AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Open Board Meeting

Wednesday, 08 July 2020

10:00am

Note:

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

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

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Published 3 July 2020

Agenda
Meeting of the Board
8 July 2020

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

Time: 10.00am

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

Agenda

Please note that agenda times are estimates only

Karakia – Meeting to open with a Karakia

10.00am **1.** **ATTENDANCE AND APOLOGIES**

Executive Leadership Team members – Mark Edwards, Chief Quality, Safety and Risk Officer, Margaret Dotchin, Chief Nursing Officer, Shayne Tong, Chief Digital Officer and Dr Margaret Wilsher, Chief Medical Officer

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

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

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

10.10pm **3.** **CONFIRMATION OF MINUTES OF 20 MAY 2020**

3.1 Confirmation of the Open Minutes of the Board meeting of 18 June 2020

	4.	**ACTION POINTS**
10.12pm	**5.**	**EXECUTIVE REPORTS**
	5.1	Chief Executives Report
	5.2	Health and Safety Report
	5.3	Human Resources Report
10.45am	**6.**	**PERFORMANCE REPORTS**
	6.1	Financial Performance Report
	6.2	Planning and Funding Outcomes Update
11.15am	**7.**	**COMMITTEE REPORTS - NIL**
	8.	**DECISION REPORTS - NIL**
	9.	**INFORMATION REPORTS**
	9.1	Taking bigger strides: Sustaining health services and tackling persistent health inequity through national public advocacy to address structural and commercial determinants of obesity and alcohol related harm
	10.	**GENERAL BUSINESS**
11.15am	**11.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Next Meeting:	12 August 2020 at 10.00am A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

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Attendance at Board Meetings

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

2020/2021

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

Attendance at Board Meetings

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

2019/2020

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

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

Register of Interests – Board

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

	Vital Healthcare Properties	
William (Tama) DAVIS	Director/Owner – Ahikaroa Enterprises Ltd Whanau Director/Board of Directors – Whai Maia Ngati Whatua Orakei Director – Comprehensive Care Limited Board Director – Comprehensive Care PHO Board Board Member – Supporting Families Auckland Board Member – Freemans Bay School Board Member – District Maori Leadership Board Iwi Affiliations – Ngati Whatua, Ngati Haua and Ngati Tuwharetoa	02.07.2020
Fiona LAI	Member – Pharmaceutical Society NZ Pharmacist – Auckland DHB Member – PSA Union Puketapapa Local Board Member – Auckland Council Member – NZ Hospital Pharmacists' Association	10.12.2019
Bernie O'DONNELL	Manager – Manukau Urban Maori Authority Chair – Board of Trustees – Waatea School Deputy Chair – Marae Trustees – Nga Whare Waatea marae Executive Member – Secretary – Te Whakaruruhau o Nga Reo Iriangi Maori Director – Maori Media Network Te Matawai Funding Panel – Te Pae Motuhake o Te Reo Tukutuku Member – Ministry of Corrections Reference Group for AOD, Alcohol and other Drugs Addictions	19.03.2020
Michael QUIRKE	Chief Operating Officer – Mercy Radiology Group Convenor and Chairperson – Child Poverty Action Group Director of Strategic Partnerships for Healthcare Holdings Limited	27.05.2020
Ian WARD	Director – Ward Consulting Services Limited Director – Cavell Corporation Limited Trustee of various family trusts Oceania Healthcare – wife shareholder	21.05.2020

Minutes
Meeting of the Board
20 May 2020

Minutes of the Auckland District Health Board meeting held on Wednesday, 20 May 2020 via Zoom commencing at 10.00am

Board Members Present	**Auckland DHB Executive Leadership Team Present**	
Pat Snedden (Board Chair)	Ailsa Claire	Chief Executive Officer
Doug Armstrong	Dr Karen Bartholomew	Director, Health Outcomes for ADHB/WDHB
Michelle Atkinson	Mel Dooney	Chief People Officer
Zoe Brownlie	Margaret Dotchin	Chief Nursing Officer
Peter Davis	Mark Edwards	Chief Quality, Safety and Risk Officer
Tama Davis	Joanne Gibbs	Director Provider Services
Fiona Lai	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Bernie O'Donnell	Rosalie Percival	Chief Financial Officer
Michael Quirke	Meg Poutasi	Chief of Strategy, Participation and Improvement
Ian Ward	Shayne Tong	Chief Digital Officer
	Sue Waters	Chief Health Professions Officer
	Dr Margaret Wilsher	Chief Medical Officer
	Auckland DHB Senior Staff Present	
	Rachel Lorimer	Director Communications
	Alex Pimm	Incident Controller COVID 19 Response Lead
	Marlene Skelton	Corporate Business Manager
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

The Board Chair, Pat Snedden welcomed the media in attendance to the meeting.

The Board Chair advised that the Board was at a mid-point between fully returning to the Board meeting schedule and having face-to-face meetings. Working with the Zoom process was effective and efficient but sometimes did not allow for a nuanced meeting and he would do what he could to make sure that everyone was included in the way that they needed to be to have a full discussion.

Karakia

Tama Davis spoke acknowledging Pat Snedden's leadership and also the very real loss that has happened through the period of lock down to our communities. Tama then led the Board in a Karakia.

Acknowledgements Of Contributions Made During COVID 19

The Board Chair, Pat Snedden opened making the following statement:

"I want to begin by offering a very warm thank you to all staff, the Board, and those that have in this period performed over and above anything expected of them before and who had been instruments of calm in this process where we as a nation have been very significantly challenged. We have seen the health sector rise to the challenge which has been highly honourable in a process that has been fraught at many points; in fact there has been great commitment to duty and to doing the right thing. I want to honour the clinical community, the people that work in our health system both in

the hospital and out in the community who have adjusted, adapted and innovated in this period of time. We as New Zealanders are blessed to have had a health community that has been so generous and accurate in being able to meet our needs to the extent that we have dodged the worst of Corona Virus so far. We can be hugely thankful for the systems that have been put in place nationally, regionally and in our local DHB that have protected our people, protected our citizens. It has been a remarkable experience to be in a position of leadership through this process where we have seen extraordinary cooperation and very clever innovation take place in a very short time and where there has been a commitment in the most stressful of circumstances. People have fronted up to the challenge.

The first thing I want to acknowledge today is the great contribution that our health governance and health workers groups have made to keeping New Zealand safe and dealing with all the aspects that have arisen from this situation. This is a poignant opportunity to express this because we appear, at least on the face of it, to be coming through this situation safely. It has been a journey of huge pressure in the system which has resulted in such a scale of intervention that we have been able to keep our population safe. My salutations and thanks to those workers and to those of you who have had to navigate a lot of complicated decision making and have managed to do that with accuracy and good humour and where things have mucked up, we have fixed them.

Thank you to you all."

LATE ITEMS OF BUSINESS

In accordance with Standing Order 3.2.9 (5) a resolution is required to be passed to allow late items of business to be considered in the confidential agenda.

There are two items:

Confidential Report - COVID-19 hospital impact status
The reason why this item is not on the agenda is that information relating to the hospital impact status level became available after the publishing of the agenda. It is required to be considered at this meeting so that the status level can be adjusted based on confirmed current activity.

Request for Authority over the Auckland DHB business information in relation to the DHB NZBN
The reason why item is not on the agenda is that the Ministry of Health (MoH) only yesterday launched a NZ COVID Tracer App. The authority sought is to enable the DHB to implement Covid-19 Contact Tracing in line with Ministry of Health requirements.

Resolution: Moved Pat Snedden / Seconded Tama Davis

That In accordance with Standing Order 3.2.9 (5) and for the reasons set out above the Board consider the following late items of business, Confidential Report - COVID-19 hospital impact status and Request for Authority over the Auckland DHB business information in relation to the DHB NZBN, in the confidential agenda, noting that at this time the Information contained in these report is related to current commercial activities

and Auckland DHB would be prejudiced or disadvantaged if that information was made public.

Carried

1. ATTENDANCE AND APOLOGIES

That the apology of Jo Agnew be received.

That the apologies of staff members Dame Naida Glavish, Rikki Nia Nia and of Rosalie Percival (for a short absence from the meeting) be received.

2. REGISTER AND CONFLICTS OF INTEREST

The Following amendments were advised:

Michelle Atkinson
Remove – "Contracting role with Shea Pita and Associates'
Ian Ward - Update
Director Ward Consulting Services Limited
Director Cavell Corporation Limited
Trustee of various family Trusts
Oceania Healthcare - wife shareholder
Zoe Brownlie
Remove RockEnrol position, and add in "Director at 'The Way We Work'" under "Belong" role.
Pat Snedden
Add "Member - Health Partners Ltd".
Remove "National Science Challenge - E Tipu e Rea A Better Start"

There were no conflicts with any items on the open agenda.

3. CONFIRMATION OF MINUTES 26 FEBRUARY 2020 (*Pages 9-23)*

Resolution: Moved Pat Snedden / Seconded Zoe Brownlie

That the minutes of the Board meeting held on 26 February 2020 be confirmed as a true and accurate record.

Carried

[Secretarial Note: Items 3.1 through 3.4 were taken as one.]

3.1 Open Minutes of the Executive Committee of the Board 1 April 2020 (*Pages 24-28)*

Resolution: Moved Pat Snedden / Seconded Tama Davis

That the minutes of the Board meeting held on 1 April 2020 be received.

Carried

3.2 Open Minutes of the Executive Committee of Board 13 April 2020 (*Pages 29-34)*

Resolution: Moved Pat Snedden / Seconded Tama Davis

That the minutes of the Board meeting held on 13 April 2020 be received.

Carried

3.3 Open minutes of the Executive Committee of the Board 24 April 2020 (*Pages 35-38)*

Resolution: Moved Pat Snedden / Seconded Tama Davis

That the minutes of the Board meeting held on 24 April 2020 be received.

Carried

3.4 Open Minutes of the Executive Committee of Board 1 May 2020 (*Pages 39-44)*

Resolution: Moved Pat Snedden / Seconded Tama Davis

That the minutes of the Board meeting held on 1 May 2020 be received.

Carried

4. ACTION POINTS (*Page 45)*

There were no outstanding actions points requiring consideration.

5. EXECUTIVE REPORTS

5.1 Chief Executives Report (*Pages 46-50)*

The Chief Executive, Ailsa Claire asked that her report be taken as read advising that it was a very high level summary of what occurred during COVID 19.

Ailsa reflected back to when the COVID 19 response team was first stood up it was anticipated that New Zealand was going to experience the same sort of situation that was occurring in other counties. What was stood up at that time was in response to that threat and to provide the resource required to deal with such a situation.

This team was set up in a structure that was different to the emergency management team structure that we are familiar with. Most Emergency Management Teams are only in existence for a short period. This was required to be in place for a considerable time.

In the early days of setting this up people were working incredibly long hours, every weekend and people gave of their time generously and without complaint. It is a credit to the organisation.

The Regional IMT which was staffed by a majority of the members of the Auckland Executive Leadership Team.

A lot of work was done early on risk assessing employees and those that needed to work from home or the vulnerable that needed to stay at home. Elective surgery was cancelled

but every attempt was made to undertake surgery from the P1 list where a patients situation was considered life threatening and later on patients that would have moved to the P1 list if surgery was not performed. This was an amazing effort by the Auckland DHB staff and something to be proud of.

During this time Management also stood up a lot of communication with patients, across the region and internally. Twice weekly Zoom meetings were provided for staff to tap into so there was an opportunity for information to be shared and for a question and answer session.

The internal communication programme has been a learning exercise and the DHB will be using what was learned moving forward. .

Ailsa was particularly proud of the work that was done in relation to supporting staff, the information given to them in how to protect their own whanau and the work done in relation to supporting low paid workers and patients who were struggling.

There were two screening tents established, one outside the ED department with screening for people coming into the hospital during Level 4 and a further screening tent at Carpark B to screen staff. Over 2000 staff were screened as part of the surveillance screening programme required to assist with data required to make the decision to move down a level.

The DHB has a very high flu vaccine rate for both community and staff within the DHB. However Maori vaccination rates need to improve.

The following was covered during discussion:

- Peter Davis commented that it was his understanding that the other DHBs had elective surgery performed from a different site and did that mean that they could continue to offer a higher level of elective surgery than Auckland DHB? Ailsa Claire advised that at Level 4 all DHBs were preparing for a pandemic so any activity that could be deferred, was deferred. This period enabled DHBs to get ready for a large influx of COVID positive patients and to train staff. It was not until DHBs reached Level 2 that the external requirements associated with travel restrictions enabled additional elective surgery to be undertaken.
- Ian Ward asked how flu vaccination rates, as at 1 May 2020, compared with those of the same period last year. Margaret Dotchin advised that as at 1 May 2020, 7,500 staff had been vaccinated compared with 5682 staff at the same time in 2019. There is no staff break down by ethnicity however the external rate of vaccination for Pacific is very good but the Maori rate of vaccination is not as high as for non-Maori or Pacific.

Resolution:

That the Chief Executives report for April-May 2020 be received.

Carried

[Secretarial Note: Item 6.1 was considered next.]

5.2 Health and Safety Report (*Pages 51-64)*

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

The key focus within Health and Safety at this time is on occupational health which has become a lot more prominent over the last couple of months due to COVID 19. The volume of work has increased. The Occupational Health service used to get between 1 and 20 calls per week for advice and that has now increased to between 5 and 20 per day at this time. That seems to be because people are more aware of the existence and importance of the service. It is evident that this team needs good support so that they are able to provide a good service now that people want to use it. It reflects the prominence that they have had within the organisation over the last weeks. They have worked well through some very trying circumstances.

Mark Edwards drew attention to page 57 of the agenda and the item "Respiratory Protection and COVID 19" advising that this is a programme of work that has traditionally existed but now needs to be expanded to become an integrated programme. It needs to encompass PPE supply, some parts of Occupational Health that looks at things such as suitable equipment, that the equipment fits people, that the environment that people are working in suits that type of equipment and there is also a clinical delivery aspect to be considered.

The following was covered during discussion:

- The Board Chair, Pat Snedden asked whether the staff knowledge, experience and expertise in utilising PPE was higher than it had been. Mark Edwards advised that, yes it was, but qualified that by adding that there was still more work to do in this area and that it had been a good opportunity for people to look at how they actually undertook their work giving consideration to the environment that they worked in and how the work flow is orchestrated. This needs to be captured to ensure improvements are made.
- The Board Chair, Pat Snedden asked whether the staff feel now that they understand the value of the gear and have the ability to use it correctly. Mark Edwards advised that the anxiety levels had reduced significantly. A focus would be kept on this area so that if there was a need to step things up again staff were comfortable and confident to be able to do that.
- The Board Chair, Pat Snedden asked Mark Edwards if anything else of note had been identified. Mark Edwards advised that another area of focus was related to vulnerable staff and fitness for work. There had been good links develop between Human Resources and Occupational Health in this area which will be enduring. Contact tracing was a further area that required a focus to remain.

Resolution:

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

Carried

5.3 Human Resources Report (*Pages 65-69)*

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

That the progress against the People Plan had been impacted by displacement through COVID 19 activity. The team have been part of the overall response and Mel was proud of how the team had come together and been flexible and responsive and cared for each other in a time that it has been necessary to do so.

The team had been involved in a number of activities but what is important right now are the four bullet points on page 67 of the agenda that will require more careful thought moving down the alert levels, in particular, the "To Thrive" programme and working with low paid workers.

The Board Chair, Pat Snedden commented that whilst the organisation had moved to a "living wage" some of those low paid workers were still under pressure through others within their whanau having lost jobs. Mel Dooney commented that in most houses those on low incomes were not the sole contributor to what made that household work from a financial sustainability perspective. We now see an increasing number of people who do not have their basic needs met and therefore be able to continue to come to work.

There is some occupational health assessment work being undertaken involving the Human Resources team to deal with the wellbeing and health needs of the workforce in a more fulsome way.

There have been several flexible changes introduced in the workplace which have involved strong engagement with the unions. Some of those changes that have worked are being looked at to be taken forward into the future way of working.

The Board Chair, Pat Snedden asked Mel to comment on what she considered to be one of the most powerful innovations to evolve within the Human Resources area during COVID 19 with Mel commenting that there had been many. The team being able to come together and get change made quickly had been notable and while not an innovation per se it had led to a significant improvement in service delivery, values, alignment and communication. This needs to be continued to what extent we can, given that it comes with a cost to peoples personal lives.

The following was covered during discussion:

Zoe Brownlie asked if there had been any lessons learned around online induction, fast tracking of recruitment and online on-boarding that would be continued in the future with Mel Dooney advising that a lot had been done because it was required but the effectiveness of this now needed to be evaluated against old practise so that the successful parts could be identified and retained. Training is not being considered in the same way that it had been have done previously but at the same time HR was conscious that online navigate does not provide a sense of community, belonging or aid relationship building. A little of the best of both worlds will need to be provided.

Resolution:

That the Board receives the Auckland DHB Human Resources report for May 2020, noting both the impact of COVID activity on progress against the People Plan Objectives and the significant activity which the team has been involved with as part of the COVID response.

Carried

[Secretarial Note: Item 6.2 was considered next.]

6. PERFORMANCE REPORTS

6.1 Financial Performance Report (*Pages 70-76)*

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

The March variance was $10.3M against budget year-to-date. The major impact on that was the impact of the strikes earlier in the financial year and the beginning of the expense showing for COVID related cost.

We don't yet have funding advice on COVID related cost compensation for the Provider Arm and the Ministry have indicated that they will wait until year end and undertake a wash-up. We do not know what differences there will be in the revenue setting. In the DHB forecast we have a worst case scenario if we are not paid for the IDFs as we would normally have been paid if we had delivered them in April and similarly around electives.

Some good news coming through in April is that we had been forecasting that there would be $15M unfavourable position year end due to additional leave liability but that now appears to be more in the vicinity of $5M-$7M unfavourable. There has been leave taken in April so the balance has not escalated as much as expected.

If the COVID impact is removed from the March and April results the actual bottom line is well within budget. The only other issue was the impact of the strikes earlier in the year on electives.

The following was covered during discussion:

The Board Chair, Pat Snedden was assured that there was no indication that there should be concern over the COVID related cost compensation for the Provider Arm; it is more the uncertainty over what form the compensation would take and when it would occur. Most of the Funder and Public Health costs have been reimbursed. The wait is really associated with what the Ministry will do in relation to the revenue settings based on how much is recovered in the last few months now that the country is out of Level 4 and getting back to delivering services.

Resolution:

That the Board receives this Financial Report for the nine months ending 31 March 2020

Carried

[Secretarial Note: Rosalie Percival left the meeting at this point. Item 5.2 was considered next.]

6.2 Planning and Funding Outcomes Update (*Pages 77-94)*

Director of Funding – Auckland-Waitemata DHBs, Debbie Holdsworth asked that the report be taken as read, advising that there were three things that she wished to highlight.

COVID 19 has had significant impact for staff who have been diverted from business as usual.

In the community space a number of the services by government definition were not classified as essential but there has been a lot of work done to ensure that they were in a position to retain their staff and the focus is now on transitioning back staff and standing up those community services with a prioritisation focus on Maori and Pacific.

Debbie Holdsworth drew attention to page 83 of the agenda and 6.2 "Uri Ririki the Child Health Connection Centre" and thanked and acknowledged Tama Davis and Bernie O'Donnell for their engagement and support at the powhiri which was welcome and appreciated.

Debbie Holdsworth drew attention to page 88 of the agenda and the Ministers letter endorsing the establishment of the Iwi Partnership Board.

Earlier in the meeting Maori flu vaccination rates were raised and as of yesterday the Ministry had agreed to fund additional Maori services, this relates to the three Maori mobile units that were operational during alert level 3 and 4. Debbie wished to acknowledge the leadership of the Chief Executives Ailsa Claire and Dale Bramley in terms of underwriting that case in terms of enabling the funding to be obtained. This will allow an increase in the number of mobile vans in metro Auckland and Auckland DHB itself. These units are nurse led and include social workers, mental health professionals and community support workers and allow a wider approach to vaccination. In terms of the approach used 3000 more older Maori were vaccinated in the last month. There is confidence that this is a successful strategy and that it will be reflected in an increase in the numbers.

There has been a lot of work done to obtain data to be sure we can identify target populations. The following was covered during discussion:

- Peter Davis drew attention to page 80 of the agenda and the reference to aged residential care facilities and asked whether the experience of gained from COVID 19 would help in the winter flu season and whether COVID had brought the wider issue of infection control to the fore in these facilities and whether it would make a difference to patients turning up to ED in the winter from these aged care facilities. Debbie Holdsworth advised that the experience has been helpful and while aged care facilities are regularly audited against standards it has highlighted that those standards could be improved so numerous learnings have come from those visits. The Ministry of Health is likely to change those standards set for audits which will in turn lift infection control requirements.
- Peter Davis drew attention to page 82 of the agenda and the reference to ASH rates and asked for an explanation of what they were. Karen Bartholomew advised it

stood for “Ambulatory Sensitive Hospitalisation”. What was referred to here is matching primary care to priority groups for vaccination and that was initially with the 65+ and then to 0-4 system level measures. This was the ASH cohort of children that have been into hospital and that was then extended across the age range. It was to help Primary Care identify and prioritise those who stood to benefit the most in receiving a flu vaccination.

Peter Davis asked if there was any way of identifying, under the umbrella of a PHO, any particular general practices which were having difficulty in preventing the occurrence of ASH admissions in the under 5’s for example or if it was that you simply had to trust the PHO to do something about it? Karen advised that this activity was specified in a system level measures work stream on childhood and adult ASH. There is a whole programme of work supporting that. It involves looking at those rates by practice and comparing practices and looking at activities and sharing learnings. Peter Davis commented that he was assured to learn that there was a quality improvement programme to improve these rates.

The Board Chair, Pat Snedden asked Karen to describe how practices were worked with to obtain the required improvement. Karen advised that there are a range of activities under the system level measures programme. They relate to conditions for ASH and one of the activities is looking at flu vaccinations for children aged 0-4 as they are one of the highest cohorts for hospitalisation for respiratory conditions. There is a programme of work around sharing learnings in this area with outreach providers as well as primary care. There are work groups that sit under each of the activities. Peter Davis commented that he was assured that this occurred and asked that reports back, on occasion, were provided to the Board as part of a wider equity lens as this would predominantly affect children from disadvantaged homes.

- Peter Davis referred to page 85 of the agenda and asked what proportion of home births was occurring. Debbie Holdsworth advised that she did not have the specific increase experienced during COVID but would obtain it. Peter Davis advised he was attempting to prompt discussion around whether some of these types of things could be shifted from the hospital environment relieving pressure by having them occur in the community. Ailsa Claire advised that there was a strategy related to primary birthing, home birthing and midwifery and she anticipated that at the next Board meeting a paper would be tabled putting forward ideas of what might be done in this area. It is anticipated that the Heather Simpsons review would also contain recommendations in this area that the Board would need to engage with.

  Board Chair, Pat Snedden commented that one of the observations that Peter Davis was making was that during this period there was a lot of care delivered closer to people’s homes by virtue of different methods such as a digital interaction that may have demonstrated an opportunity that engagement could occur early in areas of vulnerability and meet that vulnerability with an intervention that suited the individual providing more effective care.

  Ailsa Claire commented that she agreed in general but pointed out that this reference was to wealth women choosing to birth at home rather than come into

the hospital. Clearly this was enabled. The greater concern was with the vulnerable women who during this period may have missed antenatal care.

- Doug Armstrong commented that the general issue of moving primary care closer to the patient was something that required further discussion. Doug was unaware of the percentage of the population that were enrolled in a general practice under a PHO but felt that this was a major equity issue. His understanding was that general practices were operating at half capacity. Doug felt that this should be capitalised on and that GPs had a part to play in improving enrolment by contacting disadvantaged people, Maori and Pacific Island people and talking to them about their health and well-being. In his opinion this was one of the biggest steps that could be made to advance the equity of outcomes. He felt it never got addressed and that every person should be able to have a carer and be able to nominate who that carer would be.

  Ailsa Claire agreed that a conversation was required as the model of care for private practice was quite often not the one that people wished to engage with. That was why the mobile vans for Maori had proved so successful. There are others ways for people to engage over their health needs and this will be a long but important conversation. Meg Poutasi advised that the Pacific health providers during COVID 19 were regularly contacting households that identified as vulnerable which enabled them to match up their data relating to a number of issues and allowed a Pacific mobile van to do outreach for the whole family in addition to offering baseline primary care support. There is quite a bit of outreach being undertaken already but it is the model going forward that the community itself would really like that needs to be determined and how that will meet the needs of a whole family or a whole segment of the population. We are now seeing older people coming back in wanting face-to-face consultations, which is where telehealth is an option.

- Peter Davis commented that he agreed with Doug Armstrong that this was a real opportunity. His view was that while there were Maori and Pacific health providers the greater proportion of Maori and Pacific went to GPs that are not Maori or Pacific. That solid, conservative, main midstream of Pakeha and international GPs need to be engaged with to do something along the lines that Doug Armstrong has suggested to keep them in touch with what is a mobile population.

- Michelle Atkinson commented that the Maori and Pacific mobile clinics had had spectacular results making connections with families who had previously not had support from health services. We need to be aware of that.

- Fiona Lai drew attention to page 81 of the agenda and item 6.1 “Child immunisation” noting the COVID impact on the coverage during quarter four of whanau feeling reluctant to break their bubbles. Fiona considered there was a need to continue to target the vulnerable and particularly children and in doing so a need to consider other channels and ways of communication so that people know there are other ways to get their child immunised.

- Peter Davis drew attention to page 93 and the reference to the ophthalmology

service asking whether the comments meant that the service was going to be improved. In the past this had been charity service which had been improved but which he felt could be further improved. Ailsa Claire advised that the reference was to investigating whether there were greater efficiencies to be gained by offering the service differently. Ailsa commented that she was incredibly proud of the service as pre COVID it did not have significant wait times, it did not have significant numbers of people waiting for follow up and was a good high quality service.

Jo Gibbs commented that there was a board approved regional strategy for ophthalmology and the work referred to by Ailsa was to make sure that the strategy is moved forward so that the recommendations already approved by the Board are met.

Debbie Holdsworth advised that Auckland and Waitemata DHBs were receiving excellent service and that the commentary in the paper related to the inconsistency in service that Northland may be experiencing.

- Peter Davis drew attention to page 94 of the agenda and the radiology indicators. There was comment around not being able to get staff and having to outsource which worried Peter as this started a spiral where the private sector hired people at higher wages who are not available to the public sector and then the public sector had to undertake more outsourcing. Peter wanted to know if there was a way of breaking that spiral. Debbie Holdsworth commented there was concern with the recruitment pipeline currently being disrupted, although there was the benefit in not losing staff to Australia at this point. The focus was on trying to address this balance and in the conversations with the private sector it had been made clear that the intent was not to undermine the public workforce with the use of private sector resource.
- Tama Davis wished to add to the earlier conversation around Maori providers and advised that a lot of work had been done within the regional IMT with Aroha Haggie and her Maori team in relation to the Maori mobile units. Tama wanted to confirm that those mobile units were being used to target the vulnerable and hard to reach members within PHOs and to get them to engage.

Resolution:

That the Board note the key activities within the Planning, Funding and Outcomes Unit since the last update provided on 26 February 2020.

Carried

7. COMMITTEE REPORTS

7.1 Hospital Advisory Committee Unconfirmed Minutes (*Pages 95-105)*

Resolution: Moved Tama Davis / Seconded Fiona Lai

That the unconfirmed minutes of the Hospital Advisory Committee for 18 March 2020 be

received

Carried

8. DECISION REPORTS

8.1 hA Class C Share Issue (*Pages 106-107)*

The Chief Executive Officer, Ailsa Claire asked that the report be taken as read advising that periodically healthAlliance is required to make a retrospective issuance of C Class shares which are used by healthAlliance and the DHBs as a mechanism for consideration of IT assets being transferred from the DHB ownership to healthAlliance.

The following was covered during discussion:

Doug Armstrong was advised that regardless of DHB size each of the Boards got the same representation on the hA Board.

Resolution: Moved Pat Snedden / Seconded Doug Armstrong

It is recommended that the Board approve the issuance of $20,619,869 class C shares for healthAlliance N.Z. Limited.

Carried

8.2 Auckland DHB Credit Card (*Pages 108-115)*

The Chief Executive Officer, Ailsa Claire asked that the report be taken as read.

Ian Ward supported the request to use a credit card but felt that Internal Audit should be asked to review the expenditure charged to it. The Board Chair, Pat Snedden agreed.

Resolution: Moved Doug Armstrong / Seconded Michelle Atkinson

That the Board:

1. **Approves the establishment of a credit card in the name of Auckland DHB, which will be held centrally at healthSource and available for use under tightly controlled processes**
2. **Delegate authority to the Chief Executive Officer and Chief Financial Officer to sign the bank forms and documentation required for establishing the credit card account**
3. **Reviews the attached Credit card policy and provides feedback on required changes**
4. **Approves the Credit card policy, noting any changes suggested by the Board will be included in the final policy.**

Carried

9. DISCUSSION REPORTS

9.1 Auckland Regional Public Health Service Report on COVID 19 *(Pages 116-119)*

The Board Chair, Pat Snedden welcomed Dr William Rainger and acknowledged the work that had been done by ARPHS through the last months.

Dr William Rainger asked that the report be taken as read, advising that COVID 19 had been an exceptional event and one that has been going for the last four months for ARPHS where the service has had to scale up very quickly to deal with. There has been considerable support from the DHBs to do this.

Funding has been received directly from the Ministry for the COVID 19 response up until the end of this financial year. The challenge that remains is the sustainability of the response required. The Government has an expectation in terms of ARPHS ability to respond to outbreaks of COVID 19. The expectation is quite a considerable one in that ARPHS is being asked to manage up to 177 new cases per day. That is a large number of COVID cases. ARPHS is having to consider how to scale up to meet those expectations should that challenge arise.

ARPHS will engage with the Ministry further in terms of that level of response into the next financial year as there is no clarity around the cost of that at the moment.

ARPHS is going to need some form of structured regional support for the foreseeable future. Dr Rainger thanked the Board Chair for his acknowledgement of the work that has been done by the Service.

The following was covered during discussion:

- Peter Davis commented that this was a once in a life time event and that you would not be looking to establish a public health service that was ready to respond to such an event from a standing start. Peter asked what level the service should be funded and staffed at where it allowed for the required scale up to meet the Governments expectations and any future pandemic responses. Dr Rainger advised that it was about having a well built, well understood and well-practised national and regional pandemic response plan. Influenza pandemics come periodically, the last being in 2009 and we do not know when the next might be. It is about having the whole of the health and other sectors understanding their roles and being able to scale up and support a whole of health sector and whole of society response to a major event at very short notice.

  Peter Davis asked for an explanation of what “My Health Summary” was. Ailsa Claire advised that it is a patient summary care record which enables a practice to see information from another practice about a patient. It enables the DHBs to see more information from Primary Care. COVID 19 has provided an impetus to put this in place. Margaret Dotchin, Chief Nursing Officer advised that it was an initiative that came out of the Northern Regional Health Coordination Centre led by Primary Health Care and the Digital Team. It was put in place when CVAC and Mobile Testing Centres were stood up. Wherever a person sought access for testing there was

access to primary care information. Peter Davis wanted to be assured that this would continue to be available. Ailsa Claire advised that it would and that part of the regional IMT is being kept operational to oversee the completion of this initiative.

Bernie O'Donnell asked what was learned about Maori and Pacific engagement and any insights Dr Rainger could offer around what went well and what perhaps did not.

Dr Rainger advised that an internal review had been undertaken in relation to the Pacific are response which had put forward a number of recommendations amongst which better and more timely identification of interpretation needs and access to those services and not having a default setting or expectation that people will necessarily understand and for the service to be more fully proactive. Those living in challenged household circumstances where a number of people are reliant on welfare and if we are going to ask them to remain in quarantine the sector as a whole needs to be able to provide wrap around services. The regional welfare function during this pandemic has been good as this has not been available during other pandemics. It needs to be further enhanced and entry into the community can be gained through assisting contractors and services to support that. That has occurred via Whanau Ora providers and pacific Future providers. There have been some things that have been done that worked well and there are some things that can be improved on for next time.

Meg Poutasi advised that the reason that the Pacific review had been undertaken was because additional support had been stood up by the DHB to look at 85% of the Pacific positive COVID cases as there was interest in what the model of care was suggesting. Dr Rainger touched on what was found when he mentioned more timely identification of interpretation needs but there was also the understanding of what COVID was and offering self-isolation options to families as early in the clinical pathway as possible and then thinking about how to support that self-isolation for people. One of the recommendations from the review will be around ARPHS capabilities to manage that whole pathway. ARPHS is open to undertaking a similar type of review for Maori.

Michelle Atkinson commented that some of the success of the Maori and Pacific outreach programmes was attributable to the flexibility that was allowed in not predetermining what had to be delivered to each person. That has implications for how we work in partnership in the future.

Tama Davis commented that it would be good to see a Maori review to see what insights can be gained. It would be good to get a better sense of the public outreach and Iwi providers understanding of what their responsibilities were in conjunction with the IMT in relation to the stand-up of projects and processes and what made an effective outreach into areas that we would not normally be a part of including the regional welfare functions from both the perspective of the Iwi Maori provider and the Regional IMT. Dr Rainger advised that conversations were being had with Rikki Nia Nia and his team how to undertake that review and what the learnings might be.

Doug Armstrong commented that a country population wise we are only two thirds

the size of Sidney. He would instinctively favour a single public health agency. Border control and policy are national issues and it seems ineffective to fragment the national approach when New Zealand is such a small country and it is also one of the advantages of being a small country. Dr Rainger commented that Government has signalled that it would look at exactly at that issue and its intent was to look at a more centrally directed public health service. Public health services like other parts of the health sector have tended to be somewhat fragmented.

Ailsa Claire commented that what has become clear is that one policy or one process nationally is a good idea. The issues experienced in aged residential care have highlighted that too. The other issue that has become clear and it has been demonstrated with the Maori response and the contact tracing that has occurred in Auckland is it is essential that you understand the community that you are engaging with. It is a balance between having a nationally driven policy and then understanding your community and what is best undertaken locally.

Resolution:

That the Board receive the Auckland Regional Public Health Service – COVID 19 Response update report

Carried

9.2 Northern Region Health Coordination Centre – COVID 19 Update *(Pages 120-130)*

The Chief Executive Officer, Ailsa Claire asked that the report be taken as read, advising that it was an update of where the Centre is at currently and provides background information on the northern region and the three deaths that occurred within the region. It is the intent to move the Northern Region Health Coordination Centre to be a core ongoing requirement in relation to COVID. There is comment in the report about PPE and the issues in the supply chain. It also talks about the Maori and Pacific health response that has been in place and a little on CVAC. At the time it was written community surveillance testing was being undertaken. There were 100,000 tests undertaken in the northern region for COVID. That was part of the reassurance that the Government was seeking when it moved from Level 3 to Level 2 and will be required to move to Level one when they try to understand if there is any community transfer or hidden COVID in the community.

Resolution:

That the Northern Region Health Coordination Centre (NRHCC) COVID 19 Update Report be received.

Carried

9.3 Incident Management Team Update - COVID-19 Update *(Pages 128-130)*

The Director Provider Services, Jo Gibbs asked that the report be taken as read. Incident Controller COVID 19 Response Lead, Alex Pimm was in attendance to answer questions.

Jo Gibbs wanted to recognise the team approach through the IMT which had been extraordinary. Many people had made a huge contribution of time and effort often at the cost of what was happening at home. Jo recognised in particular the contributions of Alex Pimm and Emma Maddren who had essentially been leading the IMT team in a one and two roster 24/7.

The Board Chair, Pat Snedden passed on the Boards appreciation for the efforts made by Alex and Emma.

Alex Pimm commented that these events had shown Auckland DHB at its best and has shown what we are able to achieve when everyone is working together toward a common goal.

A huge amount of planning work that has occurred. Fortunately not many of those plans have had to be enacted. At the start of the process there was uncertainty around the number of cases that might occur nationally and within Auckland and the impact on Auckland Hospital. A number of different scenarios were planned for across all areas, inpatients, critical care, emergency department and the community teams. There has been some excellent clinical leadership throughout that planning process as well as working with regional partners and other DHBs. We have seen a huge change to the way we work. A large number have worked from home, there have been people implementing things across their departments in order to deliver physical distancing, to look at and ensure that the care we provide for the patients continues to be off a high quality whilst ensuring that we do everything possible to protect our staff. A whole team of people have been working on the supply chain which has been disrupted and continues to be in order to mitigate the impact so that the region can continue to safely operate.

The following was covered during discussion:

- Peter Davis asked if any recommendations were going to be made to the Government on changes to their guidelines on alert levels 3 or 4. For example, alert level 3 allowed a plumber as an essential service but elective surgery was not classified as such. Alex Pimm advised that it was important to note that some elective care was being providing during all alert levels but in line with the recommendations that was prioritised. Urgent clinical work did continue throughout that period. Jo Gibbs advised that there was a distinction between the national alert levels which were driven by cabinet as opposed to the hospital alert levels. The provider alert levels were based on safety for patients and staff within the hospital. Life and limb threatening planned care work was undertaken throughout all the alert levels. Important in doing that was that people were kept safe and physical distancing was maintained. This approach has been consistent across the region and consistent nationally.
- The Board Chair, Pat Snedden asked Alex what the stand out things had been for him during this time and that should be continued. Alex felt that it had been demonstrated the that organisation could pull people with a range of skills and knowledge and experience who can all contribute to a common goal and deliver in a short period of time. It would be good to replicate that to deal with some of the other big problems that historically have been difficult to solve and not had as much

progress made with them as we would like.

Some of the ways in which decisions have been made have worked well and an opportunity exists post COVID to replicate that. Some thought could be given to how to get the right information to the right people to get the right robust decisions.

The Communications Team have worked incredibly hard to get the right messages to key audiences. The range of activities that they have undertaken is considerable from social media videos that have a quirky messages, the way that the twice weekly meetings have been stood up, the briefings across the organisation using a webinar approach, these are all things that can learned from to enhance engagement with our people.

Doug Armstrong commented that a number of senior clinicians would have been under-utilised during level 4 and there was an opportunity that proactive contact could have been maintained with patients and he considered that this may not have occurred. Alex Pimm advised that early in the pandemic virtual and remote clinics for patients were enabled so clinicians were able to conduct out-patient appointments using Zoom and other technology. A large amount of money was invested in this area enabling face-to-face consultations to occur where required. Clinicians have not been under-utilised they have had to adapt to different ways of working with their patients. The initial feedback is that out-patients have engaged incredibly well with that process. This offers a new opportunity as to how we offer service moving forward and will part of our "Locking in the Gains" piece of work.

Resolution:

That the Board:

1. **Receives the COVID-19 Incident Management Team Update report for May.**
2. **Notes the activities and success of the Auckland DHB incident management team since January 2020**

Carried

10. INFORMATION REPORTS

10.1 Supporting the Government Push for Increased Equity in Healthcare *(Pages 131-136)*

The Board Chair, Pat Snedden felt that it was important to lay out why the Board was doing what it was doing. Firstly there was the question of how you implement equity and how you measure it, how you pay attention to it. There are numerous tricky questions associated with it. Pat thought that it was a valuable exercise for he, as Chair of the Board, to make clear the "why" of what the Board was doing. Where the uncertainties lie, and there are plenty of them and how you actually manage to get improvement in the system.

"What we have historically has been measured and found wanting in some respects, particularly if you look at though a treaty lens."

Pat commented that he had spent 35 years involved with the Waitangi Tribunal in support of

claims and as a chief negotiator for the Crown. In a personal sense Pat had had a very intimate understanding of the pressures that sit in amongst the tribal communities, particularly claimant communities. It had taught Pat that you cannot take things at face value. There is a complicated arrangement around engagement with the Treaty historically. It is only since the 1970s with the introduction of the Waitangi Tribunal and the enabling of the claims to go back to 1840 that an ability has existed for mature national conversation to take place.

There is a community of people who are variously educated about the nature of our historical engagement; tangata ti tiriti with tangata whenua. When the Board sits to consider resource allocation and have the discussion in order to meet our health constitutional requirements which are set out in the Health and Disability Act, it means that we have to be smart about it, accurate in what is done and while we have to be as cautious as we are in every other part of the business; it also means that we have to be brave.

The point of laying this out is to give members a sense of confidence that this is not any kind of reckless activity but that this is an experienced approach to addressing issues that we all know exist but often don't have the opportunity to make a difference in. The way that the paper is laid out is to indicate that there has been a clinically assessed lack of capability in meeting the needs of Maori. There would hardly be a clinician around the country working within a Provider Arm that would dispute this. This Government has made it absolutely clear that it wants to see equity advanced.

What do we do in our space to enable this to happen? How do we be smart in this, how do we be morally and ethically right about it? What do we do about the nature of the inevitable trade-offs? Therefore, if we are to become astute and enabling in this process what choices do we have to put up and make?

The paper attempts to set out all the counterfactual issues around this. It also lays out where the areas of intent ought to be. We know that the hospital is no-where near the be all and end all of treating inequity. We know that community care is a powerful and absolutely necessary way of preventing people from showing up at the hospital doors. We have a really clever clinical community with great epidemiologist knowledge who can actually put their finger on the things that make a difference. We have a set of leaders in the system who are prepared and willing to make change, to do it positively, to do it on the basis of evidence, to enable and encourage the clinical determination of evidence but to also include amongst that determination the cultural value sets, the things that are important to the people that they are in service of.

This is all about the way in which we use the power of our opportunity set here to focus and to positively change outcomes for the community. Normally under the heading of equity but also specifically meeting our constitutional treaty obligations. We need to recognise that when things are done well for Maori things go well for others too who are in need of the equity solution as well.

The paper is to encourage us to be broad thinking in the way we intervene and to be able to understand that there is good moral purpose to do this.

There are some things that came out of the pandemic that are very important. Firstly the

Maori capability to manage their own pandemic response and to provide the support required of the right kind and at the right time was illuminating when considering future possibilities. That response was resourced and then partnered with by Maori institutions that could make it right for their own people and they did. The history of pandemic for Maori is awful but in this case the intervention strategy was brilliant with an outstanding outcome. Consider the position of the Pacific community which was at maximum exposure with intensive overcrowding issues and yet they managed both a testing regime and an infection reduction. Why did that happen? We resourced it and let them get on with doing what was right for them.

What we have from this are gems of learning which in our context as a DHB we need to absolutely pivot off. We need to be un-defensive about it. What we are finding out about fellow citizens and New Zealanders is that there are ways of doing things that improve outcomes that are way better than what we have been able to do before and we should back them.

This paper is to encourage us to engage clinically and culturally with these communities to understand our Treaty responsibilities as an additional and necessary part of being tangata ti tiriti and tangata whenua and to get on with it and define as we go all the necessary genus that we will need to make change in a positive way and to be proud about it. That is the intention of the paper, for it to be discussed and if you are comfortable with it to adopt as the Boards steer for the way in which we will make future decisions and for the way in which the Board will go about this.

The following was covered during discussion:

Peter Davis

Concurred that Maori and Pacific had done a good job in setting up their own responses. However, the truth was that the effective intervention actually was associated with an early lockdown. The disease was brought to this country by middle class Pakeha who were travelling and who were in their 20s through 50s. The lockdown meant that before COVID could spread into other communities it was contained. We were lucky not clever. Marist was the only cluster where there was a 40% Maori and Pacific infection rate. Otherwise 50 % of the infections were related to Pakeha.
Pat Snedden disagreed and felt that it required a very direct and strategic intervention which, Maori in particular, had got onto early and had managed in a good way preventing a higher and wider infection rate in that community.

Bernie O'Donnell

Commented that living with a life threatening disease is not unusual some people live with that daily, things such as diabetes and heart disease. It was difficult to get some traction with our communities because they are just a complex lot that have different rules of engagement so the way in which they were engaged with was in trying to meet their basic needs, which was related to kai, and then using that opportunity to make sure that the whanau were safe. Bernie agreed that COVID was a middle class white man's disease but similar to the struggles that Maori and Pacifika communities face daily and is nothing new.

Bernie questioned where the Maori face was throughout the pandemic. He thought that the

DHB had done a tremendous job in terms of rolling out a DHB strategy. Bernie felt there was some confusion around equity and the Treaty obligations which were two different conversations. The model put up as the Northern Regional construct does not sit right in terms of what mana whenua might look like. It was very black and white for Bernie in terms of who mana whenua is in the Auckland DHB district and who are maata waka (urban Maori). If you look at urban Maori and Pacifika their issue is in the equity space but if you look at mana whenua that is a different space. When you see in a Treaty narrative that you are mixing up our Pacifika whanau with Maori that is when Mana Whenu get upset. We need to be mindful of what the goal is here and that is about honouring the Treaty and that is about mana whenua. Bernie did not know what Pat meant when he referred to tangata whenua. For Bernie it was all about mana, mana is about authority and mana whenua's authority in terms of being part of discussions in relation to whenua. We need to understand that or more confusion and upset will be created. The equity space Bernie accepted and the Northern Region model is fit for discussion and having a conversation with our whanua from Pacifika is a good conversation to have. Bernie posed the question, what does equity look like, because there are Maori health organisations that talk about the wider social and health determinants that see Maori end up in the DHBs and it is usually because they have had generations of illness and social issues and they are already damaged by the time they get to the DHB. The closest thing that addresses these inter-generational issues is Whanau Ora. The problem with Whanau Ora is that we struggle to get an engaged system and for Bernie the beginning of a really good conversation about equity is about whether the right people are in the right spaces determining the strategy for the drive toward equity. Most of the Maori communities are in the same place they have always been and that is at the bottom of the cliff. Bernie would like to see the DHB who has the capacity and capability to understand that you can get real engagement by sharing power. Sharing power with those communities that need to be addressing equity, allowing collaboration and co-design and that starts to address all the issues. Bernie reiterated that he respectfully disagreed with Pats view of what a mana whenua Crown agency relationship with the DHBs looked like. Bernie did not think that it had been correctly landed with the existing paper and if he could he would ask that this portion be retracted but realised that it was probably not now possible.

To reiterate his position Bernie said that if he had to look at his rights the problem came back to the diversity of Tamaki Makarau, the size of the population, the unique dynamic between mana whenua and maata waka (urban Maori) like Bernie himself where all his Treaty rights are looked after in the area from which he comes from. He was not sure how what Pat proposed was going to work.

Bernie commented that he had noted the word "racist" being used today and had observed some discomfort at its use. The use of that word is aimed at critiquing and criticising the system that has failed the Maori community for generations and is not aimed at a person. We now have the chance to change that and that is very exciting.

Michelle Atkinson

Supported what Bernie O'Donnell and outlined around the sharing of power and that it is the system itself that is racist and the term is not being applied to individuals. Michelle said she was excited to see this paper, it was a bold move but Michelle felt that Bernie had raised

some good points that required further discussion. Michelle acknowledged that the Board had the mandate and the ability to change a system that is not neutral or value free in order to rectify things that are known not to work.

Doug Armstrong

Commented that he stood on a platform when elected to the DHB which was based on the "best possible health outcomes for the Auckland population". That of course includes Maori and Pacifika, people in quintile 5 and people in lower socio economic groups. Doug acknowledged Pats dedication to the implementation of the Treaty but in Doug's view a discussion about power, the Treaty of Waitangi and institutional racism is a Government discussion. If the Government want DHBs to move Maori and Pacifika people up the waiting list and give them more points for the elective lists, then they are entitled to instruct the Board to do that even though Doug himself would not personally agree with it as he felt it was the wrong approach. Doug agreed entirely with the sentiment to improve Maori and Pacifika outcomes but felt that there were other ways to do that. Preferential entry could be granted to a disadvantaged group or the DHB could place additional support into those disadvantaged groups and bring them up to a level comparable with the rest of the population. Doug thought that the initial idea was to go down a path of providing support and thought that was the motive behind setting up the Maori Iwi Partnership Board, which he supported 100%, as he supported the Government providing extra funding for Maori health improvements. Doug absolutely and completely disagreed with having a prioritisation system that is race based. It was an anathema to Doug who felt it was an attempt to address a wrong by committing an even greater wrong. He felt that the majority of the national population would not support racially based prioritisation for elective surgery or indeed any of the health provision that is offered.

Zoe Brownlie

Thought that the Board was in a position where it had a voice, it might not be at a national level but it had the ability to influence at a national level. The Board was privileged to be in that position and needed to use that voice to influence.

Zoe thought that it was important to differentiate between ti tiriti and equity because they are separate issues. She absolutely supported affirmative action and doing what was required to reach equal outcomes. It was obvious that different sectors of the community had different needs. There was a need to work together and support a change of the structure in order to achieve the required change in reaching equal outcomes.

Michelle Armstrong

Wished to have her disagreement with Doug Armstrong's point of view minuted. She commented that it was known that the system was biased and that there was a clear mandate in the Treaty and from the Government to make change.

Michael Quirke

Commented that the last $200b spent had not shifted the situation. It should be noted that in the last 20 years the health sector had not been able to move what it knew to be unacceptable. On the whole Michael supported the paper and saw it as guidance before

specific interventions could be made and was not exclusionary. The point that Michael wanted to highlight was that there would be trade-offs and the Board would need to discuss what was acceptable. If all things were equal then that trade-off would have an effect and if it could be dovetailed with efficiencies then there is an argument that trade-offs aren't made where efficiencies do not exist. The Board could not shirk this local responsibility because it was actually part of a wider regional and national approach. The main thing that has changed since this issue was first raised are the COVID 19 repercussions and the associated down-stream economic activity that will take place as a result. Any attempt to structurally reduce inequity will probably result; across the board, in an erosion because of these downstream impacts.

Tama Davis

Tama commented that he agreed with the majority of the sentiment expressed. In particular he wanted to pick up on and support points made by Michael Quirke around trade-offs and the requirement for the Board discuss what was acceptable. Particularly important were changes that have presented themselves as opportunity costs, those that were economic and then the social determinants revealed by the COVID response.

In terms of the discussion around the Treaty and equity we should be taking the opportunities where we can without losing sight of the fact that there is a systemic bias in the health system. The benefit in framing the governance aspects provides the community the opportunity to drive health care approaches as needed when needed over and above what is done by the DHB institutionally. Supporting the development of these communities will then allow the DHB to capitalise on those gains.

The opportunity here is to address current inequities particularly those exacerbated by the COVID experience and in doing so have a discussion around what equity looks like and the required governance process.

Fiona Lai

Commented that she was a firm believer that the Board should be striving to obtain an equitable position. There has to be something wrong within the health system when you consider the points made by Michael Quirke. Why have we not been able to shift dialogue and the position that we are in? As a pharmacist and a 30 year resident of Mt Roskill and Wesley, when I consider this I have to seriously ask why Maori and Pacifika are still struggling and why they remain deprived.

Fiona believed that the Board needed to work within the community and educate. To get the changes required it needs at least two generational cycles. It can't be done by just the health sector alone; other agencies have to be involved.

COVID 19 has revealed that the use of telehealth has had huge benefit which can be seen in the reduced DNA rate. Fiona agreed that flexibility was required and that the Board needed to look at how services were delivered differently and that the Board could no longer sit back passively and wait for people to turn up to the hospital for treatment.

Ian Ward

Stated that first and foremost he did not consider himself a racist. Ian had been in the sector

for over twenty years and during that time, when he was a senior executive of Auckland DHB, had set up the joint venture treaty relationship company with Ngati Whatua and was the only Auckland DHB representative on that board. Ian felt he had a very good relationship then with Maori, the likes of Dame Naida Glavish, the late Rob Cooper and Alan Pivac. He had also had a very good relationship with the Samoan community and that has continued.

Ian felt that he was elected to represent all the people of Auckland.

All citizens of Auckland need to be medically treated equally and the priority of clinical treatment should be determined solely by the clinicians. Ian did not support Maori being medically treated in preference to others just because they were Maori. However, if Maori needed help with matters like transport and child care while they were in attendance at the hospital then that should be looked at.

Michelle Atkinson

In health and diagnostics and in choosing who should have surgery, people are already prioritised on gender and age and many other factors. That is because we know in certain circumstances these groups carry a higher risk profile. Clinical scoring regularly changes in response to factors of best practice and we know now that ethnicity is one of those factors.

Bernie O'Donnell

There are people here who feel affected by the use of the word "racist". Bernie commented that it is very difficult for Maori to use the word "racist" and it is used as a last resort. What is being conveyed here is that the system itself is racist; no one person is being called racist. This differentiation is distracting us from the key issue under consideration.

Community engagement needs to be rich and not just one way and if this is got right then the issues around the Treaty will look after themselves. In terms of equity we need to reach out to the right people to ensure that the strategy that we roll out is fit for purpose for our people.

Board Chairs Summary

This has been a genuine citizen's conversation, a range of views that sit within the population at large and which are represented here on the governance group.

Some of the positioning may suit some people and not others and that represents how we are as a community at large.

The reason for a paper such as this was to generate a conversation which gives us some understanding of where we all sit.

There are some things that would help to modify understanding.

Pat did not quite accept the analysis around the lack of mana whenua engagement in the Iwi Partnership Board because it came out of a mana whenua initiative and has mana whenua representation from around the region. Pat understood what Bernie O'Donnell was attempting to convey but felt it did not give enough credence to the fact that it was mana whenua groups in the regions that decided to join together.

One of the difficulties in getting into a conversation about the Treaty or equity is to apply a

label to it and in this case, the race based tag provides something of a barrier to conversation. Pat felt that he had attempted to provide a different approach with this paper. This was pandemic specific. Maori funding for the engagement in the pandemic was very significantly ethnically specific as was that applied to the Pacifika response. Based on the results obtained this was a highly laudable outcome. If one was to have described that same funding as being race based we would have found ourselves caught in this mire of interpretation and understanding and this is what gets in our way so often.

As a citizen group representative at the Board level we can say, that yes that makes sense to us collectively. Therefore language that tends to polarise is avoided because it doesn't help with accuracy and the outcome sought. What we are doing is to try to find a balance and a method for going forward.

None of us have tried to impugn clinical practice or interfere with it what we are trying to do is enlarge the opportunity set of the information that the clinicians are going to use in the cause of advancing equity. It will not be perfect.

What is identified here suggests that applying clinical practice and clinical assessment without understanding the cultural context has meant historically that people have been missed out. We can't ignore this because it is too hard.

What is being suggested is to do the things that are possible and being prepared to test to see if they provide a different outcome.

Pat commented that he would be keen to have the paper adopted so that the Executive Leadership Team could be given the necessary support required to place energy into moving forward. He asked for opinion on whether that was a reasonable position or not.

Feedback on Board Chairs Summary

Doug Armstrong

Does not support a change in recommendation to adopt the paper. The paper talks about ethnic specific interventions and I simply do not support that. It is a health discussion that is underway. Doug was happy to support a motion to receive the paper.

Michelle Armstrong

Supported adopting the paper.

Meg Poutasi

Commenting on equity and how that was perceived from a Pacifika perspective. Meg noted that the discussion had not touched on the reams of evidence that existed within the surgical pathway that is relevant for Maori and the evidence that clinical leads and leaders within the organisation had looked at. A lot of that relates to the structure not being neutral in terms of impact. It is interesting to reflect on the COVID response because there was a huge effort put in by the Pacifika community to self-isolate at home. Part of the ARPHS review concentrated on every single Pacifika COVID positive case in Auckland which was 61 cases. This was to ensure that secondary transmission did not occur and that if community transmission was not active and was at a level that involved older people removing

themselves from home that other options were looked at for them. When you start to look at what Pacifika resources are required they relate to language and an understanding of what is happening in a health setting. COVID is a great opportunity to look at what has worked and what community partnerships could exist in the future.

Bernie O'Donnell

Whilst I am not entirely in agreement with the paper I certainly don't support business as usual. I am not prepared to continue doing things knowing that we are failing Maori. It is not enough to say you are democratically elected to the Board. That argument is an indictment on this country because tangata whenua and mana whenua in this space have had to be appointed to this Board as democracy does not work for minorities. Somehow we have to find a model that demonstrates and works around the diversity of our people.

It is not enough to say that, "the system works for me, why doesn't it work for you?" It doesn't work for me because I am not you and my people are Maori. The fact that I live in a different culture is the problem and why my people are struggling today.

I would support the paper because I refuse to accept that business as usual is the way that we will operate as it is no longer acceptable.

Michael Quirke

To my fellow Board members that are having this race based conversation, there is a counterpoint to that to be considered and that is statistics are telling us is that what we are rolling out now is race based intervention. This race based conversation is negated, it does need addressing but not in the form that it is travelling now as it will derail what we are trying to achieve. Reframing that conversation and how we address it is more important.

Doug Armstrong

Asked that the Board Chair consider refining the paper rather than placing members in a position of receiving or adopting it. He thought that the paper should be refined and represented.

Pat Snedden considered this a good idea. The value of the conversation as it is at the moment is showing what needs to be addressed and therefore he would be happy to have another look at it. It was an honourable way to look at it and he was not committed to having it adopted until people were comfortable that all the issues have been dealt with.

Tama Davis

It was good to understand the statistical analysis of the data sets that had been collated and the thinking that was done to inform the Board of known inequities that exist in the system and providing a way forward. Tama agreed with the collaboration aspects seeing one of the benefits as being able to influence the Government and refining some of these recommendations. That use of influence was recently utilised through the collaboration with the Iwi Partnership Board and in particular there was a result around tangihanga and the number of people allowed to attend with more managed numbers. There are absolute wins to be gained and discussions that need to continue to happen.

We are here on behalf of the Government and we know the Government wishes to address

inequity and we have a mandate to undertake this and address it in the communities from which we come from. Returning to business as usual is not an option.

Tama felt that there was an overwhelming level of support within the Board to adopt the paper.

Final Roundup by the Board Chair

I appreciate the observation that we have the support to do this, but I am also conscious that this is one of the great talisman matters guiding what we do and I would like full Board support. To do that some refinement may be necessary and I am happy to do that and return a revised version of the report in two or three weeks-time. I think that it is important that we get total support for what we are to do.

Resolution:

That the information paper supporting the Government Push for Increased Equity in Health be noted and that it be revised and presented again to the next Board meeting to be held in two or three weeks-time.

Carried

11 GENERAL BUSINESS

There was none.

12 RESOLUTION TO EXCLUDE THE PUBLIC (*Pages 137-140)*

Resolution: Moved Pat Snedden / Seconded Michael Quirke

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Apologies	N/A	N/A
2. Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of	**Commercial Activities** **Information contained in this**	That the public conduct of the whole or the relevant part of the

Confidential Minutes 26 February 2020	**report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public** [Official Information Act 1982 s9(2)(i)]	meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3.1 Endorsement of Minutes of the Executive Committee of the Board - Managing business during COVID 19 – 1 April 2020, 13 April 2020, 24 April 2020, 1 May 2020	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Confidential Action Points - Nil	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Risk Management Update	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 Chief Executives Confidential Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1	**Commercial Activities**	That the public conduct of the

Human Resources Report	Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time.	whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.1 Hospital Advisory Committee Unconfirmed Minutes – for information	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.2 Major Capital Expert Advisory Group Unconfirmed Minutes -for information	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.1 Central Plant Tunnels Procurement	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.2 Facilities COVID-19 Building Works for Infection Control	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

9.3 Building for the Future Programme: Ward 51 (ARISU) Additional Inpatient Beds by Winter 2020 Business Case	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.4 Capex Variation Approval for Mental Health Services Management of Ligature Risk, Phase 2 Project.	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.5 Workforce Central Replacement Project: Single Stage Business Case	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
10.1 Working Regionally	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

	could be used for improper gain or advantage if it is made public at this time.	
11.1 IMT Report on COVID 19 and On-going Role	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11.2 Northern Region Health Coordination Centre Regional COVID Response Update	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
12 General Business	**N/A**	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

The meeting closed at 3.45pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 20 May 2020

Chair: _____ Date: _____

Pat Snedden

Minutes
Meeting of the Board
18 June 2020

Minutes of the Auckland District Health Board meeting held on Thursday, 18 June 2020 Via Zoom commencing at 1pm

Board Members Present	**Auckland DHB Executive Leadership Team Present**
Pat Snedden (Board Chair)	Ailsa Claire Chief Executive Officer
Jo Agnew	Rosalie Percival Chief Financial Officer
Doug Armstrong	**Auckland DHB Senior Staff Present**
Michelle Atkinson	Auxilia Nyangoni Deputy Chief Financial Officer
Zoe Brownlie	Marlene Skelton Corporate Business Manager
Peter Davis	
Tama Davis	
Fiona Lai	
Bernie O'Donnell	
Michael Quirke	
Also Present	(Other staff members who attend for a particular item are named at the start of the minute for that item)
Dame Paula Rebstock	

KARAKIA

Tama Davis led the Board in a Karakia.

1. ATTENDANCE AND APOLOGIES

That the apology of Ian Ward be received.

2. REGISTER AND CONFLICTS OF INTEREST

Tama Davis requested that "Chair Mana Whenua Working Group – Auckland Council Te Kete Rukuruku" be removed from his register.

Michael Quirke requested an addition to his register of "Director of Strategic Partnerships - Health Care Holdings".

3. GENERAL BUSINESS

There was none.

4. RESOLUTION TO EXCLUDE THE PUBLIC *(Page 8)*

Resolution: Moved Pat Snedden / Seconded Jo Agnew

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

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1. Apologies	N/A	N/A
2. Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3.1 Finance, Risk and Assurance Committee Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4.1 Annual Plan and Budget 2020	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

Carried

The meeting closed at 1.10pm.

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

Chair: _____ Date: _____

Pat Snedden

Action Points from 20 May 2020 Open Board Meeting

As at Wednesday, 08 July 2020

Meeting and Item	Detail of Action	Designated to	Action by
26 Feb 20 Item 5.2	**Health and Safety Report** That a report be made to the Board on "% local Health and Safety Induction completed", what was done, what changed and what the situation looks like with the passing of six months.	Mark Edwards	12 August 2020
20 May 2020 Item 10.1	**Supporting the Government Push for Increased Equity in Healthcare** That the information paper supporting the Government Push for Increased Equity in Health be noted and that it be revised and presented again to the next Board meeting to be held in two or three weeks-time.	Pat Snedden	July 2020

Chief Executive's Report

Recommendation

That the Chief Executives report for 13 March 2020 – 7 June 2020 be received.

Prepared by: Ailsa Claire (Chief Executive)

1. Introduction

This report covers the period from 13 March 2020 – 7 June 2020. It includes an update on the management of the wider health system and is a summary of progress against the Board's priorities to confirm that matters are being appropriately addressed.

2. Events and News

2.1 Notable visits and programmes

Certification Audit

In May we received a three year certification to provide health care service. This follows the full certification audit in February which assessed our clinical departments against the Health and Disability standards.

The lead auditors were complimentary of our services and the report had only sixteen areas identified for improvement, none of these are deemed high risk.

This is testament to the work of everyone across the organisation and the team who pulled together the evidence and agenda for the audit itself.

Messages of thanks from Auckland Grammar School

Two students from Auckland Grammar visited the hospital to present CE Ailsa Claire with notes of thanks for all essential workers at Auckland DHB. These notes of thanks will be displayed in level 5 of the hospital.

2.2 COVID-19 response

COVID-19 Incident Response Team

The incident response team continues to manage the response to the threat of COVID-19. Whilst the risk of COVID-19 is now very low the team continues to manage issues relating to border controls and an unstable supply chain.

Communicating with patients and our community

During the different alert levels we were concerned about lower numbers of people coming to the emergency department. We produced a series of light hearted videos to promote that the hospital was safe and people should get the care they need when they needed it. The videos involved our own people and well known radio presenter Tammy Davis.

These videos received a high level of engagement, you can see some of the measures in the social media section.

2.3 Patients and community

2.3.1 Email enquiries

Communications manages a generic communication email box, responding to all emails and connecting people to the correct departments. For this period, 1,020 emails were received. Of these emails, 86 were not communications-related and where appropriate, were referred to other departments and services at Auckland DHB.

2.3.2 Patient experience

Some examples of patient feedback we received this month:
"I was very impressed by how very smoothly everything went, especially during covid 19. From greeting and directions given at the front door, through to reception and seeing doctor. Well done."

"I don't need to give any suggestion to you guys, you guys already doing great job, I am living far from my family but you guys are taking good care of mine and I mean it, the doctor, the nurse everyone who is part of your team and whoever connected with me in my treatment, I would like to thank them for their support and love."

2.4 External and internal communications

2.4.1 External

The Northern Region Health Coordination Centre (NRHCC) coordinated responses to COVID-19 related media requests on behalf of the northern region DHBs. The NRHCC communications team included members of the Auckland DHB communications team as well as members of the communications teams at the other Metro Auckland DHBs.

The NRHCC received 285 requests for information, interviews or access from media organisations between 20 March and 22 May.

Between 13 March and 7 June we received a further 112 requests for information, interviews or access from media organisations which were specific to Auckland DHB. The majority of requests related to the COVID-19 response and included enquiries about the visitor policy, the impact on hospital services, infrastructure changes and staff welfare. Around 10% of the enquiries over this period sought the status of patients admitted following incidents such as road traffic accidents.

The DHB responded to 35 Official Information Act requests over this period.

2.4.2 Internal

- 101 news updates were published on Hippo, the DHB intranet.

- Five editions of Pitopito Kōrero | Our News, the weekly email newsletter for all employees, were distributed.
- Three editions of the Manager Briefing were published for all people managers.
- 17 sessions were held for all employees to provide updates on COVID-19 with the opportunity for questions.
- 22 CEO update emails were sent out to all employees.

2.4.4 Social Media

Followers

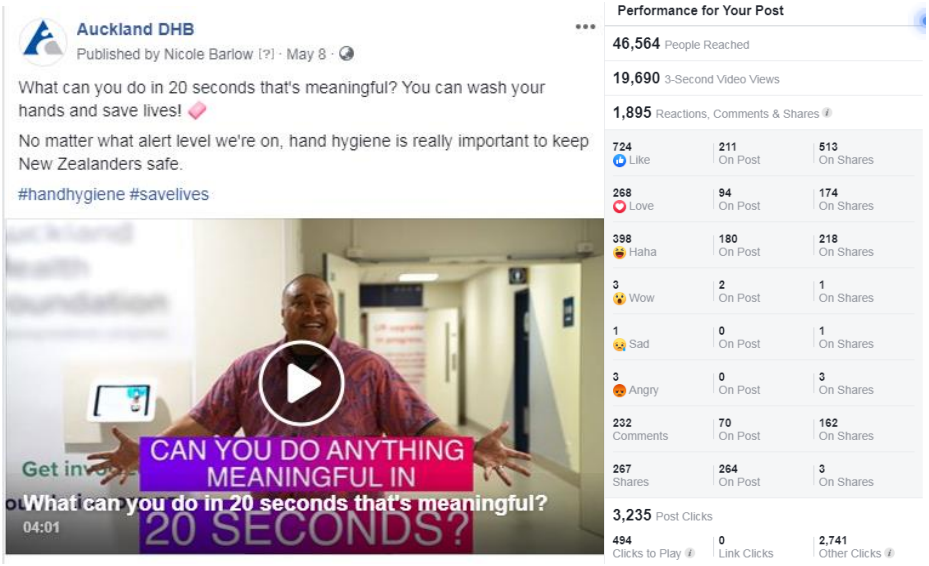
LinkedIn: 14,276

Facebook: 9,884

Twitter: 4,096

Top posts and statistics

Facebook




Auckland DHB
Published by Nicole Barlow [?] · May 29 at 10:00 AM ·
Thank you to all essential workers across New Zealand from our essential workers ❤ Here are just a few of them.
New Zealand Police St John New Zealand Fire and Emergency NZ Countdown Supermarkets PAK'nSAVE New World Four Square Supermarkets NZ Post New Zealand Customs Waitematā District Health Board Counties Manukau Health Northland District Health Board Canterbury District Health Board Bay of Plenty District Health Board Capital & Coast District Health Board (CCDHB) Hawke's... See More
THANK YOU NZ POLICE
Thank you to our GP's and practices
Thank you St Johns
Thank you to NZ Fire
THANK YOU TO ALL THE SUPERMARKET WORKERS!
Thank YOU
Thank you
Thank you NZ Customs and Immigration!
Performance for Your Post
6,900 People Reached
320 Reactions, Comments & Shares
220 Like | 166 On Post | 54 On Shares
64 Love | 50 On Post | 14 On Shares
1 Haha | 0 On Post | 1 On Shares
1 Wow | 1 On Post | 0 On Shares
1 Sad | 1 On Post | 0 On Shares
14 Comments | 11 On Post | 3 On Shares
19 Shares | 18 On Post | 1 On Shares
864 Post Clicks
623 Photo Views | 0 Link Clicks | 241 Other Clicks

2.5 Our People

2.5.1 Local Heroes

There were 12 people nominated as local heroes in March.

Congratulations to our March Local Hero – Angela Skelton, Team Administrator, Dermatology. Read Angela's nomination:

"Angela is the team support in the dermatology service. Angela champions a number of improvements in the team and across ambulatory services. Angela has imbedded health and safety including ease of access to information for staff, better recording of processes to improve business continuity planning. Angela has also updated admin functions to reduce risk and provide greater certainty of care. Some of this has been on-going for some time. Angela does all of this with the patient in mind. Her initiatives and efforts are to ensure patients are safe, receive timely care and clinical staff are supported and well placed when undertaking consultations and procedures. Angela's recent work is being used as a template for support processes across the Adult Community and Long Term Conditions Directorate."

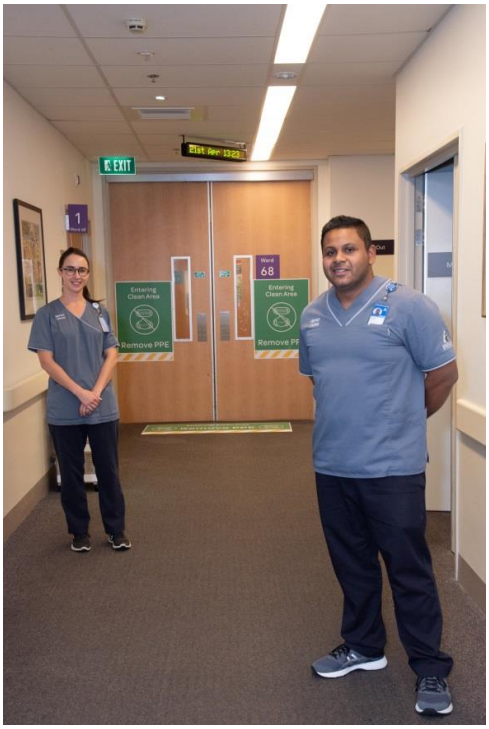
2.5.2 Our COVID-19 heroes

Over a short period of time many people stepped up in a number of different ways. This included developing new clinical guidance and systems, providing additional cleaning, supporting the incident management team or caring directly for COVID patients.

Here are some of our health heroes:

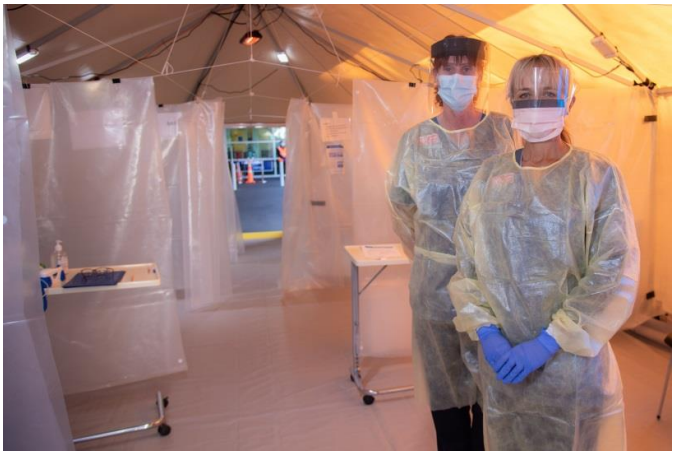
A General Medicine Consultant.

One of General Medicine's cleaners.



Senior nurses in General Medicine.

An Adult Emergency Department orderly.



Adult Emergency Department nurses in the COVID-19 triage tent.

One of the Children's Emergency Departments play specialists.

A Child Emergency Department doctor.

3. Performance of the Wider Health System

3.1 Priority Health Outcomes Summary

	Status	Comment
Acute patient flow (ED 6 hr)		May 94%, Target 95%
Improved access to elective surgery (YTD)		86% to plan for the year, Target 100%
Faster cancer treatment		May 96%, Target 90%
Better help for smokers to quit: • Hospital patients • PHO enrolled patients • Pregnant women registered with DHB-employed midwife or lead maternity	  	May 97%, Target 95% Dec Qtr 85%,Target 90% Dec Qtr 97%,Target 90%
Raising healthy kids		May 100%, Target 95%
Increased immunisation 8 months		Mar Qtr 94%, Target 95%

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

4. Financial Performance

Financial Performance

The DHB financial performance for the year to date to 31 May 2020 was a deficit of $18.3M against a budgeted deficit of $8.5M. This is $9.8M unfavourable to budget mainly due to the impacts of Covid-19 on our bottom-line. Adverse Covid-19 impact is $17.3M year to date and is mainly in the Provider arm where only Public Health related costs have been funded but the rest of the costs have not been funded. The Funder arm costs incurred for Covid-19 in payments to external providers were funded by the Ministry. The year to date result distribution across the three divisions is as follows: Provider arm unfavourable 17M, partially offset by favourable Funder result ($7M) and Governance result ($316K).

For the year end, we are forecasting a deficit of $74.8M which is mainly driven by unfunded Covid-19 costs, plus required increases in provisions for liabilities for the Holidays Act and staff long service leave and retiring gratuities.

Occupational Health and Safety Performance Report

To: Auckland DHB Board

From: Occupational Health and Safety Team

Date: May 2020

Endorsed by: Mark Edwards, Chief Quality, Safety, and Risk Officer

Presented by: Alistair Forde, Director Occupational Health and Safety

Board Action

1. Note this paper

Glossary

TRIFR Total recordable Frequency Rate (# of Lost Time (LTI), Medical Treatment (MTI) and Restricted Work (RWI) Injuries x 1000000/total personnel hours)

LTIFR Lost Time Injury Frequency Rate (# of Lost Time Injuries x 1000000/total personnel hours)

AIFR All Injury Frequency Rate (# of All LTI, MTI, RWI & First Aid Injuries x 1000000/total personnel hours)

BBFA Blood and/or Body Fluid Accident

EY Ernst and Young Limited

HSR Health and Safety Representative

HSWA Health and Safety at Work Act (2015)

LTI Lost Time Injury (work injury claim)

MFO Medical Fees Only (work injury claim)

MOS Management Operating System

PCBU Person Conducting a Business or Undertaking

PES Pre-employment Health Screening

SMS Safety Management System

SPEC Safe Practice Effective Communication (SPEC)

SPIC Safe Practice in the Community

YTD Year to date

A/A As Above

Board Strategic Alignment

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

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

Performance Summary

Lead Indicators

For the month of May 2020 we had 107 leadership activities across Auckland DHB, representing reported discussions between Advisors and workers or managers at various parts of the Auckland DHB. An overview of these and other lead indicators are summarised in the table below.

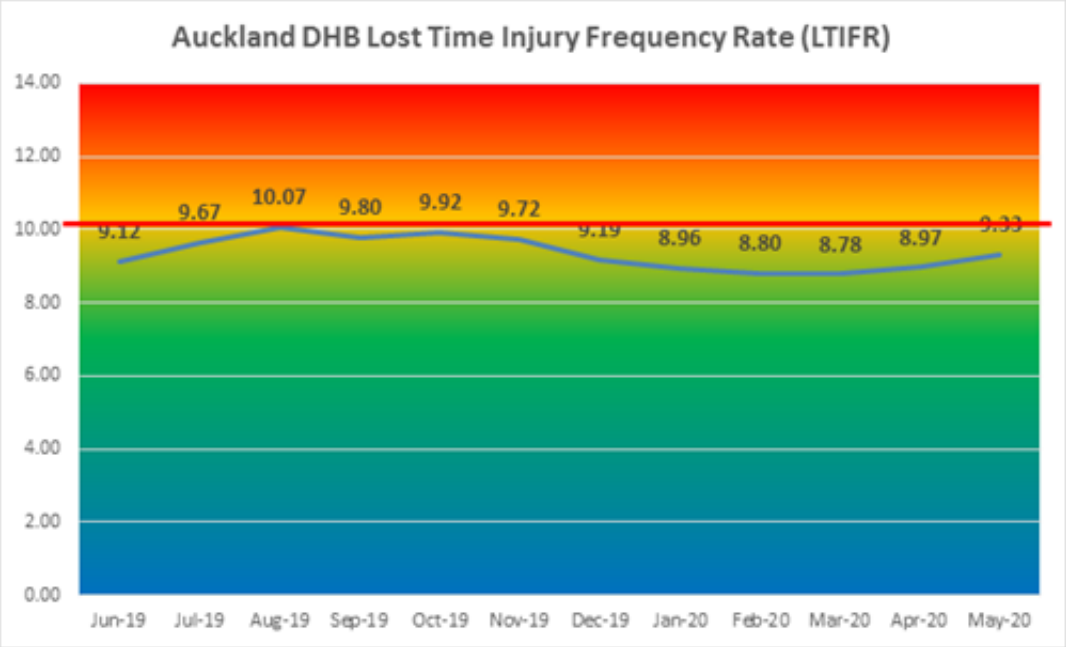
Description	Actual	Previous Month	3mth Trend	6mth Trend
Leadership Observations	196	0	↑	↑
Leadership Discussions (H&S Rep Meetings, Regional H&S Technical Advisory Group (TAG) ACC/Safe 365	107	19	↑	↑
Training (Inductions/PPE/Patient Handling)	91	87	↓	↓
Audits/Inspections	39	27	↑	↑

a. Our leadership Observations have increased from last month where we are focusing on validating the controls in place for our key workplace risks. Initial observations have highlighted insufficient data indicating that here is more work needed to understand the controls.
b. We are specifically targeting our key risks to ensure we are mitigating these such as Lone Work and Workplace Violence effectively.
c. Our leadership discussions have increased with the COVID – 19 level restrictions eased. We are emphasising the importance of continued coaching and mentoring across the Directorates.
d. We have informally reviewed the ongoing Medtech 32 requirements and found a number of issues. There were also some benefits of ongoing use. Key recommendations from this review will be worked through over the next 2 months.

Lag Indicators

Description	Target	Actual	Prev Month	3mth Trend	6mth Trend	12mth Trend
Total Recordable Injury Frequency Rate (TRIFR)(per 1,000,000 hrs)	–	**28.12**	**26.22**	**26.34**	**26.89**	**31.59**
LTI Frequency Rate (LTIFR)(per 1,000,000 hrs)	10.00	**9.33**	**9.04**	**8.78**	**9.72**	**8.46**
All Injury Frequency Rate (AIFR)(per 1,000,000 hrs)	–	**98.30**	**94.25**	**92.31**	**82.40**	**42.64**

a. Across Auckland DHB there were 36 recordable injury claims in May 2020. These are mainly Lost Time and Medical Treatment injuries.
b. The TRIFR and LTIFR both increased from last month. The ongoing increase of injuries is highlighting that we can improve injury prevention across the ADHB and requires a specific focus.
c. We reviewed our total number of injuries (1965) over the last 12 months and found that approximately 1 in 5 of our people experienced an injury. Based on our current injury trend, this number will continue.
d. We are currently engaging key stakeholders and aligning resources within the Quality, Safety and Risk to develop tools and procedures towards injury prevention and effectively validating our workplace risks and controls. This is being well received through ongoing staff engagement activities.



We are working on gaining a better understanding of the factors around this by helping improve management response time to incidents and coaching managers on how to improve the quality of

incident reports. However, even though the LTIFR is not above the target we believe that the overall number of injuries over for the last 12 months is too many. We are putting together a programme of work to reduce our LTIFR and other injuries over the next 12 months. We expect a 25% reduction across all injuries.

Risk Analysis

Occupational Health and Safety (H&S) Risk Management

Despite the general downward trend in the last 12 months, Workplace Violence has gone up by 16 incidents from the previous month's record low. We are assessing current risk management controls around this key risk to ensure these controls are effective and being followed.

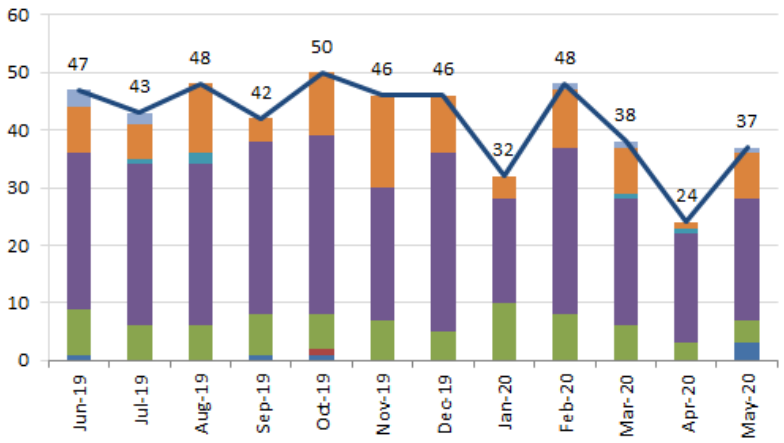
No movement is yet reflected on the heat map (Appendix 2) as we continue to validate our key risks.

We are commencing a review of all the significant risks in terms of their validity and alignment to our current activities. We expect more understanding around the validity of asbestos, confined spaces, working at height and lone workers by mid-July.

Our initial focus will be to review current activities and look for validation as to whether the current risk controls are effective or not. Ongoing focus will be what improvements are required to reduce the potential of these risks.

The H&S Advisors will undertake this piece of work and report back at the next DHB Health and Safety Governance meeting

Blood and Body Fluids Incidents



	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Unknown	3	2	0	0	0	0	0	0	1	1	0	1
Splash	8	6	12	4	11	16	10	4	10	8	1	8
Scratch	0	1	2	0	0	0	0	0	0	1	1	0
Puncture by needle	27	28	28	30	31	23	31	18	29	22	19	21
Laceration by scalpel or other sharp instrument	8	6	6	7	6	7	5	10	8	6	3	4
Laceration by bone spicule	0	0	0	0	1	0	0	0	0	0	0	0
Bites	1	0	0	1	1	0	0	0	0	0	0	3
Total BBFA's	47	43	48	42	50	46	46	32	48	38	24	37

The number of BBFAs has gone back up due to our Services returning back to work. Our priority is to reduce these incidents by validating the current controls are fit for purpose, and if they are ensuring they are being followed.

Respiratory Protection and COVID-19

Previously the Respiratory Protection Programme (RPP) at ADHB focused on TB and some oncology-medication airborne hazards. There was no established RPP for airborne hazards such as viruses. COVID-19 prompted the rapid development of an RPP including education, secure fit checking and objective fit testing. This covered approximately 2500+ staff. A train-the trainer-model, including for secure fit checking and qualitative objective mask fit testing, was used and was expanded across the organisation.

Selection of appropriate and available respirators became part of the COVID-19 Incident Management Personal Protective Equipment (PPE) work stream. A multidisciplinary team spent significant time ensuring a supply chain of appropriate respirators. Repeating fit checking and fit testing for staff in high-risk roles needed to be undertaken when respirator mask suppliers changed.

In future, the expanded RPP will need to become business as usual for all airborne hazards. It will need to be supported with resourcing including staffing, administration, documentation, educational resources and a database. Staff will undertake training as part of on-boarding and at regular intervals, as required by Health and Safety at Work legislation for airborne hazards.

Vulnerable Staff and COVID-19

At the onset of the COVID-19 response staff with underlying health issues and/or those aged over 70 years were asked to submit self-assessment forms to occupational health. Regional and national co-ordination led to an agreed framework for assessing risk in the uncertain environment. Around 1800 staff identified themselves as potentially having increased risk if diagnosed with COVID-19. Many staff also identified vulnerable family members in their bubble.

Reviewing the forms was undertaken over several weeks into April. The Occupational Health team has been providing advice and staff assessments, and has also contributed to development of guidance for managers to enable safe return to work of vulnerable staff.

Information Technology

For recording contact tracing data an interim solution is in place and we are moving to the national platform in line with Auckland Regional Public Health Service (ARPHS). Our tactical IT solutions are being reviewed to understand what the long term needs of the Occupational Health service will be.

There was an informal review completed highlighting a number of issues around the use and understanding of the system used to manage Occupational Health data and information. In brief the following was found:

What does not work so well?

- Data transmission between Occupational Health and GPs.
- Automatic demographic updates based on NHI.
- Less than optimal platform stability.
- Helpdesk availability and knowledge.
- Inconsistencies in the way Medtech is used and data captured
- Updating data for some aspects of work is manual and labour intensive
- Limited functionality for report generation.

- Complexity of layout and data entry.

What does work well?

- When used well, good population health management tool e.g. flu vaccine list
- Individual screening records
- Tasking function
- Place to put clinical notes
- Task reminders for self or others

Some recommendations made following the review were:

- Formally establish user group to meet regularly
- Establish list of enhancements to prioritise and cost to allow to for more effective use of the system until upgrade or replacement
- Establish training sessions for all users to ensure that there is some consistency of use
- Establish relationship with healthAlliance and Health Information Technology group to ensure needs are represented

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

This project continues to make steady progress with the on boarding of contractors. There are now 403 contractors signed up across the 3 DHB's. It has been difficult to generate participation from the DHBs but this being resolved with ongoing communication and stakeholder engagement. We are on track over the next month to achieving 80% completion of the Initial Assessment stage for this project. This would mean by the end of June we would expect to have approximately 480 contractors assessed. We are now framing a Business Case for years 2 and 3 by the end of June to help plan for the second and third phase of this project.

Auckland DHB Health and Safety Committee

The Auckland DHB Health and Safety Committee meet six-weekly.
Our last meeting was on the 15th of June 2020.

Appendix 1

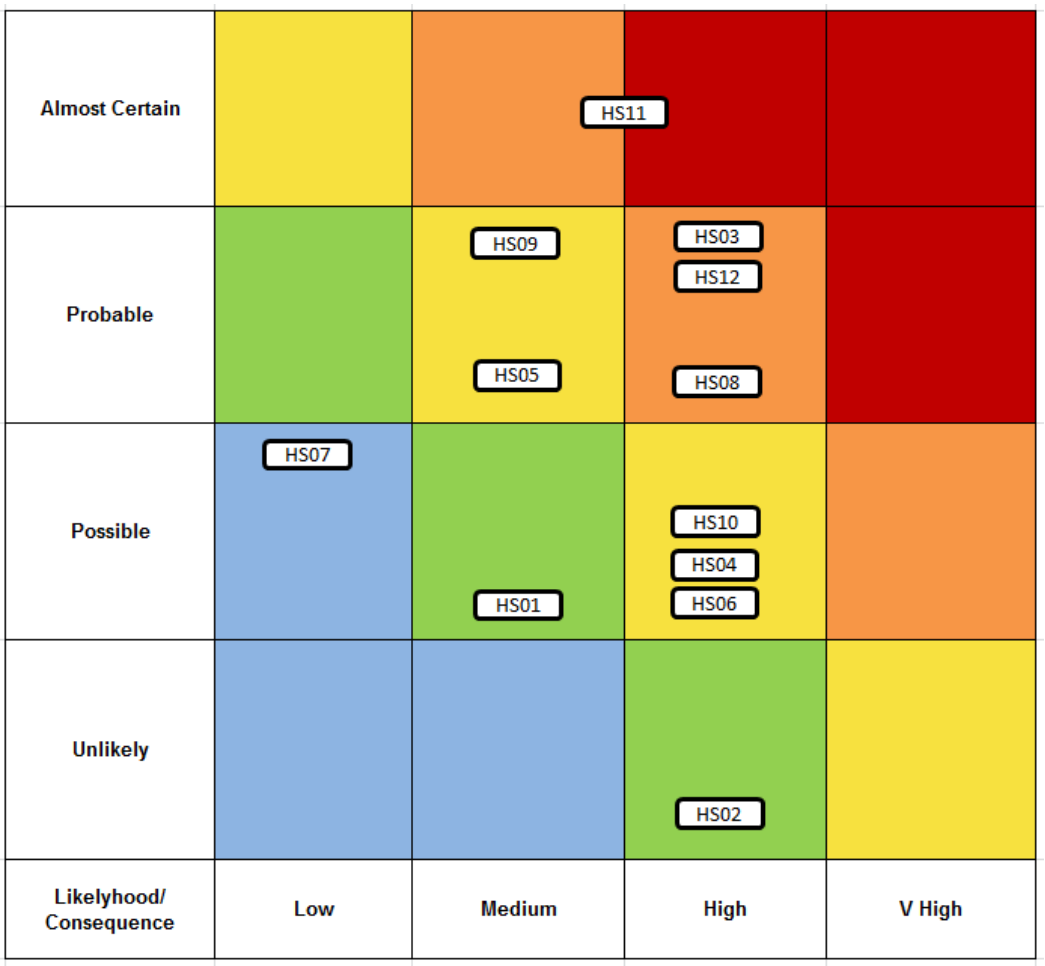
% Pre-employment screening before start date	95
Training	
# local H&S Induction completed (one month lag)	36
# H&S e-learning completed (excl. RMOs & HOs, one month lag)	51
# H&S Representatives Trained	0
# MAPA training completed in high risk WV areas	NA
Audits	
# of contractor audits completed	27
% compliance contractor audits	70
# of Hazardous Substance audits conducted	0
% Hazardous Substance audits compliant	0

NA = Not Available

Appendix 2

Health and Safety Risks

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



Key:

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

Auckland DHB Human Resources Report – Open Board

Recommendation

That the Board receives the Auckland DHB Human Resources report to June 2020.

That the Board considers the desired frequency of updates against the People and Culture plan and resolves that future updates be quarterly.

Prepared by: Mel Dooney (Chief People Officer)
Endorsed by: Ailsa Claire (Chief Executive Officer)

The purpose of this report is to provide an update on the People Progress to Plan with a status on each of the Human Resource work streams since May 2020.

The status of a number of the programs in the Key Focus Areas continues to be impacted against the planned dates due to Covid-19 which impacted activity planned during March – May. During June a number of areas have either been restarted or program content redesigned based on what we have learned.

Of note is progress made during June towards developing a draft People & Culture Strategy which will support delivery of the key strategic objectives of Te Toka Tumai. This work will also outline the activity for 20/21 People Plan. It is envisioned this will come for the Board's review and engagement at the August Meeting.

Lastly, given the nature of the work program, we would ask the Board to consider the desired frequency of progress updates. The team consider that a quarterly update going forward would be appropriate.

Auckland DHB People Plan Report - June 2020

Key Focus areas	WHAT	Status	Status comment	This period activity	Next Period Planned activity
Accelerating capability and skill	Build change capability		Paused during COVID response	CCDM & Just Culture projects reinstated	CCDM Forward Projects commencing Just Culture Training to commence
	Leadership for the future			On Hold - Moved to 2020/2021 activity	
	Implement talent management		On track	Pilot groups largely completed - final moderation sessions are in progress for next tier. Feedback from pilot groups has been positive and strong ancedotal evidence of improvements in sucession management and career development improvements exists within the groups.	Finalise remaining development plans and evaluate the pilot. Evaluate & plan 20/21 roll out for MALT / PALT development group.
Making it easier to work here	Leader Leave Manager Upgrade		Go Live impacted by IT Infrastructure Issues	Project testing plan all but completed. Go live on 15th / 16th June delayed due to uncovered server frailty. Working with HA to understand new date post server replacement.	Once date received from HA re: Server replacement plan for new cut over date. All other project requirements on track / fulfilled.
	Workforce Dimensions upgrade		Project will not be delivered on or near December 31st 2020. Mitigation plans will have to be activated on December 31st 2020	Business case finalised and contract / SOW under negotiation by procurement. Expected approvals not due to be complete until approximately July/August 2020.	Business case continues through the approval & funding gates. Regional funding approval expected formally at end June.
Building constructive relationships	Te tino o mātou - Us at our best		Ongoing / On track	Focus on strengthening weaving 'values in action' insights into directorate initiatives.	Ongoing - move to BAU.
	Just Culture		Paused during COVID response	The Steering Committee has discussed restart date, review of programme activity, training commencement etc.	Manager training to restart. Refresher development for business trainers & redrafted training plan. Planning workshop for Phase 2: programme development (applied practise)
	Supportive pathways to safely raise concerns and grievances		Paused during COVID response	No progress within June.	Progress 'Restorative Justice in the Workplace' practise in collaboration with Canterbury DHB, once domestic travel restrictions lifted.
Delivering on our promises / Caring for our people	Holiday's Act review and remediation		On track	Rectification planning underway including highly effective consultation with unions - very well attended.	Planning for rectification underway with a business case for resources required for remediation being developed - RFP process fror Vendor Support iniiatied.
	Building workforce capability towards elimination of inequity		Pivot to COVID prioritised activity	"Employee in Need" Welfare Centre concept approved by SLT. Co-design workshops with champions commenced. Staff gifting programme scoped for implementation	Centre Governance group established. Co-design workshops continue with champions. Chamption Development plans completed. Operational implementation commenced
	Hauora/Wellbeing strategy		Paused during COVID response	Focus on next 3 months and next year activity to support next normal re: COVID19. Conclude A3 workshop process to build cohesive strategy which includes expanded / appropriate Occupational Health Response.	Post Covid Wellbeng Support Activities delivered. Workplan for improved HR / Occupational Health interface. Audit of Organisational Best Practise.
	Supportive and inclusive employment practices		On track	**To Thrive:** Step up - L2 Literacy & Numeracy programme designed. **Accessabiliy:** Disability Confidence training in design **Rainbow:** Review Tick accreditation report and build action plan for 20/21	**To Thrive:** Planning for implementation of programmes. Strong connection to the Centre **Accessabiliy:** Disability Confidence training (for managers) in design **Rainbow:** workshop with Rainbow network to understand next steps.
	2020/2023 Auckland DHB People strategy & in year 20/21 Plan		Strategy development parked during COVID response	Review early drafts in line with what we have learned during COVID & amend as needed. Built engagement approach (HR team / organisation). Directorate level progress to People plan & 20/21 needs sessions completed across the business. Active involvement of Maori employee voice throughout the process.	Conclude 1st Draft Strategy & 20/21 plan. Socialise with organisational stakeholders and iterate.
Ensuring a future ready workforce	Sourcing strategy		20/21 Recruitment & Sourcing Strategy Revamp required.	Progress LinkedIn trial. Link Directorate level best practises into overarching strategic approach to sourcing. Second phase of COVID response – impacts of pipeline disruption established / solved for. Including impact of Vulnerable Services analysis	1st draft 20/21 Recruitment / Sourcing Strategy socialised with key stakeholders.

Financial Performance Report for the eleven months ending 31 May 2020

Recommendation

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

Prepared by: Rosalie Percival, Chief Financial Officer
Date: 26 June 2020

1. Executive Summary

Financial performance for the year to date (YTD) shows a deficit of $18.3M, which is $9.7M unfavourable to the budgeted deficit $8.5M. The variance is mainly driven by unfunded Covid-19 impacts. The distribution of the YTD result across divisions is as follows:

Result by Division	YTD (eleven months ending 31 May-20)		
	Actual	Budget	Variance
Funder	55,662	48,675	6,987 F
Provider	(74,298)	(57,227)	17,072 U
Governance	328	12	316 F
Net Surplus / (Deficit)	**(18,308)**	**(8,540)**	**9,767 U**

- The favourable Funder arm result reflects less than budget demand driven expenditure mainly pharmaceuticals, primary health services, uncommitted initiatives and one off prior year adjustments. Additional costs incurred in response to Covid-19 were mostly offset by additional MoH revenue ($17M year to date).
- The unfavourable Provider arm result reflects the impact of unfunded Covid-19 impacts (net $17M) as additional MoH Covid-19 funding was only provided to offset Public Health services costs.
- The Governance result is similar to the breakeven budget, with a slight favourable variance.

Year End Forecast:

We are forecasting a deficit of $74.8M against the full year budget of $20M ($55M unfavourable variance), made up as follows:

- $30M increase in the provision for the Holidays Act to reflect an additional 12 months of the liability. An assessment is being completed by EY to confirm the provision estimate.
- $25M unfunded Covid-19 full year impact.
- $8.6M increase in the provision for staff long service leave and retiring gratuities. These are subject to final was-ups based on year end data.

These are offset by underlying net savings of $8.9M. If the above impacts are excluded, the overall bottom-line would have been on budget ($20M deficit). This forecast assumes that there are no additional adverse impacts of IDFs and Planned care revenue wash-ups.

2. Summary Result and Financial Commentary for May 2020

$000s	Month (May-2020)			YTD (eleven months ending 31 May-20)			Full Year (2019/20)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Income									
Government and Crown Agency	153,100	137,876	15,224 F	1,539,355	1,519,113	20,242 F	1,679,037	1,657,122	21,915F
Non-Government and Crown Agency	7,380	8,508	1,128 U	92,604	95,512	2,908 U	101,114	104,022	2,908U
Inter- District Flows	62,456	56,624	5,833 F	626,725	629,572	2,847 U	682,047	686,196	4,148U
Inter-Provider and Internal Revenue	1,478	1,164	314 F	13,647	12,914	732 F	14,811	14,079	732F
Total Income	**224,414**	**204,172**	**20,242 F**	**2,272,330**	**2,257,111**	**15,219 F**	**2,477,009**	**2,461,418**	**15,591F**
Expenditure									
Personnel	103,977	100,343	3,634 U	1,029,744	1,014,925	14,819 U	1,171,447	1,115,795	55,652U
Outsourced Personnel	2,719	1,177	1,542 U	25,450	12,981	12,470 U	26,625	14,155	12,470U
Outsourced Clinical Services	3,253	3,741	488 F	39,660	40,919	1,260 F	43,497	44,636	1,139F
Outsourced Other Services	6,899	6,807	91 U	76,601	74,880	1,722 U	83,408	81,687	1,721U
Clinical Supplies	26,280	26,248	33 U	281,353	278,452	2,901 U	312,849	304,101	8,748U
Funder Payments - NGOs and IDF Outflows	60,415	59,095	1,319 U	639,961	646,118	6,156 F	706,545	705,213	1,331U
Infrastructure & Non-Clinical Supplies	17,720	16,824	895 U	197,869	197,378	492 U	207,485	215,831	8,346F
Total Expenditure	**221,263**	**214,236**	**7,027 U**	**2,290,638**	**2,265,652**	**24,987 U**	**2,551,857**	**2,481,418**	**70,439U**
Net Surplus / (Deficit)	**3,151**	**(10,064)**	**13,215 F**	**(18,308)**	**(8,540)**	**9,768 U**	**(74,847)**	**(20,000)**	**54,848 U**

Result by Division	Month (May-2020)			YTD (eleven months ending 31 May-20)			Full Year (2019/20)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funder	4,585	3,325	1,260 F	55,662	48,675	6,987 F	52,005	52,000	5 F
Provider	(1,260)	(13,372)	12,112 F	(74,298)	(57,227)	17,072 U	(127,169)	(72,000)	55,169 U
Governance	(174)	(17)	157 U	328	12	316 F	316	0	316 F
Net Surplus / (Deficit)	**3,151**	**(10,064)**	**13,215 F**	**(18,308)**	**(8,540)**	**9,767 U**	**(74,848)**	**(20,000)**	**54,847 U**

Commentary on DHB Consolidated Financial Performance

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

Total Revenue for the month is favourable to budget by $20M (9.9%) with major variances as follows:

- $15M (11%) favourable Government and Crown Agency revenue, mainly due to additional funding for initiatives including funding for Covid-19 costs.
- $1M (-13%) unfavourable variance in Non-Government and Crown Agency is mainly driven by Covid-19 impacts resulting in lower non resident volumes, lower donation revenue and additional revenue assumed for budget initiatives not received.
- $5.8M (10%) favourable IDFs, mainly due to the reversal of the year to date risk provisions following advice received from MoH for treatment of Covid-19 impact on IDFs. The variance also includes net adverse impact of PHO agency adjustments to appropriately account for changes in GP enrolments and fee for service wash up, and also due to prior year non-inpatient wash-up.

Total Expenditure for the month is unfavourable to budget by $7M (-3%) mainly driven by:

- $5M (-5.1%) unfavourable variance in Personnel/Outsourced Personnel costs due to above budget by 228, mainly additional resources required for the Covid-19 response, equating to a $2.2M unfavourable variance. There is also an estimated $3.3M additional cost for reduction in annual leave taken due to Covid-19.
- $1.3M (-2%) unfavourable variance in NGO costs and IDF Outflows is mainly due to new specific Cocivd-19 initiatives and additional National Haemophilia Management Group(NHMG) expenditure, partially offset by favourable demand driven expenditure, funded and unfunded initiatives not committed

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

Revenue is favourable to budget by $15M (0.7%), mainly driven by:

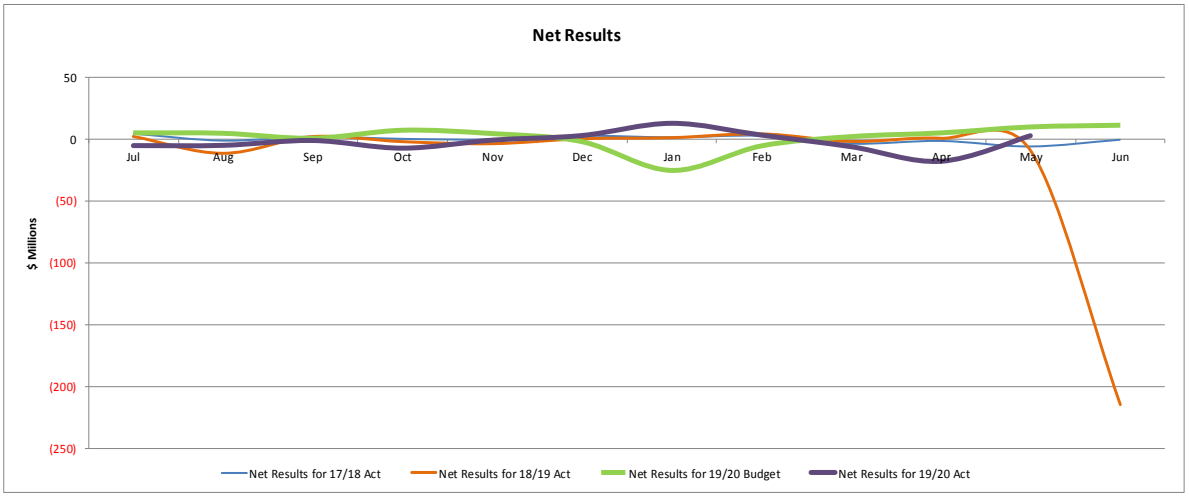
- $20M (1.3%) favourable Government and Crown Agency revenue, reflecting new Cocivd-19 funding, additional capital charge funding received for asset revaluation and additional funding for MECA (PSA and MERAS), partially offset by a shortfall in Planned Care funding.
- $3M (-3%) unfavourable variance in Non-Government and Crown Agency, mainly driven by Covid-19 impacts resulting in lower non resident volumes, lower interest revenue and reflecting additional revenue assumed for budget initiatives not received.
- $2.8M (-0.5%) unfavourable IDFs, the variance includes adverse post budget service changes and net adverse PHO wash-ups inclusive of agency adjustments. Due to new advice from the Ministry with regards to Covid-19 impacts on IDF revenue, the previous adverse provisions were reversed in the month.

Total expenditure year to date is unfavourable to budget by $25M (-1.10%), mainly driven by:

- $27M (-2.7%) unfavourable variance in Personnel/Outsourced Personnel costs, reflecting:
  - Year to date average FTE are 64 (0.7%) above budget - equating to $5.8M unfavourable.
  - Security staff $3.2M unfavourable but largely offset with favourable Outsourced security costs $2.2M favourable, reflecting transfer of security services in-house.
  - One off backdated costs relating to prior year $1.0M.
  - Estimated $13.0M additional Covid-19 related costs for reduction in annual leave taken, paid isolation leave and costs of additional resources.
  - The balance of the variance, $4.5M, represents a variation in cost per FTE between budget assumptions and actual costs.
- $1.3M (3.1%) favourable Outsourced Clinical Services is mainly driven by Covid-19 impacts resulting in lower outsource clinical costs relating to Inpatient/Daypatient services.
- $1.7M (-2.3%) unfavourable Outsourced Other Services, reflecting Covid-19 outsourced IT and human resources costs.
- $2.9M (-1%) unfavourable in Clinical supplies, mainly driven by the following key unfavourable variances:
  - A net reduction in costs due to Covid-19 $4.2M favourable - being a $6.2M reduction in costs due to the significantly reduced patient volumes in March, April and May, offset by $2.0M of additional laboratory reagent cost.
  - Funded pharmaceutical cancer treatment (PCT) costs $4.5M over budget.
  - Haemophilia blood product $2.5M over budget – this is fully funded and will be subject to full wash up.
- $6.2M (1.0%) favourable variance in NGO costs and IDF Outflows is due to demand driven nature of expenditure mainly in Pharmaceuticals and Minor Personal health, uncommitted initiatives, one off prior year adjustments, IDF outflow post budget service changes and PHO wash-ups. Additional costs incurred in response to Covid-19 were offset by additional MoH funding.

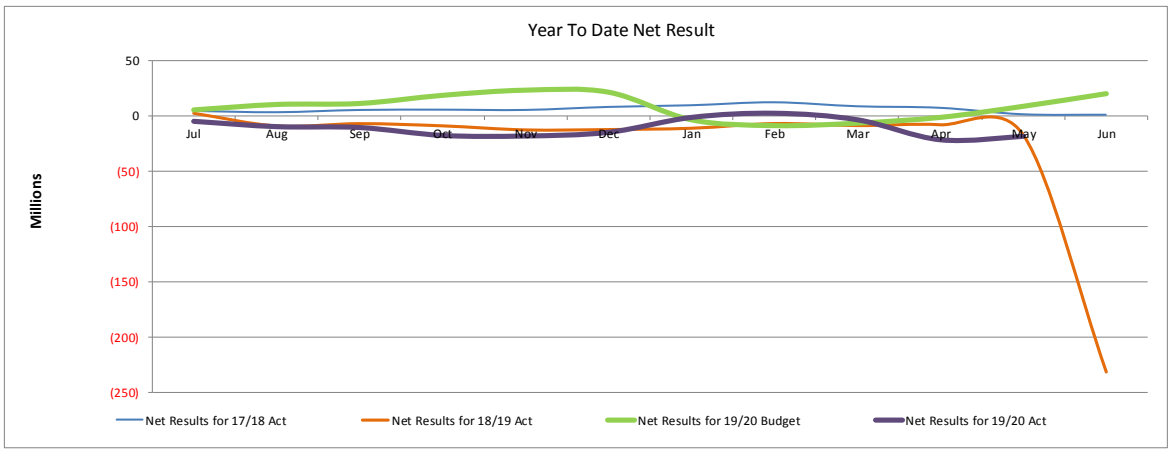
3. Performance Graphs

Figure 1: Consolidated Net Result (By Month)



$ millions	July	August	Spetember	October	November	December	January	February	March	April	May	June	Total
Net Results for 17/18 Act	4.569	(1.187)	2.114	0.283	(0.252)	2.806	1.585	2.793	(3.739)	(1.453)	(6.051)	(0.456)	1.012
Net Results for 18/19 Act	2.183	(11.446)	2.057	(2.009)	(3.665)	0.324	1.185	4.248	(1.830)	0.728	(9.280)	(214.462)	(231.967)
Net Results for 19/20 Budget	5.269	4.924	0.895	7.392	4.691	(1.834)	(25.085)	(5.260)	2.241	5.241	10.064	11.459	20.000
Net Results for 19/20 Act	(4.968)	(4.764)	(0.776)	(7.055)	(0.494)	3.289	13.310	3.679	(5.846)	(17.834)	3.151		(18.308)

Figure 2: Consolidated Net Result (Cumulative YTD)



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

4. Financial Position

4.1 Statement of Financial Position as at 31 May 2020

$'000	31-May-20			30-Apr-20	Variance	30-Jun-19	Variance
	Actual	Budget	Variance	Actual	Last Month	Actual	Last Year
Public Equity	913,147	976,874	63,727U	909,872	3,274F	889,380	23,767F
Reserves							
Revaluation Reserve	599,151	599,151	0F	599,151	0F	599,151	0U
Accumulated Deficits from Prior Year's	(688,960)	(688,958)	1U	(688,960)	0F	(456,995)	231,965U
Current Surplus/(Deficit)	(18,306)	(8,540)	9,766U	(21,458)	3,152F	(231,965)	213,658F
	(108,114)	(98,347)	9,767U	(111,266)	3,152F	(89,808)	18,306U
Total Equity	**805,032**	**878,527**	**73,494U**	**798,607**	**6,426F**	**799,572**	**5,461F**
Non Current Assets							
Fixed Assets							
Land	347,122	347,122	0U	347,122	0F	347,122	0F
Buildings	603,680	628,306	24,626U	606,083	2,403U	631,462	27,783U
Plant & Equipment	82,060	99,939	17,879U	80,409	1,651F	86,580	4,520U
Work in Progress	101,094	149,420	48,326U	100,205	889F	52,223	48,871F
Total PPE	1,133,955	1,224,787	90,832U	1,133,818	136F	1,117,387	16,568F
Investments							
- Health Alliance	70,158	71,003	845U	70,158	0F	70,066	93F
- NZHPL	10,193	6,714	3,479F	9,911	282F	6,714	3,479F
- ADHB Term Deposits > 12 months	-	15,000	15,000U	-	0F	15,000	15,000U
- Other Investments	938	-	938F	938	0F	937	1F
	81,289	92,717	11,428U	81,007	282F	92,717	11,428U
Intangible Assets	2,194	1,419	775F	2,255	61U	1,810	384F
Trust Funds	15,831	17,200	1,369U	15,773	59F	17,200	1,368U
	99,314	111,336	12,022U	99,035	279F	111,727	12,413U
Total Non Current Assets	**1,233,269**	**1,336,123**	**102,853U**	**1,232,853**	**416F**	**1,229,114**	**4,155F**
Current Assets							
Cash & Short Term Deposits	136,133	101,305	34,828F	130,413	5,720F	97,046	39,087F
Trust Deposits > 3months	18,316	13,300	5,016F	19,557	1,241U	13,300	5,016F
ADHB Term Deposits > 3 months	15,000	15,000	0F	15,000	0F	15,000	0F
Debtors	22,700	30,081	7,381U	30,002	7,303U	30,081	7,382U
Accrued Income	59,126	56,786	2,340F	35,292	23,834F	56,786	2,340F
Prepayments	1,912	996	916F	2,112	199U	996	917F
Inventory	35,156	14,357	20,799F	35,685	530U	14,356	20,799F
Total Current Assets	**288,344**	**231,825**	**56,519F**	**268,062**	**20,282F**	**227,566**	**60,778F**
Current Liabilities							
Borrowing	(1,520)	(3,879)	2,359F	(1,410)	109U	(1,079)	441U
Trade & Other Creditors, Provisions	(186,227)	(166,668)	19,559U	(189,157)	2,930F	(147,836)	38,391U
Employee Entitlements	(444,493)	(428,008)	16,485U	(430,944)	13,548U	(428,009)	16,484U
Funds Held in Trust	(1,308)	(1,275)	33U	(1,308)	0F	(1,308)	0U
Total Current Liabilities	**(633,547)**	**(599,830)**	**33,717U**	**(622,819)**	**10,727U**	**(578,231)**	**55,316U**
Working Capital	**(345,203)**	**(368,005)**	**22,802F**	**(354,757)**	**9,554F**	**(350,665)**	**5,462F**
Non Current Liabilities							
Borrowings	(9,357)	(19,697)	10,340F	(9,596)	239F	(8,983)	373U
Employee Entitlements	(73,677)	(69,894)	3,783U	(69,894)	3,783U	(69,894)	3,783U
Total Non Current Liabilities	**(83,033)**	**(89,591)**	**6,558F**	**(79,490)**	**3,543U**	**(78,877)**	**4,156U**
Net Assets	**805,032**	**878,527**	**73,494U**	**798,607**	**6,426F**	**799,572**	**5,461F**

Commentary

The major variances to budget are summarised below:

Property, Plant and Equipment:
The variance reflects capital expenditure tracking below budget as at May 2020. Budgeted capital spend is based on timing of implementation of capital projects as advised by services which may vary due to timing of capital approval, procurement and implementation timeframes. A number of Capital projects were also paused or delayed due to Covid-19.

Cash and Short Term Deposits:
The higher than budgeted balance mainly reflects the impact of the delay in the capital program on cash and timing of receipts and payments. The cash balances include $15M ADHB investment that matured and has not yet been rolled over.

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

Trade & Other Creditors and Provisions:

Trade & Other Creditors, Provisions:	**$000's**
Trade Creditors (including accruals)	162,522
Income in Advance	23,611
Total	186,227

4.2 Statement of Cash flows as at 31 May 2020

$000's	31-May-20			YTD (eleven months ending 31 May-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Revenue Received	204,355	203,717	638F	2,286,821	2,252,119	34,702F
Payments						
Personnel	(86,646)	(100,477)	13,831F	(1,009,477)	(1,015,541)	6,064F
Suppliers	(50,162)	(46,775)	3,387U	(545,081)	(520,317)	24,764U
Capital Charge	0	0	0F	(23,109)	(24,022)	913F
Payments to other DHBs and Providers	(60,416)	(59,095)	1,321U	(639,959)	(646,117)	6,158F
GST	(1,383)	0	1,383U	(179)	0	179U
	(198,608)	(206,347)	7,739F	(2,217,806)	(2,205,997)	11,809U
Net Operating Cash flows	**5,747**	**(2,630)**	**8,377F**	**69,015**	**46,122**	**22,893F**
Investing						
Interest Income	187	454	267U	3,981	4,994	1,013U
Sale of Assets	0	0	0F	135	0	135F
Purchase Fixed Assets	(4,554)	(13,335)	8,781F	(66,002)	(146,685)	80,683F
Investments and restricted trust funds	1,218	0	1,218F	7,929	0	7,929F
Net Investing Cash flows	**(3,150)**	**(12,881)**	**9,731F**	**(53,957)**	**(141,691)**	**87,734F**
Financing						
Interest paid	(22)	(116)	94F	(551)	(1,180)	629F
New loans raised	0	4,000	4,000U	2,137	13,514	11,377U
Loans repaid	(130)	0	130U	(1,323)	0	1,323U
Other Equity Movement	3,274	7,954	4,680U	23,767	87,494	63,727U
Net Financing Cash flows	**3,122**	**11,838**	**8,716U**	**24,030**	**99,828**	**75,798U**
Total Net Cash flows	**5,720**	**(3,673)**	**9,393F**	**39,088**	**4,259**	**34,829F**
Opening Cash	130,413	104,979	25,434F	97,046	97,047	1U
Total Net Cash flows	5,720	(3,673)	9,393F	39,088	4,259	34,829F
Closing Cash	**136,133**	**101,306**	**34,828F**	**136,136**	**101,306**	**34,828F**
ADHB Cash				132,885	98,400	34,485F
A+ Trust Cash				2,903	2,562	341F
A+ Trust Deposits - Short Term < 3 months & restricted fund deposits				346	343	3F
				136,133	**101,306**	**34,828F**
ADHB Short Term Investments 3 > 12 months				15,000	15,000	0F
A+ Trust Short Term Investments 3 > 12 months				18,316	13,300	5,016F
ADHB Long Term Investments				-	15,000	15,000U
A+ Trust Long Term Investment Portfolio				15,831	17,200	1,369U
Total Cash & Deposits				**185,281**	**161,805**	**23,474F**

Planning Funding and Outcomes Update

Recommendation

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

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

Glossary

ARC	-	Aged Residential Care
ARDS	-	Auckland Regional Dental Service
ARPHS	-	Auckland Regional Public Health Service
B4SC	-	B4 School Checks
CBAC	-	Community Based Assessment Centres
CHCC	-	Child Health Connection Centre (Uri Ririki)
CSCS	-	Cervical Screening Coordination Service
CT	-	Computed Tomography
DHB	-	District Health Board
EP	-	Electrophysiology
ESPI	-	Elective Services Performance Indicators
FCT	-	Faster Cancer Treatment
GP	-	General Practitioner/General Practice
HH	-	Healthy Homes (Noho Āhuru)
HIPAA	-	Health Insurance Portability and Accountability Act
HPV	-	Human Papilloma Virus
HVAZ	-	Healthy Village Action Zones
IDF	-	Inter District Flow
IMT	-	Incident Management Team
LARC	-	Long Acting Reversible Contraception
MELAA	-	Asian & Middle Eastern Latin American and African
MHA	-	Mental Health and Addictions
MMR	-	Mumps, Measles and Rubella
MoH	-	Ministry of Health
MRI	-	Magnetic Resonance Imaging
MSD	-	Ministry of Social Development
NCHIP	-	National Child Health Information Platform
NCSP	-	National Cervical Screening Programme
NGO	-	Non-Governmental Organisation
NIR	-	National Immunisation Register
NRA	-	Northern Region Alliance
NRHCC	-	Northern Region Health Coordination Centre
OIS	-	Outreach Immunisation Service
PFO	-	Planning, Funding and Outcomes

PHAP	-	Pacific Health Action Plan
PHARMAC		The Pharmaceutical Management Agency
PHO	-	Primary Health Organisation
POAC	-	Primary Options for Acute Care
PPAL	-	Positive Parenting Active Lifestyle
PPE		Personal Protective Equipment
PRRT	-	Peptide Receptor Radionuclide Therapy
SOI	-	Statement of Intent
SPE	-	Statement of Performance Expectations
TDU	-	Transportable Dental Units
WCTO	-	Well Child Tamariki Ora

1. Purpose

This report updates the Auckland District Health Board (DHB) on Planning and Funding and Outcomes (PFO) activities and areas of priority, since its last meeting on 20 May 2020.

2. Planning

2.1 Annual Plans

The Ministry of Health (MoH) have adjusted the 2020/21 annual planning timelines and processes in response to the disruption caused to DHBs in their response to COVID-19.

Feedback on the first draft 2020/21 Annual Plans along with adjustments to the planning guidance as a result of COVID-19 have been received and revisions to Annual Plans are currently underway.

The MoH's financial monitoring team will continue to engage on financial templates during this period.

Central Government Agencies considered a range of options to allow for the impact on timelines caused by the COVID-19 response work, including modifying legislative requirements to assist entities to manage legislative planning and reporting requirements. Thus, there is now a modification to the Crown Entities Act (149CA) – below.

149CA Responsible Minister may grant extension of time for obligation to prepare statement of performance expectations: COVID-19

(1) A responsible Minister may grant an extension, of up to 3 months, for a Crown entity to prepare the Crown entity's statement of performance expectations that is due to be prepared for the financial year beginning on 1 July 2020.

(2) However, the responsible Minister must not grant an extension unless the responsible Minister is satisfied that, as a consequence of the effects of COVID-19,—

(a) the Crown entity is unable to, or will experience significant difficulties if required to, prepare the statement of performance expectations before 1 July 2020; or

(b) the Crown entity is unable to adequately assess how its operations in the forthcoming financial year will be affected and the extension will enable it to provide a better statement of performance expectations than it would be able to if the extension were not granted.

(3) If the responsible Minister grants an extension under this section,—

(a) the time for providing a draft statement of performance expectations to the responsible Minister under section 149I(2)(a)(i) is extended by the same period; and

(b) the entity must (despite section 149I(2)(c)(i)) provide the final statement of performance expectations to its responsible Minister as soon as practicable after receiving the responsible Minister's comments (if any) but before the end of the period of the extension; and

(c) the responsible Minister must, as soon as practicable after granting the extension, notify the Crown entity of the extension and the Minister's reasons for granting it; and

(d) the Crown entity must, as soon as practicable after receiving notice under paragraph (c), publish notice of the extension, and the Minister's reasons for granting it, on an Internet site maintained by or on behalf of the Crown entity; and

(e) the Crown entity must include, in the next annual report that it provides to its responsible Minister for presentation to the House of Representatives under section 150, a statement of the extension and the Minister's reasons for granting it.

(4) This section is repealed on 1 October 2020.

Section 149CA: inserted, on 30 April 2020, by section 40 of the COVID-19 Response (Taxation and Other Regulatory Urgent Measures) Act 2020 (2020 No 10).

This legislation was passed on 30 April 2020 allowing Ministers to extend the time for meeting planning requirements that apply under the Crown Entities Act 2004 by up to three months due to the impacts of COVID-19. The relevant extension will be repealed on 1 October 2020.

The Minister of Health has agreed to extend the timeline for finalising and publishing DHBs 2020/21 statement of performance expectation (SPE) to 15 August 2020. The extension also applies to DHBs statement of intent (SOI) if we are choosing to produce one (noting the Minster of Health did not ask DHBs to produce updated SOIs for 2020/21).

The reason the extension has been granted is to reflect the revised timelines agreed for finalising 2020/21 DHB annual plans due to COVID-19 impacts, and to ensure quality SPE/SOI documents are produced that align with DHB annual plans and appropriately reflect COVID-19 recovery.

The legislation requires DHBs to publish a notice of the extension on their website, and the Minister's reasons for granting it. A statement of the notice and the reasons for granting it will also needs to be included in our annual report.

2.2 2019/20 Annual Reports

The Audit Plan has been agreed with the auditors and interim audit has commenced.

3. COVID-19 Response

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

Team members are now in the process of returning to their usual responsibilities.

4. Primary Care

4.1 COVID-19 Impacts

It is too early to tell what the impact of the rahui on general practice and community pharmacy. As advised in the last update consultation rates at general practice declined by 50% or more, with a corresponding decrease in dispensing of medications. However, consultation rates are reported to be increasing as we have moved from alter level 4 to 2. Now we are at alert level 1 we would anticipate a return back to pre-rahui levels of patient engagement.

A set of metrics to measure primary care activity have been developed and will be available on an on-going basis. There is still work required to capture the data consistently so the robustness and accuracy of the data will improve over time. The following graph showing consultations per 1000 enrolled population by week and ethnicity is an example of the data being captured.

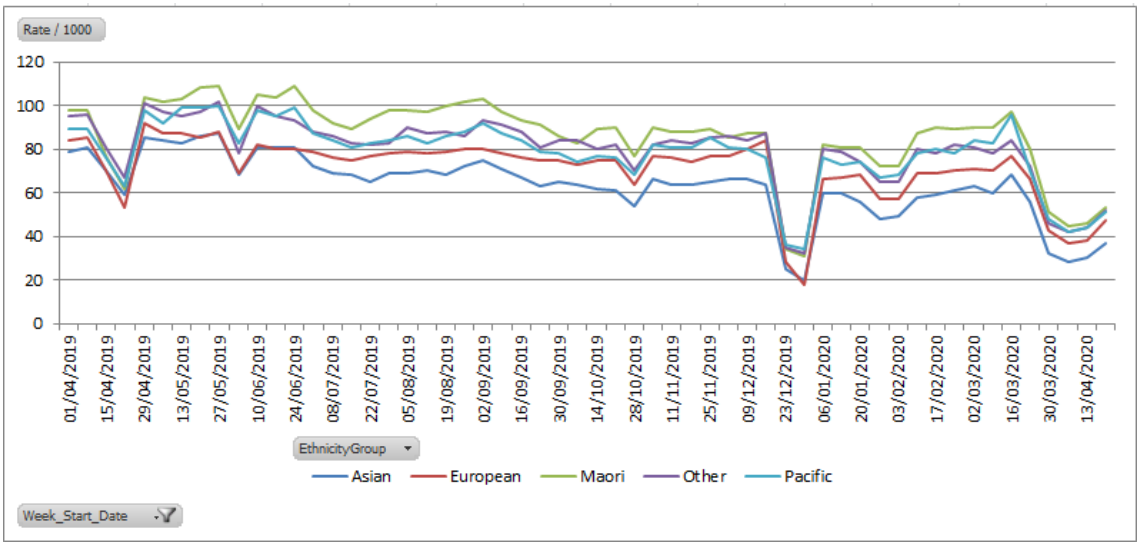


Figure 1. Weekly Primary Care consultations per 1000 enrolled population by ethnicity in 2019 and 2020 (Auckland DHB).

Work has been undertaken with PHOs nationally to look at how some of the changes, such as use of digital consultations, can be retained and included in business as usual. A proposal on this is being prepared for consideration.

5. Health of Older People

5.1 Aged Residential Care

In April the Government announced $26 million funding support for aged residential care (ARC) for additional costs incurred by COVID-19. Additional costs included managing residents in isolation, extra monitoring/screening of residents and staff, extra cleaning and communication particularly ensuring residents had regular contact with their families. This funding was allocated to ARC facilities based on set rates for the four levels of care and applied to the number of residents in the facility

prior to the lockdown. The ARC sector has been clear that their view is the additional costs incurred are significantly higher than $26 million.

PFO has been holding debrief sessions on ARC facilities' experiences during the lockdown through the local ARC Steering Group and cluster groups. ARC remains a high risk setting for a COVID-19 outbreak as the country moves to Alert Level 1 and contingency planning for such an event is a priority.

ARC audits were put on hold by HealthCERT until September but they will now re-start sooner; the start date will be confirmed by the MoH within the next week.

5.2 Other Health of Older People Services

Non-essential Home and Community Support Services are being reinstated but it requires a case by case discussion with clients and their families eg some clients are hesitant to have support workers back in their homes.

Dementia day programmes started delivering limited services under Alert level 2 eg limits on the number of participants and social distancing rules but a return to usual service will occur under Alert Level 1.

The In Home Strength and Balance Programme for falls prevention is now operating at full capacity.

6. Child, Youth and Women's Health

6.1 Immunisation

6.1.1 Childhood Immunisation Schedule Vaccinations

Monitoring of the cohort of children turning 8 months of age during quarter 4 indicates 93% are already fully immunised, however we are unlikely to meet the 95% target. Despite concerns of COVID-19 impact, we are achieving the same coverage as the same time last year for the total population. Māori coverage for this quarter is 81%, approximately 1% ahead of the same time last year. With the Outreach Immunisation Service (OIS) re-starting the drop-in aspect of their service, all immunisation services have now resumed.

The COVID-19 impact is more likely to be felt in the first quarter of 2020/21. We are monitoring 6 month and 18 month immunisation coverage as a measure of timeliness. The 3 month rolling average coverage for children turning 6 months appears stable, however the one month rolling average, a more 'real-time' indication, has shown a reduction in coverage. This is consistent with community feedback regarding reluctance to access health services. Tamariki Māori have been most affected by the drop in on-time coverage and we are working with our Primary Healthcare Organisations (PHOs) and Well Child Tamariki Ora (WCTO) colleagues on initiatives to catch up these children.

6.1.2 Influenza vaccination

There has been strong demand for the influenza vaccine this year. High coverage was an important part of the COVID-19 response as reducing the impact of influenza takes pressure off the health sector.

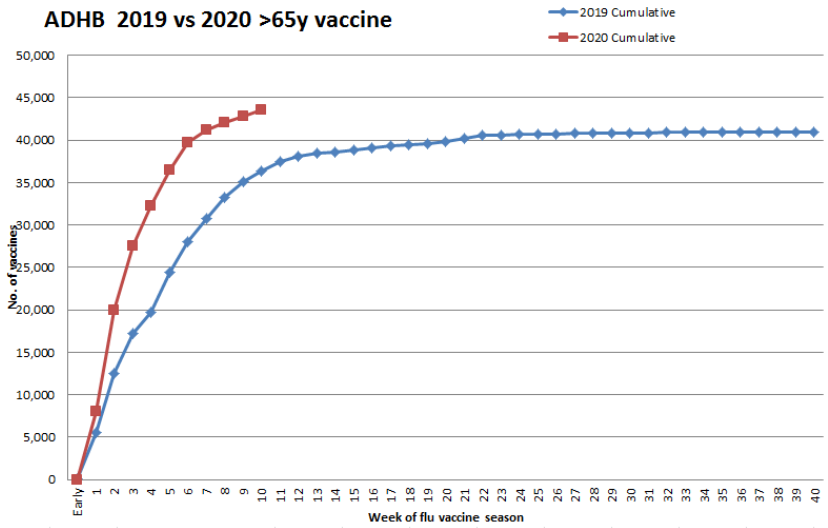


Figure 2. Number of influenza vaccines given to over 65 year olds in 2020 and 2019 (Auckland DHB).

Tracking of vaccines given to over 65 year olds in 2020 against the same week of 'flu vaccine being available in 2019 has demonstrated a significant increase in early demand. The sector is commended for responding to this high demand.

The Pharmaceutical Management Agency (PHARMAC) has now sourced a supply of the Northern Hemisphere 'flu vaccine – three of the four strains match the vaccine being used in New Zealand. The MoH have requested that the northern hemisphere vaccine be used for those that are not eligible for funded 'flu vaccination, allowing the New Zealand matched vaccine to be prioritised for those most vulnerable to complications of the 'flu.

Supply of the 'flu vaccine for under 3 year olds is almost exhausted despite supply being three times that used in 2019. The MoH ring-fenced 2,000 doses, with Metro Auckland collectively bidding for a supply of these vaccines. This vaccine is only to be used for eligible patients.

The Auckland and Waitematā DHBs 'flu Rapid Response project ran for 6 weeks taking an intentional approach to increase access for Māori, Pacific and those living in quintile 5 areas. Throughout April and May the small team delivered in-home 'flu vaccinations and street level clinics for those unable to attend a primary care provider. A whole of whānau approach was taken so while 'flu was the entry point, people of all ages in the household were offered any immunisation they were due. More than 450 people were given at least one immunisation by the team with about half delivered in the home. The project closed on 31 May 2020. Further review and analysis will be provided in the next funder report. Learnings from the Child, Youth and Women's team led rapid response team are being shared with the Māori and Pacific-led mobile clinic planning teams.

6.1.3 Measles

The MoH has provided funding for a Measles, Mumps and Rubella (MMR) vaccination catch-up programme, targeted at the 15-29 year old age group, with a focus on Māori and Pacific communities. A draft plan is with the Māori Health Gain and Pacific Health Gain teams for feedback. The plan intends to build on the successes of the Enhanced School Based Health Service and School Based Immunisation Programmes, along with additional initiatives to engage Kura Kaupapa, Tertiary Institutes, Family Planning, Sexual Health clinics and specific workplaces. Primary care, Pharmacy and dedicated teams to support the delivery of the programme will be part of the response.

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

6.2 Uri Ririki – Child Health Connection Centre

The Uri Ririki - Child Health Connection Centre (CHCC) is now established. Uri Ririki comprises teams of administrators tasked with management of the National Immunisation Register (NIR), National Child Health Information Platform (NCHIP) and Noho Āhuru – Healthy Homes (formerly called Kāinga Ora). The full complement of administrators have been appointed and the service management level is being further developed. An operations manager has been seconded for six months to oversee the next stage of service development and a new clinical lead role is being progressed to work across the 3 register-based services, with a focus on improving equity for the highest needs children.

The repatriation of the NIR into Uri Ririki - Child Health Connection Centre continues to have been a success, providing ongoing support to general practices and immunisation providers. The NIR has successfully moved to a new national platform via clinical portal. The local team conducted some user acceptance testing and are helping work through teething issues.

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

Linkages with the Ministry of Social Development (MSD) continue to evolve, with business processes in place to share contact information for children who are overdue immunisations and unable to be located with current information. This will continue to be finessed. There is a strong focus on ensuring privacy and security processes are followed.

Noho Āhuru – Healthy Homes (HH) has largely resumed business as usual. Referrals are coming through slowly, with an increase compared to the level 4 period, but still substantially less than usual for this time of year. This likely reflects reduced engagement with health services. Noho Āhuru-Healthy Homes social work providers are completing home visits and assessments. Protocols are in place around screening, Personal Protective Equipment (PPE) and social distancing. Where families are not comfortable with a home visit at the current time, the assessment is deferred and a new time will be offered. Capacity in some partner agencies is limited at present. Significantly for the service, MSD are still unable to resume housing assessments for our whānau. We are working to prioritise housing assessment for cases with risk for rheumatic fever with MSD. Housing assessment at MSD was expected to resume at level 2. This will have an impact on the ability to resolve cases swiftly.

The charity Variety has agreed to provide funds for ‘beds for kids’ to our service for another year. This enables Noho Āhuru – Healthy Homes to provide beds and bedding for many households. Habitat for Humanity, which has been a partner for several years, providing minor repairs, curtains and home performance advice has not been successful in gaining the philanthropic funding they were seeking. We are working with them to understand what a more modest service for our whānau might look like and to consider other sources of funding. A pilot project with similar goals around working with landlords and home performance education has been funded separately with Sustain and Enable. Sustain and Enable will see a small number of families across the metro Auckland region and evaluate how they can most effectively and efficiently provide support to families in problematic housing.

As at 31 May 2020, Auckland DHB received 1,373 referrals to Noho Āhuru – Healthy Homes. This included 5,175 family members getting access to healthier home interventions. Of the referrals received, 453 (33%) were for families with a newborn baby or hapu woman.

6.3 Well Child Tamariki Ora and B4 School Check

Following moving to alert level 4 of the COVID-19 response and guidance from the MoH, the Well WCTO and B4 School Check (B4SC) within Auckland DHB moved to a virtual provision of services. Although the recommendation was to move to virtual services, Starship community continued to prioritise face to face visits for whānau with children between 0-3 months of age especially for those whānau with highest health and social needs.

All the WCTO virtual services were prioritised for the following:

- Whānau with new babies.
- Whānau with infants aged between birth and 3 months who are:
    - Māori and/or Pacific
    - first time parents
    - living in areas of high deprivation
    - where the WCTO nurse has identified high need
- Any whānau where the WCTO nurse had assessed high long-term need or risk to child health and wellbeing outcomes.

In addition to virtual WCTO services, Ngati Whatua Orakei and Health Star Pacific provided food vouchers as well.

All new face to face B4SC contacts were suspended during alert Level 4 COVID-19 response and the provider was requested to plan on how to catch up all those checks that had been deferred. Plunket continued engagement with high needs whānau and kept them informed about when the B4SC would start again. Engagement was via phone, Facebook messenger or zoom.

During alert level 2 COVID-19 response, the face-to-face WCTO and the B4SC services have resumed. However, it is expected that WCTO services will be delivered through a mix of virtual (telephone and video call) and in person contacts as services adjust to the new normal for care delivery. For both WCTO and B4SC services, providers have been advised to follow the health professional home visit guideline which advises on pre- contact screening for COVID-19 risk.

6.4 Rheumatic Fever

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

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

6.5 Children and Adolescents’ Oral Health

During Level 2, Auckland Regional Dental Service (ARDS) is operating 16 fixed hub clinics across metro Auckland. Planning is underway to get Transportable Dental Units (TDUs) operating again. Some schools are reluctant to have TDUs at their campus as school principals are apprehensive about bringing outside families and children into their campus. At the moment priority is given to children within their own schools and with alert level changes more and more schools are willing to have

TDUs at their schools. Priority is given to schools based on decile ratings, percentage of Māori and Pacific children and number of children overdue for treatment at a particular school.

To address urgent need and service interruption caused by COVID-19, ARDS is prioritising extractions and seeing children who had pain during alert levels 4 and 3. As a result routine appointments are not offered at the moment. The second priority is given for children needing restorations on their permanent teeth which will be followed by those who have decay in deciduous teeth. A detailed recovery plan is being developed by ARDS.

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

The emergency relief of pain service continues to operate at Buckland Road dental facility for low income adults.

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

In alignment with MOH/Dental Council New Zealand guidelines during Level 2, phone calls from hapu māmā were triaged and appointments offered for relief of pain or immediate concern that meet clinical guidelines. In addition, appointments were offered for extractions and permanent restorations if graded by the dentist as Priority 1-3 status. The service will resume as normal for Hapu Māmā Oranga Niho Ki Tamaki under Level 1.

6.6.1 Referrals

Forty-six referrals have been received and 42 of the 46 referrals have been accepted (91%). Of the 4 declined referrals, 3 were declined as the patients were living out of the area and 1 was declined as it was a duplicate. 45 of the 46 referrals were from Auckland DHB community midwives (98%). The average age of the hapu māmā referred to the service is 28 years old (the range is 19 to 39 years of age). 66% the hapu māmā referred to the service were Pacific Island; 29% were Māori; 4% were NZ European; 1% Asian.

6.6.2 Attendance

In total, 91 appointments have been booked between 20 February 2020 and 2 June 2020. Of these 91 appointment bookings, 54 appointments were attended by 20 hapu māmā (attendance rate of 59%). The 20 hapu māmā who have attended have averaged 2.7 appointments each thus far (the range is between 1 and 5 appointments each). The average appointment length of the 54 attended appointments was 64 minutes (the range is between 25 minutes and 120 minutes). Of those who attended, 63% were Pacific Island; 31% were Māori; and 6% were New Zealand European. There was a 41% Did Not Attend rate. The midwives have been asked to provide additional encouragement to many hapu māmā in support of attendance.

6.7 Contraception

Commencement of services through the primary care agreements for contraception counselling and the provision of Long Acting Reversible Contraception (LARCs) has been slow during COVID response period. An agreement to manage service claims through the Primary Options for Acute Care (POAC) administration mechanism provided by Clinical Assessments Limited is being finalised.

Family Planning Association are progressing their plans to provide training in the insertion and removal of LARCs and contraception counselling. This will supplement the DHBs training of its own staff.

Several oral contraceptive pills have been difficult to obtain due to supply issues. PHARMAC and Medsafe have worked to identify alternatives. The disruption remains a concern.

6.8 Maternity

Maternity services continued throughout all Alert levels. DHB services have led and communicated changes within the DHB services, such as using virtual consultations where possible. There have been significant considerations for primary birth centres and Lead Maternity Carer midwifery services in relation to the safety of practice, as well as enabling safe home visiting for service delivery during this time. Services such as Pregnancy and Parenting have gone online during Level 4 and this platform has enabled some support to be provided to women who have seen other services reduced. The virtual service was reported to be very successful. The Funder will undertake a consumer survey to obtain insights into the stresses and successes that have emerged during this period.

Occupancy and length of stay at both Auckland Hospital and Birthcare have remained lower than pre-COVID averages. Births at Birthcare have remained at around the same level, while homebirths appear to have increased. Data to confirm this is being sought. The reduction in postnatal stays at both Auckland Hospital and Birthcare are thought to reflect women's preference to return home as soon as they can. Higher levels of support may have been available in many homes during lock-down.

6.9 Fertility

Fertility services are continuing to function with appropriate minimisation of face to face and other precautions. Prioritisation of services to minimise the impact of delays is being implemented and 'catch up' will be monitored over the coming months. Due to high demand relative to the size of the Northern Region Fertility Service, wait times are already substantial across all aspects of the service.

6.10 Cervical and Breast Screening

The National Cervical Screening Programme (NCSP) has signalled a return to normal screening. The implementation of this remains challenging in light of the capacity of primary care to provide high contact activities such as cervical screening in the current context, and the capacity of labs to prioritise processing cytology tests.

NCSP recently released new guidelines in addition to the previous newsletter advice in relation to the change to the test of cure pathway for women after completion of colposcopy. The Cervical Screening Coordination Service (CSCS) in PFO has provided communications to the primary care sector regarding the change and will follow up with new guidelines. This will involve a review of relevant advice provided through Health Pathways and similar tools as well as working to ensure that implementation is planned and communicated with Colposcopy services.

Concern remains in the primary care sector around capacity to resume screening 'as normal', and the competing demands of catching up normal screens delayed due to COVID-19 restrictions and prioritising women who have never been screened, have become overdue or not regularly screened and those with a history of cervical abnormalities. Women who have never been screened, who are very overdue for screening or overdue with a history of cervical abnormality are at the greatest clinical risk for cervical cancer.

The shift to Human Papilloma Virus (HPV) Primary Screening (primary HPV testing) has been planned by the National Cervical Screening Programme (NCSP) for several years. Previous commencement dates for this change in testing protocol were delayed due to the availability of an updated register

to support the screening programme with new protocols. The National Screening Unit has indicated that they will work towards a shift to primary HPV testing is indicated to commence from 2021. The change in test is supported by strong evidence and is now the accepted standard internationally. Implementation of the planned change was recommended by the Parliamentary review of the NCSP in 2018. An HPV primary screening programme provides a number of opportunities to improve the reach of the screening programme and address capacity constraints. Most screening would become 5 yearly rather than 3 yearly, and the possible inclusion of self-testing could reduce the reliance on face to face visits to health care practices for a large proportion of visits, enabling a focus on follow up visits and targeted support where risk is identified through the screening test. The recent experiences of service delivery under COVID-19 has reinforced the value in reconsidering how services are provided. We are optimistic that the service delivery model under an HPV primary screening programme will enable a more woman centred and sustainable cervical screening programme to be delivered.

7. Mental Health and Addictions

7.1 Response to COVID-19

7.1.1 Infection Prevention and Control Assessments – COVID-19 Preparedness Site Assessments

The directive on the 11 April 2020 from the Director General of Health for all ARC facilities in the country to be comprehensively assessed on their level of preparedness for COVID-19 and to identify any actions to improve their readiness was subsequently extended to mental health and addictions (MHA) and disability residential services.

Northern region MHA Portfolio Managers and Mental Health Specialist Services have jointly taken a lead on providing COVID-19 preparedness assessments (infection prevention and control) for all Non-Government Organisation (NGO) residential, treatment and respite facilities in the region. This has been overseen by the NRHCC, with support and direction from each DHB's Incident Management Team (IMT).

In the MHA process, fifteen Auckland DHB area NGO providers (33 sites) have completed a self-assessment in the first instance, followed by a virtual site visit assessment from nurse-led teams from Provider arm, with oversight and support by PFO. Information from the self-assessments and virtual site-visits has been collated and each Provider will be supported to complete all required actions. This will ensure full preparedness for infection prevention and control in the COVID environment.

The Digital Enablement team (Auckland DHB) was engaged to develop a digital assessment form and platform for management of the site assessment data in the Microsoft Teams environment. This form and data management platform is being used by all four DHBs in the Northern region. All staff involved in the virtual site assessments have been provided with Teams and digital form training.

7.1.2 Counselling and group services

Hearts & Minds is a North Shore-based NGO funded to provide health navigation services, individual face to face counselling and primary mental health group therapy. As a response to COVID-19, Hearts & Minds has been provided with emergency funding of $50,000 to move its counselling and group services to a tele-health / online basis from March to 30 June 2020. Services provided include:

- Online groups
  Two initial online groups (1 hour sessions over 6 weeks) commenced on 13 April 2020. Participants in these groups have been asked to complete written evaluation forms. Hearts and Minds are currently considering a group in Mandarin.

- Telephone counselling
  This service has received 16 referrals and Hearts & Minds are promoting it.

Hearts & Minds will provide specific reporting on utilisation of the emergency funding.

7.2 Whakatau Mai/The Wellbeing Sessions

Developed by Changing Minds, in consultation with Planning and Funding, Whakatau mai/The Wellbeing Sessions are a MoH funded initiative developed in response to COVID-19. The Ministry has provided $261,465 for a six-month period until October 2020. Whakatau mai provides a series of wellbeing-focussed safe and interactive online webinars, groups and activities sessions designed to encourage wellbeing and connection; along with access to mental health support. Each session has trained mental health support and peer support workers to offer 1:1 assistance to participants needing extra support without requiring escalation to acute care or crisis teams. Therefore, this initiative may reduce pressure on existing DHB secondary services, while also increasing access and choice by offering a professional peer-led alternative to help-lines. As a trusted mental health service provider, Changing Minds are part of a network of connected mental health organisations across the country and is able to provide further referrals and escalate as required.

Many New Zealanders struggle to access secondary mental health services as they do not reach the threshold for care. Whakatau mai/The Wellbeing Sessions give people early access to support via easily accessible online platform and therefore is a sustainable solution to early access and choice far beyond the global pandemic. Entry to Whakatau Mai is by open and accessible registration processes, self-referral or any other referral source, including community support services and public health promotion. Registration criteria include digital signing of a non-disclosure agreement /confidentiality agreement and rules of engagement in the service. Each session is double encrypted with a unique link and password on registration, has a waiting room to prevent unregistered access, and is Health Insurance Portability and Accountability Act (HIPAA) compliant and moderated.

Following a successful pilot in April, twenty-two wellbeing sessions were offered in May and numbers of sessions per week are increasing exponentially. Topics in May ranged from fitness and nutrition, to peer-to-peer support groups examining gratitude and curiosity, to Hauora wellbeing, journaling and dealing with grief. Supporting Families also provide weekly seminars for whānau and those supporting someone else with mental health challenges. In addition to wellbeing sessions for the public, a seminar and workshop session has been co-hosted using the Whakatau Mai secure online platform, to allow Balance Aotearoa to facilitate lived experience feedback on a suicide prevention strategy. This demonstrates the wealth of opportunities provided via this platform.

To date, feedback has been extremely positive. Ninety-eight percent of respondents from the post-session survey confirm Whakatau Mai has helped them with their mental health and 95 percent would recommend the free virtual events to others. Interestingly, half the respondents said they took the session both for their own mental health and wellbeing and to support someone else, suggesting the programme also meets the need of whānau and friends.

Ongoing evaluation is a key component and will be used to demonstrate the need for sustainable funding.

7.3 Government Inquiry into Mental Health and Addiction Services (He Ara Oranga) and the Wellbeing Budget

7.3.1 Improved Access and Choice Integrated Mental Health

Following successful negotiations with the Ministry of Health, a revenue contract was signed by Auckland DHB on behalf of the Metro-Auckland collaborative in April 2020. Of the $18.7 million

revenue available within the initial 15-month term, $15.6 million is for service delivery and $3.1 million for enablement and workforce development.

This work is being progressed with the next stage involving Auckland DHB entering into contracts with Counties Manukau Health and Waitematā DHB.

7.4 Suicide Prevention and Postvention

The suicide prevention and postvention governance group recommenced their scheduled monthly meetings after a brief disruption during COVID-19. At the meeting, a process for signing off on the Suicide Prevention and Postvention Action Plan 2020/23 was established. This will occur after the working group has completed the work on revising this action plan and presented the final draft.

The process for recruitment for a suicide postvention facilitator is underway.

The Zero Suicide Framework Project has been on hiatus during the COVID-19 response. The project sponsor and manager are reconvening with Provider arm senior leadership to discuss bringing the project back online the week of June 8 2020.

8. Māori Health Gain

8.1 Māori mobile units

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

The core elements of this service are:

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

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

8.2 Kaimanaaki services

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

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

9. Pacific Health Gain

9.1 Pacific Health Action Plan (PHAP) Priority 3 – Pacific people eat healthy and stay active

The Pacific health gain team continues to support the implementation of the Positive Parenting Active Lifestyle (PPAL) to improve the participation rate of Pacific parents with children under 5 years of age. A key focus has been in relation to programme planning and support to engage with different Pacific communities and families.

9.2 Healthy Village Action Zones and Enua ola programmes

The Healthy Village Action Zones (HVAZ) and Enua ola service review recommendations have been considered and are ready to be discussed with key stakeholders, however, this was put on hold due to the COVID-19 pandemic. The HVAZ workforce has been involved in disseminating COVID-19 public health messages and delivering community education sessions within the community.

9.3 Influenza vaccinations

The Pacific health gain team advised and continues to contribute to the development of the Metro Auckland Influenza Vaccine Equity Project 2020. A number of strategies are being employed to increase 'flu vaccination uptake amongst Pacific peoples which include participation of primary care practices, pacific providers and a campaign to raise awareness targeting Pacific communities. As of 29 May 2020 69% of eligible Pacific people aged 65 years and over, domiciled in Auckland DHB, had received their 'flu vaccination.

9.4 Pacific Regional response to COVID-19

A Pacific regional response team was established in March to ensure that Pacific peoples and communities in the Northern Region are well supported and protected from COVID-19 and its complications. The Pacific mobile services were established as part of the COVID-19 response to improve access to vulnerable populations, those in high need and unable to access a CBAC or designated General practice for a COVID-19 swab and general assessment. Negotiations are underway to ensure this service continues until about August/September 2020 and is expanded to include primary care. It is envisaged that the service will still have the ability to support regional response work related to any future outbreaks or clusters.

10. Asian, Migrant and Former Refugee Health Gain

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

- **Implement the Asian, migrant, former refugee and current asylum seeker health plan 2020-2023.**

Significant intelligence throughout this COVID-19 pandemic has highlighted the vulnerability and inequities experienced for some Asian & Middle Eastern, Latin American & African (MELAA) subgroups. Further work is being considered as to how these needs may be met to enable a workforce cultural support response in Auckland DHB to be developed.

10.2 Increase access and utilisation to Health Services

Indicators:

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

The Asian PHO enrolment rate for Quarter 2 2020 was 86% (Auckland DHB) an increase of 1% between Quarter 1 2020 and Quarter 2 2020. Asian enrolment increased by 2,206 individuals. Auckland DHB has reached the interim 71% process target due to the change of the projected populations based on the 2019 population update. Next financial year's target will updated to reflect a 90% process target, to align with the national target. We will work on actions to increase pathways to primary care access and utilisation for our new Asian migrants.

The refreshed New Zealand Health & Disability System video in English has been finalised, and simplified Chinese, and rolling subtitles for Korean communities are being added. Online New Zealand Health & Disability System materials for Thai, Khmer, Farsi, Urdu, Somali, Tamil, Amharic, Tigrinya, Swahili, and Punjabi are also being developed to support the increasing communities settling and resettling in metro Auckland in these languages.

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

The national Quota Health Service Model will now roll out with the aim to start on 1 July 2020 (as planned). The July quota refugee intake is on-hold due to the global COVID-19 pandemic.

The 'Improving access to general practice services for former refugees and current asylum seekers' agreement' for the PHOs has been rolled over for the next financial year.

11. Hospitals

11.1 Cancer target

Auckland DHB has maintained compliance with the Faster Cancer Treatment (FCT) 62 day indicator having achieved 94.9% for the rolling six month period Oct-Mar 2020 and the Northern region rate for the same period is 84.3%. Throughout the COVID response, the Regional Cancer and Blood service maintained access to all elements of non-surgical treatment services and was able to reduce waiting times in Radiation Oncology.

11.2 2019/20 Auckland DHB Planned Care Initiative (formerly Elective Surgical Health Target)

As a result of the required COVID response, Auckland DHB limited elective surgery to high priority patients from late March to mid-May. For the year to date period to February, the ADHB provider

was achieving 90% of the planned inpatient surgical discharges for the Auckland DHB population, with an end of year forecast of approximately 1500 discharges less than planned. Due to reduced elective activity between March and June approximately 1300 patients did not receive elective surgery as planned. The provider has increased elective surgery production and expects to be achieving 100% of planned weekly discharges by the end of June. The Ministry of Health has agreed to make the full revenue payment due to the DHB for the month of June if the DHB exceeds 85%of the planned elective discharges and at this point the provider is confident that we can achieve this requirement.

11.3 Elective Services Performance Indicators (ESPI) Compliance

The Auckland DHB ESPI compliance position for both outpatient assessment (ESPI 2) and surgical and treatment services (ESPI 5) has deteriorated as a result of the substantially reduced access to planned care specialist assessment and treatment services during the COVID 19 response. Ministry of Health data available early June shows that in March 1375 (8.9%) patients were waiting more than four months for outpatient assessments (ESPI 2) compared with 3.4% patients in February. This number is expected to increase substantially in the month of April. In April there was a significant reduction in the number of patients added to inpatient treatment waiting lists compared with February as a result of the cancellation of many clinics. In February 10% of patients on the inpatient treatment waiting lists were waiting more than four months and this has increased to 36% end of May. At this time it is too early to establish how long it will take to make a material improvement in the waiting time position; however the DHB expects to be delivering 100% of the weekly planned volumes by mid-June.

11.4 Orthopaedics

The discharge shortfall pre the impact of COVID was tracking ahead of the same period last year however Orthopaedic patients will have been disproportionately impacted by the cancellation of routine elective surgery during the COVID response, due to the relatively higher proportion of patients on this waiting list with a routine priority.

11.5 2019/20 Auckland DHB provider performance

For the period to March 2020 there were higher levels of acute activity than for the same period last year, however during the period of the COVID response (from national level 4 lockdown to national level 2) there was a significant reduction in the number of acute admissions to hospital with 20-40% less discharges per week from late March to late May compared with the same weeks in 2019. Acute admissions have yet to return to the same weekly levels as last year. For the May year to date period acute WIES discharges are 1.9% ($17.4M) less than planned and all medical and surgical elective discharges are 5.7% ($21.7M) less than planned, however there is an agreement in place for Auckland DHB to receive revenue at the planned levels for the months March – June inclusive.

11.6 Cardiac service demand

ADHB has developed a proposal for internal investment to address the regional electrophysiology (EP) waiting list; however this has not been progressed during the period of the national and regional COVID response. As for all other elective services, the waiting list has increased since March and there is a need to progress the internal investment needed to support the recovery of this waiting list.

11.7 Ophthalmology service demand

The restrictions associated with national alert levels 4 and 3 have had a significant impact on the outpatient first specialist assessment and follow up waiting lists given the high volume nature of this service, and together with capacity constraints prior to COVID, work is currently underway to source additional private community facility agreements to increase the capacity of the service to meet demand.

11.8 Policy Priority areas

Colonoscopy Indicators

Auckland DHB has consistently been unable to meet the national waiting time indicators for P2 colonoscopy and surveillance colonoscopy over the last 24 months. A plan was established to sustainably address these waiting lists in the week immediately prior to national lockdown at alert level 4. The outsourcing of 550 colonoscopies that was supposed to commence in mid-March, will now commence in early June. Due to reduced colonoscopy services being provided during the COVID response it is estimated that an additional 350 patients may now need to be outsourced. The combined increased regional demand for colonoscopy services is likely to exceed available capacity in private and public facilities and recovery of the waiting list position is expected to be slow. Opportunities to improve internal production were identified in March and work needs to be initiated to support and implement the identified improvements. As a result of the impact of COVID the Ministry of Health has deferred the roll out of the Bowel Screening Programme from August 2020 to November 2020.

Radiology Indicators

Auckland DHB has been unable to meet the waiting time indicator for MRI for a prolonged period of time and the reduced capacity as a result of implementing measures during the COVID-19 response means this situation is substantially worse and there has been a similar impact on the timely delivery of CT scans. Work has been undertaken to understand the regional demand for all Radiology modalities by DHB of service and identify the requirement to increase the use of private capacity. Additional private capacity for MRI is being accessed for ADHB to recover the backlog from COVID-19 reduction in capacity. The use of private comes with a relatively high risk of reducing DHB capacity if workforce is recruited from DHBs to manage this increased demand in private. Further consideration needs to be given to managing the consequences of increasing DHB outsourcing and this is in discussion regionally at present.

11.9 National Services

Following a MOH decision to fund access to Peptide Receptor Radionuclide therapy (PRRT) in Australia for specific patients with neuroendocrine tumours, a number of patients travelled to Melbourne for treatment and this process was facilitated by the ADHB clinical teams and funder. As a result of increasingly stringent border restrictions these arrangements had been put on hold during Level 3 and 4 national lockdown; however restrictions have been lifted with the assistance of the Australian Border Force and Ministry of Health, meaning patients are able to again access this treatment. . ADHB continues to develop the business case for planned implementation of the national PRRT service in 2021.

2020/21 Planned Care services

DHBs received Planned Care Policy advice from the Ministry of Health on the 5th June. This advice addresses the requirements for ongoing annual increases in access to assessment and treatment services that has been a longstanding priority of successive governments. This advice excludes the three year $283M funding announced by Government to support the COVID recovery. Auckland DHB has been allocated additional funding of $2.9M to increase access to planned care for 501 patients including 259 inpatient surgical discharges, 76 minor procedures and 172 non-surgical interventions. In addition to addressing the 2019/20 discharge shortfall (estimated pre COVID to be approximately 1500 discharges), there is a commitment to undertake all of this increased activity within the ADHB provider services. Oral Health treatment services for children have been identified as a key priority area for increased investment in 2020/21 with regional work underway to redesign the patient pathway and significantly reduce the time to treatment.

Regional Service Planning post COVID

The Auckland/Waitematā DHB Hospital funding team was deployed fulltime to support the Northern Region Health Coordination Centre (NRHCC) response to COVID with the Hospital Funder taking responsibility for leading the Regional Hospital Provider Planning and Capacity Response. As a result of benefits identified through different ways of working regionally across a number of functions in the NRHCC, the Northern region CEOs have agreed to extend the Regional Hospital Planning response to support a regionally consistent, equity focussed recovery of planned care services. One focus area is a programme of work to address longstanding vulnerable services with the intention of developing more sustainable and integrated regional services to support the whole population of the Northern region. The work programme is led by the Auckland DHB CEO and is supported by the Auckland DHB/Waitematā DHB Hospital Funding team and the Northern Regional Alliance (NRA) Chief Executive and team. A Regional Service Improvement Group meets weekly to support rapid progress of this work and both Maori and Pacific regional clinical leadership groups are being formally established to provide advice, input and oversight of the work programme.

Taking bigger strides: Sustaining health services and tackling persistent health inequity through national public advocacy to address structural and commercial determinants of obesity and alcohol related harm

Recommendations

That the board:

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

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Endorsed by:	Peter Huskinson (CEO, NRA) and Nick Chamberlain (CEO, NDHB)

Overview

1. DHB Chairs and Chief Executives have agreed to establish a new National Public Health Advocacy team to address the structural and commercial determinants of obesity and alcohol related harm. This paper provides a briefing for DHB boards about the new Public Health Advocacy team. For further information about this work or to provide feedback please contact Dr Rob Beaglehole at: Rob.Beaglehole@nra.health.nz

Context

2. Obesity and alcohol related harm are major public health challenges in NZ. Every year there are almost 10,000 premature deaths from unhealthy diet and unhealthy weight, and New Zealand ranks as the third most obese population of the 36 countries in the OECD. Both alcohol and obesity are major drivers of inequity for Māori, Pacific, and communities with high deprivation.

Risk Factor	Premature Deaths p.a	Years Lived with Disability p.a	Comment
Unhealthy Diet and High BMI	9,600	47,000	Third highest obesity prevalence among OECD countries. Significantly higher rates for Maori and Pacific
Alcohol Use	1,260	13,600	Estimated to be a factor in half of serious violent crimes in NZ

3. Effective public health legislation and policy initiatives are the most financially affordable and cost-effective interventions available to New Zealand to improve health status & health equity.1, 2These levers have the largest potential impact but require a sustained and smart strategic multi-year

[1] World Health Organisation, Tackling NCDS: *Best buys' and other recommended interventions for the prevention and control of non communicable diseases*. WHO, 2017.
[2] Masters et al., *Return on investment of public health interventions: a systematic review.* Journal of Epidemiology and Community Health, 2017.

approach to secure implementation.

4. Research shows that the public and policy makers can often focus on supporting individuals to make health choices but neglect the structural factors that currently make it easier for people to choose, (or default to) less healthy options, which can be particularly acute in communities facing high deprivation. There can also be commercial factors in play, sometimes putting individual firms in an invidious position that they feel they would be at a competitive disadvantage to be the first to act on a health related issue if their rivals do not. Smart public policy can ensure all firms act, and the most responsible firms feel confident to show early leadership.

5. The current coalition government has wellbeing policy objectives which are potentially congruent with this agenda but is starting from a food environment and regulatory position that benchmarks poorly against international comparators.

6. A hui and national workshop on these issues last year with DHB Chairs, Chief Executives and Ministry of Health representatives suggested that DHBs would be well placed to take forward advocacy and noted the importance of building cross party support to create the right climate for robust public health national policy that can be maintained across electoral cycles and changes in government.

7. COVID-19 and New Zealand's response to it also provide opportunities to progress this work. COVID-19 has highlighted the importance of public health. There is an increasing recognition and valuing of public health services and approaches. The response to the pandemic has also demonstrated New Zealanders willingness to make changes to our lifestyles and behavior in order to protect the most vulnerable.

8. The establishment of a National Public Health Service will strengthen the leadership of public health in NZ. The size and scope of this service is not yet clear and it is expected that at least initially it will have a focus on health protection. The National Public Health advocacy team will link and work with the new National Public Health Service as it develops.

Establishment of the Public Health Advocacy team

9. Following this hui DHB Chairs and CEOs agreed in late 2019 to establish a new national Public Health Advocacy team. The overarching aims for this work is:

   To improve the sustainability of the health system and help eliminate health inequities.

   To establish & deploy strategic communications and advocacy capability, using DHB assets, partners and connections to secure public and cross-party support for a more assertive national policy, smart regulation and legislation to make greater impact on structural and commercial determinants of health.

   The Northern Regional Alliance is hosting the new team under the leadership of Dr Nick Chamberlain, CEO of Northland District Health Board and national lead DHB Chief Executive for Public Health. Vui Mark Gosche, Board Chair of Counties Manukau District Health Board has been appointed by the national DHB Chairs to act as the Chair sponsor for the work that the team will be undertaking. DHBs have agreed to provide $400,000 initial funding for the establishment of this team in its first year.

10. A steering group with expert support drawn from across New Zealand is being established to help guide and advise on the priorities and work programme. Membership will include representatives from a range of DHBs and public health units as well as strong Maori and Pacific representation.

11. Doctor Rob Beaglehole has been appointed to lead the new team's establishment and development. Rob is a dentist and public health specialist. He currently works as the public health advocate in Nelson Marlborough District Health Board. Rob previously served as a senior political advisor to the Minister of Health and has worked internationally for the World Health Organisation and World Dental Federation. Due to the Covid-19 crisis Rob will initially be seconded into this role at 02.FTE until October 2020.

12. The team will complement the work of the Health Promotion Agency nationally, and the good practice

that exists within District Health Boards, regional Public Health Units, and partner agencies, and provide a valuable supportive resource for policy makers and leaders. The work will include co-ordination with DHB public health leaders to ensure the relevant DHB policies are strengthened, consistent, and reflective of best practice (e.g. healthy food and drink policies).

Next Steps

13. Preparatory work is underway and opportunistic support is being provided while DHBs and the health sector are focused on the COVID 19 response. Key next steps include the following:

    i. Building relationships with key stakeholders

    ii. Establish the expert steering group to help guide and advise on the team's priorities and work programme. (The group will be convened as New Zealand moves beyond the pandemic response and into recovery)

    iii. Recruit a Strategic Communications lead

    iv. Develop and agree initial priorities and work plan. Potential focus areas include:

    - Reviewing existing DHB Healthy Food and Beverage policies and implementation plans
    - Formulating a plan to support schools to adopt best practice Food and Beverage policies
    - Investigating where the reformulation of food process is up to with a focus on sugar and salt reduction
    - Identifying opportunities to address structural factors to reduce alcohol related harm

14. Regular updates will be provided once DHBs return to business as usual.

Appendix 1: Agreed Public Health Advocacy funding split by PBFF Shares as used in the 2019/20 PBFF model

DHB	Overall PBFF Share	$ Value
Auckland	9.51%	$38,031
Bay of Plenty	5.61%	$22,443
Canterbury	10.84%	$43,347
Capital & Coast	5.70%	$22,792
Counties Manukau	11.00%	$44,015
Hawkes Bay	3.84%	$15,361
Hutt	2.97%	$11,875
Lakes	2.50%	$10,013
Mid Central	4.00%	$16,018
Nelson Marlborough	3.39%	$13,579
Northland	4.64%	$18,561
South Canterbury	1.40%	$5,611
Southern	6.75%	$27,001
Tairawhiti	1.27%	$5,070
Taranaki	2.61%	$10,426
Waikato	8.98%	$35,921
Wairarapa	1.10%	$4,387
Waitemata	11.39%	$45,574
West Coast	0.86%	$3,456
Whanganui	1.63%	$6,516
Total	**100.00%**	**$400,000**

Resolution to exclude the public from the meeting

Recommendation

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

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

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

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