AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Open Board Meeting

Wednesday, 18 May 2022

10:00am

Note:

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

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

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

Published 13 May 2022

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

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

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

Well Being to All.

Open Agenda
Meeting of the Board
18 May 2022

Venue: **A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton** **Time: 10.00am**

Board Members Pat Snedden (Board Chair) Jo Agnew Doug Armstrong Michelle Atkinson Zoe Brownlie Peter Davis Tama Davis (Board Deputy Chair) Fiona Lai Bernie O'Donnell Michael Quirke Ian Ward **Seat at the Table Appointees** Krissi Holtz Maria Ngauamo Kirimoana Willoughby Shannon Ioane	**Auckland DHB Executive Leadership** Ailsa Claire — Chief Executive Officer Mark Edwards — Chief Quality, Safety and Risk Officer Debbie Holdsworth — Director of Funding – ADHB/WDHB Michael Shepherd — Interim Director Provider Services Sue Waters — Chief Health Professions Officer Auxilia Nyangoni — Acting Chief Financial Officer Sarah McLeod — Acting Chief People Officer **Auckland DHB Senior Staff** Jennie Montague — Head of Executive Services **Committee Coordinator** Nerissa Navarro (Other staff members who attend for a particular item are named at the start of the respective minute)

Agenda

Please note that agenda times are estimates only

KARAKIA

10:02 **1.** **ATTENDANCE AND APOLOGIES**

10:04 **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?

10:05 **3.** **CONFIRMATION OF OPEN MINUTES 06 April 2022**

10:10 **4.** **ACTION POINTS**

4.1 Waitangi Tribunal report on COVID alignment

10:15 **5.** **EXECUTIVE REPORTS**

5.1 Chief Executive's Report

5.2 Health and Safety Report

10:50	**6.**	**PERFORMANCE REPORTS**
	6.1	Financial Performance Report
11:00	**7.**	**COMMITTEE REPORTS**
	7.1	Hospital Advisory Committee Executive Report
	7.2	Disability Support Advisory Committee Executive Report
12:00	**8.**	**DECISION REPORTS**
	8.1	Amended Occupation Health and Safety Policy
12:10	**9.**	**INFORMATION REPORTS - NIL**
12:10	**10.**	**GENERAL BUSINESS**
	10.1	Petition to Auckland DHB Board received from Richard Stein Chairman, Crohn's and Colitis New Zealand Charitable Trust.
12:40	**11.**	**RESOLUTION TO EXCLUDE PUBLIC**

Next Meeting:	Wednesday, 29 June 2022 at 10.00am Marion Davis Library, Building 43, Auckland City Hospital, Grafton

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Attendance at Board Meetings

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

2021/2022

Members	28 July 21	29 Sept 21	3 Nov 21	15 Dec 21	26 Jan 22	23 Feb 22	6 April 22	18 May 22	29 June 22
Pat Snedden (Board Chair)	1	1	1	1	1	x	1		
Joanne Agnew	1	1	1	1	x	1	1		
Doug Armstrong	1	1	1	1	1	1	1		
Michelle Atkinson	1	1	1	1	1	1	1		
Zoe Brownlie	x	1	1	1	1	1	1		
Peter Davis	1	1	1	1	1	1	1		
Tama Davis	x	1	1	1	1	1	1		
Fiona Lai	1	1	1	x	1	1	1		
Bernie O'Donnell	x	1	x	x	1	1	1		
Michael Quirke	1	1	1	1	1	1	1		
Ian Ward	1	1	1	1	1	1	1		

Seat at the Table

Members	26 May. 21	28 Jul. 21	29 Sep. 21	3 Nov 21	15 Dec. 21	26 Jan 22	23 Feb 22	6 April 22	18 May 22	29 June 22
Kirimoana Willoughby	1	nm	nm	x	nm	x	1	1		
Krissi Holtz	1	1	1	1	1	1	1	1		
Maria Ngauamo	1	1	1	1	1	x	1	x		
Shannon Ioane	1	nm	nm	1	nm	1	1	1		

Key: 1 = present, x = absent, # = leave of absence, c = cancelled nm = non member

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 Shareholder – Ayers Snedden Consultants Ltd Executive Chair – Manaiakalani Education Trust Director – Te Urungi o Ngati Kuri Ltd Director – Wharekapua Ltd Director – Te Paki Ltd Director – Ngati Kuri Tourism Ltd Director – Waimarama Orchards Ltd Chair – Auckland District Health Board Director – Ports of Auckland Ltd	01.07.2021
Jo AGNEW	Professional Teaching Fellow – School of Nursing, Auckland University Casual Staff Nurse – Auckland District Health Board Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Shareholder – Karma Management NZ Ltd (non-Director, majority shareholder) Member – New Zealand Nurses Organisation [NZNO] Member – Tertiary Education Union [TEU]	30.07.2019
Michelle ATKINSON	Director – Stripey Limited Trustee - Starship Foundation Contracting in the sector Chargenet, Director & CEO – Partner	21.05.2020
Doug ARMSTRONG	Trustee – Woolf Fisher Trust *(both trusts are solely charitable and own shares in a large number of companies some health related. I have no beneficial or financial interest* Trustee- Sir Woolf Fisher Charitable Trust *(both trusts are solely charitable and own shares in a large number of companies some health related. I have no beneficial or financial interest* Member – Trans-Tasman Occupations Tribunal Daughter – *(daughter practices as a Barrister and may engage in health related work from time to time)* Meta – Moto Consulting Firm – (*friend and former colleague of the principal, Mr Richard Simpson)* NZX shares which may include from time to time the health related shares EBOS , Fisher and Paykel Healthcare,Ryman Healthcare, Green Cross Healthcare	21.10.2021
Zoe BROWNLIE	Co-Director – AllHuman Board Member – Waitakere Health and Education Trust Partner – Team Leader, Community Action on Youth and Drugs Advisor – Wellbeing, Diversity and Inclusion at Massey University	26.05.2021
Peter DAVIS	Retirement portfolio – Fisher and Paykel Retirement portfolio – Ryman Healthcare Retirement portfolio – Arvida, Metlifecare, Oceania Healthcare, Summerset, Vital Healthcare Properties Chair – The Helen Clark Foundation	22.12.2020
William (Tama) DAVIS	Director/Owner – Ahikaroa Enterprises Ltd Whanau Director/Board of Directors – Whai Maia Ngati Whatua Orakei Director – Comprehensive Care Limited Board	10.03.2022

	Director – Comprehensive Care PHO Board Board Member – Yellow Brick Road Board Member – District Maori Leadership Board Iwi Affiliations – Ngati Whatua, Ngati Haua and Ngati Tuwharetoa Director - - Board of New Zealand Health Partnerships Elected Member – Ngati Whatua o Orakei Trust Board Board Member – Auckland Health Foundation Director to Emerge Aotearoa Trust and Emerge Aotearoa Limited Strategic Director, Maori – University Services (wholly owned by The University of Auckland)	
Krissi HOLTZ	Primary Employer – ASB Bank	07.07.2021
Shannon IOANE	Member – Public Service Association (PSA) Employee at Starship Children's Hospital – Allied Health/Child Health ADHB	07.07.2021
Fiona LAI	Member – Pharmaceutical Society NZ Casual Pharmacist – Auckland DHB Member – PSA Union Puketapapa Local Board Member – Auckland Council Member – NZ Hospital Pharmacists' Association Board of Trustee – Mt Roskill Primary School Vaccinator	21.11.2021
Maria NGAUAMO	Employee – NZ Ministry of Foreign Affairs and Trade (MFAT) Pacific Health Scholarship – Ministry of Health	04.04.2022
Bernie O'DONNELL	Chairman Manukau Urban Māori Authority(MUMA) Chairman UMA Broadcasting Limited Board Member National Urban Māori Authority (NUMA) Board Member Whānau Ora Commissioning Agency National Board-Urban Maori Representative – Te Matawai Board Member - Te Mātāwai. National Māori language Board Owner/Operator– Mokokoko Limited Senior Advisor to DCE – Oranga Tamariki Engagement Advisor – Ministerial Advisory Panel – Oranga Tamariki Kura Ratapu – Radio Waatea - Wife	08.07.2021
Michael QUIRKE	Chief Operating Officer – Mercy Radiology Group Convenor and Chairperson – Child Poverty Action Group Director of Strategic Partnerships for Healthcare Holdings Limited Board Director – healthAlliance Director - New Zealand Musculoskeletal Imaging Limited	30.08.2021
Ian WARD	Director – Ward Consulting Services Limited Director – Cavell Corporation Limited Trustee of various family trusts Oceania Healthcare – wife shareholder	21.05.2020
Kirimoana WILLOUGHBY	Employer – Ngati Whatua Orakei Whai Maia Ltd Director – The Hearing House Board	01.03.2022

Minutes
Meeting of the Board
06 April 2022

Minutes of the Auckland District Health Board meeting held on Wednesday, 06 April 2022 via Zoom at 10am

Board Members Pat Snedden (Board Chair)[Left during item 5.1] Jo Agnew Doug Armstrong Michelle Atkinson Zoe Brownlie [Arrived during item 5.2] Peter Davis Tama Davis (Board Deputy Chair) Fiona Lai Bernie O'Donnell Michael Quirke Ian Ward)[Left during item 5.1] **Seat at the Table Appointees** Krissi Holtz Kirimoana Willoughby Shannon Ioane	**Auckland DHB Executive Leadership** Ailsa Claire — Chief Executive Officer Dr Karen Bartholomew — Director, Health Outcomes for ADHB/WDHB Mark Edwards — Chief Quality, Safety and Risk Officer Dr Debbie Holdsworth — Director of Funding – ADHB/WDHB Auxilia Nyangoni — Interim Chief Financial Officer Michael Shepherd — Interim Director Provider Services Shayne Tong — Chief Digital Officer **Auckland DHB Senior Staff** Ruth Bijl — Funding and Development Manager Women's Child and Youth Health Sarah McLeod — HR Director Organisational Development Jennie Montague — Head of Executive Services Nerissa Navarro — EA Deputy Board Chair and Chief of Strategy Marlene Skelton — Corporate Business Manager Megan Wiltshire — Director Communications and Stakeholder Engagement (Other staff members who attend for a particular item are named at the start of the respective minute)

Acknowledgement of Service – Marlene Skelton

The Board Chair, Pat Snedden on behalf of the Board thanked the Corporate Business Manager, Marlene Skelton for her service to the Board over her nine year tenure commenting that the position was a specialised one and in these times when the Board had been required to operate in entirely different ways it had required someone who was adroit in managing and keeping the Board informed. Not only do you need to be clear and fair to those you are listening to but you also have to have the ability to impartially respond when someone challenges what you may have recorded.

There has barely been a time over the last four years that something has been wrong. Marlene has the skill to take quite complicated things and make them clear. The Board Members have relied on that skill to ensure the tone and the methodology of running the board and committee meetings is right and that members feel like they are being supported such that they can concentrate on their governance roles. Marlene has been a consistent asset to the Board.

The Chief Executive, Ailsa Claire added that there was a little more to the role than the Board saw. There were the challenges of getting papers from staff members on time and following up the Board action. Ailsa acknowledged the work undertaken to make this happen.

KARAKIA

The Karakia was led by Tama Davis.

1. ATTENDANCE AND APOLOGIES

That the apology of Maria Ngauamo, Seat at the Table member be received.
That the apologies of Pat Snedden for temporary absence from meeting between 11am and 1pm, Ian Ward for absence from the meeting between 11.45am and 1pm and the apology of Zoe Brownlie for late arrival [11am] be received.

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

There were no new interests to record and no conflicts with any item on the open agenda.

3. CONFIRMATION OF MINUTES 23 FEBRUARY 2022 (*Pages 9-35)*

Resolution: Moved Peter Davis / Seconded Michelle Atkinson

That the minutes of the Board meeting held on 23 February 2022 be confirmed as a true and accurate record.

Carried

4. ACTION POINTS (Page 36)

4.1 Digital tools related to supporting management of COVID 19 *(Pages 37-45)*

Shayne Tong, Chief Digital Officer advised that there had been work done with the Northern Region Health Coordination Centre (NRHCC) and the Ministry of Health over the last two years to develop and set up digital systems to support covid-19 and vaccinations.

Auckland DHB had implemented some tactical digital solutions early in the COVID 19 outbreak while work was underway in the Ministry to implement national systems to support testing and vaccination. Through NRHCC a mobile testing application was provided to assist the regional workforce, including nurses in MIQ facilities to keep track of patients' and visitors' testing regimes.

Auckland DHB also did a lot of workflow and automation around enabling the redeployment of staff and in relation provision of an interim vaccine booking system until the national Book myVaccine app was launched two to three months later.

Shayne Tong in referring to his presentation updated the Board on where the DHB and region was now in their journey. Work continues with the Ministry to implement national systems and the releases of the different functionality and features of these systems. In the early days, our response was around border control and testing. This was the main driver of the initial digital solutions that were stood up; testing of border workers and incoming

travellers, contact tracing, and community testing sites.

For some time now, the COVID in the Community framework has been focused on consumers, people living with COVID and self-managing. There has been a lot more integration with primary and secondary care providers to give them some capability to manage the response. Part of this relates to the welfare response which is the area of MBIE (Ministry of Business, Innovation and Employment) and MSD (Ministry of Social Development). The diagram [in slide pack] of the ecosystem of the broader COVID response locally, regionally and nationally, along with the different key stakeholders (MSD, public health, primary and secondary) shows how complex the response has been.

Shayne Tong advised that we now have some enduring digital assets that can be scaled to maturity and scaled for future use moving forward. Auckland DHB had worked closely with the Ministry to implement these solutions. These solutions can integrate back to the COVID Immunisation Record (CIR). A more joined-up approach with the Border Clinical Management system was implemented. This enabled getting the testing results through EpiSurv, integrating the data into contact tracing providing an end-to-end digital solution.

The Chair Pat Snedden asked about the status and the quality and level of engagement with the public around these digital initiatives knowing that we didn't get things right from the beginning. Shayne Tong advised that the engagement was increasing. There is now a self-service portal that enables the public to book their vaccination schedule and access their vaccination record. In October 2021, My COVID Record was launched where the public could record, update and access their test results. Testing (including RaT) is a lot more integrated and joined up, not just from a consumer but also from primary and secondary perspective.

Shayne Tong continued his presentation.

Auckland DHB stood up an interim vaccine booking system (BookMyVaccine) which was used for four months and saw about 400,000 vaccines administered to the local population. A seamless migration was then made to the national platform. The vaccine pass and COVID record came after that.

There is now a self-service portal for patients and whānau to access their own vaccine and test record. The Border clinical Management Systems is being rebranded to CinC (COVID in Community) that provides additional services to patients depending on the severity of their COVID symptoms. This has been a two-year journey and an incremental and agile approach was taken to deliver the digital solutions over this time, leveraging new and modern cloud-based technologies for NHRCC, the digital teams in the DHBs, and the Ministry itself. This enabled the older, siloed systems in a few of our sector to be identified and upgraded.

Pat Snedden was advised that this is now a national response. Auckland DHB plugs into and takes the capability that gets developed, and helps prioritise road maps and development activities. When they are ready to implement, we work with our teams at NRHCC to operationalise the system.

Shayne Tong advised that there is now a stronger connection with Primary Care to better manage the use of the systems and capability. Although they are national systems run by the Ministry, Auckland, being the largest region in the country and where the highest caseload of

COVID has existed has been a strong link, providing key leadership around strategy and direction making and the prioritisation of a lot of this capability.

Pat Snedden opened the floor for questions and further discussion

Michael Quirke expressed appreciation for the presentation acknowledging a better understanding of what was in place and was impressed at what the teams had done. The number of digital initiatives implemented in a short timeframe is a good news story.

Michael Quirke inquired about the issues with regard to CiCM. He had heard of issues raised by GPs at the peak of the Omicron outbreak and would like to know whether they had been addressed from a Primary Care perspective.

Shayne Tong advised that the issues had to do with the speedy pace of deploying features and functionality and the inconsistent release of codes. While testing is done prior to deployment things were being done at fast pace and like most IT projects, there would always be issues around communication and change management. To get GPs agreement and buy-in has been a complex undertaking but there is now less concern and a higher uptake.

Responding further to Michael Quirke's query about feedback from GPs the Chief Executive Ailsa Claire commented that Shayne Tong had in some ways underplayed the enormity of what was done and also the leadership that he showed nationally in trying to pull everything together. It's very difficult to describe how the systems were not communicating with each other. When attempts were made to do what should have been simple things like a risk assessment and transfer of patients on to primary care there were complexities involved. Ailsa Claire added that GPs appear happy and more comfortable with the IT system now.

Jo Agnew commented that the presentation was a good way to understand the system and agreed that is it a good news story that needs to be out there in the public to make people aware of how much has actually been done with Peter Davis agreeing.

Peter Davis asked to what extent the systems that have been established specifically for COVID are transferrable to manage other issues, for example, the immunisation programme. Shayne Tong advised that the situation will improve particularly with the one health system, one strategy, one plan and one approach that Health New Zealand and Maori Health Authority are taking. National sector CIOs have worked closely with the Ministry of Health, and this in part is why there has been success in securing $400M for the sector - $200M of which is effectively for HIRA or the National Health Information Platform which is run out of the Ministry; and $200M for capability uplift. That will allow the DHBs to keep operating and keep systems safe and secure with regards to debt and potential cyber security.

Ailsa Claire advised that it was important to talk about the HIRA system as the system puts an integrator engine across the top which enables a lot of dispersed systems to pass information to each other. That is absolutely vital and that is why getting it funded is reason to celebrate.

Shayne Tong commented further on Peter Davis' point about scalability. From an immunisation perspective, by choosing new, modern cloud-based technologies it is much

easier to scale. Shayne Tong s personal view was that the COVID immunisation register and the re-platforming or redevelopment of the national immunisation register to the same modern and scalable platform would allow integration. The move to new modern cloud-based technologies and also the move to one health system will make integration easier.

Resolution:

That the report Digital tools related to supporting management of COVID19 be received.

Carried

5. EXECUTIVE REPORTS

5.1 Chief Executive's Report *(Pages 46-56)*

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

Northern Region Coordination Centre

The Northern Region Coordination Centre, as the move was made from vaccination to testing, had to pivot dramatically to provide centres for the public to pick up rapid antigen tests. Initially those centres were meant to service those people who were symptomatic but the wider population wanted them placing pressure on the centres. Staff were subject to abuse during this period from members of the public who were frustrated at having to wait long periods of time to get a RAT test. The situation now is a lot calmer.

Whānau HQ

The redevelopment and support of Whānau HQ also occurred during this period.

When a positive test is confirmed people are assessed as to whether they are of low, medium or high risk. If they are Māori and Pacific they are moved to the specific Māori and Pacific support teams for management. All others move to primary care for assessment and support.

The Māori and Pacific providers responded extremely well during this period and worked well with MSD and other partners to the point where a Whānau ora approach was in place. What would be ideal is to maintain this approach and result going forward into what is predicted to be a challenging winter with rounds of COVID, Influenza and general winter ailments. What has worked well for COVID should work well in other circumstances.

There were also significant changes to the borders and the reduction in the number of MIQ facilities. We provide the health support to the borders and MIQs. There has been a significant amount of infrastructure in the digital space to supply chain that has been provided. It is not a simple matter to stand up a testing station or vaccination centre without a considerable amount of work sitting behind the scenes. The NRHCC, when things are quieter, have been asked to provide a piece on what they did as it is important to not loose sight of what was done and the effort expended.

Redeployment of Staff

During this time attempts were being made to redeploy staff back into the DHBs. The challenge with staffing has been that a number were sick, or the DHB was carrying vacancies or there were staff members looking after sick Whānau. Staffing has been and continues to be one of the DHBs biggest challenges.

While reducing number of patients in hospital is good it is to be remembered that the DHB is still operating at only just above minimum service delivery because of workforce issues and growing acute demand.

The following was covered during discussion:

Doug Armstrong was advised that there were no issues with the supply of rapid antigen tests and PPE. There have been occasions when people have said that they cannot access N95 masks. An N95 mask needs to be properly fitted for it to be effective. They are uncomfortable to wear and very stuffy. Science and clinical need indicates that in many settings an N95 mask is not required. A normal surgical mask has the same clinical efficacy in the majority of cases.

Doug Armstrong inquired about the COVID drugs and asked whether a GP can simply write a prescription for them. Mike Shepherd advised there was a list of criteria governing the drugs and a pathway that informs clinicians whether or not their patient is eligible for this medication and once prescribed it needs to be accessed via a pharmacy.

Doug Armstrong then asked whether the care in the home system was working appropriately. Ailsa Claire replied that it was and that people deemed medium and high risk, particularly Māori and Pacific, are getting good support from the service or their GP. It was advised that a routine question during screening was whether a person identified as Māori or Pacific to ensure that the services offered are culturally appropriate. People are generally assessed and individual requirements are noted to alleviate personal difficulties of the patient and the household.

Doug Armstrong was advised that whilst the DHB was operating under minimum service acute care and care for people who were classified as P1 and P2 where an elective procedure cannot wait were being seen and received care. Some outpatient clinics have still been able to be offered at Greenlane.

Peter Davis commented that over the last two years there had only been 50 deaths and with Omicron deaths now number around 450. He asked why, with a variant that was said to be more mild than others, there were a reported 20-30 deaths per day. It was advised that while Omicron was a milder variant it was considerably more transmissible and was reaching a larger number of vulnerable people. While the percentage of people requiring hospitalisation was low just because so many people have it there are a larger presenting to hospital and dying.

It should be noted that the reported number of deaths should be read “deaths with COVID”. When presenting to hospital it was not known they had COVID, they came for other reasons and when they died it was found that they had COVID too. It is very difficult to know what

the impact would have been for the normal health outcome for these people.

Mike Shepherd added that there had been no proper outbreak of COVID in New Zealand prior to Omicron. The country's borders have been contained. If you to look to other countries mortality New Zealand was doing well in comparison.

Jo Agnew was advised that the process for increasing the numbers of patients able to have surgery was staff dependant at the moment but the most that could be done was being done. The determination of those prioritised as P1 or P2 was a purely clinical decision. It was made sure that equity implications were managed as well when decisions were made.

Continuation - Redeployment of Staff

As staff sickness has increased the DHB has had a comprehensive programme of redeployment in place. This was not merely redeployment of clinical staff although there have been anaesthetists working in the ED, surgical nurses have been on wards, but also non-clinical staff have been supporting too.

The Board should acknowledge formally not just those doing extra hours in their normal roles, but those who have been prepared to be flexible and do very different things. This has not always been the case in other DHBs. The team supporting these people with inductions has also been very good. Jennie Montague expanded on this advising on the type of tasks people were undertaking which was broad, from answering calls from Whānau through to scheduling and rostering. What was gratifying was that people were signing up for the most difficult shifts to cover, those in the evening.

Ailsa Claire advised that this process required a lot of communication and unsolicited feedback given by Unions had been positive with them relaying that they had been well communicated with during this period.

Pride Month

It was unfortunate that Pride month occurred during this period as the DHB was not able to celebrate as it would have wished to do but did manage to run a campaign as outlined on page 48 of the agenda.

Wellbeing and Check-ins for Staff

The camaraderie has been very good. The people volunteering and coming into the clinical areas and those receiving them had a positive experience. However, there is not getting away from the fact that there are fatigued staff. This has been acknowledged in small ways such as giving out free coffee cards, wellbeing check-ins for staff and snack boxes. There have been a number of care packages given out to staff by the Welfare Centre.

During the worst of it the hospital was challenged in to fill evening and night shifts. Many of the staff offering to do that were doing so in overtime. Clear rules were set around how many hours people could work.

[Secretarial Note: The Board Chair, Pat Snedden left the meeting at this point and the Deputy Board Chair, Tama Davis assumed the chair.]

New Senior Leaders

Jennie Montague – Head of Executive Services

Jennie previously worked within the public service and has been working for the DHB for six years in various operational manager and general manager roles and will now be providing direct support for the Chief Executive and Director Provider Services in assisting with the transition to Health NZ and some governance tasks.

Malcolm Underwood – Director Cardiovascular Directorate

Malcolm is a very experienced surgeon and a committed leader. It is hoped that he will start in the role at the end of this month. Joanne Bos who has been covering this role has done so very ably and management are grateful for her and the Cardiovascular teams support during this recruitment period.

Fritha Hanning – Director Cancer and Blood Service

The move of Richard Sullivan to a Director of Surgery role has allowed Fritha Hanning, who has been in the unit for some time, to be appointed as Director Cancer and Blood Service.

Action

That the Board express their appreciation to all staff who volunteered and provided support and coverage during the height of the Omicron outbreak.

Resolution:

That the Chief Executives report for 4 February 2022 – 20 March 2022 be received.

Carried

5.2 Health and Safety Report *(Pages 57-67)*

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

Incidents

The service specific recommendations related to an assault on a staff member of ACOS, [which occurred in the service user's home] have now been implemented. These relate to actions at the team meeting each day including a robust risk assessment being completed, and having two people in attendance when visiting high risk service users.

Risks

The fatigue risk was moved from high to critical early in the Omicron outbreak. This move was based on standard health and safety advisor observations and feedback that on top of constrained workforce availability the situation was likely to get tighter particularly as staff got sick or their whānau got sick and staff needed to be at home to support them. Working in this environment is more fatiguing because you have the donning and doffing of PPE and the associated difficulty in communicating making things less efficient and harder to undertake routine tasks.

The initiatives introduced in response were redeployment to critical areas for both clinical and non-clinical staff, initiatives to increase capacity in hard to staff shifts and moving to a minimum service delivery model. There was a period of around three weeks where Omicron was at its peak but over the last two weeks that pressure has eased. The health and Safety team have advised that the fatigue risk is being managed well at this time and that the initiatives that were introduced were seen by staff as being very helpful. When a formal reassessment is conducted it is likely that the fatigue risk will return to high.

There has not been the internal capacity to conduct a deep dive into fatigue. There are some national initiatives underway at this time such as the survey to be conducted by the National Fatigue Minimisation Team, which the DHB will take part in and a number of other planned activities. The DHB is developing a working group which will oversee these activities.

Totika Certification

A letter was sent to all contractors around six weeks ago urging them to sign up to the Tōtika scheme. However at last count; of the 800 contractors needing to complete the exercise there were still 500 who had not done so. The deadline for completion having passed consideration is now being given to what the DHBs next steps will be. It has been difficult to get existing contractors to sign up to this health and safety certification.

The contractor management system due for implementation in late May will be able to provide one place to view contracts which will greatly assist those staff managing contractors.

Highlights

Health and safety representative (HSR) participation and Union engagement over the last period has been good. There has been union and HSR involvement in the "COVID Exposure in the Workplace Group" where they have proved to be valuable members. Other DHBs are now looking closely at this work.

The following was covered during discussion:

Bernie O'Donnell asked in terms of the Whānau workforce and nursing shortage what the current situation was and if it was still a major concern. Advice was given that it was still a challenge. In the nursing workforce there was a significant shortage, there were nurses leaving, it was an older workforce and there was a dropout rate for new graduates throughout the course of training. Sarah McLeod commented that there were initiatives underway to ease the situation and to retain people. Margaret Dotchin, Chief Nursing Officer has been leading a significant piece of national work relating to the national nursing pipeline looking at how to attract people into nursing and through a career progression. That has been well received and it is expected that value will be seen from this over time.

From an Auckland DHB perspective a range of initiatives are being looked at to have in place more efficient recruitment processes to not only attract people but getting them into the workforce as soon as possible. There are a large number of recruitment campaigns underway to source talent.

Ailsa Claire commented that even before COVID there were concerns about the nursing pipeline not just within the DHBs but also in places such as aged residential care. The situation was made worse by the borders closing but with the borders re-opening that is not guaranteed to resolve the situation. The work being undertaken by Margaret Dotchin looks at everything from recruitment to the nature of the training being offered the dropout from different training packages, right the way through to how people are retained and supported. There is a specific programme around Māori and Pacific nurses within this piece of work. The inability to have nursing capacity in place going forward is a major issue for the DHB. Omicron has made the situation worse as there was already an underlying vacancy factor.

With all the recruitment underway everything possible is being done but it won't provide an immediate fix of the problem.

Ailsa Claire commented that it would be worth having Margaret Dotchin attend the next Board meeting to describe what the DHB has done. Auckland DHB is leading this space nationally. Some of the programmes instituted in the hospital have been very good. Margaret is also working closely with aged residential care as in some ways their situation is even more challenging, particularly with the pay differential between nurses in aged residential care and those within the hospitals. It is hoped that pay equity will encourage people to stay in New Zealand rather than go to Australia and encourage them to see it as a rewarding profession.

Michael Quirke made a suggestion that to manage those contractors that had yet to sign up to Tōtika the Board escalated to each contractors chairperson or board outlining their responsibility in terms of the Health and Safety Act and pointing out that they would be remiss in some of their core responsibilities in not signing up.

Mark Edwards acknowledged that was a helpful suggestion. What was important was gaining an understanding of who was on that list, what they did and what risk was posed. A risk assessment would now be undertaken from a health and safety, relationship and service provided point of view. They will then be contacted directly.

Michael Quirke asked whether it was known what was driving the aggressive behaviour increasingly being seen in the satellite dialysis units and whether this was an unexpected trend. Mark Edwards advised that it could be attributed to life in general being more difficult for people, there are people in their families who are sick, there are now more restrictions on what they can do while they are in the dialysis unit and therefore some irritation and frustration are coming to the fore.

Doug Armstrong commented that he hoped that Health NZ and the new Māori Health Authority took up the issue around workforce qualifications and registration and looked closely at the training role that DHBs played in obtaining the workforce that they required. The requirements are more restrictive than overseas counties and he felt this was driven by tertiary education providers rather than the health sector itself.

Zoe Brownlie was advised that it was unlikely that the National Fatigue Minimisation Team survey results would be available prior to 1 July. The working group terms of reference are in

progress and the Board would be updated at the next meeting.

Michael Quirke commented the lone worker risk had also increased referring to the uptake of the Get Home Safe App wanting to know why instances had increased when actually less work was being done. Was this app working as intended, was it the right solution if the uptake was not there? Mark Edwards advised that one of the findings of the ACOS review was that the uptake in that particular service had been relatively low over the COVID pandemic. The app was to be in place for three months before a formal review of the risk would be undertaken noting that use had not been formally mandated when it was originally introduced. A stakeholder process had to be undertaken before mandated use could be enforced.

Action

1. **That Margaret Dotchin present a deep dive into the nursing shortage to the May Board meeting**
2. **Sarah McLeod to provide, via email, the current nursing turnover rate.**

Resolution:

That the Board receives the Health and Safety Report for April 2022

Carried

6. PERFORMANCE REPORTS

6.1 Financial Performance Report *(Pages 68-71)*

Auxilia Nyangoni, Acting Chief Financial Officer asked that the report be taken as read, highlighting key variances within the Financial Summary Table:

For the month of February, there was a surplus of $8.2M against a planned deficit of $451k; therefore the month of February was favourable by $7.8M. The variance is realised in the Funder ($5.8M favourable) and provider ($1.8m favourable).

The favourable Funder variance derives from demand-driven services like Pharmaceuticals, PHOs (including quarterly wash ups), aged residential care and various other initiatives which have been delayed. The favourable Provider arm variance reflects a $1.7M COVID impact.

The $7.7M favourable position for the month further improves the year to date (YTD) favourable position from $49M realised in January to $53.8M. $20.6M of the YTD favourable position is attributed to the Funder Arm and is mainly due the same demand-driven areas noted for the month).

$31.7M of the favourable YTD position relates to the Provider Arm, with $9.9M attributed to COVID (mainly contribution from Labs) and $21M to business as usual (BAU) operations, mainly driven by vacancies. BAU FTEs were 407 favourable for the month of February (equating to about $24.5M). We are also favourable in BAU clinical supplies because we have

not been able to deliver the planned volumes. For the period to February, we delivered 95% of volumes against the base contract; that equates to about $57.6M of volume under delivery. $28.5m of the volumes under delivered are for IDFs and Planned Care which are washed-up. We have provided for this adverse wash-up. If the wash-up does not occur, that will be an upside to our result.

Forecast position is a $43M deficit against the approved budget deficit of $73M.

Auxilia Nyangoni noted that as part of the March month-end process and in preparation for year end, balance sheet reconciliation and accruals will be reviewed and the year end forecast updated. The updated forecast will be provided at the next FRAC meeting.

Auxilia Nyangoni advised that Auckland DHB is one of the DHBs with a strong balance sheet with equity of over $750M million, and a good cash balance of about $220M as can be seen in the Cash Flow statement.

Auxilia Nyangoni advised that in relation to the capital budgeting process, based on instructions from the Interim Health NZ, DHBs have been advised to prioritise their capital expenditure (Capex) requirements and submit these. There is no intention to reprioritise baseline Capex nationally which means that Auckland DHB can complete its Capital Plan on the basis of the current and expected cash position.

Deputy Chair Tama Davis commented that the Board's current financial position and the strong cash flow position the DHB is would assist when stepping forward and preparing for the transition.

There were no questions.

Resolution:

That the Board Receives the Financial Report for the period ended 28 February 2022

Carried

[Secretarial Note: Item 7.2 was considered next.]

7. COMMITTEE REPORTS

7.1 Hospital Advisory Committee Executive Report (*Pages 72-83)*

Dr Mike Shepherd, Director Provider Services as that the report be taken as read, advising as follows:

Omicron Response

The response has been an incredible team effort across the organisation requiring and hour to hour, 24/7 operational function to be in place to manage delivery. There have been staff working in enhanced roles as daily response function leads. In particular, Margaret Dotchin, Emma Maddren, Sam Titchener, Duncan Bliss and Alex Pimm who have done an incredible job in managing capacity challenges. There was at least 1000 staff who had been diagnosed

COVID positive in the last month which doesn't include those other staff who had to take leave to look after whānau who have had COVID or through other commitments. Unlike other lockdowns this time we have seen an increase in acute levels, a return to normal level if not more, making it a very challenging operational time.

Omicron Planning Work Streams

It has been important to capture positive learning and any improvement opportunities from this last period of which there have been many. Work continues to use this information to plan the winter response.

Māori Health Response

Attention was drawn to page 75 of the agenda and the update on the Māori health response which has been a focus of the Provider Arm.

Directorate Updates

Attention was drawn to pages 76-81 where key business initiatives had been highlighted.

It was noted that tribute should be paid to the teams as they had continued to progress tis work through the Omicron surge.

Planned Care

Attention was drawn to pages 81-83.

Page 81 addresses the prioritisation process used around planned care and would answer the questions asked by Jo Agnew around the focus given to Māori and Pacific patients, the long wait patient, P1s and P2s and to Doug Armstrong's interest around the overall planned care position.

For historical context the DHB was probably at its best position in July 2021 as at that point there was around 2-3% non-compliance in ESPI2 and around 10-15% non-compliance in ESPI5. There were around 300 patients in the over 250 day period whereas now we have over 1100.

There were no questions and the Deputy Board Chair thanked Provider Arm staff for the effort taken in the preparation of a concise overview of the current situation.

Resolution:

That the Board receives the Hospital Advisory Committee report for April 2022.

Carried

[Secretarial Note: Item 8.1 was considered next.]

7.2 Community and Public Health Advisory Committee Executive Report (*Pages 84-95)*

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

Debbie Holdsworth advised that the team still remained heavily involved in the COVID response and wished to acknowledge the on-going contribution of Primary Care, Pharmacy and Māori and Pacific provider's right from vaccination through to testing and more recently COVID care in the community under the Whānau HQ banner.

There have been challenges in the workforce in the Aged Residential Care sector with whom the Funding team had been working in close partnership. Pride can be felt at the efforts these staff have made. Across the metro Auckland 72% of the facilities have had outbreaks to manage. That is a total of 189 exposure events across the district and around 1800 positive residents. The mental health NGO providers have not had quite the same impact and are coping well. It all indicates that the sectors have been well prepared with good processes in place.

The team are trying hard to continue BAU activity despite COVID 19. This covers childhood immunisation, there has been an expanded outreach, the regulatory changes required to increase the scope of pharmacy vaccinators and the COVID 19 vaccination workforce has started. The Flu vaccination campaign started at the beginning of the month and PHARMAC have agreed to expand the eligibility to Māori and Pacific dropping the age range down to 55 from 65 for the rest of the population.

Karen Bartholomew spoke to the Māori health pipeline work advising that work had begun on lung cancer screening. The Te Oranga Pūkahukahu Lung Cancer Screening Research Programme is going well. There have been 30 scans completed. The Lung Cancer Multidisciplinary Meeting (MDM) reported back to the team last week that they had seen the first ever 'screen detected' lung cancer come through the MDM, and how important a milestone they felt this was for the country. There are now another seven general practices that have agreed to participate which is very welcome news. Work is being done with Counties Manukau and Northland DHBs to expand the programme in October.

HPV Self-Testing is also progressing well with a third clinic on board and test numbers are just above 200 with work being done on a telehealth expansion programme.

A second Abdominal Aortic Aneurysm and Atrial Fibrillation (AAA/AF) screener has been brought on board. This allows expansion to Northland DHB aiming for June, depending on the COVID impacts there.

The Hepatitis C programme is also one third through to completion as noted on page 95 of the agenda. This programme has been prioritised despite COVID as it is critical to get these people treatment at the right time. A service user evaluation for Māori patients who have been treated for Hepatitis C has also been completed. Findings can be used to enhance the development of further Hepatitis C treatment services, based on Māori experiences of treatment and self-identified solutions for improvement in hepatitis C care.

The following was covered during discussion:

Peter Davis referred to the low cervical screening rates for Māori and asked how much of that related to a failure of the system to get them enrolled or was it due to the fact that they are just not receiving service. Karen Bartholomew advised that the drop occurred before COVID but COVID has had a substantial impact on coverage. It is not necessarily about

primary care enrolment, as those enrolled also have low coverage however, one of the projects running under the HPV programme will look specifically at Māori women who are not enrolled in primary care. The issue will be able to be quantified once that project is completed.

Peter Davis was puzzled that someone could not be enrolled in the system. Usually these are the most disadvantaged. Karen advised that this was PHO enrolment and cervical screening is a primary care-based programme on the whole although there are some outreach services through support service providers and through family planning alternative options. Karen agreed that if there was not good primary care access then accessing services like cervical screening becomes problematic and that is why the project is being undertaken so specific services offered to that group of people.

Peter Davis asked whether under Health NZ there would be more comprehensive enrolment platform so that if people do not actually make the effort to enrol, they are known about and can be reached out to. Karen advised that this would be one of the benefits of the new NCSP programme change to come in 2023. With primary HPV screening a population register will be introduced so it won't matter if people are not enrolled.

Ruth Bijl advised that with childhood immunisation there had been an excellent register for many years and yet as you can see from the data there are a considerable number of young children who are not immunised. There is also a very good committed outreach immunisation service. In spite of this, efforts made and health promotion initiatives it takes more than just having a service to engage people for it to be effective.

Debbie Holdsworth advised that COVID had demonstrated the acceptability of multiple access points, pharmacies being one of them and expanding the scope of pharmacists to vaccinate children will be very important.

Michael Quirke referred to the Pacific Navigator programme asking whether the DHB is employing more into the programme and expanding the scope or is it more that redeployment is occurring to open up the service in this current environment. Debbie Holdsworth advised that in the context of the report what was referred to was contracting with providers. There are DHB navigators in the Hospital then there are Pacific navigators in the community. The service is being grown.

Michael Quirke was advised that Aged Residential Care was at the forefront of the outbreaks in August 2022. This did not impact Auckland DHB to the same extent that Waitematā DHB was affected. There were four significant outbreaks, the first in a dementia unit which was challenging. The Funder has now had quite some practise managing these and it has allowed networks to be set up with providers with regular meetings. As the public health settings have changed it has enabled the way things are managed to be streamlined. A good triage system exists which allows risk assessment of the nature of the outbreak and the type of facility involved. If the provider is well managed and the outbreak is considered low risk, they may self-manage just touching base with the DHB. If it is high risk then the DHB will be actively involved. The team has good established processes under the very good leadership of Kate Sladden. The fact that these events are not news worthy reflects the good relationships with the sector and how well prepared the sector itself has been along with

92% of residents being boosted.

Doug Armstrong drew attention to section 4.5 of the report on contraception and particularly Long-Acting Reversible Contraception (LARC) asking whether lower socio-economic groups are able to readily and freely access LARC. Ruth Bijl responded that every effort was made to make the service readily available. COVID had made it more difficult to access services during lockdowns. Family Planning was a significant provider of these services and one of the challenges is that there was quite a long waiting list at Family Planning Clinics for the service. It would be good to see more resource within Family Planning as it is a well known and respected service within the community.

Bernie O'Donnell commented that he found the framing of the question problematic particularly when it centred on birth control and a targeted audience. He did not wish non-Māori or non-Pasifika telling Māori and Pasifika what they should be doing.

The Deputy Board Chair, Tama Davis acknowledged Bernie O'Donnell's point and re-centred the conversation so that it was to do with understanding the level of access to a service. From a practical perspective the service is not well known in the community. The conversation should be about getting greater resource through existing networks.

Jo Agnew drew attention to 7.2 and the criteria required for people using the Abdominal Aortic Aneurysm and Atrial Fibrillation (AAA/AF) Screening service. Karen Bartholomew advised that it was still research and not yet a service. Several independent projects had been engaged in, one with all Māori in Auckland and Waitematā DHBs , another with Pacific men and one is to start with Pacific women. It is to be extended as a project in Northland DHB and will be run differently as community by community it will be decided what is best for that community. It could be via Primary Care or through Marae or community venues. A rural pathway will be different than what occurred in metro Auckland. This work will feed into the design of a potential national programme.

Fiona Lai asked whether there was any report on Asian Health with Debbie Holdsworth advising that there had been a lot of input by that team into the COVID response with some activity occurring in the recent migrant space.

Resolution:

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

Carried

8. DECISION REPORTS

8.1 Director Appointment to the HealthSource New Zealand Limited Board *(Pages 96-98)*

Ailsa Claire, Chief Executive advised that this was a technical requirement as Justine White had left the organisation management were asking that Auxilia Nyangoni as the Acting Chief Financial Officer be appointed as the Auckland DHB representative on the HealthSource NZ

Board.

Resolution: Moved Doug Armstrong / Seconded Michael Quirke

That the Board

1. **Note the requirement to appoint a new shareholder director to HealthSource New Zealand Limited, in place of Justine White.**
2. **Resolve Auxilia Nyangoni (ADHB Acting CFO) is appointed as the Auckland DHB shareholder director of HealthSource New Zealand Limited and the company be notified accordingly.**
3. **Delegate authority to the Auckland DHB Chair to execute all documentation necessary to formalise this appointment**

Carried

9. INFORMATION REPORTS - NIL

10. GENERAL BUSINESS

The Deputy Board Chair, Tama Davis made a comment that as individual board members and as part of a collective Board, there is a journey that has been agreed the Board make in support of ti tiriti in action and equity. There will be robust discussion around how this is approached and there will always be some tensions for us as board members to test one another in these spaces. This needs to be done with charity and in some cases being clear around positions is one way of supporting overall collective growth and the decision making required to support the executive to enact board decisions. While the board may have difficult conversations we should always approach those being mindful and with an understanding that we are all heading on one direction.

11. RESOLUTION TO EXCLUDE THE PUBLIC *(Pages 99-101)*

Resolution: Moved Tama Davis / Seconded Jo Agnew

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
2.0 Conflicts of Interest	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]
3.0 Confirmation of Confidential Minutes of the Board – 23 February 2022	**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 Circulated Resolution – Auckland District Health Board – Facilities Infrastructure Remediation Programme Variance Request to CIC – 17 March 2022	**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 Circulated Resolution – NRHCC Whānau HQ Budget Addendum for Metro DHB Board Approval – 30 March 2022	**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]
4.0 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 [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act

	could be used for improper gain or advantage if it is made public at this time	1982 [NZPH&D Act 2000]
6.1 Chief Executives Confidential 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)]	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 [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]
8.1 Finance, Risk & Assurance Committee l 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 Executive 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 Capex Variation Whānau Room Rejuvenation Project and Starship L5 Refurbishment	**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	
10.0 Discussion Reports- Nil	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11.0 Information Reports - Nil	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
12.0 General Business	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

The meeting closed at 2.30pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 06 April 2022

Chair: _____ Date: _____

Pat Snedden

Action Points from 6 April 2022 Open Board Meeting

As at Wednesday, 18 May 2022

Meeting and Item	Detail of Action	Designated to	Action by
Item 5.1 6 April 2022	**Board Appreciation** That the Board express their appreciation to all staff who volunteered and provided support and coverage during the height of the Omicron outbreak.	Ailsa Claire Via staff webinar	Complete
Item 5.2 6 April 2022	**Nursing Shortage – Deep Dive** That Margaret Dotchin present a deep dive into the Whanau workforce and nursing shortage to the May Board meeting.	Margaret Dotchin	18 May 2022
Item 5.2 6 April 2022	**Nursing Turnover Rate** Provide, via email, the current nursing turnover rate.	Sarah McLeod	18 May 2022
Item 10.2 23 February 2022	**Waitangi Tribunal report on COVID** That a future Hospital Advisory report contain information about the Waitangi Tribunal report on COVID and how the DHB planned to engage with and respond to the recommendations within that report.	Mike Shepherd/ Anthony Hawke	18 May 2022

Item 10.2 23 February 2022	**Waitangi Tribunal report on COVID** That the next Hospital Advisory report contain information about the Waitangi Tribunal report on COVID and how the DHB planned to engage with and respond to the recommendations within that report.	Mike Shepherd/ Anthony Hawke	18 May 2022

This item reflects how the Provider Arm has responded to these Waitangi Tribunal report recommendations.
The Committee should please note that many of the recommendations in fact apply to the wider community provision of COVID response which has been led by the NRHCC and is not part of the Provider Arm monitored by the Hospital Advisory Committee.

Waitangi Tribunal Report Recommendations	Alignment to Māori Strategic Approach & Te Tiriti o Waitangi Position Statement	Alignment to ADHB's Covid Response
Further funding, resourcing, data, and other support to Māori service providers and communities to support their pandemic response We recommend that further funding, resourcing, data, and other support should be urgently provided to assist Maaori service providers and communities with: • the continuing, urgent vaccination effort – including for the paediatric vaccine and booster vaccine – especially in rural areas and in communities living in areas with lower socio-economic decile ratings. • targeted support for whaanau hauaa and taangata whaikaha. • testing and contact tracing. • caring for Maaori with COVID-19. • self-isolation and managed isolation programmes.	*Kāwanatanga* • **Advance Māori-Crown partnerships:** We will actively look for opportunities for Māori health development to be increasingly led by Iwi and hapu, including transferring resources and sharing design, decision-making, monitoring and evaluation of services for Māori • **Develop Māori health sector capability and capacity:** We will spread, strengthen, sustain and support high-quality Māori health and disability sector and provider development through funding, partnerships, collaborations, communication and sharing of resources	Āwhinatia te Tangata project which seeks proactive contact with Māori patients and whānau has shown a reduction in DNA at this early stage. We hope this will be confirmed as we analyse on-going data which suggests a profound shift in access for whānau to treatment and care. This project is in partnership with Ngāti Whātua Ōrākei Marae, and the whānau support aspect of the project in the community. Successful development of mana whenua led vaccination site has occurred
Collection of and reporting on data relating to ethnicity and on people with disabilities	*Kāwanatanga* • **Insights and evidence:** We will advance the Māori health and	• All covid response data being recorded by

We recommend: • the Crown prioritise the work to improve the quality of quantitative and qualitative data on taangata whaikaha and whaanau hauaa in partnership with Maaori disability care providers and community groups. This data and information should be made public and be easily understandable and accessible, subject to relevant legislation.	disability evidence base that contributes to improved Māori health and wellbeing, by ensuring we collect and report accurate Māori ethnicity data for all of our services & programmes *Tino Rangatiratanga* • **Insights and evidence:** We will share Māori-specific data on performance, service utilisation, investment, workforce and other relevant areas as determined by our Tiriti partner, which will contribute to Māori analytical capability and contribution	ethnicity through the power BI dashboards (i.e. HITH dashboard, covid diagnosis by ethnicity dashboard)
Monitor the pandemic response to ensure accountability to Māori We recommend: • the Crown strengthen its monitoring regime to enable it to identify, in as close to real time as possible, whether or not its policy settings in relation to Maaori are working as expected, so as to enable the Crown to change those settings to achieve the desired and intended results, and remain accountable to its Treaty partner. • the Crown partner with Maaori to determine what elements of the pandemic response should be monitored and how that monitoring should be reported.	*Kāwanatanga* • **Advance Māori-Crown partnerships:** We will actively look for opportunities for Māori health development to be increasingly led by Iwi and hapu, including transferring resources and sharing design, decision-making, monitoring and evaluation of services for Māori • **Increase Māori leadership:** We will actively support professional development of Māori leaders and emerging leaders within all Departments of the DHB and within Iwi *Oritetanga* • **Monitoring and responding to persistent inequities**: Achieve equitable outcomes for Māori by measuring and reporting service utilisation (or lack of utilisation) specifically for Māori as tangata whenua, and developing specific strategies and innovations to address persistent inequities (e.g. re-designing service models or resourcing tangata whenua to help address inequities)	• Māori leads sitting in partnership on each of the COVID/winter planning work streams • Upskilling and diversifying kaimahi Maori taking leadership roles to increase overall Maori leadership within the organisation. • Establishment of oranga coordinator response – unified service of care across the region
Ensure the paediatric vaccine and booster vaccine rollout is equitable We recommend: • the Crown partner with Maaori to design and implement an equitable paediatric and booster vaccine sequencing framework for Maaori, incorporating the expert advice offered in this inquiry	*Oritetanga* • Ending unjust and unfair Māori health inequities by resourcing actions that achieve tangible health outcomes for whānau Māori • **Responding to Institutional Racism and Bias:** Re-organising our systems and practices to address institutional barriers and racism within the organisation (e.g. eligibility and assessment criteria, care planning, discharges, whānau and community engagement, communication methods	From an equity perspective • As part of planned care recovery we have been prioritising Māori patients • We have been planning regional recovery efforts by prioritising Maori
Empower Māori to coordinate the Māori	*Tino Rangatiratanga*	• Establishment of He Ara Whiria response with

pandemic response we recommend that future engagement between Maaori and the Crown, with the national collective proposed by the claimants and with other Maaori groups, should reflect the following principles: • it must give effect to tino rangatiratanga in its constitution and decision-making processes; • it must be broadly representative of Maaori iwi, providers, and other national groups including but not limited to all of the interested parties who participated in this priority inquiry; • similarly, it must have access to a broad range of expertise, including from Maaori health, whaanau ora, and disability service providers; • it must meet regularly; • Maaori must influence the agenda; • key Ministers should be actively engaged • key Crown officials should be actively engaged • any pending Cabinet papers that materially impact on the Maaori pandemic response should be tabled, and discussed.	• **Supporting Māori in the Māori-Crown partnership:** Negotiating and transferring necessary resources to Māori to partner successfully with us as Kāwanatanga • **Developing Māori health sector capability and capacity:** Investing in Māori health and disability sector and provider development as determined by Māori. This will include strengthening the professional, clinical and community capability of Māori workforce and health leaders within Iwi / Māori (as well as within the DHB) • **Respecting the societal structures of Māori:** We acknowledge that Māori society is made up of many forms and structures in the community — who operate nationally, regionally, locally, at a hapū / Marae level, in urban and rural communities and at a whānau level. We will respect this diversity and work with those who share the commitment to improving Māori health and wellbeing	Maori Health leads • Increased influence of kaiārahi nāhi in planned care and scheduling • HiTH partnership with MRCH • Āwhinatia te Tangata project as noted above

Chief Executive's Report

Recommendation

That the Chief Executives report for 21 March 2022 – 1 May 2022 be received.

Prepared by: Ailsa Claire (Chief Executive)

1. Introduction

This report covers the period from 21 March 2022 – 1 May 2022.

2. Events and news

2.1 Omicron and winter readiness

As Omicron transmission continues within our community and the winter season approaches, we are preparing our teams and hospitals for the challenges that this will bring. In addition to COVID-19, we expect to see a range of other viruses within the hospital setting including influenza and RSV which, as has been well documented, we're likely to see more of this year with the borders reopening.

During this time, we are expecting to have an increased workload and we are anticipating our available workforce will again be impacted due to illness and isolating.

A steering group has been set up to ensure we are as well prepared as possible for what winter might bring. There are six streams of work managed by the group to help us navigate these challenges – these include focusing on recruitment drives, role development opportunities and the continuation of task teams which were implemented during the COVID-19 Omicron surge. Our daily operations team will also continue to distribute workload and workers to the right places so we continue to deliver the best possible care for our patients.

2.2 Flu vaccination focus

One of our current staff focuses is our flu vaccination campaign to help protect our kaimahi and, ultimately, our community. We have multiple onsite clinics and roaming vaccinators for staff to get vaccinated.

2.3 Transition to Health New Zealand and the Māori Health Authority

The Executive Leadership Team members, along with other senior health leaders, were this month briefed on the new operating model and the tier two structures of Health New Zealand and the Māori Health Authority.

Understandably, there is a lot of interest from our people as to what these changes will mean for them. Packs of information are being made available for us to take teams through the changes, noting that we are in the early phases of this change so there is still work ahead to agree how we deliver services that are “nationally planned, regionally delivered and locally tailored”.

A number of DHB chief executives will stay in post until 30 September to help support the transition into the new structures.

2.4 Tū Pono Āroha – patient administration system

Last year we procured our new patient administration system which will help us transform our patient administration services. The project aims to improve the equity of access to health services and improve the experience for patients, their whānau and our staff.

The pace is picking up now to deliver the new system by March 2024 and we now have some great people on board to help deliver the programme.

We've now been gifted the name **Tū Pono Āroha** - *Loyal to all services with compassion* - by Dame Naida Glavish. This name really reflects what we want to achieve from this transformative change.

2.5 Starship Foundation Fellowship project highlighted

The Starship Foundation's latest impact story (case study) features Dr Zoe Vetten, a Starship Foundation Fellowship recipient researching a cardiac condition called Tetralogy of Fallot.

The McFadden family have shared their story of daughter Eloise (Ellie) born with the condition. Around fifteen children from across New Zealand are diagnosed with Tetralogy of Fallot every year. You can watch the video story here.

Dr Vetten's research project analyses ten years' of in-utero scans to examine early markers for Tetralogy of Fallot. She hopes it will help Starship identify which children will need urgent surgery, and those who can safely wait a few months. This will hopefully reduce emergency admissions like Ellie's and give families more certainty about their likely treatment pathway.

3. Communication and Engagement

3. 1 External Communication

Between 21 March 2022 and 1 May 2022, we received 80 requests for information, interviews or access from media organisations. Requests focused on the impact of COVID-19 on our hospital services, birthing with COVID-19 and planned care.

Around 20 per cent of the enquiries over this period sought the status of patients admitted following incidents such as road traffic incidents and water incidents.

We responded to 30 Official Information Act requests over this period.

3. 2 Internal Communication

Communications has continued at pace to ensure we keep our people informed of key developments, in particular in relation to the Omicron surge and winter planning:

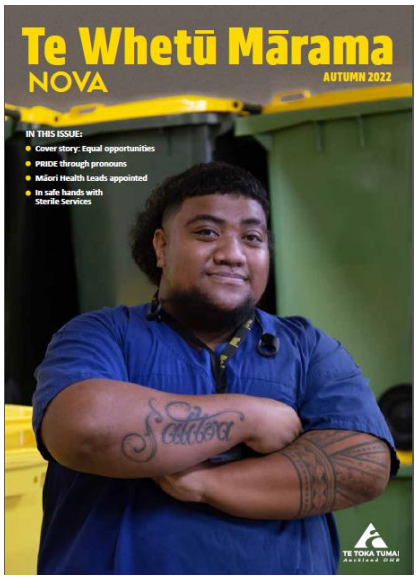
- **Six** editions of Pito Pito Kōrero | Our News, the weekly email newsletter for all employees, were distributed.
- **Six** editions of the Manager Briefing were published for all people managers.
- **Five** COVID-19 update emails were sent out to all employees.
- **Five** Winter Planning update emails were sent out to all employees.
- **One** all staff webinar was broadcast.

For this period, 653 emails were received. Of these emails, 81 were non-communications-related and where appropriate, were referred to other departments and services at Auckland DHB.

Te Whetū Mārama | NOVA Autumn Edition 2022

We released our Autumn edition of the staff magazine - Te Whetū Mārama | NOVA.

This issue is available online and in print and includes a number of stories about teams across the organisation including a focus on our new Māori Health Leads.



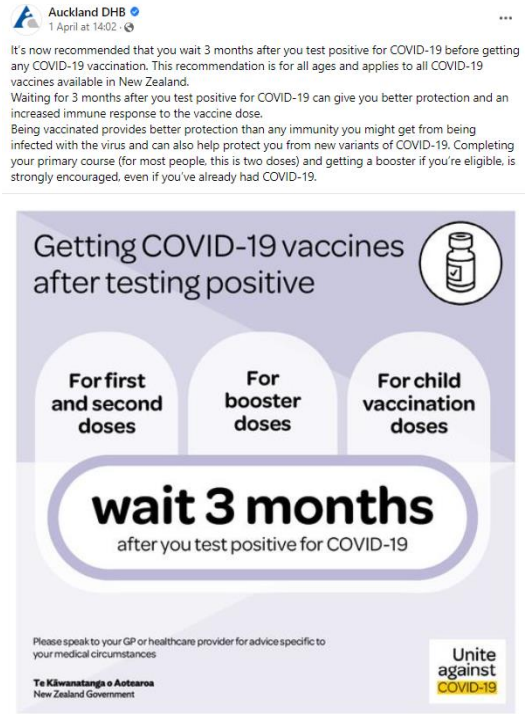
3.3 Social Media

We continue to engage with our community on social media, celebrating achievements and sharing important health messages.

Some of the information we have shared includes:

- Planned care
- Neurodiversity Celebration Week
- Right care for you
- Ramadan
- Influenza
- Volunteering Auckland Award
- Holiday messaging
- Cornwall Park Hospital
- Earth Day
- Anzac Day

Top performing social media posts



4. Our People

4.1 New Senior Leaders appointed

Māori Health Lead for Patient Management Services

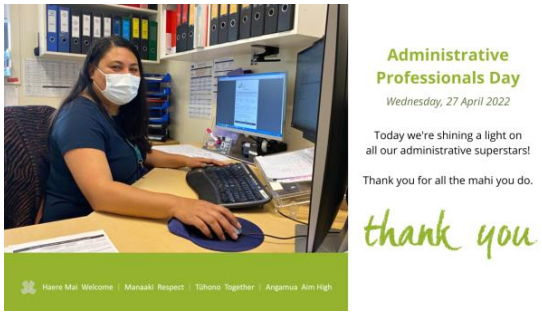
Congratulations to Tui Blair of Ngāti Whātua for being appointed as the Māori Health Lead for Patient Management Services.

Tui joined the organisation in August last year as Mana Whanua Site Lead for our community vaccination sites and went on to support a comprehensive outreach vaccination programme across Tāmaki Makaurau and Te Tai Tokerau. Prior to this, Tui worked as a case manager at MSD leading teams supporting people across the community.

4.2 Celebrating our people and services

We celebrated International Sterile Sciences Day on 15 April using the theme “Heart of the Hospital” to demonstrate how essential it is to have clean and sterile instruments for every procedure. The Sterile Sciences Services team does an outstanding job processing around 5 million surgical instruments every year so we can provide the safest surgical care for our patients in a timely manner.

And on 27 April, we celebrated Administrative Professionals Day with our administrative super stars. Often in the role of behind the scenes heroes, they play a critical part in making sure things run smoothly right across Te Toka Tumai.



5. Priority Health Outcomes Summary

National Health Targets Performance Summary – March 2022

	Status	Comment
Acute patient flow (ED 6 hr)		Mar 80%, Target 95%
Improved access to elective surgery (YTD)		R/U , Target 100%
Faster cancer treatment		Mar 92%, Target 90%
Better help for smokers to quit: • Hospital patients • PHO enrolled patients • Pregnant women registered with DHB-employed midwife or lead maternity	 	Mar 91%, Target 95% R/U, Target 90% Dec Qtr 100%, Target 90%
Raising healthy kids		Dec Qtr 95%, Target 95%
Increased immunisation 8 months		Mar Qtr 87%, Target 95%

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

R/U: Result Unavailable

6. Financial Performance

The 2021/22 Annual Plan approved by the Board in August 2021 included a budget deficit of $73M comprising $40M for an increase in the liability for non-compliance with the Holidays Act and $33M for Business as Usual (BAU) operations.

The financial result for the nine months ended 31 March 2022 is a deficit of $11.0M against a budgeted deficit of $50.9M, thus favourable to budget by $40.0M. The favourable position to budget was realised in the Funder arm ($27.0M favourable), the Provider Arm ($11.3M favourable) and the Governance arm ($1.7M favourable). The favourable position is attributed to Business as Usual (BAU) operations ($45.7M favourable), mainly due to reduced Funder demand driven expenditure (pharmaceuticals, aged residential care, carer support, labs), prior year adjustments, lower clinical supplies expenditure due to reduced throughput, and additional revenue realised.

The net Covid-19 impact is an unfavourable position of $5.7M for the year to date reflecting unfunded Covid-19 impacts, mainly wash-up provisions for under delivery of Planned Care and IDF volumes during the delta and omicron surges. Overall, Covid-19 funding realised for the period was $206M, this covered vaccinations, community testing, Public Health Services, laboratory testing, quarantine, border control and other Covid-19 response costs. However, Covid-19 related costs in the same period were $211.7M, hence the $5.7M unfavourable impact year to date.

7. Auckland DHB at a glance

Patient Experience

3,220 patients completed our patient experience survey between 21 March - 1 May 2022

88.5% rated their experience very good or excellent

The **top three** things making a difference to their care

- Communication
- Care and compassion
- Safety and high quality care

Patients

In March & April 2022 across Auckland DHB:

122,972 outpatient appointments took place

11,228 presentations to the Adult and Children's Emergency Departments

4,800 surgeries discharged

The mean occupancy for the Adult hospital at 12am was **650**

Communications

from 21 March - 1 May 2022

80 media requests

30 Official Information requests

653 emails to the generic communications inbox

193,886 page views on the Auckland DHB website

815,910 people reached on Facebook

Health and Safety Report

Recommendation

That the Board receives the Health and Safety Report for May 2022.

Prepared by: Alistair Forde (Director Occupational Health and Safety)
Endorsed by: Mark Edwards (Chief Quality, Safety, and Risk Officer)

Glossary

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)
PCBU	Person Conducting a Business or Undertaking
PES	Pre-employment Health Screening
SI	Safety Intervention (previously MAPA)
SMS	Safety Management System
SPEC	Safe Practice Effective Communication (SPEC)
SPIC	Safe Practice in the Community
WPV	Workplace Violence and Aggression
YTD	Year to date
A/A	As Above

Board Strategic Alignment

Te Tiriti o Waitangi in action	*Occupational health, safety and wellbeing has a close alignment with the Kia Ora tō Wāhi Mahi vision through the development of safety culture and leadership, empowering and developing our leaders to help us flourish and grow by supporting our leaders' capability to nurture their own wellbeing and the wellbeing of their team and keep their people safe, and improving connections and collaboration across the DHB.*
Eliminate inequity	*This report details how we are ensuring integrity associated with meeting ethical and legal obligations, and how we are working towards eliminating inequity and strengthening our cultural diversity.*
People, patients and whānau at the centre	*This report provides information on how the work we are doing that supports patient safety, workplace safety, visitor safety, worker health and wellbeing. Health, safety and wellbeing risks and programmes are inherently focused on staff, patients, visitors, students and contractors.*
Digital transformation	*This report provides information on the progress of work in progress to enhance our OH&S information management system and integrate data within the service and across QSR*

Resilient services	*This report provides information on the progress of work programmes and strategies to implement effective resourcing solutions that meet our organisations newfound need for Occupational Health and Safety, promote a culture for our people where we empower and promote good processes and reliable systems to enable delivery of resilient services, information and insight into workplace incidents and what Auckland DHB is doing to respond to these and other workplace risks.*

1. Executive Summary

The purpose of this report is to provide an update on the progress of Occupational Health and Safety risk related activities since March 2022.

There have been two changes in risk ratings to key health and safety risks for the reporting period. Fatigue Management risk, which was temporarily moved to critical based on the potential impact on staffing numbers through the Omicron surge and peak periods, has been reduced to high. The risk rating for Hazardous Substances has reduced to medium from high, based on effective controls around storage and handling. All other key risks ratings remain the same.

Five WorkSafe Notifiable Events occurred in this reporting period, primarily from WPV incidents involving patient assaults on staff. All incidents were reported to WorkSafe, who required no further information or action. We have increased our resourcing to support the Mental Health Services to help reduce this risk.

The Tōtika programme is progressing, however there is still a large number of contractors yet to complete their registration and assessment information requirements. This is being actively followed up.

We have revised our approach to Fatigue Management, rather than undertaking a deep dive at this stage, we will instead focus on establishing a Fitness for Work Steering Committee. The Steering Committee will guide development of a Fatigue management work plan mapping out how we will manage fatigue systematically across the organisation, including the development of systems to ensure that we have access to better data.

The Health, Safety and Wellbeing Governance Committee for 19 April was rescheduled to May due to the majority of participants needing to focus on delivery of core hospital services and has not taken place at the time of reporting.

2. Risk Analysis

2.1 WorkSafe Notifiable Events

There have been five WorkSafe Notifiable Events this reporting period, the majority of which relate to WPV involving staff assaults by patients.

We continue to observe escalated behaviours that are concerning and an increase in the number of notifiable events relating to WPV in high risk services. Due to the increasing number of assaults, Occupational Health and Safety are working closely with the relevant leadership teams and affected staff to reduce this risk as soon as possible. We are working this through specifically with the Mental Health Leadership team as well as the PSA, who have advocated for increased support to reduce the

risks in Mental Health Services, and we have additionally increased our resourcing around Mental Health Services.

Our initial findings from the incidents in Mental Health areas have noted inconsistent staff practices with respect to processes, general situational awareness around the risk of violence and the need to put further clinical and non-clinical controls in place to protect staff from serious harm. The key lessons learned from these incidents and investigations will be reported to the Health, Safety and Wellbeing Governance Committee and shared across the organisation where relevant.

2.2 Key Risks

Summary

Since the last report, the ratings for two of the risks have changed. One of the risks has had its rating reduced from Critical to High with the other risk rating reducing from High to Medium. There are currently six key risks rated as high with the remaining six risks rated either medium or low.

We have reduced the Hazardous Substances risk to medium. Fatigue Management, which temporarily moved to Critical based on the potential impact on staffing numbers through the Omicron surge and peak periods, has been moved back to High.

As noted above we continue to observe escalated behaviours that are concerning and an increase in the number of notifiable events relating to Workplace Violence and Aggression in high-risk services. To provide immediate controls for staff working in high risk areas, interventions such as the delivery of Safety Intervention and situational awareness training have been prioritised. We have also increased our resourcing around Mental Health due to the recent number of serious incidents.

We observed increased levels of WPV related to some dementia patients having to spend more time in the hospital due to constrained community resourcing. We are currently reviewing controls specific to managing these patients to reduce the potential risk associated with these types of involuntary incidents.

It is noted that while there has been a high response to the correspondence issued to contractors regarding final dates for compliance for the Tōtika programme, the number of completed assessments and registrations is lagging so that a significant number of identified contractor suppliers are yet to meet the registration and assessment requirement. We are working to assist contractors through the process. We will be putting in place a Contracts Steering Committee focusing on the governance aspects around contracts and contractor/supplier management. This will help improve our contract health and safety maturity and also the resilience in our overall approach to contractors and suppliers. In addition, a further 500 HealthSource suppliers have recently been identified and are still to be contacted and categorised.

There were nineteen reported moving and handling incidents in March. This is consistent with the reported two-year average of twenty-two reported incidents. The Moving and Handling Steering Committee held its first meeting since being reestablished in April, with the meeting focusing on the Terms of Reference and ensuring the group has the right membership to ensure that it can direct and focus its key priorities and programme of work across the most affected service areas.

Fatigue Management remains at high due to the effect of a constrained staffing situation being exacerbated by the potential burden of additional reduced staffing due to the effects of the persistent COVID impact across the community and the flow-on impact on our staff members and

their families. The Health and Safety team report that there is active management of this risk across Directorates, and our monitoring and observations indicate that controls are working, with services actively managing this risk well. The active redeployment and planned service management approach activated and deployed across the organisation also had a significant and positive impact on the management of this risk over the peak periods of the Omicron outbreak. We will be focusing on establishing a Fitness for Work Steering Committee that will guide development of a Fatigue management work plan that maps out how we will manage fatigue systematically across the organisation.

3. Key Initiatives and Activities

3.1 Digital Transformation

The upgrade to our current Occupational Health Patient Management System has been significantly delayed by non-signing of the Commercial agreement. Auckland DHB legal services are now involved and are working towards an appropriate resolution with the vendor. We anticipate this will be signed off by mid-May.

3.2 Occupational Health and Safety Work Plan

Activities related to progressing the Occupational Health and Safety Work Plan have stalled due to lack of resourcing and staff sickness. We will be looking to get this and other work plans back on track through a revamped resourcing plan which will include a OHS Systems manager.

3.3 Occupational Health

The Occupational Health Steering Committee remains focussed on service and process improvement opportunities and four key risks (Pre-Employment Health Screening, Capacity, Data, and Medtech). Risk assessments have been completed and activities to address each risk are being prioritised within an action plan for implementation.

The work relating to medical assessments of vulnerable workers is nearing conclusion and will be absorbed into BAU Occupational Health work.

4. Auckland DHB Health, Safety and Wellbeing Governance Committee

The Health, Safety and Wellbeing Governance committee meeting for 19 April was rescheduled to May due to the majority of participants remaining focussed on delivery of core hospital services and has not taken place at the time of reporting.

Key areas of discussions and focus on the agenda are:

- Directorate level health, safety and wellbeing performance
- HSR capability, training and development in collaboration with WorkSafe and NZSIM
- An Auckland DHB wide process to enable increased opportunities for worker involvement and representation
- An update on the Staff Staffing programmes of work
- The re-established Moving and Handling Committee and intended areas of focus
- HSW Governance Committee self-evaluation and review

Key areas of focus for our union partners continue to include:

- Expediting and progressing the formalisation of a bipartite working group to develop a Worker Participation Agreement

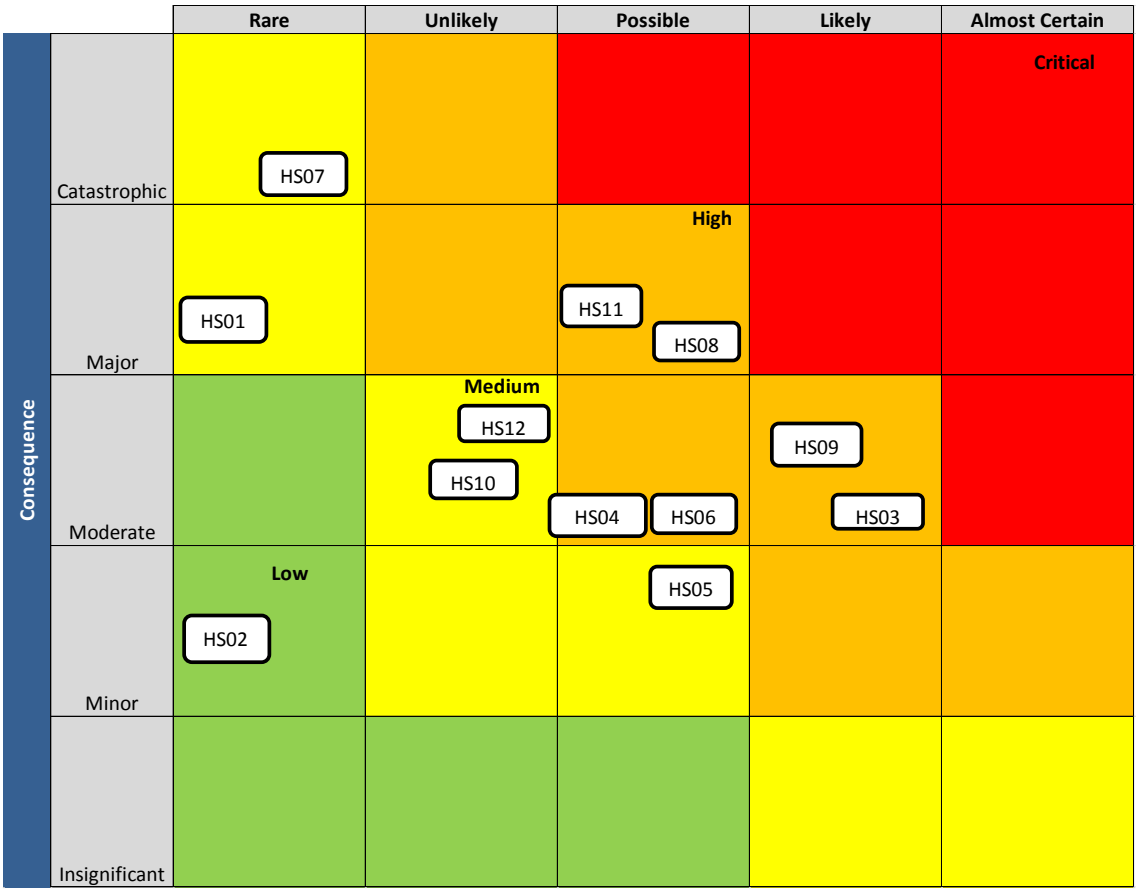
- Increasing opportunities for worker involvement and participation
- Staff safety and fatigue management
- Provision of support and leadership development opportunities for HSRs
- Moving and Handling and IPC training for ward supporters involved in redeployment efforts

5. Internal audits

Planning for the intended Health & Safety joint Audit by Regional Internal Audit and KPMG focused on staff wellbeing is currently on hold pending discussions around capacity for this to proceed, noting that the risk and issues related to wellbeing are well understood across the business.

Appendix 1

Risk Heat Map



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 (except Covid-19)

Appendix 2

Health and Safety and Environment Key Risk Audit Schedule

Key Risk	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
HS11 - Workplace Violence and Aggression	✓	✓	✓	✓	x	✓		✓									
HS 12- Biological Hazards	✓	✓	✓	✓	x	✓		✓									
HS08 - Contractor Management	✓	✓	✓		x	✓		✓									
HS04 -Lone Worker Protection		x		✓			✓										
HS 01 - Asbestos Management		x		✓			✓	✓									
HS 03 - Manual Tasks (including patient handing)		x		✓	x		✓										
HS 06 - Working at Heights			x		x			x									
HS07 - Hot Works			x		x			x									
HS09 - Fatigue Management			x	x	x	x		✓									
HS10 - Hazardous Substances				✓	x	x		✓									
HS05 - Vehicles and Driving				✓		x											
HS02 -Confined Spaces				✓		x											

Key: ✓ = completed x = not completed

Financial Performance Report for the period ended 31 March 2022

Recommendation

That the Board Receives the Financial Report for the period ended 31 March 2022

Prepared by: Angela Sinclair, Acting Deputy Chief Financial Officer
Endorsed by: Auxilia Nyangoni, Interim Chief Financial Officer
Date: 11 May 2022

1. Statement of Financial Performance for the period ending 31 March 2022

The net financial result for the month of March 2022 is a deficit of $22.3M which is $13.7M unfavourable against the budgeted deficit of $8.6M. For the year to date (YTD), a deficit of $11.0M was reported against a deficit budget of $50.9M, thus favourable to budget by $40.0M.

The full year forecast has been updated to a deficit of $43.5M, which is $29.5M favourable to the approved full year budget deficit of $73M. The forecast reflects the YTD Covid-19 unfavourable position of $5.7M plus an additional $12.2M unfavourable position for balance of the year; BAU favourable position YTD $45.7M with continuing smaller favourable variances to year end (mainly BAU FTE vacancies and on-going favourable Funder variances in Pharmaceuticals, Aged Residential Care, Lab services, Oral Health and PHOs).

The summary financial performance for the month and YTD are summarised in the Table below:

$000s	Month (Mar-2022)			Year to Date 2021-22			Full Year (2021-22)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Income									
Government and Crown Agency	176,887	161,155	15,732 F	1,613,242	1,450,437	162,804 F	2,110,755	1,935,832	174,923F
Non-Government and Crown Agency	10,030	8,436	1,593 F	74,916	76,170	1,255 U	128,296	101,508	26,788F
Inter- District Flows	57,873	66,133	8,260 U	572,093	595,196	23,103 U	754,652	793,595	38,943U
Inter-Provider and Internal Revenue	245	1,535	1,291 U	13,942	13,863	79 F	17,959	18,469	510U
Total Income	**245,034**	**237,259**	**7,774 F**	**2,274,192**	**2,135,667**	**138,525 F**	**3,011,662**	**2,849,404**	**162,258F**
Expenditure									
Personnel	124,355	109,771	14,583 U	1,028,159	973,710	54,449 U	1,383,860	1,307,404	76,456U
Outsourced Personnel	4,789	2,355	2,434 U	44,018	21,199	22,820 U	58,539	28,265	30,274U
Outsourced Clinical Services	4,921	3,783	1,137 U	33,757	34,284	527 F	46,465	45,652	813U
Outsourced Other Services	6,113	7,376	1,264 F	69,531	66,388	3,143 U	92,708	88,518	4,191U
Clinical Supplies	27,355	30,661	3,306 F	259,395	263,901	4,506 F	323,673	349,726	26,053F
Infrastructure & Non-Clinical Supplies	28,052	18,122	9,930 U	222,370	163,114	59,257 U	318,347	217,498	100,849U
Funder Payments - NGOs and IDF Outflows	71,760	73,778	2,018 F	627,943	664,005	36,062 F	831,570	885,340	53,770F
Total Expenditure	**267,344**	**245,847**	**21,497 U**	**2,285,174**	**2,186,601**	**98,573 U**	**3,055,162**	**2,922,404**	132,758U
Net Surplus / (Deficit)	**(22,311)**	**(8,588)**	**13,722 U**	**(10,982)**	**(50,934)**	**39,952 F**	**(43,500)**	**(73,000)**	**29,500 F**

Result by Division $000s	Month (Mar-2022)			Year to Date 2021-22			Full Year (2021-22)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funder	6,395	0	6,395 F	26,982	0	26,982 F	34,000	0	34,000 F
Provider	(28,928)	(8,588)	20,339 U	(39,601)	(50,925)	11,324 F	(78,830)	(73,000)	5,830 U
Governance	222	0	222 F	1,638	(9)	1,646 F	1,330	0	1,330 F
Net Surplus / (Deficit)	**(22,311)**	**(8,588)**	**13,722 U**	**(10,982)**	**(50,934)**	**39,952 F**	**(43,500)**	**(73,000)**	**29,500 F**
COVID-19 Net impact on bottom-line	(15,676)	(1)	**15,675 U**	(5,748)	(4)	**5,744 U**	(17,972)	0	**17,972 U**
Holidays Act Impact	(3,334)	(3,334)	**0 F**	(30,002)	(30,002)	**0 F**	(40,000)	(40,000)	**0 F**
BAU Net impact on bottom-line	(3,301)	(5,254)	**1,953 F**	24,768	(20,928)	**45,696 F**	14,472	(33,000)	**47,472 F**
Net Surplus / (Deficit)	**(22,311)**	**(8,588)**	**13,722 U**	**(10,982)**	**(50,934)**	**39,952 F**	**(43,500)**	**(73,000)**	**29,500 F**

Commentary on Significant Variances for the Year to Date

Revenue

Total revenue YTD is favourable to budget YTD by $138.5M (6.5%). The key variances are as follows:

- Covid-19 response funding $145.5M favourable covering vaccinations, community testing, ARPHS, laboratory testing, MIF, border control and other response costs.
- Covid-19 Provision for planned care and IDF revenue wash-up during lockdown and surge months $34.0M unfavourable – reflecting reduced volumes during these periods.
- BAU Provision for planned care and IDF revenue wash-up $8.0M unfavourable.
- MOH Nursing Pay Equity funding $36.4M favourable reflecting actual costs incurred.
- ACC revenue $2.5M favourable for one off backdated prior period wash-up.
- Donation Income $1.9M reflecting additional funding received for projects.
- MOH base revenue $5.0M favourable for one off backdated prior period wash-ups.
- Funder NGO Covid-19 response revenue $10.3M unfavourable, fully offset by reduced Covid-19 contract expenditure.

Expenditure

Total expenditure YTD is unfavourable to budget by $98.6M (-4.5%). The key variances are as follows:

- Combined Personnel and Outsourced Staff costs $77.3M (-7.2%) unfavourable, with the key variances as follows:
  - Unbudgeted Covid-19 related expenditure of $61.4M.
  - BAU costs $15.4M (1.6%) unfavourable, with the key variances as follows:
    - Nursing Pay Equity costs $36.4 M unfavourable (offset by additional funding)
    - BAU FTE 387 below budget $29.9M favourable
    - Lower annual leave taken during the year to date than the phased assumption $8.7M unfavourable due to lower annual leave taken during Covid-19 lockdown and surge periods.
- Outsourced Other costs $3.1M (-4.7%) unfavourable, mainly unbudgeted healthAlliance costs.
- Clinical Supplies are $4.5M (1.7%) favourable to budget. Underlying this is a $2.8M Covid-19 related unfavourable variance that is offset by a $7.3M favourable BAU position, reflecting reduced volumes during Covid-19 lockdown.
- Infrastructure & Non Clinical Supplies $59.3M (-36.3%) unfavourable, related to unbudgeted Covid-19 expenditure $52.2M (e.g. vaccination and community testing centre leases and urgent facilities work, with offsetting Covid-19 revenue). BAU costs are $8.0M (5.0%) unfavourable reflecting facilities and IT project costs.
- Funder payments to NGOs and IDFs $36.1M (5.4%) favourable mainly due to:
  - Utilisation variances across Funder NGO demand driven services mainly Pharmaceuticals $15M, Aged Residential Care and Carer Support $7M, Laboratory Services $2M, Oral Health $1.3M and GP Demand Services $1.6M. Pharmaceuticals expenditure for year to date was in part a result of the retrospective impact of a designated component of this expenditure being reclassified as COVID-19 expenditure as required by the Ministry. COVID-19 has had an indirect impact on Funder expenditure in terms of reduced utilisation for demand based services and reduced opportunity/capacity to progress potential new service initiatives. This is partially offset by adverse variances in PHO Services and Home Support.
  - IDF Outflows variances were $1.2M favourable for the year to date, mainly driven by favourable 2020/21 final wash-ups settled in October 2021 and 2021-22 quarterly PHO wash-ups related to agency arrangements.
  - NGO Covid-19 Contract Expenditure was $10.3M favourable, however, there is no impact on the Funder core result as this is fully offset by unfavourable Covid-19 funding.

Volumes

Overall volumes are reported at 93.5% of base contract for the year to date - this equates to $77.1M below contract of which $42.0M is subject to wash-up liability for Planned Care (excluding August and September which the MOH have advised won't be subject to wash-up) and IDFs. A provision of $42M is in the accounts.

FTE

Total FTE (including outsourced) for the month of March 2022 was 10,707 FTE which is 304 higher than budget. Of thisCovid-19 FTEs were 537 above budget and BAU is 233 FTE below budget.

2. Statement of Financial Position as at 31 March 2022

$'000	31-Mar-22			28-Feb-22	Var	30-Jun-21	Var
	Actual	Budget	Variance	Actual	Last Mth	Actual	Last Year
Public Equity	997,121	1,050,214	53,093U	991,648	5,473F	964,383	32,738F
Reserves							
Revaluation Reserve	643,988	643,988	0U	643,988	0F	643,988	0U
Accumulated Deficits from Prior Year's	(888,955)	(917,216)	28,262F	(888,955)	0F	(792,742)	96,213U
Current Surplus/(Deficit)	(10,980)	(22,685)	11,705F	11,330	22,310U	(96,229)	85,249F
	(255,947)	(295,913)	39,966F	(233,637)	22,310U	(244,983)	10,964U
Total Equity	**741,174**	**754,301**	**13,127U**	**758,011**	**16,838U**	**719,400**	**21,774F**
Non Current Assets							
Fixed Assets							
Land	397,089	397,089	0F	397,089	0F	397,089	0F
Buildings	596,171	660,786	64,615U	599,989	3,818U	621,314	25,143U
Plant & Equipment	82,683	98,215	15,532U	83,236	553U	91,861	9,178U
Work in Progress	159,343	164,908	5,565U	146,158	13,185F	96,596	62,748F
Total Property, Plant & Equipment	1,235,286	1,320,998	85,712U	1,226,472	8,814F	1,206,860	28,427F
Investments							
- Health Alliance	78,787	79,676	889U	78,787	0F	79,676	889U
- Health Source	271	-	271F	271	0F	-	271F
- NZHPL	6,607	7,295	688U	6,683	76U	7,295	688U
- Other Investments	617	-	617F	617	0F	-	617F
	86,282	86,971	689U	86,359	76U	86,971	689U
Intangible Assets	2,054	10,781	8,727U	2,130	76U	2,751	697U
Trust Funds	15,948	17,577	1,629U	16,729	781U	17,577	1,629U
	104,285	115,329	11,044U	105,218	933U	107,299	3,014U
Total Non Current Assets	**1,339,571**	**1,436,328**	**96,756U**	**1,331,690**	**7,881F**	**1,314,159**	**25,413F**
Current Assets							
Cash & Short Term Deposits	275,674	151,394	124,279F	223,608	52,066F	202,469	73,205F
Trust Deposits > 3months	2,482	10,707	8,225U	16,716	14,234U	10,707	8,225U
ADHB Term Deposits > 3 months	-	-	0F	-	0F	-	0F
Debtors	43,727	44,859	1,132U	87,982	44,255U	44,859	1,132U
Accrued Income	83,136	76,452	6,684F	104,857	21,721U	76,452	6,684F
Prepayments	7,520	5,392	2,128F	8,256	737U	5,920	1,600F
Inventory	19,230	16,275	2,955F	18,827	403F	16,275	2,955F
Total Current Assets	**431,769**	**305,079**	**126,690F**	**460,246**	**28,477U**	**356,682**	**75,087F**
Current Liabilities							
Borrowing	(3,612)	(2,828)	784U	(3,605)	7U	(2,828)	784U
Trade & Other Creditors, Provisions	(241,917)	(222,902)	19,015U	(245,510)	3,592F	(222,902)	19,015U
Employee Entitlements	(673,905)	(646,986)	26,919U	(673,905)	0F	(616,986)	56,919U
Funds Held in Trust	(1,423)	(1,410)	13U	(1,410)	13U	(1,410)	13U
Total Current Liabilities	**(920,857)**	**(874,126)**	**46,731U**	**(924,430)**	**3,573F**	**(844,126)**	**76,731U**
Working Capital	**(489,088)**	**(569,047)**	**79,959F**	**(464,183)**	**24,904U**	**(487,444)**	**1,644U**
Non Current Liabilities							
Borrowings	(16,042)	(19,689)	3,648F	(16,227)	185F	(13,949)	2,093U
Employee Entitlements	(93,268)	(93,291)	23F	(93,268)	0F	(93,366)	98F
Total Non Current Liabilities	**(109,310)**	**(112,980)**	**3,670F**	**(109,495)**	**185F**	**(107,315)**	**1,995U**
Net Assets	**741,174**	**754,301**	**13,127U**	**758,011**	**16,838U**	**719,400**	**21,774F**

3. Statement of Cash flows as at 31 March 2022

$000's	Month (Mar-2022)			Year to Date 2021-22		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Revenue Received	307,939	237,042	70,897F	2,274,707	2,133,707	141,000F
Payments						
Personnel	(124,247)	(103,104)	21,143U	(970,398)	(913,709)	56,689U
Suppliers	(63,107)	(53,909)	9,198U	(560,614)	(473,388)	87,226U
Capital Charge	0	(2,899)	2,899F	(17,114)	(26,094)	8,981F
Payments to other DHBs and Providers	(71,760)	(73,779)	2,019F	(627,943)	(664,011)	36,068F
GST	(2,961)	0	2,961U	2,405	0	2,405F
	(262,076)	(233,692)	28,384U	(2,173,665)	(2,077,202)	96,462U
Net Operating Cash flows	**45,863**	**3,350**	**42,513F**	**101,043**	**56,505**	**44,538F**
Investing						
Interest Income	403	219	184F	2,364	1,971	393F
Sale of Assets	0	0	0F	101	0	101F
Purchase Fixed Assets	(14,434)	(31,007)	16,574F	(74,432)	(200,144)	125,712F
Investments and restricted trust funds	14,987	0	14,987F	9,277	0	9,277F
Net Investing Cash flows	**956**	**(30,788)**	**31,744F**	**(62,690)**	**(198,173)**	**135,483F**
Financing						
Interest paid	(48)	(100)	53F	(661)	(901)	240F
New loans raised	(178)	0	178U	1,953	7,697	5,745U
Loans repaid	0	(255)	255F	827	(2,033)	2,860F
Other Equity Movement	5,473	12,001	6,528U	32,737	85,831	53,094U
Net Financing Cash flows	**5,247**	**11,646**	**6,399U**	**34,855**	**90,594**	**55,739U**
Total Net Cash flows	**52,066**	**(15,792)**	**67,859F**	**73,208**	**(51,074)**	**124,282F**
Opening Cash	223,608	167,186	56,422F	202,468	202,468	0F
Total Net Cash flows	52,066	(15,792)	67,858F	73,206	(51,074)	124,280F
Closing Cash	**275,674**	**151,394**	**124,280F**	**275,674**	**151,394**	**124,280F**

ADHB Cash	249,413	137,878	111,535F
AHREF Cash	26,261	11,765	14,496F
AHREF & Restricted Deposits < 3 months	0	1,751	1,751U
Closing Cash	**275,674**	**151,394**	**124,280F**
ADHB Short Term Investments 3 > 12 months	0	0	0F
AHREF Short Term Investments 3 > 12 months	2,482	10,707	8,225U
ADHB Long Term Investments	0	0	0F
AHREF Long Term Investment Portfolio	15,948	17,577	1,629U
Total Cash & Deposits	**294,104**	**179,678**	**114,426F**

Hospital Advisory Committee Report

Recommendation
That the Board receives the Hospital Advisory Committee report for May 2022.

Prepared by: Michael Shepherd (Director of Provider Services)
Endorsed by: Ailsa Claire (Chief Executive)

Kuputaka: Glossary

Acronym/term	Definition
Hui	Meeting, gathering
Kaiārahi Nāhi	Nurse Navigator
Kaimahi	Worker, Employee, Staff member
Rōpū	Group

1. Executive Summary

The Executive Leadership Team highlights the following activity for the May 2022 Board Meeting:

- Over the past 6 weeks Te Toka Tumai has been running at 93.1% occupancy at our peak time at 10am, whilst under considerable pressure to resource our available bed capacity. Starship has been running at 90.6%.
- Baseline inpatient occupancy has increased during February, March and April and is expected to be at 2021 levels for May and June as we approach winter. This is likely to be impacted by any secondary Covid-19 wave over the coming months and the level of Planned Care being undertaken.
- Workforce and resourcing available bed capacity pressures continue to be a key issue.
- Transplant volumes have been maintained despite the other pressures we have been experiencing.

2. Service Reports

2.1 Māori Health Provider Services

The Māori Health Team recruitment to Director of Māori Nursing and Māori Health Leads within Directorates has been completed. Work has begun orientating the workload of our team across the organisation in alignment with the Directorate Business plan objectives.

We have adopted our Winter Planning response – He Ara Whiria (the path that is woven) which underpins the networked approach the Māori Health Team works towards unifying the organisation's Te Tiriti o Waitangi Position Statements. The intention is to provide mana whenua endorsed positions that support the organisation as a whole on our journey to strengthen our connectivity to our strategic pillars related to enacting Te Tiriti o Waitangi and achieving equity.

Kaiārahi Nāhi continue to make the transition from pilot into the fabric of related Directorates. This includes recruitment for new positions in Te Pūriri o Te Ora as well as Starship Children's Health. The Oranga Coordinator kaimahi maintain their position within the rōpū and continue to work alongside

our patients and their whānau diagnosed with Covid-19 and also now respiratory illness as per the prescription of the Winter Planning programme.

2.2 Āhua Tohu Pōkangia Perioperative Services Equity Update

The past two months have been challenging for all services and much work has gone into maintaining and enhancing our equity focus on managing the urgent planned care delivery through the Omicron outbreak. Our staff were redeployed, in very significant numbers, to provide care in the wards and the emergency department during the surge and while non-urgent planned care was suspended, helping to ensure safe care of acute and urgent planned care surgical patients throughout.

Dr Jack Hill commenced as Māori Health Lead for Āhua Tohu Pōkangia and is contributing greatly. He is keen to explore education sessions with our rangatahi at the medical school and has some innovative plans to explore the model of Te Whare Tapa Whā in the emerging specialty of Perioperative Medicine. As many will appreciate, the time of surgery can be very stressful and worrisome and attending to the four cornerstones of health (taha tinana, taha wairua, taha whānau and taha hinengaro) will surely better prepare our patients for the challenge. Jack has also become involved with advising the Kaiārahi Nāhi team to manage their cases and his wise advice is appreciated. He will also provide key input into business case submissions, with a focus on Te Tiriti o Waitangi and equity and with the deep clinical experience that he brings to the table.

We now turn our attention to the twin challenges of planned care management and staffing pressure, particularly amongst our nursing colleagues. We are looking at short-term and longer strategic steps required to improve staffing levels and we will work alongside other directorates and our partners in education to enhance opportunities for rangatahi to enter a career in the operating rooms.

2.3 Cardiovascular Directorate Equity Update

We have been developing a work plan to deliver the Te Tiriti o Waitangi and Equity priorities of the directorate business plan. As per the current plan, a key initiative will be a review of outpatient services to improve access for Māori and Pacific patients and increasing the number of kaimahi Māori staff in the directorate in line with our A3 commitments. For example discussions have begun around establishing a lead role in outpatient clinics to champion Tikanga best practice principles, team interconnection and leadership for cultural change to improve Māori and Pacific attendance and engagement. Additionally included in the A3 is the motivation to convert the Māori Covid-19 surge response rōpū into a new BAU. On-going kōrero and a proposal for this mahi is been developed.

The Vascular service has been identified as vulnerable and it has been agreed to establish a regional vascular service. Planning is well underway with an established project structure, including Māori and Pacific leads and a clinical lead. The initial focus is on improving access to and the quality of outpatient clinics, with clinics managed by Te Toka Tumai staff now scheduled at North Shore Hospital and investment in capital equipment to improve diagnostics at Counties Manukau and Northland DHBs. An additional Senior Medical Officer has been hired as a joint Te Toka Tumai/Counties Manukau DHB appointment and a regional after-hours roster is under development.

2.4 Te Pūriri o Te Ora Cancer and Blood Services Equity Update

Te Pūriri o Te Ora has progressed our Te Tiriti o Waitangi and equity work over this quarter bringing to life the Āwhinatia te Tangata project. This project makes contact with whānau prior to their first appointment with the service and also for those whānau experiencing cancer and Covid-19 infections. This proactive contact with Māori patients and whānau has shown a reduction in DNA at this early stage. We hope this will be confirmed as we analyse on-going data which suggests a profound shift in access for whānau to treatment and care. This project is in partnership with Ngāti Whātua Ōrākei Marae, and the whānau support aspect of the project in the community will begin in the next month. In this development we have engaged with Te Rūnanga o Ngāti Whātua and through this have developed a regular meeting in order to strengthen our on-going relationship.

Te Pūriri o Te Ora aims to increase its recruitment and retention of kaimahi Māori and Me Kōrero Tahi Tātou Interviews are being piloted currently as part of our commitment to Pūmanawa Tāngata. Through this pilot we expect to develop strategies and take action on the wellbeing support and career development of our Kaimahi Māori staff.

Our Haematology Model of Care project is being progressed with the story of the Migration of Māori to Aotearoa symbolic of the journey the Haematology service is travelling within Te Pūriri o Te Ora. According to many tribal narratives, Kupe was the first Pacific explorer to discover the islands of Aotearoa. Stories about his exploration on his waka, the *Matawhaorua* or *Matahourua*, differ from region to region but often feature a fight with a great wheke (octopus). The voyage itself was long, navigators used the stars to set their direction and course and set the sails accordingly. The ocean state, winds, currents and weather battled the fleet. Some say that different waka had arguments over which direction to take and went separate ways, however most landed safely in new lands. This analogy with haematology is the journey we are experiencing currently. The opportunities to change course and move into a team based service has been taken, it is stormy like the weather at sea and the destination of our service has been unclear until now. We have set our sail to reach a destination of a new and improved resourced model of care, new outpatient services to develop contemporary services for the northern region haematology patients undergoing Stem cell transplant and with a Te Aō Māori world-view. We aim to take this important story across the rest of the services within Te Pūriri o Te Ora.

2.5 Surgical Services Equity Update

- The Māori Health Lead for Surgical Services has been recruited to and is about to be announced. This will help the Directorate ensure Māori worldviews, values and wairuatanga are respected and actively apply Māori intelligence across the Directorate to improve Māori Health Gain.
- Surgical planned care at Te Toka Tumai has continued to prioritise long waiting Māori patients and Pacific patients as we have emerged from the Omicron surge. Additional consideration is given to Māori patients and Pacific patients when needing to consider deferral when resourced bed capacity is an issue to ensure we maintain trust and confidence in the planned care pathway, particularly if they have already experienced a previous deferral. Maintaining safe and effective delivery of surgical services allows our kaimahi Māori to speak with confidence, when engaging with whānau who are referred to for surgical care.
- Outsourcing and wetleasing for clinically urgent patients in Neurosurgery, General Surgery, Urology, and ORL was arranged over the Omicron surge (March and April 2022) enabling our most urgent patients to get their planned care within the operating rooms at Te Toka Tumai and through these private facilities. The Kaiārahi Nāhi continued to support these patients getting their planned care through private facilities and received good feedback about their experiences.
- Outsourcing options have been arranged through to June 2023 for Urology and Neurosurgery to assist with reducing waiting times. This supports building a resilient service able to eliminate inequity by reducing waiting times for Māori and delivering surgery within expected timeframes improving health outcomes. Further services are being considered for outsourcing. Ensuring we can provide safe healthcare to maintain the physical wellbeing will support the holistic wellbeing of our Māori patients and whānau. Māori patients receiving their surgery at the time expected aims to reduce impacts socially, financially and reduce extra clinic appointments that become financially burdensome to whānau.
- Following the success of the Leading for Equity session arranged for Surgical and Perioperative staff in February 2022, we have continued to encourage our people leaders to complete Leading for Equity. We are looking to arrange another Surgical Services session as this is a key module for our Pūmanawa Tāngata Strategy.

2.6 Women's Health Directorate Equity Update

<u>Te Tiriti o Waitangi</u>

Review of the Āhuru Mōwai (Sheltered Haven) Maternity Framework developed by one of the service leaders has been delayed due to the leadership changes and the overall staffing difficulties. However, the recent appointment to the Māori Health and Equity leadership position will enable progress to be made.

Particularly, but not exclusively, through the Te Manawa o Hine service, Women's Health is working on:

- Increasing the use of Te Reo Māori

- Reviewing systems not designed for or with Māori and promoting Kaupapa Māori
- Reducing barriers to access, through location of community clinics
- Working on normalising the practise of karakia for every hui
- Promoting and normalising the practice of traditions of tūpuna/ancestors such as muka/flax fibre and use of kawakawa preparation.

Eliminate Inequity

Women's Health have a variety of equity focussed projects underway, which include:

- Engagement process clarifying service issues particularly from an equity perspective. Focus on Māori and other consumer feedback, Kaimahi Māori and other staff feedback, to assist future service design.
- Te Manawa o Hine – further develop continuity of care Māori midwifery team and implement similar care option for Pacific parents. Promote and enable continuity of midwifery care.
- Work to increase the number of Māori and Pacific midwives at Te Toka Tumai, as well as promote leadership roles throughout the service. Recently we appointed to Associate Director of Midwifery for Māori Health and Equity. We also appointed another Associate Director Midwifery role, with the successful candidate being of Māori descent. The A+ Student midwifery scholarships are supporting the appointments of both Māori and Pacific midwifery graduates and we have a dedicated Clinical Charge Midwife who is also our Pacific midwifery Liaison.
- Implement Kai Awhina to work with Te Manawa o Hine to support whānau Māori with navigation of the health and social services processes, assist with breastfeeding and parent-craft education, budgeting etc. This has been approved and position descriptions are about to be developed.
- Redesign of the women's assessment unit and processes to improve the journey for whānau accessing this service, in particular to ensure equitable and timely access for all based on clinical need.
- Prioritising surgery for Māori patients, Pacific patients and long wait patients as a priority for general gynaecology planned care.
- Supporting the provision of Long Acting Reversible Contraceptives in primary community environments close to home for Māori, Pacific and other high needs groups.

Digital Transformation

Months of planning the implementation of the maternity clinical information system, commonly referred to as Badgernet, culminated in a successful switch over to the next system on 1 May 2022. The implementation to date has been relatively successful, especially given the staffing levels and the low rate of pre-implementation training.

Staff are now "learning on the job", but whilst this is currently leading to service challenges, all staff appear to recognise the benefits that will accrue for the patients and staff, once it is fully implemented.

As a bi-product of this change the maternity service is now fully equipped with "computers on wheels". These are a pre-requisite to introducing effective "bedside handover". The women's service views bedside handover as a critical component of the Partners in Care approach encouraged across our DHB.

People, Patients and Whānau at the Centre

One of the positives to come from managing Covid-19 has been the focus the women's service has put on growing the Partners in Care approach across all parts of our service. However, much remains to be done before our service could truly claim to be a patient and whānau centred service. Change is required across systems, policy, process, culture and attitudes. Role modelling from the Directorate Leadership Team is essential to what will need to be incremental change. Review of some of our critical processes, such as management of induction of labour, are underway. Good progress is being made in identifying (through the feedback process) consumers who have the ability and willingness to contribute to our on-going service redesign work.

A cautious approach is being taken to the pace of change, within the Directorate, because unsurprisingly staff morale reflects the stressors of the last twelve months, not the least of which is the staffing levels. Recruitment initiatives are in place, including action being given to what can be done locally to improve the "pipeline" particularly for midwives.

Although staff health and well-being is being affected by the staffing levels, we are working hard to ensure staff feel valued, informed and empowered. Recent planning for facility improvements, for women's assessment unit and Tamaki, has an immediate positive impact on staff enthusiasm and morale.

Resilient Services

Our vacancy rate does impact on the stability and reliability of many aspects of service delivery, meaning staff are constantly working to maintain patient safety. Whilst successful recruitment will, at this stage, have the most impact on improving service resilience a number of other initiatives are in place to build service resilience:

- Strengthening the clinical governance framework, in the first instance to improve the management of adverse events
- Review of critical policy settings
- Exploring an extension to the current midwifery incentives programme
- Re-design of the after hour roster for SMOs
- Improving the learning experience for RMOs, especially the house officers

3. Financial Report

The Provider Arm result for YTD March 2022 is $11.3M favourable. The underlying BAU result is $17.1M favourable and the impacts of Covid-19 are $5.8M unfavourable.

Overall volumes are 94% of contract for the YTD - this equates to $77.1M below contract. This unfavourable contract position equates to an estimated $42.0M washup liability for planned care (excluding August and September which the MOH have advised will not be subject to washup) and

IDF. This washup liability has been predominantly provided for under Covid-19 ($34.0M), reflecting the significant decrease in volumes during the lockdown and surge periods. The remaining $8M washup liability for periods outside lockdown and surge has been recognised in the BAU result.

BAU Result

The $17.1M favourable YTD BAU result is driven by the following key variances:

Favourable:

- Personnel and outsourced personnel costs are $21.0M favourable (after offsetting additional MOH funding received for the unbudgeted costs of Nursing pay equity). This is a reflection of BAU FTE averaging 387 below budget for the YTD, partly offset by lower levels of annual leave taken.
- Clinical Supplies are $7.3M favourable due to lower acute volumes during the lockdown and surge periods.
- ACC revenue is $2.5M favourable due to a one off backdated prior period washup.

Unfavourable:

- Planned Care and IDF washup liability $8M for periods outside lockdown and surges.
- Other expenditure $5.7M unfavourable reflecting higher than planned HealthSource and healthAlliance costs and additional facilities and IT project costs.

Covid-19 Result

The $5.8M unfavourable YTD Covid-19 result is driven by the $34M wash-up liability resulting from the significant decrease in volumes during the lockdown and surge periods. This is mostly offset by the favourable contribution margin from laboratory PCR testing. Most of the Covid-19 response workstreams such as vaccinations and testing are breakeven.

Disability Support Advisory Committee Report

Recommendation

That the Board:

1. **Receives** the report from the Disability Advisory Committee

Prepared by: Jennie Montague, Head of Executive Services
Endorsed by: Sue Waters Chief Health Professions Officer

1. Executive Summary

The work of Disability Advisory Committee has continued despite the disruption from Covid-19. This report provides an overview of some key work and issues

2. New Ministry for Disabled People

The recent reforms of the Health system and evolving government priorities have provided an opportunity to review the current arrangements for working with, and supporting, the one in four New Zealanders that identify as disabled.

The Government is introducing a Ministry for Disabled People – to lead the realisation of a true partnership between the disability community and government, and to help drive on-going transformation of the disability system in line with the Enabling Good Lives (EGL) approach.

The new Ministry will take on most functions currently delivered by the Disability Directorate (DSD) in the Ministry of Health (MoH), as well as taking on new responsibilities.

The ambition for the new Ministry is aspirational. To truly transform the way government serves disabled people, tāngata whaikaha Māori, families and whānau, the Government decided to look beyond disability supports to examine and strengthen the cross-government disability system.

The new Ministry will have a range of functions that will expand in the future as Disability System Transformation progresses.

All government agencies will continue to have responsibility to disabled people, for example the health system continues to have responsibility for the health outcomes of disabled people.

This will mean:

- ensuring the Enabling Good Lives vision and principles as the basis on which government supports disabled people across their lives
- working in partnership with disabled people and ensuring a high level of trust and transparency
- lifting the profile and visibility of disability across government

Ensuring the system:

- gives full effect to the voice of disabled people, families, and whānau, and to Te Tiriti o Waitangi
- is consistent with the United Nations Convention on the Rights of Persons with Disabilities and the United Nations Declaration on the Rights of Indigenous Peoples
- aligns with the principles and approaches of Whānau Ora

- strengthening disability rights approaches across government strategies, including the Child and Youth Wellbeing Strategy, Better Later Life – He Oranga Kaumātua, the New Zealand Disability Strategy, and Mahi Aroha – the New Zealand Carers' Strategy
- improving cross-government disability data and information
- developing a disability-focused research and evaluation strategy

The new Ministry for Disabled People will also:

- Lead the Disability System Transformation work
- Operate as a Ministry, including providing policy and budget advice to the Minister of Disability Issues
- Manage relevant legislation
- Fully implement, from an initial pilot, the Enabling Good Lives approach (including funding)
- Continue to work with MoH on broader health and statutory requirements
- Continue to work with MoH on payment processes (until transition)
- Operate the needs assessment system
- Provide for long term home based and community support for 43,000 people
- Provide equipment and modification services to 83,000 people
- Provide 22,000 people access to hearing aid and subsidy schemes
- Process 90,000 to 100,000 claims
- Manage bulk funded providers
- Manage 1,500 contracts and 975 service providers
- Manage appropriation of $1.8b

The appointment of the Chief Executive for the new Ministry is being managed independently by Te Kawa Mataaho, the Public Service Commission, as are all central government agency chief executive appointments.

Consultation is underway on a final name for the new Ministry that will incorporate English, te reo Māori and New Zealand Sign Language. This name will replace its current name, Ministry for Disabled People. This will be the first time a government ministry has had a name in all three languages.

The final name is expected to be confirmed before the new Ministry commences on 1 July 2022. In the meantime, so that contracts for services can be transferred and technical aspects of the new Ministry can be set up, Ministry for Disabled People will be used as the new Ministry's legal name.

3. Auckland DHB Accessibility Update

An overview report on the accessibility workplan at Auckland DHB is provided as an appendix to this report. This is a priority work programme in order to progress towards a more inclusive and diverse workplace. Auckland DHB has made a commitment to, and our focus aligns with, the implementation of the New Zealand Disability Strategy 2016-2026, as well as principle recommendations in recent reviews, including the Disability Support and Recommendations for DHB's report

Key recent activities include:

- **Focus on working as a Northern Region**
- **Accessibility Tick**
  Auckland DHB completed our third year as members of the Accessibility Tick programme
- **Supporting Employees with an Access Need – A Managers Guide to Recruitment**

- **Kaupapa Māori Disability Training**
- **Lunchtime Lived Experience Speaker Series**

Better health, inclusion and participation for disabled people were clearly communicated in the Health and Disability System Review, with a priority action and explicit focus on equity.
We have a responsibility to become a truly inclusive employer that acknowledges, protects and enhances the mana of our people and considers disability in all aspects of our equity work.

4. Child Development Services (CDS) Programme of Work

Child Development Services (CDS) received additional funding in the 2019 wellbeing budget to expand and transform service delivery nationally. The priorities for this 4-year work programme are to develop a new national operating model for CDS services ensuring equity of access irrespective of postcode, and an expansion of services to see additional children.

Key items of note for the board in this programme of work are:

- CDS service providers are still awaiting a ministerial announcement as to where CDS services will sit under the health and disability reforms.
- National objectives for the CDS expand and transform programme of work are to deliver a new operating framework for service delivery
- Embedding Enabling Good Lives (EGL) principles into service delivery within the Northern Region is a priority, and will require practice shifts within services

It is pleasing that an additional 2116 children have accessed services in the Northern Region since January 2020 as a result of this programme.

A more detailed report on Child Development Services (CDS) Programme of Work is provided as an appendix to this report.

5. COVID-19 NRHCC Disability Response

Vaccination programme

The metro Auckland disability community was a priority population in the Covid-19 . There were a number of key actions to make sure this priority population was specifically considered by the vaccination programme. A number of key actions were taken including:

- All disabled people who were known to us (funded by MoH, DHB, ACC) who had not been vaccinated by October were followed up individually by either Taikura, Māori or Pacific providers or the disability specialist team at Whakarongarau.
- An in-person accessibility audit was undertaken at all large vaccination centres by Vivian Naylor, Barrier Free Advisor & Educator from CCS Disability Action.
- An outreach service began with visits to disability residential providers in July 2021. A significant amount of planning went into these events including site visits, discussions around consenting processes and supported decision-making conversations between providers, GPs, families and clients. By November 2021 the team had completed up to three

visits to some residences and vaccinated 1858 people. In 2022 the team contacted the group homes and offered another visit for boosters for the population. All visits were completed by the middle of February.

- In 2021 we vaccinated 2232 people in their homes, and as at 13 April 2022 we have vaccinated a further 154 with their primary doses, 671 boosters and 46 tamariki. Many Māori and Pacific providers were also delivering in-home vaccination

Outbreak response and preparedness

In 2022 we continue to provide support to the disability residential providers in metro Auckland. There 27 residential providers with over 400 homes between them. As the outbreak started, we supported providers to access appropriate PPE and RATs and advocated on their behalf to Healthcare Logistics (HCL) for a rapid service, provided public health support and referred some to other DHB services including MeRCH.

A more detailed report on theCOVID-19 NRHCC Disability Response is provided as an appendix to this report.

6. Conclusion

It is recommended that the Board receive the report from the Disability Advisory Committee

AUCKLAND DHB ACCESSIBILITY UPDATE

Recommendation

That the Board:

1. Receives the report and notes the status and progress

7.2

Prepared by: Adele Thomas - Practice Lead, Organisational Development (Supportive Employment)

The purpose of this report is to provide an update and inform new work in the area of Accessibility at Auckland DHB in order to progress towards a more inclusive and diverse workplace.

Background

Auckland DHB has made a commitment to, and our focus aligns with, the implementation of the New Zealand Disability Strategy 2016-2026, as well as principle recommendations in recent reviews, including the Disability Support and Recommendations for DHB's report (Lalit Kalra, Jan 2021).

We are a founding member of the Accessibility Tick programme and a fully accredited Hearing Workplace, through the NZ Foundation for the Deaf and Hard of Hearing accredited workplace program (HAWP).

With the government's recent announcement for Disability Systems Transformation and the Accessibility for New Zealanders Bill, Auckland DHB should be resolute in its commitment to continually progress good practice around disability, to become a fully inclusive and accessible workplace for our people and patients, and ultimately see more disabled people in meaningful careers.

24% of New Zealand citizens identify as having some form of disability. Disabled people experience significant inequities, across health, employment, education, communication and technology, physical environments, transportation, facilities and services.

Diversity & Inclusion linked to Pūmanawa Tāngata

Accessibility is included in Pūmanawa Tāngata (our people strategy) and sits under Tupuranga Tahi 'Strengthen our organisational culture and values'.

Benefits of a Disability Inclusive Workforce
There are many benefits of having a disability inclusive workplace. Some of these are:

- Socio-economic benefits
- Positive impact on workplace culture
- Improved retention rates
- Access to a hidden talent pool
- Diversity of thought and innovation
- Disabled workforce more representative of the community we serve
- Improve patient experience and health outcomes for disabled communities

- Enhanced social and ethical reputation as an employer

Vision and Objectives

Auckland DHB is a leading employer of disabled people, where all employees are encouraged to become disability confident, drawing in disabled people into a variety of roles where they are supported to thrive.

- Auckland DHB actively seeks to employ disabled people
- Auckland DHB workplaces are accessible and provides reasonable accommodations enabling all employees to do their jobs and fully participate in the workforce
- All workplaces are safe spaces that value diversity
- All employees understand the social and economic benefits of diversity and inclusion

RECENT ACTIVITY AND ACTIONS

Focus on working as a Northern Region

As part of planning for working under Health NZ and the Māori Health Authority, the four northern region DHBs are working closely together in their focus on disability. The metro-Auckland DHB staff has developed strong relationships and share information and resources. Recently, Northland DHB has been included in areas of work, particularly the focus on employing more disabled people. Auckland DHB has attended two national DHB meetings discussing work being done across the country to improve the experience of staff with disability, impairment and long-term conditions, and increase the number of disabled people employed.

Accessibility Tick

Auckland DHB completed our third year as members of the Accessibility Tick programme. At the annual assessment at the end of 2021, the Accessibility Tick Programme Director was pleased with the progress that our DHB is making in the nine outcome areas of the Tick. We have developed the 2022 Action Plan and have completed the first quarterly review for 2022. The four northern region DHBs are all members of the Accessibility Tick programme and are already working together, which bodes well for on-going work under Health NZ and the Māori Health Authority.

Supporting Employees with an Access Need – A Managers Guide to Recruitment

The guide aims to support Recruiters and Hiring Managers to ensure an inclusive recruitment process for disabled people. We have recently developed a generic e-Learning module to support the guide. This was developed by, and will be used across, the three metro-Auckland DHBs, with a view that it could be also be a national e-Learning tool.

Kaupapa Māori Disability Training

To enable the vision of care that is culturally safe and improve the experience of whānau hauā/tāngata whaikaha (Māori disabled people) we are building our staff capability through the development of a disability responsiveness training module that focuses on kaupapa Māori. It includes mātauranga Māori content so that staff are well equipped with information to guide their practice.

The three metro-Auckland DHBs are currently engaging with Te Roopu Waiora, a kaupapa Māori disability organisation, to develop the training content.

We are planning to have two parts to the training. There will be foundational level training, which will be an e-Learning module and hosted on the Ko Awatea Learn platform. This will provide basic

knowledge that includes mātauranga Māori and kaupaua Māori consideration when caring for whānau hauā, including cultural perspectives and perception of disability within Te Ao Māori. The key learning will be concepts to consider as a clinician/health care provider when working with whānau hauā.
This will be followed by a one-hour kanohi to kanohi or virtual webinar that takes the foundational learning and builds in practical experience. This will include whānau hauā talking about their health service experiences, how these could be improved and provides some practical tips.

'**Organisational Inclusiveness for People Impacted by Disability'** research project commenced and facilitated by ThinkPlace and Curative. We have partnered with Counties Manukau DHB for phase one and Waitemata DHB will join for phase 2. Insights will inform and guide our priorities for action.

Lunchtime Lived Experience Speaker Series
This series commenced on April 28th with Natasha Gallardo CE National Foundation Deaf & Maddy Uaine and NFD Youth Advisory Group member and Dan Buckingham CEO Attitude Pictures ex Wheel Black and Paralympian on June 1.
The series was postponed due to Covid but will continue in 2022 . We are planning as Auckland Metro DHB's to film these as e-bites instead of face to face sessions. This series is part of our work towards de-stigmatising disability and making it more visible.

Hearing Accredited Workplace Programme (HAWP)
Auckland DHB signed up to the Hearing Accredited Workplace Programme (HAWP) through the National Foundation for the Deaf, in March 2021 and received full HAWP accreditation on 1 December 2021.
Hearing Health Workshop delivered by National Foundation for the Deaf (NFD) on March 19.
'Deaf and Hard of Hearing' page and resources created on Hippo (printable resources; communication posters, safe listening posters etc.)
Free hearing checks delivered annually to staff by Triton Hearing & NFD via iPad kiosks with good uptake. **Free Full diagnostic test** vouchers were provided to staff, where a follow up was recommended after initial screening.
HAWP e-Learning modules uploaded to Ko Awatea Learn
Cards demonstrating how to sign common words useful in a medical environment designed, printed and distributed across the organisation and uploaded to accessibility page on Hippo as a resource.
Two **NZSL workshops** delivered to staff accompanied by cards demonstrating some useful common words and phrases in Te Reo and English.

Building a Disability Confident Organisation Interactive Live Webinar delivered

Creating Accessible Documents e-Learning module developed uploaded to Ko Awatea Learn and shared with Metro Auckland DHB's.

Reasonable Accommodations Guideline drafted for review, including how to access funding for equipment, etc.

2022 GOALS

Automatic shortlisting of access need candidates
Auckland DHB has a policy to automatically shortlist all Māori and Pacific candidates who meet the minimum criteria for the role. We are recommending a similar policy is extended to people with

access needs where they make an application to roles at Auckland DHB and meet eligibility requirements. Also endorsed by the DiSAC Committee in August 2021.

Accessibility Charter
By signing the charter, Auckland DHB would endorse its commitment to accessibility and mandate staff to work towards an accessible environment. This includes taking appropriate measures to ensure people with disabilities can access, on an equal basis with others, information and communications. These measures include the identification and elimination of barriers to accessibility.
This recommendation was also presented to and endorsed by the DiSAC Committee in August 2021.

Launch the reasonable accommodations guideline, the managers guide to recruitment and supporting e-Learning and deliver a series of face to face disability confidence workshops to managers. Ensuring these processes are supported in an end-to-end manner will enable a disabled person and hiring managers/recruiters to confidently navigate and have confidence in the process.

Commence phase two of the research project

Co-design **neurodiversity in the workplace e-Learning module**. This will be developed by, and used across the three metro-Auckland DHBs, with a view that it could be also be a national e-Learning tool.

Conclusion

Better health, inclusion and participation for disabled people were clearly communicated in the Health and Disability System Review, with a priority action and explicit focus on equity.
We have a responsibility to become a truly inclusive employer that acknowledges, protects and enhances the mana of our people and considers disability in all aspects of our equity work.

This is a big culture transition that will happen as people shift their behaviours over time. What we can do in the short-term is support the capabilities, opportunity, and motivation for people to change themselves, which will lead to the ultimate outcome we desire.

To	DISAC
From	Denise Janes
Date	10/5/2022
Subject	Child Development Services (CDS) Programme of Work

Recommendations

We recommend that DISAC:

- **Note**. CDS service providers are still awaiting a ministerial announcement as to where CDS services will sit under the health and disability reforms.
- **Note:** National objectives for the CDS expand and transform programme of work are to deliver a new operating framework for service delivery
- **Note:** Embedding Enabling Good Lives (EGL) principles into service delivery within the Northern Region is a priority, and will require practice shifts within services
- **Note:** An additional 2116 children have accessed services in the Northern Region since January 2020

Background

Child Development Services (CDS) received additional funding in the 2019 wellbeing budget to expand and transform service delivery nationally. The priorities for this 4-year work programme are to develop a new national operating model for CDS services ensuring equity of access irrespective of postcode, and an expansion of services to see additional children.

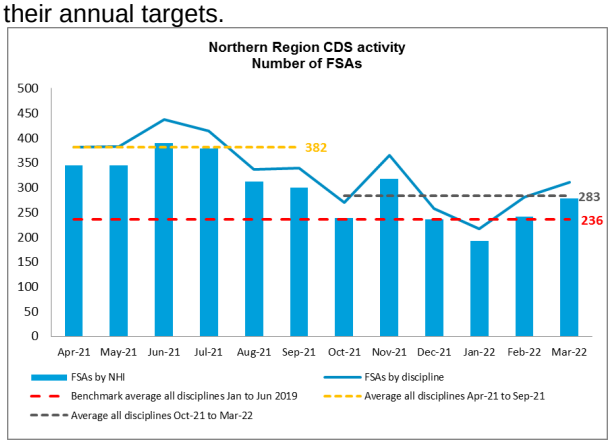
The Northern Region received additional funding for expansion of services and innovation funding to lead 11 projects. Completed innovation projects are currently being evaluated nationally to inform the new national operating framework. The new operating framework is under development and this work is being led by Disability Support Services.

Health and Disability reforms will impact CDS services. We are currently awaiting a ministerial announcement as to whether CDS services will sit under Health NZ or under the new Ministry for Disabled People. Irrespective of that decision, CDS services recognise the importance of embedding EGL principles into models of care, which will require practice shifts within services.

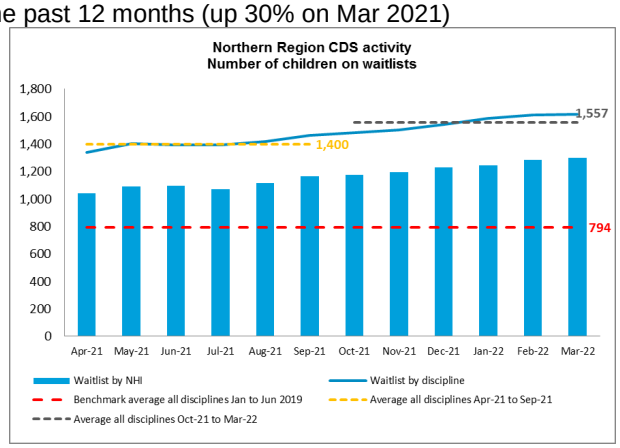
Regional Progress

Despite the challenges of providing services within a COVID environment, 2116 additional children have accessed CDS services across the region since the commencement of the work programme in January 2020.

<u>2021/22 progress:</u>
There has been a large uplift in the numbers of additional children who receive CDS services from the benchmark. For the year to date (9 months), 578 additional children have received FSAs. Two DHBs have met their annual targets (and will continue to do so if performance remains above baseline). The other two DHBs are on track against their annual targets.



Waiting Lists:
Demand in the region has not abated. The Mar 2022 waitlist of 1,299 (individual children) for the region is the highest it has been over the past 12 months (up 30% on Mar 2021)



There are a number of quality improvement projects underway in the region:

- Improved data quality has been a focus with aligned demographic data now collected across services in the region. Analysis of this data is currently underway to understand waiting lists and access to service from an equity perspective.
- Implementation of a regionally consistent entry to service approach that embeds Enabling Good Lives principles, is whānau directed with a clear tamaiti/ whānau plan developed to support developmental needs.
- A project is underway to understand Kaupapa Māori options to deliver CDS services. Phase 1 of the project focus will be in Northland; Phase 2 focus will be metro Auckland.
- Strengthening workforce capability through 2 new regional workforce roles which will be piloted over 12 months (A clinical coach for Occupational Therapy, and a clinical educator).

Innovations Summary

Innovation	Led By	Completed	Date due for completion	National evaluation
Calderdale	NDHB	√		April 2022
0-3 Neonatal Pathway	WDHB	√		March 2022
By Parent for Parent	WDHB	√		February 2022
Transition of young people into adult services	WDHB	√		February 2022
Gateway	NDHB/ADHB	Phase 1	December 2022	March 2022
Haere Mai	ADHB	Phase 1		May 2022
Autism Friendly Hospital	CMDHB	Phase 1	June 2023	
Workforce Development Plan	NRA	Phase 1	June 2023	
Entry/Exit	NRA		June 2023	
Care Pathway Classification	NRA		June 2022	March 2022
Outcomes Framework	NRA		December 2022	June 2022

All innovations will be evaluated by a national panel to determine next steps. 12 innovations from across the country have been through the evaluation process, with common themes emerging across a number of projects such as care co-ordination, peer support models, tamaiti/ whānau centred goal setting, cross agency collaboration. These themes will inform the new operating framework.

Next Steps

There are a number of areas of focus the Northern Region in 2022/23

- Representatives from the region are involved in the national evaluation panel for innovations
- Input into development and implementation of the new national operating framework
- Implementation of regional quality improvement projects

COVID-19 NRHCC Disability Response

This report provides an overview of the NRHCC vaccination programme, outbreak preparedness and response for the metro Auckland disability community for 2021-22.

For any further queries please contact Katie Daniel, Senior Project Manager at the NRHCC via email katie.daniel@health.govt.nz.

Vaccination programme

Communication

In 2021 we sent out regular information and vaccination invitations to disabled people through Need Assessment Service Coordination (NASC) agencies and through a network of 49 key stakeholders in the disability sector, including NZ Disability Support Network, Disability Connect and People First. We developed specific communications for deaf people and people with Autism among others.

All disabled people who were known to us (funded by MoH, DHB, ACC) who had not been vaccinated by October were followed up individually by either Taikura, Māori or Pacific providers or the disability specialist team at Whakarongarau.

We continue regular communications to the sector with a focus on the how to prepare for COVID-19, available support, and the flu vaccine.

Site accessibility

An in-person accessibility audit was undertaken at all large vaccination centres by Vivian Naylor, Barrier Free Advisor & Educator from CCS Disability Action. These audits occurred shortly after the sites opened. The recommendations were implemented and following this, the accessibility of each site was updated on the NRHCC website and the National Immunisation Booking website for people to read before booking. All large vaccination centres had accessible parking and access to public transport and other options included low sensory environments and unisex toilets. After making a booking people were also able to select a support option including an NZSL interpreter (123 NZSL interpreters were booked). These options were triaged by our Consumer Experience team; sign language interpreters were booked in advance and any other support requests (eg. support person required) were sent to the site leads.

Other initiatives including the Drive-through vaccination centres and transport assistance were viewed very favourably by the Disability sector although specific uptake is unknown.

Outreach to disability group homes and disability specialist schools

An outreach service began with visits to disability residential providers in July 2021. A significant amount of planning went into these events including site visits, discussions around consenting processes and supported decision-making conversations between providers, GPs, famiies and clients. By November 2021 we had completed up to three visits to some residences and vaccinated 1858 people. In 2022 we contacted the group homes and offered another visit for boosters for the population. All visits were completed by the middle of February.

We also provided outreach to 11 disability specialist schools in the region, starting in early August 2021. Many of the schools opened under alert level 4 precautions to facilitate vaccinations for their communities. Outreach teams provided the service in a safe and accessible way and vaccinated 1212

people. In 2022 we revisited the specialist schools to offer vaccination for Tamariki aged 5–11 and boosters for rangatahi aged over 18. Many students stay at specialist schools until age 21. As the booster is now advised for rangatahi aged over 16 years we have again offered outreach to these schools.

The outreach teams visited over 100 disability group homes and specialist disability schools in 2021 with a significant number of further visits in 2022.

In-home vaccination

In-home vaccinations began at the end of September. We offered vaccinations to anyone unvaccinated in the household and were able to vaccinate whole households together, in some instances up to 6 people in one home. In 2021 we vaccinated 2232 people in their homes, and as at 13 April 2022 we have vaccinated a further 154 with their primary doses, 671 boosters and 46 tamariki. Many Māori and Pacific providers were also delivering in-home vaccination, however these numbers are not included in the above.

Needle phobia

In 2021 we supported an overview of support for needle phobia across all service areas and made improvements including the purchase of buzzy bees, a numbing and distraction tool. We supported the identification and triage of needle phobic persons' to appropriate services (70 people were triaged) and in extreme cases referred them to sedation clinics set up by ADHB and WDHB (30 people were fully vaccinated in our sedation clinics with more having one dose only). In 2022 a similar process was developed for needle phobic tamariki and they were triaged to play specialists at Starship Hospital. Many people with moderate to severe needle phobia were successfully managed by the community vaccination centres, GPs, pharmacies, and by our in-home teams.

Vaccination outcomes

In the disabled population, funded by the MoH in Auckland DHB, all ages achieved a 90% or higher rate of vaccination.

Across the wider disability sector MoH worked with the Social Wellbeing agency to look at tracking vaccinations for all disabled people (including those not receiving MoH support). The results show that metro Auckland DHBs had the highest vaccination rates for disabled people in the country (see attached).

Outbreak response and preparedness

In 2022 we continue to provide support to the disability residential providers in metro Auckland. There 27 residential providers with over 400 homes between them. As the outbreak started, we supported providers to access appropriate PPE and RATs and advocated on their behalf to Healthcare Logistics (HCL) for a rapid service, provided public health support and referred some to other DHB services including MeRCH.

As a result of this regular huis were set up with disability residential providers and ARPHS/ NRHCC to build good linkages to the sector. These meetings provided public health advice, support to interpret MoH polices and allowed providers to share concerns, raise queries and discuss ways of working.

We also developed a guidance document for them to help distil the complex information coming from the MoH. As policy advice changes the document is updated and recirculated. The guidance

document also clearly outlines where to go for ARPHS, clinical and other supports available, it provides links to IPC advice, and a process for bulk uploading RAT results.

We have recently invited Northland providers to join this hui. The MoH has advised that they are looking to make the guidance information a national document for other DHBs to use.

SOCIAL WELLBEING AGENCY | TOI HAU TĀNGATA

Information sheet

Analysis: COVID-19 vaccine uptake for disabled people

7.2

December 2021

Approach

When people are vaccinated, only information necessary to match their vaccination to their health record is collected – people are not asked whether they are disabled.

The Ministry of Health asked the Social Wellbeing Agency to create a disability indicator using the Integrated Data Infrastructure (IDI) and look at vaccinations for disabled people. We matched COVID-19 vaccine data with datasets within the IDI, which is anonymised.

We can estimate that there are about 1.2 million disabled people. We can see how many people in this group are vaccinated, but not who is or is not. There are strict laws about using this information; we cannot identify individuals or contact people using this data.

Vaccination data enters the IDI every two weeks – these findings are as of **30 November 2021.**

Our analysis focused on non-vaccination to help the vaccine rollout by showing where more support was needed. The attached graphs on **non-vaccination** informed the insights in this info sheet.

Creating a disability indicator

We created the disability indicators based on the Washington Group Short Set (WGSS) in the IDI. We used a variety of sources to identify people with functional disabilities in line with the WGSS questions - *Walking, Seeing, Hearing, Remembering, Washing, and Communication*.

This methodology estimated approximately 1.2 million disabled people.

The Social Wellbeing Agency worked on this methodology with the Ministry of Health. Defining disability for the uses of data will never be perfect because there are many lenses to a disability, but this is a massive step for providing helpful information to the disabled community. Our approach aligns with the 2019-2023 Disability Action Plan.

Key insights

- 90% of disabled people have received at least one dose of the vaccine, compared to non-disabled (83%)
- 84% of Māori disabled and 85% of Pacific disabled have had at least their first dose, compared to Māori (74%) and Pacific (79%) non-disabled people.
- Auckland DHBs have the highest vaccination rates for disabled people in the country (92%)

Types of impairment

We categorised our overall disability indicator:

- 0 if no functional difficulty;
- 1 if an individual has at least one functional difficulty classed as high, but none classed as very high; and,
- 2 if an individual has at least one functional difficulty classed as very high.

People with a disability or impairment in the **1** category have higher rates of receiving at least one dose of the vaccine than **2**

We can see in the data that more disabled people with complex needs have slightly lower vaccination rates than those with less difficulty (88.6% vs 90.2%).

However, disabled people living in residential care facilities have incredibly high rates (94.9%) of having received at least one dose of the vaccine.

Hearing or remembering

Rates of non-vaccination for the overall disabled population is low. However, the biggest gaps are observed among those with hearing and remembering difficulties.

People with hearing difficulties are **less likely** to have had at least their first dose of the COVID-19 vaccine than the overall disabled population but still are 5.5 percentage points ahead of non-disabled people.

People with remembering difficulties have similar levels of having at least one dose as non-disabled people.

Ethnicity

Vaccination rates for Māori and Pacific disabled people are still climbing, not slowing as we see in other populations. In some DHB areas, these rates are accelerating.

84% of Māori disabled and 85% of Pacific disabled have had at least their first dose, compared to Māori (74%) and Pacific (79%) non-disabled people

DHBs

All DHBs are making significant progress with vaccinations for disabled people (see graphs). For some DHBs (i.e. Tairāwhiti, Southern), we are witnessing Māori and Pacific disabled people still getting vaccinated at a steady rate. Vaccinations rates are accelerating.

Auckland DHBs have the **highest vaccination rates** for disabled people in the country (92%)

Learning impairments and people who are autistic

We also estimated vaccination rates for people with learning (intellectual) impairments (ID) and autistic people.

Overall, individuals with learning (intellectual) impairments or who are autistic have vaccination rates broadly in line with the non-disabled population (84.6% and 85.3%). But there are pockets within these communities who are still lagging, e.g. younger people (12 to 24-year-olds) with learning (intellectual) impairments (81.6%).

Occupational Health and Safety Policy Review

Recommendation

That the Board:

1. **Receives** the amended Occupational Health and Safety Policy.
2. **Notes that:**
    a. The policy is due for review by June 2022.
    b. The amendments made to the policy are interim to enable Auckland DHB to have a current policy in place whilst a full strategic review takes place over the next 12 months in collaboration with workers and our union partners.
3. **Approves** the amended interim policy for adoption.

Prepared by: Michelle Webb (Business Support Advisor Occupational Health and Safety)
Endorsed by: Alistair Forde (Director Occupational Health and Safety)
Approved by: Mark Edwards (Chief Quality, Safety & Risk Officer/ HSW Governance Committee Chair)

Glossary

HSW	Health, Safety and Wellbeing

1. Executive Summary

The Occupational Health and Safety Policy is due for review by June 2022.

The policy had been reviewed late last year with minor amendments relating to ownership and grammar and being made.

Since that time the approach to governance and leadership has evolved and the policy may no longer fit with the direction of travel Auckland DHB and its union partners want to take.

With the policy due to expire in June 2022, there is insufficient time for a full revision of the content in collaboration with workers and our union partners.

The wording in the interim policy has been:

- Aligned with our desired direction and strategic goals
- Consulted on with the wider organisation and
- Endorsed by the HSW Governance Committee who now recommend the Board approve it for adoption.

2. Conclusion

It is recommended that the Board approve the interim policy for adoption to ensure Auckland DHB has a current policy as of June 2022, to allow adequate time for consultation, engagement and development of a more fit for purpose policy going forward.

Health and Safety Policy

Unique Identifier	HS01/POL/002 – v01.00
Document Type	Policy
Risk of non-compliance	may result in significant 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 directorates
• Department(s)	All departments
• Used for which patients?	N/A
• Used by which staff?	All staff
• Excluded	
Author	Director - Occupational Health and Safety
Authorisation	
• Owner	Chief Executive & Endorsed by The Board
• Delegate / Issuer	Chief Quality, Safety and Risk Officer
First issued	07 June 2019
This version issued	[Publish Date] - reviewed
Review frequency	Yearly

Contents

Health and Safety Policy

A safe environment for everyone
A culture of excellence in health and safety performance

1. Statement of Intent

Auckland DHB recognises that the safest and healthiest workplaces are ones where the PCBU and its workers engage and work together. Auckland DHB is committed to improving health and safety in the workplace by promoting cooperation between the DHB, workers and unions representing workers, and to ensuring our obligations, risks and any harm are understood, regularly discussed,and assessed.
We are committed to the development of a positive health and safety culture, providing safe and secure facilities and the training needed to ensure workers can keep themselves safe in our workplace.
We want to understand our hazards and reduce our risks, reduce injury rates and fully support workers who experience an injury in our workplace.

2. Principles

We will partner with our people to ensure they feel safe, supported and cared for. We will do this by:

- Embedding Occupational Health and Safety into our everyday work.
- Providing appropriate resourcing to support our Occupational Health and Safety objectives.
- Providing education and training for workers, to ensure all workers know how to take reasonable care of their own Health, Safety and Wellbeing at work.
- Ensuring that all workers take reasonable care of their own Health, Safety and Wellbeing.
- Ensuring people managers have clearly defined Health and Safety responsibilities and accountabilities, and identify any continuous improvement opportunities.
- Having a commitment to comply with relevant legislation, Auckland DHB Policies and Procedures, Codes of Practice, standards and safe operating procedures.
- Setting appropriate performance criteria, with a focus on the implementation of annual Health and Safety Plans and measuring and monitoring progress at all levels.
- Ensuring the Auckland DHB Occupational Health and Safety system supports continuous improvement, is reviewed annually and updated to reflect changes in the work environment, legislation, or other impacts.
- Ensuring we engage with and enable the participation and representation of workers and their representatives in relation to Health and Safety matters before adopting or implementing any changes which may impact on our workers, visitors, and patients.

3. Policy Statement

We will put this policy into practice by integrating health and safety into all aspects of our operations. We will actively encourage good health and safety practices and apply effective policies, standards, systems and processes. We will measure and monitor our progress towards our performance objectives to understand our success.

Ailsa Claire	Pat Snedden
Chief Executive	**Board Chair**

Published [Publish Date]

Petition to the Auckland DHB Board

Recommendation

That the Board

1. **Receive** the petition from Richard Stein regarding a request for Auckland DHB employ a specialty nurse in Starship Community Services

2. That the minute extract from the discussion of this item be provided in response.

Prepared by: Jennie Montague, Head of Executive Services

1. Overview

- A petition was received by the board chair from Richard Stein, Chairman, Crohn's and Colitis New Zealand Charitable Trust on 11 May 2022.
- The petition requests that Auckland DHB urgently begin the process of hiring a paediatric IBD Clinical Nurse Specialist at Starship.
- The petition and the letter to the chair of the board are attached.
- The petition had received 1324 signatures at the time of receipt on the 11 May 2022. Auckland DHB received a file of confirmation of the names of the signatories but have not included them in the pack.

Crohn's and Colitis New Zealand Charitable Trust
P O Box 41145, Eastbourne, Lower Hutt 5047
W: www.crohnsandcolitis.org.nz
Charities Commission registration number: CC43580
E: info@crohnsandcolitis.org.nz

Auckland District Health Board
Board Chair - Pat Snedden
E: boardenquiries@adhb.govt.nz

c.c. CEO, Ailsa Claire, AilsaC@adhb.govt.nz
Dr Helen Evans, HEvans@adhb.govt.nz

11 May 2022

Kia ora Mr. Snedden, Chair of the Auckland DHB,

Five days ago, a petition was launched asking Auckland DHB to hire a paediatric IBD Clinical Nurse Specialist at Starship. The petition already has over 1300 signatures. While this is just one nursing position, the impact on the health and well-being of the hundreds of Starship children with Crohn's disease and ulcerative colitis in the North Island would be immeasurable. It would prevent ED visits, hospitalisations and save money. Most importantly, it is necessary if we are to deliver an acceptable level of care to children with IBD. The reasons are explained in the body of the petition, and I think they are self-explanatory.

We were assured over a year ago by the hospital administration that a business case was in the process of being written, but were dismayed to find through an OIA request that this has not occurred. We have repeatedly been told that there is no funding available, despite the fact that the 2021 Auckland DHB budget allocated for over 130 new RN and senior nursing positions.

I have tried working through normal channels for the past 15 months, but have met with no success or assurance that this position will ever be filled. Each day that goes by, children are being denied the basic care and support that they require and deserve.

Auckland DHB has the opportunity to address and correct this situation before it is disestablished in a couple of months.

Our request is very simple: to urgently begin the process of hiring a paediatric IBD Clinical Nurse Specialist at Starship. I am certain that my gastroenterology physician and nursing colleagues at Auckland DHB will agree that this is long overdue.

I would be happy to discuss this further or speak directly to the Board to answer questions.

Kind regards,

Richard E. Stein MD

Richard Stein, MD, FRACP, FACG
Gastroenterologist
Chairman, Crohn's and Colitis New Zealand Charitable Trust
Ph: (+64) 0275 454539

Enc: Petition
List of signatories (as of 11 May 2022)

To: Starship Hospital and the Auckland DHB

Our children with Crohn's disease and ulcerative colitis deserve the same care as adults!

Campaign created by
Richard Stein

For years, the hospital has acknowledged the critical importance of this role in providing standard-of-care treatment for children with Crohn's Disease and ulcerative colitis. However, no IBD Clinical Nurse Specialist has been employed at Starship.

It is time that Starship honoured the lives of the children that have been impacted by their inaction, and employ an IBD Clinical Nurse Specialist.

Why is this important?

New Zealand has one of the highest rates of Crohn's disease and ulcerative colitis (known as inflammatory bowel disease or "IBD") in the world. These diseases are chronic and relapsing illnesses, characterised by sudden flares, emergency department visits, frequent hospitalisations, and, often, surgery. It is estimated that there are 20,792 New Zealanders with these diseases and the number is expected to double in the next ten years. Many of these patients are children.

While almost every DHB in NZ funds adult IBD specialty nurses, there is not a single paediatric IBD nurse in all of New Zealand, not even at our largest paediatric centre, Starship Hospital. The issue of equity for this very vulnerable segment of our population needs to be raised.

The critical role of the IBD nurse is to provide direct, immediate medical access and assessment to children when their disease suddenly flares. In these situations, it is prompt treatment which prevents lengthy hospitalisations and life-altering surgery. In addition, IBD nurses are the primary educators of both patients and caregivers, they manage immunosuppressive medications, ensure that preventative measures such as vaccinations and screening procedures are

1,324 of 2,000 signatures

Sign the petition

First Name * (required)

Last Name * (required)

Email * (required)

Postcode (use 0000 if outside of New Zealand) * (required)

Phone Number

SIGN

Your personal information will be kept private and held securely. By submitting information you are agreeing to ActionStation keeping you informed about campaigns and agree to the use of cookies. Privacy policy

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10.1

up-to-date, provide advice on diet, manage side effects of medications, and ensure compliance with treatment regimens. Not only does the work of the IBD nurse improve patient outcomes, but it significantly frees up time for their physician colleagues to perform other tasks.

The impact of the IBD Clinical Nurse Specialist on patient outcomes and hospital costs has been well and repeatedly documented. A recent study reported in the British Medical Journal in 2020, demonstrated a one-third decrease in hospitalisations in the year following the addition of an IBD nurse to the GE team (P=0.002). Similar results were reported in a study from the Royal Adelaide Hospital in the Journal of Crohn's and Colitis.

Hiring a single nurse will not only save taxpayers tens of thousands of dollars, but, most importantly, will help keep our children out of the hospital and out of surgical theatres. It will ensure that our children have access to the same quality care that is routinely available to adult IBD patients in New Zealand and to other children throughout the world.

10.1

CATEGORIES

Equality and fairness Inclusive and diverse communities

Reasons for signing

> Because children in New Zealand with IBD deserve better.
>
> Katie B. 2022-05-09

> Awesome cause!!!
>
> Kim W. a day ago

> They need help
>
> Raewyne R. 2 days ago

Updates

1 day ago

1,000 signatures reached

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
1.0 Attendance and Apologies	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]
2.0 Conflicts of Interest	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]
3.0 Confirmation of Confidential Minutes 6 April 2022	**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 Circulated Resolution FIRP Tranche 2 Central Plant & Tunnel Contract Approval 03 May 2022		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]
4.0 Confidential Action Points	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for

		withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4.1 Nursing Shortage – Deep Dive	**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)] **Obligation of Confidence** Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
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 [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 Chief Executives Confidential Report - verbal	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [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]
6.2 Update on the transition to Health New Zealand and the Maori Health Authority – verbal update	**Obligation of Confidence** Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report.	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 People and Culture Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for

	disadvantaged if that information was made public [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)]	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)] **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]
8.2 Hospital Advisory Committee Executive Report	**Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time [Official Information Act 1982 s9(2)(c)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.1 NRHCC Retrospective Contract Approvals	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.2 50 Grafton Infrastructure Renewal 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)]	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	**Commercial Activities**	That the public conduct of the whole or

Taylor Centre Relocation to 50 Grafton Road Business Case	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)]	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 Variations Approval for: 160 Grafton Road fitout project; Carpet to vinyl flooring replacement A32 project; Linac cooling system upgrade; Hospital orderly management system 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 [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]
9.5 Clinical Transcription and Dictation 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)] **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]
10.1 Provision for Continuity of Independent advice to Auckland DHB during the transition to Health NZ	**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]
11. Information Reports - Nil	n/a	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act

		1982 [NZPH&D Act 2000]
12 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]