AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Open Board Meeting

Wednesday, 20 May 2020

10:00am

Note:

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

Via Zoom

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Published 15 May 2020

Ilo

Agenda
Meeting of the Board
20 May 2020

Venue: Via Zoom **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
	Riki Nia Nia	General Manager, Maori Health
	(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 and the Board Chair will consult with you as to when breaks are required.

Karakia

Karakia	*Translation*
Tu taua mai I runga, Tu taua mai I raro, Tu taua mai I roto, Tu taua mai I waho, Ki tau ai! Ko te mauri tu, Ko te mauri tau, Ko te mauri ora, Haumi ee! Hui ee! Taiki ee!	Draw forth from above Draw forth from below Draw forth from within Draw forth from the environment Vitality and wellbeing for All Strengthened in Unity.

10.05am	**1.**	**ATTENDANCE AND APOLOGIES**
10.07am	**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?
10.10am	**3.**	**CONFIRMATION OF OPEN MINUTES 26 FEBRUARY 2020** **Presented for Information Only**
	3.1	Open Minutes of the Executive Committee of Board 1 April 2020
	3.2	Open Minutes of the Executive Committee of Board 13 April 2020
	3.3	Open Minutes of the Executive Committee of Board 24 April 2020
	3.4	Open Minutes of the Executive Committee of Board 1 May 2020
10.15am	**4.**	**ACTION POINTS**
10.15am	**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
11.05am	**7.**	**COMMITTEE REPORTS**
	7.1	Hospital Advisory Committee Unconfirmed Minutes
11.07am	**8.**	**DECISION REPORTS**
	8.1	hA Class C share issue
	8.2	Auckland DHB Credit Card
11.15am	**9.**	**DICSCUSSION REPORTS**
	9.1	Auckland Regional Public Health Service Report on COVID 19
	9.2	Northern Region Health Coordination Centre – COVID 19 Update
	9.3	Incident Management Team Update - COVID-19 Update
11:45am	**10.**	**INFORMATION REPORTS**
	10.1	Supporting the Government Push for Increased Equity in Healthcare
	11.	**GENERAL BUSINESS**
12.15pm	**12.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Next Meeting: 1 July 2020 at 10am

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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	01 Jul. 20			
Pat Snedden (Board Chair)	1	c					
Joanne Agnew	1	c					
Doug Armstrong	1	c					
Michelle Atkinson	1	c					
Zoe Brownlie	1	c					
Peter Davis	1	c					
Tama Davis	1	c					
Fiona Lai	1	c					
Bernie O'Donnell	1	c					
Michael Quirke	1	c					
Ian Ward	x	c					

Key: 1 = present, x = absent, # = leave of absence, c = cancelled, resigned = r

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 Chair – National Science Challenge Programme – A Better Start 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	05.03.2020
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 Contracting role – Shea Pita and Associates Chargenet, Director & CEO – Partner	25.02.2020
Doug ARMSTRONG	Trustee – Woolf Fisher Trust *(both trusts are solely charitable and own shares in a large number of companies some health related. I have no beneficial or financial interest – I have no beneficial or financial interest)* Trustee- Sir Woolf Fisher Charitable Trust *(both trusts are solely charitable and own shares in a large number of companies some health related. I have no beneficial or financial interest – I have no beneficial or financial interest)* Member – Trans-Tasman Occupations Tribunal Daughter – *(daughter practices as a Barrister and may engage in health related work)* Meta – Moto Consulting Firm – (*friend and former colleague of the principal, Mr Richard Simpson)*	20.04.2020
Zoe BROWNLIE	Director - Belong Director - GenderTick Partner – CAYAD, Auckland Council Committee Member – RockEnrol Steering Committee	24.02.2020
Peter DAVIS	Retirement portfolio – Fisher and Paykel Retirement portfolio – Ryman Healthcare	19.11.2019

	Retirement portfolio – Arvida, Metlifecare, Oceania Healthcare, Summerset, 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 Chair Mana Whenua Working Group – Auckland Council Te Kete Rukuruku Board Member – Freemans Bay School Board Member – District Maori Leadership Board Iwi Affiliations – Ngati Whatua, Ngati Haua and Ngati Tuwharetoa	12.12.2019
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	12.12.2019
Ian WARD	Member – Ward Consulting Services Beneficiary – Trust Holding Shares Oceania Healthcare investments - wife	17.04.2020

Minutes
Meeting of the Board
26 February 2020

Minutes of the Auckland District Health Board meeting held on Wednesday, 26 February 2020 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 10:30am

Board Members Present	**Auckland DHB Executive Leadership Team Present**	
Pat Snedden (Board Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Mel Dooney	Chief People Officer
Doug Armstrong	Margaret Dotchin	Chief Nursing Officer
Michelle Atkinson	Mark Edwards	Chief Quality, Safety and Risk Officer
Zoe Brownlie	Joanne Gibbs	Director Provider Services
Peter Davis	Rosalie Percival	Chief Financial Officer
Tama Davis (Deputy Board Chair)	Meg Poutasi	Chief of Strategy, Participation and Improvement
Fiona Lai	Shayne Tong	Chief Digital Officer
Bernie O'Donnell	Sue Waters	Chief Health Professions Officer
Michael Quirke	Dr Margaret Wilsher	Chief Medical Officer
	Tim Wood	Acting Director of Funding Auckland and Waitemata DHBs
	Auckland DHB Senior Staff Present	
	Rachel Lorimer	Director Communications
	Marlene Skelton	Corporate Business Manager
	Melissa Moser	Executive Business Manager
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

1. ATTENDANCE AND APOLOGIES

That the apology of Board Member Ian Ward be received.

That the apologies of Executive Leadership Team members, Dr Karen Bartholomew, Director, Health Outcomes for Auckland and Waitemata DHBs, and Dr Debbie Holdsworth, Director of Funding – Auckland and Waitemata DHBs be received.

2. REGISTER AND CONFLICTS OF INTEREST

The Board Chair Pat Snedden asked that his register be amended by the removal of "Board Member – Kainiga Ora Homes and Communities Board.

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

3. CONFIRMATION OF MINUTES 18 DECEMBER 2019 (*Pages 10-25)*

Resolution: Moved Pat Snedden / Seconded Zoe Brownlie

That the minutes of the Board meeting held on 18 December 2019 be confirmed as a true and accurate record.

Carried

4. ACTION POINTS *(Page 26)*

There were no outstanding actions to review.

5. EXECUTIVE REPORTS

5.1 CHIEF EXECUTIVE'S REPORT *(Pages 27-38)*

Ailsa Claire, Chief Executive Officer asked that the report be taken as read and drew attention to points as follows:

Prime Ministerial announcement: capital funding for PICU expansion

Prime Minister Jacinda Ardern visited Starship Hospital on 31 January to meet staff and families, and announce a $25 million investment in the expansion of our paediatric intensive care unit (PICU).

This was a good result for Auckland DHB as nationally there are a lot of issues with PICU and Auckland DHB is experiencing a lot of use by other DHBs of our PICU unit.

Industrial Action

Industrial action by Medical Sonographers finished on February 17 when union members voted to accept the latest offer from the metropolitan Auckland DHBs.

This offer was accepted after facilitation and the mediation was consistent with the offer made by DHBs. This has solved the immediate problem but the waiting list, as a result of the strike action, is still to be resolved. Some outsourcing will be required but not to the level first envisaged.

Measles Mumps Rubella vaccination catch-up campaign announced

Minister Genter announced a commitment of $23 million with additional funding to come.

More than 350,000 additional Measles Mumps Rubella (MMR) vaccines are earmarked for the campaign, and are expected to arrive in April after a six month manufacturing process.

Auckland City Mission Christmas activity

In December, we provided opportunities for staff to contribute to the Mission's Christmas appeal, and our people gave 1,700 items and $4,389.51 in cash donations. This was a somewhat disappointing result as it was less than in previous years.

Year of the Nurse and Midwife 2020

The World Health Organisation (WHO) has designated 2020 as the "Year of the Nurse and midwife" in honour of the 200th birth anniversary of Florence Nightingale.

Margaret Dotchin, Chief Nursing Officer advised that Auckland DHB we are taking the year as an opportunity to shine a light on all of our amazing nurses and midwives for the things that they do every day that make such a difference to patients, whānau and their colleagues. "Hearts and Minds" stories will be collected around the privilege of nursing and the difference that can be made every day.

Local Heroes

There were 24 people nominated as local heroes in December, and 10 in January. Ailsa Claire explained to new Board members that this was a way in which Auckland DHB recognised the good things that staff were consistently achieving and that it was common to have numerous entries making it extremely difficult to just pick a few to acknowledge.

Priority Health Outcomes Summary

Ailsa Claire commented as follows:

The acute patient flow and improved access to elective surgery are below target as a result of consistent pressure and activity that is now typical of the winter period and which has flowed through the summer period with no signs of significantly abating.

Access to elective surgery is improving in Adult Health although not to the same degree in Children's Health. Efficiency programmes of work have been undertaken analysing how people are moving through the pathway to surgery. This has highlighted some issues with equity. Effort and focus has been placed on maximising the use of the Greenlane Clinical Centre which is now offering surgery 6 days a week.

PHOs in the area of "Better help for smokers to quit" are closer to achieving the target of 90%.

Auckland DHB does well when benchmarked against other DHBs for child immunisation.

Financial Performance

Of note is that the revised budget with a deficit of $20M has been accepted by the Ministry of Health.

Clinical Governance

Auckland DHB has had two people recognised in the New Year Honours, Dr Diane Webster for her contribution to the health of babies across New Zealand and former Clinical Director of General Surgery, Dr Murray MacCormack for services to health through his surgical work.

The following point was made during discussion of this item:

- Fiona Lai commented that she was a fan of health promotion and asked what plan was in place to deliver the more than 350,000 additional Measles, Mumps and Rubella (MMR) vaccines and was advised that this was a complex situation that warranted a separate report from Dr Karen Bartholomew at a future meeting in order to answer the question.

Resolution:

That the Chief Executives report for February 2020 be received.

Carried

5.2 Health and Safety Report *(Pages 39-91)*

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

- That there is a move within the public sector to increase the strength of health and safety. Ailsa Claire is lead DHB CEO for this work as a part of her leadership role on workforce.
- There is a Health and Safety Leaders Forum currently underway in Wellington at which the newly appointed Director of OHS, Alistair Forde and Occupational Health Clinical Lead, Dr Alexandra Muthu are in attendance.
- Health and safety is embedded in Auckland DHB via Health and Safety representatives in services and groups reporting to a Corporate Health and Safety Committee which reports through to the Board. There is some work to be done around engagement in some areas at the local health and safety level.

The following points were made during discussion of this item:

- It was explained that the star burst diagrams provide easy visibility of health and safety maturity showing where an area is strong and where more there is need for more work.
- Safe 365 helps to assess and benchmark the current state of health and safety maturity across contractors. It enables registered contractors to demonstrate their health and safety training and credentials. Auckland DHB is one of three DHBs engaged in a pilot of Safe 365. $1.5M is being spent as an injury prevention grant from over three years.
- Michael Quirke drew attention to page 45 of the agenda and item 3.7 Lead Indicators, specifically, % local H&S Induction completed (YTD) at 42%, commenting that this should be of concern to the Board. He wished to know the context of this and why it was so low. Sue Waters advised that induction was completed in three phases, the Navigate training, a local health and safety induction and then e-training modules in Ko Awatea. The local health and safety induction is being undertaken and a form filled out but that form often is not electronically filed. That is one reason why the figure is low. Mark Edwards advised that the Health and Safety team are looking at how to make this easier process. The Board were advised that it would take 6 months to effect an improvement as some culture shift was also required.
- Advice was given that the needle stick injuries rate fluctuation was in part attributable to when intakes of junior doctors occurred. It was possibly still an under-reporting of the actual number. There is no investigation currently underway to look at improving this but there are plans to do so.

Action

That a report be made to the Board on "% local H&S Induction completed", what was done, what changed and what the situation looks like with the passing of six months.

Resolution:

That the Health and Safety Performance Report for December 2019 be received.

Carried

6. COMMITTEE REPORTS

6.1 Planning and Funding Outcomes Update *(Pages 80-92)*

Tim Wood, Acting Director of Funding asked that the report be taken as read, advising as follows:

MMR Catch-Up

The $23M announced is actually $23M per annum for three years. It is unknown how much of this funding will be allocated to Auckland DHB. The challenge for the DHB is in tracing young Maori, those who have left school. Currently it is being investigated what other actions can be taken to improve access outside of visiting a GP.

Funded Family Care

Eligibility of funded family carers will expand to include partners and spouses of those with high or very high support needs, children and young people under 18 years, and the minimum age to be a family carer will lower to 16 years. This will be effective from June 2020 for DHBs.

There will be no change to the employment arrangements or pay rates for funded family carers under DHB policies as they are currently employed by providers and already receive pay rates consistent with the wider care and support workforce as a result of the pay equity settlement.

National Child Health Information Platform and NIR Transition (NCHIP)

When the national register was handed back to the DHBs in December there were some 1200 outstanding error messages within the Auckland and Waitemata DHBs. This is now down to a handful. This is an incredibly important quality measure which reflects both how well the new team are functioning and will hopefully have a positive flow on impact to our immunisation target.

Improved access and Choice

The MoH have notified the three metropolitan Auckland DHBs that they will enter in to an agreement for this. This involves a team consisting of health improvement practitioners, who are clinically qualified, and health coaches who receive through a warm hand over from a GP people with mental well-being need. Additionally this expands the Awhi Ora model developed by Auckland DHB in collaboration with patients in need, general practice, and mental health NGOs. The programme has a focus on equity with areas of high needs patients being prioritised. National Child Health Information Platform and NIR Transition

Haven Recovery Café

The Haven (Recovery Café) located on Karangahape Road in Auckland Central continues to experience high levels of utilisation. The Ministry of Health have advised that they want this initiative expanded and would fund two more cafes.

Pacific Health

Attention was drawn to Pacific Health initiatives on pages 88 and 89.

Iwi Board

The Board Chair, Pat Snedden drew attention to page 86 of the agenda and advised that the first Board meeting occurs on Friday, 28 February. A letter of affirmation for the Board is expected from the Minister this week.

The following points were made by board members during discussion of this item:

- Bernie O'Donnell commented that he was not seeing the required messages supporting Maori equity issues within the report.
- Peter Davis asked how NHI data was used to track and trace people through the system for example MMR catch-up data, how is it ensured that this is lodged in NCHIP. Tim Wood advised that there is an agreement with partners in relating to the sharing of data. Specific areas are improving for instance eye screening which is more sophisticated than it once was. Shayne Tong advised that NCHIP was allowing data at a macro level to aggregate from various sources. The Ministry of Health have a keen interest in this at the moment.
- Jo Agnew drew attention to page 91 of the agenda commenting that it was heartening to see the 10% more elective adult orthopaedic discharges being performed over last year. Jo Gibbs noted that there had been a seasonal dip over the Christmas period but numbers were now coming back into line.

Resolution:

That the Board note the key activities within the Planning, Funding and Outcomes Unit since the last update provided on 18 December 2019.

Carried

6.2 Novel Coronavirus (COVID-19) – Update *(Pages 93-95)*

Ailsa Claire, Chief Executive introduced William Rainger, Medical Officer of Health at the Auckland Regional Public Health Service who was the public health lead for the corona virus.

The Board Chair, Pat Snedden invited Dr Rainger to comment on what the Board should be ready to deal with and what communications should be going out.

Dr Rainger provided some background to the current situation advising that the internationally, most cases remain within mainland China with a spread beginning through Asia and Italy.

One person carrying the virus on average is affecting up to two others unlike measles where

one person on average infects up to 15 others. In countries where there had been the opportunity to prepare the spread of the virus had been much slower. Around 2% of China's population were affected but lower overall elsewhere. There had been no confirmed cases in New Zealand.

Dr Rainger was asked to outline what messages should be conveyed to the public. He commented that people should practice the normal sorts of hygiene disciplines such as washing hands, staying away from people and work if there was a suspicion of infection and to utilise reputable and authoritative sources of information.

The DHB needs to prepare for what will probably come to New Zealand and knowing that it will be as it faces a winter season. The likelihood of a widespread outbreak of the virus in New Zealand was probably low to moderate. The situation could be assisted by pushing the seasonal vaccination campaign really hard and engaging with communities to get messages out.

The Board Chair, Pat Snedden asked what mobilisation campaign was needed around those messages. Margaret Dotchin, Chief Nursing Officer advised that the Northern Regional Health Co-ordination Centre had a role to manage preparedness and co-ordinate a response. Local control was provided by way of "whole of health service" coordination with cooperation by numerous agencies to ensure preparedness. The Hospital Provider Arm was looking at hospital capacity to respond as part of a metro Auckland approach. Clinical technical advisory groups are established. A critique of pathways and timelines was being undertaken. Rachel Lorimer, Director of Communications advised that lots of conversations were underway about the virus at many levels. .

The following points were made by board members during discussion of this item:

- Tama Davis commented that unhelpful information was contained in current communications leading to a spike in xenophobic rhetoric about who could and could not come onto marae. There was a need for a single core message and he was looking for guidance in this respect.
- Fiona Lai reiterated Tama Davis's comments. The Asian community had similar concerns. Fiona wanted people told how they might actually contract the virus to allay fears. Let people know about hand hygiene, what the reputable media sources were and link this with the flu vaccination messages.
  Rachel Lorimer advised that work had begun with the Asian communities with videos prepared in Mandarin and Cantonese. The team is also working closely with primary care to provide them with the same messages which come from a single source.

  Ailsa Claire asked if the DHB could intervene on social media platforms to correct misinformation and was advised that this was extremely difficult and tricky and it would be more effective to release our own information and push it hard.
- Bernie O'Donnell commented that it needed to be clear what was to be told and when it was to be told. He was not hearing any clear key messages at this point. Dr Rainger commented that the virus was not sufficiently well understood to be able to give detailed messaging. General advice is that you must be within one metre of an

infected person for 15 minutes before you are at risk.

- Doug Armstrong commented that the community is not receiving very coherent messages. The Ministry of Health are doing a television campaign but at a very high level. People don't care about that. They want the simple common sense messages. Key bullet points are best so they are remembered, which are not alarmist and can be emphasised time and time again.

The Board Chair, Pat Snedden summarised the discussion by relaying that currently the Ministry of Health are the lead, there is a strategy and a method being employed at a local level around communication but information about the virus is still being collected.

The public are asking the health sector what we know and what they should be doing. So, continue to put out what we know and be authorative and clear and if we get it wrong then own up and correct it. The DHB needs to be out in front of its communities.

There is a need to target Maori communities and Rachel Lorimer is to talk to Tama Davis and Bernie O'Donnell about required communications.

Resolution:

That the Board:

1. Notes that as of 21 February 2020 there are no current outbreaks of 2019 Novel Coronavirus in New Zealand; however the likelihood of an imported case in New Zealand is high with low to moderate risk of a widespread outbreak.

2. Notes the regional response to the current outbreak overseas

Carried

6.3 System Level Measures – Quarter 2 Report *(Pages 96-124)*

Tim Wood, Acting Director of Funding asked that the report be taken as read, advising as follows:

System Level Measures is a programme that the Ministry of Health rolled out across Primary Care and the DHBs. The programme has six system level measures with activities themed and aimed at making a shift in performance.

The three metropolitan Auckland DHBs and the 7 PHOs are involved. The initial plan involved 106 measures which have now been reduced to 60 but it is felt that this still too many to report on. This year there is a refresh of the plan with a focus on a smaller number of things to ensure that there is more success with these.

The following points were made during discussion of this item:

- Peter Davis noted that ASH accounted for 30% of admissions and questioned whether through the use of the patient NHI number the particular practices involved could be identified so that this level of admission rate could be addressed. Tim Wood added that the ability of a practice itself to provide an intervention was hindered by a number of things not least the housing situation of a number of clients. The Board Chair, Pat Snedden enquired whether there was evidence that

more people were in healthier housing and that this was actually addressing the issues. Tim Wood reported that there was evidence to this effect.

- Tama Davis commented that anecdotal information was available pointing to cost of accessing a health service via PHOs that pushed people to come to the hospital because the service is free. Tim Wood concurred that cost is an issue for a number of whanau. The cost of a visit to a general practitioner, even if that is only $19, is still too much for some large families. However, the national policy determines the co-payments general practitioners can charge.

  Bernie O'Donnell commented that the damage was already done by the time they got to the hospital setting and added that effort needed to be applied to looking at how to intervene at an earlier stage. He also added that for the Auckland mana whenua Maori population access via local iwi avenues was not always effective. Tama Davis agreed that Iwi were not the only avenue of access but mana whenua, alongside the DHB have a responsibility to deliver healthy outcomes.

Resolution:

That the Board note the Quarter two results for the third SLM Improvement Plan.

Carried

7. FINANCIAL PERFORMANCE

7.1 Financial Performance Report *(Pages 125-131)*

Rosalie Percival, Chief Financial Officer asked that the report be taken as read, advising that members might note that the variance for January appeared somewhat odd but that this was because a rebalance of the budget was not allowed. The DHB had been reporting to various deficit budgets while awaiting final approval for from the Ministry of Health. As a $20M deficit budget had finally been approved there would be a stable budget to report on from this point forward.

The Board Chair, Pat Snedden asked what might cause anxiety. Rosalie advised that:

There is the 5.2M adverse variance to the revised budget year to date which was made up of $4.2M relating to provisions for payment of wash-up of planned care services which were not delivered due to strike action and $1m of additional costs relating to the measles epidemic. There is also the potential for further disruption to planned care activity and also to DHB costs in general from external factors such as Covid-19 virus.

Resolution:

That the Board receives this Financial Report for the seven months ending 31 January 2020

Carried

8. COMMITTEE REPORTS

8.1 Hospital Advisory Committee *(Pages 132-143)*

Tama Davis (Interim Committee Chair) asked that the report be received.

Jo Agnew made the point that Maori and pacific nurses were under-represented in nursing generally and specifically in Child health. Jo was advised that Maori and Pacific were hyper represented in complexity around numbers and that the DHB did not have the right number of Maori and Pacific nurses at this time.

Resolution:

That the unconfirmed minutes from the Hospital Advisory Committee meeting held on 12 February 2020 be received.

Carried

8.2 Joint Community and Public Health Advisory Committee *(Pages 144-147)*

Zoe Brownlie as the only member of the committee from the previous Board confirmed that the minutes were true and correct.

Resolution:

That the minutes of the Joint Community and Public Health Advisory Committee meeting held on 30 October 2019 be received.

Carried

[Secretarial Note: Item 10.1 was considered next.]

9. DECISION REPORTS - NIL

10. INFORMATION REPORTS

10.1 Director Appointment to the healthAlliance N.Z. Limited Board *(Pages 148-149)*

Rosalie Percival, Chief Financial Officer advised that this was an administrative matter following the resignation of the Northern DHB member and where a replacement was being proposed. As per the constitution all four northern DHBs must agree the appointments.

Resolution: Moved Pat Snedden / Seconded Doug Armstrong

That the Board:

1. **Note that the shareholders have, or are proportioning to, appoint a new director to healthAlliance NZ Limited, in place of Mr Meng Cheong**
2. **Resolve that Dr Michael Roberts be appointed as a Class A director of healthAlliance NZ Limited and the company be notified accordingly**
3. **Delegate Authority to the Northern Region DHB Chairs to execute all**

documentation necessary to formalise this director appointment.

Carried

10.2 Human Resources Report *(Pages 150-158)*

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

- HR Services work programme - Workforce Dimensions
  Work is currently underway to develop a business case for Workforce Dimensions which is a new version of the current rostering and time and attendance system Workforce Central. The current version uses flash and in December 2020, flash will no longer be supported and therefore there will be significant risk around the ability to roster and pay employees. This is a shared system with Waitematā, and with Counties Manukau moving to Workforce Dimensions, so the business case is being developed regionally. This business case is being developed with urgency due to the risks associated.
- Hauora: Auckland DHB Healthy Workplace Plan
  Around a 1000 people participated in workshops during January through mid-February contributing thought to how wellbeing could be improved. This work will be aligned with the national Wellbeing Strategy (Kahui Oranga).

Resolution:

That the Board:

1. Receives the Auckland DHB Human Resources report for February 2020.

2. Notes the progress on Auckland DHB People programme commitments.

Carried

11 GENERAL BUSINESS

There was none to consider.

12 RESOLUTION TO EXCLUDE THE PUBLIC

Resolution: Moved Pat Snedden / Seconded Michelle Atkinson

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 18 December 2019	**Commercial Activities** **Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public** [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3.1 Endorsement of Resolution of the Executive Committee of the Board - Managing clinical risk for general and cardiac ultrasound during APEX Sonography industrial action	**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	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]

	time.	
6.1 Chief Executives Confidential Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 Human Resources Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.1 Finance, Risk and Assurance Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.2 Hospital Advisory Committee Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	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 Review of 2020/21 Annual Plan – draft 1 for Auckland DHB	**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	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]

	time [Official Information Act 1982 s9(2)(k)]	
9.2 Auckland DHB Single Provider Specialist Palliative Care	**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 Strategic Themes and Strategy Development	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.4 Committee Membership	**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]
9.5 Commercial Services Transport and Parking Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.6 Building for the Future Business Case	**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]
10 Discussion Reports - Nil	**N/A**	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of

		information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11.1 Auckland DHB Planned Care Update (Elective Services)	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
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 4.10pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 26 February 2020

Chair: _____ Date: _____

Pat Snedden

Open Minutes
Meeting of the Executive Committee of the Board
01 April 2020

Minutes of the Auckland District Health Board Executive Committee meeting held on Wednesday, 01 April 2020 via Zoom commencing at 1.00pm

Board Members Present	**Auckland DHB Executive Leadership Team Present**	
Pat Snedden (Board Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Mark Edwards	Chief Quality, Safety and Risk Officer
Zoe Brownlie	Rosalie Percival	Chief Financial Officer
Peter Davis	**Auckland DHB Senior Staff Present**	
Tama Davis	Marlene Skelton	Corporate Business Manager
Bernie O'Donnell	(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 Executive Committee of the Board in the Karakia.

English translation

"We thank you for this time to come together as a Board to share our collective intelligence, energy and understanding of what is going on in our communities today with the hope that we may be able to draw on this expertise to move forward. We ask you to look after those that find themselves in difficult circumstances. In this time of crisis for Aotearoa we ask you to guide us to give us the strength and understanding and expertise to move forward for the benefit of the community.

Amen"

[Secretarial Note: Tama Davis is to send out and share the words to the Karakia that he uses.]

1. ATTENDANCE AND APOLOGIES

There were no apologies

2. REGISTER OF INTERESTS AND CONFLICTS OF INTEREST

There were no changes to the interests register and no conflicts of interest with any item on the agenda.

3. CONFIRMATION OF OPEN MINUTES 23 MARCH 2020

Resolution: Moved Jo Agnew / Seconded Dame Paula Rebstock

That the minutes of the Briefing of the Executive Committee of the Board held on 23 March 2020 be confirmed as a true and correct record

Carried

4. ITEMS TRANSFERRED FROM CONFIDENTIAL

The following resolutions were transferred from the confidential agenda:

4.1 Delegations During COVID 19 Event Response

[Was confidential item 2]

Resolution: Moved Pat Snedden / Seconded Jo Agnew

That the Executive Committee of the Board:

1. **Approves the following changes to delegated authority levels to enable appropriate and efficient response and decision making on urgent and unbudgeted COVID-19 events and will stop on advice from the CEO to the Board that these are no longer required**

Proposed Das for COVID-19 requests only (In $'000s)		Capex Delegations			Opex Delegations	
Role	Name	Current		Proposed	Current	Proposed
		Budgeted	Unbudgeted	All	All	All
CEO	Ailsa Claire	500	300	1,000	3,000	No change
CFO	Rosalie Percival	250	150	500	1,000	No change
ADHB IMT COVID-19 Controller	Alex Pimm	100	50	200	250	No change

2. **Delegates Authority to the Board Chair and Chief Executive Officer to jointly approve COVID-19 related operational spend required under emergency for a value up to $20M, with any such approval being reported to the Executive Committee of the Board within 48 hours.**
3. **The Corporate Business Manager to append a list of any such items approved to each meeting of the Executive Committee of Board so that patterns and trends can be identified.**

Carried

4.2 Delegated Authority Conferred to CEOs During COVID 19

[Was confidential Item 3]

Resolution:

That the letter from the Ministry of Health be noted.

Carried

5. RESOLUTION TO EXCLUDE THE PUBLIC FROM THE MEETING

Recommendation: Moved Pat Snedden / Seconded Jo Agnew

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Verbal Report on IMT Process	Commercial Activities Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] Prejudice to Health or Safety Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time [Official Information Act 1982 s9(2)(c)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
2. Delegations during COVID-19 Event Response	Commercial Activities Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Delegated Authority Conferred to CEOs During COVID 19	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. Request for endorsement of urgent procurement of	Commercial Activities Information contained in this report is related to commercial activities and Auckland DHB would	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information

	PPE for COVID 19 by Auckland DHB on behalf of the Northern Region	be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] Prejudice to Health or Safety Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time [Official Information Act 1982 s9(2)(c)]	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.	Auckland DHB upgrade of Concerto to Regional Clinical Portal	Commercial Activities Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] Negotiations Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.	Finance, Risk and Assurance Report from 18 March 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)] Negotiations Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

The meeting closed at 2.12pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 01 April 2020

Chair: _____ Date: _____

Pat Snedden

Open Minutes
Meeting of the Executive Committee of the Board
13 April 2020

Minutes of the Auckland District Health Board Executive Committee meeting held on Monday, 13 April 2020 via Zoom commencing at 4.30pm

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
Zoe Brownlie	Jo Gibbs	Director Provider Services
Peter Davis	**Auckland DHB Senior Staff Present**	
Tama Davis	Marlene Skelton	Corporate Business Manager
Bernie O'Donnell	(Other staff members who attend for a particular item are named at the start of the minute for that item)	
Dame Paula Rebstock		

PUBLIC ATTENDANCE

Radio New Zealand – Rowan Quinn

Radio NZ has made a request for items 2, 3 and 4 in the unconfirmed confidential minutes of the 1 April 2020 meeting to be transferred to open agenda.

Rowan Quinn addressed members commenting that she did not need to tell them of the huge impact COVID-19 was having on Aucklanders and New Zealanders, whether that was to their health, their families' health, their mental health, their incomes or their way of life.

Rowan argued that it was in the public interest for most matters regarding the virus, and the health response to it, to be discussed in an open and transparent manner in the spirit of the democratically elected board system and the Official Information Act.

Rowan also argued that public interest outweighs the reasons (commercial sensitivity and worries about prejudice to health and safety) listed for keeping this information confidential.

There have been questions raised about the distribution and the availability of PPE. This issue is one that affects thousands of staff and patients, and potentially the hundreds of thousands of people in the Auckland DHB's area. They should have transparency into decisions being made about it.

Rowan asked that when items were placed in confidential session that careful consideration be given as to whether they could not in fact be considered in open agenda.

The Board Chair, Pat Snedden acknowledged that Rowan put forward an important point of view and that the Board itself tried to be a source of information from the Auckland DHB that the public could absolutely rely on. At the same time it had to be acknowledged that there were issues arising so quickly that if the Board could not be completely clear on those issues then they could not put information in the public arena until clarity did exist.

The determination that has to be made here is the importance around …. [*Pat Snedden lost connection to the Zoom meeting at this point, then picking up again*] I understand entirely your

concerns and it is completely legitimate for the Board to be as transparent as it possibly can be in the interests of the health of the population that we are in service of but I also point out that in a fast moving environment, where we are working largely from information from Incident Management Teams and we are attempting to do the very best that we can to keep the population safe, we are having to make judgements required on behalf of the population in our roles as governors. Sometimes these judgements are having to be made without full information and therefore will occur in confidential session until a clear and unambiguous message can be made to the public. Sometimes that is awkward and difficult and will sometimes be frustrating for the media but in this fast moving environment care needs to be taken with information released and how we message what is being done.

Decisions around conferment of delegated authority during COVID 19 have been moved to the open agenda but the item dealing with PPE cannot be released while there is confusion and sensitivity around the issue and a potential for unclear messaging.

Rowan Quinn responded saying that sometimes uncomfortable things are part of the facts of a matter and just because something is uncomfortable does not mean it should not be in the public arena. Rowan acknowledged the sensitivity of what was being dealt with and the fact of privacy and commercial sensitivity but wanted to remind members that consideration should always be given to what could be transferred to open session. She was pleased that this discussion had occurred in the public part of the meeting.

[*Pat Snedden lost connection to the Zoom meeting at this point*]

Tama Davis assumed the chair. He thanked Rowan Quinn for her attendance and for raising an important issue.

A discussion was had in relation to Public access to Board meetings during COVID 19 going forward. Ailsa Claire advised that she and the Board Chair, Pat Snedden had been discussing how this would be managed. As the situation is now stabilising there is an opportunity to have regular Board meetings of a more formal nature. Consideration was being given to when and how frequently this it is a public organisation.

Up until now things had been happening so quickly that the Executive Committee of Board was being used to manage day-to-day arrangements. Now that a much more stable position had been attained a full formal Board meeting would be held within the next few weeks with formal papers describing where the organisation is at.

The position now is that public documents around planning can be put forward. One good reason for doing that is to provide assurance to the public that coming into the hospital is safe. The lockdown has engendered a fear of moving outside of one's own home and this has meant that a lot of the hospitals business as normal is not occurring. This relates to people who would normally be seen with chronic conditions but are now coming into the ED very late. The Board now has to demonstrate in the public domain that a hospital is not a place that you should feel unsafe; it is probably one of the safest places as management of infection is well understood and strictly followed. Therefore, it is proposed that some clear reports around what stage the hospital is at and where it is with its planning should be released.

Rowan Quinn thanked Ailsa Claire for the clarification and left the Zoom meeting.

1. ATTENDANCE AND APOLOGIES

There were no apologies

2. REGISTER OF INTERESTS AND CONFLICTS OF INTEREST

There were no changes to the interests register and no conflicts of interest with any item on the agenda.

3. CONFIRMATION OF OPEN MINUTES 1 APRIL 2020

Resolution: Moved Jo Agnew / Seconded Zoe Brownlie

1. **That the minutes of the Briefing of the Executive Committee of the Board held on 1 April 2020 be confirmed as a true and correct record**
2. **That the decisions made for items 2 and 3 dealing with delegated authority be transferred to the Open Minutes of 1 April 2020.**

Carried

4. ITEMS TRANSFERRED FROM CONFIDENTIAL AGENDAS OF 1 AND 13 APRIL 2020

The following resolutions were transferred from the confidential agenda of 1 April 2020

4.1 Delegations During COVID 19 Event Response [was confidential Item 2]

That the Executive Committee of the Board:

1. **Approves the following changes to delegated authority levels to enable appropriate and efficient response and decision making on urgent and unbudgeted COVID-19 events and will stop on advice from the CEO to the Board that these are no longer required.**

Proposed Das for COVID-19 requests only (In $'000s)		Capex Delegations			Opex Delegations	
Role	Name	Current		Proposed	Current	Proposed
		Budgeted	Unbudgeted	All	All	All
CEO	Ailsa Claire	500	300	1,000	3,000	No change
CFO	Rosalie Percival	250	150	500	1,000	No change
ADHB IMT COVID-19 Controller	COVID 19 Controllers	100	50	200	250	No change

2. **Delegates Authority to the Board Chair and Chief Executive Officer to jointly approve COVID-19 related operational spend required under emergency for a value up to $20M, with any such approval being reported to the Executive Committee of the Board within 48 hours.**
3. **The Corporate Business Manager to append a list of any such items approved to each meeting of the Executive Committee of Board so that patterns and trends can be identified.**

4.2 Delegated Authority Conferred to CEOs During COVID 19 [was confidential Item 3]

Resolution:
That the letter from the Ministry of Health be noted.

The following resolution was transferred from the confidential agenda of 13 April 2020

4.3 Public Access To Board Meetings During COVID 19 [was confidential Item 6.1]

The Executive Committee of Board:

1. **Gives approval for Executive Committee of Board meetings to be held as special meetings and for the agendas to be published to the Auckland DHB website two clear working days prior to the meeting, except where an emergency situation arises and that all meetings be held via Zoom with the facility for press and public to join by registering an interest to do so and that minutes be produced and published as soon as practicable following a meeting.**
2. **That a formal full Board meeting be held within the next four weeks.**

5. RESOLUTION TO EXCLUDE THE PUBLIC FROM THE MEETING

Recommendation: Moved Jo Agnew / Seconded Zoe Brownlie
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. Chairs Verbal Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be	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]

	prejudiced by publication at this time [Official Information Act 1982 s9(2)(c)]	
2. CEOs Verbal Briefing COVID 19	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time [Official Information Act 1982 s9(2)(c)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Public Access To Board Meetings During COVID 19	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. Execute Regional Rehabilitation Equipment Rental Services with Invacare	**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]

	Information Act 1982 s9(2)(c)]	

Carried

The meeting closed at 6.00pm.

Signed as a true and correct record of the Board meeting held on Monday, 13 April 2020

Chair: _____ Date: _____

Pat Snedden

Minutes
Meeting of the Executive Committee of the Board
24 April 2020

Minutes of the Executive Committee of the Board meeting held on Friday, 24 April 2020 via Zoom and Teleconference commencing at 12 Noon

Executive Committee of Board Members Pat Snedden (Board Chair) Jo Agnew Zoe Brownlie Peter Davis Tama Davis (Board Deputy Chair) Bernie O'Donnell Dame Paula Rebstock	**Auckland DHB Executive Leadership** Ailsa Claire Chief Executive Officer Rosalie Percival Chief Financial Officer Joanne Gibbs Director Provider Services **Auckland DHB Senior Staff** Marlene Skelton Corporate Business Manager (Other staff members who attend for a particular item are named at the start of the respective minute)

KARAKIA

Tama Davis led the Executive Committee of Board in the Karakia. This Karakia was constructed with COVID 19 I mind by Scotty Morrison. It is designed to bring us together and to understand that this is a journey that we have to take together as a nation and we need to support and be kind to one another.

Karakia	*Translation*
Tu taua mai I runga, Tu taua mai I raro, Tu taua mai I roto, Tu taua mai I waho, Ki tau ai! Ko te mauri tu, ko te mauri tau, ko te mauri ora, Haumi ee! Hui ee! Taiki ee!	Draw forth from above Draw forth from below Draw forth from within Draw forth from the environment Vitality and wellbeing for All Strengthened in Unity.

1. ATTENDANCE AND APOLOGIES

There were none.

2. REGISTER AND CONFLICTS OF INTEREST

There were no changes to the interests register and no conflicts with any items on the agenda.

3. CONFIRMATION OF MINUTES 13 APRIL 2020 (Pages 6-11)

Resolution: Moved Jo Agnew / Seconded Dame Paula Rebstock

That the minutes of the Board meeting held on 13 April 2020 be confirmed as a true and accurate record.

Carried

4. MAJOR CAPITAL EXPERT ADVISORY GROUP – NEW APPOINTMENT (Page 12)

The Board Chair, Pat Snedden asked that the report be taken as read, advising that he remained conscious of providing opportunities for members across the business. Doug Armstrong was happy to stand aside and encourage Fiona Lai to take up the position.

The appointment allows a member to gain experience and provide continuity during this tenure of the Board. The business of this Advisory Group is something that will be discussed routinely throughout the remainder of the Board term and we have a Board with high levels of intelligence and competence and providing opportunities for members in new areas is something to be encouraged.

Resolution: Moved Pat Snedden / Seconded Zoe Brownlie

That the Executive Committee of Board approve the removal of Doug Armstrong from and the appointment of Fiona Lai to the Major Capital Advisory Expert Group

Carried

5. GENERAL BUSINESS

There was none.

6. RESOLUTION TO EXCLUDE THE PUBLIC (Pages 13-14)

Resolution: Moved Pat Snedden / Seconded Jo Agnew

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Apologies	N/A	N/A
2. Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Confidential Minutes 13 April 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

	[Official Information Act 1982 s9(2)(i)]	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 Hospital Administration 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]
4.2 Purchase of Digital Mobile Imaging Machines	**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]
4.3 TeleHealth Equipment	**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]
5.1 Contracts Signed Under Delegated Authority	**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	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]

	report and would prejudice or disadvantage if made public at this time.	

The meeting closed at 1.10pm.

Signed as a true and correct record of the Executive Committee of the Board meeting held on Friday, 24 April 2020

Chair: _____ Date: _____

Pat Snedden

Minutes
Meeting of the Executive Committee of the Board
01 May 2020

Minutes of the Executive Committee of the Board meeting held on Friday, 01 May 2020 via Zoom and Teleconference commencing at 12.45pm

Executive Committee of Board Members Pat Snedden (Board Chair) Jo Agnew Zoe Brownlie Peter Davis Tama Davis (Board Deputy Chair) Bernie O'Donnell Dame Paula Rebstock	**Auckland DHB Executive Leadership** Ailsa Claire — Chief Executive Officer Mark Edwards — Chief Quality, Safety, and Risk Officer Joanne Gibbs — Director Provider Services Rosalie Percival — Chief Financial Officer Shayne Tong — Chief Digital Officer **Auckland DHB Senior Staff** Marlene Skelton — Corporate Business Manager (Other staff members who attend for a particular item are named at the start of the respective minute)

KARAKIA

Tama Davis led the Executive Committee of Board in the Karakia. This Karakia was constructed with COVID 19 I mind by Scotty Morrison. It is designed to bring us together and to understand that this is a journey that we have to take together as a nation and we need to support and be kind to one another.

Karakia	*Translation*
Tu taua mai I runga, Tu taua mai I raro, Tu taua mai I roto, Tu taua mai I waho, Ki tau ai! Ko te mauri tu, ko te mauri tau, ko te mauri ora, Haumi ee! Hui ee! Taiki ee!	Draw forth from above Draw forth from below Draw forth from within Draw forth from the environment Vitality and wellbeing for All Strengthened in Unity.

1. ATTENDANCE AND APOLOGIES

There were none.

[Secretarial Note: The Board Chair, Pat Snedden allowed a discussion on digital innovation to be carried over from an earlier verbal Board Briefing on the issue and it is reported under general business.]

2. REGISTER AND CONFLICTS OF INTEREST (Pages 4-6)

There were no changes to the interests register and no conflicts with any items on the agenda.

3. CONFIRMATION OF MINUTES 24 APRIL 2020 (Pages 7-10)

Resolution: Moved Pat Snedden / Seconded Zoe Brownlie

That the minutes of the Board meeting held on 24 April 2020 be confirmed as a true and accurate record.

Carried

4. OCCUPATIONAL HEALTH AND SAFETY PERFORMANCE REPORT (Pages 11-24)

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

This report was in a new format that was an attempt to be more succinct. A new Health and Safety team started in the middle of April during COVID 19 which had been difficult for them but they had done an amazing job.

At the height of COVID 19 the team had increased to 48 people involved with:

- Vulnerable staff self-assessments for around 1900 people
- Contact tracing. There were 4 staff in March with positive results but not contracted through the work environment
- Advice to people about PPE
- Staff testing

The following points were made during discussion of this item:

- The Board Chair, Pat Snedden commented that staff had been anxious in regard to PPE and asked how that situation was now. Mark Edwards advised that staff were anxious for a number of reasons. These were around the risk and understanding what that risk was, what PPE to use in various situations and how to use PPE correctly. There was a prevalent opinion that PPE was the only protection against COVID 19. There were rumours about the logistics and supply chain associated with PPE and a fear that there would not be enough. People were looking at social media and monitoring the situations overseas and fearful that New Zealand would follow those patterns. This anxiety has now abated and is not so widespread.
- Mark Edwards advised that there were some small pockets of clinicians that would continue to use PPE in the future that perhaps in the past would not have. This related to oral and head and neck surgery. Mark Edwards commented that there was a requirement for a broader understanding of PPE and where it would be required within the hospital going forward.
- Ailsa Claire advised that a regional evaluation of Residential Care Facilities had been undertaken. 70 facilities within the Auckland DHB catchment had been visited. The DHB is supporting two, Ellerslie Gardens and Remuera Rest Home and Hospital. A nurse who had been working in St Margaret's Rest Home had also had a contract with Remuera Rest Home and Hospital and as a possible case had triggered contact tracing within the Remuera Rest Home and Hospital where 11 resident close contacts had been established. Nine residents had been transferred to Auckland Hospital as a precautionary measure and Auckland DHB continues to support that residential care

facility as a number of staff have been stood down.

- Mark Edwards advised members that a significant number of lower paid workers had completed employee welfare forms and had been provided assistance to do this. Ailsa Claire added that welfare checks were performed for all these staff. Staff had been sent to shift change meetings to explain in person what assistance was available for them.

  The Board Chair, Pat Snedden commented that these are a vulnerable group of workers performing valuable infection control work and are not paid appropriately for the risk that they are undertaking. They are needed because if they are not there working then the rest of the hospital cannot function.

- Tama Davis referred to page 11 of the agenda and mention of manual handling where there was insufficient resourcing to provide manual handling task training and asked what was being done to address the gap. Mark Edwards advised that manual handling accounted for the largest lost time injury. There was only one trainer across the organisation. There was a requirement for a package of training that fit the work being undertaken by different groups of staff. The human aspect needed to be addressed rather than treating it purely as a standard training exercise. When this work was undertaken it would be reported back to the Board.

- Peter Davis made the comment that reducing occupational health risks increased staff safety and ultimately increased productivity and patient experience. There was a need to ensure that this link is made.

- Dame Paula Rebstock referred to page 13 of the agenda and point (f) commenting that the information is backward looking. She would be interested in highlighting the risks and having forward looking indicators which could be used to take the organisation from Level 3 down to Level 2.
  Mark Edwards agreed that this was a relevant observation with for example slips/trips and falls having the potential to be more serious risks with more people returning to work during Level 2. Work is being done to identify a tool for staff to use to assess risks in the workplace and to know what controls and mitigations should be in place for each risk.

- Dame Paula Rebstock expressed concern for Residential Care Facilities moving from Level 3 to Level 2 and understanding what was required of them. Now that the DHB appeared to have a role in the wider community should the DHB be assessing the facilities risks going into Level 2? Ailsa Claire advised that a comprehensive evaluation check list was used when visiting the 70 facilities. As they move down the alert levels they can now understand what they should be doing. The DHB needs to be careful not to take this responsibility from the facilities. This recent evaluation has exposed the vulnerable nature of residential care facilities and how they are operated; there will be conversations at a national level in that regard.

  Mark Edwards pointed out that in the past audits on these facilities historically had been paper based and that style of audit did not equate with actually having someone physically visit the premises. Audits are not part normally part of the DHBs remit. This recent evaluation was undertaken at the express direction of the Director of Health.

- Dame Paula Rebstock commented that the approach these facilities took in Level 2 around a visitor policy would be critical. Ailsa Claire advised that these facilities were in the same position as hospitals when it came to visitors. National guidance made it clear who could or could not enter a facility. An evaluation must be conducted of

who they were allowing to enter. There had initially been some conflicting information given around bubbles and how bubbles could be joined. The Northern region has adopted the approach that it must be a consistent person from a bubble who may visit each time.

Resolution: Moved Pat Snedden / Seconded Jo Agnew

That the Executive Committee of Board receive the Occupational Health and Safety Performance Report for March 2020

Carried

5. GENERAL BUSINESS

Digital Innovation

Shayne Tong, Chief Digital Officer was in attendance to answer questions about the paper circulated to members.

The Board Chair, Pat Snedden commented that the five key discussion points raised by Shayne Tong around remote working, virtual consultation and telehealth, automation and workflow, data and intelligence and a patient administration system were all things that had become game changers in a very short period of time. The challenge was how to firmly imbed them and to further enhance what now exists over the next three months.

The reduction in DNA from 12% down to 1% was amazing. There was a need to quantify the patient experience as it is a very customer focused process. It was noted that a large number of consults were via telephone and the challenge was now to move more fully to video consultations.

The Chief Executive, Ailsa Claire commented that it was recognised that our instance of telehealth was not telehealth in the truest sense as it was more of a telecommunication process but it provides a good basis for moving forward.

In response to a question for an opinion on what had moved the DHB forward Shayne Tong advised; the ability to work remotely, telehealth and the flexibility within the workforce. In terms of efficiency; Paperlite, Azure and Office 365 had been big gains. Shayne provided an example of where this technology could be applied to better manage visitors to the Hospital and avoid the need to have staff asking questions and manually capturing that data.

Assurance was given that Microsoft Azure was hosted in Australia and carried all the required certifications. Any time a solution was proposed for use within Auckland DHB a risk assessment was completed.

Bernie O'Donnell commented that it was good to see the improvement of connectivity. There needed to be more understanding of what the DHBs goals were in this area and more work done to understand the characteristics and psyche of those we are encouraging to connect in order to be fully successful. Bernie noted that there were people that try to hide from the system and often they are some of the most vulnerable and in need.

Peter Davis suggested that there were learnings to be acquired from what had been done within the education system during the lockdown period. Shayne Tong advised that the All-

Of-Government group were already in conversation around how to leverage off this work.

6. RESOLUTION TO EXCLUDE THE PUBLIC (Pages 25-26)

Resolution: Moved Pat Snedden / Seconded Jo Agnew

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Apologies	N/A	N/A
2. Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Confidential Minutes 24 April 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. General Practice Access to Diagnostics funding for Ultrasound and X-Ray GP	**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]
5.	**Commercial Activities**	That the public conduct of the

Planning for the Next Three Months	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]

The meeting closed at 2.25pm.

Signed as a true and correct record of the Executive Committee of the Board meeting held on Friday, 01 May 2020

Chair: _____ Date: _____

Pat Snedden

Action Points from 26 February 2020 Open Board Meeting

As at Wednesday, 20 May 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

Chief Executive's Report

Recommendation

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

Prepared by: Ailsa Claire (Chief Executive)

1. Introduction

This report covers the period from 14 March 2020 – 4 May 2020. It covers a summary of the management of the COVID-19 pandemic planning.

2. Events and News

2.1 Covid-19 Response

In late January we stood up a full-time Auckland DHB Incident Management Team (IMT) to plan our response to COVID-19.

The IMT has been structured in line with New Zealand's coordinated incident management structure (CIMS).

The Auckland DHB IMT links to the Northern Region Health Coordination Centre through the incident controller.

With only two days to plan for alert level 4, the IMT and others across the organisation responded quickly to ensure that staff and patients were safe, and that we complied with alert level 4 restrictions.

Many employees were set up to work from home, where practical.

Some elective surgeries were cancelled, and many outpatient appointments were carried out by phone and Zoom.

Thank you to the many people at Auckland DHB who worked above and beyond at this unprecedented time to plan for COVID-19. We also thank the Auckland DHB's Board for their support.

2.2 Patients and Community

2.2.1 Communicating with our patient and communities

Information about our hospital services and healthcare has been provided in a range of languages. A social media plan was put in place to encourage people to seek the healthcare they needed, and to assure our community that it was safe to come to hospital, and that we were here to care.

2.2.2 Health screening patients

A tent was put in place outside AED to ensure that all patients were screened for COVID-19 symptoms, to keep staff and other patients safe. Patients who did not require hospital level care, but had COVID-19 symptoms, were asked to contact Healthline and isolate at home.

The tent was well received by both patients and staff, who said that it made them feel safer.

Screening tent outside the Adult Emergency Department, Auckland City Hospital

2.3 Internal Communication

Regular communications were provided, including a twice-weekly live webinar. Thirteen webinars have taken place, and in total 16,939 people either viewed these live or watched the recording later.

In addition, a series of briefings took place with employees who are less likely to access digital communications, for example cleaners, orderlies, and security staff.

The Protecting Your Whānau guide was also produced. It provided staff with information on how to protect their families from COVID-19, where to access food and financial support, as well as general information about the virus, childcare, and parking.

2.3.1. Staff safety and COVID-19 testing

Staff were required to get tested if they had COVID-19 related symptoms, or were close contacts of COVID-19 cases. To make it easier for employees, and to reduce the time to getting results, an onsite testing centre was established.

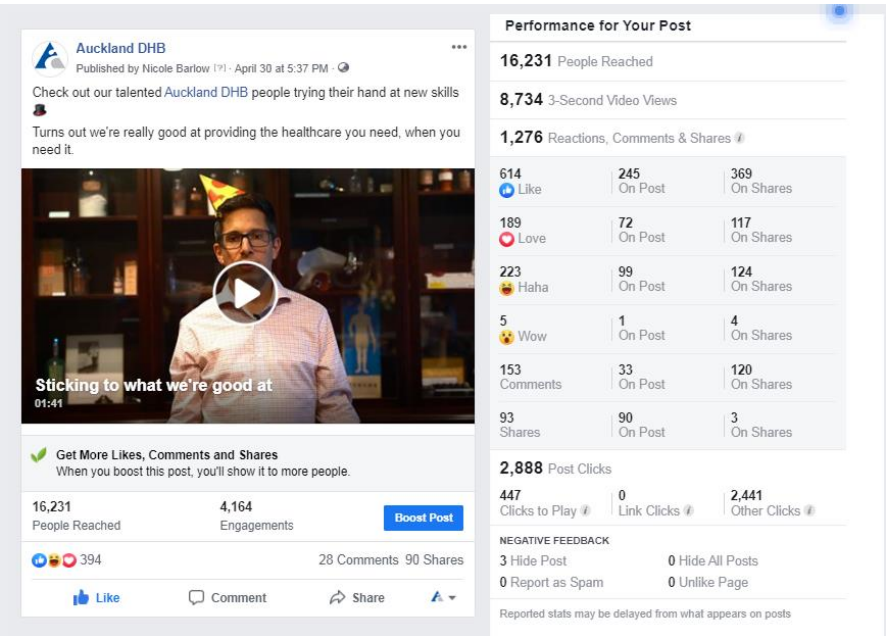
2.3.2 'Flu vaccine

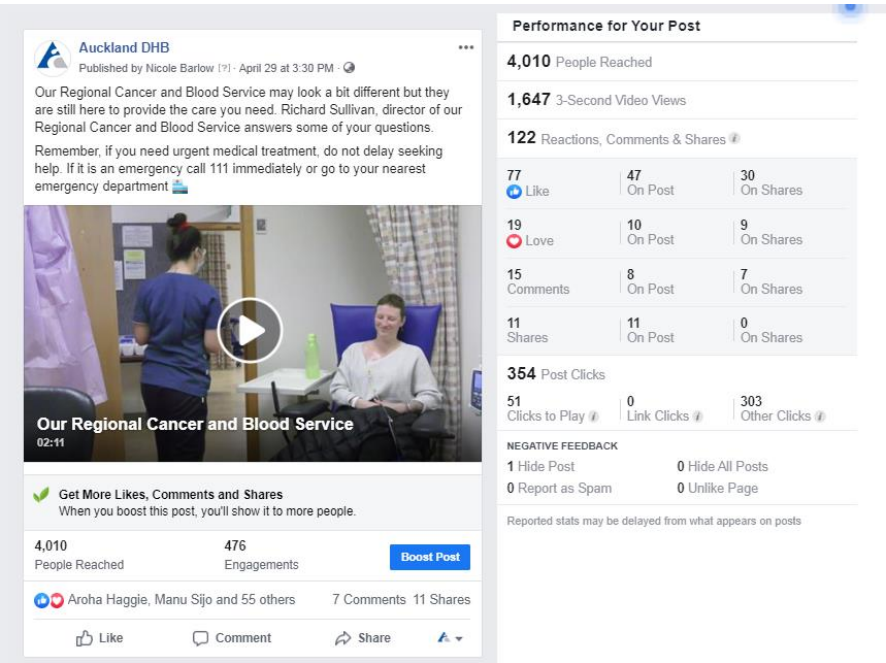
The 'flu vaccination campaign started early, and phase one used in-team vaccinators and focused on high priority groups. Fixed venue clinics started in mid-April and will continue throughout May. As at 1 May 2020 7,200 employees had received the 'flu vaccination.

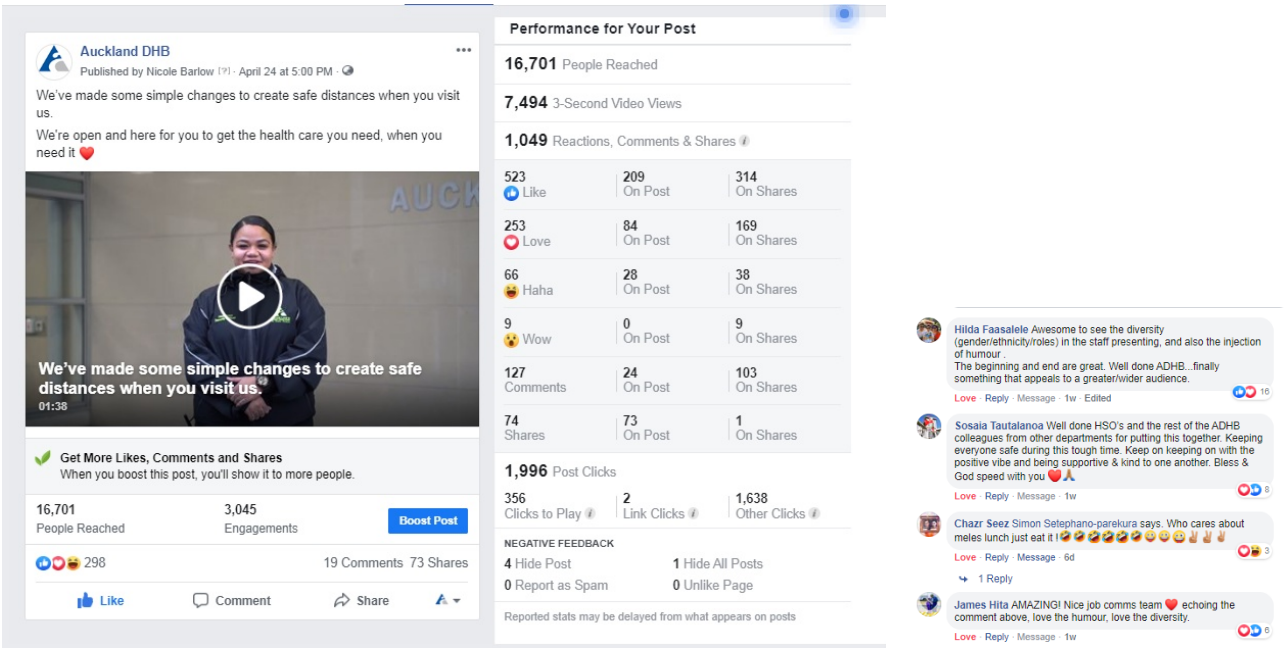
We also encouraged more vulnerable members of our community to get vaccinated, for example, Kaumātua, Kuia, pregnant women, and those with underlying health conditions.

2.4 Social Media

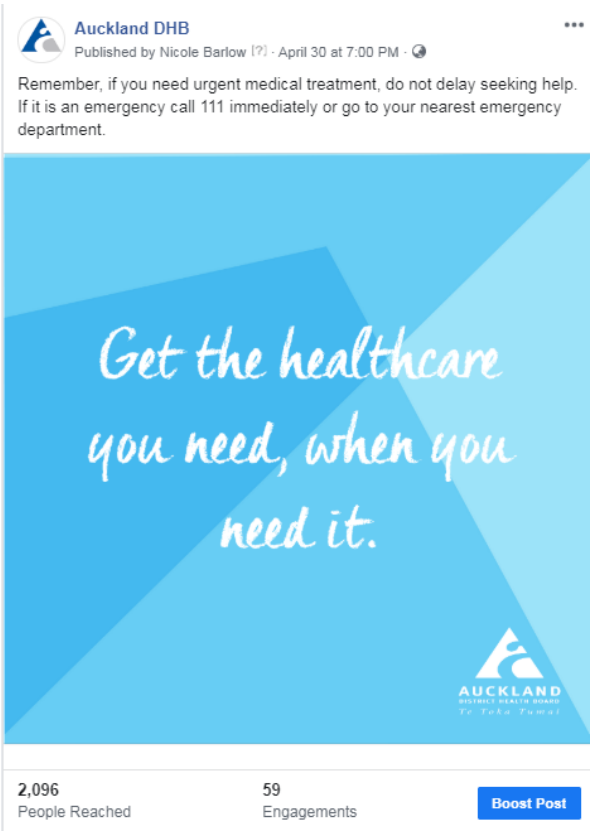
- LinkedIn: 14,017 | Facebook: 9,527 | Twitter: 4,077 | Instagram: 1,001


Auckland DHB
Published by Nicole Barlow · April 30 at 5:37 PM
Check out our talented Auckland DHB people trying their hand at new skills
Turns out we're really good at providing the healthcare you need, when you need it.
Sticking to what we're good at
01:41
Get More Likes, Comments and Shares
When you boost this post, you'll show it to more people.
16,231 People Reached
4,164 Engagements
Boost Post
394
28 Comments 90 Shares
Like
Comment
Share
Performance for Your Post
16,231 People Reached
8,734 3-Second Video Views
1,276 Reactions, Comments & Shares
614 Like | 245 On Post | 369 On Shares
189 Love | 72 On Post | 117 On Shares
223 Haha | 99 On Post | 124 On Shares
5 Wow | 1 On Post | 4 On Shares
153 Comments | 33 On Post | 120 On Shares
93 Shares | 90 On Post | 3 On Shares
2,888 Post Clicks
447 Clicks to Play | 0 Link Clicks | 2,441 Other Clicks
NEGATIVE FEEDBACK
3 Hide Post
0 Hide All Posts
0 Report as Spam
0 Unlike Page
Reported stats may be delayed from what appears on posts


Auckland DHB
Published by Nicole Barlow · April 29 at 3:30 PM
Our Regional Cancer and Blood Service may look a bit different but they are still here to provide the care you need. Richard Sullivan, director of our Regional Cancer and Blood Service answers some of your questions.
Remember, if you need urgent medical treatment, do not delay seeking help. If it is an emergency call 111 immediately or go to your nearest emergency department
Our Regional Cancer and Blood Service
02:11
Get More Likes, Comments and Shares
When you boost this post, you'll show it to more people.
4,010 People Reached
476 Engagements
Boost Post
Aroha Haggie, Manu Sijo and 55 others
7 Comments 11 Shares
Like
Comment
Share
Performance for Your Post
4,010 People Reached
1,647 3-Second Video Views
122 Reactions, Comments & Shares
77 Like | 47 On Post | 30 On Shares
19 Love | 10 On Post | 9 On Shares
15 Comments | 8 On Post | 7 On Shares
11 Shares | 11 On Post | 0 On Shares
354 Post Clicks
51 Clicks to Play | 0 Link Clicks | 303 Other Clicks
NEGATIVE FEEDBACK
1 Hide Post
0 Hide All Posts
0 Report as Spam
0 Unlike Page
Reported stats may be delayed from what appears on posts


Auckland DHB
Published by Nicole Barlow · April 24 at 5:00 PM ·
We've made some simple changes to create safe distances when you visit us.
We're open and here for you to get the health care you need, when you need it
We've made some simple changes to create safe distances when you visit us.
01:38
Get More Likes, Comments and Shares
When you boost this post, you'll show it to more people.
16,701 People Reached
3,045 Engagements
Boost Post
298
19 Comments 73 Shares
Like
Comment
Share
Performance for Your Post
16,701 People Reached
7,494 3-Second Video Views
1,049 Reactions, Comments & Shares
523 Like 209 On Post 314 On Shares
253 Love 84 On Post 169 On Shares
66 Haha 28 On Post 38 On Shares
9 Wow 0 On Post 9 On Shares
127 Comments 24 On Post 103 On Shares
74 Shares 73 On Post 1 On Shares
1,996 Post Clicks
356 Clicks to Play 2 Link Clicks 1,638 Other Clicks
NEGATIVE FEEDBACK
4 Hide Post 1 Hide All Posts
0 Report as Spam 0 Unlike Page
Reported stats may be delayed from what appears on posts
Hilda Faasalele Awesome to see the diversity (gender/ethnicity/roles) in the staff presenting, and also the injection of humour .
The beginning and end are great. Well done ADHB...finally something that appeals to a greater/wider audience.
Love · Reply · Message · 1w · Edited
Sosaia Tautalanoa Well done HSO's and the rest of the ADHB colleagues from other departments for putting this together. Keeping everyone safe during this tough time. Keep on keeping on with the positive vibe and being supportive & kind to one another. Bless & God speed with you
Love · Reply · Message · 1w
Chazr Seez Simon Setephano-parekura says. Who cares about meles lunch just eat it !
Love · Reply · Message · 6d
1 Reply
James Hita AMAZING! Nice job comms team echoing the comment above, love the humour, love the diversity.
Love · Reply · Message · 1w


Auckland DHB
Published by Nicole Barlow · April 21 at 11:39 AM ·
Kia ora whānau, it's still very important to get your flu vaccination in preparation for winter, especially for kaumātua and kuia who are 65 years and older.
The flu vaccine does not protect against COVID-19; however it will help prevent the flu, which is a serious illness.
The flu vaccination is FREE for people 65 and over, but you need to call your doctor first and follow their instructions. They will take all the necessary steps to keep you safe.... See More
AUCKLAND
Free flu vaccinations for kaumātua and kuia 65 and over
2,030 People Reached
78 Engagements
Boost Post


Auckland DHB
Published by Nicole Barlow · April 30 at 7:00 PM ·
Remember, if you need urgent medical treatment, do not delay seeking help. If it is an emergency call 111 immediately or go to your nearest emergency department.
Get the healthcare you need, when you need it.
AUCKLAND
2,096 People Reached
59 Engagements
Boost Post

2.5 Our People

In a short space of time our people have stepped up to establish new ways of working, and have responded quickly in a fast-changing environment. We are putting in place a programme to recognise some of our COVID-19 heroes.

5.1

Here are some of our laboratory team.

Occupational Health and Safety Performance Report

To: Auckland DHB Board

From: Occupational Health and Safety Team

Date: April 2020

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

Presented by: Alistair Forde, Director Occupational Health and Safety

Recommendation

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

Glossary

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

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

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

BBFA Blood and/or Body Fluid Accident

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

OHS Occupational Health and Safety

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 April 2020 we had 19 leadership activities across Auckland DHB for the following.

Description	Actual	Previous Month	3mth Trend	6mth Trend
Leadership Observations	0	5	⟷	⟷
Leadership Discussions (H&S Rep Meetings, Regional H&S Technical Advisory Group (TAG) ACC/Safe 365	19	5	⟷	⟷
Training (Inductions/PPE/Patient Handling)	36	62	⟷	⟷
Audits/Inspections	27	24	⟷	⟷

Table 1 has been introduced to summarise our lead indicator performance activities. There is intent to introduce targets and trends once we have several months of data to compare our on-going performance requirements which will be highlighted in the Activity Analysis section below.

a. The OHS team observed a decrease in COVID-related activities by the end of the month. However COVID-19 has fundamentally changed the work of the team. Our observations and discussions are now starting to evolve into managing COVID-19 as part of our everyday work.
b. We are working through key processes to manage our people's concerns related to returning to work in the current COVID-19 environment. We are working to support and deliver relevant processes in line with our people managers, ensuring there is an integrated approach to reducing our people's on-going concerns.
c. The software solution to support contact tracing and other related activities is on track to be more robust by the end of May.
d. Our current human resourcing has peaked and will start to reduce in the coming weeks as internal demands for staff self-assessments and contact tracing decrease.
e. There were 0 internal inspections completed due to the support required to help the Incident Management Team around the COVID-19 outbreak.

Refer Appendix 1

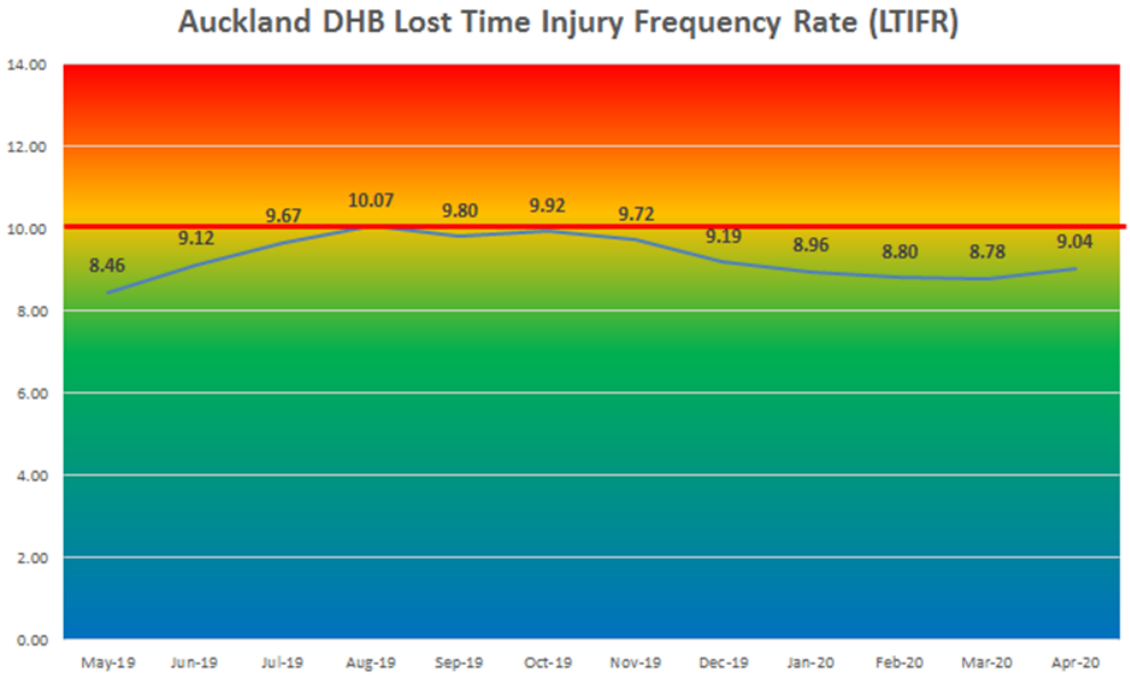
Lag Indicators

Description	Target	Actual	Prev Month	3mth Trend	6mth Trend	12mth Trend
Total Recordable Injury Frequency Rate (TRIFR)(per 1,000,000 hrs)		24.50	24.30	23.59	24.33	28.35
LTI Frequency Rate (LTIFR)(per 1,000,000 hrs)	10.00	9.04	8.78	8.80	9.72	8.46
All Injury Frequency Rate (AIFR)(per 1,000,000 hrs)		145.59	147.86	147.64	156.14	182.99

a. Across Auckland DHB there were 29 recordable injuries reported. These are mainly recorded as Lost Time and Medical Treatment related injuries.
b. The key insight from these three metrics (LTIFR & TRFIR & AIFR) is whether or not our current injury risk mitigation strategies are working and whether the lead indicators are working as intended. Our insight from April is that we still have work to do reducing our injuries across Auckland DHB. We plan to start a discussion around strategy and planning to address this.
c. As we transition out of COVID-19 national level 3 to level 2 our observations are highlighting an opportunity to introduce smarter tools to help to validate our workplace risks and controls. This is being well received through ongoing staff engagement activities.

Activity Analysis

Lost Time Injury Recordable Frequency Rate



As we move toward Level 2, having more patient and staff interactions has brought different risks back into our workplace which will likely have an impact on our LITFR. We are quickly ramping up the OHS team to restart working in the Directorates providing practical, hands-on advice to ensure consistent information and risk controls are being applied.

Risk Analysis

OHS Risk Management

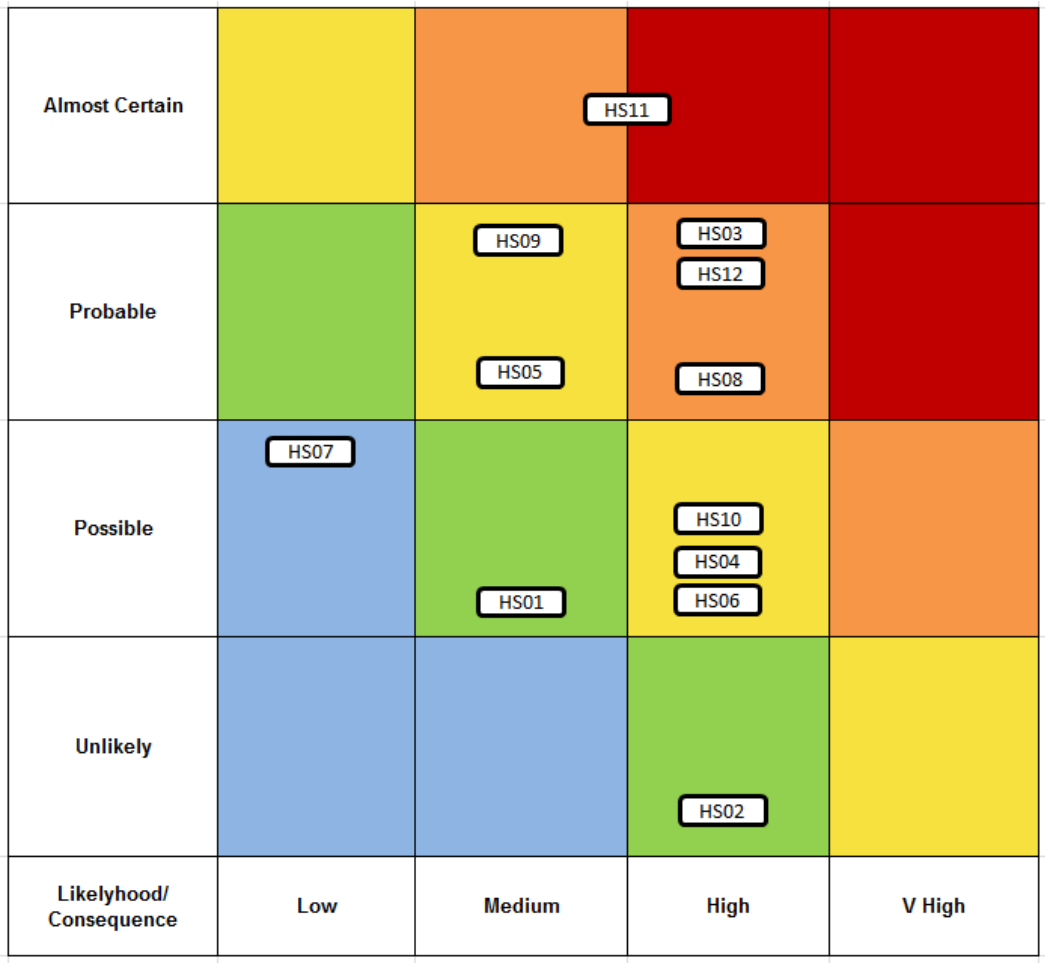
There are currently 2 high (Consequence/Likelihood) OHS risks. The first is related to COVID-19 and has been a focus of activity through March and into April. The second is Workplace Violence and a project stream is underway with a focus on reducing this.

There have been no further updates from the previous Board report as these activities will continue through to the end of May before further controls/processes are introduced.

Refer Appendix 2

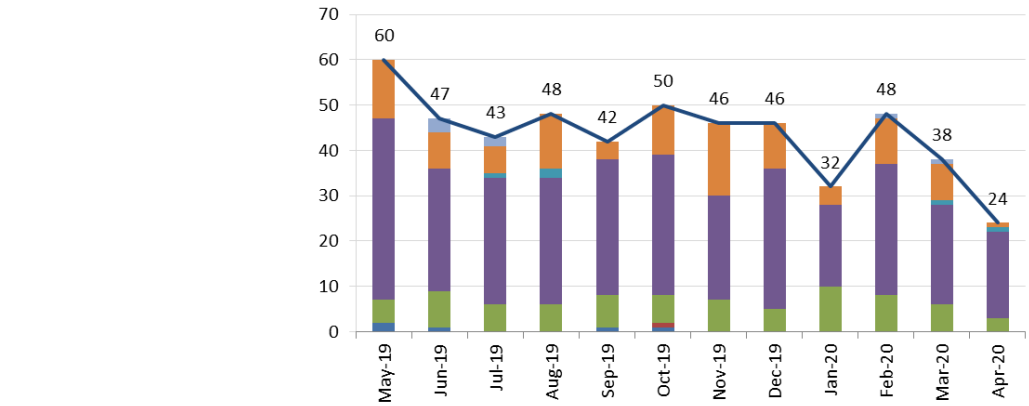
Risk Heat Map

We have also introduced a Risk Heat Map to better describe our current position. This map will start to reflect downward or upward trends in all of our OHS risks from month to month based on observations, insights and key lag information data.


Almost Certain
Probable
Possible
Unlikely
Likelyhood/ Consequence
Low
Medium
High
V High
HS11
HS09
HS05
HS03
HS12
HS08
HS07
HS01
HS10
HS04
HS06
HS02

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

Blood Body Fluids Analysis Causes



	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Unknown	0	3	2	0	0	0	0	0	0	1	1	0
Splash	13	8	6	12	4	11	16	10	4	10	8	1
Scratch	0	0	1	2	0	0	0	0	0	0	1	1
Puncture by needle	40	27	28	28	30	31	23	31	18	29	22	19
Laceration by scalpel or other sharp instrument	5	8	6	6	7	6	7	5	10	8	6	3
Laceration by bone spicule	0	0	0	0	0	1	0	0	0	0	0	0
Bites	2	1	0	0	1	1	0	0	0	0	0	0
Total BBFA's	60	47	43	48	42	50	46	46	32	48	38	24

A steady decline is most likely aligned to the decreased work activities across Auckland DHB. As we start to transition into COVID-19 Level 2, we expect to move more toward normal. We are currently working across relevant Directorates to ensure our awareness and current controls are in place and followed.

Contact Tracing

There were two COVID-19 contact traces (from one cluster) and one Varicella contact trace in April.

COVID-19

- Work areas affected: Commercial Services
- Number of staff involved: 6
- 5 close contacts - 14 days isolation; 4 symptomatic staff had swab test; 1 positive swab

COVID-19

- Work areas affected: Commercial Services/ Ward 77
- Number of staff involved: 21
- 13 close contact - 14 days isolation, 7 symptomatic staff had swab test, 1 positive swab

Varicella

- Work area affected: SSH 23B & Radiology
- Number of staff assessed: 37
- All immune. No further actions required

Respiratory Protection and COVID-19

As noted last month COVID-19 has driven a need for an expanded respiratory protection programme which 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 need to undertake training as part of on-boarding and at regular intervals, as required by Health and Safety at Work legislation for airborne hazards. We are currently developing a programme of work around this.

Vulnerable Staff and COVID-19

More than 1900 staff were concerned that they were at increased risk of severe COVID-19 illness if infected. 5% of forms were from staff aged 70 years or over. Many (41%) staff also identified vulnerable family members in their bubble. 41% of staff were working in areas that would care for COVID-19 patients, and 48% were working in clinical areas that would care for non-COVID-19 patients. Staff received a recommendation based on their health status as tabled below. Many staff already working in clinical areas that would be non-COVID areas are fit to work in COVID-work streams with the appropriate PPE for the work task if needed.

Staff health condition	From work area	OH recommendation
Category 1	41%	56%
Category 2	48%	30%
Category 3	7%	11%
Category 4	4%	3%

Some COVID-work stream services have found their rosters significantly impacted by the recommendation that specialised clinicians should not work with COVID-19 patients. Back-up plans in the short term and longer term succession planning are needed.

Auckland DHB Violence and Aggression Steering Committee

The MAPA training has not re-started due to physical distancing requirements. Of note, the incumbent trainer has left their position. Other aspects of the programme are continuing.

Information Technology

COVID-19 highlighted that the IT hardware and software available to the OHS team was not fit for purpose.

A regular channel to engage with the Health Information Technology (HIT) team who are managing the technology delivery needs has been established. The need to progress this is critical, and has been identified to the HIT team accordingly, although progress continues to be slower than desirable.

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

There are now 117 contractors (increase of 10 since the last report) aligned to the ADHB signed up (63 who work solely for ADHB, while a further 54 work for ADHB and at least one other DHB). Overall there are 274 contractors signed up across three DHBs. The uptake has been slower than planned due to several factors, including the COVID-19 outbreak resulting in a shift of focus to other priorities. The priority now is to ensure we achieve 80% completion of the Initial Assessment stage for this project, approximately 480 contractors assessed by the end of June. A summary of the project is attached to this report to engage with the Board and engender support for the next phase and the remaining two years of the project.

Auckland DHB Health and Safety Committee

The Auckland DHB Health and Safety Committee meet six-weekly. The last meeting was on Monday 10 February 2020. Due to the COVID-19 outbreak the April meeting did not take place. Minutes can be accessed on Hippo.

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 is a table of the key risks identified within Auckland DHB from an Occupational Health and Safety perspective. Risk areas have been highlighted where updates have occurred.

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
 COVID-19 – on-going risk	Risk of staff contracting COVID-19 at work. Risk of staff with COVID-19 infecting other staff and patients. Staff with underlying health issues unable to remain deployed in previous work roles.	Stay at home if sick – message reinforced. Hierarchy of controls in place in workplace. PPE including respiratory protection program. Staff self-assessment then process with line managers and Occupational Health when required.	High (10) – Even with the low disease prevalence in the community, this risk remains high due to the potential high consequence of infection.
 Asbestos Management	The Procedure covers the whole of the organisation. Recent external audit findings were positive. Currently being reviewed and developed into a Group Operational Procedure.	No further action taken due to COVID-19. Reviewing all risks and assigning resources to ensure risks are being managed.	Medium (6) –There is always a “risk” of asbestos exposure in the current environment however it is of note that there has never been a positive air sample taken at Auckland DHB for asbestos and there are no recorded incidents of asbestos exposure on record.
 Confined Spaces	A Group Operational Procedure has been approved and rolled out through Auckland DHB.	No further action taken due to COVID-19. Reviewing all risks and assigning resources to ensure risks are being managed.	Low (3) – There are no recorded instances of confined spaces work being conducted outside of the facilities remit. However, best practice indicates a need to change to a group level procedure to capture all workers at Auckland DHB not just those falling under the facilities remit.

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
 Manual Tasks (including patient handing)	The Moving and Handling Procedure has been approved and rolled out through Auckland DHB.	No further action taken due to COVID-19. Reviewing all risks and assigning resources to ensure risks are being managed.	Medium (6) – Currently Auckland DHB has one nurse trainer responsible for initial and refresher training for all of Auckland DHB. To comply with the current WorkSafe guide – Moving and Handling in Healthcare[1], all new starters require at least one training session and a two yearly refresher for all staff. Further to this, there is insufficient resourcing to provide general Manual Tasking training to the greater workforce in high-risk areas such as Cleaning services.
 Lone Worker Protection	A Group Operational Procedure has been approved and rolled out through Auckland DHB.	No further action taken due to COVID-19. Reviewing all risks and assigning resources to ensure risks are being managed.	Medium (6) – Generally those areas working in lone worker situations have their processes in place which are working. Continuously monitored at the Security for Safety steering group GetHomeSafe App now in Phase 2 rollout Increased numbers using the App to 630 staff Mental Health Services user training 60% complete with target of 100% by the end of February are transitioning across to using the app Adult Medical Services infectious diseases team identified as needing the app and training is booked.

[1] WorkSafe New Zealand 2018, *Moving and Handling people in the Healthcare industry*, viewed 20 February 2019, https://worksafe.govt.nz/topic-and-industry/health-and-safety-in-healthcare/moving-and-handling-people-in-the-healthcare-industry/

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
 Vehicles and Driving	The Auckland DHB Motor Vehicle policy applies.	No further action taken due to COVID-19. Reviewing all risks and assigning resources to ensure risks are being managed.	Medium (6) – Generally those areas working with company vehicles have localised processes and procedures. Vehicle incidents are being recorded in DATIX, and scope of work is underway to develop a group level Standard Operating Procedure.
 Working at Heights	A Group Operational Procedure has been approved and rolled out through Auckland DHB.	No further action taken due to COVID-19. Reviewing all risks and assigning resources to ensure risks are being managed.	Medium (6) – A Group Level Operational Procedure is now in effect and covers all workers on all Auckland DHB sites.
 Biological Hazards	There are currently many documents held at both a Corporate and a directorate level covering different aspects of Biological hazards, e.g. BBFA's, clinical waste.	No further action taken due to COVID-19. Reviewing all risks and assigning resources to ensure risks are being managed.	Medium (6) – For ease of reference and use by workers throughout Auckland DHB it is necessary to have a corporate level Procedure in place setting a minimum standard for all facets of biological hazards. Individual directorates or workgroups can expand on this minimum requirement at a local level.
 Hot Works	A Group Operational Procedure has been approved and rolled out through Auckland DHB.	No further action taken due to COVID-19. Reviewing all risks and assigning resources to ensure risks are being managed.	Medium (6) – A Group Level operational Procedure is now in effect and covers all workers on all Auckland DHB sites
 Contractor Management	There is a Health and Safety Contractor Policy and several HR policies. Auckland DHB is in the second phase of a project to rollout SAFE365 through our contractor chain with funding from ACC.	No further action taken due to COVID-19. Reviewing all risks and assigning resources to ensure risks are being managed.	Medium (6) – The subcontractor management document requires updating, and it is appropriate to have this at a corporate level to ensure the same standard is applied across all contractors, regardless of where they operate in the business.

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
Fatigue Management	Currently no comprehensive up to date group level procedure in place.	No further action taken due to COVID-19. Reviewing all risks and assigning resources to ensure risks are being managed.	Medium (6) – There are currently various documents in place covering different aspects of fatigue management. However, no comprehensive document covering the entire business. Fatigue, Wellbeing and worker health would be included in this area.
Hazardous Substances	Hazardous Substance Group Operational Procedure has been approved and rolled out through Auckland DHB. Health and Safety Policy in place and ChemWatch system in place. Chemwatch access issues were identified and corrected to enable workplace managers more control of their reported quantities. Guideline document for creating hazardous substance inventories via Chemwatch was drafted and submitted for peer review. A Chemwatch review showed many areas had not uploaded information. Misconceptions relating to hazardous substances were observed to be a main reason for underreporting of hazardous substances. Laboratories still not Part 18 compliant. CAPEX applications	No further action taken due to COVID-19. Reviewing all risks and assigning resources to ensure risks are being managed.	Medium (6) – Through the internal audit process it has been found that much improvement can be made in the handling and storage of hazardous substances. The new Group Operational Procedure and internal auditing regime is proving very effective in identifying areas for improvement, especially around storage facilities.

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
	toward compliance drafted and/or submitted. Non-compliances noted relating to workplaces already covered by location compliance certificates. Certifier findings relating to Gas Store in ACH Building 46 addressed.		
 Workplace Violence and Aggression	Project underway	No further action taken due to COVID-19. Reviewing all risks and assigning resources to ensure risks are being managed.	High (10) – This is classified as high risk as workplace violence is a frequent occurrence. There is currently a project stream underway to focus on this area. Staff are also being trained in de-escalation techniques to better address violence in the workplace, specifically with MAPA approach to de-escalation.

Auckland DHB Human Resources Report

Recommendation

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.

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

1. Introduction/Background

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 March 2020. The People Plan provides a pathway for us working together so we can deliver on our promise to provide an environment where our people can do their 'life's best work' for our patients, their whanau, and the communities.

The A3 summary is a new format of the update report for the Board, and we would welcome any feedback on the presentation and content.

A significant amount of activity under the People Plan has been paused or amended over the course of the COVID response. During that time, the Human Resources team have been deployed into support for the incident management teams for the DHB, the Northern region and nationally.

2. Human Resources COVID-19 Response Activity

Auckland DHB People & Welfare Work Stream

As the Level 4 lockdown began the team was set up to ensure fast turnaround of information and activity in support of and at the request of the Auckland DHB Incident Management Team. The group met daily (7 days a week) to review actions underway and resource against any new actions identified or requested. This allowed for organised and efficient response to the ADHB Incident Management Team.

Some of the specific activity which was undertaken is listed below.

Area	Activity undertaken
Staff Accommodation	At the beginning of April, a temporary accommodation process was put in place to support our employees in need. Since April we have had 44 requests received with 27 being accepted, of which 13 are currently in our accommodation at our Greenlane premises. 8 found alternative accommodations and 4 rejected our offer. Three employees who were advised to leave their rentals due to being essential health workers. 67% of granted requests were due to vulnerable family members in their bubble. As at 11 May 2020 the predicted costs are approx.~$12K and 10 people remain accommodated at our Greenlane facilities.

Low Paid Workers Outreach	To reach our non-digital employees with our communications we needed to augment the digital (CEO Briefing & Hippo) communications with face to face. Briefing material was created by our communications team and delivered by volunteers from across the HR & IMT teams, to meetings across our Security / Orderly / Cleaning / CSSD teams across both locations. These messages were also delivered to our Compass Kitchen staff. Feedback from these sessions has been extremely positive – people have expressed they have felt supported and cared for. Questions from our staff at these sessions have waned indicating we have addressed their needs.
Online Induction	We have converted our face to face induction (Navigate) to an online course. This has been sent to any new starters since March 2020 as well as recent starters who have previously not attended Navigate. More than 160 people have completed the module.
Temporary Assignment	To facilitate nurses being deployed to alternative duties elsewhere in the hospital, we have established a union endorsed temporary assignment process. Once finalised the process will be handed over to the temporary bureau to manage. To date we have used this temporary resource pool for areas such as ARPHS, Occupational Health, staff testing and the screening of visitors.
Reporting	Reporting has been set up and is regularly provided to show the number of staff taking Paid Special Leave, those caring for their child when no other options were available and weekly absenteeism across the hospital which is broken down into each directorate. Regular reporting to the Ministry also occurs.
Fast-track Recruitment & On-boarding	Fast–track recruitment and on-boarding processes were developed to ensure the most efficient and fast processes to get people into our workforce where we had a surge of new workforce required. These were agreed across the region for all DHBs. 168 new employees employed using this process over the period. This included roles in Critical Care, Laboratories, Radiology, and for the Bureau.
International Recruitment	As border restrictions become much tighter our Recruitment and askHR teams have been in regular contact with International candidates who arrived during lock down, or who have forward arrival dates and are without appropriate visas etc. Where required, the team have worked with the Auckland DHB IMT to ensure immigration agencies are aware of key personnel arriving and to support new arrivals through their quarantine period.
Employee Relations	Weekly Union Engagement meetings have been set up whereby we have provided updates on both what is happening within the hospital as well as matters of particular interest to the union, and where we wish to discuss with them prior to releasing to the organisation. These

	include PPE, Return to Work for both our Vulnerable workers and those working from home and temporary assignments. The unions are also provided with information around Aged Residential Care, staff testing and staff surveillance testing. These meetings have been extremely well received by the unions, who wish for these weekly meetings to continue for the foreseeable future. Directorates are identifying areas of change that have occurred during Covid which we would like to maintain. These may require consultation retrospectively.
Casual Employees	In line with the State Services Commission requirement, a decision was reached to pay our casuals employees who were available for work, considering the financial impact on this workforce due to the drop in hours available to them during Covid. 283 people received these payments during level 4/3 with a cost of ~$467K.
Occupational Health Assessment support	A range of support has been provided to the Occupational Health & Safety team which from on-boarding a significant number of temporary resource to assist with the >1,800 staff assessments and requirement for staff testing & surveillance. The two teams have worked collaboratively to; both address Union concerns raised regarding vulnerable employee assessments, and preparation of our Managers for the Return to Work process in an environment of low community prevalence (Level 2).

Greater than 90% of the Payroll, Ask HR, Recruitment and Organisation Development teams have been working from home over the period. They have delivered from their living rooms and their offices and have been amazing in how they have responded to the needs of the organisation.

There are many insights which now need to be considered as we move into the 'next normal' period where we are living with COVID. Many of which will have significant implications on the People Plan. These areas include:

- Providing sustainable support to our low paid workers / people in need. The scale of the economic impact of the pandemic are not yet fully understood for Aotearoa. What is clear is that our low paid workers will be impacted and our Too Thrive program will need to be augmented. This has resulted in the development of a Manaaki centre concept.
- Our vulnerable worker occupational health assessments have highlighted that some of our people need better health support. As a provider of health services, we need to do more, particularly for our Maori & Pacific workforce, in meeting these needs.
- Ensuring the wellbeing of our leaders and people – providing tools, and the opportunity to practise, so that our leaders can deal with what is happening for them, and for their people.
- Providing guidance to the organisation as vulnerable workers and those working from home transition back to the office. The organisation needs a more comprehensive policy and guidance which retains the flexibility benefits we have seen over the period is urgent.

- There are several changes to work practises which have been put in place over the period which both employees and the DHB would like to maintain. These changes will require discussion and agreement with employees and unions in a more formal sense.
- Disruption to workforce pipelines due to gaps in the University training year, and lack of ability to recruit internationally, will be felt. The exact nature of this impact is to be worked through at the national and local level.

Northern Region HCC – Workforce and H&S Technical Advisory Group.

The Workforce TAG was set up in early March to ensure provision of H&S and workforce advice to the Northern Region Health Response. Areas of focus for the team; which was staffed with representatives from across the region, included wellbeing, occupational health and safety, employment relations, and workforce logistics.

A significant success of the period was the Regional Portal which was developed for people to register their interest in helping in the COVID response. Greater than 3,600 people enrolled in one of either the general, Pacific, or Maori workforce portals. This sourcing approach allowed for the needs of surge workforces for Healthline, ARPHs, CBACs, Community, Border, Quarantine & most recently Aged Residential Care responses to be managed with less impact on DHB workforces. Over 315 people were deployed from this portal.

Members of the Auckland HR team were deployed as part of the Pacific & Maori Response teams at the Regional level.

National Workforce Technical Advisory Group

At the National level, a Workforce Technical advisory group was set up with membership from; the Ministry of Health, lead CEs (Auckland & Taranaki), the TAS ER lead & lead GM's HR (Canterbury & Auckland). The group has worked well over the period with strong collective engagement and communication. It will continue for the foreseeable future as we manage the workforce implications across the system of the COVID response.

Auckland DHB People Plan Report - May 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	All activities on pause due to COVID response	CCDM & Just Culture projects reinstated
	Leadership for the future			On Hold - Moved to 2020/2021 activity	
	Implement talent management		On track	All Pilot groups have completed mapping their people and final moderation sessions are in progress for next tier.	Finalise development plans and evaluate the pilot. Evaluate use for MALT / PALT development group.
Making it easier to work here	Leader Leave Manager Upgrade		Go live reset to June 15th and 16th - No impact to Holidays Act	Parallel testing underway, reports being tested and rewritten where required.	Full cutover activity and go live planned for June 15th and 16th.
	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 being developed and contract under negotiation by procurement. Expected approvals not due to be complete until approximately July/August 2020.	Getting business case finalised and through the approval gates.
Building constructive relationships	Te tino o mātou - Us at our best		On track	Specific activity has been on hold due to COVID response. Focus on two key insights 'Be Kind to each other' and 'I've got your back' and been agile in application.	Focus on strengthening weaving 'values in action' insights into directorate initiatives to help manage the challenges & change in coming months.
	Just Culture		Paused during COVID response	Last certification training completed in February. We have approx. 180 certified employees who form the champions group. The Manager training due to start 24 March was put on hold.	The Steering Committee to discuss the restart date, review the project plan, policy development and online training options /approach.
	Supportive pathways to safely raise concerns and grievances		Paused during COVID response	No significant activity this period.	Review '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 consultation with unions .	Planning for rectification underway with a business case for resources required for remediation being developed.
	Building workforce capability towards elimination of inequity		Pivot to COVID prioritised activity	This pivoted to support current need - distribution of care packs, workforce wellbeing survey and implementation of identified support strategies ie. Māori Leadership webinar and online Karakia sessions.	Development of Maanaki Centre approach to deliver sustainable support options for our people in need. This work focuses on our Māori, Pacific and To Thrive groups as a priority.
	Hauora/Wellbeing strategy		Paused during COVID response	Focus on Wellbeing during COVID19. Participated in region / national response with Manager tools and advice.	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.
	Supportive and inclusive employment practices		On track	**To Thrive:** Implementation of internships (Labs & Patient Admin). **Accessibility:** Recruitment pathway implemented **Rainbow:** Maintained Tick accreditation	**To Thrive:** Step up - L2 Literacy & Numeracy programme designed. **Accessabiliy:** Disability Confidence training (for managers) implemented. **Rainbow:** Review Tick accreditation report and build action plan for 20/21
	2020/2025 Auckland DHB People strategy		Strategy development parked during COVID response	No significant activity this period.	Review early drafts in line with what we have learned during COVID & amend as needed. Build engagement approach (HR team / organisation). Directorate level progress to People plan & 20/21 needs sessions rescheduled. MALT workforce strategy review participation once restarted
Ensuring a future ready workforce	Sourcing strategy		20/21 Recruitment & Sourcing Strategy Revamp required.	Responded to COVID recruitment demands with revised fast track processes to meet volume requirement. Strategy development / changes parked in the period.	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

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

Financial Performance Report for the nine months ending 31 March 2020

Recommendation

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

Prepared by: Rosalie Percival, Chief Financial Officer
Date: 30 April 2020

1. Executive Summary

The DHB is operating to a revised budget of $20M approved by the Board and pending approval by the Minister of Health.

Performance against the revised budget for the month of March 2020 shows a net deficit of $5.8M which was unfavourable to the net deficit budget of $2.2M by $3.6M. For the year to date (YTD), a net deficit of $3.6M was reported against a net surplus budget of $6.8M, thus unfavourable to budget by $10.4M.

The YTD result is distributed across divisions as follows:

Result by Division	**YTD (nine months ending 31 Mar-20)**		
	Actual	**Budget**	**Variance**
Funder	47,732	42,025	5,707 F
Provider	(51,852)	(35,286)	16,568 U
Governance	496	26	470 F
Net Surplus / (Deficit)	**(3,625)**	**6,765**	**10,390 U**

- The Funder arm result reflects expenditure being favourable to budget due to demand driven nature of expenditure mainly across Mental Health, Medical/Surgical and Personal Health. The funder result also includes additional funding received from MoH to support primary and community care responses to Covid-19 (bottom-line neutral).
- The Provider arm result reflects expenditure being unfavourable to budget mainly due to higher than budget personnel, outsourced clinical services and clinical supplies. COVID-19 related costs incurred to March amount to $1.8M. These costs exclude commitments amounting to $5M of which costs will come through in future months and PPE supplies procured amounting to $20M (expected to be reimbursed by MoH).
- The Governance result is favourable and close to budget, mainly due to favourable movement in the Infrastructure and non-clinical supplies expenditure offsetting unfavourable movements in other expenditure categories.

Year End Forecast:

We are forecasting a deficit of $71M against the revised budget of $20M, thus $52M unfavourable. This is worse that the previous forecast deficit of $27M that would have been unfavourable to budget by $7M. The main drivers for the worsening forecast (i.e. $45M worse than prior forecast) are:

- $15M adverse wash-up for Planned Care due to under-delivery of volumes
- $13M adverse wash-up for IDFs due to under-delivery of volumes
- $15M unfavourable personnel costs due to additional leave liability
- $2M additional costs across various categories offset by savings.

We have assumed the following in coming up with these forecasts:

- IDFs and Planned Care revenue will be washed up on as usual based on volume performance.
- No additional revenue is provided to offset the impacts of Covid-19 for the Provider arm
- The forecasts are still subject to the final actuarial valuation for staff liabilities
- The overall cost impacts of Covid-19 are subject to change depending on developments around Covid-19.

2. Summary Result and Financial Commentary for March 2020

$000s	Month (Mar-2020)			YTD (nine months ending 31 Mar-20)			Full Year (2019/20)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Income									
Government and Crown Agency	145,836	137,853	7,982 F	1,244,783	1,243,397	1,386 F	1,594,826	1,657,122	62,296U
Non-Government and Crown Agency	7,288	8,510	1,222 U	78,704	78,483	220 F	163,471	104,022	59,449F
Inter- District Flows	56,370	56,624	254 U	513,890	516,325	2,435 U	679,682	686,196	6,514U
Inter-Provider and Internal Revenue	1,145	1,164	19 U	11,101	10,586	516 F	14,594	14,079	516F
Total Income	**210,638**	**204,151**	**6,487 F**	**1,848,478**	**1,848,791**	**313 U**	**2,452,574**	**2,461,418**	**8,844U**
Expenditure									
Personnel	96,973	91,963	5,011 U	826,037	817,081	8,955 U	1,119,004	1,115,795	3,209U
Outsourced Personnel	2,235	1,175	1,060 U	19,357	10,627	8,730 U	22,885	14,155	8,730U
Outsourced Clinical Services	4,342	3,720	622 U	33,508	33,458	50 U	45,048	44,636	412U
Outsourced Other Services	6,920	6,807	113 U	61,987	61,265	722 U	80,148	81,687	1,539F
Clinical Supplies	26,983	26,272	711 U	235,045	228,477	6,568 U	311,208	304,101	7,107U
Funder Payments - NGOs and IDF Outflows	61,118	59,095	2,023 U	513,307	527,927	14,620 F	684,752	705,213	20,461F
Infrastructure & Non-Clinical Supplies	17,912	17,359	553 U	162,862	163,190	327 F	212,609	215,831	3,222F
Total Expenditure	**216,484**	**206,392**	**10,092 U**	**1,852,103**	**1,842,026**	**10,078 U**	**2,475,653**	**2,481,418**	5,764F
Net Surplus / (Deficit)	**(5,846)**	**(2,241)**	**3,605 U**	**(3,625)**	**6,765**	**10,390 U**	**(23,080)**	**(20,000)**	**3,080 U**

Result by Division	Month (Mar-2020)			YTD (nine months ending 31 Mar-20)			Full Year (2017/18)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funder	3,411	3,325	86 F	47,732	42,025	5,707 F	52,000	52,000	0 F
Provider	(9,199)	(5,547)	3,652 U	(51,852)	(35,286)	16,568 U	(75,550)	(72,000)	3,550 U
Governance	(58)	(19)	38 U	496	26	470 F	470	0	470 F
Net Surplus / (Deficit)	**(5,846)**	**(2,241)**	**3,605 U**	**(3,625)**	**6,765**	**10,390 U**	**(23,080)**	**(20,000)**	**3,080 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 $6.5M (3.2%) favourable with major variances being in:

- $8M (5.8%) favourable Government and Crown Agency revenue, mainly due to new COVID-19 revenue for the Auckland Regional Public Health Service and to fund Community Based Assessment Centres (CBAC), Primary Care Response and Virtual Consultations, which all have equivalent expenditure variances resulting in a nil impact on core result. There was also additional Capital charge revenue received for asset revaluation.
- $1.2M (-14.4%) unfavourable variance in Non-Government and Crown Agency is mainly driven by the investment losses in the A+ Trust investment portfolio this month due to the COVID-19 impact on the global markets.

Total Expenditure for the month is unfavourable to budget by $10M (-4.9%) mainly driven by:

- $6M (-6.5%) unfavourable variance in Personnel/Outsourced Personnel costs – Total FTE for the month were 9,730 which was 131 above budget, equating to a $1.3M unfavourable variance. There are also an estimated $1.7M additional Covid-19 related costs for reduction in annual leave taken, paid isolation leave and costs of additional resources. The balance of the unfavourable variance ($3M) reflects higher cost per FTE for the month due to actual versus budget phasing.

- $2M (-3.4%) unfavourable variance in NGO costs and IDF Outflows mainly due to new COVID-19 related expenditure accounted for in the month and year to date relating to Community Based Assessment Centres (CBAC) and Primary Care Response and Virtual Consultations. Additionally expenditure for Auckland DHB's share of National Haemophilia Management Group increased costs was accounted for in March.

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

Total Revenue year to date is unfavourable to budget by $313K (-0.02%), mainly driven by:

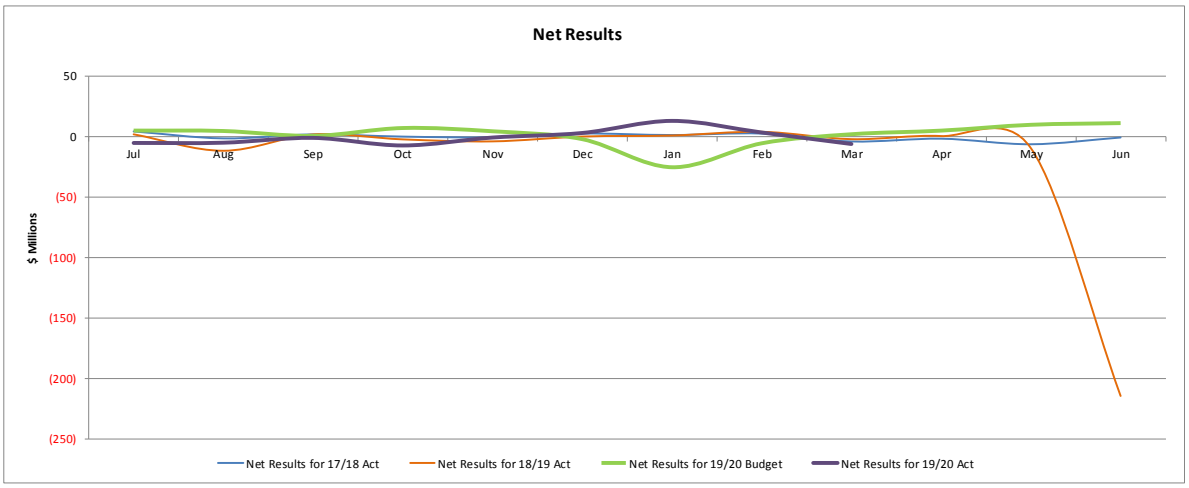
- $1.4M (0.1%) favourable Government and Crown Agency revenue, mainly driven by new COVID-19 funding for the Auckland Regional Public Health Service, additional capital charge received for asset revaluation and additional Planned Care funding of shortfall for quarter one settled in December 2019.
- $2.4M (-0.5%) unfavourable Inter-District Flows, mainly due 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 year to date is unfavourable to budget by $10M (-0.55%), mainly driven by:

- $17.7M (-2.1%) unfavourable variance in Personnel/Outsourced Personnel costs, driven by the following:
  - Year to date average FTE are 32 (0.3%) above budget - equating to $3.5M unfavourable.
  - Security staff $2.4M unfavourable but largely offset with favourable Outsourced security costs $1.9M favourable, reflecting transfer of security services in-house.
  - One off backdated costs relating to prior year $1.0M.
  - Estimated $1.7M additional Covid-19 related costs for reduction in annual leave taken, paid isolation leave and costs of additional resources.
  - The balance of the variance, $9.2M, represents a 1% variation in cost per FTE. This would be expected to partially reverse over the balance of the year due to the high budget phasing for quarter four, but this will now be impacted by an expected increase in special paid leave (such as isolation leave) and a decrease in annual leave taken during the coming months.
- $7M (-2.9%) unfavourable in Clinical supplies, mainly driven by the following key unfavourable variances:
  - Additional costs for the Covid-19 response $1.1M unfavourable, with the most significant cost being laboratory reagent costs.
  - Funded pharmaceutical cancer treatment (PCT) costs $4.0M over budget.
  - Haemophilia blood product $2.1M over budget – this is fully funded and will be subject to full wash up.
- $15M (2.8%) favourable variance in NGO costs and IDF Outflows mainly due new COVID-19 related expenditure accounted for in the month and year to date relating to Community Based Assessment Centres (CBAC) and Primary Care Response and Virtual Consultations. Additionally expenditure for Auckland DHB's share of National Haemophilia Management Group increased costs was accounted for in March. Other contributors to the variance include IDF impact of changes in PHO GP enrolments and post budget service changes, the normally expected variations in service delivery/claiming, expired contracts not renewed, budgeted initiatives not yet contracted for and the release of historical contracted expenditure risk accruals which are deemed to be no longer at risk.

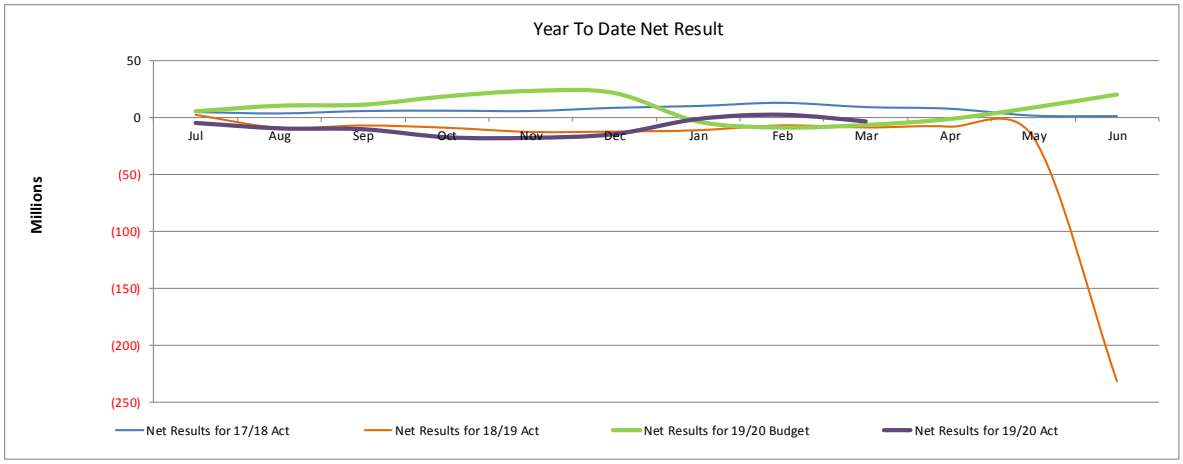
3. Performance Graphs

Figure 1: Consolidated Net Result (By Month)



$ millions	July	August	September	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)				(3.625)

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)			
Variance to Budget 19/20	(10.238)	(19.926)	(21.598)	(36.045)	(41.229)	(36.107)	2.289	11.227	3.140			20.000

4. Financial Position

4.1 Statement of Financial Position as at 31 March 2020

$'000	31-Mar-20			29-Feb-20	Variance	30-Jun-19	Variance
	Actual	Budget	Variance	Actual	Last Month	Actual	Last Year
Public Equity	906,649	960,966	54,317U	906,649	0F	889,380	17,269F
Reserves							
Revaluation Reserve	599,151	599,151	0F	599,151	0F	599,151	0U
Accumulated Deficits from Prior Year's	(688,960)	(688,959)	0U	(688,960)	0F	(456,995)	231,965U
Current Surplus/(Deficit)	(3,624)	6,769	10,392U	2,222	5,846U	(231,965)	228,341F
	(93,432)	(83,040)	10,392U	(87,586)	5,846U	(89,808)	3,624U
Total Equity	**813,217**	**877,926**	**64,709U**	**819,063**	**5,846U**	**799,572**	**13,646F**
Non Current Assets							
Fixed Assets							
Land	347,122	347,122	0U	347,122	0F	347,122	0F
Buildings	608,342	628,581	20,239U	610,543	2,201U	631,462	23,120U
Plant & Equipment	81,929	100,069	18,140U	79,567	2,362F	86,580	4,651U
Work in Progress	94,995	131,543	36,548U	92,370	2,625F	52,223	42,772F
Total PPE	1,132,388	1,207,315	74,927U	1,129,602	2,786F	1,117,387	15,001F
Investments							
- Health Alliance	70,158	71,003	845U	70,066	93F	70,066	93F
- NZHPL	9,629	6,714	2,915F	9,346	282F	6,714	2,915F
- ADHB Term Deposits > 12 months	-	15,000	15,000U	-	0F	15,000	15,000U
- Other Investments	937	-	937F	937	0F	937	0F
	80,724	92,717	11,993U	80,350	375F	92,717	11,993U
Intangible Assets	2,321	1,490	831F	2,400	79U	1,810	511F
Trust Funds	15,471	17,200	1,729U	16,913	1,442U	17,200	1,729U
	98,516	111,407	12,891U	99,662	1,146U	111,727	13,211U
Total Non Current Assets	**1,230,904**	**1,318,722**	**87,818U**	**1,229,264**	**1,640F**	**1,229,114**	**1,790F**
Current Assets							
Cash & Short Term Deposits	148,145	107,830	40,315F	121,744	26,401F	97,046	51,099F
Trust Deposits > 3months	17,300	13,300	4,000F	15,800	1,500F	13,300	4,000F
ADHB Term Deposits > 3 months	15,000	15,000	0F	20,000	5,000U	15,000	0F
Debtors	29,382	30,081	699U	48,363	18,981U	30,081	699U
Accrued Income	44,131	56,786	12,655U	44,564	433U	56,786	12,655U
Prepayments	2,853	996	1,857F	2,839	14F	996	1,858F
Inventory	34,811	14,357	20,454F	14,938	19,873F	14,356	20,455F
Total Current Assets	**291,623**	**238,350**	**53,273F**	**268,248**	**23,374F**	**227,566**	**64,057F**
Current Liabilities							
Borrowing	(1,399)	(3,079)	1,680F	(1,398)	2U	(1,079)	320U
Trade & Other Creditors, Provisions	(182,704)	(160,393)	22,311U	(165,449)	17,253U	(147,836)	34,868U
Employee Entitlements	(444,190)	(428,008)	16,182U	(430,554)	13,636U	(428,009)	16,181U
Funds Held in Trust	(1,308)	(1,275)	33U	(1,308)	0U	(1,308)	0U
Total Current Liabilities	**(629,600)**	**(592,755)**	**36,845U**	**(598,709)**	**30,890U**	**(578,231)**	**51,369U**
Working Capital	**(337,978)**	**(354,405)**	**16,427F**	**(330,461)**	**7,516U**	**(350,665)**	**12,688F**
Non Current Liabilities							
Borrowings	(9,815)	(16,497)	6,682F	(9,846)	31F	(8,983)	832U
Employee Entitlements	(69,894)	(69,894)	0U	(69,894)	0F	(69,894)	0F
Total Non Current Liabilities	**(79,709)**	**(86,391)**	**6,682F**	**(79,741)**	**31F**	**(78,877)**	**832U**
Net Assets	**813,217**	**877,926**	**64,709U**	**819,063**	**5,846U**	**799,572**	**13,646F**

Commentary

The major variances to budget are summarised as:

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

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

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

Trade & Other Creditors and Provisions:

Trade & Other Creditors, Provisions:	**$000's**
Trade Creditors (including accruals)	158,067
Income in Advance	24,622
Provisions (Litigation)	15
Total	182,704

4.2 Statement of Cash flows as at 31 March 2020

$000's	31-Mar-20			YTD (nine months ending 31 Mar-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Revenue Received	238,930	203,697	35,233F	1,874,872	1,844,708	30,164F
Payments						
Personnel	(83,338)	(92,097)	8,759F	(809,855)	(817,429)	7,574F
Suppliers	(62,113)	(47,311)	14,802U	(450,856)	(428,770)	22,086U
Capital Charge	0	0	0F	(23,109)	(24,022)	913F
Payments to other DHBs and Providers	(61,118)	(59,095)	2,023U	(513,305)	(527,927)	14,622F
GST	(2,801)	0	2,801U	(547)	0	547U
	(209,370)	(198,503)	10,867U	(1,797,672)	(1,798,148)	476F
Net Operating Cash flows	**29,560**	**5,194**	**24,366F**	**77,200**	**46,560**	**30,640F**
Investing						
Interest Income	299	454	155U	3,333	4,086	753U
Sale of Assets	(9)	0	9U	135	0	135F
Purchase Fixed Assets	(7,692)	(13,335)	5,643F	(56,563)	(120,015)	63,452F
Investments and restricted trust funds	4,283	0	4,283F	8,993	0	8,993F
Net Investing Cash flows	**(3,118)**	**(12,881)**	**9,763F**	**(44,102)**	**(115,929)**	**71,827F**
Financing						
Interest paid	(12)	(116)	104F	(421)	(948)	527F
New loans raised	0	4,000	4,000U	2,137	9,514	7,377U
Loans repaid	(30)	0	30U	(986)	0	986U
Other Equity Movement	0	7,954	7,954U	17,269	71,586	54,317U
Net Financing Cash flows	**(42)**	**11,838**	**11,880U**	**18,000**	**80,152**	**62,152U**
Total Net Cash flows	**26,400**	**4,151**	**22,249F**	**51,098**	**10,783**	**40,315F**
Opening Cash	121,744	103,679	18,065F	97,046	97,047	1U
Total Net Cash flows	26,400	4,151	22,249F	51,098	10,783	40,315F
Closing Cash	**148,145**	**107,830**	**40,314F**	**148,145**	**107,830**	**40,314F**
ADHB Cash				145,623	104,925	40,698F
A+ Trust Cash				2,177	2,562	385U
A+ Trust Deposits - Short Term < 3 months & restricted fund deposits				345	343	2F
				148,145	**107,830**	**40,314F**
ADHB - Short Term 3 > 12 months				15,000	15,000	0F
A+ Trust Deposits - Short Term 3 > 12 months				17,300	13,300	4,000F
ADHB Deposits - Long Term >12 months				-	15,000	15,000U
A+ Trust - Long Term Investments > 12 months				15,471	17,200	1,729U
Total Cash & Deposits				**195,916**	**168,330**	**27,585F**

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 26 February 2020.

Prepared by: Wendy Bennett (Manager Planning and Health Intelligence), Joanne Brown (Funding & Development Manager Hospitals), Vicki Scott (Acting 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: Tim Wood (Acting Director Funding), Dr Karen Bartholomew (Director Health Outcomes)

Glossary

AAA	-	Abdominal Aortic Aneurysm
ACC	-	Accident Compensation Corporation
ARC	-	Aged Residential Care
ARPHS	-	Auckland Regional Public Health Service
CBAC	-	Community Based Assessment Centres
CDA	-	Combined Dental Agreement
CHIL	-	Child Health Information Link
CT	-	Computed Tomography
CTOs	-	Community Treatment Orders
CUR	-	Census Usually Resident
CVD	-	Cardiovascular Disease
DHB	-	District Health Board
DSME	-	Diabetes Self-Management Education
DSS	-	Disability Support Services
EP	-	Electrophysiology
ESPI	-	Elective Services Performance Indicators
FCT	-	Faster Cancer Treatment
GP	-	General Practitioner/General Practice
IDF	-	Inter District Flow
MELAA	-	Asian & Middle Eastern Latin American and African
MMR	-	Mumps, Measles and Rubella
MoH	-	Ministry of Health
MRI	-	Magnetic Resonance Imaging
NCHIP	-	National Child Health Information Platform
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
PHO	-	Primary Health Organisation
PPE		Personal Protective Equipment

PRRT - Peptide Receptor Radionuclide Therapy
SME - Self-Management Education

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 26 February 2020.

2. Planning

2.1 Annual Plans

The Ministry of Health (MoH) have adjusted the 2020/21 annual planning timelines and processes and have indicated that there may be further adjustments as more detail comes to hand.

Feedback on the first draft 2020/21 Annual Plans along with adjustments to the planning guidance as a result of COVID-19 are expected in mid May and any further revisions to Annual Plans will not need to be submitted to the MoH until at least mid June.

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

Central Government Agencies have advised that they are exploring a range of options, including potentially modifying legislative requirements to assist entities to manage legislative planning and reporting requirements.

The MoH is also considering how the impacts of COVID-19, the level 4 national lockdown and the future path to recovery are likely to impact on the planning advice previously provided.

3. COVID-19 Response

Many of the Planning Funding and Outcomes team had been 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 been put 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.

In accordance to a national approach we have confirmed minimum funding levels for many of our providers to ensure that they retain staff and can have services back up and running as soon as possible as we move through the various levels of the rahui.

Many providers have responded exceptionally to COVID-19. The use of virtual care has blossomed so that people can still access support and care with the necessity for face to face care. We are now considering how some of these new approaches can be embedded where appropriate as they offer an opportunity to improve access and efficiency of service delivery.

4. Primary Care

4.1 Response to COVID-19

The primary focus has been on the set up of the 14 Community Based Assessment Centres (CBACs), five mobile primary care services and supporting the sector to respond to patient need.

Thanks need to be given to many community providers who were asked to, and did, respond very quickly in setting up assessment facilities and services. A number of the providers closed down their usual operations to enable these assessment centres to be set up.

As at May 6, over 37,000 people have been swabbed, through the CBACs and primary care mobile units with a further 14,542 swabs were taken in general practice or urgent care centres. Establishing CBACs in specific locations, Māori-led and Pacific-led CBACs, and the addition of mobile testing units are credited with enabling good reach of Māori and Pacific communities:

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

Māori	14%
Pacific	19%
European	46%
Asian	16%
MELAA	2%
Other	3%

The overall rate of testing (CBACs and all other testing) is higher for Māori (at 491 per 10,000 northern region population) than non-Māori (at 389 per 10,000 northern region population).

4.2 COVID-19 Impacts

It is too early to tell what the impact of the rahui on general practice and community pharmacy. Early indications are that during level 4 consultation rates at general practice declined by 50% or more with a corresponding decrease in dispensing of medications. The key concern is that patients have put off seeking medical advice and as a consequence there may be deterioration in health outcomes. However, part of the decline in consultations associated with lower ACC claims as a consequence of reduced sporting and vehicle related injuries. Regular national and regional communication approaches have been undertaken encouraging people to attend primary care and the hospital for acute care.

There are reports of financial hardship and potentially some of these providers possibly closing. There have been cash injections by the MoH in to both these parts of the sector to support them. Closures of general practices in particular could lead to access issues. The team are monitoring closures and will consider impacts for patient access and care.

5. Health of Older People

5.1 Aged Residential Care

A COVID-19 outbreak in an aged residential care (ARC) facility can be devastating due to the high risk of poor health outcomes for vulnerable residents if they become infected; this has been demonstrated overseas and in recent months in New Zealand. A suite of ARC COVID-19 guidance was developed via the Northern Region Health Coordination Centre (NRHCC). This was across a three phase planning approach – preparedness, alert and outbreak control. This guidance included an assessment process, rapid testing response, the development of a testing alert system (for ARC staff and residents) and detailed outbreak management guidance aligned with the national Health Quality and Safety Commission guidance.

There have been two ARC facilities in Auckland DHB affected by COVID-19 events:

- Ellerslie Gardens; where one resident tested positive for COVID-19 as an inpatient at Auckland City Hospital (ACH). There were extensive possible contacts across all staff (62) and residents (85) at the facility who were placed in isolation for 14 days.
- Facility B; where one staff member was identified as a probable case, and six staff members and 11 residents were identified as close contacts. Seven residents have been admitted to ACH to enable appropriate isolation practices to occur. The lay out of the facility including shared bathrooms meant this was not possible if all residents remained on site.

Planning and Funding (PFO) have facilitated daily Outbreak Management Team meetings for the two facilities including representatives from: the IMT; DHB geriatricians, nurse practitioners and gerontology nurse specialists; and ARPHS medical officers of health and health protection officers.

The COVID-19 outbreaks in Auckland DHB facilities along with five others in ARC facilities across the country have highlighted the most pressing issues during such an event are replacing facility staff when they are stood down at very short notice, ensuring the facility is appropriately able to isolate residents and ensuring robust infection prevention control (IPC) is in place. The reality is that very few facilities would be able to manage a COVID-19 outbreak without significant DHB resource and support particularly to back fill staff, and contingency planning should be on this basis.

Due to the vulnerability of the ARC sector to COVID-19 outbreaks, there was a directive on the 11 April 2020 from the Director General of Health for all facilities to be comprehensively assessed on their level of preparedness for COVID-19 and to identify any actions to improve their readiness. PFO had previously completed a risk screening tool across all Auckland DHB facilities so those identified as highest risk were assessed first. Assessment teams including gerontology nurse specialists and IPC expertise have now completed assessments of all 69 facilities in Auckland DHB.

Preparation for the rollover of the national Age Related Residential Care Agreement for the 1 July 2020 is underway and a review of the cost impact estimations is expected in early May.

5.2 Home and Community Support Services

During the lockdown all Home and Community Support Service (HCSS) providers were required to cease delivery of non-essential services; this was due to a reduced workforce (e.g. 15% of support workers are over 70 years) and to reduce non-essential visits to clients (Alert level requirement)7.

HCSS providers were asked to identify all their vulnerable clients and ensure services to these clients were prioritised.

The DHB has requested HCSS providers carry out welfare checks on any clients who are not currently receiving services or whose care package may have been reduced. These calls are at least once a week. Providers are asking a wide range of questions covering social risks, shopping requirements, loneliness, and clinical deterioration. In many cases these calls are being carried out by registered health professionals.

PFO has been meeting twice a week with the HCSS providers to discuss any concerns and issues. The quality nurse leader has been attending one of these weekly meetings to ensure correct infection prevention control measures are in place and correct use of personal protective equipment (PPE).

Although not a national directive, a modified COVID-19 preparedness assessment has been carried out with Northern Region HCSS providers by the DHB programme managers. This has been seen as a useful process both by the providers and the DHB.

6. Child, Youth and Women's Health

6.1 Immunisation

6.1.1 Childhood Immunisation Schedule Vaccinations

Provisional results for the Immunisation Focus Area for Quarter 3 2019/20 indicate that Auckland DHB did not achieve the 95% target for babies being immunised by 8 months of age, with coverage of 93.5%. The Q3 2019/20 coverage is higher than the national average of 91% and is in keeping with coverage achieved for the same time last year. The quarter is impacted by access to, and prioritisation of, immunisation during the holiday period. There continues to be an equity gap for Māori (83.5%) and Pacific (90%), with a reduction in coverage over the quarter for both groups.

Coverage at 24 months remains stable at 95%, and reflects the hard work by the sector during the measles outbreak. There has been an improvement in coverage at 5 years of age to 91%. ADHB is also above the national average coverage for 24 months (92%) and 5 year old (90%).

It is expected that COVID-19 will impact immunisation coverage in quarter 4, with reports of many whānau feeling reluctant to leave their bubbles to go to primary care practices. PHOs report that there was some reduction in the usual recall processes during the initial stages of lockdown as focus shifted to establishing virtual clinics, however practices now have processes to separate well patients coming for immunisation from unwell patients seeking medical attention. Additionally, our Outreach Immunisation Service paused their home visiting service at the start of the Level 4 lockdown whilst access to PPE and home visiting protocols were established. The OIS service has resumed and have had success in immunising, including offering influenza immunisation to eligible patients. However, they have also reported some families feeling reluctant to have the service in their 'bubble'.

We are monitoring 6 month and 18 month immunisation coverage as a measure of timeliness particularly for the impact of COVID-19. 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.

6.1.2 Influenza vaccination

There has been strong demand for the influenza vaccine this year. Due to COVID-19, the Ministry of Health brought the official start of influenza vaccination season forward two weeks, to ensure that eligible patients were able to access influenza vaccination. Influenza vaccination will not protect against coronavirus, but reducing the impact of influenza takes pressure off the health sector. In response to the strong demand, the Ministry extended the period in which only eligible patients and frontline workers could access the vaccine to the end of April, however all people can now access the vaccine.

DHBs have been tasked by the Ministry of Health to review all influenza vaccination orders for their region to approve distribution by Healthcare Logistics.

- PHARMAC has secured 1.76M influenza vaccines for 2020, an increase from the 1.34M vaccines used in 2019. As at the close of business on 29 April 2020, over 1.3M doses of influenza vaccine had been distributed nationally, with approximately 31% of stock attributed to providers in Metro Auckland DHBs.
- 21,000 influenza vaccines licensed for 6 to 35 month olds had been secured by PHARMAC, which was a significant increase in the 6,500 doses used in 2019. Approximately 36% (6,900 doses) of national supply (18,930 doses) had been distributed to general practices across metro Auckland DHB. A small amount of stock has been ring-fenced by the Ministry of Health for high-risk children and providers have been asked to only immunise those young children who are eligible for funded vaccination.

PFO has led a metro Auckland working group to provide oversight of the flu vaccine supply as well as identifying initiatives to improve equity of immunisation coverage. In particular this group has identified high priority practices (based on high numbers of Māori and Pacific patients) and has sought to ensure that they obtain sufficient vaccine supply. In addition, in support of equity of influenza coverage, a DHB nurse vaccinator outreach service has been stood up and is offering in-home immunisation to eligible Māori, Pacific and Q5 patients. The first priority was children aged 0-4 years who had been hospitalised with a respiratory condition and who are not registered with a PHO. This activity is in addition to those children referred to the HealthWEST OIS service for childhood immunisations who are also eligible for flu vaccination.

We have worked with our midwifery colleagues and created a referral pathway for Māori, Pacific and/or quintile five women who require antenatal immunisation (flu and pertussis) and have been unable to access via their GP or pharmacy. These women will be offered the same DHB in-home immunisation service.

At the request of the PHOs, a similar process to the 0-4 ASH lists has been followed for eligible people aged 5-64 years. These lists have now been provided to the relevant PHOs for follow up. A data clean process is underway for those people not enrolled in a PHO with a view to offer them the free in home immunisation via the DHB nurse vaccinator service. As the Māori-led mobile primary care services are established, families will be offered a choice of service provider.

The success of the new outreach service will be evaluated with a view to continuation of the service to improve equity for Māori, Pacific and Q5 communities.

6.1.3 Measles

The Ministry of Health had been looking to the DHBs for plans for MMR vaccine catch-up programmes, particularly targeted at the 15-29 year old age group. With the COVID-19 situation, the request for catch up plans has been removed; however PFO will assess how MMR vaccination can be provided in workplaces and schools. At this time, we are obtaining data on the level of under-immunisation in young people served by the DHB funded school based health services.

6.2 Uri Ririki – Child Health Connection Centre

In March, a powhiri was held to officially open Uri Ririki - Child Health Connection Centre (CHCC) and welcome the permanent staff. Uri Ririki comprises teams of administrators tasked with management of the National Immunisation Register (NIR), National Child Health Information Platform (NCHIP) and Noho Āhuru – Healthy Homes (formerly called Kāinga Ora).

During the COVID-19 lockdown, the National Immunisation Register (NIR) team provided business as usual activities from their homes. 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. Since the last funder report, the service is now fully staffed by permanent staff, including some who joined the team from the previous provider, HealthWEST, and others who were part of the original temporary administrative team who elected to apply for permanent positions.

The National Child Health Information Platform (NCHIP) is now live for the early adopters (the CHCC users), enabling a point-of-care view of each child's progress through the universal health milestones from 0 to 6 years of age. A key focus of the early adoption is ensuring confidence in data. There has already been success in identifying children known to the NCHIP system that were not known to the National Immunisation Register. User acceptance testing is underway for the second phase of NCHIP implementation, which will enable better data manipulation to more easily identify at risk children and sharing of lists with service providers.

Linkages with the Ministry of Social Development continue to evolve, with completion of the first sharing of contact information for children who are overdue immunisations and unable to be located with current information. This will continue to be finessed to ensure privacy and security processes are maintained.

Noho Āhuru – Healthy Homes continued to operate within the constraints of lockdown. The service implemented virtual visiting as much as possible, to support whānau with urgent matters during Level 4. Home visits were suspended during Level 4 but are now resuming with protocols in place around screening, PPE and social distancing. Capacity in some partner agencies will have an impact on the ability to resolve cases swiftly. MSD currently are unable to process housing assessments but these are expected to resume under Level 2.

As with most other health services, there has been a lower rate of referrals since COVID-19 restrictions were put in place. Full completion of assessments has been slowed by a delay of home visits during Level 4, and completion of follow on activity such as with MSD has also been impaired. We continue to work with whānau with a high level of sensitivity to additional needs at this time and expect and encourage increasing referrals in the coming months.

As at 31 April 2020, Auckland DHB received 1,361 referrals to Noho Āhuru – Healthy Homes. This included 5,104 family members getting access to healthier home interventions. Of the referrals received, 447 (33%) were for families with a newborn baby or hapu woman.

6.3 Rheumatic Fever

One area of increased health need that has been evidenced is a possible increase in Rheumatic Fever (RhF) presentations. The dominant messaging regarding COVID-19, the restrictions to primary care, closure of schools and concerns about reluctance to present to health care services has resulted in loss of messaging about RhF prevention. Discussions are underway with primary care, school health services and the MoH about the need for renewed communication about RhF prevention and empirical antibiotic treatment and COVID-19 testing for communities at risk of RhF per the National Health Foundation Guidelines. There is reason to be concerned about a range of unmet health needs associated with poverty, which is likely to become more marked as the impact on the economy becomes embedded. The need for Healthy Housing type services, and other services that reach out to communities will become more necessary to prevent disparities widening.

6.4 Children and Adolescents' Oral Health

Since 24 March 2020, in line with the COVID-19 alert levels and recommendations from the Ministry of Health and Dental Council, the Auckland Regional Dental Service (ARDS) is providing essential dental services only. Essential dental services are defined as:

- Severe pain that cannot be controlled by medication;
- Fractured teeth or pulpal exposure, if pain not able to be managed;
- Oro-facial swelling that is serious and worsening despite taking antibiotics;
- Post-extraction bleeding that the patient is not able to control with local measures;
- Dental conditions that have resulted in acute systemic illness or raised temperature as a result of dental infection; or
- Acute infections that is likely to exacerbate systemic medical conditions such as diabetes.

All other previously booked non-essential dental appointments have been postponed. During Level 3, ARDS has maintained six Relief of Pain clinics for non-aerosol generating procedures for low COVID-19 risk patients only. Planning is underway to extend treatment appointments as we move down in alert levels to see patients requiring deciduous teeth extractions with symptoms currently successfully managed by medications, and to patients with deciduous teeth extractions required as part of their pre-existing treatment plans.

Across metro Auckland, PPE is being supplied to 50 private dental practices in the community that have a Combined Dental Agreement with the DHB to provide essential dental services. These practices are providing emergency dental services for adolescents and adults in the community.

Through Auckland Regional Hospital and Specialist Dental Service, an emergency relief of pain service is being operated for low income adults at Buckland Road dental facility. This service is also available for COVID-19 patients and suspected COVID-19 patients who need urgent dental care.

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

In keeping with the Ministry of Health and Dental Council criteria during COVID-19, patients of Hapu Māmā Oranga Niho Ki Tamaki are receiving telephone advice, electronic prescriptions for medical management of pain or infections, and face-to-face clinic appointments for emergency essential dental treatment.

To date, 44 referrals were received by the service.

- 42 from midwives, one was from a GATEWAY coordinator and one from a GP
- 42 of the 44 referrals met criteria, one was a duplicate and one lived out of the area.

Appointments

- 27 of the 42 accepted referrals were undergoing their first episode of care (that is, they've had at least one appointment with the service) before Level 4.
- Appointments are averaging 60 minutes each, and 2 women have had 5 appointments each to date
- Of the 15 who have not yet had an appointment, 6 referrals are awaiting triaging and 9 are currently on the Supportive Treatment Pathway as contact has been unable to be achieved despite exhausting all avenues.

6.6 Contraception

A number of health care practitioners responded to the Registration of Interest (ROI) process for provision of services to increase access to Long Acting Reversible Contraception (LARCs). These services will complement the network of services provided through DHB women's health clinics as well as the Auckland Regional Sexual Health Services and others such as Family Planning Association. These services are intended to target women with increased barriers to health services. Women do not need to be enrolled with a PHO to receive services, but to be eligible must be Māori, Pacific, Q5 or have other issues (such as addictions) which increase the risk of poor outcomes for mother or baby. Provision across the network will be monitored over the coming 12 months and if geographic or service access gaps remain, additional work will be undertaken to address access barriers.

6.7 Maternity

Maternity services have 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 LMC 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 has been 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 at both ACH and Birthcare have reduced significantly with anecdotal feedback that women are preferring to remain in or quickly return to their home 'bubble'. Also anecdotally, there has been an increase in home births. The number of access agreement holders at Birthcare have increased, but seemingly the number of births at Birthcare have not. Birthcare is funded on actual

utilisation of services, but have received a funding guarantee from the Funder which will ensure that funding levels are similar to pre-COVID-19 numbers from April till June.

6.8 Fertility

Fertility services, excluding preservation, were suspended during Level 4. Providers quickly resumed service delivery once the country returned to Level 3. Steps have been taken to ensure that no one is disadvantaged by the suspension of services. In re-starting services priority groups were identified. Steps have been taken to minimise the number of face to face services required.

6.9 Cervical and Breast Screening

Cervical and Breast Screening services were suspended during Alert Level 4. The National Cervical Screening Programme has signalled a gradual return to normal screening under level 3. 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.

In addition to COVID-19 interruption of services, a number of service changes have been signalled by the NCSP in relation to the cervical screening programme including change to the test of cure pathway for women after completion of colposcopy. The Cervical Screening Coordination Service (CSCS) in PFO will work with the sector to support the implementation of the NCSP guidance as capacity allows in the sector.

6.10 Child, Youth and Women's response to COVID-19 IMT

In addition to the information above in regards to establishment of the DHB influenza nurse vaccinator service, members of the Child Youth and Women's PFO team have contributed to the COVID-19 IMT team. One member has been assisting with PPE order and distribution processes, whilst another led the set-up of the Buckland Road dental clinic and supported access to PPE for dental clinics.

Our cervical screening coordination service nurse specialist has been re-deployed to the airport in the early stages of the COVID-19 response and more recently is providing support to immunisation services, in particular, providing additional clinics in community maternity services and as part of the immunisation services described above.

Our SUDI prevention regional coordinator has been re-deployed to maternity clinical services since late March 0.5FTE.

7. Mental Health and Addictions

7.1 Response to COVID-19

7.1.1 Semi-independent Supported Step-down Accommodation service

In the early stages of Alert Level 4, a group of service users were identified who could not be discharged from acute mental health services (inpatient, acute alternative or respite), as they could not return to a flat / boarding house or to live with elderly and frail parents.

A proposal was made to the NRHCC for an interim accommodation service for these service users in metro Auckland. The proposal was approved and the service was contracted to an NGO, Kāhui Tū Kaha from 20 April 2020 to 30 June 2020. The service provides in-reach support by a dedicated mental health support worker, medication support/delivery, food (in a manner that reduces communal use of kitchens) and transition support to permanent accommodation. As of 4 May 2020 there were 6 people living in the facility.

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

7.2.1 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 $18.7m revenue available within the initial 15-month term, $15.6M is for service delivery and $3.1M for enablement and workforce development.

Implementation and delivery of the entire programme will be overseen by an enablement team. Helen Wood has been appointed on a fixed term basis to establish this team. She will report directly in to a governance group with representation from across the sector. Synergia have been contracted to provide a revised rollout schedule and budget that aligns with the collaborative priorities, Ministry revenue contract and training availability. This will form the basis of all contracts with providers and between DHBs. Contracts between the DHBs will likely be backdated to 1 March 2020.

It is recognised that population seeking MHA services will have ongoing and novel needs because of COVID-19 and while general practice is significantly impacted, Integrated Primary Mental Health &

Addiction Services can help meet those needs. Many providers have outlined means for delivering support through virtual methods and we will continue to work with practices and providers to implement as much of this programme as is presently possible.

7.2.2 Financial Sustainability of NGO Alcohol and Drug services

As previously reported, the Ministry of Heath allocated $3m to the Northern Region to improve the financial sustainability of NGO Alcohol and Drug services. Following a regional consultation process, the Ministry of Health approved a proportional uplift for all AOD services along with adjustments to reduce the disparities between residential providers funded to provide the same services. A revenue contract with the approved funding allocation to Auckland DHB was received in May 2020. The funding is for a total of four financial years backdated to 1 July 2019. Auckland DHB will receive a total of $1,968,277 per annum, a total of $7,873,108 over the duration of this agreement. At that point the Ministry of Health will consider devolution of the funding to the DHB. Contracts with NGO providers are currently being drafted with the uplift to be applied at contract rollover (July 2020).

7.3 Suicide Prevention and Postvention

The suicide prevention and postvention governance group will reconvene to sign off the draft Suicide Prevention and Postvention Action Plan 2020 – 2023 soon. A working group has completed the work on revising this action plan. One of the focus areas in the action plan is to have a more effective coordination in postvention support and enable whānau, loved ones and friends to access the appropriate bereavement support at the right time and right place.

Funding for 1.25 additional FTE was recently made available by the Ministry to support postvention efforts and services across Auckland and Waitemata DHBs. This funding is for a fixed terms of 18 months. A job description is being developed and recruitment process will commence soon.

8. Māori Health Gain

8.1 Iwi-DHB Partnership Board

On 5 March 2020, the Board Chairs for Northland, Waitematā and Auckland DHBs received a letter of support from the Minister of Health, Hon. Dr David Clark, endorsing the establishment of the Northern Iwi-DHB Partnership Board. This confirmed that the Partnership Board is now a ‘class or person’ under section 39(5) of the Public Health and Disability Act 2000.

The members of the Partnership Board are:

- Rick Witana, Chair, Te Rūnanga nui o Aupōuri
- Hayden Edmonds, Chair, Ngāti Wai
- Wallace Rivers, Chair Te Rūnanga o Ngāi Takoto
- Harry Burkhardt, Chair Northland DHB
- Professor Judy McGregor CNZM, Chair Waitematā DHB
- Pat Snedden MNZM, Chair Auckland DHB

As a class or person under the Act, the Partnership Board, that previously received endorsement from each of the respective DHB Boards and iwi partners – Te Kahu o Taonui, will operate as a chair to chair partnership between DHB and iwi governance groups to:

a. Determine Māori health outcomes and Māori health equity priority areas for the three northern DHBs
b. Provide Māori health leadership, advice and guidance across all DHB funded and provided services, activities and workforce to meet their Treaty of Waitangi and statutory obligations to Māori
c. Oversee resource allocation and investments made by the three DHBs for the purpose of achieving Māori health outcomes and advancing Māori wellbeing
d. Engage experts and advisors to carry out work and complete specific tasks on behalf of the Northern Iwi-DHB Partnership Board

The group has met throughout March and April on COVID-19 specific issues, and another meeting is currently scheduled for early June 2020.

8.2 Māori provider support (during COVID-19)

The Māori Health Gain Team has worked with local Māori health providers to ensure they continue to operate essential services during each alert level. This included the development of specific engagement protocols, workforce support (online vaccinator training, and accessing the Northern Region Alliance workforce pool) dissemination of PPE, ordering vaccines, contracting/reporting, communication and financial support. The latter is in reference to $243,067 Ministry of Health funding injected into the Auckland DHB catchment area to support Māori health providers to prepare for and respond to COVID-19 (similar funding was also made available across all DHBs).

All Māori health providers in our district have maintained services, albeit, under very different engagement protocols. This has included stratifying their enrolled clients by levels of need, with high need patients identified as those that will require on-going face to face engagement, while low need patients had their care plans updated and weekly phone contact implemented. This has been the common approach across the region implemented by Māori health providers.

8.3 Māori response to COVID-19

Māori health teams across the northern DHBs have joined up under Aroha Haggie and Riki Nia Nia to form a regional Māori Incident Management Team within the NRHCC. All of the Māori Health Gain Team have taken up roles within this regional group, and as a result, our focus has specifically been on COVID-19 responses.

Key projects:

- **Māori provider development funding: $1,605,331**
  We have supported the investment of $1.6M across the northern region to directly support Māori providers to prepare for and respond to COVID-19. These contracts are held between each Māori health provider and the Ministry of Health.
- **Ngā Kaimanaaki Phase 1**
  The Northern Region Health Coordination Centre supported the implementation of Ngā Kaimanaaki. This service will see 60 Kaimanaaki (most of whom are community leaders) roles

employed by Māori health providers to support their efforts to identify, assess and engage vulnerable whānau in deprived communities. This service also provides access to a whānau support fund to cover the costs of essential items for homes, and for whānau wellbeing.

- **Ngā Kaimanaaki phase 2 (iwi extension)**
  Phase 2 of Ngā Kaimanaaki increases the Kaimanaaki workforce by 200 across the Northern and Waikato regions. Iwi will implement this service across all alert levels over the next three months to support our most vulnerable whānau through these difficult times. Kaimanaaki will be used to protect their communities through identifying and assess whānau in need, responding to their needs, providing transport essential items and goods for kaumātua.
- **Māori focused flu immunisations**
  We have put in a regional bid to access the Ministry of Health's Māori Flu Vaccination funding on behalf of Māori health providers across our region. We are proposing to resource providers to deliver community based (in home, appropriate community venues) flu vaccines for kaumātua, (and other eligible whānau) with additional support offered following a brief on-site assessment by clinicians.

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 Diabetes Co-design project

A Pacific focus group was held with 20 community participants (people with Type 2 Diabetes and carers) to review and feedback on the summary of insights from Phase1 of the Diabetes Care Improvement co-design project. The participants appreciated the opportunity to be part of this process and to also share their experiences in living with or caring for someone with diabetes.
All participant feedback has been collated and will inform the diabetes co-design project team about Pacific peoples understandings, needs and insights.

9.3 Self-management and Diabetes self-management education programmes

The Pacific health gain team supported the implementation of Self-Management Education (SME) / Diabetes SME (DSME) programmes to four Samoan and three Tongan community groups across Auckland DHB. The programmes were well received by the participants as they were delivered in the Samoan and Tongan languages. It was also an opportunity for participants to share their journey in living with chronic conditions and action weekly plans in improving healthy lifestyle practices.

9.4 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.

9.5 Pacific Abdominal Aortic Aneurysm

A Pacific brochure and resources which included a Pacific survivor story has been developed. The first Steering Committee meeting was held in early March with approval for AAA scanning to commence at the end of March starting with Tongan clients. Data systems to capture the targeted clients and community venues for testing were confirmed and ready to start the Pacific AAA Screening, when COVID-19 restrictions came into effect. The project has been put on hold for now and will resume in due course.

9.6 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 24 April 57% of eligible Pacific people aged 65+ domiciled in ADHB had received their flu vaccination.

9.7 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. This has included supporting Pacific-led CBACs, Pacific mobile services, intersectoral welfare related workstreams and contact tracing.

10. Asian, Migrant and Former Refugee Health Gain

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

An Asian, migrant, former refugee and current asylum seeker health plan 2020-2023 has been developed and will be tabled to the Alliance Leadership Team (ALT) at the next available meeting.

Samantha Bennett has been working in the NRHCC Communications team to ensure COVID-19 planning to Asian, new migrant, former refugee and current asylum seeker communities are included in the regional response. A coordinated Asian Campaign was rolled out across metro Auckland in mid February, and a targeted Communication Plan, in partnership with ethnic partners, to ethnic communities in over 31 languages has been implemented as part of the launch of the ARPHS front facing communities webpage, https://www.arphs.health.nz/covid-19-information-for-our-communities.

Significant intelligence throughout this pandemic of 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.

10.2 Increase access and utilisation to Health Services

Indicators:

- Increase by 2% the proportion of Asians who enrol with a Primary Health Organisation (PHO) to meet 85% (Auckland DHB) by 30 June, 2020

The Asian PHO enrolment rate for Quarter 1 2020 was 85% (Auckland DHB). Between Q1 2020 and Q4 2019, the number of Asian enrolees increased by 1,564. The PHO enrolment has increased significantly for Auckland DHB from 71% (Q4 2019) due to the change of the projected populations based on '2019 Update' as compared to old '2018 Update' used for Q4 2019 update. Although the, Asian populations based on this new data ('2019 Update' from Stats NZ/MoH) have 'increased' for Counties Manukau DHB, and Waitematā DHB respectively (total increase= 6,214 for the 3 metro Auckland DHBs), compared to last quarter, the Asian population of Auckland DHB has declined, resulting in an 'improved' PHO enrolment rate.

Work has been undertaken with the Clinical Advisory Services Aotearoa (CASA) to guide a coordinated approach with key Filipino and Asian partners to better understand the cultural and/or settlement issues that many have impacted on a cluster of suspected suicide cases for Filipino individuals living in Auckland DHB.

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 Rohingya, Khmer, Farsi, Urdu, Tamil, Somali, Amharic, Tigrinya, Swahili, and Punjab are also being developed to support the increasing communities settling and resettling in metro Auckland in these languages.

A concurrent Influenza Campaign message to Asian & MELAA communities over 65 years has been rolled out during COVID-19 outreach in the NRHCC Communications team.

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 Refugee Programme e.g. refugee intakes from UNHCR is on hold for May due to COVID-19. The roll out of the national Quota Health Service Model is also on hold.

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 94.6% for the rolling six month period Oct-Feb 2020 and the Northern region rate for the same period is 84%. Auckland DHB service has implemented additional evening shifts and the outsourcing of Radiotherapy to the private provider ceased at the end of February 2020.

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

At the end of March 2020 Auckland DHB was achieving 94% of planned elective surgical discharges and this is consistent with prior months. COVID-19 has affected capacity from March onwards which will have a significant impact on the ability to achieve the expected volumes for 19/20.

11.3 Elective Services Performance Indicators (ESPI) Compliance

The ESPI compliance position for both outpatient assessment (ESPI 2) and surgical and treatment services (ESPI 5) is unchanged with Auckland DHB being non-compliant with national expectations and deteriorated further in March due in part to COVID-19 response in latter part of that month ADHB clinical leaders will work with colleagues regionally to agree the approach to prioritisation across all surgical specialist services to ensure there is consistency in the level of access regionally. At this time it is too early to tell what a reasonable timeframe for recovery will be however the Ministry of Health is signalling 18 months.

11.4 Orthopaedics

The discharge shortfall pre the impact of COVID was tracking ahead of the same period last year however the extent to which this will recover is uncertain given the relative clinical prioritisation for capacity that needs to occur.

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. The impact of COVID-19 led to reduced acute demand and it is not clear how this demand will track as changes to alert level 3 occurs and with the onset of winter months.

11.6 Cardiac service demand

ADHB has developed a proposal for internal investment to address the regional electrophysiology (EP) waiting list. This will need to be assessed against other options to address this demand including a change of thresholds in light of potential competing demand for investment in other services to address the COVID-19 response.

11.7 Ophthalmology service demand

There is a commitment to reinstate regional discussions during the post COVID-19 response to address issues of inequity and inconsistency within the Northern region (including Northland DHB). Regional work will recommence within the next two weeks.

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. Work is now needed to understand the implications of not being able to proceed with this plan over the last six weeks and the consequence of not being able to undertake any P2 colonoscopy

and very limited surveillance colonoscopy. In light of the impact on demand and capacity on all Northern region DHBs there is a need ensure the recovery plan is developed on a regional basis to ensure an equity focused response.

Radiology Indicators

Auckland DHB has been unable to meet the waiting time indicator for MRI for a prolonged period of time. The reduced capacity as a result of implementing measures during the COVID-19 response means this situation is substantially worse and there is an equal impact on the timely delivery of CT scans. Work is underway to understand the regional demand for all Radiology modalities by DHB of service as there is likely to be a substantial requirement to increase the use of private 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. However as a result of increasingly stringent border restrictions these arrangements have been put on hold.

Minutes
Hospital Advisory Committee – Provider Equity Meeting
18 March 2020

7.1

Minutes of the Hospital Advisory Committee – Provider Equity meeting held on Wednesday, 18 March 2020 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 1.30pm

Committee Members Present	**Auckland DHB Executive Leadership Team Present**	
William (Tama) Davis (Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew (Deputy Chair)	Mel Dooney	Chief People Officer
Doug Armstrong (via Zoom)	Mark Edwards	Chief Quality, Safety and Risk Officer
Michelle Atkinson	Joanne Gibbs	Director Provider Services
Zoe Brownlie (via Zoom)	**Auckland DHB Senior Staff Present**	
Peter Davis	Duncan Bliss	General Manager Perioperative Directorate
Fiona Lai	Ian Costello	Director of Clinical Support Services
Bernie O'Donnell	Mr Arend Merrie	Director Surgical Services
Michael Quirke (via Zoom)	Dr Robert Sherwin	Director Women's Health
Also Present	Abel Smith	Acting General Manager, Pacific Health
Ian Ward (via Zoom)	Dr Michael Stewart	Director Cardiovascular
	Dr Richard Sullivan	Director Cancer and Blood and Deputy Chief Medical Officer
	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)	

1. KARAKIA/APOLOGIES

Bernie O'Donnell led the Committee in a Karakia.

The Following apologies were received from members of the Executive Leadership team; Margaret Dotchin, Chief Nursing Officer, Dr Debbie Holdsworth, Director of Funding – ADHB/WDHB, Rosalie Percival, Chief Financial Officer, Meg Poutasi, Chief of Strategy, Participation and Improvement, Shayne Tong, Chief Digital Officer, Sue Waters, Chief Health Professions Officer and Dr Margaret Wilsher, Chief Medical Officer and senior staff member, Rachel Lorimer.

2. REGISTER AND CONFLICTS OF INTEREST

Bernie O'Donnell requested the following change to be made to his interest register: "Member Alcohol and Additions Reference Group, Department of Corrections", to be added.

There were no other conflicts of interest with any item on the open agenda.

3. CONFIRMATION OF MINUTES 12 February 2020 (Pages 8-18)

Resolution: Moved Fiona Lai / Seconded Zoe Brownlie

That the minutes of the Hospital Advisory Committee for 12 February 2020 be rconfirmed as a true and correct record.

Carried

4. ACTION POINTS (Pages 19)

The action "inpatients with Social Complexity – Deep Dive" was closed due to the new focus to be applied to Advisory Committee business.

5. PERFORMANCE REPORTS

5.1 Provider Arm Operational Performance – Executive Summary (Pages 20-23)

Jo Gibbs, Director Provider Services asked that the report be taken as read, advising that the COVID 19 response had been of significant impact on the Provider Arm.

Jo drew attention to the following:

- The target was not met by the Adult Emergency Departments during January 2020 (80.42%). During February, investment had been made (as per budget) for the commencement of the POD model. Some improvements in the AED waiting times was expected (although overall flow will not be impacted by this investment).
- Performance against the MRI target of 95% of referrals completed within six weeks had improved in February 2020 to 42.1% (41.8% general and 50.9% for Cardiac MRI) compared to performance in January 2020 of 34.8%. There is still a significant gap between wait times, and the National target.
- Work is underway, jointly with the Planning and Funding team to submit a business case to the Ministry of Health for the commencement of Bowel Screening during 2020, as per the National Programme.
- The development of a Surgical Integrated Operations Centre to provide visibility of current processes and identify opportunities to ensure operating rooms at Greenlane Surgical Unit (GSU) are effectively used increasing throughput, are now largely complete.
- The BFTF Programme and Tranche 1 cases have been approved by the Board and will be presented for further regional and CIC endorsement for Crown funding.

There were no questions.

Resolution:

That the Hospital Advisory Committee receives the Provider Arm Operational Performance – Executive Summary for March 2020.

Carried

5.2 Provider Arm Scorecard (Pages 20-25)

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

The following point was raised in discussion:

- Bernie O'Donnell drew attention to page 24 of the agenda and the DNA rate for Māori not being met asking for a future discussion on how this issue might be tackled and enable equity to be met.

Resolution:

That the Hospital Advisory Committee receives the Provider Arm Scorecard for March 2020.

Carried

[Secretarial Note: Item 5.4 was considered next.]

5.3 Cancer and Blood Directorate (Pages 26-34)

Dr Richard Sullivan, Director Cancer and Blood and Deputy Chief Medical Officer asked that the report be taken as read and invited questions.

- The "percentage of day surgery rate" currently showing as zero was questioned. If it was not done then it should not be incorporated in the report.
- Jo Gibbs drew attention to page 28 of the agenda and the initiatives around and the success of a recent Greenbelt project. This work showed a demonstrable reduction in the 'did not attend' rate for first specialist appointment for Māori and Pacific patients, based within the breast tumour stream, which had the ability to transfer attributes of that work to other tumour streams.
- Bernie O'Donnell was given a brief overview of the newly established Cancer Control Agency which leads the National Cancer Programme. This independent agency is hosted by the Ministry of Health and is tasked with putting equity first, ensuring every New Zealander has the same access to high quality screening and care. Ailsa Claire as lead CEO for Cancer, Chair of the Cancer Health Information Strategy Group and Chair of the Northern Region Cancer Governance Group and Dr Richard Sullivan as Director Cancer and Blood Directorate, Director Cancer Outcomes Auckland District Health Board and the Director of the Northern Cancer Network are members of the Agency. There are three Māori and three non - Māori members. The Agency has met twice and is still in the forming stage.

  Ailsa as Chair of the Northern Region Cancer Governance Group also supplies a regional lens. Ailsa advised there is a need for a stronger line of sight between regional and national agencies.
- Ian Ward was advised in relation to the completion time for the Brachytherapy Bunker development project that the design phase had been finalised and the business case is due to go CAMP. Final completion time cannot yet be determined

given COVID-19, and the impact on National and local capital budget allocations.

[Secretarial Note: Item 5.5 was considered next.]

5.4 Cardiovascular Directorate (Pages 35-47)

Dr Michael Stewart, Director Cardiovascular asked that the report be taken as read, highlighting key points as follows:

- In relation to equity it was pleasing to see a growing Māori and Pacific workforce as reported on page 39 of the agenda. A hui within the cardiovascular service for Māori nurses was recently held that was aimed at networks which supported their professional and personal development. The nurses are looking at a future work plan for themselves and for patients through different pathways.
- A project underway that encourages Māori patients to attend heart clinics is the result of an earlier Greenbelt project.
- A commencement of a 6-month pilot of extended hours in Ward 31 to increase the day stay volumes for EP and angiography patients began in January. Senior staff have volunteered to help staff during the pilot phase to ensure that this can be done within existing staffing.
- A full time permanent SMO has been successfully recruited into the Vascular Service and to commence in early March 2020 and there have been appointments into the SCD roles for Cardiology and CTSU.
- Of concern is that the service continues to be challenged in meeting PVS volumes and the revenue position reflects a year to date result of $5.13M U. The service is working with the leadership team to ensure every opportunity for full utilisation of lists is happening with escalation plans in place for cancellations across the directorate. Recovery plans are in place to deliver the increased productivity that is required to improve this position, although these are challenged by acute demand, industrial action in CIU, and SMO and allied health workforce shortages.

The following points were raised in discussion:

- There was a brief discussion around cardiology procedures, in particular day stay volumes and appropriate day stay pathways. This was seen as one way to be able to see more Auckland patients. There was some discussion around the range of accommodation options available for those requiring to stay the night before surgery with it being noted that for those coming from out of Auckland there is currently the option of Te Whare Awhina and Ronald McDonald House. The issue of funding these new pathways has still to be resolved.
- Peter Davis commented that late start times as referred to on page 38 of the agenda must be costing the DHB a considerable amount. Advice was given that reasons for late starts were many and varied. The current PIMs system works well but its age prohibits easy modification so the issue remains difficult to resolve.
- Peter Davis commented that he did not see that the DHB was responsible for the

readmission rates. Once a person had been discharged assistance should be available from within the community. Dr Michael Stewart advised that the DHB had some responsibility to ensure a patient was not readmitted particularly in ensuring that they are treated correctly on the occasion of the first admission.

[Secretarial Note: Item 5.3 was considered next.]

5.5 Clinical Support Services (Pages 48-59)

Ian Costello, Director of Clinical Support Services asked that the report be taken as read, advising as follows:

- There is concern around MRI capacity. Recent approval was gained to outsource 1100 scans. Other imaging modality is still in strike recovery mode.
- The Lab and Radiology accreditation audit was recently held with no major issues being identified. Forensic Pathology Services completed their audit yesterday and only minor corrective actions were identified.

5.6 Perioperative Services Directorate (Pages 60-68)

Duncan Bliss, General Manager Perioperative Directorate asked that the report be taken as read, highlighting the following key point:

- That single instrument tracking a project that had featured in reports for the last 8 years was now completed with all instruments being bar coded. It has however been discovered that the silver nitrate in the water does degrade the bar codes and it is being investigated how this can be remedied.

The following points were raised in discussion:

- Peter Davis commented that the recruiting undertaken in the UK had seemed to be successful and asked how this had been achieved. Duncan advised that this was because teams had been sent to the UK with a remit of encouraging applicants to come to NZ and work for one year and then targeting those that had enjoyed their time here and providing help with visa applications.
- Jo Agnew was advised that the average time to get an anaesthetic technician into NZ was 9 months. There was a brief discussion around the training courses provided in NZ, which might be of 6 to 9 month duration as opposed to the 9 month wait time for someone from overseas. It was advised that both methods were employed as there simply were not enough anaesthetic technicians worldwide to fill countries vacancies. Those from overseas had the added value of coming with experience and perhaps other qualifications.
- Jo Agnew asked what number of Māori staff the DHB had working in theatre and was advised that there was not the number that there should be and that initiatives were being worked on to increase the number.

5.7 Pacific Heath Services (Pages 69-75)

Abel Smith, Acting General Manager, Pacific Health asked that the report be taken as read, drawing attention to key points as follows:

- The Health Science Academy Evaluation on page 70 of the agenda where two schools were signed up with a further two being worked with in anticipation of having them join.
- A PALT (the Pacific Alliance Leadership Team) half day workshop was recently held to discuss and finalise a Pacific Workforce Strategy.
- The Faster Cancer treatment target was met 100% for Pacific People in the December period. The Cancer services had gone through Kapasa training which raises awareness of the data and the value of engaging with the patients appropriately.
- There was a dip for both immunisation rates for 8 months olds and Primary care work with smokers. The target for cervical screening was not met. The target for breast screening was exceeded. Ambulatory Sensitive Hospitalisation rates remain high for 0-4 years old and half the volume for older age groups.
- Hearts and Diabetes checks for Pacific peoples are tracking in a favourable direction. Unfortunately oral care remains problematic for Pacific young people.

The following points were raised in discussion:

- There was a discussion around whether the Pacific Health Service was responsible for delivering to some of the targets which might be seen to be the responsibility of other Directorates. Abel advised that the service was committed to addressing these target gaps, particularly where they feel the service could make a difference.
- Peter Davis felt that some of the measures could not be laid at the door of the hospital but are better seen as the responsibility of primary and community care. Bernie O'Donnell disagreed saying that the hospital needed to show some leadership in promoting change.

5.8 Surgical Services Directorate (Pages 76-85)

The Committee Chair, Tama Davis advised the committee that Mr Arend Merrie was stepping down from the role of Director Surgical Services and returning to his surgical work. On behalf of the Committee Tama thanked Arend for his contribution during his time in the role.

Mr Arend Merrie, Director Surgical Services asked that the report be taken as read advising as follows:

- The Directorate was a diverse one with over 1000 FTE offering a number of complex services. It required a close relationship with Perioperative Services in order to be able to function well and meet its goals

- The Directorate is on track with recruitment
- Ways of accessing equity are being looked at
- Within Planned Care there has been a focus on the Greenlane Surgical Centre. There has been an increase of 1000 discharges allowing 507 extra discharges to be made. This year a further 900 have to be delivered and currently this is tracking to plan
- Financially the net result is unfavourable although the situation is improving in the nursing space.

The following points were raised in discussion:

- Peter Davis was advised that outsourcing for orthopaedics was not a new phenomenon and had been in place for the last three years.
- An explanation was given that a patient attender was a health care assistant who requires additional training to provide assistance at bedside, usually with issues around frailty and dementia, or other behaviours of concern.

5.9 Women's Health Directorate (Pages 86-97

Dr Robert Sherwin, Director Women's Health asked that the report be taken as read and drew attention to:

- The Equity Dashboard mentioned on page 87 of the agenda which has been formulated to assist in the identification of inequities
- Te Manawa o Hine mentioned on page 87 of the agenda and recruitment within that service, particularly the appointment of Nicole Pihema
- The work commenced to increase the number of Māori midwives in the workforce to improve service to Māori.
- The directorate is $1.3M favourable year to date.

There were no questions.

5.10 Provider Arm Financial Performance Report (Pages 98-108)

Jo Gibbs, Director Provider Services asked that the report be taken as read, advising that the January month had been a complicated one with the requirement to right size the financial reporting given the approval of the $20M deficit budget. The Provider Arm was $6M unfavourable to budget.

Resolution:

That the Provider Arm reports 5.3 to 5.10 be received.

Carried

6. RESOLUTION TO EXCLUDE THE PUBLIC (Pages 109-111)

Resolution: Moved Michelle Atkinson / Seconded Fiona Lai

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Karakia Attendance and Apologies	N/A	N/A
2. Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Confidential Minutes 12 February 2020	**Commercial Activities** **Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public** [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Confidential Action Points	**Commercial Activities** **Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public** [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Term of Reference & Meeting Forward Plan	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i))

		of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 Clinical Support Oversight Report – MRI Capacity	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.2 Head and Neck Oversight Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.3 Perioperative Services – Shortage of Perioperative Workforce Oversight Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.4 Radiotherapy Workforce Oversight Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982	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

	s9(2)(i)] **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.	6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.5 Women's Health – Midwifery Recruitment and Retention Oversight Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 Clinical Quality and Safety Service Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.2 Policies and Procedures (Controlled Document Management)	**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]
8.1 Theatres Workforce Project	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if	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

	that information was made public [Official Information Act 1982 s9(2)(i)] **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.	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 4.00pm.

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

Chair: _____ Date: _____

Tama Davis

healthAlliance
Right behind better healthcare

Decision Paper
hA Class C share issue
May 2020

Recommendation

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

Prepared by:	Richard Hooper, hA, head of Finance
Reviewed by:	Simon Jones hA CFO

1. Purpose

To seek the approval of the Auckland DHB Board for healthAlliance N.Z. Limited (hA) to issue additional class C shares. This has been approved by the hA Board.

2. Background

The Class C shares are used by hA and the DHB's as a mechanism for consideration given for IT assets being transferred from the DHB's to ownership at hA. This can occur from two types of situations:

1. The DHB's acquire IT assets directly themselves; or
2. The DHB's request and pay for IT projects to be completed by hA.

In either of these situations the asset ownership is transferred to hA, and in consideration of the value of the assets, hA issues shares to the respective DHB.

For situations where the DHB has requested hA to complete IT development, then this work must be paid for by the DHB before the shares can be issued.

The hA Shareholders Agreement requires DHB Shareholder approval prior to the issue of shares. Once approved by the all DHB Shareholder's, hA is able to issue the shares, updating both the hA company records and the Companies Office details.

3. C Class Share Issuance

Periodically hA is required to make a retrospective issuance of class C shares for situations described above.

The last time Class C shares were issued was in August 2019 for assets transferred up to 30 June 2018. hA is now proceeding with the retrospective issuance of class C shares for the financial year ended 30 June 2019. Shares will only be issued after payment has been received in full from the respective

DHB's.

The value of capital spend has been approved by the DHB's and the figures have been verified as part of last year's hA regular independent year-end audit by Audit New Zealand.

The value of this proposed share issue is $20.620m, bringing the total value after the proposed issue to $180.295 million. The details are as noted below.

Class C Share Summary by DHB

	Existing Shares	This Proposed issue	Total Shares (post this share issue)
NDHB	$16,781,482	$795,256	$17,576,737
WDHB	$39,454,934	$638,760	$40,093,694
ADHB	$63,677,161	$6,603,898	$70,281,059
CMDHB	$39,761,318	$12,581,956	$52,343,274
	$159,674,895	**$20,619,869**	**$180,294,764**

A separate issuance for shares relating to the year ending 30 June 2020 will be scheduled for later in the 20/21 financial year.

Auckland DHB Credit Card

Recommendation

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; and**
4. **Approves the Credit card policy, noting any changes suggested by the Board will be included in the final policy.**

Prepared by: Auxilia Nyangoni, Deputy Chief Financial Officer
Endorsed by: Rosalie Percival, Chief Financial Officer
Endorsed by: Executive Leadership Team, Date: 12 May 2020

1. Board Strategic Alignment

Operational and financial sustainability	The DHB needs to implement appropriate policies and processes to guide and facilitate efficient expense payment processes while also ensuring that there are sufficient controls to effectively manage use of DHB funds.

2. Executive Summary

The purpose of this paper is to seek approval from the Board to establish a single Auckland DHB Credit Card that would be centrally held at healthSource and to review the proposed ADHB Credit Card policy.

3. Overview

Currently Auckland DHB (the DHB) does not have a corporate credit card facility and as such do not have a credit card policy.

There is a need for the DHB to establish a Credit card facility to facilitate payments for services or products that are not easily payable under the current payment mechanisms (e.g. invoicing). A Credit Card policy has been drafted and is attached for review and approval. The draft policy provides the framework for the use of the ADHB credit card.

Purchase transactions are processed through the Oracle system where purchase orders are created, approved and matched to supplier invoices for payment. All suppliers must be set up in Oracle in order for invoices to be paid. To set up a new supplier, a new supplier form is created and once the supplier has supplied certain information and the supplier form is approved, the supplier is set up in master data and available for use in Oracle. To order from the supplier, a purchase order is created, approved and the goods or services supplied. Once the goods or services are completed and receipted, the invoice is processed against the purchase order and the supplier is paid. The Oracle processes are set up to be standardised and they work well for the majority of transactions which the DHB undertakes.

There are some situations, where the DHB needs to make a one off purchase. The supplier in this case will only be set up for use once and then retired from the system. In these cases the costs of set up outweigh the benefits of set up and one time use. There are also situations where the suppliers will only accept online or credit card payments.

Recently, ADHB wanted to do some advertising on Facebook as part of its social media strategy for COVID-19, but has been advised the only way to pay is by registering a credit card with the DHB's Facebook account.

ADHB was also advised by an overseas based specialised lab testing provider, that they will only accept prepayment before the testing will be undertaken. The prepayment transaction is possible within Oracle but it does require the creation of one off infrequent individual foreign currency payment.

For annual subscriptions and registrations, there is an increase in the number of organisations requiring online or credit card payments only.

The above situations are only a few of the examples of non standard transactions which take place. In these situations, often processing the transaction with a credit card can be more cost efficient.

At Waitemata DHB, a credit card is held by healthSource for limited use, under tight controls for such non standard situations. Counties Manukau DHB has a credit card policy and credit card facilities also managed with tight controls.

4. Key features of the credit card

The DHB will have one credit card and will be using a BNZ Corporate virtual credit card which consists of a card name, number and expiry date. There will be no actual physical card.

The credit card details will be held centrally at healthSource by the Manager Financial Control and payments will only be processed against the card once approved by the Chief Financial Officer or her delegate. This arrangement will ensure segregation between the order and approval process of the purchase which will take place at the DHB and the credit card payment process which will be at healthSource.

The credit card will not have the ability to advance cash.

The proposed credit card limit is $10,000. We consider this limit amount reasonable as this is the minimum delegation level within the Delegated authority policy.

Use of the credit card is controlled where all credit card purchase transactions must comply with the ADHB Credit Card policy.

5. Credit Card Use

Specific Credit card policy needs to be in place for using the credit card to minimise some of the risks associated with it. These risks include the credit card being used for inappropriate business-related expenditure and for personal benefit.

The credit card must be used only for valid DHB business purchases and when the purchase transaction is infrequent or does not naturally fall within the standard oracle process. These types of purchase transactions include:

- Overseas purchases that are small value or one-off
- Supplier accepts payments via credit card only
- On-line transactions
- Non-catalogue one off purchase

In order to use the credit card, a standard form is completed (known as an SO12). The form should include justification for the payment to be made by credit card.

The SO12 is completed when the appropriate person with delegated authority approves the purchase. The completed SO12 is send to the ADHB Corporate Finance team for review to ensure compliance with ADHB policy on the use of credit card.

The Chief Financial Officer or her delegate approves the credit card payment of the completed SO12. Corporate Finance will send the approved SO12 to HealthSource to process credit payment.

On a monthly basis,

- BNZ sends both ADHB Corporate finance and healthSource a copy of the credit card statement; and
- healthSource prepares the monthly reconciliation of the Credit Card account and sends this to ADHB Corporate Finance for review.

We consider approval of credit card purchases by the CFO or her delegate to be appropriate due to the sensitive nature of credit card spending.

6. Purchasing cards

ADHB is currently working with BNZ to explore the implementation of a Purchasing card (P-card) program across the DHB. Similar to a credit card, the P-card is a form of charge card with set limits which can be used by authorised individuals or teams within the ADHB Services. The P-card program will be linked to an expense management system which will have functionalities to enable on-time coding and approval of transactions as it occurs.

We understand the P-card program takes six to eight weeks to implement and the cost for the expense management system will be between $3,000 to $8,000, depending on the system functionalities the DHB wants to have. We will present a paper on the proposed P-card program to the next Finance Risk Assurance Committee meeting.

Waikato and Hutt Valley are two DHBs who are currently using the P-card program. We are aware that Counties Manukau DHB is also looking into the P-card program.

10. Conclusion

It is recommended that the Board approves that the DHB establishes a Credit card facility with BNZ to be held centrally at healthSource and also approves the ADHB Credit Card policy attached, subject to any changes suggested by the Board at the meeting.

Credit Card Policy

Unique Identifier	[Category]
Document Type	Policy
Risk of non-compliance	very unlikely to result in harm to the patient/DHB
Function	Administration, Management and Governance
User Group(s)	Auckland DHB only
• Organisation(s)	Auckland District Health Board
• Directorate(s)	All
• Department(s)	All
• Used for which patients?	N/A
• Used by which staff?	All Staff
• Excluded	
Keywords	Credit Card
Author	Deputy Chief Financial Officer
Authorisation	
• Owner	Chief Financial Officer
• Delegate / Issuer	
Edited by	Document Control
First issued	Click here to enter a date.
This version issued	[Publish Date] - Choose an item.
Review frequency	3 yearly

Contents

1. Purpose of policy

This policy is to outline the purpose of the ADHB credit card and the framework for its use to ensure it is in line with ADHB objectives relating to the use of its publicly funded income.

1.1 Scope

This is an ADHB-wide policy. Accordingly, it applies to all staff of ADHB, including all ADHB employees (full time, part time, casual, temporary and locums), and contractors of ADHB including healthSource employees

2. Definitions

Terms and abbreviations used in this document are described below:

Term	Definition
ADHB	Auckland District Health Board
CFO	Chief Financial Officer
DCFO	Deputy Chief Financial Officer
DFA	Delegated Financial Authority
SO12	Standard Form 12

3. Policy

3.1 Key Principles

The purpose of the credit card is to facilitate purchase transactions where the use of the standard purchasing process through Oracle is not an not practical or not viable. These types of purchase transactions include:

- Overseas purchases that are small value or one-off
- Supplier accepts payments via credit card only
- On-line transactions
- Non-catalogue one off purchase
- At the discretion of the CFO, payments which are considered urgent and essential warranting the use of credit card.

There is only one ADHB credit card and its limit is set at $10,000. The credit card must only be used for the monthly limit it was authorised for. If this limit is insufficient, the matter should be raised with the DCFO.

The card issuer is currently Bank of New Zealand. The ADHB credit card held centrally at healthSource by the Manager Financial Control. ADHB and healthSource must adhere to the card issuer's conditions of use of the card at all times.

Specific procedures and guidelines in this policy for using the credit card are to minimise some of the risks associated with credit cards. These risks include the credit card being used for inappropriate business-related expenditure, for personal benefit and used fraudulently.

3.2 Procedure

A standard form 12 is completed known as an SO12 for payments processed through the ADHB credit card. The SO12 should include justification for the credit card payment method and supported by appropriate documentation verifying the purchase including invoices, recent quotations etc. The SO12 is completed when the appropriate person with delegated authority, refer to Delegated Authority Policy, approves the purchase.

Once the SO12 is completed, it must be sent to ADHB Corporate Finance to review compliance with this policy.

The CFO or her delegate approves the completed SO12 for credit card payment.

ADHB Corporate Finance will submit the CFO approved SO12 to healthSource to process the Credit card payment.

3.3 Appropriate Use

Credit cards should only be used for appropriate business related expenses, and where the purchase meets the purpose and the types of transactions the credit card is for.

In the first instance, staff should explore the option of obtaining goods or services via Oracle as the main ADHB procurement method before selecting credit card purchase and payment.

It is prohibited to use ADHB credit cards for:

- Personal purchases, even if the employee intends to reimburse ADHB.
- Cash advances through a credit card

3.4 Receipts

In addition to credit card dockets, individual merchant receipts must be obtained for each credit card transaction. The payment transaction should collaborate to an approved SO12.

The merchant receipt must itemise the purchases that were made, and the cost of each item. All original receipts must be retained for monthly summaries, as a photocopy will not be acceptable. This is necessary for the validation of charges to the credit card, and if it is not followed the card holder may be held liable for the costs incurred that are not accompanied by a receipt, voucher or invoice.

- For individual expenses over the value of NZ$50,or over inclusive of GST (other than where the payment has been made outside of New Zealand) the receipt/invoice must be a GST receipt/invoice (i.e. receipt showing a GST registration number). Purchases from organisations within New Zealand without a valid GST number should be discouraged.
- Foreign currency purchases must be accompanied by a receipt or invoice.
- Where the purchases have been transacted via the internet, full documentation supporting the purchase must be downloaded and printed or screenshots taken if applicable. This should include online order forms completed when purchasing.

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3.5 Online purchases

Credit card payments over the Internet need to reflect good security practice, such as purchasing from only established reputable companies and suppliers known to ADHB.

3.6 Keeping the Credit Card Secure

Only the authorised credit card holder should use the credit card in any transaction. The card is the responsibility of the card holder, and therefore they should take due care and precautions to ensure that the card is kept safely and is not available for the use of others.

If the credit card is stolen, the card holder must notify the card issuer (i.e. the Bank), the Police, Security (if applicable) and the Deputy CFO immediately. Bank of New Zealand can be notified on the following number: 0800 300 667 in New Zealand and +64 470 9201 for cards that are lost or stolen overseas.

3.7 Consequences of unauthorised use

Credit card usage will be regularly audited by ADHB internal and/or external audits. ADHB considers any breach of this policy to be serious misconduct and reserves the right to follow a breach with disciplinary action, in accordance with the appropriate procedures designated by the Discipline and Dismissal Policy.

3.8 Reporting

ADHB Corporate finance will maintain a register of approved SO12 requests for credit card payments.

Monthly reconciliation of the credit card account is prepared by healthSource, this includes coding to the general ledger and reconciling the credit card transactions to Receipts.

A copy of the completed reconciliation by healthSource is sent to ADHB Corporate finance for review.

BNZ sends a copy of the monthly credit card statement to both ADHB Corporate finance and healthSource.

Reconciliations and copies of approved SO12 form requests and valid receipts for the payments are filed with healthSource.

3.9 Internal Control

The credit card payment is processed by healthSource only when purchases comply with this policy.

Credit card limit cannot be exceeded.

Cash withdrawal is not permitted.

Monthly reconciliations of the credit card account is performed and reviewed independently by the ADHB Corporate Finance team.

The internal audit work programme will incorporate reviews of P-card expenditure and process on a periodic or as required basis.

4. Legislation

None

5. Associated documents

Delegated Authority Policy
Discipline and Dismissal Policy
Fraud
Travel Policy
Sponsorship donations, gifts and corporate hospitality Policy
Expenses - Personal work related Policy

6. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this ADHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

7. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed ***before*** the scheduled date, they should contact the owner or Document Control without delay.

Auckland Regional Public Health Service – COVID 19 Response

Recommendation

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

Prepared by: William Rainger, Director, ARPHS
Endorsed by: Margaret Wilsher, (Chief Medical Officer
Endorsed by: Ailsa Claire, Chief Executive Officer

1. Executive Summary

The Auckland Regional Public Health Service (ARPHS) is providing an update on its ongoing response to COVID-19 to the Auckland DHB Board

2. Introduction/Background

A novel coronavirus (causing the illness COVID-19) originating in Wuhan City, Hubei Province was first detected in December 2019. ARPHS stood up an Incident Management Team (IMT) for its response to COVID-19 on 23 January 2020. On 24 January 2020, the Ministry of Health (MoH) set up a team to monitor the situation and activated its Influenza Pandemic Plan. On 31st January 2020, the Northern region activated the Northern Region Health Coordination Centre (NRHCC). New Zealand's first COVID case was in Auckland on 28 February 2020 (imported case from Iran). As at 12 May 2020 09:00hrs nationally there have been 1497 (confirmed and probable cases) and 21 deaths.

3. Auckland Region

As at 12 May 2020 there have been 541 confirmed and probable cases of COVID-19 in the Auckland region (397 confirmed and 144 probable), 1104 closed cases , 3 deaths and 16 significant clusters (of which 3 originated outside of Auckland). The number of cases dropped rapidly from the peak of 35 cases on 28/03/2020 to on average one – two cases per day during May 2020. The highest numbers of cases have been reported from WDHB (234) followed by ADHB (178), CM Health (126) and other PHUs (3).

4. ARPHS Operational Response

ARPHS response and subsequent goals have changed over time in line with the public health requirements and size of the response.

At the beginning of February, ARPHS activated its Business Continuity Plan to maintain essential Public Health services while staff were redeployed to the COVID-19 response. Currently approximately 80% of ARPHS staff is focussed on the COVID-19 response, with 20% focussing on essential business as usual. On the 12 May 2020, 110 staff were rostered on the COVID-19 response.

The initial focus was to 'Keep It Out' by maintaining a border protection response. ARPHS initiated its presence at the Auckland International Airport (AIAL) on 27 January 2020 and was supported by DHB and Auckland Council staff. ARPHS provided a border protection response 21 hours per day 7 days per week at Auckland International Airport, in addition to provision of sea border protection activities.

Once cases started to occur ARPHS response shifted to case and contact management including:

- receiving notifications
- receiving laboratory confirmations and informing cases of results
- interviewing cases (or caregivers)
- providing education, isolation advice and ARPHS resources for COVID-19 to facilities, the public and health care providers
- contact tracing including identifying relevant contacts of the case, ensuring contacts are aware of their risk of exposure; and advising the appropriate measures to prevent further disease transmission i.e. isolation or quarantine
- daily symptom checking of contacts
- providing advice and welfare referrals (if needed)
- training and on boarding seconded and temporary staff (including DHB staff)
- reporting and surveillance
- liaising with NRHCC, National Health Coordination Centre and the Ministry of Health.

Initially most confirmed cases in Auckland had links with international travel or known cases, however over time there were some cases for whom no link was readily apparent. The number of cases reached its peak at the end of March 2020 with more than 30 cases per day. Subsequently, with the closing of the borders and the introduction of lockdown (Alert Level 4) the number of cases has fallen dramatically. However, the complexity of the work has increased as more cases are related to outbreaks in settings with higher risk such as hospitals and Aged Care Facilities.

5. Planning for the next Phase

The government has made it clear that confidence in New Zealand's ability to identify, quarantine and monitor close contacts is critical. The Ministry has advised Public Health Units that this must be able to be sustained for a minimum of 12 months.

During Alert Level 4 ARPHS was fortunate to utilise 89 external staff members to support its public health response. As the alert levels are been lifted for most of these staff have returned to their usual roles. In order to continue case and contact management at the projected notification rates, ARPHS will require ongoing workforce support.

The country will move to COVID-19 Alert Level 2 shortly. The Ministry is continuing to develop a national contact tracing service and has asked public health units to be plan to be able to collectively manage up to 500 new COVID-19 cases per day. For ARPHS this equates to retaining the capacity to respond to 177 new cases a day. At the peak of the epidemic curve to date (late March) ARPHS was managing slightly over 30 new cases a day. The capacity and capability needed to meet the Government's requirements presents ARPHS and the northern region with a very significant challenge. In order to build and maintain the capacity required, ARPHS will require significant support from the DHBs.

Our assumption is that for the next six to 12 months ARPHS will continue to deliver core 'Stamp It Out' public health actions:

- public health surveillance and reporting,
- public health management of notified cases,
- contact tracing and follow up (including monitoring effective isolation and quarantine),
- outbreak investigation and management, and
- provision of public health advice.

Our assumption is that ARPHS will not be required to deliver the 'Keep it Out' actions of:

- border screening, or
- provision or oversight of quarantine facilities.

In order to deliver meet Government expectations ARPHS will require the following support from the DHBs:

- community welfare including links to Government agencies such as WINZ and MBIE, accommodation support and provision of welfare packages,
- provision of staff with requisite specialist public health and management skills and those able to be trained,
- coordination of staffing requests,
- Maori and Pacific community engagement,
- development and implementation of IT support (eg contact tracing apps and links with new national systems),
- forums or advisory groups for regionally consistent policy,
- liaison with primary care, and
- media liaison.

6. Finance

YTD Apr-20 Results

ARPHS YTD Apr-20 result is a deficit of $44k against the budget of $132k deficit, a favourable budget variance of $88k.

YTD Apr-20 revenue is favourable by $1.957m primary driven by COVID-19 PHU funding of $1.93m to Apr-20. YTD Apr-20 expenditure is unfavourable by $1.869m mainly due to the COVID-19 costs to Apr-20 of $1.93m offset by savings in BAU business $70k.

STATEMENT OF FINANCIAL PERFORMANCE

ARPHS

Reporting Date: Apr-20

($000s)	MONTH			YEAR TO DATE (10 months ending Apr-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	1,670	1,668	2 F	17,490	17,469	21 F
Funder to Provider Revenue	147	147	0 F	1,469	1,469	0 F
Other Income	4	5	(1) U	56	50	6 F
Total Revenue	**1,821**	**1,820**	**1 F**	**19,015**	**18,987**	**27 F**
EXPENDITURE						
Personnel						
Personnel Costs	1,576	1,451	(125) U	13,884	14,063	179 F
Outsourced Personnel	7	42	35 F	277	423	146 F
Outsourced Clinical Services	0	1	0 F	7	7	(0) U
Clinical Supplies	5	10	6 F	94	105	11 F
Infrastructure & Non-Clinical Supplies	83	96	13 F	934	972	38 F
Total Expenditure	**1,671**	**1,601**	**(70) U**	**15,196**	**15,570**	**373 F**
Contribution	**150**	**219**	**(69) U**	**3,818**	**3,418**	**400 F**
Allocations						
Overhead - Ring fenced Services	364	334	(31) U	3,645	3,323	(323) U
Direct Cost	6	23	17 F	217	227	10 F
NET RESULT	**(220)**	**(137)**	**(82) U**	**(44)**	**(132)**	**88 F**

FY19/20 Full Year Forecast – BAU

FY19/20 full year forecast is a deficit of $650k which is $130k unfavourable against the budget. ARPHS year-end position has been gradually improving during the financial year, from a starting position of $2.1m deficit to current $650k, an improvement of $1.5m is primarily driven by a freeze on 11.45 FTE positions and savings on other operating expenditure.

COVID-19 related costs are funded by the Ministry PHU funding and there is no bottom-line impact to ARPHS BAU budget.

ARPHS Full Year Forecast					
$'000s	FY 19/20 Fcst	FY19/20 Budget	FY 18/19 Act	Var FY19/20 Forecast v FY19/20 Budget	Var FY 19/20 Fcst v FY 18/19 Act
Revenue					
PBF Revenue	1,762	1,762	1,914	0F	152U
MoH Contracts - Non-Devolved	20,804	20,805	18,659	1U	2,145F
Other Government (Non-MoH, Non-Other DHBs)	-	-	-	0F	0F
Other DHBs (InterProvider revenue	-	-	150	0F	150U
Patient & Consumer Sourced				0F	0F
Trust & Donation Income			-	0F	0F
Financial Income				0F	0F
Other Income	60	60	65	0U	5U
Total Revenue	**22,626**	**22,627**	**20,788**	**1U**	**1,839F**
Expenditure					
Personnel					
Medical	4,430	4,422	4,342	8U	88U
Nursing	3,166	3,077	3,187	89U	21F
Allied Health	5,113	5,398	5,791	285F	678F
Support	-	-	-	0F	0F
Management/Admin	4,155	4,182	3,339	27F	816U
Savings				0F	0F
Total Personnel	**16,864**	**17,079**	**16,659**	**215F**	**205U**
Outsourced					
Outsourced Personnel	500	507	534	7F	34F
Outsourced Clinical Services	14	9	9	5U	5U
Outsourced Other				0F	0F
Total Outsourced Services	**514**	**516**	**543**	**3F**	**30F**
Clinical Supplies	146	126	125	20U	21U
Infrastructure and Non-Clinical	1,227	1,164	1,328	63U	101F
Internal Allocation	4,525	4,263	4,696	262U	171F
Total Expenditure	**23,276**	**23,148**	**23,351**	**128U**	**75F**
Net surplus / (Deficit)	**(650)**	**(521)**	**(2,564)**	**129U**	**1,914F**

COVID-19 costs

The Ministry has allocated $5.1m PHU funding in late March which was placed on the balance sheet as income in advance. The revenue is then released to the profit and loss monthly to cover the Covid-19 costs.

COVID-19 costs to YTD Apr-20 are $1.9m. The costs to 15th March 2020 relate to the border response at the Auckland International Airport. The costs incurred in the second half of Mar-20 and Apr-20 are primarily driven by case and contact management operational requirements.

As at Apr-20, $3.2m PHU Covid-19 funding is still available on the balance sheet. It is forecast total Covid-19 related spend at the end of this financial year is $4.3m.

To: Judy McGregor, Chair, Waitematā DHB
Harry Burkhardt, Chair, Northland DHB
Pat Snedden, Chair, Auckland DHB
Mark Gosche, Chair, Counties Manukau DHB
Nick Chamberlain, CEO, Northland DHB
Ailsa Claire, CEO, Auckland DHB
Margie Apa, CEO, Counties Manukau DHB

From: Dale Bramley, Lead CEO, Northern Region Health Coordination Centre

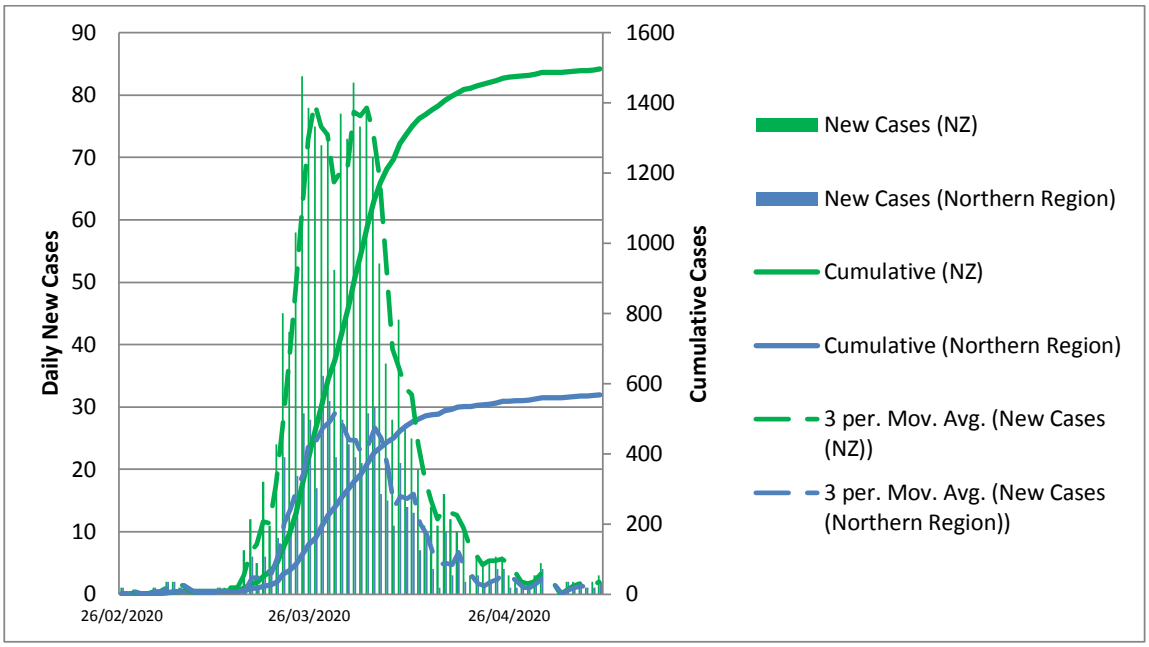
Re: COVID-19 Information for Open Board (May 2020)

Situation as at 12 May 2020

As at 9am Tuesday 12 May 2020, New Zealand was at COVID-19 Alert Level 3, with a step down to Alert Level 2 scheduled for 11.59pm on Wednesday 13 May.

There were 1,497 confirmed and probable cases in New Zealand, of which 1,398 cases had recovered. Sadly, there have been 21 deaths. Of these, the Northern Region has had 568 cases and three deaths.

NZ and Northern Region cases by date of confirmation



Northern Region Health Coordination Centre (NRHCC)

In late January, the Northland, Waitematā, Auckland, and Counties Manukau DHBs activated the Northern Region Health Coordination Centre (NRHCC) to manage the COVID-19 health sector response.

Located at Auckland City Hospital, the NRHCC brings together expertise from the four DHBs, Auckland Regional Public Health Service (ARPHS), the Northland DHB Public Health Unit, primary care, Auckland Council Emergency Response (welfare) and a regional Clinical Technical Advisory Group. Each of our four DHBs has a local Incident Management Team which is represented on the NRHCC.

In recent months the NRHCC moved to a dedicated space and expanded significantly to include work streams focused on Māori health, Pacific health, aged residential care, logistics (supply chain), and hospital capacity and response.

The objectives of the NRHCC are to: support the ARPHS-led public health response; ensure operational preparedness for the expected management of cases in DHB facilities; and manage communications with health and community care providers and our Northern Region communities.

It works closely with the National Health Coordination Centre (NHCC), the Office of the Minister of Health, the Auckland PHOs, aged residential care providers, NGOs, Police, and other health and social sector agencies.

Plans are being developed to transition the NRHCC to a reduced model, appropriate to the next phase of the pandemic.

Hospital preparedness

Infection control protocols in our hospitals and other sites are in place to protect staff, patients and whānau. These are regularly reviewed and updated as we change alert levels and the number of people on our sites changes.

Our four DHBs are now increasing the numbers of patients seen by services that were reduced during the national Alert Level 4 lockdown period. The reduction was to protect patients, whānau, and staff from the risk of COVID-19 infection and in order to prepare for a potential surge of COVID-19 patients.

This increase in planned care is being managed in a way that means our hospitals could quickly reduce the number of inpatients to accommodate a future influx of COVID-19 patients needing hospital care.

As we resume services that were paused during the lockdown period, we are looking at our waiting lists to identify the people with the highest clinical need. We recognise these are frequently Māori and

Pacific peoples who are also often the first to miss out at times of high demand or when there are other barriers to healthcare.

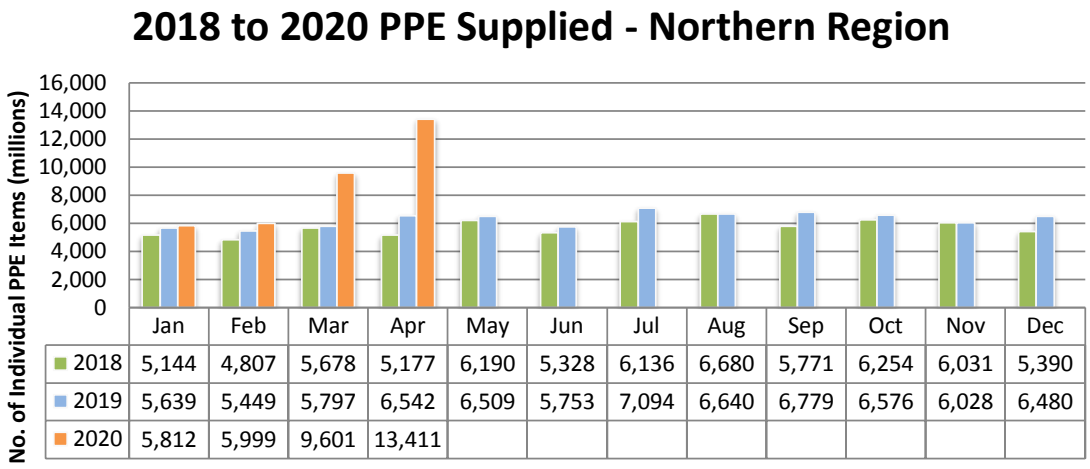
The four DHBs are working together to develop a consistent framework to address these clinical needs. Solutions may vary between the DHBs so that they are tailored to the local needs. The planning process will be data and evidence-based and in some DHBs will include clinical technical advisory groups.
We are committed to working together to deliver better health outcomes for Māori and Pacific people and as a result improve the health of our whole community.

Personal protective equipment (PPE)

The Northern Region DHBs are involved in work at a local, regional and national level to monitor and manage the long-term supply of PPE, working with local manufacturers and international suppliers.

A regional distribution process is in place to ensure we have the right equipment in the right place at the right time to support DHB staff, primary and community care and others, so they can safely care for patients. Since 1 March 2020 25.7m individual items of PPE (the majority being gloves) have been distributed to hospitals and community providers in the Northern Region.

Year-on-year comparison of PPE provided monthly in the Northern Region - includes gloves, masks, gowns, hand gel, and face/eye protection.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2018	5,144	4,807	5,678	5,177	6,190	5,328	6,136	6,680	5,771	6,254	6,031	5,390
2019	5,639	5,449	5,797	6,542	6,509	5,753	7,094	6,640	6,779	6,576	6,028	6,480
2020	5,812	5,999	9,601	13,411								

Different care settings require different levels of PPE. In all settings hand hygiene and physical distancing are the foundations for keeping everyone safe and reducing the transmission of COVID-19. Clinical guidelines (*Best use of PPE COVID-19*) have been produced and provided to staff along with on-going training and fitting of key elements such as N95 masks.

We understand that wearing of masks can make someone feel more protected, even if this is not required as PPE. Staff at our four DHBs are welcome to wear a surgical mask if they choose to do so.

Non-PPE use of masks can also increase the risk of infection and we have provided guidelines to ensure our staff are safe whatever their preference.

Pacific health response

The Pacific Response within the NRHCC is led by Fepulea'i Margie Apa (Counties Manukau DHB Chief Executive) and Markerita (Meg) Poutasi (Auckland DHB Chief of Strategy).

Elements of the response include:

- Two Pacific Community Based Assessment Centres (CBACs) in Otara and Panmure and two mobile clinics (Panmure and The Fono) with an aim to make testing accessible to Pacific communities. The mobile clinics use existing outreach models with strong community links.
- The mobile clinics have a social/welfare component so they can assess and address other needs. This is part of a broader welfare work stream.
- Community outreach, including early and ongoing engagement with Pacific community leaders and Pacific health providers.
- Support for Pacific providers including workforce.
- Social and wrap around support for Pacific COVID-19 positive families (aligned with Auckland Regional Public Health Service).
- Contract tracing workforce to support the Auckland Regional Public Health Service.
- The launch of https://preparepacific.nz/ website and Facebook group supported by the four DHBs. The aim is to build trust and confidence in the information received with language specific content in Samoan, Tongan, Cook Island Maori and Niuean. Content includes health professional panels in Pacific languages discussing issues arising in the community.
- Other targeted communications activity including Pacific media, support from Pacific social media champions, culturally appropriate resources in multiple languages. (For some examples see https://www.arphs.health.nz/covid-19-information-for-our-communities/)

In addition, general NRHCC activity has reached our Pacific populations - one of the high access GP clinics for testing was based in Mangere and had equally high levels of Pacific testing as the CBACs.

It is also important to acknowledge the response to COVID-19 from our Pacific communities who have been accessing testing for COVID-19 at a high rate (see later section on testing).

Māori health response

A regional Māori Response Team has been established to ensure a collective and efficient response is made to meet the needs of our Māori population during this challenging time. It covers all four DHBs and is led by Aroha Haggie (Director Funding & Health Equity, Counties Manukau DHB) and Riki Nia Nia (General Manager Māori Health, Waitematā and Auckland DHBs).

Elements of the response include:

- Liaison with iwi leaders, national Māori Health GMs, and national Māori pandemic leads. Through these close working relationships, we contributed to the development of the Maori Provider Framework for COVID-19.
- Access to COVID-19 testing for whānau is supported by CBACs set up in partnership with two Māori providers (Whanau Ora and Waipareira Trust), kaupapa Maori designated practices, and mobile testing clinics. The mobile clinics can also assess and address other needs.
- The employment of 60 full-time equivalent kaimanaaki (community health workers) to support whānau wellbeing during and post the COVID-19 outbreak in partnership with iwi and Māori health providers. This first phase of the Ngā Kaimanaaki service will be followed by a second phase of an iwi-led outreach programme of care and support for Māori whānau and communities across the region.
- A database of health professionals from Māori communities to support our communities in the fight against Covid-19: nurses and midwives, medical, social workers, community health workers, mental health support workers, whānau ora navigators, Kaiataawhai, Kaimanaaki, and kaitautoko, counsellors, youth workers, administrators and others. They are available and can be deployed across community services such as Primary Health Services, Public Health (ARPHS), and Community Based Services etc.
- A communications and engagement strategy for Māori including the launch of daily social media programme The Whanaau Guide to COVID-19, advertising on targeted channels, and the creation of specific resources for Māori. Recent resources include videos featuring Tammy Davis and Pio Terei that explain what to expect and do as we change alert levels and encourage whānau to safely continue to access health services through the pandemic.

Primary and community care

The NRHCC is working in partnership with PHOs, general practice, community pharmacies, aged residential care providers, and NGOs to respond effectively to the pandemic. This includes a new national response framework for primary care and community care, similar to the existing hospital framework.

New clinical guidelines and protocols have been developed by the regional clinical TAG with input from these groups and drawing on MOH guidance and WHO advice. These include credentialed COVID-19 management algorithms to allow appropriate triage assessment and management of potential COVID-19 cases presenting to primary and community care in different settings. We have undertaken assessments of infection prevention and control processes including Personal Protective Equipment and are providing PPE and other supports.

Good progress is being made on Your Health Summary, a secure clinical portal that will enable clinicians working at CBACs or designated practices to view the health records of people being tested for COVID-19, improving continuity of care.

Primary care providers in the region have also been proactive in offering different options for care that don't require travel or face-to-face consultation. These include telephone and video appointments and have been well received by our communities.

COVID-19 Testing

Access to testing for COVID-19 is a key component of managing the pandemic. Testing in the Northern Region was set up quickly in the early stages, and around 40% of all tests in New Zealand are carried out at laboratories in the Northern Region. As at 12 May, more than 80,000 tests have been processed in our region.

During March and April, 14 CBACs were set up in metro Auckland and seven in Northland – most in a matter of days. These centres have been essential in providing our communities with safe and convenient access to swabbing. We are currently reducing the number of CBACs in Auckland, and increased COVID-19 testing is taking place at designated general practices and urgent care centres. These continue to provide good geographical coverage and capacity.

Northland DHB has worked with nine Māori health providers to deliver mobile testing clinics from Kaipara to the Far North, enabling greater access for those living in remote communities. In Auckland, six mobile testing vans are also making it easier for people to access swabbing in their communities.

Ethnicity breakdown of cases and tests as at 12 May 2020

	Cases %	Tests %	Northern Region population
Māori	8.9%	16.3%	13%
Pacific	10.7%	16.7%	12%
Asian	21.1%	15.9%	26%
Other	59.3%	50.5%	49%
Unknown	0%	0.5%	-

Targeted Community Testing

In addition to testing people who meet the COVID-19 case definition, we are conducting targeted community testing of people as part of the Ministry of Health's ongoing surveillance against COVID-19.

Testing people without symptoms helps provide assurance that there are not undetected cases of COVID-19 in the community and that it is safe to move down the alert levels. It is voluntary and is being

offered to people in the following categories:

- essential workers at Māori health providers and Pacific health providers,
- healthcare workers in hospitals, laboratories, CBACs, and elsewhere in the community,
- people working at Auckland Airport including aircrew,
- staff at hotels being used for mandatory isolation,
- police and ambulance staff, and
- people associated with known clusters e.g. Marist College and aged residential care facilities.

There has been high uptake of testing by DHB staff, with almost 5,000 staff across our four DHBs tested by 12 May. This provides additional reassurance our hospitals remain safe places to visit.

Aged and other residential care

New Zealand has avoided the high need for hospital services, particularly ICU care, experienced in many parts of the world.

In this context, aged residential care (ARC) facilities have emerged as one of our highest risk areas and a regional work stream has been set up to support work that the individual DHBs are doing with ARC providers in their areas.

Virtual and onsite visits are being carried out to better understand how our DHBs can increase their support for ARC facilities to prevent COVID-19, and to minimise the impact of an outbreak if it occurs. Resources, training and other expertise and support is being provided as needed. Similar work is underway to develop resources and processes to support residential care providers in the mental health and addiction, and disability sectors.

There are two COVID-19 clusters in the region associated with ARC facilities, one at St Margarets Hospital & Rest Home, the other at Ellerslie Gardens. In both cases, the relevant DHB is supporting the facility with expert advice, staffing, and other needed infection prevention and control measures.

Border activity

The NRHCC continues to manage the health response and support border measures at Auckland International Airport.

We have a close working relationship with the stakeholders at the airport including the Airport company, Customs, MPI, Police and Aviation Security.

Current focus areas include: assessing the now small number of international arrivals and providing health advice as they transition into managed quarantine, exit screening Pacific Island and other repatriation flights; testing asymptomatic people who work at the airport as part of national surveillance activity; and providing input and advice to the Tasman Border Re-opening project.

Public Health response and contact tracing

While the number of COVID-19 cases has steadily declined from the peak of 39 cases per week at the end of March to fewer than three per day, Auckland Regional Public Health Service (ARPHS) is still managing complex clusters and maintaining surge capacity for contact tracing. Establishing the source of transmission for all cases, where possible, has been key to inform the Government's decision on moving to lower levels of restrictions. Public health staff have spent long hours investigating cases and clusters to map possible community transmission, providing essential epidemiological data for the regional and national response.

The service is preparing to scale up its ability to manage cases, contact tracing and any potential outbreaks. It is also identifying the resources and procedures required to respond early to outbreaks. Current clusters in aged residential care, at Waitakere Hospital, and Marist College have demanded high levels of practical and public health support. ARPHS worked with the NRHCC and the Board of Trustees to retest over 600 students and staff at Marist, and communicate that the school is now safe to open its gates. ARPHS is refining its standard operating procedures and resources for COVID-19 cases in a range of education and other institutional settings.

COVID-19 Incident Management Team Update

Recommendation

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**

Prepared by: Alex Pimm (Incident Controller / COVID-19 Response Lead)
Endorsed by: Joanne Gibbs (Director Provider Services)
Ailsa Claire (Chief Executive)

Acronyms

SARS-CoV-2	Novel coronavirus that causes COVID-19 (serve acute respiratory syndrome coronavirus 2)
COVID-19	The disease cause by the SARS-CoV-2 virus (coronavirus disease 2019)
IMT	Incident Management Team
DHB	District health board
PPE	Personal protective equipment
NRHCC	Northern Regional Health Coordinating Centre
ARPHS	Auckland Regional Public Health Service

1. Summary

Auckland DHB established an incident management team (IMT) in January 2020 following an assessment that the novel coronavirus (SARS-CoV-2 / COVID-19) could cause a significant impact to the New Zealand health system. Since then the IMT has evolved to meet the changing needs and risks of the organisation and Auckland population.

The IMT has engaged well with the Northern Regional Health Coordinating Centre (NRHCC), which has been coordinating activity across the Northern Region (Counties Manukau, Auckland, Waitematā and Northland DHBs catchments). In addition, the IMT team has worked closely with IMTs established in other DHBs, ARPHS, Ministry of Health and others.

The IMT has enabled rapid decision making across the DHB. It has also provided leadership and management throughout this event in collaboration with directorate teams. The team have supported new ways of working – within the IMT and across the organisation - including using a range of ways of engaging with teams throughout the DHB.

2. IMT activities

The IMT has undertaken a range of actions and activities to both plan for and respond to the impacts of COVID-19 on Auckland DHB and the population. The IMT has operated within the NZ Coordinated Incident Management Structure (CIMS). This has provided key linkage points with other DHBs, the NRHCC, Ministry of Health, and other agencies. The table below summaries the focus areas within each of the functions established within the IMT.

Function	Focus areas
Incident controller	Leadership and direction; decision making; NRHCC member
Planning and intelligence	Reporting; data analysis; capacity planning; regional planning link
Clinical operations (previously split: clinical technical advisory group; and operations)	Daily operations; clinical advice; clinical pathways; capacity management; security
Safety and risk	Occupational health; clinical safety; risk management; visitor policy
Logistics	PPE; IT; facilities; supply chain
People and wellbeing	Staff welfare; recruitment; people logistics; union engagement
Engagement and communications	Internal communications; staff engagement; social media
Residential care	Preparedness assessments; response to outbreaks
Legal; ethics; finance	Advisors to the executive response leads, CEO, incident controller and IMT

Some notable achievements of the IMT include:

- Development of clinical guidelines and pathways to support potential COVID-19 patients, including rapidly updating guidelines in response to the changing case definition, number of patients, and information about the virus.
- Development of hospital capacity plans to cope with an influx of large number of patients with COVID-19 symptoms, including the increase on the number of people that could be care for on a ventilator.
- Support to new ways of working, e.g. use of Zoom for meetings and teaching, and rapid resolution of issues by small focussed teams.
- Engagement with 'front-line' teams through a range of methods includes face-to-face discussions on wards and in clinical environments.
- Humorous videos released through social media to support key public messages.
- Preparedness assessments of over 80 residential care facilities and intensive support to facilities experiencing an outbreak.
- Enhancing security arrangements and the implementation of visitor screening stations at hospital entrances.
- Establishment of on-site staff testing, including testing of over 1,800 staff as part of national asymptomatic surveillance testing.
- Multiple staff welfare activities, including providing accommodation, welfare packs, paid leave and other supports.
- Creation of a second resus space in the adult emergency department.
- Development of guidelines for safe use of PPE.
- Rapid deployment of alternative PPE devices where the supply chain has been disrupted, including the testing and fitting of alternative masks.
- Weekly (and twice-weekly) all staff briefings to keep people updated on COVID-19 developments and what that means for Auckland DHB and working here.
- Roll-out of remote consultations across most outpatient clinics to enable patients to have their appointments from home.
- Large numbers of people supported to work from home.
- Development of staff assessment tool and subsequent review of 1,800 self-assessments by Occupational Health.
- Prioritisation of planned care, enabling urgent work to continue.
- Liaison with Auckland Transport to prioritise public transport routes to hospitals.

- Extensive engagement with staff unions and developing a positive relationship that will endure beyond the immediate impact of COVID-19.
- Work with Ministry of Health, Immigration NZ and Auckland International Airport to support international medical referrals to Auckland DHB.
- Release of COVID-19 live hospital dashboard.

As the organisation transitions from an incident management approach to a longer-term response, a focus will remain on ensuring that all risks and issues due to COVID-19 continue to be managed.

3. Recommendation

It is recommended that Auckland DHB Board notes the activity and overall success of the COVID-19 IMT.

Supporting the Government Push for Increased Equity in Health

Recommendation

That the information paper supporting the Government Push for Increased Equity in Health be received.

Prepared by: Board Chair, Pat Snedden

Since mid - 2018 we have at Auckland DHB had a clear focus on understanding ethnic inequities – both for Treaty reasons and the 'over and above' health outcome impacts that ethnicity has over other parameters such as socio-economic status. This discussion has not been plain sailing but we have managed to encourage discussions within the business examining 'institutional racism'. Our current system privileges some groups already. Maori and Pasifica are not in that group usually. It is important to be explicit about this. COVID gives us a big-bang opportunity to reset. The clinical community has positively engaged with this challenge and have determined to set out an evidence base for better and fairer treatment, starting with what is immediately in front of us for decision making; the restart of planned care and elective surgery.

How do we do this? Addressing inequities requires trade-offs. Our system currently makes trade-offs (usually in favour of the total population, the majority) – these are mostly not explicit. Making a trade-off in another direction explicit is important, and this is where the discomfort lies. Framing it as a zero-sum game however makes it unnecessarily a binary situation. The waiting list work is about prioritisation, it isn't that people will miss out, but it does change who gets up the queue earlier to address known inequities and improve outcomes.

Proportionality is also important. We know that there are elective surgical inequities and they need to be managed but this area of disadvantage is small compared to the magnitude of inequities generated by the social determinants of health, barriers to primary care access, later diagnosis, attrition across clinical pathways and necessary comorbidity management. These latter areas have got to be our focus, but the surgical wait list issues can be the leverage for the real action on these. Simply being successful in getting prioritised waiting lists happening is nowhere near enough on its own.

There is of course a wider context for this action.

For more than twenty years, the report on WAI 2575 concluded in its finding late last year: "(the) Crown has breached the Treaty of Waitangi by failing to design and administer the current primary health care system to actively address persistent Māori health inequities and by failing to give effect to the Treaty's guarantee of tino rangatiratanga (autonomy, self-determination, sovereignty, self-government)." This finding was supported by the Crown who "acknowledged the situation has not substantially improved since 2000: Māori continue to experience the worst health outcomes of any population group in New Zealand."https://waitangitribunal.govt.nz/news/report-on-stage-one-of-health-services-and-outcomes-released/

In early 2018 as the start of my tenure as Chair WAI 2575 was at the hearings stage. My early discussions with the Minister confirmed equity was high on his agenda. In late 2018 and early 2019 there were a series of discussions with the five DHBs from the Waikato north, encouraged by the Minister. The aim was to seek to establish common purpose around the recognition of Te Tiriti in the health sector and the improvement of access to services for Maori. Those conversations culminated in the formation of our Northern Iwi/DHB Partnership Board, approved with Ministerial sign-off on 5 March 2020 (attached below).

If we are to improve equity, "address persistent Maori health inequities" and meet our Te Tiriti responsibilities it follows we must change practice. But which practices do we change, and how do we do this and what happens to those who might stand to miss out from such a change?

One set of practices that we have already changed with the Minister's approval is the delegation of functions to the Partnership Board. They are to:

- Determine Maori health outcomes and Maori health equity priority areas for the three Northern DHB areas
- Provide Maori health leadership, advice and guidance across all DHB funded and provided services, activities and workforce to meet their Treaty of Waitangi and statutory obligation to Maori
- Oversee resource allocation and investments made by the three DHBs for the purpose of achieving Maori health outcomes and advancing Maori wellbeing
- Engage experts and advisors to carry out work and complete specific tasks on behalf of the Partnership Board

This approval allows each DHB to delegate functions, duties or powers to this Iwi/DHB Board. The impact of this delegation has been most usefully experienced during the pandemic where the Northern Iwi/DHB Partnership Board meeting with the Regional IMT has approved funding to Maori providers to address local community requirements for safety in the pandemic across the region.

This joint decision making has been both timely and effective. Pandemics have historically been very devastating for Maori https://thespinoff.co.nz/atea/18-03-2020/why-equity-for-maori-must-be-prioritised-during-the-covid-19-response/. Not this time, so far.

What we have noted in the Northern region is that positive action, taken by DHBs to work directly with Maori communities has worked where they have the decision rights as to the intervention appropriate to their needs. The effect has been to reduce the risk of infection for Maori to levels at or below the levels achieved for all other communities and to have some of the highest testing rates. This has never previously occurred. Maori leadership in provision of care has reached deep into their communities and has become the most reliable conduit of information on their population health during this virus. DHBs have never before had this level of support on the ground and data about the Maori populations. The net outcome has been a significant public health safety net supported by Maori interests to protect their people. The Northern Iwi/DHB Partnership Board has been the conduit for resourcing this safety net alongside the local Maori community investment which has been extensive, profound and insightful. Right here, we have found a new way of working. This is the enlargement of equity in action.

We have found direct engagement with the Pacific communities where they also have decision rights over intervention options has worked. It was they who designed and determined the style of intervention in the region including the mobile testing and the outcome has been the lowest infection rates per head of population of any of the population groups. This is very significant as the Pacific population is living in some of the most overcrowded communities in our region. The community disciplines that have created this outcome are very impressive. Part of this success must be the extent of community control of options. This is not our normal practice through contract provision in health so this challenges our paradigm thinking.

Both the Maori and the Pasifika interventions have been ethnic specific. And they have both worked exceptionally well.

Such success has raised the expectation that if a change of practice in a pandemic can generate such positive health equity outcomes for both communities what should we change to make improvements in a non-pandemic setting? Could we get substantially improved results if we relied more on community engagement to direct more of the services available? How might these changes increase equity and provide a fairer health delivery system for all users? Within six weeks we have discovered in real time and under extreme pressure the power of a regional, delegated Iwi/DHB decision making model.

What of other direct changes to clinical practice that might deliver improved outcomes for Maori and Pasifika? Our feedback is their use of online tools for consultations between clinicians and patients at home has heavily reduced the DNA (did not attend) rates for patients. This has been one of the biggest areas of inequity. Before Covid-19 patients who couldn't attend consultations when booked because they couldn't afford transport or they couldn't get care for the kids then missed out and dropped down the priority list. With online consultations now possible patients with wifi access can engage together with their whanau if they wish in a non-stressful environment. It is not perfect and digital enablement is not right for every consultation but the experience has been powerful and positive for those who often miss out. We are further testing extension to this concept by building in care navigation with people with appropriate language and culture.

All this innovation and learning now points us to the next *Everest for equity*. WAI 2575 is clear that "Māori continue to experience the worst health outcomes of any population group in New Zealand." None of us believe this is right or fair. Doing nothing won't work as the Tribunal makes clear on the lack of progress over the last 20 years.

So we must act to change practice. We are explicitly taking on this challenge by testing as to whether we have the right approach to the waiting list for surgery. We want to see Maori health improve and thus timely and appropriate access to surgical intervention is a data point in this journey. This is inherently challenging. If we advantage one person or group we are disadvantaging others. Even the language of trying to do the right thing can get us into strife.

Let us therefore seek clarity. We want our clinical assessment process to be intrinsically evidence based and fair to our population within the resources available. But it hasn't been and we can't avoid that. The evidence is in from the Tribunal and the Government agrees. There are multiple reasons for this and they have been extensively argued and published. I propose that we don't spend our energy there as the studies emphasise the dilemma without the practical solution. Rather why don't we reframe this differently?

Suppose we began our new approach with a special focus on referred patients who are Maori and Pasifika with ethnic specific interventions where the judgement of our clinicians supports this making a difference? What if we decided that over a twelve month test period we would seek to make the clinical pathway to treatment more visible, faster and more supported for these citizens by intervening early to improve their life course outcomes.

Our data shows Maori and Pasifika patients take longer to move from referral to listing for procedure and often have to present multiple times during the pathway and have a higher DNA rate across the pathway. What if we tailored the support to reduce this time, including reducing the DNA rate using the Maori and Pasifika networks that have been so efficient in the pandemic? Clinicians would address this directly through the priority waiting on the elective list.

The test for ourselves might be described thus. The Government has committed to a goal of higher levels of equity in the health services particularly in relation to meeting its Treaty obligations and more generally to the Pasifika and low income populations. We accept this challenge and will test different approaches to addressing this goal using an evidence based framework that explicitly recognises clinical prioritisation and the cultural knowledge and support that brings the service innovation required to provide enhanced outcomes for these populations being served.

Appendix 10.1.1 – Letter Hon. Dr David Clark – Northern Iwi-District Health Board Partnership Board

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

05 MAR 2020

Mr Harry Burkhardt
Ms Judy McGregor
Mr Pat Snedden
Northern District Health Board Chairs
C/- Waitematā District Health Board
Private Bag 93-503
Takapuna
Auckland

10.1

Tēnā koutou

Northern Iwi-District Health Board Partnership Board

Thank you for your letter of 18 December 2019 seeking my approval for the formation of the Northern Iwi-District Health Board Partnership Board (the Board). I understand from your letter that a lot of work has been put into the relationship agreement between the three District Health Boards and Te Kahu o Tāonui, the Tai Tokerau Iwi Chairs Forum.

I understand from your letter that it is your intention to delegate the following functions to the Partnership Board:

- Determine Māori health outcomes and Māori health equity priority areas for the three northern DHB areas
- Provide Māori health leadership, advice and guidance across all DHB funded and provided services, activities and workforce to meet their Treaty of Waitangi and statutory obligations to Māori
- Oversee resource allocation and investments made by the three DHBs for the purpose of achieving Māori health outcomes and advancing Māori wellbeing
- Engage experts and advisors to carry out work and complete specific tasks on behalf of the Partnership Board.

I am pleased to be able to confirm my approval of the Northern Iwi-DHB Partnership Board as a class or person under section 39(5) of the Public Health and Disability Act 2000. This approval will allow each DHB to delegate functions, duties or powers to the Board.

The Associate Minister of Health, Hon Peeni Henare, would like to meet with the Board within the next six months to develop an understanding of the Board's aspirations for Māori health and wellbeing and how the Board will take on the perspectives of hapū, iwi and Māori that are not directly represented on Te Kahu o Tāonui.

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I wish the new Board well and I support their focus on the achievement of successful Māori health outcomes and in advancing the wellbeing of whānau, hapū and iwi within your catchment areas.

Nāku noa, nā

Hon Dr David Clark
Minister of Health

Cc Hon Peeni Henare, Associate Minister of Health

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 26 February 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]
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	**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 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	**Commercial Activities** Information contained in this report is	That the public conduct of the whole or the relevant part of the meeting would

Procurement	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)]	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	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]

	and would prejudice or disadvantage if made public at this time.	
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 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]
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]