'with compassion' and 'better, best, brilliant' in their daily work. They go above and beyond the call of duty, often working long hours and continuously striving for better outcomes for our patients. Their hard work over the years is truly appreciated and valued."

Daphne Nevard - Team Leader Paediatric Outpatients, Paediatrics, Child, Women & Family.
Nominated by Tammy O'Brien.
"I would like to acknowledge Daphne's tireless work in this ever-changing COVID-19 environment. The running of outpatients has had so many changes and iterations as alert levels have changed and this has put enormous pressure on our outpatient administrative staff. Daphne has borne the brunt of this due to staff shortages. She has responded to these pressures with clear communication and her 'can do' attitude, always striving to do the best for our families. I appreciate your hard work Daphne and all the different 'hats' that you have to wear on a daily basis. We are very lucky to have you and want you to know how much your hard work is appreciated."

Anahera Edwards - Health Care Assistant, Muriwai Ward, Specialty Medicine and Health of Older People.
Nominated by Tim West.
"Anahera is always willing to go the extra mile to assist our patients. Her genuine compassion and positive attitude are a credit to both herself and the DHB as a whole."

Man Mohan Lal - Clinical Coordinator/Registered Nurse, Isa Lei Services, Specialist Mental Health & Addiction Service.
Nominated by Dilrukshi De Silva.
"For his dedication to patient care - taking steps beyond his role as a clinical coordinator for Takanga A Fohe. When a client refused to attend a family court hearing for their Mental Health Act review, he went to the patient's house before his hours-of-work and was able to get his consent and bring him to the court hearing. This assisted the patient's treatment under the MHA to continue in the community."

Violet Tuala - Mental Health Psychiatric Assistant, Kauri Unit, Specialist Mental Health & Addiction Service.
Nominated by Christine Hakaraia.
"Violet has been supportive of her colleagues and gives aroha to all. Her standard and practices-of-care to the service users is impeccable. Violet is vigilant and safety-conscious, always thinking outside the square. Reporting to the nirse in charge if there is not enough staff cover on the open ward, or any risks are identified. She is an asset to have on Kauri ward."

Unaloto Olosoni - Cleaner, Clinical Support Services, Hospital Operations.
Gloria Marino - Cleaner, Clinical Support Services, Hospital Operations.
Desiree Hernandez - Cleaner, Clinical Support Services, Hospital Operations.
Marina Guevarra - Cleaner, Clinical Support Services, Hospital Operations.
Nominated by Tony McGeady.
"For always going the extra mile and having a smile on your face even though the work is difficult at times. Una, Gloria, Desiree and Marina work really well as a team together and have strong connections with everyone at Waiatarau. They always strive to get the job done to a very high standard and are always caring and aware of the needs of others. Thanks for all of your hard work."

Josephine McCabe - Registrar, General Medicine, Acute & Emergency Medicine.
Nominated by Penny Andrew.
"Josie has worked in Ward 11 since it began taking COVID-19 patients. Prior to that she worked with COVID-19 patients in the ESC. She is incredibly hard working, committed to quality and patient safety and goes above and beyond to make sure our staff and patients receive the best possible care. Thank you Josie."

Penny Andrew - Director, New Initiatives, Corporate.
Laura Broome - Project Manager, New Initiatives, Corporate.
Nominated by Joel Rewa-Morgan.
"For exemplary manaakitanga and kaitiakitanga, and for supporting my team's wellbeing."

Julie Bromley - Charge Anaesthetic Technician, Department of Anaesthesia, Surgical & Ambulatory Services.
Nominated by Joanne Shirtcliffe.
"Julie has been instrumental in organising education for ward staff about managing deteriorating COVID-19 patients. She has taken on additional responsibilities and worked tirelessly to support the Waitematā DHB COVID-19 response from a clinical perspective. Julie has a fantastic attitude and is a huge support for all staff."

Rita Singh - Multi Skilled Worker Supervisor, Multi Skilled, Specialist Mental Health & Addiction Service.
Nominated by John Hanna.
"Rita is a great supervisor to her staff, always accommodating their needs whether work-related or personal. Rita has a very positive personality and a sunny disposition which flows on to her team. Any problems we have, she always comes back with a solution. We are blessed having her to support us as a team."

Lynda Moloney - Physiotherapist, Inpatient West Therapies, Allied Health.
Nominated by Kate Donovan.
"Lynda is always a pleasure to be around and is a great person to both work with and learn from. She takes on every day with a can-do attitude and is a constant source of care and a friendly chat on both the good and the challenging days. She embodies the Waitematā DHB values effortlessly. Lynda has been involved in many complex patient situations over the past year or so, and has consistently advocated for patients and their families to ensure the best possible outcome. Thanks Lynda, we are so lucky to have you as part of our team."

Melchor Varias - Cleaner, Clinical Support Services, Hospital Operations.
Nominated by Adrian Ryan.
"Melchor works with the cleaner night team. As a level one cleaner, Melchor does all the COVID-19 patient rooms and all the level one cleans all over the hospital. He always works hard and is very good at completing his duties. Melchor works very well within the team and is great to get on with. Melchor can be busy at times as he is the only one on until 7am."

Ronald Reyes - Registered Nurse, Pohutukawa Unit, Specialist Mental Health & Addiction Service.
Nominated by Ryan Pinero.
"Ronald is a wonderful nurse. He is one of the friendliest people that I know and he always arrives with a smile on his face and a happy greeting for his co-workers and clients. Although Ronald is responsible for his service-users for the shift, he can often be found assisting other colleagues with their tasks. Ronald can communicate effectively and manage challenging behaviours shown by our service-users. He is a huge asset to our unit and is so deserving of this recognition."

Julie Bromley - Charge Anaesthetic Technician, Department of Anaesthesia, Surgical & Ambulatory Services.
Nominated by David Resoli.
"Balancing COVID-19 and business as usual is a challenge for all of us. Julie has really risen to this challenge and has led – from the front – a number of our COVID-19 preparedness work streams and our wider theatres projects. Recognising the great job she has been doing it is with genuine, heartfelt affection her team have honoured her with the moniker the "impossible demands

manager". She has a well-deserved reputation for using teamwork to find ways to overcome what would have been thought to be impossible. Julie – thank you very much for the support you provide and for the leadership you bring."

3.2 Health, Safety and Wellbeing Performance Report

Recommendation:

That the report be received.

Prepared by: Michael Field (Group Manager, Occupational Health and Safety Service),
Ian Gotty (Principal Advisor, Health and Safety, Facilities Services Group) and
Naomi Heap (Wellbeing Strategy and Programme Lead)
Endorsed by: Fiona McCarthy (Director, People and Culture)

1. Purpose of report

The purpose of the Health, Safety and Wellbeing Performance Report is to provide quarterly reporting of health, safety and wellbeing performance including compliance, indicators, issues and risks to the Waitematā District Health Board, (Waitematā DHB).

2. Strategic Alignment

Community, whanau and patient centred model of care	This report comments on issues and risks that impact on staff health and safety, and therefore patient care and organisational culture, as well as activities that support staff wellbeing in the delivery of patient centred care.
Emphasis and investment on both treatment and keeping people healthy	This report comments on organisational health, safety and wellbeing information via incident reports, health monitoring and identified hazards. It also outlines investment and actions that support keeping our people healthy and well.
Intelligence and insight	This report provides information and insight into staff welfare, staff workplace incidents, and what Waitematā DHB is doing to respond to these and other workplace risks.
Evidence informed decision making and practice	The leading and lagging indicator dashboard is based on current best practice indicators and targets. Risk controls are regularly audited to align to an evidence base. Wellbeing activities in this report are informed by feedback from staff and wellbeing best practise.
Outward focus and flexible, service orientation	Health, safety and wellbeing risks and programmes are focused on staff, visitors, students and contractors. All strategic and operational work programmes and policy decisions are discussed with relevant services, such as site visits and approaches to reduce risks. Wellbeing activities are aimed at what staff can practically engage with and respond to the needs of our people.
Operational and financial sustainability	As appropriate, programmes of work will outline how services will ensure operational sustainability, how measures of success are set and value and return on investment is monitored.

3. Executive Summary

COVID-19 response

During COVID-19 Alert Levels 4 and 3, the Occupational Health and Safety Services (OH&SS) are heavily focussed on COVID-19 related Occupational Health work, while ensuring that the day-to-day health and safety work is maintained (incident follow-up and investigation etc.).

Current OH&SS focus is on the following:

Worker Policies and Procedures: Input into policy on COVID-19 exposure events (when staff can return to work) and updated guidance for staff and managers as we transition to the new COVID-19 protection framework on 3 December 2021.

Changes to Pre-Employment Screening requirements: We have updated all COVID-19 vaccination health screening questions, following the public health order announcement, to ensure that all potential new staff are fully vaccinated prior to commencement of employment. Any potential new staff member who has not had, or not planned a vaccination, is now unable to commence employment.

We are also providing risk assessments on how to best protect staff at work who have obtained a medical exemption.

Psychosocial risk factors: We have added a series of psychosocial impact statements to our incident forms to help us identify psychosocial factors that are impacting our staff. Understanding these factors will help us proactively develop initiatives to support staff when an incident occurs, for example where psychological harm may have occurred.

Supporting other Persons in Charge of Businesses or Undertaking (PCBUs) in our Region:
Many aligned PCBUs do not have their own Occupational Health and Safety teams, so have requested support from us. This has included:

- New Zealand Police: Provision of advice regarding Personal Protective Equipment, mask fit testing, and contact tracing.
- Externally managed vaccination Trusts: Managing Blood and Body Fluid Exposure (BBFE) events for their workers.
- Compass Medirest: Provision of Pre-Employment Screening, including COVID-19 vaccination requirements and screening.
- Auckland University of Technology and Unitec: Provision of recommendations for mask fit testing for students and undertaking mask fit tester training for selected staff.

Mask Fit Testing: The purpose of mask fit testing is to ensure relevant staff are fitted for a mask that is to be worn for any aerosol generating procedure, and for staff working in our COVID-19 patient pathways. We currently have 100% of our staff in COVID-19 patient pathways fit tested and 69% of other staff fit tested where they are required to wear an N-95 mask sessionally for other patient care interactions.

Vulnerable Worker Risk Assessments: This work is a national requirement, and designed to assess the suitability of staff with underlying health conditions (comorbidity) to work in different areas of the DHB during community spread of COVID-19. This ensures that any staff with higher risk factors are appropriately deployed to minimise risk to them. As national assessment criteria change, staff are reassessed.

Other work includes:

- Responding to staff queries via the OH&SS COVID-19 email address
- Union engagement and provision of information.

October 2021 reporting period update

For the October reporting period, Waitematā District Health Board has met the majority of leading and lagging indicators.

The Lost Time Incidents (LTIs) requiring less than seven days off work is 49% against a target of 65%. (i.e. 49% of the injury claims required less than seven days off work). While this represents a negative trend, the nature of incidents has been reviewed and there are no areas for concern, it is simply that the same events this month have led to a higher number of days off work. This can relate to a number of contributing factors, which can either increase the severity of harm or the time required for recovery, such as age.

Pre-employment screening (PES) prior to commencement is at 55% against a target of 70%. We have seen a very high level of staff recruitment occurring, much of which relates to COVID-19 specific roles across the organisation, which has outstripped our ability to keep up. Recruitment for additional resource to address this is almost complete.

In relation to top accident types:

1. Nine Slips, trips and falls were recorded in October. Most of these incidents related to workplace hazards (tripped on uneven surfaces, slipped on liquid spills, slipped on stairs, poor lighting and chairs sliding out from under people). We have implemented numerous control measures for slips, trips and falls, including signage, posters, wet floor processes, environmental audits and regular communications to health and safety representatives and managers.

2. There were eight moving and handling patient incidents recorded in October.
   - Most of the incidents are due to adjusting bedridden patients from a lying to a sitting position or adjusting them while in bed.
   - The remainder of the incidents were transferring patients.

   The Moving and Handling team review all incidents to identify what corrective actions are required, including, where appropriate, moving and handling equipment, if not currently available.

3. There were 35 physical aggression incidents reported in October. Many of these incidents related to specific service users, with individual service users triggering numerous incidents, often over a short period of time while they were most unwell. In October, all of the 35 incidents of physical aggression were caused by people who had no intention to cause harm (were not cognitively aware of their actions and therefore the consequence of their actions).

Some of the actions to mitigate the impact of physical aggression include:

- De-escalation and aggression management training.
- Clinical care arrangements including low sensory environments and pre visit checks.
- Duress alarms.
- On body cameras (security team).
- Appropriate staffing and skill mix.
- Clinical pathways for care from the Emergency Department to ward to respite care.
- Safe reception areas.
- Escalation response procedures.

Health and Safety Scorecard

October 2021

Trend data 12 month period

Lagging Indicators

	Actual	Target	Trend
Total number of reported incidents	411	-	
Number of notifiable events	-	-	
Injuries			
Total number of injury claims	24	-	
Number of injury claims (work-related hazard)	**19**	-	
Total Lost time injury claims	11	-	
Lost Time injury claims (work related hazards)	**11**	-	
Total Lost time injury frequency rate - rolling 12 month average	15	<14	
Lost time injury frequency rate rolling 12 month average (work related hazards)	13	<14	
Total lost time injury frequency rate for month	**10.47**	-	
Lost time injury frequency rate for month (work related hazards)	**10.47**	-	
Total Lost time injury <7 days - rolling 12 month average	**49%**	>65%	
Lost time injury <7 days - rolling 12 month average (work related hazards)	**48%**	>65%	
Costs of injury claims for month	$159,645.50	-	

Top Three Incident types

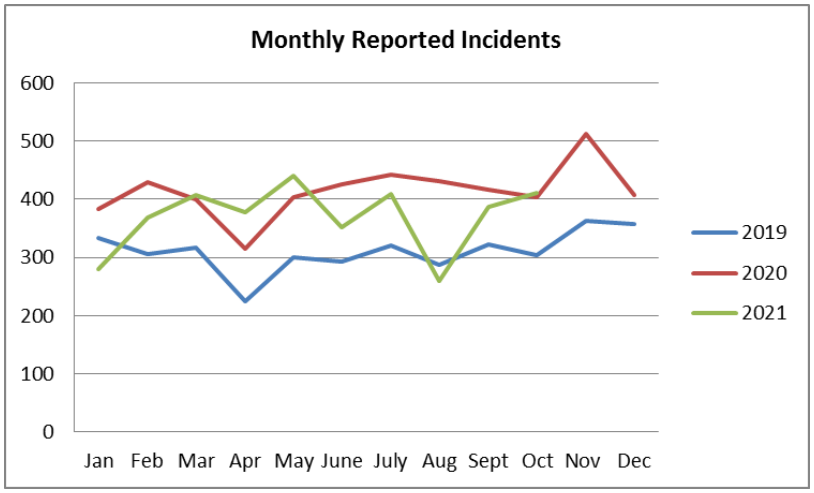
1	Safety Concern	137	-
2	Exposure to Infections	50	-
3	Physical Assault	31	-

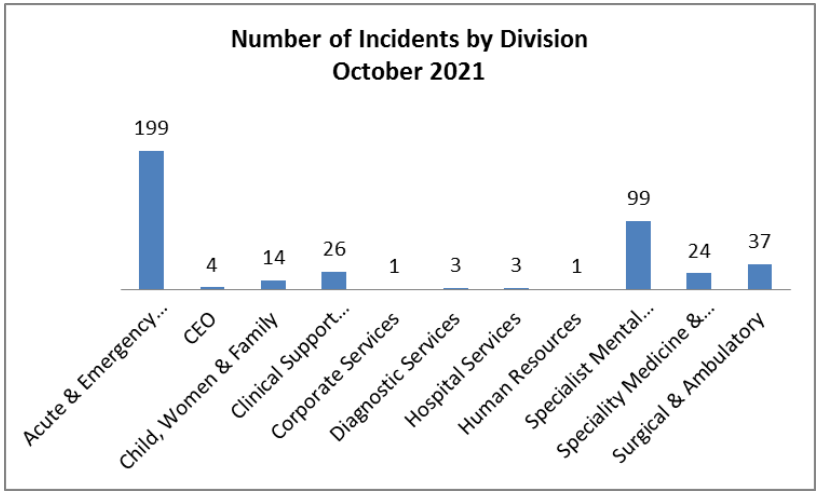
Leading Indicators

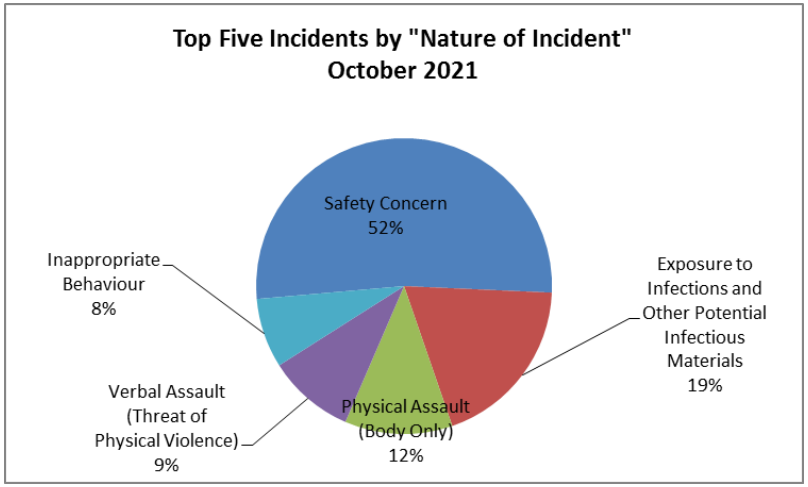
	Actual	Target		Trend
Number of H&S Representatives vacancies	9	<10	●	
H&S Representative training completed	91%	90%	●	
Pre-employment screenings pre-commencen	55%	70%	●	
Significant hazards reviewed by Managers	88%	80%	●	
Significant hazards reviewed by OH&SS	94%	95%	●	
Staff hand hygiene	92%	80%	●	

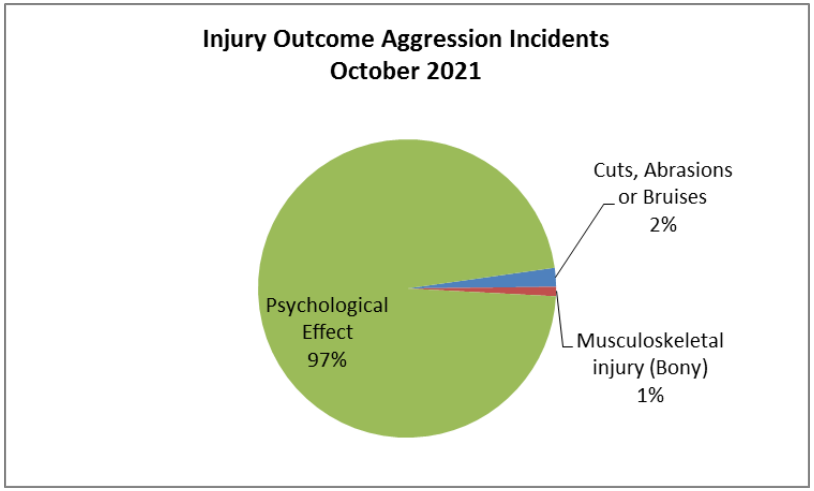
Acheivement Criteria		Rating	
On target or better		Achieved	●
95-99.9%	0.1-5% away from target	Substantially achieved	●
90-94.9%	5.1-10% away from target*	Not achieved, but progress made	●
<90%	>10% away from target**	Not achieved	●

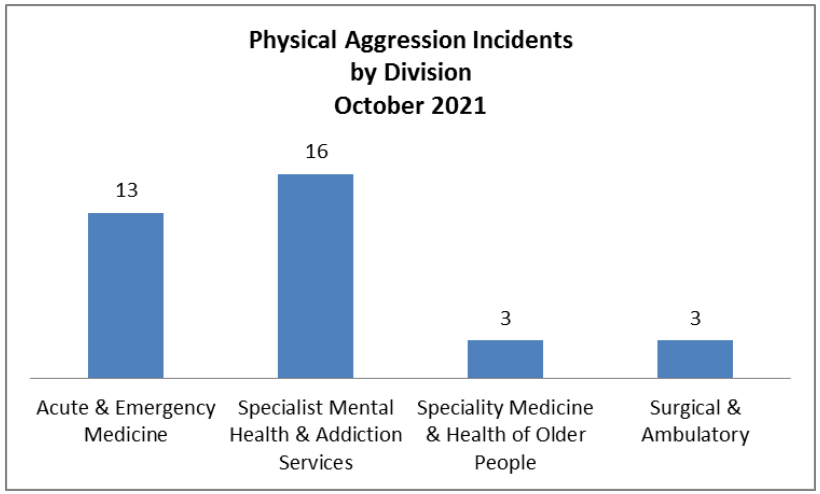
4. Performance Dashboard

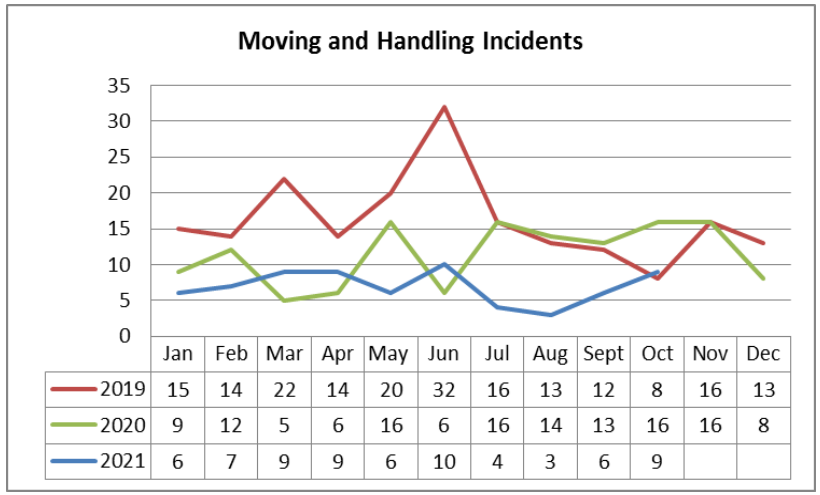




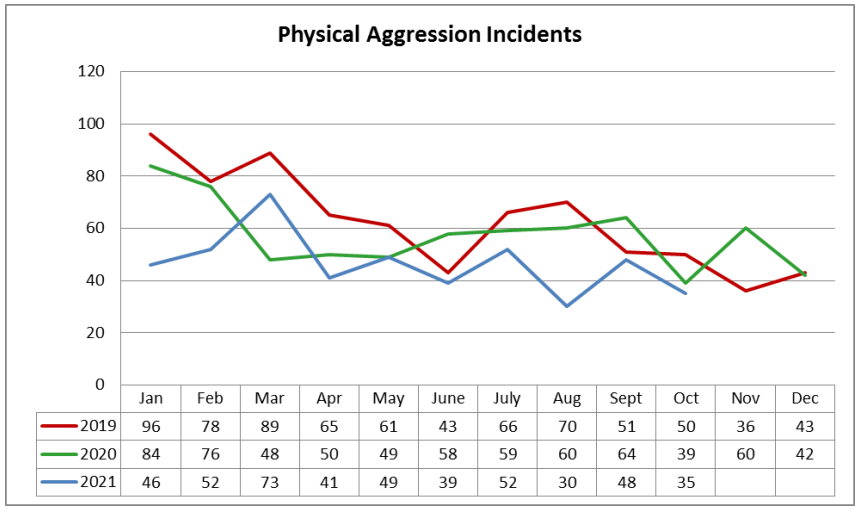




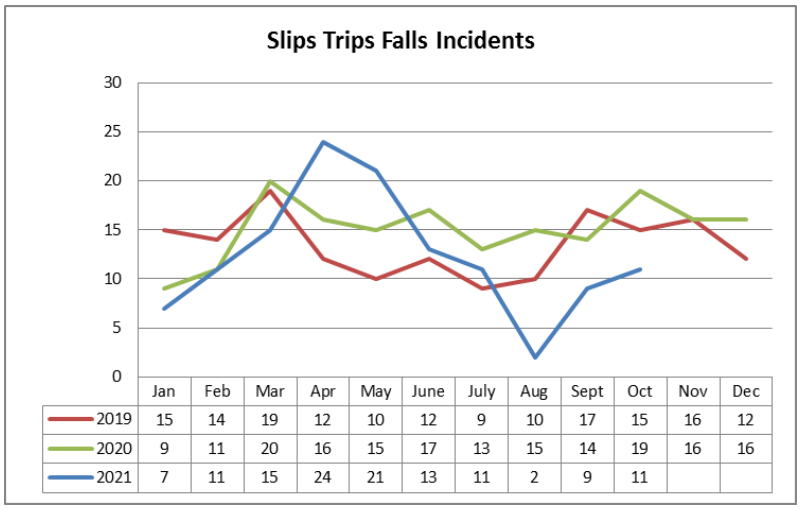




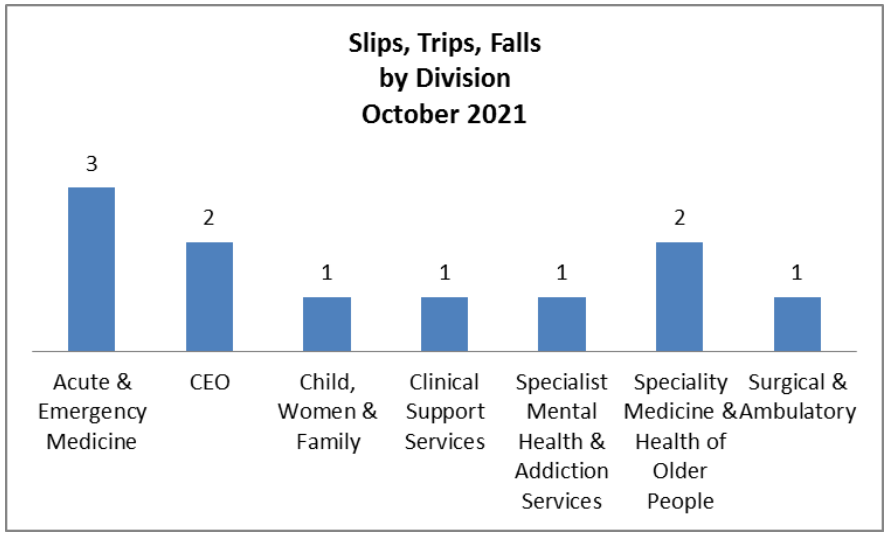
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
2019	15	14	22	14	20	32	16	13	12	8	16	13
2020	9	12	5	6	16	6	16	14	13	16	16	8
2021	6	7	9	9	6	10	4	3	6	9		



	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
2019	96	78	89	65	61	43	66	70	51	50	36	43
2020	84	76	48	50	49	58	59	60	64	39	60	42
2021	46	52	73	41	49	39	52	30	48	35		

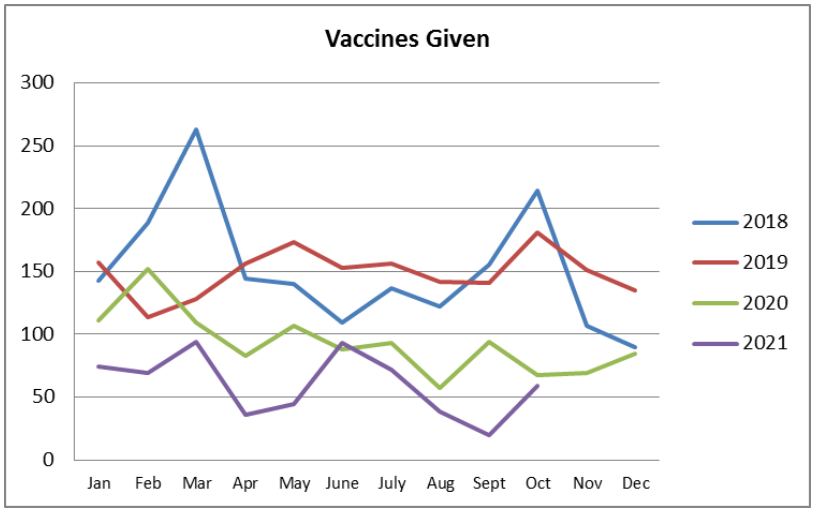


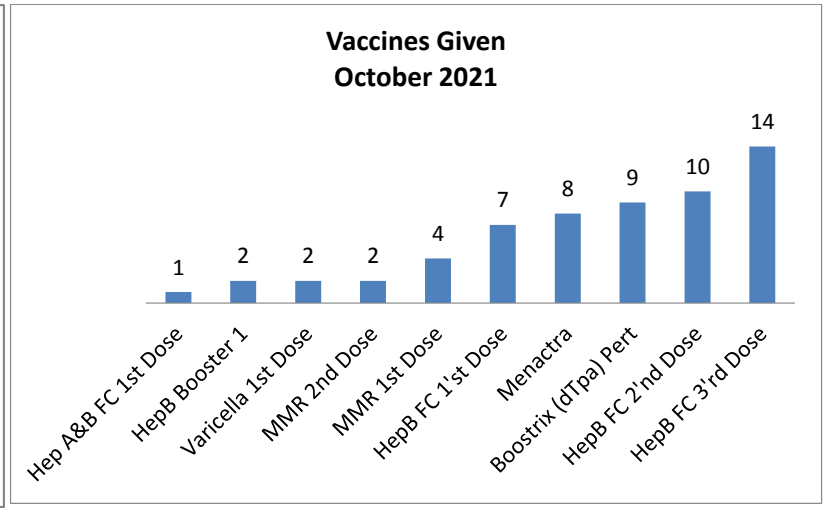
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
2019	15	14	19	12	10	12	9	10	17	15	16	12
2020	9	11	20	16	15	17	13	15	14	19	16	16
2021	7	11	15	24	21	13	11	2	9	11		

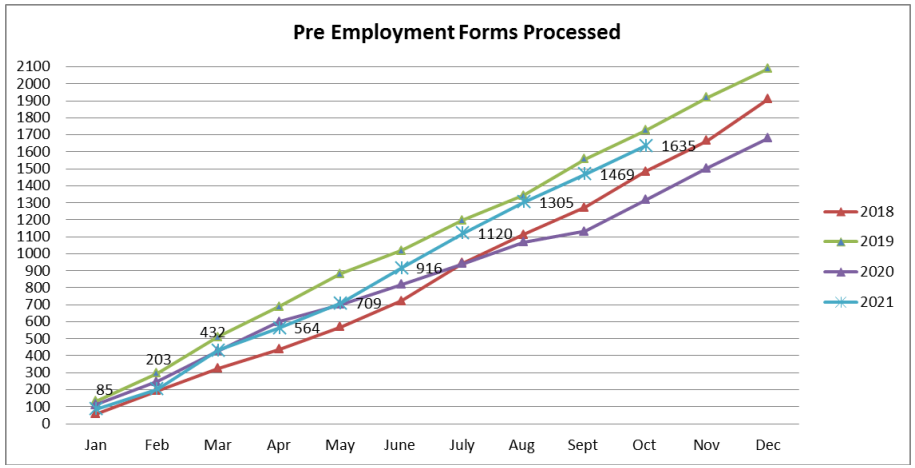

Slips, Trips, Falls
by Division
October 2021
3
2
1
1
1
2
1
Acute & Emergency Medicine
CEO
Child, Women & Family
Clinical Support Services
Specialist Mental Health & Addiction Services
Speciality Medicine & Health of Older People
Surgical & Ambulatory

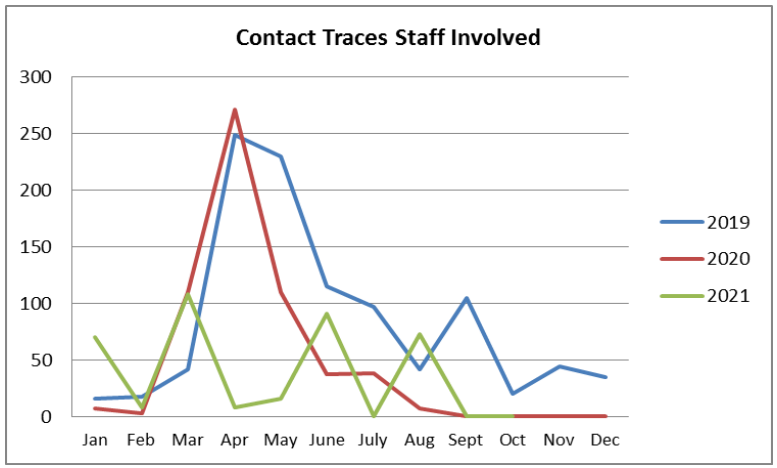
Occupational Health Activity

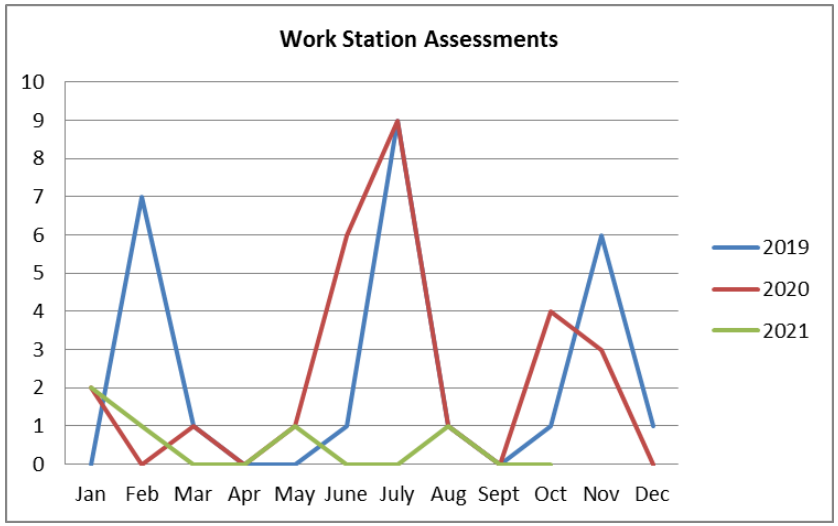
Outlined below is a summary of occupational health activity undertaken in the Waitematā DHB.

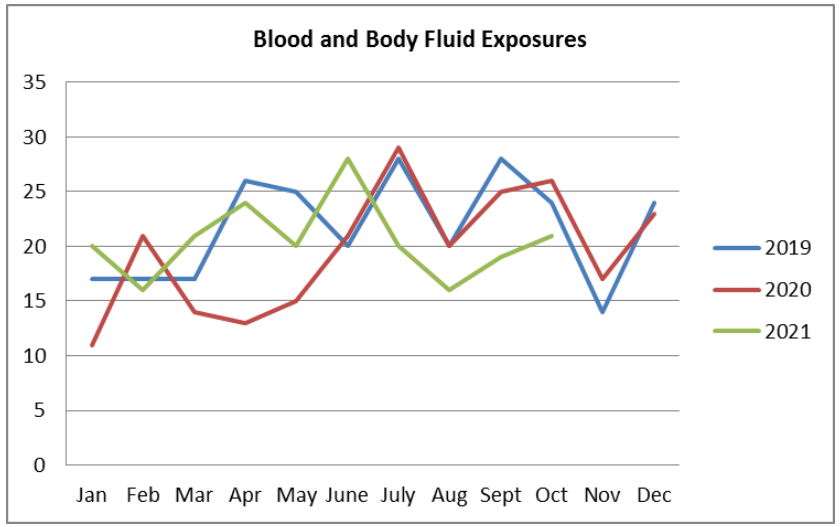


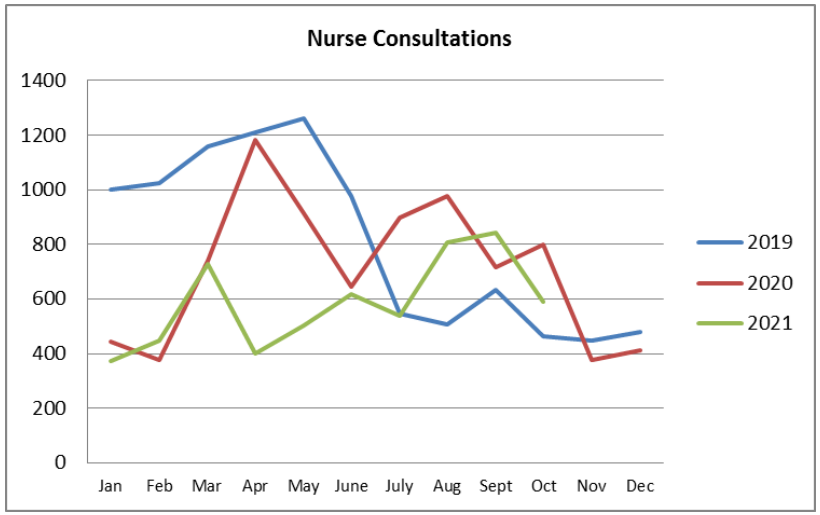


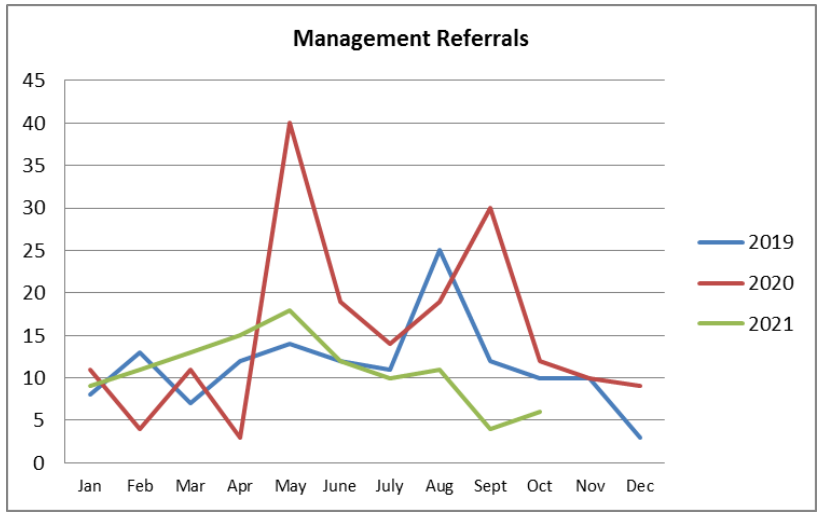

Pre Employment Forms Processed
2100
2000
1900
1800
1700
1600
1500
1400
1300
1200
1100
1000
900
800
700
600
500
400
300
200
100
0
85
203
432
564
709
916
1120
1305
1469
1635
Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
2018
2019
2020
2021


Contact Traces Staff Involved
300
250
200
150
100
50
0
Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
2019
2020
2021


Work Station Assessments
10
9
8
7
6
5
4
3
2
1
0
Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
2019
2020
2021


Blood and Body Fluid Exposures
35
30
25
20
15
10
5
0
Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
2019
2020
2021


Nurse Consultations
1400
1200
1000
800
600
400
200
0
Jan
Feb
Mar
Apr
May
June
July
Aug
Sept
Oct
Nov
Dec
2019
2020
2021


Management Referrals
45
40
35
30
25
20
15
10
5
0
Jan
Feb
Mar
Apr
May
June
July
Aug
Sept
Oct
Nov
Dec
2019
2020
2021

5. Work related injury Claim Data for October 2021

Outlined below is our injury claims data for October. Work injury claims data is for all work injuries currently managed by the Waitematā DHB, including injuries that occurred in previous years, up to and including injuries for August 2021. High accident events account for approximately 73% of the cost of claims, as below:

INJURY CLAIM DATA

Total: Injury Claim Report for October 2021				
Lost days	**Treatment cost**	**Weekly compensation costs (80% of salary)**	**Staff cover cost**	**Total**
Number of lost days for month	$ total for month	$ total for month	$total cover cost for month	Total $ cost for month
270	$24,553.97	$60,040.68	$75,050.85	$159,645.50

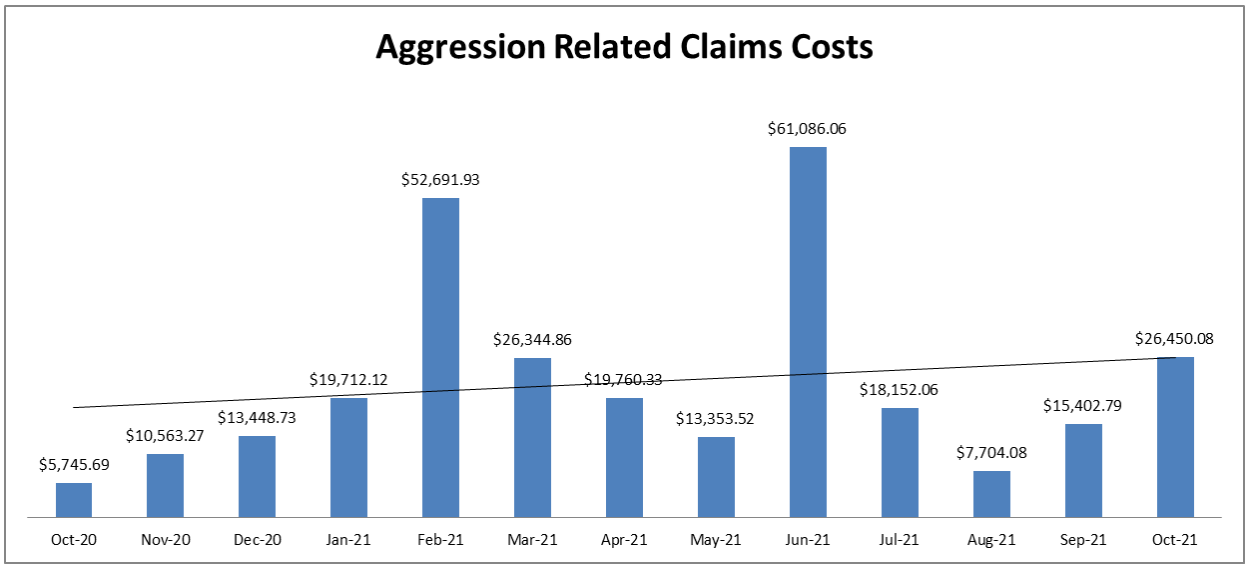
High Accident Injury type	Lost days this month	% of cost this month	Cost this month	12 month trend for injury claims
Slips Trips Falls	52	23%	$36,021.27	↓
Moving and handling	66	34%	$54,097.71	↓
Aggression	59	16%	$26,450.08	↑

* Actions taken to mitigate high accident types are noted in the Executive Summary.

** Total cost by month is inherently inaccurate, as we are only able to report cost as we are invoiced for it, which can often occur months after the cost was incurred.

Overview
Of the 11 lost time claims lodged in October 2021: • Five had seven days or less of lost time and have returned to full duties. • Four had over seven days of lost time and have returned to full duties • Nil had over seven days of lost time and are now fit for selected work • Two other staff members remain fully unfit.
Out of the 11 lost time injury claims 11 involved work related hazards • Five had seven days or less of lost time and have returned to full duties. • Four had over seven days of lost time and have returned to full duties • Nil had over seven days of lost time and are now fit for selected work • Two other staff members remain fully unfit.

The table below has been included to provide information on the total cost of aggression related injury claims specifically (13-month rolling table). Members will see the 12-month trend is still elevated caused by several months' worth of claims arriving in June – therefore do not see this trend as a concern.



7. Facilities Services Group – Health and Safety Update

In line with the October update, health and safety lag indicators are on target as project volumes step up to normal levels.

One near miss event is noted in the reporting period – an unidentified buried electrical cable was damaged during excavation work on the Totara Humour site. The cable was repaired and an investigation has been conducted. The finding was identification of an opportunity for better pre-commencement site investigation.

In response to the Health Vaccination Order requiring vaccination of contractors attending DHB sites, notices have been sent to all Facilities Services suppliers and contractors requiring confirmation of compliance. A high level of response and confirmation of compliance has been received to date. It is planned to commence spot audits of contractors on site to verify the supplier undertaking received. Suppliers that have refused to confirm they are compliant or fail at audit will be excluded from our sites.

8. Wellbeing Update

Actvities and outputs within the three key work streams – October and November 2021		
• Wellbeing strategy document in progress, strategy principles discussed with the Executive Health, Safety and Wellbeing are: ○ *Wellbeing work is Tikanga led and demonstrates commitment to Te Tiriti o Waitangi* ○ *Wellbeing work is based on respectful, appreciative relationships grounded in care and compassion – is mana enhancing* ○ *Wellbeing work complies with standards prescribed by WorkSafe under the Health and Safety at Work Act.* • Review of the ISO 45003 Wellbeing standards to align with Te Whare Tapa Wha Wellbeing model is in progress.	• Wellbeing eLearning launched on Ko Awatea Learn • Launched Psychological impact statements in the RL6 for Aggression incidents. • Discussions on-going for the staff wellbeing dashboard. • Staff Health, Safety and Wellbeing &W Committee – review of literature to inform possible question sets for surveying staff on Health, Safety and Wellbeing engagement.	• Mental Health Awareness Week (September). We ran a series of recorded webinars. These will be on the Wellbeing StaffNet page. • BNZ financial wellbeing programme continues on line • Winter staff support plan was fully planned and ready to launch but had to be cancelled due to the COVID level 4 lockdown. This plan will be re-initiated once gatherings are once again possible. • Planning for Staff Christmas Day meals is underway. • Donations to Well Foundation by Countdown Supermarkets for welfare packs for staff. • Staff Christmas Activities are underway including the much loved Christmas Decoration competition. • Wellbeing check-ins, webinars and mindfulness sessions continue. • Regular updates of information on COVID wellbeing page. • Continuing off Raise (our employee assistance programme).

Memorandum of Understanding with Midwifery Council of New Zealand

Recommendation:

That the Board signs two memoranda of understanding (Appendix A and B) with the Midwifery Council of New Zealand, these will remain in place until 30 June 2021

a) **One in relation to the roles and responsibilities of Waitematā District Health Board employed midwife clinical coach, to enable recruitment of Return to Practice midwives**
b) **One in relation to the roles and responsibilities of Waitematā District Health Board employed midwife clinical coach, to enable recruitment of Internationally Qualified Midwives.**

Prepared by: Emma Farmer (Director of Midwifery)
Endorsed by: Mark Shepherd (Director of Hospital services), Amanda Mark (General Counsel)

Glossary

HPCAA	–	Health Practitioners Competence Assurance Act
MECA	–	Multi-employer collective agreement
MERAS	–	Midwifery Employee Representation and Advisory Service
MOU	–	Memorandum of Understanding
NZNO	–	New Zealand Nurses Organisation
RTP	–	Return to Practice
IQM	-	Internationally Qualified Midwives

1. Executive Summary

The Midwifery Council of New Zealand has requested that Waitematā DHB enters into two Memoranda of Understanding with them. The Midwifery Council is seeking assurance from the DHB that the employed Midwife Clinical Coach will work collaboratively with them to meet their legal responsibilities under the Health Practitioners Competence Assurance Act (HPCAA) 2015, in supervising both:

a) Return to practice (RTP) midwives
b) Internationally qualified midwives (IQM)

The terms of the MOU are well within the capacity and capability of the maternity service and support our aspirations to recruit more midwives.

The MOU have been reviewed by Amanda Mark and have been approved.

2. Strategic Alignment

The MOU aligns with the DHBs aspirations to have a workforce that it fit for purpose and meets the needs of our population.

The Midwife Clinical Coach role is funded by the Ministry of Health so there are no funding requirements to fulfil the expectations of this MOU.

Community, whanau and patient centred model of care **Operational and financial sustainability**	Having a sufficient number of suitably qualified midwives supports appropriate and timely care of mothers and infants

3. Introduction/Background

As part of the 2019 MECA negotiations a Midwifery Accord was signed between the Minister of Health, the DHBs, the Midwifery Union MERAS and the New Zealand Nurses Organisation. The Accord detailed how parties would work together to support the recruitment and retention of midwives in DHBs. Subsequent to the signing of the Accord an Accord working group was established.

The Accord working group has a number of work streams aimed at improving recruitment and retention of midwives in the workforce. One of the streams was to introduce a Midwife Clinical Coach role in each DHB. The Midwife Clinical Coach role is aimed at providing clinical support and supervision to new graduates and new staff to increase confidence and smooth transition to the workplace.

From 1 July 2021 the Ministry of Health has funded Waitematā DHB to employ 1.5FTE Midwife Clinical Coaches. Two clinical coaches have been appointed 0.75FTE at North Shore and 0.75FTE at Waitākere Maternity units.

The Midwifery Council of New Zealand has the legal responsibility under the Health Practitioner Competence Assurance Act 2015 to ensure that midwives returning to practice after a break of three years or more and overseas trained midwives are safe to practice in New Zealand.

In order to recruit RTP midwives and Internationally Qualified Midwives the maternity service needs to work with the Midwifery Council to ensure that these midwives meet the required competencies. The Midwifery Council has agreed that the DHB employed Midwife Clinical Coach can act in a supervisory role if the DHB has signed a memorandum of understanding with the Council.

The memoranda outline the following:

1. The skills and requirements to be employed as a Midwife Clinical Coach
2. The supervision required of internationally qualified midwives
3. The supervision required of RTP midwives
4. The reporting requirements to the Midwifery Council by the Midwife Clinical Coach
5. The reporting requirement to the Midwifery Council by Waitematā DHB

4. Risks/Issues

There are no anticipated risks associated with signing the MOU and it will enable the maternity services to continue with the plan to recruit more midwives.

5. Conclusion

The service recommends that the board signs the memoranda in order to progress this work

MOU attached

Te Tatau o te Whare Kahu
Midwifery Council

MEMORANDUM OF UNDERSTANDING

BETWEEN THE MIDWIFERY COUNCIL OF NEW ZEALAND ("THE COUNCIL")

AND WAITEMATĀ DISTRICT HEALTH BOARD ("THE DHB")

1. Purpose

1.1. The purpose of this Memorandum of Understanding is to set out the basis on which the role of "Midwife Clinical Coach" will undertake to be the supervisor for midwives, employed by the DHB, who are returning to practice ("**RTP midwives**"), in accordance with the Council's Return to Practice Policy.

1.2. RTP midwives are midwives that have not held an annual practising certificate ("**APC**") for three years or longer. When an RTP midwife applies for their first APC following the period of three years or more, a condition is put on their scope of practice requiring the RTP midwife to complete a Return to Practice Programme ("**RTP Programme**"). Part of the RTP Programme includes a requirement to have a supervisor for the duration of the RTP Programme.

1.3. The responsibility for ensuring that registered midwives are meeting the required standard of competence lies with the Council, as the responsible authority under the Health Practitioners Competence Assurance Act 2003. The condition to complete the RTP Programme, including the requirement to have a supervisor, is part of that competence assurance process.

1.4. This Memorandum of Understanding recognises the importance of the Council maintaining a high level of oversight over the Midwife Clinical Coach role, while respecting the DHB's role as the Midwife Clinical Coach's employer.

2. Applicant requirements

2.1. The successful applicant for the Midwife Clinical Coach role must:

(a) be a registered midwife;
(b) have a minimum of five years' post-qualification clinical experience;
(c) hold a current practising certificate;
(d) have no conditions on their scope of practice or practising certificate;
(e) have never been the subject of any adverse finding of any professional disciplinary body;
(f) demonstrate clinical and cultural competence to a high standard; and
(g) be fully engaged in the Council's Recertification Programme.

2.2 The successful applicant to the Midwife Clinical Coach role will not have a managerial or reporting relationship in relation to any of the DHB's RTP midwives. If that occurs, the DHB will promptly inform the Council so that other arrangements may be made in respect of any RTP midwives with whom that managerial or reporting relationship exists.

2.3 The successful applicant must sign an agreement with the Council outlining the responsibilities of their role as supervisor to midwives undertaking the RTP Programme.

3. Role requirements

3.1 The Midwife Clinical Coach role will involve a minimum of 4 hours per month supervision of each midwife in an RTP programme.

3.2 The Midwife Clinical Coach will provide 1.5 hour(s) per month of active supervision to each RTP midwife for whom they are the supervisor. "Active supervision" means face to face meeting for the purpose of discussing clinical practice. Active supervision does not mean clinical oversight of practice. The remainder of allocated time is spent in preparation for supervision and for the purposes of providing a report to the Council.

3.3 The Council understands that the Midwife Clinical Coach will have other responsibilities and requirements placed on them by the DHB
that must be fulfilled. The DHB will ensure that the
Midwife Clinical Coach has sufficient capacity in their workload to fulfil the requirements at [3.1] and [3.2] above.

3.4 The DHB will ensure that the Midwife Clinical Coach is not placed in a situation where they have a managerial or reporting relationship to the RTP midwife that they are supervising, even temporarily.

3.5 The Midwife Clinical Coach must report directly to the Council every calendar month. The reporting must be in the form required by the Council as part of the agreement entered into with the Midwife Clinical Coach.

3.6 The Midwife Clinical Coach is required to notify the Council and the DHB immediately if they become aware of any of the following in relation to an RTP midwife:

(a) Any of the following issues regarding the midwife's competence to practice as a midwife:
   1. a pattern of behaviour that demonstrates a departure from accepted standards of competence in the returning midwife's practise;
   2. a series of errors in the returning midwife's practise;
   3. flaws in the midwife's clinical judgement, decision making or processes; and/or
   4. obvious gaps in the midwife's knowledge as a midwife.

(b) The midwife's practice is impacted by the midwife's physical or mental health.

(c) Any issues or investigations around the midwife's professional behaviour.

(d) The midwife's involvement in a critical incident where the midwife played a pivotal role in the care provided (as opposed to simply providing assistance to another midwife). If this occurs, the Midwife Clinical Coach must keep the Council informed and up to date in respect of any investigations and outcomes arising from the critical incident.

3.7 If non-compliance with the reporting requirements occurs, the Council will bring this to the DHB's attention. The DHB will address any non-compliance by the Midwife Clinical Coach as it considers appropriate.

4.0 Notifications regarding Midwife Clinical Coach

4.1 The DHB will inform the Council of the successful applicant(s) for the Midwife Clinical Coach role(s) in a timely manner.

4.2 The DHB will inform the Council of any resignation, suspension or termination of employment from the Midwife Clinical Coach role as soon as reasonably practicable.

4.3 The DHB and the Council will notify each other immediately if they become aware of the following issues regarding the Midwife Clinical Coach's competence to practice as a midwife:

(a) a pattern of behaviour that demonstrates a departure from accepted standards of competence in the Midwife Clinical Coach's practice as a midwife;
(b) a series of errors in the Midwife Clinical Coach's practise;
(c) flaws in the Midwife Clinical Coach's clinical judgement, decision making or processes; and/or
(d) obvious gaps in the Midwife Clinical Coach's knowledge as a midwife.

4.4 The DHB will notify the Council immediately if it becomes aware that the Midwife Clinical Coach's practice is impacted by the Midwife Clinical Coach's physical or mental health.

4.5 The DHB will notify the Council immediately if it becomes aware of any issues or investigations around the professional behaviour of the Midwife Clinical Coach.

4.6 The DHB will notify the Council immediately if it becomes aware of the Midwife Clinical Coach's involvement in a critical incident where the midwife played a pivotal role in the care provided (as opposed to simply providing assistance to another midwife). The DHB will keep the Council informed in respect of any investigations or other outcomes arising from the critical incident.

Signed on behalf of the Midwifery Council _____

Date:

Signed on behalf of Waitematā District Health Board _____

Date: End date: 30 June 2022

End

MEMORANDUM OF UNDERSTANDING BETWEEN

THE MIDWIFERY COUNCIL OF NEW ZEALAND ("THE COUNCIL")

AND

WAITEMATĀ DISTRICT HEALTH BOARD ("THE DHB")

1. Purpose

1.1 The purpose of this Memorandum of Understanding is to set out the basis on which the role of "Midwife Clinical Coach" will undertake to be the supervisor for midwives, employed by the DHB, who have obtained registration based on overseas qualifications, in accordance with the Council's Registration Policy for Internationally Qualified Midwives and Registration Policy for Applicants currently registered in Australia applying under the Trans-Tasman Mutual Recognition Act 1997 (collectively referred to in this MOU as "IQ Midwives").

1.2 IQ midwives are internationally qualified applicants, that is, anyone who has completed a midwifery qualification outside of New Zealand. IQ midwives can apply to the Midwifery Council (the Council) seeking registration as a midwife in New Zealand.

1.3 The responsibility for ensuring that registered midwives are meeting the required standard of competence lies with the Council, as the responsible authority under the Health Practitioners Competence Assurance Act 2003. The condition to complete an Overseas Competence Programme, including the requirement to have a supervisor for the duration of the Overseas Competence Programme, is part of that competence assurance process.

1.4 This Memorandum of Understanding recognises the importance of the Council maintaining a high level of oversight over the Midwife Clinical Coach role, while respecting the DHB's role as the Midwife Clinical Coach's employer.

2 Applicant requirements

2.3 The successful applicant for the Midwife Clinical Coach role must:

(a) be a registered midwife;
(b) have a minimum of five years' post-qualification clinical experience;
(c) hold a current practising certificate;
(d) have no conditions on their scope of practice or practising certificate;
(e) have never been the subject of any adverse finding of any professional disciplinary body;
(f) demonstrate clinical and cultural competence to a high standard; and
(g) be fully engaged in the Council's Recertification Programme.

2.2 The successful applicant to the Midwife Clinical Coach role will not have a managerial or reporting relationship in relation to any of the DHB's IQ midwives. If that occurs, the DHB will promptly inform the Council so that other arrangements may be made in respect of any IQ midwives with whom that managerial or reporting relationship exists.

2.3 The successful applicant must sign an agreement with the Council outlining the responsibilities of their role as supervisor to midwives undertaking an Overseas Competence Programme.

3. Role requirements

3.1 The Midwife Clinical Coach role will involve a minimum of 4 hours per month supervision of each midwife in an Overseas Competence programme.

3.2 The Midwife Clinical Coach will provide 1.5 hour(s) per month of active supervision to each IQ midwife for whom they are the supervisor. "Active supervision" means face to face meeting for the purpose of discussing clinical practice. Active supervision does not mean clinical oversight of practice. The remainder of allocated time is spent in preparation for supervision and for the purposes of providing a report to the Council.

3.3 The Council understands that the Midwife Clinical Coach will have other responsibilities and requirements placed on them by the DHB that must be fulfilled. The DHB will ensure that the Midwife Clinical Coach has sufficient capacity in their workload to fulfil the requirements at [3.1] and [3.2] above.

3.4 The DHB will ensure that the Midwife Clinical Coach is not placed in a situation where they have a managerial or

reporting relationship to the IQ midwife that they are supervising, even temporarily.

3.5 The Midwife Clinical Coach must report directly to the Council every calendar month. The reporting must be in the form required by the Council as part of the agreement entered into with the Midwife Clinical Coach.

3.6 The Midwife Clinical Coach is required to notify the Council and the DHB immediately if they become aware of any of the following in relation to an IQ midwife:

(a) Any of the following issues regarding the midwife's competence to practice as a midwife:
1. a pattern of behaviour that demonstrates a departure from accepted standards of competence in the IQ midwife's practise;
2. a series of errors in the IQ midwife's practise;
3. flaws in the midwife's clinical judgement, decision making or processes; and/or
4. obvious gaps in the midwife's knowledge as a midwife.

(b) The midwife's practice is impacted by the midwife's physical or mental health.

(c) Any issues or investigations around the midwife's professional behaviour.

(d) The midwife's involvement in a critical incident where the midwife played a pivotal role in the care provided (as opposed to simply providing assistance to another midwife). If this occurs, the Midwife Clinical Coach must keep the Council informed and up to date in respect of any investigations and outcomes arising from the critical incident.

3.7 If non-compliance with the reporting requirements occurs, the Council will bring this to the DHB's attention The DHB will deal with any non-compliance by the Midwife Clinical Coach in the same manner as it would non-compliance with any other aspect of the Midwife Clinical Coach's role.

4.0 Notifications regarding Midwife Clinical Coach

4.1 The DHB will inform the Council of the successful applicant(s) for the Midwife Clinical Coach role(s) in a timely manner.

4.2 The DHB will inform the Council of any resignation, suspension or termination of employment from the Midwife Clinical Coach role as soon as reasonably practicable.

4.3 The DHB and the Council will notify each other immediately if it becomes aware of the following issues regarding the Midwife Clinical Coach's competence to practice as a midwife:

(a) a pattern of behaviour that demonstrates a departure from accepted standards of competence in the Midwife Clinical Coach's practice as a midwife;

(b) a series of errors in the Midwife Clinical Coach's practise;

(c) flaws in the Midwife Clinical Coach's clinical judgement, decision making or processes; and/or

(d) obvious gaps in the Midwife Clinical Coach's knowledge as a midwife.

4.4 The DHB will notify the Council immediately if it becomes aware that the Midwife Clinical Coach's practice is impacted by the Midwife Clinical Coach's physical or mental health.

4.5 The DHB will notify the Council immediately if it becomes aware of any issues or investigations around the professional behaviour of the Midwife Clinical Coach.

4.6 The DHB will notify the Council immediately if it becomes aware of the Midwife Clinical Coach's involvement in a critical incident where the midwife played a pivotal role in the care provided (as opposed to simply providing assistance to another midwife). The DHB will keep the Council informed in respect of any investigations or other outcomes arising from the critical incident.

Signed on behalf of the Midwifery Council

_____

Date: _____

Signed on behalf of Waitematā District Health Board

_____

Date:
End date: 30 June 2022

4.2 Childhood Immunisation

Recommendation:

That the Board:

1. **Note consistent with international trends, childhood immunisation coverage has dropped nationally and is most acute in Auckland with prolonged and repeated COVID-19 lock-downs, and for Maori (who, along with Pacific, are most likely to be impacted by outbreaks) to a point where the risk of an outbreak of measles or pertussis is significant.**
2. **Note the report prepared by the Northern Region Child Health Steering Group, outlining the wide ranging recommendations of the Group, requiring a whole of system response.**
3. **Note the Ministry of Health's renewed focus on delivery of the MMR campaign targeting 15 – 30 year old Māori and Pacific peoples, which has remained a focus of the DHBs.**
4. **Note the planned local immunisation campaign's messaging about the importance and safety of childhood vaccination, led by high profile Māori and Pacific clinical champions.**
5. **Endorse the outlined immediate response through a determined focus on delivering all missed vaccinations at any vaccination event, and engaging the whole whānau at any vaccination opportunity by all vaccination providers.**

Prepared by: Ruth Bijl (Funding and Development Manager – Child, Youth and Women); Georgina Tucker (Clinical Leader – Uri Ririki)
Endorsed by: Dr Aumea Herman (Director Pacific, WDHB), Dr Owen Sinclair (Te Rarawa, Paediatrician, WDHB), Dr Debbie Holdsworth (Director Funding), Dr Karen Bartholomew (Director Health Outcomes), Ailsa Claire (Chief Executive)

Glossary

ADHB – Auckland District Health Board
CMH – Counties Manukau Health
CHSG – Northern Region Child Health Steering Group
IMAC - Immunisation Advisory Centre
MMR – Measles, Mumps and Rubella
WDHB – Waitematā District Health Board

1. Executive Summary

A report was prepared by the Northern Region Child Health Steering Group (CHSG) in response to significant clinical concern about falling vaccination rates, particularly for tamariki Māori after the previous COVID lockdowns (the report was developed prior to the August Delta outbreak, however the concerns have been highlighted further in the current COVID outbreak). The reduction in coverage and loss of herd immunity puts the community at risk of an outbreak of vaccine preventable disease which would hit Māori and Pacific disproportionately. Based on previous outbreaks, there will likely be hospitalisations and possibly deaths and significant morbidity, particularly for children aged under five years of age. The best protection is achieved through on-time vaccination from pregnancy. A comprehensive northern region action plan has been proposed, but in the immediate time-frame a communication plan is being delivered alongside the request to the sector to focus on delivering all missed vaccines at any vaccination event, and to offer the suite of vaccinations to whānau when-ever and where-ever they are engaged by health service providers.

2. Background

Falling childhood immunisation rates following COVID-19 is an international trend which is being seen nationally however more acutely metro Auckland with prolonged and repeated lockdowns. Following on-going discussions with the Board and collective concerns regarding declining childhood immunisation, we requested the Northern Region Child Health Steering Group (CHSG) undertake a review of our immunisation system and advise their recommendations for improvement. We have also continued to raise our concerns nationally requesting national leadership and are pleased to advise the Director General wrote to all Chief Executives on 6 December 2021 directing a renewed focus on delivering Measles, Mumps and Rubella (MMR) vaccinations in preparation for the potential re-opening of our borders in 2022.

The Northern Region DHBs' report: Immunisation of Tamariki 0-4 years in the Northern Region: Review July 2021 (Appended), was developed by the Northern Region Child Health Steering Group (CHSG). This was response to regional data presented to the group by the Funding Manager, Child, Youth and Women's Health, Planning Funding and Outcomes Unit highlighting plummeting immunisation rates and growing inequities of immunisation coverage for tamariki across the Northern Region. Particular concern was raised regarding tamariki Māori living in Counties Manukau, where coverage had dropped in the March 2021 reporting to 65%, as shown in Table 1 below. Coverage rates for all DHBs in the northern region had dropped to alarming levels.

The figure below from the regional report, provides 3-month trend data for the 8-month milestone since 2018. This highlights the continued decline in immunisation rates for tamariki Māori in the Northern Region with coverage below 80 % in all districts by June 2021. This is below the rate required to prevent outbreaks of vaccine preventable diseases and is well below the national target of 95%.

The equity gap for tamariki Māori in the Northern Region was increasing prior to the onset of the COVID-19 pandemic. However, COVID-19 has had a significant and enduring impact on childhood immunisations both within New Zealand and internationally. Providers also identified the introduction of the 12-month MMR vaccine as a contributor to the reduction in immunisation rates.

As stated in the regional report, significant risk exists from the very low child immunisation rates within the Northern Region population. The current border closures are keeping most vaccine preventable diseases out of the country. However, without a population health strategy there will be future vaccine preventable disease outbreaks, with significant morbidity and potential deaths Measles and pertussis are of particular concern with any outbreak likely to significantly impact Māori and Pacific children and their communities. The regional report describes structural barriers and ongoing programme failures within the health system perpetuating inequity for tamariki Māori in relation to immunisation, requiring an urgent and targeted response across the health system to fulfil Te Tiriti o Waitangi obligations.

The key themes identified by the review are as follows:

1. Chronic inequities in immunisation coverage: Long term systemic failures have caused barriers for whānau Māori immunisation services in New Zealand. Covid-19 has stretched health services to capacity creating unpredictable challenges and widened health inequities. Pae Ora Healthy Futures for Māori (Whakamaua), and the health system re-structure provide us with an opportunity for reform.
2. Systemic racism and bias: Conscious and unconscious bias creates barriers for whānau trusting and accessing primary care and health services. Te Tiriti o Waitangi based leadership is key to ensure any service development is meaningful, culturally safe and sustainable.
3. Referral pathway timeliness: The referral and enrolment to practice processes create gaps in a critical time period for relationship building between whānau and primary care and subsequently successful immunisation. Maternal vaccination provides a protective mechanism and an opportunity to further the conversation, trust and confidence around childhood immunisation and the early relationship with primary care. Immunisation is best considered holistically within the context of whānau needs.
4. Reporting and IT systems: Current reporting does not meet the needs of teams or enable early support to the immunisation journey. Reporting needs to reflect a proactive approach

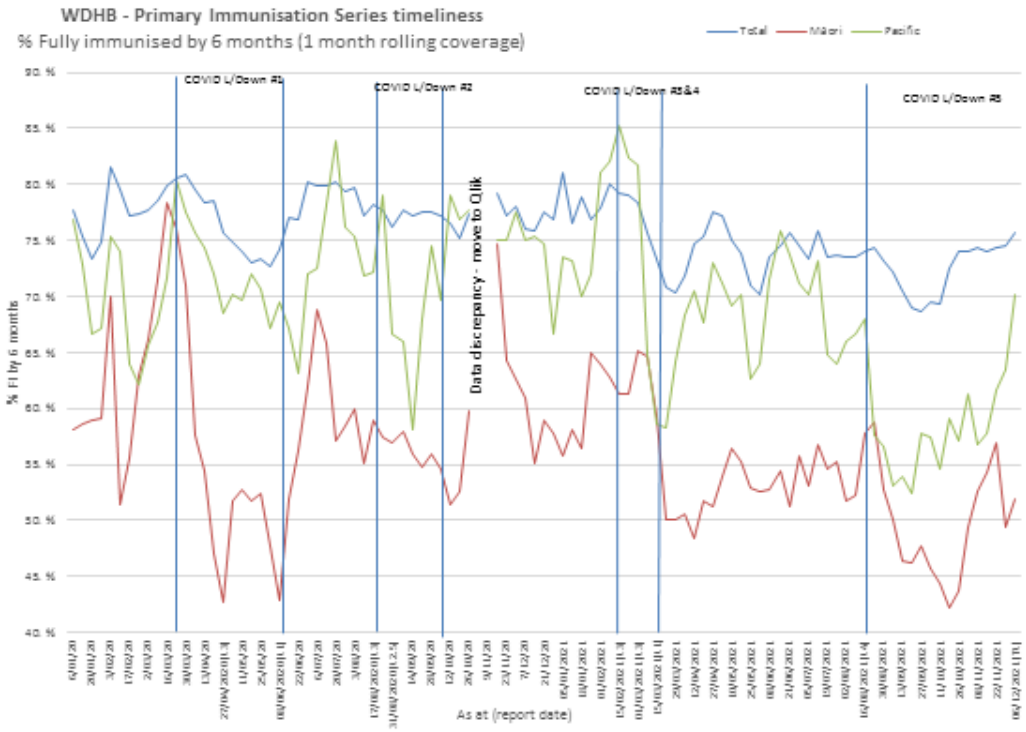
to immunisation and to allow for reporting of individual vaccination events. This includes the positive reinforcement of maternal immunisations and the protective factors influencing immunisation. Proactive and real time reporting would increase the timeliness of recalls for vaccination only if it occurs earlier than the current 8-month focus. An IT system with flexibility and improved access could eliminate cost and time consuming practices used to manage the current system. For example, having availability of on-line booking systems for whānau.

5. Workforce Capacity: Workforce is a limited resource and has been stretched to cover other priorities. Childhood vaccinators need to have protected time and resources to meet the demands of the current situation. Growing workforce capacity and using the semi-skilled workforce emerging from Covid-19 offers an opportunity to support whānau to navigate the health system. A training platform that is Te Tiriti o Waitangi compliant will enhance learning and resources available for staff and whānau.
6. Language, communication and relationship: Health outcomes are dependent upon a trusting relationship between whānau and health services, and between all health providers. A holistic approach to care that crosses the life span sits well in primary health; for childhood immunisation a well-child context is appropriate. Messaging needs to be consistent, friendly, available at all times and non-biased.
7. Covid-19: Covid-19 has added an extra layer of complexity impacting on whānau who are protecting their tamariki from potential risk of exposure. The changes in daily practices required for Primary Care to manage population wellbeing reduces the availability for staff to work face to face with whānau impacting on relationship building, trust and opportunities to provide immunisations.
8. Funding: System funding has siloed immunisation and services. A full review of commissioned services is indicated.
9. Getting it right from the beginning: Evidence shows that completion of the 6 week vaccination is a reliable indicator that the childhood series will continue to be completed on time. However, it is recognised that a poor experience at this 6-week event can have a lasting impact on engagement with immunisation and the health system in general.

Obviously these themes require a whole-of-system response, but there are some immediate actions that can be employed.

1. Current state in Waitematā DHB and immediate response

Immunisation coverage and activity is routinely reported to the Board through the Community and Public Health Advisory Committee (CPHAC). In the June 2021 report, the Board was informed that coverage for tamariki Māori at 8 months of age was 81%. The following graph showing the 6 month rolling average was presented to demonstrate the impact of lockdowns on on-time immunisation coverage. The blue line represents Total, the green line Pacific, and the red line Māori.



In Waitematā DHB as at 30 November 2021, on-time coverage is 74% at 6 months for the total population, 49% for tamariki Māori and 60% for Pacific. At 8 months, total coverage is 87% at 8 months, Māori 71% and Pacific 78%, the current low 6 month coverage predicts an ongoing decline in coverage at 8 months. In comparison, coverage at 6 months a year ago (to 30 November 2020) was 80% for the total population, 61% for Māori and 80% for Pacific; at 8 months coverage was 91% for the total population, 77% for tamariki Māori and 93% for Pacific.

A number of actions are already underway. These include:

1. The on-going delivery of services through the Outreach Immunisation Service, noting service disruption over lock-downs.
2. Providing lists of children (and their contact details) aged 2- 5 years who have not had at least one MMR vaccine dose to the Māori and to the Pacific mobile providers to increase outreach service capacity. We are currently working with the Māori Health Gains team on a second wave to focus on 14 to 24 month olds tamariki Māori without one dose of MMR.
3. Refinement of processes within the NIR team, including phoning practices regarding enrolled children who are over-due.
4. Refinement of processes in primary care practices to create a 'baby hour' (a wellness focus).
5. Developing the tools and skills at COVID-19 vaccination centres to check vaccination status on the NIR and to administer vaccinations as required.
6. Progressing approvals for Pharmacists to administer childhood vaccinations, and all pregnancy vaccinations.
7. Development of key messages for a communications campaign.

There is an urgent need to get messages out to communities regarding the importance and safety of pregnancy and childhood immunisations. A suite of messages has been developed, with the intent of refining messages with local communities, and pushing them out via a range of media. However, the

onus needs to be on health service providers to be culturally competent and for vaccination programmes to:

1. Ask and offer all immunisations at any immunisation event.
2. Ask and offer all immunisations to all the whānau when people present for, or are engaged by health services.

3. Whole of system response

The regional report provides a more comprehensive suite of actions (Appendix 1). An overview of these is provided in the table appended. The table of recommendations for Immunisation System Change can be found on page 6 of the report.

Responsibility for actions outlined are yet to be determined. Areas of where responsibility may currently sit are depicted by the following code:
Green = Ministry of Health
Red = Regional
Orange = Primary Care
Blue = DHB's
Yellow = Immunisation Advisory Centre (IMAC)

4. Conclusion

As immunisation coverage has dropped, protection against vaccine preventable diseases has reduced to the point where communities are at risk of severe disease, especially measles and pertussis, with future borders opening heightening that risk. Māori and Pacific children and their whānau through low immunisation coverage carry a disproportionate risk of experiencing high disease burden should an outbreak occur. The health system needs to re-focus efforts around childhood (and pregnancy) vaccinations with urgency. In addition to community messaging, in the immediate term, all providers need to ask and offer all vaccinations, and ask and offer these for all whānau.

Table 1:	Real Time Data and digital Enablement	Language	Communications Media	Structural Enablement	Integrated Whānau Care (Imms +)	Workforce	Funding	Intersectoral Working
Immediate – 0-3 months	Increase Qlik responsiveness and timeliness of reporting	Develop strengths based Primary Care consistent whānau contact messaging e.g. Text precalls, recalls, letters etc.	Communication (MEDINZ) to Primary Care to accept all new-born Baby Nominations	Removal of all barriers to enrolment through relaxation of eligibility e.g. - no birth certificate required to be immunised	Community engagement to identify groups requiring proactive community supported immunisation	- Prioritise skilled child health workforce for vaccination with alternatives for Covid response	A resourced catch-up programme for 0-4 years	Involve all key sector partners and stakeholders in developing a regional action plan
	Identify susceptible population. NHI level epi data on current immunisation coverage 0-4 year identify geographical areas for urgent attention. Identify N 0\1\2\ MMR.	Develop Regional Best Practice documents ensuring they are strengths based and Te Tiriti responsive.	Te Tiriti responsive and Te Reo accessible media campaign 0-4 year immunisation.	Extend B enrolments to 6 months	Proactive Integrated whānau care programme (OIS)	Strengthen opportunistic hospital and outpatient immunisations.	Payment of birth certificates IN priority populations	Identify sectors that work with priority populations. Opportunities for MoU (or similar) and supportive immunisation (e.g. Housing initiatives including access to integrated whānau care)
	Review of data system across the region to establish a clear plan of work	Identify key champions with Primary Care and Midwifery teams for relationship building	DHB sharing of communications and media practices across the region to ensure consistent messaging.	Prioritisation of integrated whānau care for Māori and Pasifika populations	Establish the who, how and when for the work programme	Gain clarity of the distribution of the current vaccination workforce. Potential opportunities to integrate immunisation activity differently	Review of capitation and funding of vaccinations to be in line with Covid-19	
	Tidy up connected health information services; including NES and NIR	Recommendations to IMAC to review responsiveness of website and resources to Te Tiriti o Waitangi	Update personal details at every opportunity across services. Flexible delivery aims to provide vaccinations at every available opportunity.	Relationship building with key stakeholders; Midwifery college, midwives, Pharmacy, MSD		Identify training pathways for future workforce. Consider options for Integrated Whānau Care (e.g. unregulated Kaimahi trained for Covid vaccination)	Avoid short term narrow focus contracts and move towards commissioning of holistic models of care (Imms +)	
			Work with midwives/midwifery college to ensure the correct GP for baby is identified at birth to ensure nomination goes to the correct practice.	For the 3 critical system issues, develop a regionally consistent solution for short term and recommendations for long term re-design				
Medium term 3 months-1 year	NCHIP reporting informs proactive anticipatory approach	Work with midwifery workforce to ensure positive strengths based messaging for immunisation	MOH and Māori Health Board to establish leadership for Imms programme based on Te Tiriti	Develop a plan for systematic process to maintain up to date contact details across all health points (NHIP).	Develop relationship with Māori Health Board and MOH to establish work on foundational documents	Policy/funding preparedness for future workforce - covid kaimahi	Policy/funding preparedness for future workforce - covid kaimahi	Development guidance for positive conversations with whānau about immunisation - see Comms/media
	NCHIP uptake in Counties Manukau	Training the workforce in strengths based enabling language and actions. Awareness therefore to overcome individual and practice level bias.		Standardise a regional pathway of care	Leverage from current work in the region that is performing well	Enablement of care by micro credentialed workforce (policy/funding)	Enablement of care by micro credentialed workforce (policy/funding)	Plan for digital enablement of contact sharing
	Development of a real-time Child Health Indicator monitoring dashboard	Connect with MOH and Māori Health Board for guidance with leadership			Develop regional strategy around delivery and capacity building	Development of workforce cultural competency with framework and resources	Review of across sector funding of immunisations in line with the vaccinating workforce identified e.g. Pharmacy	
	Review recommendations from Covid-19 experience							
Long term > 1 year		Have a structure in place that is working in Te Tiriti for workforce development, training, resourcing						

Appendix 1: **The Northern Region DHBs' report: Immunisation of Tamariki 0-4 years in the Northern Region: Review July 2021**

IMMUNISATION OF TAMARIKI 0-4 YEARS IN THE NORTHERN REGION: REVIEW JULY 2021

Immunisation Working Group

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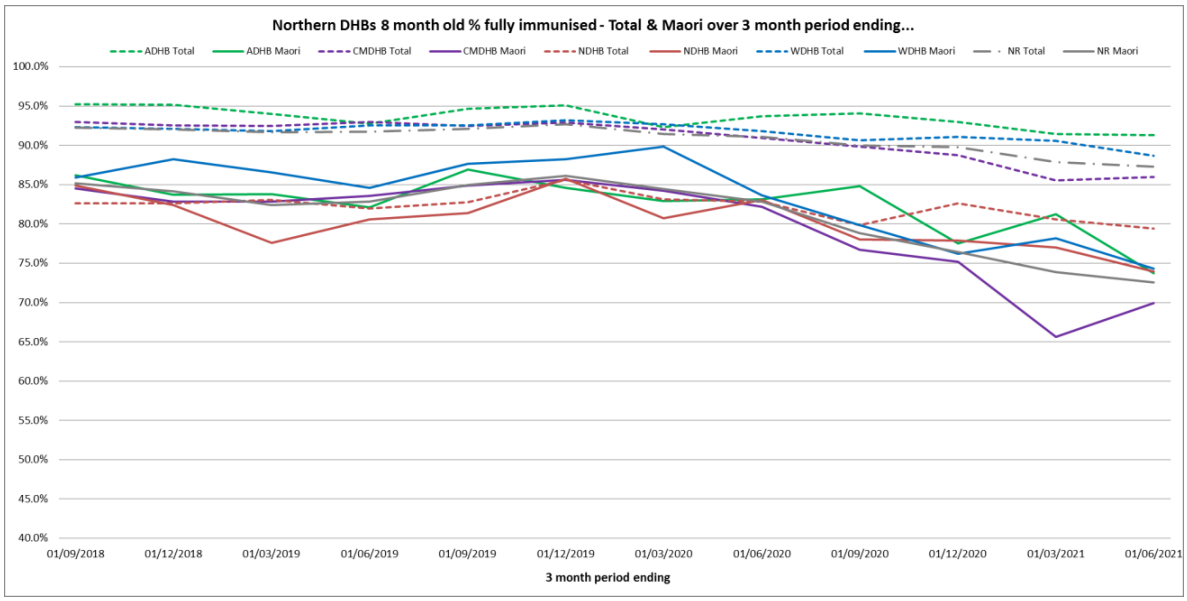
Immunisation of Tamariki 0-4 years in the Northern Region: Review July 2021

Executive Summary

In April 2021 the Northern Region Child Health Steering Group (CHSG) requested the development of a working group to formulate an urgent report for delivery in early August 2021. This was in response to regional data highlighting plummeting immunisation rates and growing inequities of immunisation coverage for tamariki across the Northern Region.

The review undertook to understand the state of regional childhood immunisation programmes including within the innovation space and to provide a series of recommendations. A sense of urgency and a requirement for a 'call to action' prompted the shortened time frame.

The table below provides 3-month trend data utilising the Ministry of Health 8-month milestone report since 2018. This highlights the continued decline in immunisation rates for tamariki Māori in the Northern Region. This significant downward trend shows that coverage has fallen below 80 % in most districts. This is below the rate required to prevent outbreaks of VPD (vaccine preventable diseases) and is well below the national target of 95%.



This equity gap for tamariki Māori in the Northern Region was increasing prior to the onset of the COVID-19 pandemic. COVID-19 has had a significant impact on childhood immunisations both within New Zealand and internationally. Additionally, providers point to factors around the introduction of the 12-month MMR vaccine as also attributing to the reported reduction in immunisation rates.

Significant current risk exists from the very low immunisation rates within our population. The current border closures are keeping most VPD out of the population. However, experience tells us that without a population health strategy we will be faced with future VPD lethal outbreaks within clusters. This will invariably inequitably impact Māori and Pacific children and their communities.

Structural barriers and ongoing program failures within the health system continue to perpetuate inequity for tamariki Māori in relation to immunisation. This requires an urgent and targeted response across all of the health system to fulfil Te Tiriti o Waitangi obligations.

The Northern Region must also deliberately target equity of outcomes for Pacific children.

Establishment of a Northern Regional Working Group

Membership of the working group was inclusive of the four districts within the Northern Region. The kaupapa (foundational principles) of the mahi required representation from Māori to achieve tino rangatiratanga and partnership in alignment with Whakamaua – Māori Health Action Plan 2020-2025 (Appendix 1).

There was leadership from a range of settings including DHBs, Primary Care and Funding & Planning. Working group members used DHB networks to include a much wider group of informants, limited only by the short time frames. Group participant's names are listed in Appendix 2.

Project Scope

The working group scope included a regional stocktake to describe current state for childhood immunisations. The focus was intentional toward tamariki Māori and their whānau. The working group committed to deliver a report identifying key immediate actions. The working group have confidence that strategies that improve immunisation rates for tamariki Māori will also lift other priority group immunisation rates for other populations.

Strategy

The working group followed the whānau journey to immunisation from pregnancy to the completion of the childhood series until the four year 4 immunisations.

Service delivery and reporting in the first instance requires focus on the successful completion of the 6-week immunisation. The ongoing strategy is to achieve immunisation scheduled events on-time at 6-weeks, 3-months and 5-months of age.

The table on Page 6 provides a summary of key issues and recommendations. Short term actions are focussed on VPD outbreak prevention and redress of growing inequities. Medium term and long-term recommendations are discussed in more detail and provide consideration to inform any future changes in the model of care for the northern region.

Stocktake of current service delivery

A stocktake of current regional immunisation activity was collated. This is represented in a matrix in Appendix 5. This wasn't broad enough to identify all Primary Health Care General Practices that are currently vaccinating.

Key themes from this review

Chronic inequities in immunisation coverage: Long term systemic failures have caused barriers for whānau Māori immunisation services in New Zealand. Covid-19 has stretched health services to capacity creating unpredictable challenges and widened health inequities. Pae Ora Healthy Futures for Māori (Whakamaua), and the health system re-structure provide us with an opportunity for reform.

Systemic racism and bias: Conscious and unconscious bias creates barriers for whānau trusting and accessing primary care and health services. Te Tiriti o Waitangi based leadership is key to ensure any service development is meaningful, culturally safe and sustainable (Jopnoe, 2021).

Referral pathway timeliness: The referral and enrolment to practice processes create gaps in a critical time period for relationship building between whānau and primary care and subsequently successful immunisation. Maternal vaccination provides a protective mechanism and an opportunity to further the conversation, trust and confidence around childhood immunisation and the early relationship with primary care (Wing Cheuk Chan, 2021) (Appendix 3). Immunisation is best considered holistically within the context of whānau needs.

Reporting and IT systems: Current reporting does not meet the needs of teams or enable early support to the immunisation journey. Reporting needs to reflect a proactive approach to immunisation and to allow for reporting of individual vaccination events. This includes the positive reinforcement of maternal immunisations and the protective factors influencing immunisation (Wing Cheuk Chan, 2021). Proactive and real time reporting would increase the timeliness of recalls for vaccination only if it occurs earlier than the current 8-month focus. An IT system with flexibility and improved access could eliminate cost and time consuming practices used to manage the current system. For example, having availability of on-line booking systems for whānau.

Workforce Capacity: Workforce is a limited resource and has been stretched to cover other priorities. Childhood vaccinators need to have protected time and resources to meet the demands of the current situation. Growing workforce capacity and using the semi-skilled workforce emerging from Covid-19 offers an opportunity to support whānau to navigate the health system. A training platform that is Te Tiriti o Waitangi compliant will enhance learning and resources available for staff and whānau.

Language, communication and relationship: Health outcomes are dependent upon a trusting relationship between whānau and health services, and between all health providers. A holistic approach to care that crosses the life span sits well in primary health; for childhood immunisation a well-child context is appropriate. Messaging needs to be consistent, friendly, available at all times and non-biased.

Covid-19: Covid-19 has added an extra layer of complexity impacting on whānau who are protecting their tamariki from potential risk of exposure. The changes in daily practices required for Primary Care to manage population wellbeing reduces the availability for staff to work face to face with whānau impacting on relationship building, trust and opportunities to provide immunisations.

Funding: System funding has siloed immunisation and services. A full review of commissioned services is indicated.

Getting it right from the beginning: Evidence shows that completion of the 6 week vaccination is a reliable indicator that the childhood series will continue to be completed on time (Rumball-Smith, Declining Care: A child's vaccination pathway, 2015). [i]However, it is recognised that a poor experience at this 6-week event can have a lasting impact on engagement with immunisation and the health system in general.

Key short time recommendations requiring immediate action

- Engage all key sector partners and stakeholders in developing a Regional Action Plan to achieve a planned recovery of immunisation rates and re-address inequities.
- Specifically prioritise prevention of VPD outbreaks i.e. Measles and Pertussis. Direct focus toward communities with the lowest vaccination coverage; under 5 year olds and antenatal coverage.
- 'Business as usual' will not have the capacity to address this alone.
- A collective impact approach will be required to increase resourcing to immunise children across the entire health system.
- Endorse the need for strong Māori health leadership.
- Consider a regional Incident Management Team (IMT) approach with associated funding under 'missed planned care'.
- Leverage off increased immunisation workforce before dissolution post COVID response.
- Resource culturally and community responsive communication programmes alongside 'catch up'.
- Continue progress to ensure immunisation systems have flexibility to deliver integrated whānau care with a whole of life course approach.

Primary Care – inclusive of GPs, Pharmacies, WCTO, Māori Providers, Midwives

- Ongoing stocktake and consultation regionally is required within Primary Care General Practice to identify current capacity, the impacts of Covid and enablers they can identify.
- The working group endorses the current MEDINZ messaging:
    - Mandatory acceptance of all new-born referrals by Primary care practices.
    - Primary care to continue to concentrate on the 6-week vaccination event.
    - Primary care to prioritise childhood immunisations and continue to vaccinate throughout all COVID levels.
    - Prioritisation of Māori and Pacific whānau.

Outreach Immunisation

- Ongoing prioritisation of Outreach Immunisation Services (OIS) that includes home visiting options.
- Endorse current and further innovation for well child outreach including immunisation clinics.

Escalation to the MoH with the following additional recommendations:

Immediate requests:

- Integration with a National approach.
- Prioritisation and visibility of antenatal immunisation coverage.
- Temporary suspension of any mandated requirements for enrolment and immunisation e.g. ensure birth certificate is not required for immunisation.
- B enrolments are automatically extended to 6-months to limit potential disenrollment.
- Clarification of which immunisations can be co-administered with COVID (relevance to School Based Health Services).
- Data level reporting at 2-years is misleading. Reporting for childhood immunisations needs to occur at real time and at all milestones; especially at 6-weeks to influence proactive, successful immunisation.

Longer term:

- Current systems for data and reporting are no longer fit for use. Any planning for a new NIR must include additional functionality to improve communication and accessibility of immunisation events and system responsiveness.

Table of Recommendations for Immunisation System Change:

Responsibility for actions outlined are yet to be determined.

Areas of where responsibility may currently sit are depicted by the following code:

Green = Ministry of Health
Red = Regional
Orange = Primary Care
Blue = DHB's
Yellow = IMAC

Table 1:	Real Time Data and digital Enablement	Language	Communications Media	Structural Enablement	Integrated Whānau Care (Imms +)	Workforce	Funding	Intersectoral Working
Immediate – 0-3 months	Increase Qlik responsiveness and timeliness of reporting	Develop strengths based Primary Care consistent whānau contact messaging e.g. Text precalls, recalls, letters etc.	Communication (MEDINZ) to Primary Care to accept all new-born Baby Nominations	Removal of all barriers to enrolment through relaxation of eligibility e.g. - no birth certificate required to be immunised	Community engagement to identify groups requiring proactive community supported immunisation	- Prioritise skilled child health workforce for vaccination with alternatives for Covid response	A resourced catch-up programme for 0-4 years	Involve all key sector partners and stakeholders in developing a regional action plan
	Identify susceptible population. NHI level epi data on current immunisation coverage 0-4 year identify geographical areas for urgent attention. Identify N 0\1\2\ MMR.	Develop Regional Best Practice documents ensuring they are strengths based and Te Tiriti responsive.	Te Tiriti responsive and Te Reo accessible media campaign 0-4 year immunisation.	Extend B enrolments to 6 months	Proactive Integrated whānau care programme (OIS)	Strengthen opportunistic hospital and outpatient immunisations.	Payment of birth certificates IN priority populations	Identify sectors that work with priority populations. Opportunities for MoU (or similar) and supportive immunisation (e.g. Housing initiatives including access to integrated whānau care)
	Review of data system across the region to establish a clear plan of work	Identify key champions with Primary Care and Midwifery teams for relationship building	DHB sharing of communications and media practices across the region to ensure consistent messaging.	Prioritisation of integrated whānau care for Māori and Pasifika populations	Establish the who, how and when for the work programme	Gain clarity of the distribution of the current vaccination workforce. Potential opportunities to integrate immunisation activity differently	Review of capitation and funding of vaccinations to be in line with Covid-19	
	Tidy up connected health information services; including NES and NIR	Recommendations to IMAC to review responsiveness of website and resources to Te Tiriti o Waitangi	Update personal details at every opportunity across services. Flexible delivery aims to provide vaccinations at every available opportunity.	Relationship building with key stakeholders; Midwifery college, midwives, Pharmacy, MSD		Identify training pathways for future workforce. Consider options for Integrated Whānau Care (e.g. unregulated Kaimahi trained for Covid vaccination)	Avoid short term narrow focus contracts and move towards commissioning of holistic models of care (Imms +)	
			Work with midwives/midwifery college to ensure the correct GP for baby is identified at birth to ensure nomination goes to the correct practice.	For the 3 critical system issues, develop a regionally consistent solution for short term and recommendations for long term re-design				
Medium term 3 months-1 year	NCHIP reporting informs proactive anticipatory approach	Work with midwifery workforce to ensure positive strengths based messaging for immunisation	MOH and Māori Health Board to establish leadership for Imms programme based on Te Tiriti	Develop a plan for systematic process to maintain up to date contact details across all health points (NHIP).	Develop relationship with Māori Health Board and MOH to establish work on foundational documents	Policy/funding preparedness for future workforce - covid kaimahi	Policy/funding preparedness for future workforce - covid kaimahi	Development guidance for positive conversations with whānau about immunisation - see Comms/media
	NCHIP uptake in Counties Manukau	Training the workforce in strengths based enabling language and actions. Awareness therefore to overcome individual and practice level bias.		Standardise a regional pathway of care	Leverage from current work in the region that is performing well	Enablement of care by micro credentialed workforce (policy/funding)	Enablement of care by micro credentialed workforce (policy/funding)	Plan for digital enablement of contact sharing
	Development of a real-time Child Health Indicator monitoring dashboard	Connect with MOH and Māori Health Board for guidance with leadership			Develop regional strategy around delivery and capacity building	Development of workforce cultural competency with framework and resources	Review of across sector funding of immunisations in line with the vaccinating workforce identified e.g. Pharmacy	
	Review recommendations from Covid-19 experience							
Long term > 1 year		Have a structure in place that is working in Te Tiriti for workforce development, training, resourcing						

Immunisation Programme Delivery Nationally

The national immunisation system was last reviewed in 2016. Since that time health teams have continued to work hard to lift immunisation rates and connection with services for Māori (MOH, 2016). Despite intent, and occasional instances of achieving equity for Māori, rates of immunisation for Māori are continuing to drop. There is a long-standing history of a system that underperforms and continues to fail Māori. Consistent regional services operating under national oversight would provide transparency of care and service delivery.

A well-functioning immunisation program is a cornerstone of population health. The rate of pneumococcal infection associated with RSV is rising and adults may be at risk from under vaccinated children. There is a high risk of child mortality secondary to cluster outbreaks of VPD. The situation has been compounded by the Covid-19 outbreak for both New Zealand and our Pasifika neighbours.

Business as usual is not enough to remedy or impact the current situation. Immediate and intentional disruption of the current childhood immunisation programme is required to have any impact on tamariki wellbeing. Strategic change across the Northern region that is intentional and culturally responsive will need to specifically prioritise immunisation for the 0-4-year-old population.

Consistent throughout the themes was the notion that the additional MMR vaccination resulted in a significant increase in workload in an already under resourced workforce. A subsequent 20% reduction in vaccination rates noted by CMDHB (Wing Cheuk Chan, 2021) is thought to reflect capacity issues relating to programme delivery.

The implementation process for change and communication regarding the new MMR event was also described as inadequate. As a result, there has been confusion for the health workforce and whānau.

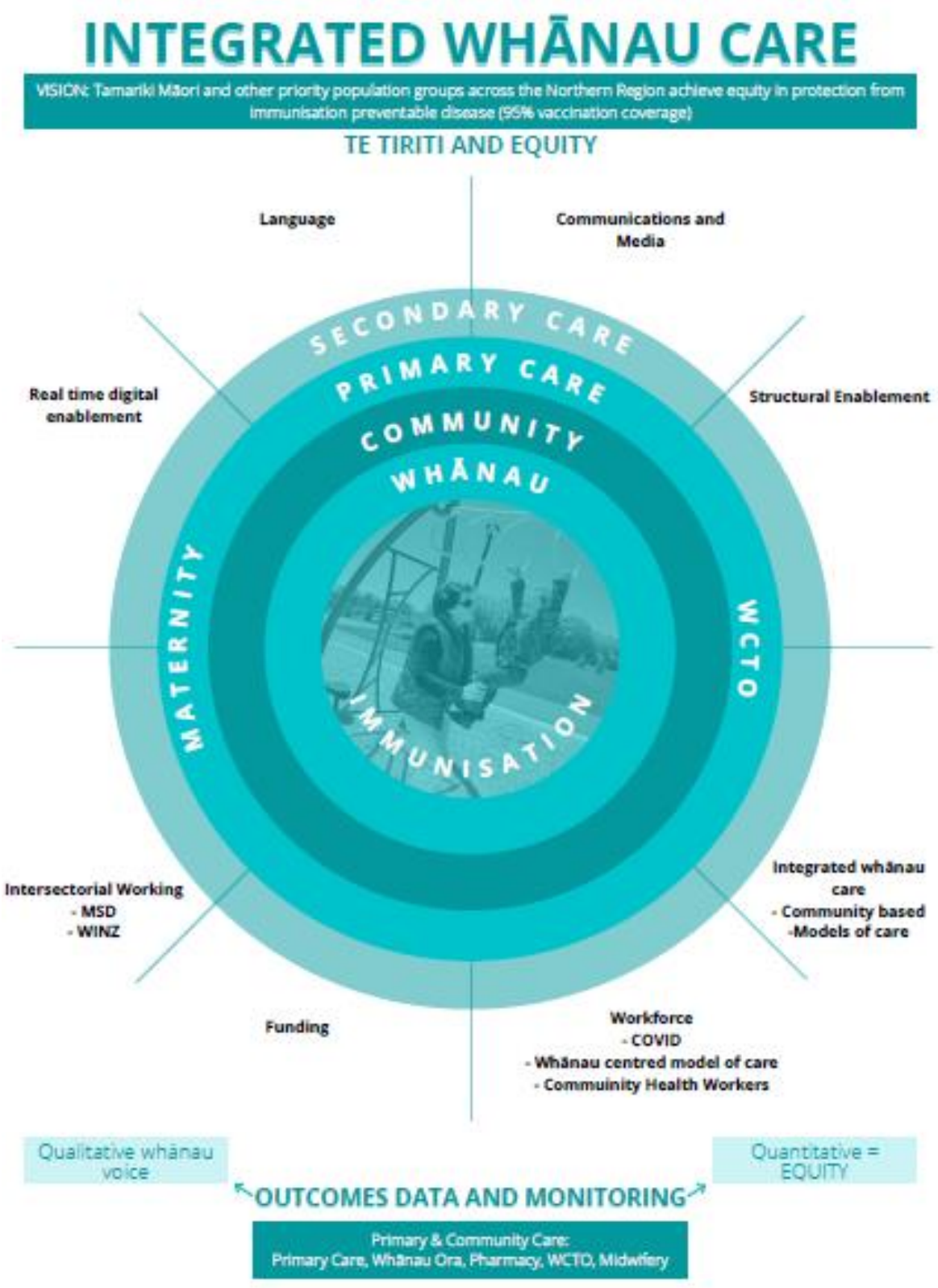
This highlights the need for carefully planned consistent national messaging for Child health immunisations working in partnership with key stakeholders to create a consistent confident approach.

Integrated Whānau Care – Immunisation - A Call to Change

The diagram below provides a model to visualise the factors that influence the whānau journey to reach immunisation. These are discussed further describing the areas of influence where change to the immunisation system is required.

The vision for immunisation provides the aspirational goal to achieve equity in immunisation for tamariki:

> Tamariki Māori and other priority population groups across the Northern region achieve equity in protection from immunisation preventable disease (95% vaccination coverage). All whānau will have equal opportunity to successfully immunise tamariki on time.


INTEGRATED WHĀNAU CARE
VISION: Tamariki Māori and other priority population groups across the Northern Region achieve equity in protection from immunisation preventable disease (95% vaccination coverage)
TE TIRITI AND EQUITY
Language
Communications and Media
Real time digital enablement
Structural Enablement
SECONDARY CARE
PRIMARY CARE
COMMUNITY
WHĀNAU
MATERNITY
IMMUNISATION
WCTO
Intersectorial Working
- MSD
- WINZ
Integrated whānau care
- Community based
-Models of care
Funding
Workforce
- COVID
- Whānau centred model of care
- Community Health Workers
Qualitative whānau voice
Quantitative = EQUITY
OUTCOMES DATA AND MONITORING
Primary & Community Care:
Primary Care, Whānau Ora, Pharmacy, WCTO, Midwifery

Overarching principles: Te Tiriti and Equity

Successful immunisation starts with the underpinning principles and the framework of service delivery. The working group propose that all future work for immunisation is underpinned by Whakamaua as the framework to deliver vaccination regionally.

Whakamaua emphasises the significance of Te Tiriti o Waitangi as a foundational document. The text of Te Tiriti, including the preamble and three articles, along with the Ritenga Māori declaration, are the enduring pillars of Whakamaua. (Hon Peeni Henare, Whakamaua-Māori Health Action Plan 2020-2025) (Appendix 2).

The health and disability system is committed to fulfilling the special relationship between Māori and the Crown under Te Tiriti o Waitangi (Te Tiriti). With regard to the text of Te Tiriti and declarations made during its signing – the Ministry of Health (the Ministry), as the kaitiaki and steward of the health and disability system (under article 1 of Te Tiriti), has the responsibility to enable Māori to exercise authority over their health and wellbeing (under article 2) and achieve equitable health outcomes for Māori (under article 3) in ways that enable Māori to live, thrive and flourish as Māori (Ritenga Māori declaration[1]).

The social determinants of health and living in hardship continue to impact community's access to health care. Deprivation is reported to have the most significance on timely immunisations when experienced during the first year of a child's life (Rumball-Smith, Declining Care: A child's vaccination pathway, 2015). Māori are over represented in those living in areas of high social deprivation (50%). Whānau are more likely to immunise their child when services are holistic, close to home with established relationships with the provider (Rumball-Smith, Childhood immunisation in Northland, background paper, 2016). This fits well within a model that has a lifespan approach.

Other population groups may require further exploration to consider specific individual impacting factors, such as rural populations and children with disability or high health needs.

A number of system 'fixes' have been made to the delivery system for immunisation. This has created a cumbersome system that continues to create further structural barriers and increases inequity for Māori.

For the purposes of this report the working group developed themes to describe the structural barriers and identify enablers to successful childhood immunisation.

[1] Ritenga Māori declaration (often commonly referred to as the 'fourth article') was drafted in te reo Māori and read out during discussions with rangatira about Te Tiriti. The Ritenga Māori declaration provides for the protection of both religious freedom and traditional spirituality and knowledge (Te Puni Kokiri 2001).

System Enablers

Real time data and digital enablement

For the last five years Primary Health organisations reporting has focused at 8 months for childhood immunisations. Immunisations are overdue by 4 weeks prior to activating alternative systems and focuses only on the completion of the three immunisation events, rather than each individual event being delivered on time. With the knowledge that the 6-week immunisation event is a strong indicator of successful completion of the early childhood series, reporting the vaccination coverage at 8 months is too late. There is a missed opportunity to aim for timely vaccination to provide maximum protection to infants.

All teams report that the National Immunisation Register (NIR) does not interface with the National Enrolment System (NES). This has the effect of the wrong practice being contacted about overdue immunisation events, which can lead to delays in follow-up processes such as referral to OIS. The NIR requires significant manual re-alignment and clean-up to keep the system up to date as well as significant follow-up of immunisation events that are not messaging to the NIR from practice data. Various approaches are in use to overcome the system issues; however, the system remains reactive rather than proactive. Specific capacity is urgently needed to redesign to a proactive data driven systematic equity based approach.

Some system issues have impacted on the enrolment to PHO e.g. GP clinics access NIR through the Health link platform, messaging issues between NIR/PMS systems and Med Tech Evolution has resulted in inability to process new-born nominations in some clinics.

Joined up data across the system is important for identifying opportunities for system improvement. Currently there is no transparency of service delivery in the region. In addition, the current systems are not able to capture how many children are being referred to OIS by individual practices versus other providers. When an immunisation event is missed early activation of supports from a proactive system is required for successful immunisation to be achieved. There is potential to decrease the burden of managing system issues to free up valuable clinician time. A positively geared system would also be reflected in reporting and messaging to whānau, shifting the narratives to a positive framework.

The Qlik platform is a useful tool to increase the transparency of immunisation coverage through reporting. However, there are system limitations for how the current reporting is used. For example, for this report we were unable to gain specific graphed reporting for the 6-month coverage from MOH. Current reporting is for 8-months coverage and data is loaded up until March 2021 only, a current 5-month gap in reported immunisation data. Whilst reports can be run for 6-month coverage this creates additional data analysis burden. Having a central methodology that is embedded in Qlik would increase data consistency. Having data available that is up to date and has the flexibility to report on all ages and individual immunisation events will increase response time to immunisation success e.g. being able to report on timeliness to 6 week immunisations in real time at a population level, compared to NHI level data being analysed.

A new register for Covid-19 is currently in use and may be a precursor for the new NIR system which has been in the pipeline for a few years now. This is an opportunity to design a positively geared proactive system. This replacement cannot be delayed, too much administrator time is spent undertaking workarounds for a legacy system that has outgrown its capabilities.

Recommendations:

- A full review of the data and information systems to understand the detail of the current systems and work out the priorities of work.
- Resource is identified and funded to redesign the data system that reflects a proactive equity based approach and that is fit for purpose.
- MOH investment includes an immunisation recording system with flexible digital capacity that supports timely analysis of all immunisation events.
- The current systems established in response to Covid-19 are considered and are used where the legacy elements are appropriate.
- The National Enrolment Service and NIR data have a 'tidy up'. Explore what opportunities there are for future management. Identify who is not enrolled and shape a planned approach for the future.
- Future management opportunities of the system are explored.
- Work out what needs to happen for Counties Manukau to be successfully enrolled on NCHIP.
- Explore reporting for use in Primary Care services so that enrolment numbers and care is visible.

Language Korero

The way language is used in communication with whānau, between services and for reporting immunisation impacts all aspects of the immunisation journey (Rumball-Smith, Childhood immunisation in Northland, background paper, 2016). Personal values and beliefs of the health provider toward immunisation are reflected in the way messages are delivered. This can be both positive and negative, depending on the relationship built with the mother, health literacy, resources and support given ((Sinclair, 2021), (Gauld, 2020)). Language and messaging are also likely to impact the maternal response to vaccination and may increase the burden of care experienced by a woman.

Whānau come in to contact with many services that will have influence on the immunisation conversation. Even when a child is not enrolled in a PHO they are likely to have had at least one recorded contact with another health service over the first 6 weeks of life (Wing Cheuk Chan, 2021). This presents many opportunities to reinforce the vaccination message at all service encounters across health in the first instance.

The language and behaviours used during the early journey to enrolment have been described by Māori whānau as racist, discriminating and unfriendly (Gauld, 2020) (Sinclair, 2021). Development of best practice messaging and education is required to support health professionals to overcome personal and practice induced bias/racism so that whānau are welcomed and empowered to confidently immunise. This needs to align with the positive outcomes associated with immunisations to lift community's expectations of service delivery.

The Immunisation Advisory Centre (IMAC) is the lead agency under the MOH contracted to provide the training for vaccinators and immunisation information. There has been inconsistent use of Māori and Pasifika staff employed to work with a cultural lens within IMAC since 2017. Roles which had subsequently been discontinued may be now recreated for the Covid-19 vaccination space. Staff within the Northern Region report a lack of easy to find, culturally appropriate resources. Translated material is available on Health ED via the Health Promotion Agency; although translated material may not necessarily be culturally appropriate. To maintain our commitment to Te Tiriti o Waitangi culturally appropriate training and resources is a high priority to address.

Successful transition for whānau through the health journey and the messaging from all health services is crucial for determining the relationship with Primary Health and the future success of immunisation. Trust and relationship building are a key part of health and wellbeing for Māori. Inconsistent messaging, lack of service co-ordination and communication supports the cycle of mistrust and overburden .

Recommendations:

- Strong relationships across all community and health partnerships to build consistency in messaging language and trust is prioritised. The role of the midwife is pivotal and the links with Primary Care General Practice could be strengthened through collaborative working on the enrolment to practice process.
- A relationship is established with the Māori Health Board to provide leadership to build the framework for immunisation. Consider the Northland DHB work to see what learnings could springboard in to a regional system reframe.
- Training and resources are Te Tiriti o Waitangi compliant.

Communication & Media

Media and communications about childhood immunisations are being targeted throughout the region creatively. There is a need for consistent messaging that is Te Tiriti o Waitangi compliant, with potential strengthening in the Region by sharing resources and feedback from the Hui currently working with community partners.

How immunisation messaging is delivered impacts on Whānau choice and confidence to vaccination (Gauld, 2020). Proactive approaches to immunisations that include holistic and 'fun' aspects e.g. weaving days are also positively influencing Whānau confidence.

The positive outcomes associated with immunisation should be reflected in the messaging used in promotion across the region. Campaigning using high profile sports to ambassador the immunisation message as proactive role models is being warmly received by the public. (Rumball-Smith, Childhood immunisation in Northland, background paper, 2016).

Counties Manukau have commissioned a Kaupapa Māori provider pilot to deliver 'Connect-up' as part of the MMR vaccine catch up for 15-30-year olds. This initiative has a wider whānau focus on immunisation information and support kiosk based in the local mall. Whānau are encouraged by trained whānau support workers to come in and check their vaccination status. Education and vaccination opportunities are supported by the mall Pharmacy's and whānau primary care providers.
Whānau report that incomplete messaging acts as a barrier to immunisation. The information about immunisation needs to be full including pros and cons for whānau to make decisions for their tamariki, whānau need to feel that they have been given enough time with their health provider to make an informed decision.

Sharing of information across services and the region would begin to address the need to standardise the messaging and resources around immunisation to bring some consistency and surety for whānau.

Recommendations:

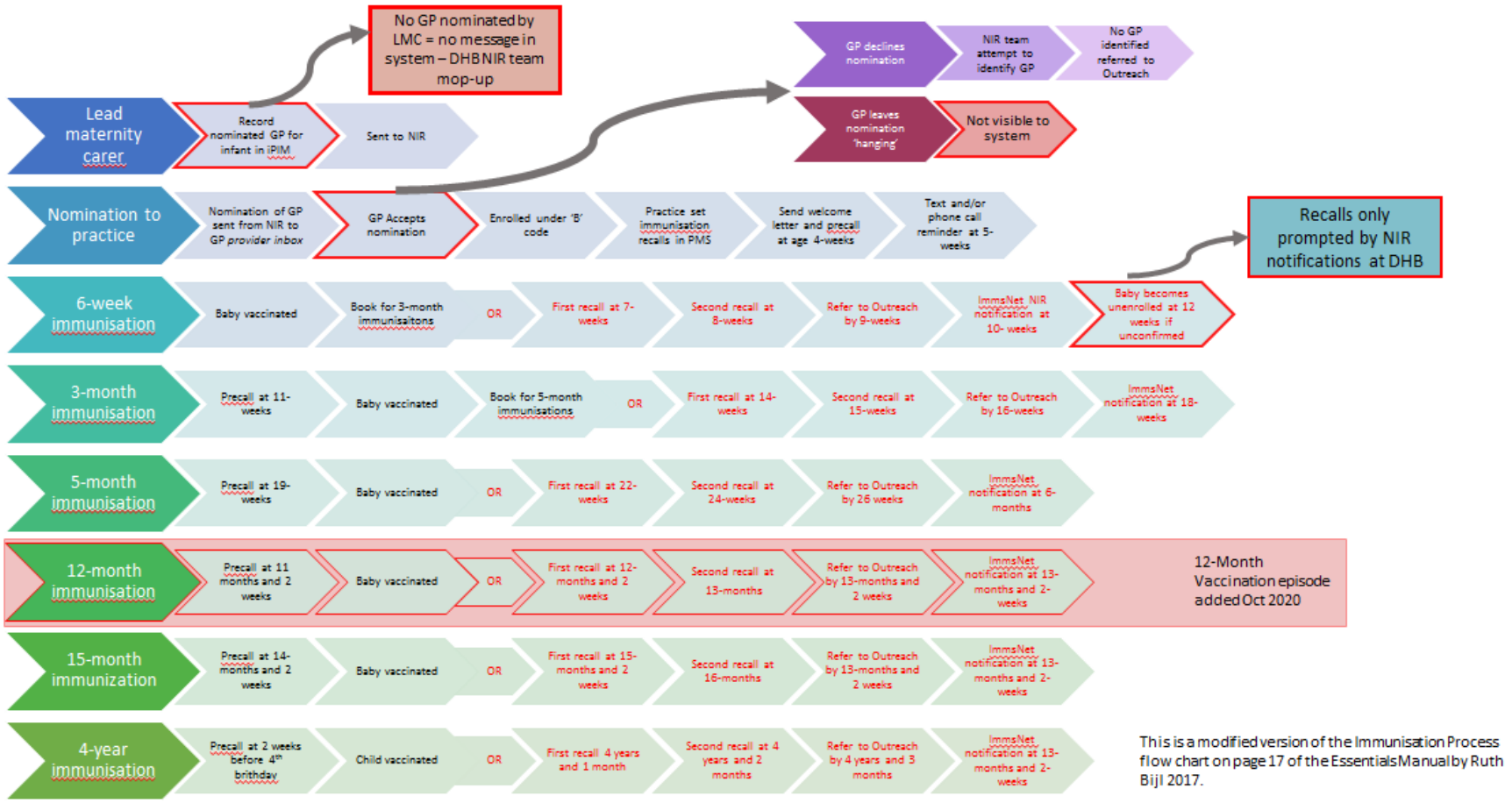
- Immunisation messaging will benefit from a regional approach where resources, campaigning and media are standardised and consistent. All immunisation providers will require access to shared resources.
- Use of a communication team will ensure message transparency.
- Consideration that MOH and the Māori Health board lead central messaging that is Te Tiriti o Waitangi compliant.

Structural Enablement

There are three critical system issues common across the four northern DHB's that create barriers to access to immunisation that disproportionally affect Māori and are outlined in heavy red in the diagram below:

1. GP nomination and referral
2. Referral acceptance at Primary care
3. Primary care B Enrolment successfully converting to full enrolment

Immunisation process flow chart 2021



The successful completion of the 6-week immunisation is seen as a reliable indicator of the likelihood whānau will continue the vaccination series on time and to completion.

Primary Care General Practice provide the majority of childhood immunisations in the Northern Region. Outreach immunisation services attempt to vaccinate those who are not immunised in a timely way. Primary Care Data shows that this immunisation system has historically under performed for Māori; (Table 31 (Wing Cheuk Chan, 2021)).

The two significant events impacting 0-4-year-old immunisation since March 2020 are described below:

- The effects of the COVID-19 pandemic lockdowns and changes in care because of infection prevention control measures have led to a significant impact on overall capacity in primary care. Cheuk Chan et al. 2021 report a 20% reduction in total 0-4-year immunisation episodes across the system in Counties Manukau Health domiciled children over the 12-month period ending March 2021.
- An additional childhood vaccination event at 12-months of age added to the national vaccination schedule in October 2020. This has increased total vaccination episodes from five to six in the 0-4-year-old cohort increasing the burden of activity in the system by 20%. As a result, a concerted effort is now required to avoid falling further behind in immunisation in the current scheduled period.

This has increased the number of events Primary Care provide, and reduced the time available for staff to undertake recall and follow-up of the original immunisation events. This also includes reduced time to respond to information requests from the NIR teams required to keep the data on the NIR accurate.

Early and continuous enrolment in Primary Care is a strong predictor of improved immunisation outcomes (Grant et al 2010 BMJ). Enrolment to Primary Care prior to 6 weeks of age, with no subsequent enrolment gap, is a protective factor in support of childhood immunisation. Being a part of a Primary Care Practice population enables recalls and reminders for immunisation events. (Wing Cheuk Chan, 2021). The systems in use to support enrolment from the time of birth are creating barriers to successful enrolment and increasing the potential for gaps in the referral and reporting systems. Provisional enrolment created at the time of birth (via NIR nominated provider messaging) provides initial funding for the child. However, this expires after 12 weeks if the enrolment is not converted to full enrolment. Anecdotal evidence reports that practices do not undertake recalls for ‘casual’ patients. New-born babies become ‘casual’ if their pre-enrolment is not converted to full active capitation enrolment.

There are several barriers to primary care enrolment. Primary Care Practices are sometimes reluctant to accept new-born nominations if they do not know the mother. If a woman does not have a high need for primary care prior to having their baby, there is an increased likelihood of non-acceptance of the new-born enrolment. Some Primary Care Practices have closed books to accepting any new patients due to capacity issues.

There have been some regional responses to try and improve enrolment rates. For example, NDHB has focused on improving enrolment to GP Practice through mandatory acceptance of all new-born notifications to Primary Care referrals, even when the mother is not a current patient. This has shifted enrolment from 49% in May of this year to 72% at the beginning of July. Likely fluctuations are expected. However, the positive and quick increase in enrolment numbers is an early indication of success. All services are engaged in regular reporting and multi-service review meetings to signal data discrepancies and areas of issues for early action.

It is important to remove all barriers and foster the early relationship Māori whānau experience with Primary Health to prevent enrolment gaps and dis-enrolment. (Wing Cheuk Chan, 2021). One barrier to converting pre-enrolment to full primary care enrolment is the requirement for birth certificates as proof of eligibility for funded healthcare. At a cost of $33, this is prohibitive for many of high needs families.

There is variability in primary care and practice level response to the new-born notification referral and subsequent engagement with whānau. Some practices have taken a proactive approach and use dedicated staff to maintain reporting and acceptance of new-born referrals. Within Auckland and Waitematā DHBs, funded Immunisation Co-ordinators within larger practices support smaller practices and other non-primary care providers. They have been pivotal in supporting Primary Care Practices with their immunisation practices, follow-up of new born enrolment and overdue immunisations. Our current IT systems make this process labour intensive.

Standardising pathways of whānau centred care delivered from the first new-baby notification offers the best opportunity to improve immunisation in Primary Care. Best Practice Manuals have been in circulation since 2010 across Auckland and Waitematā DHBs. These resources have also been shared within the wider Northern Region. There is good evidence that standardising best practice at the early transition points results in sustained improved outcomes. This includes; correct identification of GP, acceptance of GP nomination from new-born referral, and intentional, proactive early engagement. Achieving both primary care full enrolment and on-time 6-week immunisation are the best measures of improvement.

Intentional and proactive engagement with whānau Māori at the community level provides a flexible approach to care (Sinclair, 2021). Immunisation Coordinators and Community Health Assistants that mobilise around whānau and offer home visiting options have reported success along with use of mobile units in some cases (Papakura Marae). Health West has used a pop up unit at Hoani Waititi Marae in response to a community request for an increased presence of the health team on site. This is staffed by two nurses, a GP and administration support to provide a holistic service for the whole whānau including vaccination education and opportunistic events. Co-ordinated activity is considered to be easier if care is PHO led or where the practice is larger and robust management systems are in place. (Sinclair, 2021).

Recommendations:

- Immediate action is required to remove all barriers to immunisation so that whānau can be immunised more flexibly across the health care continuum. Temporary relaxation of the enrolment criteria requiring a birth certificate for capitation to be received by Primary Care before being able to provide new-born vaccination.
- Review of eligibility criteria and recommend that there is no charge for birth certificates.
- That ‘B’ funded enrolments are extended to six months to prevent unnecessary disenrollment from Primary Care and ensure continued recall for immunisation.
- Relationship building and communication is prioritised with Midwifery services to positively influence the nomination and referral flow to Primary Care.
- Standardise regional pathways of care.
- MOH reporting via Qlik increases its ability to provide more sensitive reporting of individual vaccination events and to have a central control of the methodology applied to the data.

Workforce

The pivotal New Zealand Immunisation Determinants study found that immunisation coverage is associated with practice staffing and shortages, independently of socio-economic factors (P=0.004). (Cameron C Grant 2. H.-H.-S., 2018) (Cameron C Grant N. M., 2010).

The workforce delivering childhood immunisations has not been possible to clearly identify or quantify. There are multiple contracts and providers with no current reporting available. Though there are published guidelines that support service delivery, practice varies between individual providers.

It is widely reported that the workforce has been re-directed to Covid-19 swabbing and the new 12-month immunisation event as a priority. This has impacted on the availability of the vaccination workforce. Covid-19 vaccination urgency has driven the development of a new unregulated, micro-credentialed vaccination support workforce, many of whom are Māori or Pasifika. There is an unprecedented opportunity to create new pathways of career development for this newly introduced workforce to support roles in healthcare.

Conversely all services agree that it takes special skill to vaccinate a child well. The current workforce of specialist nurses is a relatively small number. They are a limited resource which needs to be strengthened both in numbers and quality of service delivered. Practitioner skill includes working with bicultural understanding and a commitment to education and holistic care, specifically targeted to care of whānau. This is different to service provided for adult population vaccination.

Most immunisation events occur in Primary Care who are reporting loss of the nursing workforce in many practices. The usual pipeline of international recruits has been suspended and anecdotally nurses have taken up roles in the Managed Isolation and Quarantine facilities or in the Covid-19 vaccination programme.

OIS have had inconsistent success in providing immunisation. They are reported to have had positive influence on whānau confidence in subsequently achieving immunisation success (Wing Cheuk Chan, 2021). In 2020 there was a 20% reduction in vaccination episodes across the system in Counties Manukau Health area triggering an overwhelming increase in the number of referrals to OIS. Most vaccinations for children who were referred to OIS eventually occurred in Primary Care. Stress on the OIS system reduced its effectiveness and thereby disproportionately disadvantaged Māori and Pasifika populations who are more likely to engage with the OIS for vaccinations.

There is an opportunity to utilise a non-vaccinating support workforce and rethink OIS to a proactive integrated whānau service that supports vaccination in primary care. Anticipating extra demand on an OIS type service in future lockdowns should be planned for with availability of dedicated resource.

All DHB's have increased options within the DHB workforce to provide more opportunity for whānau to immunise. This includes using or trialling a mixture of services to offer extended hours or weekend clinic options. Some hospitals deliver opportunistic vaccination. For example, WDHB uses an opportunistic vaccinator at Waitakere Hospital who works across the children's ward, ED and antenatal clinic. ADHB have an antenatal vaccinator. The role focuses on providing antenatal immunisation. However is also able to support children to be immunised alongside general anaesthetic for dental surgery or other operations when requested.

The role of immunisation as part of discharge planning needs to be strengthened. If a child is well enough to be discharged, it is well enough to be immunised. Vaccinations can be provided in hospital at the time of discharge to provide immunisation rather than advising whānau that they are overdue and to see their GP.

All DHB's have nurses working with children in the community but not all offer a vaccination service. There is a difficult balance between providing immunisation services that are easy and convenient for whānau to access, while continuing to encourage relationship building with PHO services. (Wing Cheuk Chan, 2021)

Cultural responsiveness and addressing bias, beliefs and values underpins excellence in delivering meaningful health care. A standardised training programme and resources that are shared across the region would be beneficial. Counties Manukau are currently reviewing the Māori vaccination workforce and are supporting development of education sessions for Māori providers. There is a need to be able to share resources across the region to encourage consistency of practice and to reduce duplication of work.

Covid-19 has had a significant impact on the workforce as staff are seconded to other priorities. Skilled paediatric vaccinators are lost to Covid-19 programmes reducing workforce capacity. For the remaining staff this is increasing the day to day work demands. Staff retention and replacement of the retirement or loss to other regions or areas remains problematic. Pay with changes to MECA agreements have been one factor.

Recommendations:

- Stop seconding workforce to other areas to be able to prioritise childhood immunisations.
- Increase the opportunity for immunisations in other services. Identify the requirements of Urgent Care, Pharmacy, and Midwifery Services to complete childhood vaccinations supported by robust reporting systems for recall with associated communication back to Primary Care.
- Strengthen the opportunistic vaccination process for when a child is about to discharge from hospital.
- Develop career pathways for a new workforce. Consider opportunities for Health Care Assistants.
- Develop consistent training in korero, understanding of cultural bias and strengthen cultural awareness for the vaccination workforce.
- Development of shared cultural resources for regional use.
- Review of payment structures for vaccinating staff and nursing staff in role in Primary Care.

Funding

Funding drives service delivery and determines where resources are provided. Payment for Covid-19 vaccinations includes an increased payment for weekend and after-hours immunisations, this is not the case for childhood immunisation. To ensure equitable service delivery a review of the costings for immunisation across the whole sector would support the resources required to complete all immunisations.

There are co-existing demands on the immunisation workforce with Covid-19 vaccination as well as catch up campaigns for MMR, HPV and other adult vaccinations. As reported, the additional childhood immunisation event (12 month) in the last year has added pressure on an already stretched system and means work demand have outstripped workforce capacity. With no increase in staffing or funding to achieve the required vaccinations some report that everyday business is not achievable. Services are in a seemingly impossible 'catch up' phase to complete the overdue immunisations.

The OIS primary initiative provides a service to 'mop up' overdue unvaccinated infants, made up of quite small teams and is an expensive model of delivery of care. Agreements with OIS providers such as Health West Te Puna Manawa in Auckland and Waitematā DHBs includes a whānau-centred model to include antenatal and other catch-up immunisations. However the capacity to do this at scale is limited when the emphasis is on the under 6-year-old population and limited appointment times. OIS does not have the capacity to provide extended services to whānau who report a preference to be seen by OIS rather than attending a Primary Care Practice.

An Integrated Whānau Care Immunisation approach to address all whānau immunisation needs is proposed for consideration in place of the current OIS. While this may seemingly distract from childhood immunisation, over the whole system it is more whānau centric and promotes efficient use of the existing vaccination workforce. To achieve this merging of historically distinct funding pools will be required.

Funding short term contracts to employ staff to work in the childhood immunisation space has created an opportunity to employ and work with whānau in the community. For example, WDHB/ADHB have worked with Te Whānau o Waipareira in 2018 on an enhanced Well Child Tamariki Ora service to provide immunisation alongside well child checks. Lack of vaccinator workforce prevented this service from continuing as envisaged.

Small, short term contracts create an opportunity to pilot approaches. However, they also create uncertainty and risk. Lack of continuity may also have an overall detrimental effect when the approach predominantly is established to address unmet need for tamariki Māori.

The future state requires commissioning bold new ways of working with adequate capacity and resources to positively impact Māori childhood immunisation.

Recommendations:

- Capitation should include a package of care.
- A dashboard used across Primary Care Services will provide transparency so that enrolment numbers and care is visible.
- Pharmacy to claim for funding for maternal pertussis vaccinations.
- Mandate catch-up immunisations as part of discharge planning for hospital admissions.
- Short term contracts are least favourable and to review all funding as part of the new model of care from a regional perspective.

Intersectoral Working

The working group discussions have identified that easy to find, holistic, timely and consistent messaging across service providers is essential. Consistent information concerning immunisations across the whole journey, including maternal immunisations, is key to increasing whānau knowledge, confidence and decision making around immunisation.

All service partners e.g. MSD, and Housing have a role to play supporting whānau to engage with Primary Care, and support the delivery of consistent immunisation messaging. Cross sectoral, appropriate information sharing with consent is needed to ensure babies are not lost to immunisation opportunities.

Trust and relationship building are a key part of health and wellbeing for Māori. Inconsistent messaging between services, lack of service co-ordination and communication, supports the cycle of mistrust and overburden (Funding Maternal vaccines in pharmacy: effects on uptake, 2020).

Recommendations:

- All services recommended to update a child's details and check immunisation status at every health encounter, including access to systems such as NCHIP that provide a holistic snapshot of children's access to universal health services.
- Agency collaboration to develop a MoU for information sharing regarding the priority population.
- Shared resources and communication strategies for immunisation.
- Digital system enablement for contact sharing.

Covid-19

Covid-19 has presented different challenges in relation to access to health services, beliefs and values related to vaccination, vaccine hesitancy and confidence. It has contributed to the acceleration of the statistical downward trends indicating the difficulties around accessing health care and immunisation. The Ministry of Health guidance is to continue to prioritise national schedule vaccinations in Alert Level 4, although practical implementation is variable.

Common themes reported by whānau and staff are related below:

Whānau report they are waiting longer to be seen due to change in clinic protocols. Antenatal visits are commonly occurring virtually with less opportunity for maternal and childhood opportunistic conversation and immunisations. Some whānau reported that PPE wearing was off-putting reducing confidence attending clinics due to the increased or perceived risk of exposure to illness.

Primary care clinics have had to change processes and environments to maintain patient safety.
An increased focus on Covid-19 management has reduced staff input to and follow-up with regular immunisation programmes. In some cases, changes in clinic protocols have seen whānau turned away and sent to ED services for the unwell child. As a result there is a loss for opportunistic care. Immediate health needs are met by another health provider. However the holistic review of the child and other siblings could have been completed at the clinic including an immunisation discussion. Work pressure due to vaccinators seconded to Covid-19 programmes has reduced workforce capacity.

Recommendations:

- Review the new systems developed in response to Covid-19 and see what legacy processes can be used.
- Review outbreak preparedness plans and consider alternate pathways to on-time immunisation.

  during lock down periods.

Outcomes: Data and Monitoring

The desired outcome for immunisation services is to achieve the vision of equity across the region for Māori whānau to immunise tamariki on time by six weeks of age. Achievement of this goal is directly impacted by the processes, service messages, interactions, reporting and systems available.

The Qlik platform is a useful tool to increase the transparency of immunisation coverage through reporting. Current limitations and opportunities are outlined above under 'System enablers'.

The legacy National Immunisation System is dysfunctional and also discussed above under 'System enablers' however requires specific emphasis.

Presently it is requiring significant administrator time to ensure it is recording accurate data. The system not being integrated with the National Enrolment System can mean an outdated provider is being followed up regarding overdue immunisations, Auckland and Waitematā DHB have estimated that the NIR clinic for a child is correct for 85% of the population under 5 years of age, with over 8,000 children having an outdated provider as their nominated clinic on the NIR – a significant amount of data-clean up required to update this. Likewise, this is seen at a practice level where they receive NIR notifications for patients no longer in their care, including for adults who have transferred to other practices. The administrative burden is lengthened by ongoing messaging issues between Patient Management Systems and the NIR. Where practice records of an immunisation event do not transmit successfully to the NIR, this requires time at both the NIR and practice end to rectify the record. The design of the NIR also reflects a primary care model that is no longer reflective of the current state; for example, having a specified GP rather than a clinic, and that authorised vaccinators do not need a GP to oversee the immunisation event of a child.

Joining up data across the system will be essential to have a view of what is working and what is not and priority areas for action. It is important that data is both qualitative information from the whānau voice, and quantitative to achieve the understanding of effective service delivery.

Recommendations:

- MOH review and recommission the reporting system to be able to provide consistent reports across the childhood immunisation series, including a focus on graphs and coverage at the timeliness milestone rather than the health target age (e.g. 8 months, 18 months and 4.5 years).
- Emphasis is given to commissioning the replacement of the National Immunisation Register that is fit for purpose.

Integrated Whānau Care (Immunisation +)

Described below are some of the current pieces of work across the region that demonstrate an integrated holistic approach to immunisation.

Ngā Tātai Ihorangi

Early this year Northland DHB started a rebrand of their services. Ngā Tātai Ihorangi adopts a common operating language and philosophy of care, taking a holistic service approach (Northland Distric Health Board, 2021). This is being used to shift the narrative around immunisations to empower whānau positively through use of language (affirming), consistency and getting back to basics. The focus of this programme is to start early and co-ordinate services with Hapū Waingangā (early pregnancy service). There has been intentional system change to use a whānau journey approach. Service delivery across all agencies focuses on welcoming whānau into the practice in a warm, welcoming and affirming approach, recognising that immunisation is just one way whānau will be able to successfully look after tamariki. Languaging is whānau focused and acknowledges diversity, strengths and range of needs. Development of a common language and vision is shared across all agencies to create consistency and strength of care.

In Counties Manukau, Papakura Marae has approximately 3000 enrolments, 92% attending are Māori. In a recent report the following strategies are attributed to the on-going strive for success of the practice (Anderson P., 2021)**:**

- **Real time data** – being able to see who is due for immunisation and what has been missed for easy reporting and making the most out of every opportunity – able to offer vaccinations every time whānau present to clinic.
- **Flexibility** – seen as a very important factor in meeting people where they can – offering extended practice hours, weekend clinics, pamper days, providing transport for appointments.
- **Equity lens** – taking an in-depth approach to understanding what people need to succeed, often requiring going above and beyond what some might feel is needed.
- **Champions** – whānau are given the 'why' people would be following up about immunisations and the target that was important for all (i.e. 8-month immunisation for Māori).
- **Culturally appropriate** – showing an open willingness to understand individual cultural needs.
- **Welcoming, transparent sharing of information** – early referrals with an open-door policy using a Community health worker for personal follow up when needed.

There is a planned Hui for WDHB/ADHB to explore what the local challenges are for Māori and what strategies have been helpful in the trial of a flexible, community-based approach to care.

By bringing together the current programmes and strengths of each area in the region there is opportunity to share a common vision, resources and training to lift the immunisation programme. Any future work could address equity through a shared vision so services could work consistently in partnership. Working within the current health reforms a Regional governance structure could support the work required to see a transformation across the Northern Region while continuing to support the individual local population needs.

Conclusion

Long term systemic failure continues to cause barriers for whānau Māori accessing immunisation services in New Zealand. There are small teams of DHB NIR staff currently trying to hold the system together to manage critical system issues which urgently need to be addressed. In the current Covid environment, and with health system reform planning, there is opportunity to make effective change at pace. Immunisation services can be restructured with a goal of achieving Tino rangatiratanga with partnership to shape the health service to deliver improved immunisation outcomes for whānau.

Holistic services, working flexibly with whānau and integrated with Primary Care are currently practiced in pockets throughout the region. A positively geared service model that understands the needs of Māori and resourced to provide immunisations for the whole whānau for instance, could mobilise the workforce proactively while meeting the needs of whānau.

A regional approach to care through a shared framework offers opportunity to remodel the current programme that is not fit for purpose. Digital alignment will go some way to addressing processes, however, it is the how services are delivered that most importantly requires a different approach.
Pae ora healthy futures for Māori (Whakamua) requires a rethink of the immunisation programme Integrated Whānau Care is the proposed conceptual framework that looks to change how we currently work with whānau across the immunisation journey. Te Tiriti o Waitangi underpins the work to give the lens through which services can positively respond to, and provide an immunisation service that is culturally aware and responsive and ultimately successful in lifting Māori and other priority group immunisation.

Appendix

Appendix 1:

Whakamaua https://www.health.govt.nz/system/files/documents/publications/whakamaua-maori-health-action-plan-2020-2025-2.pdf

Appendix 2:

The Working Group

The working group has met 6 times since the beginning of May 2021 and includes regional Māori representation and all DHB's. Representation from primary care has been sought along with data analysts reporting on data consistency. The scope of this work is focused on the scheduled vaccinations from birth to five years of age (Early Childhood Series). Members of the working group are as below:

Working group membership and key contributions from:

NDHB:

- Koha Aperahama – Hapū Waingangā Programme Manager
- Ailsa Tuck – Community Paediatrician
- Catherine Jackson – Public Health Physician
- Delwynne Sheppard – Divisional Manager, Community Clinical Services
- Clarissa Thompsen – Mama, Pepe, Tamariki locality, Mahitahi Hauora

WDHB and ADHB:

- Georgina Tucker – Immunisation Programme Manager
- Ruth Bijl – Funding and Planning
- Natalie Desmond – Funding and Planning
- Owen Sinclair – Te Rarawa, Paediatrician
- Scott Abbot – Māori Health Gains Team

CMDHB:

- Christine McIntosh – GP Liaison, Clinical Lead
- Carmel Ellis – Provider Arm
- Sharon McCook – General Manager Māori health Development
- Claudelle Pillay- NIR

PRIMARY CARE PHO:

- Kristin Shepherd - Immunisation Co-ordinator Pro-Care
- Catherine Roscoe

NRA:

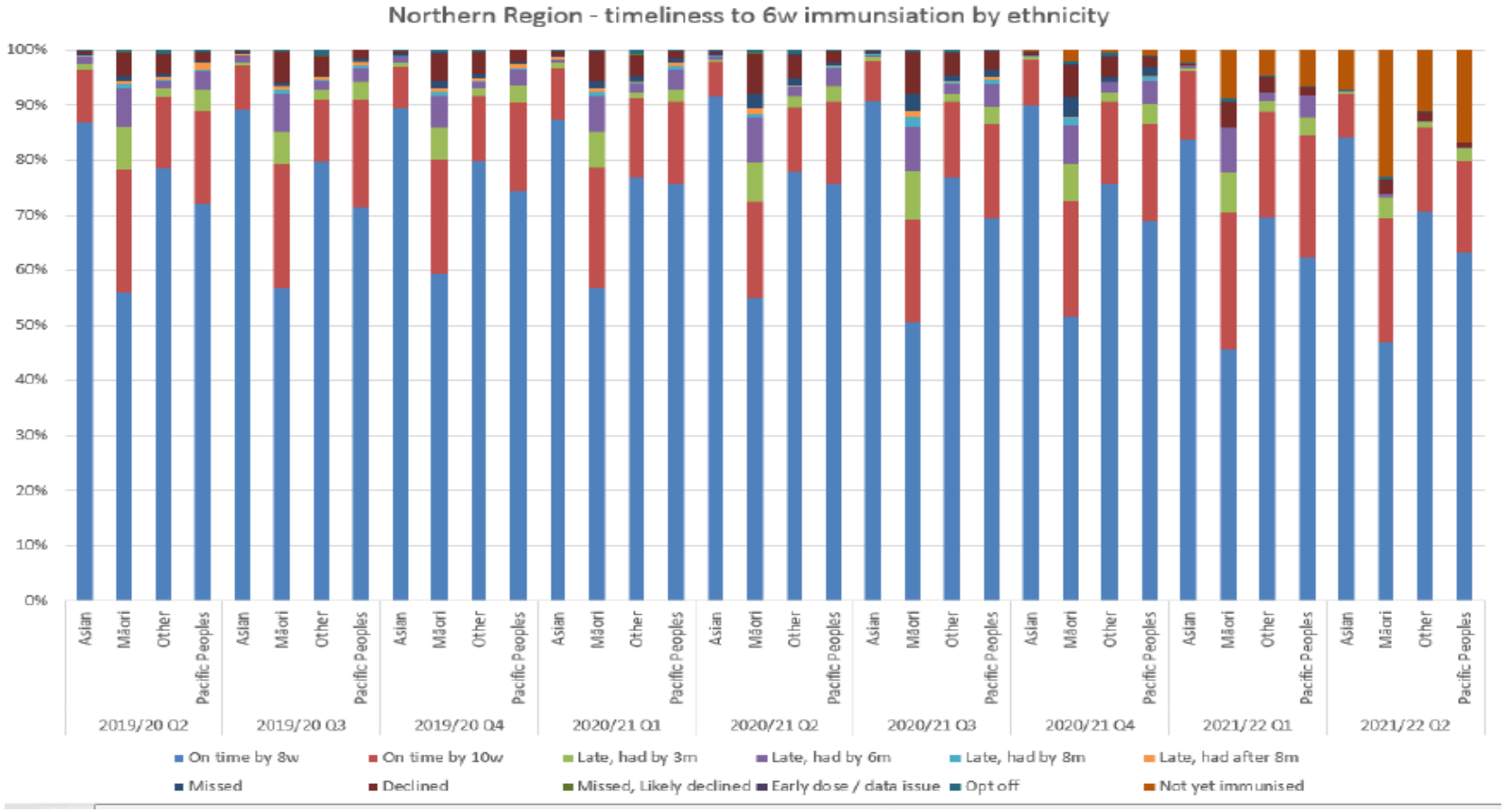
- Richelle Timmins – Project Manager
- Pam Henry – Child Health Project Manager

Appendix 3:

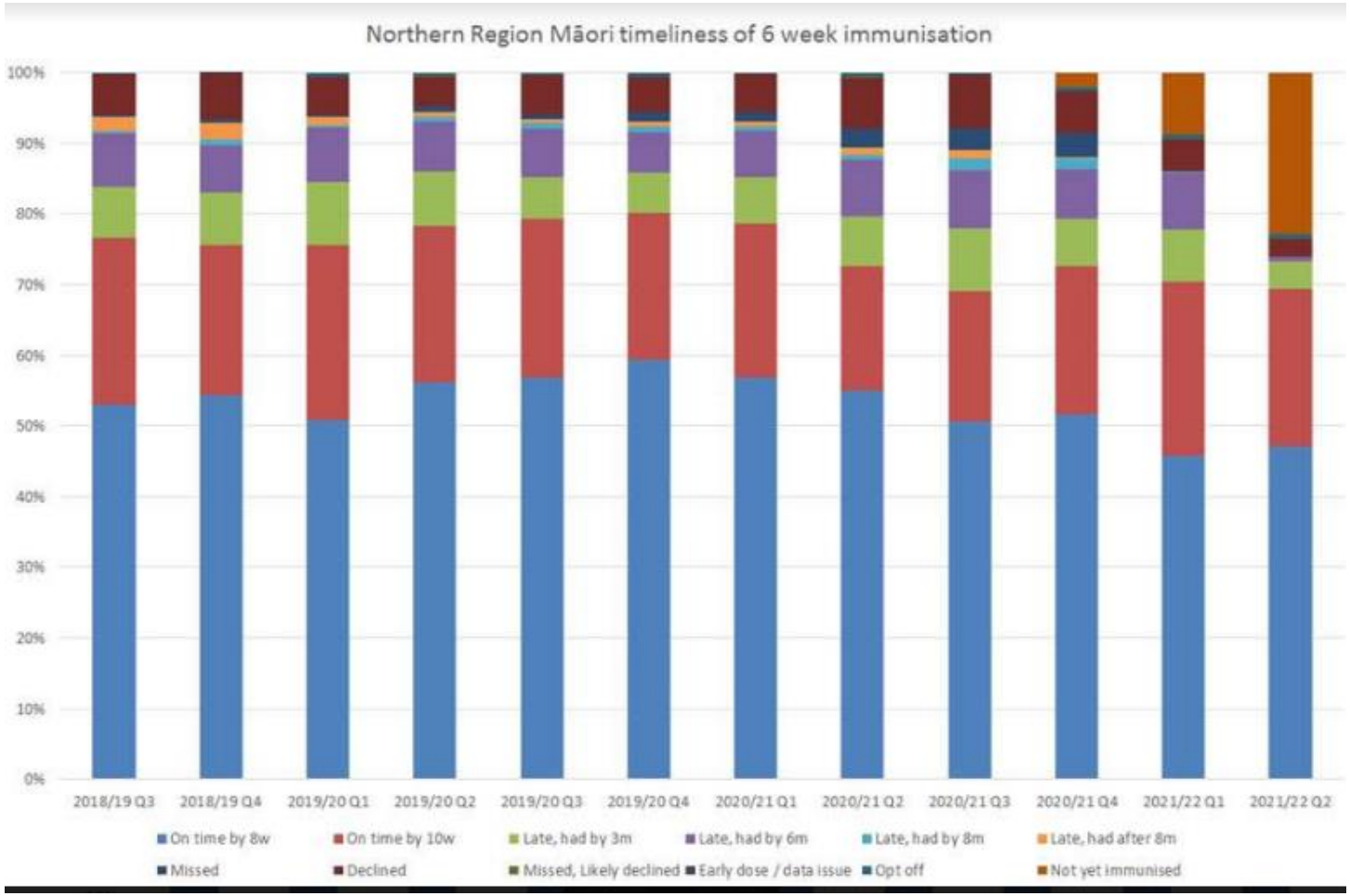
Report Wing et al 2021 Immunisation coverage (primary series) and children's interactions with t....docx

Appendix 4: Northern Region Timeliness to 6 week immunisation by ethnicity (Tucker, 2021)

Combined data measuring timeliness of 6-week immunisation over 3 years shows that Māori are less likely to receive immunisation or receive immunisations on time compared to all other ethnic groups.



In the 2021/2022 Q2 a reportable change in children not being immunised emerged as a large proportion of Māori children compared to other ethnic groups who are not yet immunised (25%). Vaccinations being completed between 6 and 8 months indicate a growing number of children are receiving 'catch up' immunisations suggesting whānau are experiencing significant barriers to vaccinating tamariki on time. (Tucker, 2021)



Appendix 5: Regional Matrix of Current Childhood Immunisation Activity

	Pressure Points	Flexible approaches	Current Projects	Cultural responsiveness
NDHB	• Referral from Maternity to PHO remains paper not electronic. • Follow up processes are not consistent e.g. whānau opting off - may get offered a vaccination if they come to the practice but there are no regular call backs. • How to increase whānau choice re: Māori health providers? Capitation and funding a current barrier if there are no GP in the practice. • PHN team covers the OIS contract, staff are being assigned to Covid team reducing workforce. • Rural areas take double the time due to travel, low staffing, and are poorly resourced. • Whānau are opting off as not wanting their details held by another authority. Beliefs around personal information, how this is stored and used. • High 5 forms- not working remains a paper exercise not electronic. 20 % not being filled out correctly. • Social determinants of health are high impacting on access to health care. • Current structure is not collaborative making it difficult to create change or make improvements in the system.	• EN training scheme being trained as vaccinators and will cover BAU vaccinations not just Covid response. • Holistic, wrap around, welcoming, giving choice. • Working the Hapū Wainganga services for early start.	• Ngā Tātai Ihorangi since beginning of 2021 Rebranding philosophy of care. • Health care navigator works alongside whanau. • Mandating acceptance of a new referral for enrolment of new-born in to practice. • 6/12 project mapping the journey conception – 5 years. • Using a health Coach: Tangi Devan – kaupapa Māori walks alongside whānau to navigate health – positive feedback from whanau.	• Ngā Tātai Ihorangi. • Kaupapa Māori health coach.
ADHB / WDHB	• NIR system. • Seasonal flu vac increasing pressure on capacity. • Workforce capacity & Staff attrition impacted by Covid and vaccination roll-out. • Decreased opportunity for Antenatal Imms - WDHB opportunistic vaccinator seconded to Covid & many antenatal visits virtual. • WCTO change in service model due to Covid - not seeing all babies - but prioritising M,P&Q5 babies.	• Pop up clinics, wrap around services. • Opportunistic vaccinator WDHB 0.8 FTE (request to increase this FTE). • ADHB antenatal vaccinator also supports childhood imms under GA. • Health WEST OIS trialling drop-in Saturday clinic once per month. • From 2020 service spec has whānau centred model including weeknight, weekend and opportunistic imms. • Mobile clinic in low decile street for flu vaccine during lockdown.	• Review of 6w imms Timeliness for Northern Region. • Next step to identify provider and timeliness at 3m. • NCHIP, MSD work for children with no address. • Creation of Uri Ririki CHCC - NCHIP, NIR, missed event service - more information reviewed to locate families. • ADHB & WDHB monthly case review (Māori 6m not fully immunised). • NIR team track and trace of children through milestone age for automated referral.	• Work based at local marae and kura. • Māori provider hui to understand challenges and identify next strategies. • Encourage Māori WCTO. • providers to immunise. • Education includes tamariki telling their own stories of immunisation being shared across media platforms.

	Pressure Points	Flexible approaches	Current Projects	Cultural responsiveness
CMDHB	• Increasingly families are requesting OIS before being overdue for imms but not currently contracted to provide this. • There was a 20% fall in number of vaccinations administered in 2020 compared to 2019 for all children under 5-years in CM Health. The most significant drop was in the August 20 lockdown. • There has been an increase in discrete vaccination events in the 0-5-year group with the addition of the 12 month MMR and PCV. • The majority of children who did not meet the 8-month imms milestone had some contact with the health system which presents an opportunity to promote/support vaccination and update contact details.	• Whānau focused/centred recognising the spectrum of needs and diversity of experience. • Māori infants are kept on OIS for future events unlike other infants who are returned to PC. • Whānau journey approach for Māori providers.	• Contracted provider OIS (Plunket) discontinuing and will be brought into KF provider and staffed by 3 FTE OIS vaccinating nurses. • Focus on the role of provider or (COVID-19) site in community and targeted communications to reflect this. • Stocktake of Māori providers re vaccination workforce (as part of regional COVID work) with associated workforce modelling. • Other screening programmes could be a proxy for the types of information/supports that whānau need for informed decision-making and to counter historical mistrust in health system (particularly those screening programmes where equity is 'designed in' from beginning and that target key decision-makers in whanau. • Learnings from local COVID-19 communications planning at Māori-led vaccination sites.	• Integrated communications approach currently being developed based on review of evidence and feedback from whanau. • Supporting development of IMAC education sessions for Māori providers.
Pro Care feedback	• Culturally appropriate education for staff; resources are required. • Current gap in training on how to effectively communicate with Māori when vaccine hesitant. • Consistency of practice in early pregnancy and use of a consistent Assessment tool. • Increased need for interpreter services and language appropriate resources. • COVID related work dominates time resources and the prioritisation of work loads. • Education for staff re catch up schedules and schedule changes. • Primary care Workforce depleted with secondment of Practice nurses to COVID vac centres.	• Use of the whānau tree to contact whānau who were more mobile during COVID lockdowns. • Early engagement, use of B codes and accepting New-born nominations. • PHOs have managed own promotional work e.g. in malls. • Pro Care pilot of PJs and nappies. • NHI level imms data Reported to practices – identifies imms due and overdue, with filter for ethnicity for specific follow up. • Support to practices to complete NHI overdue lists by due date, and F/U on New-born enrolments.	• Pro care IC's working with Data teams to develop multiple lists for pregnancy NHI, MMR, Flu, childhood imms to establish if opportunities are being missed in the practice. • Procare ICs Involved in the 0-4 yr. best start group for connection between GPs, MWs, NGOs and other support services in nearby communities.	

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(n.d.).

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Tucker, G. (2021). *Immunisation in the Northern Region.* Auckland.

Wing Cheuk Chan et al, D. P. (2021). *Immunisation coverage (primary series) and children's interactions with the health system .*

[i] (Wing Cheuk Chan, 2021)

4.3 Director Appointment to the healthAlliance NZ Limited Board

Recommendation:

That the Board:

a) **Note that Northland DHB have nominated Nicole Anderson as a Class A director of healthAlliance N.Z. Limited in place of Dr Michael Roberts;**
b) **Resolve that Nicole Anderson be appointed as a Class A director and the company be notified accordingly; and**
c) **Delegate Authority to the Board Chair to execute all documentation necessary to formalise this director appointment.**

Please see the attached paper submitted by healthAlliance for consideration by the Board.

Decision Paper
Director Appointment to the healthAlliance N.Z. Limited Board

DECEMBER 2021

Recommendation

It is recommended that the Board:

Note

(a) Northland DHB have nominated Nicole Anderson as a Class A director of healthAlliance N.Z. Limited in place of Dr Michael Roberts;

Resolve

(b) Nicole Anderson be appointed as a Class A director and the company be notified accordingly; and

Delegate

(c) Authority to the Northern Region DHB Chairs to execute all documentation necessary to formalise this director appointment.

Prepared by:	George Smith, hA Head of Corporate Services Simon Jones, hA CFO
Reviewed by:	Clayton Wakefield, hA Board Chair

1. Purpose

To seek DHB Board approval and a shareholders resolution to appoint Nicole Anderson (Northland DHB Director) as a Class A director of healthAlliance N.Z. Limited (hA).

Nicole Anderson is the Northland DHB nominated replacement for Mr Michael Roberts (NDHB CMO) who has resigned from the hA Board by virtue of his resignation from Northland DHB.

2. Background

The hA Constitution and Shareholders Agreement provides that all shareholders appoint directors.

Auckland, Counties Manukau, Northland, and Waitemata DHBs (the Northern Region DHBs) each hold one quarter of the Class A shares. The hA Constitution provides, inter alia, that Class A shareholders may appoint up to four Class A directors. Custom and practice has been for each Northern Region DHB to appoint one Class A director.

3. Auckland DHB Class A Director Nomination

Northland DHB has nominated Nicole Anderson (Northland DHB Director) as their Class A director.

> Nicole Anderson (DipAcc, DipBus, DipMgt, PGDPH) is a professional director and a chartered member of the Institute of Directors (CMInstD) with a background in accountancy, health and business development.
>
> Nicole is currently a Board member on the Northland District Health Board, Chair of Northland Inc, Director NZ Blood Service, Co-Chair SCENZ, a Member of the Accreditation Council and NorthTec along with the Ngapuhi Asset Holding Company.
>
> Ko Ngāpuhi tōna iwi, nō Hokianga ia.

4. hA Board Composition

The hA Board composition following approval of these recommendations, is set out below:

	hA Board of Directors **(following endorsement of this proposal)**
Class A shareholder directors	• Catherine Abel-Pattinson (CMH Director) • Dr Andrew Brant (WDHB Deputy CEO) • Michael Quirke (ADHB Director) • *Nicole Anderson (NDHB Director) – proposed*
Independent directors	• Clayton Wakefield (Chair) • Roger Jones • Russell Jones

5. Next steps:

The next steps are:

1. DHB Boards to approve and resolve the appointment and delegate authority to execute documentation to DHB Chairs – *upcoming DHB Board cycle*
2. DHB Chairs to sign the relevant documentation – *upcoming DHB Board cycle*
3. hA to update the Companies Office – *within 10 days of the final DHB Board approval.*

NOTICE OF APPOINTMENT OF DIRECTOR

TO: healthAlliance N.Z. Limited (**Company**)
585 Great South Road
Penrose
Auckland

Notice is hereby given by the Class A Shareholders pursuant to the Company's constitution that the following person be appointed as a Class A director with effect from 16 December 2021:

1. Nicole Anderson

DATED _____

SIGNED on behalf of **WAITEMATA DISTRICT HEALTH BOARD** by:

_____
Signature of authorised signatory

_____
Name of authorised signatory

Note: The same resolution will be sought from each of the Class A Shareholders.

5.1 Financial Report - October 2021

Recommendation:

That the financial report be received.

Prepared by: Lorraine Ridgwell (Corporate Finance Manager) and Cliff La Grange (Deputy Chief Financial Officer - Funder)
Endorsed by: Robert Paine (Executive Director Finance, People and Planning)

Glossary

ACC	-	Accident Compensation Commission
ADU	-	Acute Diagnostics Unit
AIR	-	Advanced Interventional Radiology
CWD	-	Case Weighted Discharges
DHB	-	District Health Board
ED	-	Emergency Department
ESC	-	Elective Surgery Centre
FPIM	-	Financial and Procurement Information Management System
FTE	-	Full Time Equivalents
IDF	-	Inter District Flow
MECA	-	Multi-Employer Collective Contract
MH&AS	-	Mental Health and Addiction Services
MHSOA	-	Mental Health Services Older Adults
MoH	-	Ministry of Health
MRI	-	Magnetic Resonance Imaging
NGO	-	Non-Government Organisation
NRHCC	-	Northern Regional Health Coordination Centre
NZNO	-	New Zealand Nurses Organisation
ORL	-	Otorhinolaryngology
PACU	-	Post Anaesthetic Care Unit
PBFF	-	Population Based Funding Formula
PVS	-	Production Volume Schedule
PHO	-	Primary Health Organisation
RMO	-	Resident Medical Officer
SMO	-	Senior Medical Officer
SLA		Service Level Agreement

Background

The report summarises the unaudited financial performance of the Waitematā District Health Board for the month and year to date ended 31 October 2021. The report covers all operating units of the Waitematā DHB, being the Funder Arm, Provider Arm and Governance.

1. Executive Summary

The Waitematā DHB BAU operating result prior to the impacts of COVID-19 for the month of October 2021 was favourable to budget by $1.486m, with an actual deficit of $0.977m against a budgeted deficit of $2.462m.

The Waitematā DHB BAU operating result for the year to date 31 October 2021, prior to impacts of COVID-19 was favourable to budget by $3.512m, with an actual deficit of $7.443m against a budgeted deficit of $10.955m, which is an excellent result given the additional challenges being faced in the current operating environment.

The operating result is impacted upon by a net $0.296m of additional revenue for COVID-19 in the month and costs of $2.239m for the YTD and therefore the overall result for the month is $1.808m favourable in the month and $1.227m favourable for the year to date.

Table: Financial Indicators for October 2021

FINANCIAL PERFORMANCE									
$ millions	Month			YTD			Full Year at 30 Jun 21		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funder Arm	0.640	0.100	0.540	1.240	0.400	0.840	2.40	1.20	1.20
Provider Arm	-1.886	-2.562	0.676	-9.530	-11.355	1.825	-19.10	-20.70	1.60
Governance Arm	0.269	0.000	0.269	0.847	0.000	0.847	1.15	0.00	1.15
DHB Operating Result: Surplus/(Deficit)	-0.977	-2.462	1.486	-7.443	-10.955	3.512	-15.55	-19.50	3.95
Extraordinary costs									
Covid-19 Revenue / (Expense)	0.296	-0.026	0.323	-2.239	0.046	-2.285	0.00	0.00	0.00
Holidays Act	-1.667	-1.667	0.000	-6.667	-6.667	0.000	-20.00	-20.00	0.00
DHB Result : Surplus / (Deficit)	-2.347	-4.155	1.808	-16.348	-17.576	1.227	-35.55	-39.50	3.95

The impact of the Holidays Act is included in this year's plan at $20.0m for the year and accrued to budget at $6.667m for year to date and therefore does not impact on the overall planned result.

The BAU operating result prior to the impacts of COVID-19 for the year to date reflects a favourable performance in all arms; Funder Arm $0.840m, Governance Arm $0.847m and $1.825m in the Provider Arm.

1.1 Highlights

The DHBs BAU operating result for the year to date at 31 October 2021, prior to the impacts of COVID-19, was favourable to budget by $3.512m noting the key factors below:

Funder $0.840m favourable for the year to date (excluding COVID-19 impact) - key financial performance factors:

- $2.8m adverse impact resulting from the Ministry clawing back 2021/22 Funding Envelope revenue relating to Pharmaceuticals (Waitematā DHB share $8.4m of $76.0m for the year).
- $2.7m favourable impact of 2020/21 Pharmaceutical funding which the Ministry had directed DHBs to hold in balance sheet for utilisation in 2021/22.

Provider $1.825m favourable year to date (excluding COVID-19 impacts) - key financial performance factors:

- Additional revenue from court reporting and insurance risk share arrangement
- Favourable personnel costs due to vacancies
- Favourable outsourced Clinical Services, due to low volumes in particular for radiology services
- Unfavourable outsourced staff costs, primarily medical staff in Mental Health and administration staff in Clinical Records and Clinical typing.
- Savings on Outsourced Corporate Services
- Favourable clinical supplies and outsourced Corporate service costs, due to savings and provisional initiatives yet to commence.

Revenue of $10.12m has been accrued to cover the unbilled portion of net claimable direct costs in relation to the COVID-19 response, this includes cost of redeployment and backfill of staff and regional costs via NRHCC for the delivery of the vaccination programme.

Governance $0.847m favourable for the year to date - key financial performance factors:

- Favourable to budget resulting mostly from vacancies for budgeted roles not recruited to.

Extraordinary costs year to date are:

- Holidays Act provision for 2021/22 are $6.667m as planned
- Net COVID-19 expense of $2.239m after offsetting revenue ($2.285m variance to plan).

For commentary refer to section:

- 2.0 Clinical activity (including a service breakdown of acute and elective performance).
- 3.0 Waitematā DHB financial performance
- 4.0 Funder Arm financial performance
- 5.0 Provider Arm financial performance
- 6.0 Waitematā DHB financial position

2. Clinical Activity

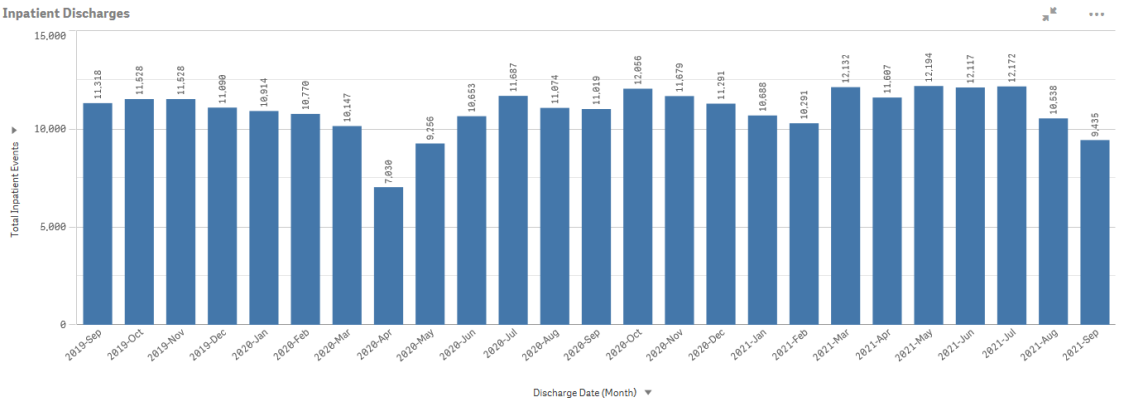
2.1 Clinical Activity Scorecard

Table: Clinical Scorecard for October 2021

CLINICAL ACTIVITY									
	Month			YTD			Full year		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
ED attendances	8,415	9,406	991	35,300	38,357	3,057	108,974	113,095	4,121
Acute Volume (WIES)	5,421	5,893	472	22,806	23,442	636	68,545	69,488	943
Elective Volume (WIES)	1,470	1,510	-41	5,201	6,176	-975	18,989	18,014	-975
A negative variance in ED attendances reflects higher than planned presentations									
A negative variance in Acute volumes (WIES) reflects higher than planned acute demand									
A negative variance in Elective volumes (WIES) reflects under delivery of planned contract									

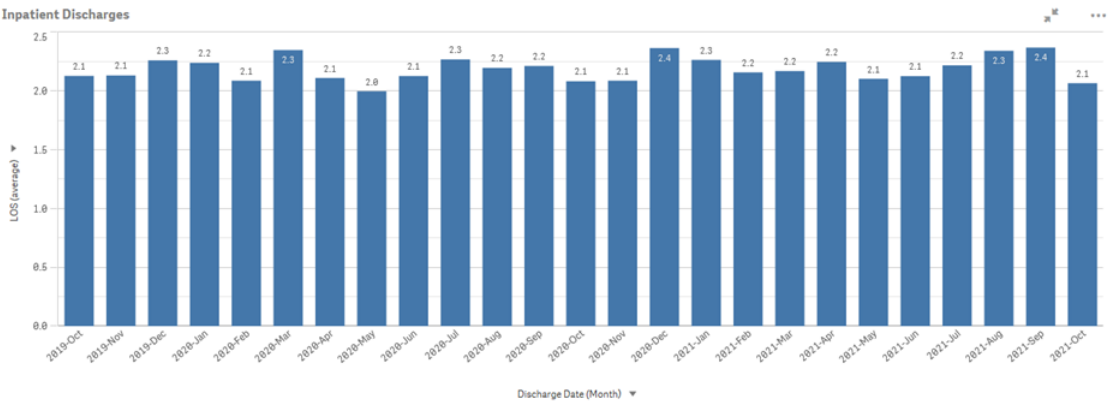
Clinical volume commentary for YTD October 2021

Total inpatient discharges in October 2021 were 10,793. Due to impact of COVID-19, this was lower than the October 2020, mainly impacted by COVID-19, as shown in the graph below:



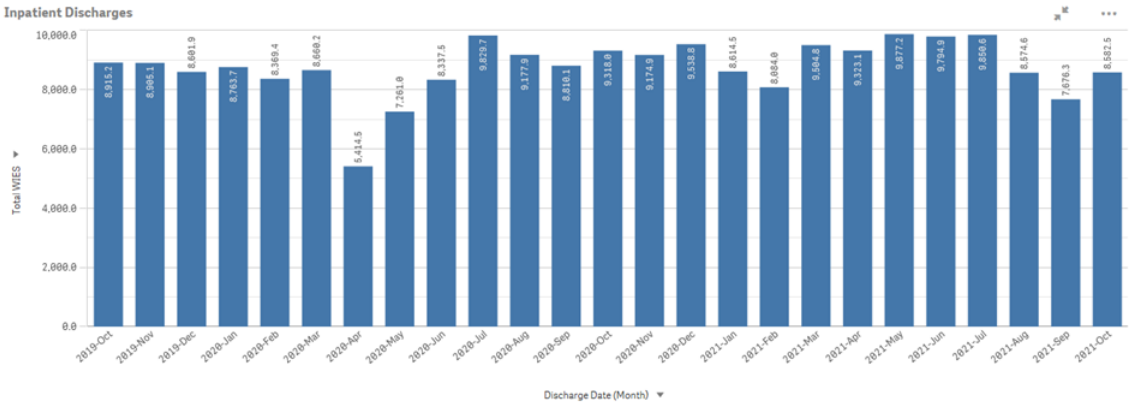
From 18 August 2021, reduced operating levels at ESC were in effect and by 24 August 2021 the ESC theatre suite was fully closed, resulting in the loss of four theatres. Having been operational at reduced volumes during October, the ESC theatre has since closed as of 01 November 2021 to provide additional COVID-19 ward capacity within the DHB for the expected growth in related hospitalisations.

Inpatient average Length of Stay (LoS) in the combined NSH/ESC campus and WTH hospitals in October 2021 was 2.1 days, which is consistent with the 25-month average of 2.19. Noting that Mental Health facilities are excluded, as they can have a significant impact, due to long stay inpatients.

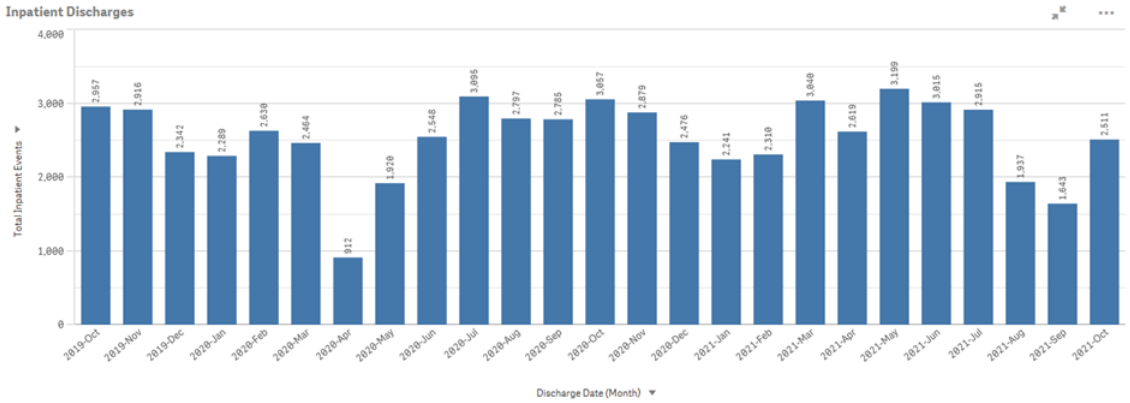


The total combined acute and elective WIES across all services is 34,684 for the year to date. This figure may increase once all clinical coding is complete; this is significantly fewer than October 2020 year to date due to the COVID-19 lockdown.

This is 2,451 WIES lower for the year to date compared with FY20, or approximately $15.0 million; the WIES volume for October 2021 reflects approximately $52.4m of case-weight revenue:



Elective discharges in the month of October 2021 at 2,511 are significantly lower than the comparable month in the previous two years; however October was not as severely impacted at August and September 2021 when ESC theatres were closed to provide additional capacity for COVID-19 patients.



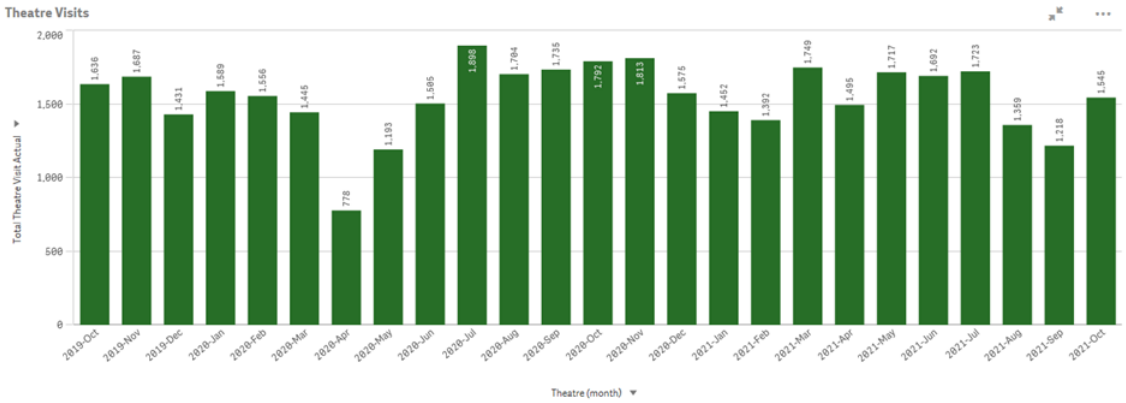
The cumulative volumes of Surgical Services (GenSurg., Ortho, Gynae, ORL and Urology) elective discharges for October YTD are significantly down, compared to the previous three years, as a result of the closure of ESC and impacts of COVID-19 lockdown.

These numbers exclude minor skin procedures carried out at GPs and outsourced procedures.

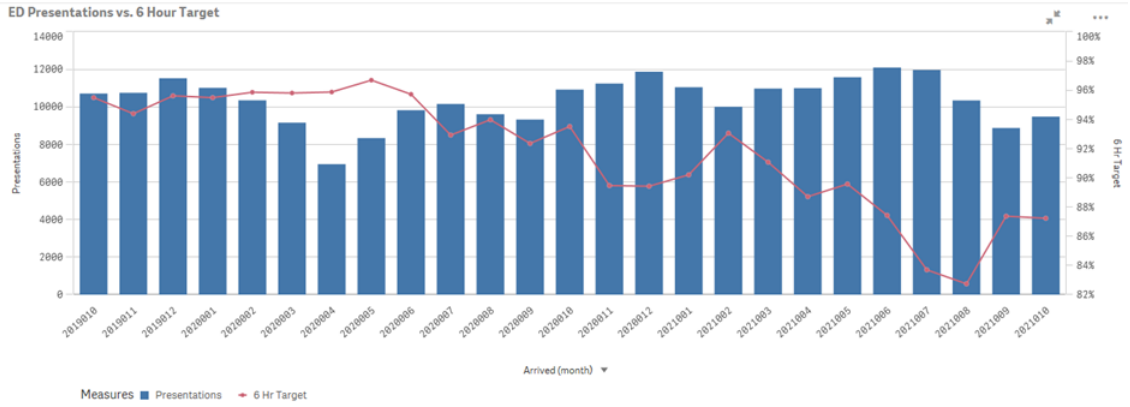
	2018/19	2019/20	2020/21	2021/22
July	1,039	1,038	1,188	1,148
August	2,123	2,134	2,306	1,893
September	3,095	3,109	3,421	2,467
October	4,133	4,140	4,590	3,489
November	5,249	5,239	5,715	
December	6,069	6,053	6,699	
January	6,958	6,960	7,524	
February	7,925	7,917	8,377	

March	9,005	8,819	9,386	
April	9,937	9,077	10,267	
May	11,004	9,678	11,354	
June	11,982	10,551	12,389	

Acute and elective theatre visits for Surgical Services (GenSurg, Ortho, Gynae, ORL and Urology) are significantly down for October YTD compared to previous years with 5,845 theatre events for the year compared to 7,129 last year (1,284 events or 18% fewer).

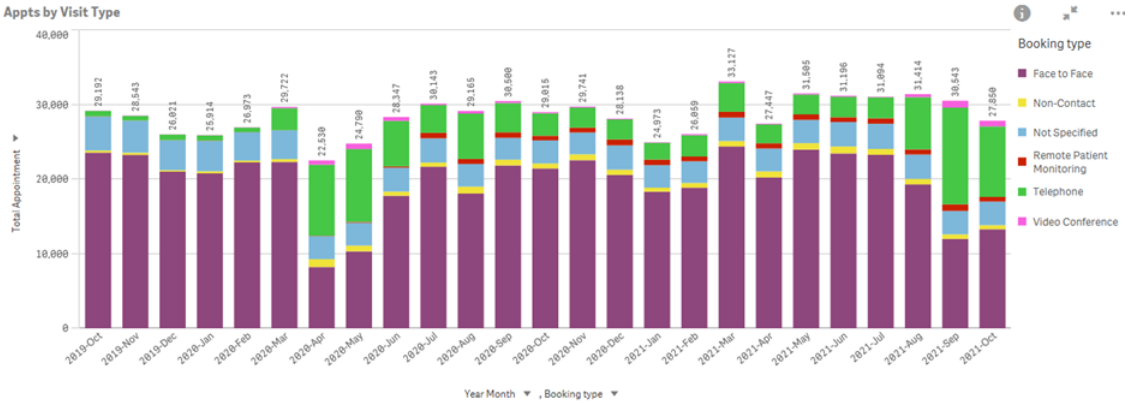


ED presentations during October 2021 at 9,483 were 13.2% lower than October 2020. The 6-hour target for the month at 87% is below the usual average of 92% over the last 25 months (note that this presentation number differs from the ED attendance number reported in the clinical activity scorecard above, as attendances exclude presentations of patients that stay less than 3 hours).

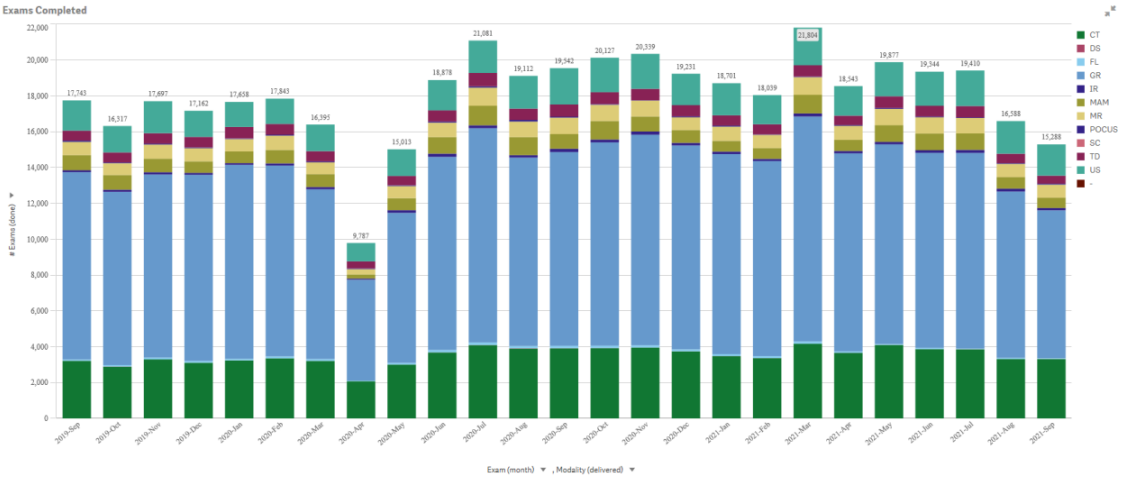


Outpatient appointments totalled 27,850 in the month of October 2021; amounting to 120,901 for this year compared to 118,421 last year (2.1% increase). Despite both financial years having COVID-19 impacts, this illustrates how the organisation has adapted to provide more non face-to-face appointments over the last 12 month. Telephone contact, video conferencing, remote monitoring and non-contact appointments have increased by 23.4% over the last rolling 12 months compared the previous rolling 12 months to October 2020.

Total non-contact appointments for October 2021 were 11,390 making up 40.9% of all outpatient appointments (compared to 15.4% in October 2020 and 3.6% in October 2019).



Radiology volumes completed in-house have also been impacted by COVID-19 and continued to decrease, with 16,859 procedures taking place in October 2021, compared with 20,127 completed in October 2020.



Of note, year-on-year there were:

- 7,024 fewer GR scans completed in-house for the year to date (14.5% decrease)
- 1,041 fewer Mammogram scans completed in-house for the year to date (27.1% decrease)
- 1,796 fewer CT scans completed in-house for the year to date (11.7% decrease)

Bed days in October 2021 (midnight census) totalled 22,539.

	2020		2021									
Hospital	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
North Shore Hospital	17,457	16,635	34,092	17,341	15,468	17,611	17,629	17,121	17,906	16,262	14,975	15,989
Waitakere Hospital	6,582	6,665	13,247	6,699	6,148	6,841	6,870	6,903	7,313	6,482	5,778	6,181
Wilson Centre	684	571	1,255	753	558	592	677	585	603	504	302	369
Total	24,723	23,871	48,594	24,793	22,174	25,044	25,176	24,609	25,822	23,248	21,055	22,539

3. Waitematā DHB Consolidated Financial Performance

The business as usual operating result for the month of October 2021, prior to the extraordinary costs of COVID-19 was favourable to budget by $1.486m and for the year to date the DHB is $3.514m favourable to budget on the same basis. This is an excellent performance given the additional challenges being faced in the current operating environment.

The net impact of COVID-19 (net of revenue and expenses) amounted to a favourable variance of $0.323m in the month of October 2021 and a negative variance of $2.285m for the year to date. This assumes revenue will be provided by the Ministry of Health to offset the reimbursable costs recorded on the DHB's COVID-19 tracker to date; noting that the budget incudes $90m of COVID-19 revenue and expenses for the full year.

The cost in relation to the Holidays Act is embedded in the plan for 2021/22 at $20.0m and is being accrued at $1.333m per month; therefore $6.667m has been accrued year to date in accordance with the plan.

3.1 Financial Result

Table: Waitematā DHB Consolidated Financial Result for the month ended October 2021

CONSOLIDATED FINANCIAL PERFORMANCE							
$ 000's	Month			YTD			Full Year
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
Crown	175,397	174,941	456	706,406	699,760	6,646	2,104,622
Other	2,061	2,051	9	2,391	8,351	-5,960	32,437
Total Revenue	**177,457**	**176,992**	**465**	**708,798**	**708,112**	**686**	**2,137,059**
EXPENDITURE							
Personnel	63,216	66,306	3,090	262,040	267,683	5,644	821,481
Outsourced Personnel	2,049	1,570	-479	8,257	6,316	-1,941	18,234
Outsourced Services	6,435	7,401	966	26,499	29,074	2,575	86,668
Clinical Supplies	11,845	12,730	885	47,176	50,335	3,159	148,882
Infrastructure & Non-Clinical Supplies	10,608	7,490	-3,118	37,127	29,833	-7,295	73,623
Funder Provider Payments	84,281	83,957	-324	335,141	335,827	686	1,007,481
Total Expense	**178,434**	**179,454**	**1,020**	**716,240**	**719,068**	**2,828**	**2,156,370**
Operating Result : Surplus/(Deficit)	**-977**	**-2,462**	**1,486**	**-7,443**	**-10,956**	**3,514**	**-19,311**
Extraordinary cost							
Net Covid-19 (Revenue)/ Expense	-296	26	323	2,239	-46	-2,285	189
Holidays Act	1,667	1,667	0	6,667	6,667	0	20,000
DHB: Surplus / (Deficit)	**-2,347**	**-4,155**	**1,808**	**-16,348**	**-17,577**	**1,229**	**-39,500**

4.0 Funder Arm Financial Performance: October 2021

The Funder consolidated core result variance is $0.5m favourable for the month and $0.8m favourable for the year to date. This is the net position across all four of the Funder divisions. The four Funder divisions are: Funder NGO, Funder Own Provider, Funder IDF and Funder Governance.

The Funder NGO division is the main focus of Funder performance and refers to contracted health services delivered by third party providers. These consist of mainly community services providers

with approximately 66% of the services being demand based. These services are mostly delivered by means of national agreements with little or no opportunity for DHBs to directly influence either the number of service providers or the number of patient/client presentations.

The table below summarises the key components of the Funder core result in terms of revenue and expenditure and core result across the four Funder divisions.

FUNDER ARM FINANCIAL PERFORMANCE

$'000	Month Oct-21			YTD Oct-21			Full Year
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE (excluding Covid-19)							
Funder NGO	53,907	53,034	872	212,273	212,137	136	636,411
Funder Own Provider	83,193	83,180	13	327,690	332,720	(5,030)	998,159
Funder IDF	31,005	31,023	(17)	124,059	124,090	(31)	372,270
Funder Governance	1,101	1,098	3	4,394	4,390	4	13,171
Total Funder Revenue	**169,205**	**168,334**	**871**	**668,416**	**673,337**	**(4,921)**	**2,020,012**
EXPENDITURE (excluding Covid-19)							
Funder NGO	52,444	52,234	(210)	207,873	208,937	1,064	626,811
Funder Own Provider	83,183	83,180	(3)	327,640	332,720	5,079	998,159
Funder IDF Outflows	31,837	31,723	(114)	127,269	126,890	(379)	380,670
Funder Governance	1,101	1,098	(3)	4,394	4,390	(4)	13,171
Total Funder Expenditure	**168,565**	**168,234**	**(330)**	**667,176**	**672,937**	**5,760**	**2,018,812**
CORE RESULT (excluding Covid-19)							
Funder NGO	1,463	800	663	4,400	3,200	1,200	9,600
Funder Own Provider	9	0	9	50	0	50	0
Funder IDF	(832)	(700)	(132)	(3,210)	(2,800)	(410)	(8,400)
Funder Governance	0	0	0	0	0	0	0
FUNDER RESULT Surplus/(Deficit)	**640**	**100**	**540**	**1,240**	**400**	**840**	**1,200**
COVID-19 Only							
Revenue	5,407	6,833	(1,426)	28,266	27,333	933	82,000
Expenditure	5,407	6,833	1,426	28,266	27,333	(933)	82,000
Net Funder Impact Covid-19	**0**	**0**	**0**	**0**	**0**	**0**	**0**
CORE RESULT (including Covid-19)							
Funder NGO	1,463	800	663	4,400	3,200	1,200	9,600
Funder Own Provider	9	0	9	50	0	50	0
Funder IDF	(832)	(700)	(132)	(3,210)	(2,800)	(410)	(8,400)
Funder Governance	0	0	0	0	0	0	0
FUNDER RESULT Surplus/(Deficit)	**640**	**100**	**540**	**1,240**	**400**	**840**	**1,200**

FUNDER REVENUE

The Funder consolidated revenue variance excluding Covid-19 is $0.9m favourable for the month and $4.9m adverse for the year to date

The drivers of the year to date variance include:

$2.8m adverse impact resulting from the Ministry removing the funding related to the Combined Pharmaceutical Budget ($76m for the National Funding Pool – WDHB share $8.4m).

$5.4m adverse impact resulting from the creation of a Planned Care Revenue risk provision. This is offset by an equivalent expenditure variance resulting in nil impact on the Funder net result.

$2.7m favourable impact resulting from a 2020/21 adjustment relating to Ministry Funding of the Combined Pharmaceutical Budget with related expenditure that offsets (as directed by the Ministry).

$0.5m favourable impact resulting from net changes to and within Ministry funded initiatives introduced after budgets had been set and have equivalent expenditure variances that mostly offset

FUNDER EXPENDITURE

The Funder consolidated expenditure variance excluding Covid-19 was $0.3m adverse for the month and $5.8m favourable for the year to date.

The drivers of the year to date variance includes:

$0.5m adverse impact resulting from changes to and within Ministry funded initiatives introduced and expensed after budgets had been set and which have equivalent revenue variances that offset.

$5.4m favourable impact of Planned Care Revenue Wash-up risk provision recovered from the equivalent Provider Arm expenditure allocation

Other factors relating to monthly variances include the normally expected variations across Funder services. These variances apply particularly within Funder NGO services and typically offset over time and arise out of seasonal/demand/utilisation variations within Community Pharmacy, General Practice, Age Related Residential Care, Home Support Services and PHO Capitation Services

FUNDER CORE RESULT

The Funder consolidated core result variance was $0.5m favourable for the month and $0.8m favourable for the year to date, as designated in the Funder Financial Performance table above.

5.0 Provider Arm Commentary on Financial Performance

5.1 Financial Statement

Table: Summary of Provider Arm Financial Performance for the year ended October 2021

PROVIDER ARM FINANCIAL PERFORMANCE							
$ 000's	Month			YTD			Full Year
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
Crown	89,378	89,786	-408	365,635	359,143	6,492	1,082,770
Other	2,031	2,046	-16	2,350	8,331	-5,981	32,377
Total Revenue	91,409	91,833	-424	367,984	367,474	510	1,115,146
EXPENDITURE							
Personnel	62,386	65,150	2,764	258,582	263,059	4,477	807,608
Outsourced Personnel	1,653	1,346	-307	7,245	5,421	-1,824	15,548
Outsourced Services	6,108	7,073	966	25,190	27,764	2,574	82,738
Clinical Supplies	11,845	12,729	884	47,174	50,330	3,156	148,868
Infrastructure & Non-Clinical Supplies	11,302	8,096	-3,206	39,323	32,255	-7,067	80,896
Total Expense	93,295	94,395	1,100	377,514	378,829	1,315	1,135,658
Provider Operating: Surplus/(Deficit)	-1,886	-2,562	676	-9,530	-11,355	1,825	-20,511
Extraordinary cost							
Covid-19	-296	26	-323	2,239	-46	2,285	189
Holidays Act	1,667	1,667	0	6,667	6,667	0	20,000
Provider: Surplus / (Deficit)	-3,257	-4,255	999	-18,435	-17,976	-460	-40,700

The BAU Provider Arm operating result for the year to date 31 October 2021, prior to the extraordinary impacts of COVID-19 was a deficit of $9.530m against a planned deficit of $11.355m and therefore favourable by $1.825m.

The overall result however shows an unfavourable variance of $0.460m, after the non-reimbursable net impacts of $2.239m for COVID-19; this being costs of $18.949m offset by $16.710m of revenue, of which $11.357m is in Laboratories for COVID-19 testing. All COVID-19 related impacts have been washed-up into Corporate and Provider Support to avoid distortion of the financial results for Provider Services.

Service Commentary on YTD result

Table: Provider Arm Financial Performance by Service for the year to date October 2021

$000's	Direct Revenue YTD			Direct Expenditure YTD			Variance	Covid-19 & Holiday Pay Impacts *	Total Variance
	Actual	Budget	Variance	Actual	Budget	Variance			
PROVIDER ARM FINANCIAL PERFORMANCE YTD									
Surgical Services Incl. ESC	3,226	2,906	320	66,096	65,202	-893	-574	0	-574
Acute & Emergency Medicine	1,115	1,068	47	54,375	55,564	1,189	1,236	0	1,236
Specialty Medicine and HOPS	3,610	3,042	568	33,783	34,323	540	1,108	0	1,108
Child, Women & Family	3,877	3,693	184	25,967	26,173	205	390	0	390
Clinical & Diagnostic Support	2,249	1,965	285	51,224	51,793	569	853	0	853
Sub-total Provider services	**14,077**	**12,674**	**1,404**	**231,445**	**233,055**	**1,610**	**3,014**	**0**	**3,014**
Specialist Mental Health & Addiction	6,364	5,334	1,029	54,855	54,312	-544	486	0	486
Regional Dental	21	175	-154	9,063	9,693	630	476	0	476
Commissioning & Community Health	6,424	7,193	-769	7,248	7,757	509	-259	0	-259
Corporate and Provider Support	341,098	340,591	508	74,904	72,576	-2,328	-1,820	-2,357	-4,177
Total Provider operating result	**367,984**	**365,967**	**2,018**	**377,515**	**377,394**	**-121**	**1,896**	**-2,357**	**-460**

Provider Services

Surgical Services and ESC (YTD combined $0.574m unfavourable to budget)

The following updates are the consolidated position for both the Surgical and Ambulatory Service (SAS) and Elective Surgery Centre (ESC):

The unfavourable variance is driven by:

- Despite the impact of COVID, YTD Revenue was $320k ahead of budget. Revenue from ACC, part of the Financial Sustainability program showed a $116k benefit against budget and was $336k more than YTD last year. ADHB sourced revenue was $70k higher than budgeted and there was a one-off benefit of backdated revenue for a LINK organ nurse in ICU, which realised a $67k benefit.
- Medical costs were approximately $336k above budget prior to COVID; a significant reason for the additional costs relate to the increased additional clinics and costs related to Saturday lists which were being run to meet surgical health targets and ESPI compliance. There was also some long term sick leave within medical that created higher than planned costs.
- While Nursing costs were on budget, the Allied Health costs were $197k over budget. Allied Health costs were driven by need to backfill roster gaps for Anaesthetic Technicians as well as costs related to the Saturday lists for theatres and endoscopy.
- Outsourced costs overspend was as a result of the need to rely on external agency nursing in theatres ($179k) to backfill vacancies.
- Clinical Supplies were below budget prior to COVID due to lower Orthopaedic costs driven by acute demand displacing elective surgeries, particularly knees.
- The service had a financial sustainability target of $1.244m YTD which has partly been met by the increased revenue described above. Other benefits are difficult to extract as they rely on a full year picture to identify the financial benefit.

<u>COVID-19 impacts $2.71m favourable:</u>

Surgical Services have recognised a COVID benefit arising from the closing of the ESC and the reduction in theatre activity at NSH since mid-August. The main benefits were in the reduction in spend on clinical supplies ($2.13m) as all but P1 planned care and acute surgeries stopped during Level 4 with a careful re-opening of planned care operations at Level 3. The closure of ESC also reduced the package of care costs ($1.02m). ESC theatre related staff were redeployed within SAS to cover vacancies during the period but the Cullen Ward staff have remained to run the COVID response in the ESC building.

Personnel costs saw a $0.365m negative impact YTD October 2021 result due to a reduction in annual leave taken and the need to backfill for staff that went on COVID related leave.
Certain revenue streams have been severely impacted by COVID ($0.280m); Auckland DHB cancelled their theatre lists at WTH and ACC revenue has dropped significantly since COVID-19 although YTD remains positive.

Acute and Emergency Medicine Services (YTD $1.236m favourable to budget)
The favourable variance is driven by:

- Emergency Department (ED) had lower patient presentations in the month compared with same period last year; this YTD, North Shore has dropped by 5% and Waitakere has increased by 8%.
- Medical staff costs are higher than planned in the month, mainly due to a high number of registrars allocated and high cost in cardiology services. Medical staff costs in ED have increased since the August 2021 Covid outbreak.
- Inpatient wards have had lower bed utilisation, due to COVID-19 impacts and Ward 11 being closed until mid-October for refurbishment to meet Covid ward requirements. However, nursing staff shortages have added pressure on existing staff and overtime has been used to cover shifts.
- Cardiology services have completed 37% more pacemakers and 7% more ICD cases YTD than the same period last year. The increased production has led to an increase in costs for Clinical Supplies and Medical staff.
- The Division has contributed $0.428m YTD to the Financial Sustainability Programme (FSP).

<u>COVID-19 impacts $1.512m favourable</u>:
There have been a number of staff stood down or on paid special leave in relation to COVID-19; the cover cost is estimated at $500k. Additional registered nurses and health care assistants were deployed at both EDs since the 18th of August, thus incurring extra staff costs of $257k by the end of the month. However, some savings from outsourced personnel cost are offsetting some of the additional costs and annual leave taken is similar to prior years.

Specialty Medicine and Health of Older Persons Services (YTD $1.108m favourable to budget)
The favourable variance is driven by:

- Revenue is $0.568m favourable, driven by higher than anticipated ACC revenue $0.194m, predominantly NAR revenue from an increase in Neck of Femur referrals and patients requiring longer term hospital stays. Research revenue of $0.313m which offsets the spend on research personnel, drugs and other research related consumables.
- Medical staff costs are favourable by $0.085m, mainly driven by vacancies (RMO under-allocations) and one off reversals of overpayments paid to SMOs.
- Other personnel groups have a combined favourability of $0.206m, mainly driven by vacancies.
- Clinical supplies are unfavourable $0.041m, due to the overspend in Renal blood tests, the service reports an increase of approximately 20 patients on the active transplant list since March 21, and 8 successful transplants completed in September 2021.
- The service has achieved $0.170m of savings in MHSOA respite service, due to the implementation of financial sustainability initiatives.
- Infrastructure and non clinical supplies unfavourable $0.804m, including the financial Sustainability savings target amounting to $0.641m to date and miscellaneous research consumables of $0.183m which is fully offset by research revenue.

<u>COVID-19 impacts $0.570m unfavourable</u>:
All services have experienced additional staff costs ($0.531m) compared to prior year trends, which is attributed primarily to staff not taking annual leave.

Child, Women and Family (YTD $0.390m favourable to budget)
The favourable variance is driven by:

- Current vacancies across Maternity inpatient services have resulted in an underspend of $348k to date. The service is working to fill as many vacancies as possible to avoid more costly use of overtime and casuals to cover roster gaps. A new initiative is underway to substitute several midwife vacancies for a midwife specialist and maternity care assistants to help maintain continuity of care. Maternity Inpatient activity is tracking at 151 WIES (6% ahead of target to date).
- Child Residential Respite and Rehabilitation is $268k favourable to date, due to staff vacancies and staff having been redirected to other services due to Covid related restrictions.
- Women's Health Colposcopy service funding is tracking $80k favourable to budget YTD. The 2021/22 National Cervical Screening Programme funding reflects a significant price increase for FSA and procedure activity.
- A one off reimbursement of overcharged Colposcopy lab tests was received from Lab Plus Auckland $140k.
- Obstetric and Gynaecology medical staffing cost pressures associated with using additional sessions and external locums to cover multiple vacancies, unbudgeted Registrar staff, sickness and high service demand ($442k). Gynaecology Elective and Acute activity tracks at 118% and 101% of target to date.
- Paediatric medical staffing cost pressures linked to long term sick leave cover and impacts of specialist neonatal nurse shortages, vacancy cover and unbudgeted registrar resource ($444k).
- Embedded Financial Sustainability savings target amount to $433k to date with benefits being realised in increased funding associated with the expense reimbursement from Lab Plus Auckland and increased Colposcopy and Residential Respite funding aligned with recent unit price increases.

<u>COVID-19 impacts $0.823m unfavourable:</u>

- The most significant Covid impact to date is related to a reduction in Residential Respite inpatient numbers and therefore a shortfall in inpatient bed day billing to the MoH. The $274k impact relates predominately to September and October 2021
- Annual leave creep remains a driver of increased COVID-19 costs; staff are being encouraged to take their leave where possible.
- Child Services Public Health Nurses, Vision Hearing Testers, Health Care Assistants and Admin staff have been redeployed to the Auckland Regional Public Health Service, vaccination centres, front of house, asymptomatic swabbing and contract tracing locations over the past 6 weeks; this has led to delays in other child health vaccination programmes; however planning is underway to catch up.

Clinical and Diagnostic Support Services (YTD $0.853m favourable to budget)
The favourable variance was driven by:

- Inpatient Pharmaceuticals are $398k favourable YTD due to lower inpatient activity and Pharmac negotiated price reductions. Patient meals are also favourable due to lower volumes YTD $242k.
- Radiology outsourced volumes are lower than plan and are $1.1m favourable YTD.
- The Financial Sustainability Programme allocated savings target for Clinical & Diagnostic Support Services is $887k unfavourable YTD; this has been partially met by new supply contracts in Pharmacy and Laboratories.

<u>COVID-19 impacts $7.895m favourable:</u>
Additional revenue in Laboratories relating to contract with Ministry of Health to provide COVID-19 testing is $11.357m YTD and offset by additional direct related costs in personnel and supplies of $3.645m YTD. The favourable impact has been washed up in Corporate to offset other unfunded and indirect Covid-19 expenditure.

Commissioning and Community Health Services

Specialist Mental Health and Addiction Services (YTD $0.486m favourable to budget)
The favourable variance was driven by:

- Revenue is $1.029m favourable to budget, made up of extra revenue for one ID patient and additional funds for new MoH contracts for Tobacco control, Infant and perinatal Mental Health and crisis support.
- This increase in revenue is offset by a reduction in court reporting revenue. Overall court reports requested are down 80% from the average due to Covid-19, in part due to less court activity and also a request from the service to stop, due to the bubble matrix operating which makes it difficult to complete the reports whilst in levels 3 and 4.
- Medical staff costs are $0.728m favourable, driven by SMO vacancies but partially offset by use 2 outsourced locums $0.514m to cover sick leave, maternity leave and vacancies.
- Nursing costs are $0.946m unfavourable due to high overtime in Adult Inpatient Units (IPUs) which continue to have high acuity presentations, along with the need for segregated staffing due to COVID-19. Forensic overtime continues to be high to allow for the Covid bubble matrix and whai ora requiring 2:1 observations due to complex needs.
- Allied Health staff costs are $0.727m favourable due to high vacancies, as the recruitment of social workers continues to be difficult.
- Other direct costs $1.161m unfavourable to budget as a result of unmet savings Financial Sustainability Programme. To date $0.167m has been met from reduced locum spend year on year within the Child & Youth service. Work is ongoing to find further savings to meet the $2.0m target which will be challenging as Covid-19 has impacted some planned sustainability initiatives.

<u>COVID-19 impacts ($1.957m unfavourable):</u>
The service has suffered a loss on court reporting revenue $0.457m and associated outsourced costs $0.228m for some of this work. The remainder is primarily for nursing personnel having to isolate; a small percentage of which are high risk staff due to age and underlying health conditions.

Population Health Services Incl. Auckland Regional Dental Service (YTD $0.217m favourable to budget)
The favourable variance is driven by:

- Staff vacancies $0.796m across both Auckland Regional Dental Services and Cancer Screening Services remain dominant driver of the favourable result
- Revenue for the YTD is unfavourable by $0.104m primarily due to lower volumes in the Maternal Oral Health project
- Favourable YTD variance in Other Direct costs exceeds the financial sustainability programme target by $0.099m. FSP savings were achieved from reduced vehicle and staff mileage costs in ARDS; additional savings were achieved in Health Promotion costs in Screening Services
- Work continues to find initiatives to meet FSP targets during the second half of the financial year; this will be challenging while simultaneously trying to apply efficiency gains to reduce arrears volumes.

<u>COVID-19 impacts ($0.470m) favourable:</u>

- Reduced YTD volumes in Breast Screening Waitemata and Northland resulted in $0.404m of lost revenue; current YTD volumes are 10,126 screens, compared with prior year volumes of 15,700
- The Auckland Regional Dental Service (ARDS) has 39,652 attended appointments YTD compared with 105,400 for the equivalent period prior to Covid-19. However, revenue received is not affected by this reduced volume and the service has recorded $0.309m of savings from reduced clinical supplies, cleaning, repairs and maintenance during Level 3 and Level 4 lockdowns
- Dental vans have been redeployed to vaccination and swabbing centres for use as offices.
- Staff costs are being impacted by staff not taking annual leave.

Corporate and Provider Arm Support Services (YTD $1.820m unfavourable to budget)

The unfavourable variance is driven primarily by:

- Centralised budget for Financial sustainability and timing of risk pool provisions
- Overspends in Facilities maintenance ($534k)

Offset by additional revenue and cost savings, including:

- $400k recovered from the insurance risk sharing arrangement for the flood that occurred at North Shore Hospital in February 2019.
- An upside of $749k in Personnel costs due to staff vacancies in Corporate
- Favourable Clinical Supplies and Outsourced Corporate service costs, due to savings and provisional initiatives yet to commence.

COVID -19 and other extraordinary impacts $2.357m unfavourable:

Consolidation of all of the above mentioned COVID-19 financial impacts from services, including:

- Annual Leave movements and Provisions for under delivery of planned care ($5.4m), offset by savings in related cost of Personnel and Clinical Supplies
- Additional revenue in Laboratories relating to contract with Ministry of Health to provide COVID-19 testing is $11.357m YTD offset by additional direct related costs in personnel and supplies of $3.645m YTD
- Revenue of $10.12m has been accrued to cover all claimable direct costs in relation to the COVID-19 response, including redeployment and backfill of staff, regional costs via NRHCC for delivery of the vaccination programme
- Shortfall of Car parking revenue ($875k) affected by reduced numbers of patients, staff and visitors on site during the COVID-19 Level 3 and 4 restrictions
- Provision for deferred CME costs ($450k) due to current travel restrictions.

6.0 Waitematā DHB Financial Position

6.1 Summary of Financial Position

Table: Summary financial position as at October 2021

$000's	31-Oct-21			Sep-21	Variance to	Jun-21
	Actual	Budget	Variance	Actual	Last Month	Actual
Crown Equity	**537,031**	**395,941**	**141,090**	**539,378**	**-2,347**	**403,955**
Represented by:						
Cash & Bank Balances	55,820	56,244	-424	25,567	30,253	77,468
Other Current Assets	127,907	77,059	50,848	136,719	-8,812	85,652
Current Liabilities	-594,340	-540,631	-53,709	-565,893	-28,446	-536,950
Net Working Capital	**-410,613**	**-407,328**	**-3,285**	**-403,607**	**-7,005**	**-373,830**
Fixed Assets	953,619	800,837	152,782	948,675	4,944	793,561
Long Term Investments in Associates	51,400	50,032	1,368	51,400	0	51,200
Term Liabilities	-57,375	-47,600	-9,775	-57,090	-286	-66,976
Total Employment of Capital	**537,031**	**395,941**	**141,090**	**539,378**	**-2,347**	**403,955**

6.2 Financial Position Commentary

The negative 'Net Working Capital' balance of $410.613m at 31 October 2021 is expected, due to the nature of current liabilities, including the increasing annual leave provisions and the current portion of other staff entitlements, such as continuing medical entitlements (CME). While these liabilities

are considered current, any significant draw down is unlikely as accrued entitlements tend to offset leave claims over time.

The opening balance for Current Liabilities includes the brought forward provision of $191m for the potential under-payment of Holiday Pay based on the workings provided by Ernst & Young in 2019/20. The Holidays Act Provision will be increased by a further $1.667m per month for the remainder this year, as per plan of $20.0m for the year.

The gain on revaluation of land and buildings $149.4m effective at 30 June 2021 and processed in July 2021 was not incorporated into the plan for 2021/22.

The 'Cash and Bank Balance' of $55.820m at 31 October 2021 is close to plan, however does reflect variances in timing of receipts and payment to suppliers and other providers.

The 'Other Current Assets' balance includes accrued revenue for reimbursement of COVID-19 related expenses, as well as outstanding payments from non-residents totalling $3.368m.

6.3 Detailed Statement of Cash Flow

Table: Detailed Statement of Cash Flow as at 31 October 2021

$000's	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
Cash flows from operating activities:						
Inflows						
Crown	205,044	182,884	22,160	716,968	731,536	-14,568
Interest Received	100	29	71	429	116	313
Other Revenue	1,418	1,634	-216	7,043	6,536	507
Outflows						
Staff	66,290	61,866	-4,424	266,025	269,227	3,202
Suppliers	18,638	22,402	3,764	94,831	96,805	1,974
Other Providers	89,687	90,790	1,103	363,458	363,160	-298
Capital Charge	0	0	0	0	0	0
GST (net)	-5,218	0	5,218	-4,693	0	4,693
Net cash from Operations	**37,165**	**9,489**	**27,676**	**4,819**	**8,996**	**-4,177**
Cash flows from investing activities:						
Inflows						
Sale of Fixed Assets	0	0	0	0	0	0
Associates	0	0	0	0	0	0
Outflows						
Capital Expenditure	6,912	6,860	-52	26,467	25,427	-1,040
Investments	0	0	0	0	0	0
Net cash from Investing	**-6,912**	**-6,860**	**-52**	**-26,467**	**-25,427**	**-1,040**
Cash flows from financing activities:						
Inflows						
Equity Injections	0	0	0	0	0	0
New Debt	0	0	0	0	0	0
Deposits Recovered	0	0	0	0	0	0
Outflows						
Interest Paid	0	0	0	0	0	0
Funds to Deposit	0	0	0	0	0	0
Net cash from Financing	**0**	**0**	**0**	**0**	**0**	**0**
Opening cash	**25,567**	**53,615**	**-28,048**	**77,468**	**72,675**	**4,793**
Net increase / (decrease)	**30,253**	**2,629**	**27,624**	**-21,648**	**-16,431**	**-5,217**
Closing cash	**55,820**	**56,244**	**-424**	**55,820**	**56,244**	**-424**
Closing Cash Balance in HZHP Sweep a	**55,820**	**56,244**	**-424**	**55,820**	**56,244**	**-424**

6.4 Cash Position

The key drivers for the variance to budgeted cash flows from operating activities is due to timing of revenue received and payments to suppliers and other provider payments.

Capital expenditure was close to plan in the month the month of October 2021.
The resurgence of COVID-19 and continued COVID-19 Alert Level restrictions has led to additional unplanned expenditure on COVID-19 preparedness and resilience projects, however is offset with some delays to planned projects.
Operating cash flow is being impacted by the retrospective billing for both the planned and the additional unplanned costs of COVID-19, as the claims and wash-up process takes approximately two to three months, after the actual expense has been incurred by Waitematā DHB.

6.1 New Zealand Health Survey update 2017-2020: How Waitematā DHB compares

Recommendation:

That the report be received.

Prepared by: Wendy Bennett (Planning and Health Intelligence), Dr Karen Bartholomew (Director Health Outcomes)
Endorsed by: Dr Dale Bramley (CEO)

1. Executive Summary

The latest data from the New Zealand Health Survey were released recently. Results for Waitematā DHB are outlined below. Overall results are positive for Waitematā DHB in many areas compared to the national averages.

2. New Zealand Health Survey update 2017-2020 comparative analysis

Self-rated health excellent, very good or good

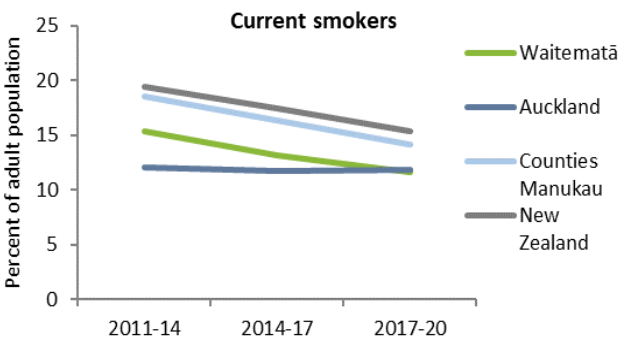
- The percentage of adults in Waitematā DHB who rate their health as excellent, very good or good is similar to the New Zealand average (89% vs 87%).
- Auckland and Counties Manukau DHBs also have high rates (88% and 86%).
- However, the rates for all Auckland DHBs and for New Zealand are three to four percentage points lower in 2017-20 than they were in 2011-14.

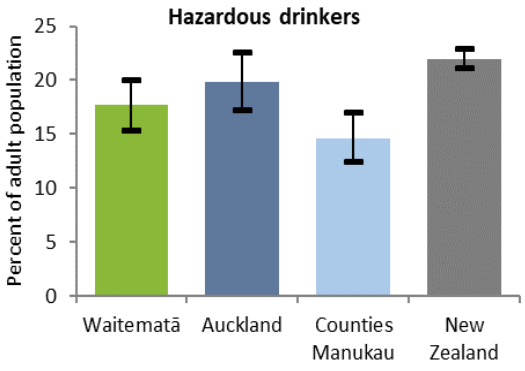
Current smokers

- Smoking rates in Waitematā and Auckland DHBs are lower than the overall NZ rate (11.6% and 11.8% vs 15.4%).
- Rates have dropped by around four percentage points since 2011-14, apart from in Auckland DHB, where they were already lower.
- There are an estimated 54,000 smokers in Waitematā DHB.

Alcohol consumption

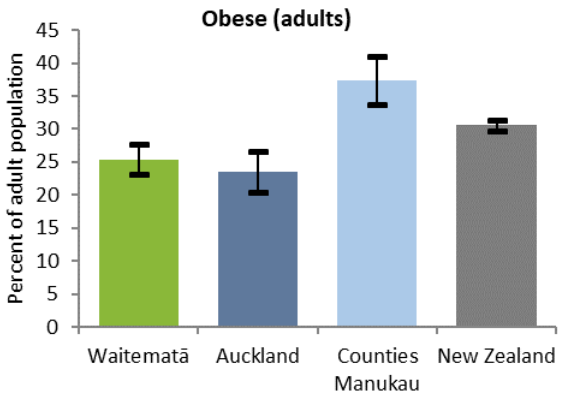
- In Waitematā and Auckland DHBs, three quarters of adults (77%) drank alcohol in the past year, a little lower than the NZ figure of 81%. Counties Manukau has a lower proportion of people who drink alcohol, at 69%.
- The proportion of adults whose drinking pattern is considered hazardous is lower in Waitematā and Counties Manukau DHBs than the NZ average (18% and 15% vs 22%).

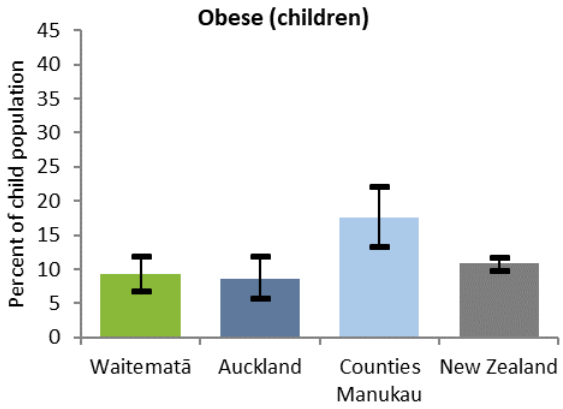




Body weight

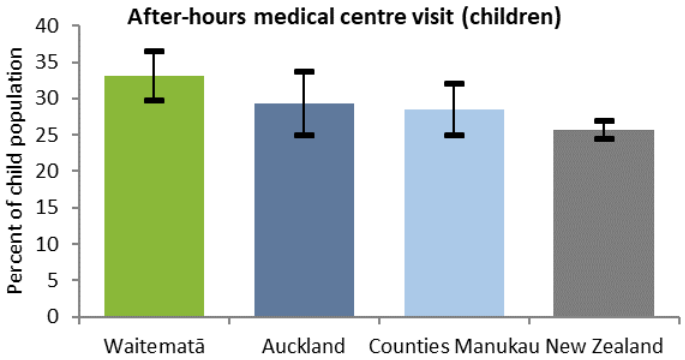
- Obesity rates in adults remain high at 25% in Waitematā and 24% in Auckland DHB, although this is lower than the rate in Counties Manukau (37%) and NZ as a whole (31%).
- The proportion of adults who are obese has not increased since 2011-14.
- 60% of Waitematā adult residents are overweight or obese, a slightly lower proportion than the NZ figure of 64%. Counties Manukau has a higher proportion of overweight or obese adults than Waitematā, at 69%.
- Waitematā's obesity rate for children is 9.2%, which is lower than the Counties Manukau rate of 17.5% but not statistically significantly different from the NZ or Auckland DHB rates.
- 30% of children in Waitematā are overweight or obese.
- 47% of Waitematā adults met recommended levels of physical activity, which was higher than Counties Manukau adults (40%) but lower than the NZ average (53%)





Primary care use and patient experience

- Three in four (77%) of Waitematā DHB adults had visited a GP in the previous year.
- This was a similar rate to the rest of metro Auckland and to NZ.
- Children in Waitematā, Auckland and Counties Manukau were more likely to have visited a GP than the NZ average (79%, 83% and 80% respectively vs 74% for NZ).
- Adults and children in Waitematā DHB were less likely to have visited a practice nurse (23% vs 28% of NZ adults, and 22% vs 26% of NZ children)
- Children in Waitematā DHB were more likely to have visited a medical centre after hours than were children in NZ overall (33% vs 26%).

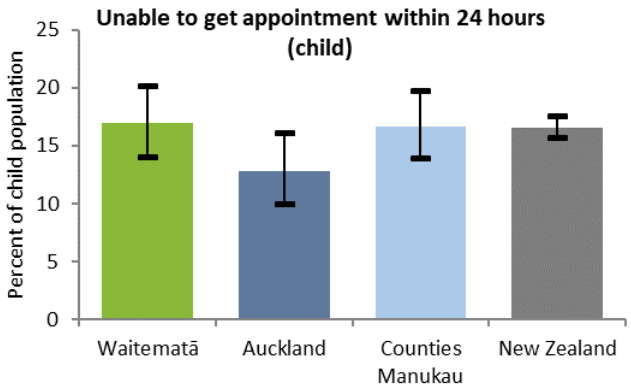


- Four out of five adults definitely have confidence and trust in their GP (similar across metro Auckland and NZ overall).

- Nine out of ten adults said their GP was good at explaining health conditions and treatments (similar across metro Auckland and NZ overall), and 87% said their GP was good at involving them in decisions.

Primary care unmet need

- 31% of Waitematā DHB adults reported some form of unmet need for primary care, in or out of hours, due to cost, transport or child care issues. This was similar to the NZ figure.
- Auckland DHB had a lower rate of unmet need at 26%.
- The proportion has increased by 7 percentage points since 2011-14.
- For Waitematā DHB children, the figure was lower at 22% but this is still more than one in four children.
- Counties Manukau has a lower rate of unmet need for GP care due to cost, at 12%, compared with 16% for Waitematā DHB adults.
- Almost one in five adults (19%) reported being unable to get a GP appointment within 24 hours and this was similar to Counties Manukau and NZ rates, although the rate in Auckland DHB was 14%.
- The picture was similar for children with 17% of those in Waitematā, Counties Manukau and NZ unable to get an appointment within 24 hours, and 13% of those in Auckland DHB, although the difference was not statistically significant.



ED visits

- 12% of Waitematā adults visited ED in the past year, lower than the NZ average of 15%.

Oral health

- 52% of Waitematā DHB adults only visit a dental health care worker when they have problems. This is lower than the proportion in Counties Manukau (62%).
- 36% have had teeth removed due to decay over their lifetime (NZ 41%).
- Three in four (74%) of Waitematā DHB children had visited a dental health care worker (81% for NZ).
- In the past 12 months, 2.5% of Waitematā children had had teeth removed due to decay, which was lower than the rate of 5.6% for Counties Manukau.

Other health conditions

- Waitematā DHB adults have similar cardiovascular health to Auckland DHB and to NZ as a whole, and generally better cardiovascular health than Counties Manukau adults. The proportion whose measured blood pressure was raised was lower than the NZ average (14% vs 18%).
- The proportion of adults who were medicated for asthma was lower than the NZ average for adults (9.6% vs 12%).
- 17% of Waitematā DHB adults reported a mood or anxiety disorder, which was a higher rate than for Counties Manukau adults (13%).

Adults NZHS 2017-20

Indicator	Waitematā	Auckland	Counties Manukau	New Zealand	WDHB compared with ADHB is:	WDHB compared with CMDHB is:	WDHB compared with NZ is:
Excellent, very good or good self-rated health	88.5	88.3	85.9	87.1			
Risk factors							
Current smokers	11.6	11.8	14.1	15.4			Better
Obese	25.4	23.5	37.3	30.6		Better	Better
Overweight (but not obese)	34.3	31.1	32	33.5			
Overweight or obese	59.7	54.5	69.3	64		Better	Better
Physically active	46.6	45.6	39.6	52.9		Better	Worse
Vegetable and fruit intake	29.7	29.9	31.3	33.4			Worse
Hazardous drinkers (total population)	17.7	19.8	14.6	22			Better
Past-year drinkers	76.6	77.1	69.4	80.6		Worse	Better
Primary Care							
GP visit	77.4	76.8	78.6	76			
Practice nurse visit	23	21.3	19.1	27.8			Worse
After-hours medical centre visit	13.4	12.3	12.9	12			
Unmet need for primary health care	30.6	25.5	29.3	31.7	Worse		
Unable to get appointment within 24 hours	19.1	14.4	19.9	21.4	Worse		
Unmet need for after-hours due to cost	7.1	5.9	5.9	6.8			
Unmet need for after-hours due to lack of transport	0.7	1.3	1.2	1.1			
Unmet need for GP due to cost	15.5	13.4	11.5	15		Worse	
Unmet need for GP due to lack of transport	2.4	3.5	4.1	3.1			
Unfilled prescription due to cost	5.7	6.6	8.4	6.1			
Definite confidence and trust in GP	79	82.2	81.2	80.9			
GP good at explaining health conditions and treatments	90.8	90.4	90.7	90.5			
GP good at involving patient in decisions	87.2	87.9	89.6	87.9			
ED visit	12.3	11.8	12.6	14.7			Lower
Private health insurance	43.3	47.9	34.5	35.8		Higher	Higher
Other health conditions							
Mood and/or anxiety disorder	17.4	16.5	13.2	20.1		Worse	
Arthritis	12.3	10.6	10.9	12.2			
Gout	2.6	2	2.9	2.3			
Chronic pain	15.6	12.8	17.1	17.3			
Asthma (medicated)	9.6	10.7	9.9	11.8			Better
Diabetes	4.1	5.4	7.7	4.5		Better	

Indicator	Waitematā	Auckland	Counties Manukau	New Zealand	WDHB compared with ADHB is:	WDHB compared with CMDHB is:	WDHB compared with NZ is:
Ischaemic heart disease	2.4	2.7	3.8	2.9		Better	
Heart failure	1.1	1.1	1.4	1.3			
Stroke	0.6	1	1.4	1.1		Better	Better
High blood pressure (medicated)	10.8	10	13.5	11.3		Better	
High cholesterol (medicated)	7.7	8.8	10.8	7.5		Better	
Raised blood pressure (measured)	14.4	17.9	19.1	17.7		Better	Better
Oral Health							
All teeth removed due to decay	2.4	2.1	3.1	3.6			Better
Dental health care worker visit	44.7	46.9	39.6	46.2			
Only visit dental health care worker for problems	52.1	46	61.7	53.4		Better	
Teeth removed due to decay in lifetime	36.4	33.7	40.4	40.5			Better
Teeth removed due to decay in past 12 months	6.5	5	6.9	6.6			

Children under 15 years NZHS 2017-20

Indicator	Waitematā	Auckland	Counties Manukau	New Zealand	WDHB compared with ADHB is:	WDHB compared with CMDHB is:	WDHB compared with NZ is:
Excellent, very good or good parent-rated health	98.5	99.1	97.6	97.9			
Risk Factors							
Obese	9.2	8.5	17.5	10.8		Lower	
Overweight (but not obese)	21.1	16.9	21.5	20.1			
Overweight or obese	30.3	25.4	39	30.8			
Exclusively breastfed until 4+ months old	56.2	59.6	47.1	49.8			
Exclusively breastfed until 6+ months old	9.7	11.9	10.7	8.2			
Solid food before 4 months	4.4	4.8	7.6	7.6			
Solid food before 6 months	43.7	41.3	32.1	46.9			
Fruit intake	71.6	72.9	69.2	73.1			
Vegetable intake	41.2	43.8	40.2	48.1			Lower
Active transport	39.7	49.9	42.1	43.1			
Physical punishment	3	3.6	6.1	4.9		Lower	Lower
Primary care							
GP visit	78.7	82.9	80	73.8			Higher
Practice nurse visit	22	26	18	26.3			Lower
After-hours medical centre visit	33.1	29.3	28.5	25.7			Higher
Last GP visit (any location) free	86.9	91.2	94	91.9		Lower	Lower
Last after-hours visit free	72	78.8	79	76.8			

Indicator	Waitematā	Auckland	Counties Manukau	New Zealand	WDHB compared with ADHB is:	WDHB compared with CMDHB is:	WDHB compared with NZ is:
Unmet need for primary health care	21.9	17.5	21.5	20.4			
Unable to get appointment within 24 hours	17	12.8	16.7	16.6			
Unmet need for GP due to cost	2.3	1.5	2.5	1.8			
Unmet need for GP due to lack of childcare	3	3.1	3.5	2.6			
Unmet need for GP due to lack of transport	2.3	3.1	3.1	2.1			
Unmet need for after-hours due to cost	2.7	3	1.9	2			
Unmet need for after-hours due to lack of transport	0.7	1.5	1.3	0.9			
Unfilled prescription due to cost	2.9	1.8	3.6	2.3			
Definite confidence and trust in GP	83.7	85.5	84.2	82			
GP good at explaining health conditions and treatments	92	97.3	92.6	91.3			
ED visit	14.6	15.9	12.9	15.3			
Private health insurance	38.9	45.4	24.5	29.7		Higher	Higher
Other health conditions							
Asthma (medicated)	13.8	11.8	12.7	13.9			
Eczema (medicated)	15	12.7	16.3	15.3			
ADHD	3.2	2.3	2	2.3			
Anxiety disorder	2.3	2.9	2.8	3.8			
Depression	0.6	0.1	0.7	0.7			
Autism spectrum disorder	2	2.1	2.2	2			
Emotional and/or behavioural problems	5.2	4.8	5	5.7			
Oral Health							
Dental health care worker visit	74.1	79.1	76.3	81.1			Lower
Teeth removed due to decay in lifetime	8.7	10.8	12.3	11.5			
Teeth removed due to decay in past 12 months	2.5	4.8	5.6	4.1		Lower	

6.2 Update on the Health (Fluoridation of Drinking Water) Amendment Bill

Recommendation:

That the Board:

Note the recent update to the Health (Fluoridation of Drinking Water) Amendment Bill and the implications for the Waitematā DHB catchment area.

Prepared by: Dr Subha Rajanaidu (Public Health Physician), Deepa Hughes (Programme Manager – Youth Health & Oral Health Services)
Endorsed by: Dr Karen Bartholomew (Director Health Outcomes)

Glossary

DHB - District Health Board

1. Executive Summary

This paper outlines the recent update to Health (Fluoridation of Drinking Water) Amendment Bill and the implications for the Waitematā District Health Board (DHB) catchment area.

2. Background

Community water fluoridation helps prevent tooth decay and reduces inequalities in oral health across the lifespan. Tooth decay is a common condition in New Zealand causing pain, infection, loss of teeth and loss of self-esteem. Oral pain can stop a person from eating, working, and sleeping. Tooth decay poses extra risks for people with specific health problems – for example, valvular heart disease, congenital heart disease, recent cardiac surgery, renal disease, bleeding disorders, and low immunity. The benefits of community water fluoridation are most pronounced for those at higher risk of poor oral health.

In New Zealand, Māori and Pacific people and people living in more deprived areas experience poorer oral health outcomes compared to other New Zealanders. Recent New Zealand studies have associated community water fluoridation with both reduced prevalence of severe caries and reduced dental hospital admissions in children, with the latter association most marked for children living in our most socioeconomically deprived areas.

The Sapere review of the benefits and costs of water fluoridation in New Zealand, estimates a net saving of over $1.4 billion over 20 years by fluoridating all public water supplies serving population of over 500. At an individual level it is estimated that the net saving is $334 per person.
Although mineral fluoride occurs naturally in water supplies in New Zealand, they are mostly at levels that are too low to provide protection against tooth decay. Community water fluoridation

allows for the adjustment of fluoride levels in a public water supply at a level where protection against tooth decay can occur. The New Zealand Ministry of Health recommends that the level of fluoride in water be adjusted to a quota between 0.7 and 1.0 parts per million (ppm). Community water fluoridation programmes have been running in countries with low natural amounts of fluoride in drinking water supplies for over seventy years. There is consistent evidence of the effectiveness and safety of these programmes in assisting with the maintenance of oral health of these communities regardless of social, economic or cultural group.

A joint report by the Officer of the Prime Minister's Chief Science Advisor and The Royal Society Te Apārangi updated in 2021 states:

"Given the caveat that science can never be absolute, the panel is unanimous in its conclusion that there are no adverse effects of fluoride of any significance arising from fluoridation at the levels used in New Zealand. In particular, no effects on brain development, cancer risk or cardiovascular or metabolic risk have been substantiated, and the safety margins are such that no subset of the population is at risk because of fluoridation."

3. The Health (Fluoridation of Drinking Water) Amendment Bill

The Health (Fluoridation of Drinking Water) Amendment Bill (the Bill) when introduced to the House in 2016, it was proposed to give the authority to fluoridate public drinking water supplies to the district health boards (DHBs). This proposition meant that DHBs would implement this by directing drinking-water suppliers to fluoride water supplies after an assessment of their community's oral health status and feasibility with any particular water-supply. In view of DHBs being disestablished and replaced by one health authority, this bill was amended earlier in 2021 to give the Director General of Health the power to issue a direction to local authority water suppliers (including bulk water suppliers) to fluoridate a public drinking water supply. This also ensures nationally consistent decision-making around community water fluoridation.

On 9 November 2021, the Bill passed its final reading and will come into effect 28 days after Royal assent. The Director General of health must take into account scientific evidence, cost-effectiveness, and local oral health outcomes when making decisions on whether to fluoridate water supplies, and is expected to commence issuing directions from mid-2022.

If the direction requires fluoride to be added to drinking water, the local authority must comply with the direction and must take all practicable steps to ensure that the fluoride is present in the water at the specified level.

Private water supplies will not be required to be fluoridated.

4. Water fluoridation in Waitematā DHB catchment

Community water fluoridation began in 1954 in New Zealand. Currently 27 out of 67 local authorities fluoridate their drinking-water supply making approximately 54 % of the total population receiving fluoridated water. Major cities like Auckland, Wellington and Dunedin comprise the greatest population coverage of water fluoridation. The combined data for metro Auckland DHBs shows that 95 % of the population receives fluoridated water. All three DHBs are serviced through the Auckland Council water supply system.

Based on the information provided by the Ministry of Health, the table below shows the water supplies that serve a population of over 500 but are not fluoridated in the Waitematā district.

District Health Board	Water Supply	Water Supply Population	Classification
Waitematā	Helensville/Parakai	4579	Minor
Waitematā	Shakespear Regional Park	1425	Minor
Waitematā	Snells/Algies	4664	Minor
Waitematā	Warkworth	4111	Minor
Waitematā	Wellsford/Te Hana	2114	Minor
Waitematā	Huia Village	597	<1000
Waitematā	Muriwai	563	<1000

The Ministry will be engaging further with local authorities on implementation in late 2021 and early 2022. Local authorities will be given the opportunity to provide information on costs and compliance dates before decisions are finalised.

5. Use of other Fluorides

Fluoride tablets have been advocated in areas without water fluoridation in the past, however since 2009 fluoride tablets are no longer recommended as a public health measure. They can be recommended by oral health professionals for at-risk individuals aged three years and over, though the availability of fluoride tablet is limited in New Zealand.

The *Guidelines for the Use of Fluorides* provides useful information for oral health professionals on the use of topical fluorides for at-risk populations to aid in reducing inequities in oral health. Toothpaste of at least 1000 ppm is recommended for all ages and should be used twice daily. In addition, for those at high risk of dental caries, oral health professionals are advised to consider using fluoride varnish (under six-year-olds) and/or fluoride foams or gels or fluoride mouth rinses for over six-year-olds.

6. References

New Zealand Guidelines Group. *Guidelines for the Use of Fluorides*. 2009. Wellington: Ministry of Health.

Inquiry into Supplementary Order Paper No. 38 on the Health (Fluoridation of Drinking Water) Amendment Bill https://www.parliament.nz/en/pb/sc/reports/document/SCR_113478/inquiry-into-supplementary-order-paper-no-38-on-the-health

Review of the Benefits and costs of Water Fluoridation in New Zealand. https://www.health.govt.nz/publication/review-benefits-and-costs-water-fluoridation-new-zealand

Sapere Research Group. 2016. The benefits and costs of water fluoridation - a summary for DHBs. Wellington: Ministry of Health.

7. Resolution to Exclude the Public

Resolution:

That, in accordance with the provisions of Schedule 3, Sections 32 and 33, of the NZ 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 items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1.	**Minutes of Meeting of the Board - Public Excluded (17/11/21)**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.
2.	**Recommendations of the Audit and Finance Committee – Public Excluded (08/12/21)**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
4.	**Chair's Report**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
5	**Draft Annual Report 2020-21**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]
6	**Managing COVID Positive Cases in the Community – Primary Care Response Draft Annual Report 2020-21**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]
7	**Ratification of actions undertaken for COVID-19 Response**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]
8	**Termination Services**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)] **Obligation of Confidence** The disclosure of information would not be

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
			in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]
9.	**Mason Clinic Trance 1B Business Case Update**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
10.	**Mason Clinic Ministry of Housing and Urban Development Roading Resource Consent Update**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
11.	**Waitakere Hospital Additional Carparks**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
			on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
12.	**Relocation of the Medically Managed Withdrawal Inpatient Service to Auckland City Mission HomeGround**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
13.	**Mental Health Services**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]