AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Open Board Meeting

Wednesday, 23 February 2022

10:00am

Note:

- **Open Meeting from 1:30pm**
- **Public Excluded to follow**

via Zoom

Healthy communities | World-class healthcare | Achieved together
Kia kotahi te oranga mo te iti me te rahi o te hāpori

Published 17 February 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
23 February 2022

Venue: Via Zoom **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 **Appointed HAC Members** Heather Came **Seat at the Table Appointees** Krissi Holtz Shannon Ioane Maria Ngauamo Kirimoana Willoughby	**Auckland DHB Executive Leadership** Ailsa Claire — Chief Executive Officer Dr Karen Bartholomew — Director of Health Outcomes – ADHB/WDHB Mel Dooney — Chief People Officer Margaret Dotchin — Chief Nursing Officer Mark Edwards — Chief Quality, Safety and Risk Officer Dame Naida Glavish — Chief Advisor Tikanga and General Manager Māori Health – ADHB/WDHB Dr Debbie Holdsworth — Director of Funding – ADHB/WDHB Meg Poutasi — Chief of Strategy, Participation and Improvement Michael Shepherd — Interim Director Provider Services Shayne Tong — Chief Digital Officer Sue Waters — Chief Health Professions Officer Justine White — Chief Financial Officer Dr Margaret Wilsher — Chief Medical Officer **Auckland DHB Senior Staff** Marlene Skelton — Corporate Business Manager (Other staff members who attend for a particular item are named at the start of the respective minute)

Agenda

Please note that agenda times are estimates only

KARAKIA

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

Board Chair, Pat Snedden

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

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

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

10.07am **3.** **CONFIRMATION OF SPECIAL BOARD OPEN MINUTES 26 January 2022**

3.1 Confirmation of Open Minutes of Board – 15 December 2021

10.10am **4.** **ACTION POINTS**

5. **EXECUTIVE REPORTS**

10.10am 5.1 Chief Executive's Report

10.30am	5.2	Health and Safety Report *[Incorporates a Presentation on Provisional Improvement Notices (PIN) and WorkSafe Improvement Notices. Material for reviewing can be found here:* https://open.spotify.com/episode/0fntH65MzU2hpakSgSti6O?si=so2HYNIGSgqAZlQ5Ae2N8g *It is strongly recommended that you read this.]*
11.00am	5.3	Human Resources Dashboard Report F22 Q2: 31 December 2021
	5.4	Pumanawa Tangata - Verbal Update
11.15am	**6.**	**PERFORMANCE REPORTS**
	6.1	Financial Performance Report
	7.	**DECISION REPORTS - NIL**
	8.	**INFORMATION REPORTS - NIL**
	9.	**GENERAL BUSINESS**
11.30am	**10**	**OPEN COMMITTEE HOSPITAL ADVISORY REPORT** [Secretarial Note: Board Chair vacates Chair for Hospital Advisory Committee Chair to assume control.]
	10.1	Confirmation of Open Minutes of the Hospital Advisory Committee meeting of 23 June 2021
	10.2	Hospital Advisory Committee Report to Board
12.30m	**11**	**RESOLUTION TO EXCLUDE PUBLIC**

Next Meeting:	Wednesday, 06 April 2022 at 10.00am
TBA	

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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				
Joanne Agnew	1	1	1	1	x				
Doug Armstrong	1	1	1	1	1				
Michelle Atkinson	1	1	1	1	1				
Zoe Brownlie	x	1	1	1	1				
Peter Davis	1	1	1	1	1				
Tama Davis	x	1	1	1	1				
Fiona Lai	1	1	1	x	1				
Bernie O'Donnell	x	1	x	x	1				
Michael Quirke	1	1	1	1	1				
Ian Ward	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				
Krissi Holtz	1	1	1	1	1					
Maria Ngauamo	1	1	1	1	1					
Shannon Ioane	1	nm	nm	1	nm					

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	26.11.2021

	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	
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) Employer – University of Auckland Internship - MSD New Zealand (Merch Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc., Kenilworth, NJ, USA (to start on 19/2/22)	11.01.2022
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	05.07.2021

Minutes
Special Meeting of the Board
26 January 2022

Minutes of the Auckland District Health Board meeting held on Wednesday, 26 January 2022 via Zoom commencing at 10:00am

Board Members Present	**Auckland DHB Executive Leadership Team Present**	
Pat Snedden (Board Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Margaret Dotchin	Chief Nursing Officer
Doug Armstrong	Justine White	Chief Financial Officer
Michelle Atkinson		
Zoe Brownlie	**Auckland DHB Senior Staff Present**	
Peter Davis	Megan Wiltshire	Director Communications and Stakeholder Engagement
Tama Davis (Board Deputy Chair)		
Fiona Lai	Auxilia Nyangoni	Deputy Chief Financial Officer
Bernie O'Donnell	Marlene Skelton	Corporate Business Manager
Michael Quirke		
Ian Ward		
Seat at the Table Appointees	(Other staff members who attend for a particular item are named at the start of the minute for that item)	
Krissi Holtz		
Shannon Ioane		

Tama Davis led the Board in a Karakia.

1. ATTENDANCE AND APOLOGIES

That the apology of Board Member Jo Agnew and Seat at the Table member Kirimoana Willoughby be received.

2. REGISTER AND CONFLICTS OF INTEREST *(Pages 7-9)*

There were no new interests to register and no member had a conflict with any item on the open agenda.

3. CONFIRMATION OF MINUTES - NIL

4. ACTION POINTS - NIL

5. EXECUTIVE REPORTS

5.1 CHIEF EXECUTIVE'S REPORT (*Pages 10-18)*

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

Christmas

While the hospital was busy over the Christmas holiday period there was time for some

celebrations as well, notably the sponsored 12 days of Christmas giveaways. Staff again participated in the Auckland City Mission appeal and donated to the DHBs own Employee Support Centre.

Climate Challenge Awards

Auckland DHB received three gold awards and one silver award from "Health Care without Harm" in the Health Care Climate Challenge which recognised the DHBs work on climate change.

Your Awesome Campaign

This campaign runs across the three Auckland Metro DHBs and is backed by Stuff. It provided the opportunity to share peoples stories and for the public to reward healthcare workers for their efforts during the COVID 19 pandemic.

Local Heroes

There has been a big catch-up on Local Hero awards. There are a number which are outlined on pages 13 and 14 of the agenda. It is good to find ways to generally celebrate people's accomplishments during this difficult time.

Communication and Engagement

There has been a lot done via social media and for internal communications during this period much of it related to the on-going response to COVID 19.

Performance of the Health System

Meeting the elective surgery target is a major challenge for the DHB in the current environment of COVID and staffing vacancies.

As the vaccinations have been rolled out to the older children there have been opportunistic vaccinations undertaken for other required immunisations. The increased immunisations target is a concern and a focus is currently being placed on it.

Financial Performance

The financial balance is tracking well. This is a complex situation as there has not been the required level of planned care undertaken which has meant too that there has been cost not incurred.

Points covered during discussion:

Ian Ward commented that the operating position of the Board looked fine.

The Board chair, Pat Snedden asked Margaret Dotchin for her observations of the events of the last two months. Margaret commented that it was all about people, the pressure on the system and the impact that this has had on people. The uncertainty about what is coming with Omicron is disturbing although there is a view to be taken by looking at what is happening in Australia and the UK. What the Board and management need to do is to look after DHB staff over the next 6 to 12 months. Significant vacancies are being held over all professional groups which is impacting on service delivery. We have to be mindful of the

impact of that on the population and what effect it has on reducing access to elective care..

The level of nursing shortage sits at 300 plus vacancies out of a total workforce of 4,500. Some areas have a 20% vacancy rate. The expected vacancy rate from Omicron could push some clinical areas to work with a 40% reduction at the peak of the outbreak.

Fiona Lai asked for an update on the percentage of staff having received their booster shot and was advised that it was around 60%. The requirement for health care workers to receive the booster has been gazetted and all must have received it by mid February.

Michael Quirke acknowledged the human resource pressure and commented that the DHB may be placed in the position of considering stand down periods to be applied during the height of the Omicron outbreak so clear guidance would be required.

Doug Armstrong requested assurance that the clinical supplies stock was sufficient and that there are no issues with supply chain. Doug wanted to be sure that there was adequate PPE supply; particularly appropriate masks, RAT tests and vaccine to cover the reduced period between the second vaccination and the booster shot being administered. Doug also wanted more information on how staff redeployment was being managed.

Ailsa Claire advised that a lot of work had been undertaken around supply chain issues which related to not just dealing with things associated with COVID 19, but also core essential business as usual requirements such as delivery of linen and food. There has been work done with DHB contractors in particular to plan for uninterrupted supply of food and linen. Regional work had been done around ensuring supply of essential items to the hospitals and the health service generally.

It is not anticipated that PPE will run out and vaccination supply is good with the reduction in time between second dose and boosters having been anticipated.

Staff redeployment is dependant on DHBs understanding what core services are to be provided in the coming months. The Northern Region has been leading a national piece of work identifying what minimum service provision would be. Tama Davis asked whether PPE supply was sufficient for PHOs as well and was advised that this was being worked on. Tama then drew attention to the 40% reduction in staff referred to by Margaret Dotchin and asked what those areas were being advised; surgical inpatient wards, emergency department, operating theatres and mental health. The effect in some areas would be mitigated by moving to minimum service delivery and others would have to be mitigated by redeployment.

Resolution:

That the Chief Executives report for 29 November 2021 – 9 January 2022 be received.

Carried

6. PERFORMANCE REPORTS

6.1 Financial Performance Report (*Pages 19-22)*

Justine White, Chief Financial Officer asked that the report be taken as read, advising that the reported results were for November and that she would provide a verbal update based on December results.

The Board is sitting with a favourable overall result and favourable business as usual result. At the end of December that favourable result was approximately $29.8M at a year-to-date level with a $13.5M favourable result in the month of December. Of the $29.8M there is $23M which relates to business as usual and $6M that relates to COVID.

COVID is showing as a positive variance because currently additional revenue is being received from lab testing which is covering other unfunded costs.

Much of the business as usual favourable variance can be attributed to people costs that remain unexpended because the DHB is unable to recruit to fill all of the vacancies for CCDM requirements. There is also some impact from untaken annual leave and a minor offset from clinical supplies where, as the DHB is behind in production in planned care we have not expended as expected on clinical supplies.

The forecast to the end of the year is hard to predict as it involves determining between what might be timing variances, versus what might become a permanent difference. At this stage it appears that the Board will be in a modest favourable position but that is very dependant on the impact of Omicron on the workforce and operations.

The cash position is still looking healthy, some of which can be attributed to the delay in our capital expenditure plans due to the inability of teams to undertake the work as they have been focussed on COVID 19. This is expected to be mostly a timing variance rather than a permanent situation.

Points covered during discussion:

The Board Chair, Pat Snedden reflected that it was interesting and rather ironic that this is the first year that in terms of staff cost the Board is well under budget.

Justine White commented that the CCDM requirements are very much around matching acuity of patients with appropriate staffing levels. The ability to fill that requirement is totally compromised as staff simply cannot be found. The underlying position is around 380 FTE favourable for December which is significant.

Michael Quirke was advised that the $13.5M favourable position related to December alone; There was a significant increase in unbudgeted revenue, such as $4.2M from the MoH in signed side contracts and another circa $2M of ACC revenue. There is also approximately $6M to $7M worth of additional revenue that relates directly to additional cost with that revenue not being in the budget, such as pay equity funding.

The Board Chair Pat Snedden commented that in terms of the nursing position the Board

pre-COVID had traditionally relied on overseas applicants and this avenue for recruiting had now stopped. He asked how this quota was now being managed. Margaret Dotchin advised that a nursing campaign was running called "Kia ora.nurse" which was an international campaign targeted at specific countries. We cannot target the usual places such as the Philippine's where traditionally a lot of the DHBs nurses have come from. Advice from WHO has requested that poorer countries not be targeted in terms of importing their workforce.

Margaret Dotchin commented that there is still a steady stream of nurses coming from overseas. There were more nurses recruited in 2021 over 2020 but turnover has also increased. The biggest cohort of new graduate nurses, over 160, will be taken in during February this year. There is national work being undertaken around nursing supply and demand as the continued pipeline supply within New Zealand itself is very important.

There has never been good workforce modelling in terms of the nursing pipeline until now. Margaret Dotchin advised she is chairing a national group which is obtaining some very good data around need by geographic region, by ethnicity and by education provider. More understanding of demand is required as more health services are brought on and as the current nursing workforce ages. What happens with retention over the next 12 – 24 months will be very important for managing future supply and demand. The turnover of nurses worldwide is increasing as nurses choose to leave that workforce after 24 months of living with and supplying care during COVID.

In New Zealand there have also been issues around terms and conditions and pay which have now been resolved. The MECA has been settled and there is agreement in principle for gender pay for nurses which will help resolve some pay concerns. What is important over the next 6 months is how the nurse workforce is supported and cared for as they care for patients.

The Board Chair, Pat Snedden asked about capital programmes and the success or otherwise with negotiations with the Centre. Justine White advised that the Health Infrastructure Unit had approved $6M capital for related builds/programmes at the start of the year. Conversations are being taking place with Treasury around the remainder of the items on the DHBs list and looking at ways these could be funded. At this stage the Board is to front foot the cost of prioritised projects [which the Board has agreed to] and conversation will take place with Treasury around what opportunities there are for funding those projects that remain un-prioritised. In regard to the Health Infrastructure Unit, there was a national funding pool of $100M with the region gaining $25M of that and Auckland DHB getting $6m of that $25M.

Michael Quirke asked that with staffing shortages had there been a shift of nurses to agencies to obtain flexibility? Margaret Dotchin advised that this was not being seen at this time. Active recruitment into the DHBs own internal nursing bureau was on-going but no casualisation of the DHBs permanent nursing workforce was being seen.

Resolution:

That the Board receives the Financial Report for the period ended 30 November 2021

Carried

7. COMMITTEE REPORTS - NIL

8. DECISION REPORTS- NIL

9. INFORMATION REPORTS

9.1 Omicron Report *(Pages 23-44)*

Ailsa Claire, Chief Executive asked that the presentation be taken as read as it had been presented to Joint Board Chairs and Board members last week, she would take questions.

Points covered during discussion:

Advice was given to Peter Davis that mortality modelling had not yet been undertaken. Peter Davis commented that Omicron would not be the last variant to hit the country and asked whether MIQ facilities, which under a severe community Omicron outbreak were to be reduced, would be available to be stood back up. Ailsa Claire advised that the MIQ supply was being maintained and in the future supply would be a national policy decision.

Michelle Atkinson was advised that there was not enough information to know when the Omicron peak would occur. There is no obvious link to the border with current Omicron cases suggesting a multi generation infection. Until more testing is done it won't be known how rapidly exposure will occur in the community.

Tama Davis acknowledged the Executive Leadership team for the work done to enable service delivery to continue over the Christmas period and keeping the Board informed about planning for the next months and the key issues and remediation required to enable services to continue to be delivered.

Resolution:

That the Board receive the January 2022 presentation on Omicron

Carried

10. GENERAL BUSINESS

There was none.

11. RESOLUTION TO EXCLUDE THE PUBLIC (*Pages 45-47)*

Resolution: Moved Pat Snedden / Seconded Tama Davis

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 - 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]
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]
5.0 Risk Report - 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]
6.1 Chief Executive's 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)] Negotiations Information relating to commercial and/or industrial negotiations in	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]

	progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)] 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 1982S9(2)(k)]	
7.0 Performance 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]
8.0 Committee 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]
9.1 Non Resident Write Off - Neurosurgery	Privacy of Persons Information relating to natural person(s) either living or deceased is enclosed in this report.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.2 Proposed Debt Write Off – NGO Provider	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]

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]

Carried

The meeting closed at 12.10pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 26 January 2022

Chair: _____ Date: _____

Pat Snedden

Minutes
Meeting of the Board
15 December 2021

Minutes of the Auckland District Health Board meeting held on Wednesday, 15 December 2021 via zoom at 10am

Board Members Present	**Auckland DHB Executive Leadership Team Present**	
Pat Snedden (Board Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Mel Dooney	Chief People Officer
Doug Armstrong	Mark Edwards	Chief Quality, Safety and Risk Officer
Michelle Atkinson	Michael Shepherd	Director Provider Services
Zoe Brownlie	Shayne Tong	Chief Digital Officer
Peter Davis	Sue Waters	Chief Health Professions Officer
Tama Davis (Board Deputy Chair)	Justine White	Chief Financial Officer
Michael Quirke		
Ian Ward	**Auckland DHB Senior Staff Present**	
	Sarah McMahon	Communications Manager
Seat at the Table Appointees	Marlene Skelton	Corporate Business Manager
Krissi Holtz		
Maria Ngauamo	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

KARAKIA

Tama Davis led the Board in a Karakia acknowledging the attendance of members of the public Stephen Evans and John Edens from Radio NZ.

1. ATTENDANCE AND APOLOGIES

That the apologies of Board members Fiona Lai and Bernie O'Donnell be received.

That the apologies of Executive Leadership Team members, Margaret Dotchin, Chief Nursing Officer, Dr Debbie Holdsworth, Director of Funding – Auckland and Waitematā DHBs, Meg Poutasi, Chief of Strategy, Participation and Improvement and Dr Margaret Wilsher, Chief Medical Officer be received.

Board Chair – Reflection on 2021

The Board Chair, Pat Snedden commented that he had been involved in governance for 40 years and had not faced anything comparable to what has occurred in this last year. As an organisation the DHB had seen the stress of a major pandemic affect it in a way that its people had responded to heroically. "We have reorganised ourselves in order to address the needs of our population while at the same time keeping our workers safe and doing the very best that we can to vaccinate the whole of the population that we are responsible for."

CEO, Ailsa Claire took over the responsibility for leading the Northern Region vaccination

programme. The northern region DHBs have concentrated as a collective on the most important thing first. That was getting people vaccinated and keeping them safe in the face of this really significant challenge posed by the Delta virus. In doing that the Board made some really clear decisions about how it would structure and run the DHB. The most important thing in this context was to have our really capable labour force attuned and available to actually to meet the needs of testing, vaccinating and of responding to those with COVID. The Board chose to look at the organisational framework and consider how the DHB could operate efficiently, how it could be responsible as a public agency and be transparent in what it was doing, how it could the apply the labour available to it in the most effective and efficient way and keep the population safe via vaccination as fast and as effectively as possible.

To do that the Board decided to distribute its labour differently. Many of the Executive Leadership Team members have seen their roles change over this last year as they have taken on other tasks associated with COVID and the consequential aspects that have come with that. The region has collaborated in a way that it never has before. The strengths of each have been called on to take on the vaccination challenge that the government gave it and to meet that challenge.

We all know that in the equity space, Māori and Pacific vaccination rates are lower than the rest of the population. We know about the threat to welfare that provides and are determined that this year finishes with the DHB meeting the targets that it has set itself of having 90% of Māori and Pacific vaccinated.

The DHB realised that in the process of following this course some of the planned care would have to be cancelled as workforce was mobilised to respond to the COVID threat. It is recognised too that some of the normal aspects around governance have had to be abbreviated and in some cases put on hold as the tasks required to provide focus on the vaccination programme were put into play.

It may be said that some things could have been done better and there are always things to be learned. However, the significant success of the vaccination programme has indicated that the right choice was made and that labour and expertise were deployed where it was needed in order to keep New Zealanders safe.

As the Board goes into the new year the previous governance structures will be restarted and a more conventional approach will be taken as the Board moves toward the transfer into Health New Zealand.

The Board Chair, Pat Snedden thanked all senior staff, Ailsa Claire for her leadership as CEO and the three other regional DHBs for their collaboration all of whom had worked hard to provide a really remarkable outcome.

All are aware of the strain in Northland and as a collective we will not leave them behind. They are making progress.

It has been an extraordinary journey, one where it would not be expected to have had this level of collaboration, working at this level of speed and with the trust and confidence in one

another to attain the result that we have.

It is true that some of the governance arrangements that were historically relied on have had to be changed but they will be reinstated in the new year. There is confidence that the Board will move into the new Health NZ arrangement with all the appropriate attention given to governance.

This has been an enormous effort to keep our population safe. The Board should be proud to be part of a regional push that has pulled this result off.

2. REGISTER AND CONFLICTS OF INTEREST *(Pages 7-9)*

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

3. CONFIRMATION OF MINUTES 3 NOVEMBER 2021 (*Pages 10-18)*

Resolution: Moved Jo Agnew / Seconded Zoe Brownlie

That the minutes of the Board meeting held on 03 November 2021 be confirmed as a true and accurate record.

Carried

3.1 Emergency Meeting of the Board 24 November 2021 *(Pages 19-21)*

Resolution: Moved Jo Agnew / Seconded Zoe Brownlie

That the minutes of the Board meeting held on 24 November 2021 be confirmed as a true and accurate record.

Carried

4. ACTION POINTS - NIL

There were no outstanding actions to review.

5. EXECUTIVE REPORTS

5.1 Chief Executive's Report (*Pages 23-34)*

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

COVID and Vaccination Rates

What has been achieved in this organisation and within the NRHCC has been amazing.

Auckland DHB has the highest vaccination rate in the country and the highest Māori vaccination rate.

The metro area has gone from zero to several thousand people being supported at home in community isolation all done via the NRHCC. Within the DHB there have been the challenges of COVID and now the hospital is extremely busy. Ailsa Claire acknowledged the effort of all at a time when the DHB had been struggling to get additional staff.

Living With COVID

Much work has been undertaken in this area looking at how to mitigate issues moving forward. The reality is that although the numbers of people in hospital are reducing the fact that care is being offered in hospital during a COVID outbreak makes tasks less efficient. Staff have to don and doff PPE and observe other health and safety measures, all of which slow things down considerably.

Staff Vaccination Rate

Ailsa Claire expressed pride in work that had been done to get the staff vaccination rate to where it was. There were less than 50 people from a workforce of 12,000 that remained unvaccinated. That includes contractors as well.

New Kidney Centre in Tamaki

This centre was provided through a partnership with the Tamaki Regeneration Company. When the service moves in with the Tamaki Regeneration Health Hub the unit can be moved to another part of Auckland. It makes dialysis more accessible for patients living in Tamaki and surrounding areas.

Woman's Health – Whitinga ora pepi

Mike Shepherd advised that the Whitinga ora pēpi 'babies transitioning to wellness', is an eight bed joint venture from Women's Health and the new born Intensive Care Unit (NICU) and is located in Ward 96. The concept being that there are some babies who are not quite ready to go home, don't need NICU care but do require some closer monitoring before being released to go home.

Mahi e Taea

Mel Dooney advised that the new Mahi ē Taea desktop and mobile application has been launched. This replaces Workforce Central for recording leave, shifts and time cards.

It is a more modern and agile cloud based system allowing a move toward more advanced workforce scheduling practises.

Complexity in Hospital System

Mike Shepherd in response to a question from the Board Chair, Pat Snedden, advised members about what might be required in the future to pivot to meet increasing complexity in the hospital system.

Patient Flow

Consideration is being given to how to make enduring improvement on the back of the changes we have made as part of living with COVID. The staff are being challenged to undertake things in a new way that follows the new direction that the health system is

moving in. As an example, the use telehealth and telephone interpreters, we now understand the benefits and limitations of these modalities much better and are working to ensure gains are not lost. Another example is planned care, where it is known that there are restrictions around what can be delivered in current environment. The focus now is on patients who have the longest waits; with a keen eye kept on equity within that process to ensure that Māori and Pacific patients are efficiently navigated through the system. Making sure that the teams understand that the work has to be done to ensure that those most in need come through the planned care process.

There are some significant challenges on the horizon around efficiency of delivery in a living with COVID environment. We need to make sure that the most is made of our finite resources. We need to make sure patients and staff are safe whilst continuing to deliver the essential healthcare the community requires. Testing and screening approaches will need to continue to be refined to support this.

It is known that Auckland DHB has to deliver the more complex care for both the region and the country so thinking has been done around how operating room resources might be optimised and shared around the region to deliver as much care as possible.

The international border opening is seen as an important risk and planning for that is underway to manage the surge of a combination of other infections in the same way that COVID has been managed. The restriction of visitors has been an important problem worked on through the year. The organisation has moved a long way to be able to recognise whanau as partners in care. Understanding how that can be enabled and people remain connected is something that has not been done as well under COVID as previously. There is an opportunity to continue to improve in this area.

There is concern that people have not been referred to the hospital during COVID. There are patients in the community who should have come to our attention. Work is being done with Primary Care and others to enable that to occur.

There is also a cohort of planned care that has not been delivered particularly in the medium and lower severity spectrum. The most urgent, time critical cases and those most likely to deteriorate quickly have had to be prioritised first. A moderate amount of lower severity work has been managed to be accomplished in the day stay care setting but there is a group of other patients that require in-patient stays and a significant component of planned care. Those are the cases that are being monitored carefully with the knowledge that they are waiting longer than we would like them to have to.

Questions from Board Members about complexity in the Hospital

The approach we are taking is to continue to maintain our outpatient and diagnostic activity as once people are seen by our clinicians, a much more accurate assessment can be made around time criticality and severity. Patients on waiting lists to see a specialist are more concerning as we are not able to stratify their clinical risk.

Primary Care and others have been communicated with to advise of the longer waits and asking that they contribute to the monitoring their patients. Once people are seen there is a good opportunity for prioritisation. Cancer treatment wait times have held up through

COVID to a large degree as they have been prioritised.

There is no doubt having people on waiting lists carries risk, so work has been done with surgeons, nurse specialists and Kaiarahi Nahi and Pacific navigators to keep in contact with patients and monitor how their conditions are progressing. It is not a perfect system with the more preferable scenario being shorter wait times. Both areas continue to be worked on.

A regional wait list approach has been taken to catching up with surgery to ensure greater inequity is not created regionally in any service. That has meant not simply getting on with Auckland DHB work but taking a wider regional view. DHBs are supporting one another to manage care for the total regional population. Teams have been instructed where there is an opportunity to do more please do it. Funding is not to be seen as a barrier. The DHB has sought to maximise access to any private capacity within the region but again this will be used in a regionally coordinated manner. National conversations have also been had to ensure that Northern Region is not differentially disadvantaged in doing this.

Service hot spots are gynaecology, ECHO and cardiology, which is a particular regional and national problem and planned care in orthopaedics, has been problematic nationally. Ophthalmology in Northland is also a concern which Auckland DHB has been trying to assist with. These are not new issues.

Advice was given that the low referral rate could not just be solved by more engagement with Primary Care as 50% of referrals actually came from other DHBs and it is also related to patient behaviour. Primary Care in metro Auckland has been under strain as it has been assisting with the vaccination programme, testing and providing other support. Conversations have been had with them and they are aware of the catch up that is required. This too is not simply a problem about capacity it is one about people themselves. They have been anxious, staying at home and reluctant to attend health facilities to take up diagnostic appointments.

It was explained that the NRHCC provided support for COVID positive patients at home, the other service was “Hospital at Home” for those patients that do not require hospitalisation for has some greater needs than would normally be able to be supported in a community isolation facility then the Provider Arm provides this support at home.

Transition Unit

A number of senior leaders have been working in the Transition Unit, in particular Mel Dooney and Shayne Tong. Jo Gibbs has been seconded to the Ministry of Health working on the vaccination programme and will next move to Health NZ to assist with health reform. Justine White has been supporting Rosalie Percival in leading the financial work for the Transition Unit. This has stretched the Executive Leadership Team but is recognition that Auckland DHB has skilled staff.

Health Awards

Ailsa Claire drew attention to the health awards outlined on pages 27-28 of the agenda

New Appointments

We're delighted to welcome Julie Patterson as Women's Health Director. Julie is a highly experienced, qualified and committed leader, with an extensive career in executive management roles.

Lisa Middelberg has been appointed as General Manager for Patient Management Services. She has extensive leadership experience across a range of services. Most recently as the Operations Lead for the COVID-19 vaccination programme.

Communication and Engagement

Ailsa Claire drew attention to 30-31 of the agenda and the extent and breadth of communications that had kept staff busy. There had been a number of webinars aimed at educating staff. As much information as possible had also been shared in the public domain.

Performance of Health System

Acute flow has particularly been affected by COVID. As the front door to the organisation this service has had to ensure all precautions around COVID are in place. It is a credit to that unit that things move safely for patients and staff.

It is pleasing to see "faster cancer treatment" targets maintained during COVID and concerning that "better help for smokers to quit" has faltered somewhat.

The biggest concern is the "increased immunisation for children" target which has suffered as a result of the COVID lockdown. There is a big push to when immunising children from 5-12 for COVID some catch-up can be undertaken at the same time. It is safe to do this.

Financial Performance

The financial performance remains strong. COVID has challenged income but overall the DHB remains in budget.

Final Questions from Board Members

Tama Davis was advised that the announcement of the new Chief Executive to Health NZ was imminent. He asked how imbedded Executive Leadership Team members were in the Transition Unit and who might be seconded to the new Health NZ unit. It was advised that Jo Gibbs had already been seconded to assist with the on-going COVID response and the public health unit. Mel Dooney has been seconded almost full time to assist with human resources issues. Ailsa Claire herself was assisting with a number of issues also.

Peter Davis asked what metrics there were that would indicate how well NRHCC was doing supporting people at home in community isolation such as the data that was provided for COVID hospitalisations, vaccination and testing. Ailsa Claire undertook to provide some data.

Zoe Brownlie was advised that the biggest decrease in child immunisation was in the Māori cohort. Now that there are vibrant viable Māori providers conversations are being had with them about how they might be supported to assist with these vaccinations. Advice was given that the situation arose because people were reluctant to expose their children to

potential places of infection or events and Auckland were using these child vaccinators at COVID sites. There is a determination to catch up on these vaccinations quickly to beat whatever the international border opening might bring into the country.

Jo Agnew was advised that not all vaccination centres were closing, numbers were being reduced at this time but there were still booster vaccinations to administer through next year. Staff are currently largely being redeployed to the Māori Providers to assist with outreach work. Then will return to assist with the 5-11 year old vaccinations.

Doug Armstrong was advised that there were no PPE supply issues and that there was enough vaccine in the country to administer booster vaccinations. It was unknown if the supply of child COVID vaccine was in the country at this time but the vaccination programme starts on 15 January 2022. RAT test supply was a Ministry of Health contract and Ailsa could not verify what the supply status was. [*Mike Shepherd was able to advise after the lunch break that he had received confirmation that two million RAT tests had arrived in the country.*]

Action

People being supported at home in community isolation

Ailsa Claire to provide data indicating how well NRHCC was performing in this area.

Resolution:

That the Chief Executives report for 30 October 2021 – 28 November 2021 be received.

Carried

[Secretarial Note: Item 10.1 was considered next]

5.2 Health and Safety Report *(Pages 35-45)*

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

- There are only 35 staff out of 12,000 who remain unvaccinated and are currently going through a human resources process.
- The Anatomical Pathology Lab in Mt Wellington over the last few years has become busier and more crowded and is in need of investment. In the last few months progress in addressing staff concerns had been slower than would be liked resulting in concerns being escalated. It is proposed to reduce the number of people in the space, reducing formaldehyde exposure by sending large specimens to other labs around Auckland and spreading the work over a longer period of time. The team are

wearing respiratory protective equipment as they need to.

- There were 4,000 staff surveillance tested over November which required a significant resource load. The current lab capacity and likely travel habits of staff over the next month that testing will now employ a RAT test instead of a PCR test.
- The ACC Accredited Employer audit appears to be going well in the cardiovascular unit.

The following was covered during discussion:

Jo Agnew drew attention to appendix one of the report and HS03 – Manual Handling asking if there had been any training for staff during the COVID period and why was it noted as a likely and moderate risk. Mark Edwards advised that it was the highest loss of work injury which was common across most of health care and it had a moderate consequence but because so much of it had to be done that is why it was classified as "likely". Training continued during COVID and was offered by an external contractor utilising simulated training which had been a good fit. That result reinvigorated the need for a steering group around all of manual patient handling and to change the way training was offered on a permanent basis.

Doug Armstrong asked that the manual handling committee highlights be incorporated in this Health and Safety report going forward.

Zoe Brownlie drew attention to page 39 of the agenda and workplace violence and aggression asking why incidents were lower during this last lockdown period and was advised that there had been a lower number of interactions across campuses

Resolution:

That the Board receives the Health and Safety Report for December 2021.

Carried

5.3 Human Resources Report *(Pages 46-50)*

Mel Dooney, Chief People Officer asked that the report be taken as read, the purpose of the report was to bring the Board's attention to the range of wellbeing support that was being provided to assist staff over what has been a very intense period.

- Effort had been made to ensure that people feel connected at work with tools being put in place to actively check in on people
- A welfare and employee support centre was in place and significant support had been provided to those in need.
- The communication approach this time had been expanded with specific approaches for managers to prepare them to be able to better support staff.

Moving forward attention would be paid to ensuring people take leave and get the rest that they required. Wellbeing would remain a consideration over the coming months.

The following was covered during discussion:

Zoe Brownlie was advised that whether staff felt supported was an individual's independent perception during what is a tricky time but that there were many ways that the organisation demonstrated supported for staff. The work that was being done in the Health Safety and Well Being Governance Committee worked together with what Human Resources were doing with both Mark and Mel sitting on the co-governance committee.

Both Michael Quirke and Krissie Holtz expressed appreciation for the work being done with Krissie noting that the it would make a difference to the Kaimahi Māori staff experience and Michael Quirke noting the largest ever intake in February for the NeTP programme in what was a tricky environment and time and what had been done in the HCA programme which had clearly been successful.

Jo Agnew commented that the nursing vacancies were driving issues within the DHB and wanted to know the impact the new graduates might have on the situation and what the level of nursing staffing currently was. Mel Dooney advised that the hospital would always be recruiting nursing staff however the DHB was able to recruit successfully as demonstrated in the paper. This staff cohort would continue to be a challenge and a lot was being done to address this. There was both National & regional work being done to support local efforts and Margaret Dotchin was involved in leading the work at all levels.

Resolution:

That the Board receives the Wellbeing Report for December 2021.

Carried

6. PERFORMANCE REPORTS

6.1 Financial Performance Report (*Pages 51-54)*

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

- The report in the agenda dealt with the October financial result
- The November result was $16M favourable. This result was made up of Aug/Sept planned care payments of $10M being paid in full. There was some additional revenue in terms of ophthalmology and some slight relief in terms of aged residential care cost of $1.5M and some reduction in pharmaceutical spend.
- Some financial upsides are being seen due to timing. For example, clinical supplies is underspent because the level of planned care has not been able to be offered but it would be expected to be spent in the next half of the financial year.

The Board Chair, Pat Snedden requested in future reporting that a section be included on the financial health of the DHB for a lift and shift to the new entity, Health NZ.

The Board Chair, Pat Snedden further suggested that given the experience of the last four

years most members would be of the view that there is a profound inconsistency around what is needed and what is provided. This is something that should be communicated to Health NZ describing where the opportunities lie and where fundamental issues have never been correctly addressed.

Resolution: Moved

That the Board Receives the Financial Report for the period ended 31 October 2021

Carried

7. COMMITTEE REPORTS - NIL

8. DECISION REPORTS

8.1 healthAlliance – DHN Shareholder Director Change for Northland (*Pages 55-57)*

There were no questions.

Resolution: Moved Pat Snedden / Seconded Doug Armstrong

That the Board:

1. **Note that Northland DHB have nominated Nicole Anderson as a Class A director of healthAlliance N.Z. Limited in place of Dr Michael Roberts**
2. **Resolve that Nicole Anderson be appointed as a Class A director and the company be notified accordingly**
3. **Delegate authority to the Northern Region DHB Chairs to execute all documentation necessary to formalise this director appointment.**

Carried

[Secretarial Note: Michael Quirke as an existing director of healthAlliance Ltd did not vote on this item.

[Secretarial Note: Item 8.3 was considered next.]

8.2 2022 Governance Meeting Structure (*Pages 58-62)*

The Board Chair, Pat Snedden advised that some of the burden had been removed from the Executive Team to allow them to deal with the Delta COVID challenge and there now exists an opportunity to reframe moving through the next six months knowing full well that there would still be a number of staff seconded to the Transition Unit and to Health NZ.

Reports historically had been over-engineered for the decisions that had to be made. The strategy is to have shorter reports with better executive summaries and recommendations which relate to decisions of governance that are required.

It was not anticipated that weekly informal Board briefings would continue once the meeting

structure was stood back up.

There were two viable options for consideration with Board Members indicating a preference for option one.

Resolution: Moved Pat Snedden / Seconded Tama Davis

That the Board approve:

1. **Option one as the meeting schedule for 2022**
2. **A cut down report template providing recommendations, an executive summary and high-level issues outlined**
3. **Only essential Executive Leadership Team and Senior Managers in attendance at meetings**

Carried

[Secretarial Note: Item 11 was considered next.]

8.3 Establishment of Executive Committee of the Board to cover holiday recess *(Pages 63)*

Pat Snedden advised that Tama Davis would chair this committee through to the third week in January. Zoe Brownlie was to be added to the committee.

There were no questions

Resolution: Moved Pat Snedden / Seconded Michael Quirke

That the Board:

1. **Approve the establishment of an Executive Committee (under schedule 3 clause 38 of the New Zealand Public Health and Disability Act 2000) to consider any matters that require the urgent attention of the Board during the Christmas/ New Year Board recess.**
2. **Approve the membership of the Executive Committee which is to comprise the Board Chair, Pat Snedden, the Deputy Board Chair, Tama Davis, the Chair, Finance, Risk and Assurance, Dame Paula Rebstock, the Chair of DiSAC, Jo Agnew, Michael Quirke, and Zoe Brownlie with a quorum of three members (the Board Chair or Deputy Board Chair need to be one of the three members).**
3. **Delegate authority to the Executive Committee of Board to make decisions on the Board's behalf relating to the urgent approval of business cases, leases and the awarding of contracts for facilities development, services and supplies and information services and on any other urgent recommendations from the Chief Executive.**
4. **Note that all decisions made by the Executive Committee will be reported back to the Board at its meeting on 23 February 2022.**
5. **Approve dissolution of the Executive Committee as at 23 February 2022**

Carried

[Secretarial Note: Item 8.2 was considered next.]

8.4 Child Immunisation Report *(Pages 64-70)*

Ruth Bijl, Funding and Development Manager – Child, Youth and Women and Georgina Tucker, Clinical Leader – Uri Ririki were in attendance to answer questions.

Ruth Bijl acknowledged the tremendous work that has gone on with the COVID 19 vaccination team and what has been achieved and the community is grateful for has been delivered. However this has come at a cost and that is the childhood vaccination programme and the risk that is faced of a potential outbreak of measles and/or pertussis both very serious diseases with the potential to hospitalise children.

Ruth Bijl was asking that every opportunity for a childhood vaccination was to be investigated and vaccination offered. This was not just of the individual sitting in front of the health professional but of their whole whanau.

The following was covered during discussion:

Advice was given that there had been a pull of resource away from child vaccination. Just because a person is a qualified COVID 19 vaccinator does not qualify that person to be able to offer child immunisations. It is unfortunate that currently Pharmacists cannot offer paediatric vaccinations. If that could be changed it would open up a significant workforce who are open long hours and are generally in the right communities and are generally a trusted part of the health system.

Ailsa Claire added that the capacity developed by Māori and Pacific providers with their reach into communities was also to be encouraged when offering childhood vaccinations. Ruth Bijl advised that Māori outreach providers had been provided with lists of children who were overdue for their MMR along with a name and address which had been successful. There had been engagement with Pacific providers to do the same. Pharmacy's remained a much untapped workforce.

Ailsa Claire advised that the vaccination team within the Ministry of Health was now developing processes related to pharmacists. Māori and Pacific felt comfortable engaging with their local pharmacist. It would be a game changer if they could offer child vaccinations.

Peter Davis commented that he was an advocate for opportunistic immunisation and asked whether at ED, Starship or after-hour's services there was an opportunity for those services to check a child's immunisation status and could pharmacies be linked into the NIS system. Ruth Bijl advised that often that in those cases the vaccine is not appropriate to be given at that time as the child is unwell in many cases. Pharmacies can look up and enter information into the NIS and the new system NRS will make this easier. However they are limited in what vaccines they can enter into the system. Georgina Tucker advised that it would be more effective to have the vaccination status entered into a child's discharge summary. They could be immunised before discharge.

Doug Armstrong commented that there must be a role for schools to be more heavily involved and that vaccinations teams going into schools offering the COVID vaccination

should also be able to offer MMR vaccinations to overdue children.

Ruth Bijl explained that there were series of vaccination events; 0-4 and then school year 7and 8 children for boostrix and HPV vaccination. Secondary school children who have a year 9 assessment where vaccination status is looked up by the nurse and any outstanding vaccinations are offered. The COVID vaccination for 5 to 11 year olds will certainly allow these questions to be asked. However, a school based environment does not pick up all pregnant women or children aged 0-4.

The childhood vaccination systems (noting the regional comments regarding whole of system reform) are generally good but resource has been sucked out of it and primary care is being asked to do many additional things, and productivity is down. In addition, families are reluctant to take well babies into a GP environment where sick people are. This is where a pharmacy environment is more appealing.

Resolution: Moved Jo Agnew / Seconded Ian Ward

That the Board:

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

Carried

[Secretarial Note: Item 5.2 was considered next.]

9. INFORMATION REPORTS - NIL

10. DISCUSSION ITEM

10.1 Auckland Health Foundation – In the new Health NZ Framework

Cindy Schroder, Director Auckland Health Foundation made a verbal presentation speaking to the Auckland Health Foundation position statement, attachment 10.1.1.

It was stressed that the Foundation wanted to explore how it could work more closely with the DHB.

The Foundation had had some fabulous success in the last few months securing funding from two donors of $3M for seed funding for the build of a fourth interventional radiology room.

It was also working more closely with the DHBs Communications team and was more able to directly offer a voice in the public media than what Auckland DHB was able to do.

They were asking for support moving forward to support a lift and shift of the Foundation in the new health reform plans and also to align philanthropy with the strategic intent of the hospital itself. A more systematic way of working together was required in relationship building and in the sharing of stakeholders.

Tama Davis acknowledged outgoing board member John Barnett's contribution to creating a "steady state" within the Foundation and noted the positive and progressive change that had been made.

The Board Chair, Pat Snedden acknowledged the stellar work that had been done and said that the Board would support the Foundations efforts and the Board would back a lift and shift into the new environment when the best methodology for that to occur had been worked out. He thanked Cindy Schroder for her attendance.

[Secretarial Note: Item 8.4 was considered next.]

11 GENERAL BUSINESS

There was none.

12 RESOLUTION TO EXCLUDE PUBLIC *(Pages 71-75)*

Resolution: Moved Pat Snedden / Seconded Ian Ward

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
3.0 Confirmation of Confidential Minutes 3 November 2021	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]
3.1 Emergency Meeting of the Board 24 November 2021	N/A	
4.0 Action Points	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Risk Management Update	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 Chief Executives Verbal Confidential Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

	and/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)] **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 1982S9(2)(k)]	
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 [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]
8.1 Finance, Risk and Assurance Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.1 160 Grafton Road - Lease	**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 Debt Write Off for	**Privacy of Persons** Information relating to natural person(s) either living or deceased	That the public conduct of the whole or the relevant part of the

Renal and Neurology Patients	is enclosed in this report.	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 Delegations during Covid-19 Response	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.4 Refreshed ISSP	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.5 New install MRI – Level 3, Auckland City Hospital	**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]
9.6 Fleet Replacements: X-Ray Room SSH Site - S3, Generic and Specialty Beds 21/22 and Ultrasound Machine Project 2021/22	**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	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]

	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)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time.	
9.7 Point Chevalier Clinic Room and Dialysis Service Facility Upgrade	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.8 Mental Health – Improved Acute Flow Telehealth 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]
9.9 ISCV Implementation (Echocardiogram) Business Case	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or	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]

	disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	
9.10 Additional Capital Funding Approval	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [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]
9.11 Annual 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]
10.1 NRHCC COVID-19 Decision Log and Financial Report – 2021/22 Quarter 1	**Obligation of Confidence** Information which is subject to an express obligation of confidence is enclosed in this report. This paper is Confidential as per Section 9(2)(f)(iv) Confidentiality of advice by officials - disclosure of the information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials.	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 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, 15 December 2021

Chair: _____ Date: _____

Pat Snedden

Action Points from 16 December 2021 Open Board Meeting

As at Wednesday, 23 February 2022

Meeting and Item	Detail of Action	Designated to	Action by
	NIL		

Chief Executive's Report

TE TOKA TUMAI
Auckland DHB

5.1

Recommendation

That the Chief Executives report for 10 January 2022 – 3 February 2022 be received.

Prepared by: Ailsa Claire (Chief Executive)

1. Introduction

This report covers the period from 10 January 2022 – 3 February 2022.

2. Events and News

2.1 Omicron preparedness

We continue our preparations for when Omicron increases in the community and hospitals. During this time we are expecting to have an increased workload, but probably even more challenging, will be the impact on our available workforce due to illness and isolating. Our daily operations team will work to distribute workload and workers to the right places.

2.2 COVID-19 booster vaccination

The booster vaccine is mandated for our workforce by 15 February.

Onsite clinics have been running to make it easy for staff to get the booster vaccine. More than 90% of staff have already had their booster vaccination. Some are not yet eligible.

We continue to support employees to get their booster.

2.3 COVID Care Community Management

COVID Care Community Management (CCCM), a single unified national digital platform used by both primary and secondary care for the clinical oversight of COVID positive and non-COVID patients/whānau self-isolating. This is a positive step forward for integrated care

across multiple providers involved in patient care. It includes “rooms”, work lists, task management, health checks, clinical care and e-Prescribing.

Until recently, access to the platform was only available to clinicians that had the stand alone platform on their system. The new release in February provides all clinicians, who have access to the Regional Clinical Portal (RCP), access to CCCM. This will provide clinicians access to all information captured by the community provider, including recent clinical records, prescriptions, community referrals and who is providing the clinical oversight.

2.4 Industrial action by APEX Medical Physicists

APEX union Medical Physicists have extended their industrial action to run until Sunday 13 February 2022.

Patient safety remains our priority and we will continue to provide radiotherapy services. We are not anticipating delays to treatment and expect any rescheduling to be minimal.

2.5 Climate change risk assessment and adaptation

We are planning ahead to mitigate the risks of climate change and build resilience.

To help us prepare for the future, AECOM will undertake the Climate Change Risk Assessment (CCRA) project for to assess the risks to our physical assets and our ability to provide health services to our communities. This initiative will also help us identify and understand our vulnerable and exposed communities impacted by climate change.

We will receive the climate change risk assessment report later in the year.

2.6 A thank you from our community

Cummins South Pacific staff and their children shared their appreciation for our teams for their work during COVID-19 and over the holiday period.

These appreciation letters have been displayed at Auckland City Hospital and have also been shared digitally.

2.7 New Zealand's future health system

Congratulations to Fepulea'i Margie Apa and Riana Manuel on their appointments as the Chief Executives to lead Health New Zealand and the Māori Health Authority through the establishment phase and into the future.

In the coming months, Health New Zealand and the Māori Health Authority will be undertaking further work on the New Zealand Health Plan – this will help determine what the sector will do – and developing a Health Charter to establish a shared vision and culture across the sector.

3. Communication and Engagement

3. 1 External Communication

Between 10 January 2022 and 3 February 2022, we received 53 requests for information, interviews or access from media organisations. This included requests for clinical information on the diagnosis of eating disorders, interview requests regarding the COVID-19 paediatric vaccination programme, and information on the ongoing response to COVID-19.

Around 16 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 18 Official Information Act requests over this period.

3. 2 Internal Communication

For this period, 335 emails were received. Of these emails, 28 were non-communications-related and where appropriate, were referred to other departments and services at Auckland DHB.

- Four editions of Pitopito Kōrero | Our News, the weekly email newsletter for all employees, were distributed.
- Four editions of the Manager Briefing were published for all people managers.
- Twelve Living with COVID-19 update emails were sent out to all employees. This includes COVID-19 booster vaccination emails.
- Four COVID-19 webinars
- One COVID-19 Manager's webinar

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:

- Childhood immunisations
- Lunar New Year
- You're Awesome campaign
- Dr Charlie Lin – December House Officer of the Month
- Kōkiri te reo Māori

- COVID-19 booster vaccinations
- Best wishes for Tonga
- RN Megan Christie – Local Hero.

Top performing social media posts

4. Our People

4.1 Clinical Research Grant recipients

The Starship Foundation recently awarded Clinical Research Grants for 2021. The recipients are:

- Dr. Ajay Iyengar - *The Australian and New Zealand Fontan Registry: FAN, ACE cessation & BUMP Multi-Centre Studies*
- Dr. Cameron Grant - *Prevention of wheeze-associated hospitalisations in preschoolers*
- Dr Elsa Taylor - *Core Outcomes in Children undergoing anaesthesia and surgery*
- Dr John Beca - *Predicting long term outcomes in infants after heart surgery - a multicentre prospective trial: The NITRIC follow-up study*

- Dr Kate Wallace - *What is the frequency and outcome of criminal investigation in children and young people seen for a medical examination for alleged sexual abuse, and what is the relationship between medical findings, charges laid and the outcome of prosecution?*

- Dr. Rebecca Slykerman - *An innovative risk calculator to predict cognitive problems in survivors of childhood cancer*

- Dr. Rebecca Slykerman - *Improving outcomes for children and adolescents living with an acquired brain injury*

Thank you to the support of the Starship Foundation helping us to bring better health and brighter futures to the children of Aotearoa.

5. Performance of our health system

Priority Health Outcomes Summary

	Status	Comment
Acute patient flow (ED 6 hr)		Jan 80%, Target 95%
Improved access to elective surgery (YTD)		74% , Target 100%
Faster cancer treatment		Jan 96%, Target 90%
Better help for smokers to quit: • Hospital patients • PHO enrolled patients • Pregnant women registered with DHB-employed midwife or lead maternity	 	 Jan 91%, Target 95% R/U, Target 90% Dec Qtr 100%, Target 90%
Raising healthy kids		Dec Qtr 95%, Target 95%
Increased immunisation 8 months		Dec Qtr 90%, 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 six months ended 31 December 2021 is a deficit of $3.9M against a budgeted deficit of $33.8M, thus favourable to budget by $29.9M. The favourable position to budget was realised in the Funder arm ($10.7M favourable), the Provider Arm ($18.2M favourable) and the Governance arm ($0.9M favourable). The favourable position is attributed to Business as Usual operations ($23.8M favourable), mainly due to reduced Funder demand driven expenditure, prior year adjustments, lower clinical supplies expenditure due to reduced throughput, and additional revenue realised. The net Covid-19 impact is a favourable position of $6.1M for the year to date partly due to prior period adjustments. Covid-19 funding realised for the period was $145.9M, 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 $139.8M, hence the $6.1M favourable impact year to date.

7. Auckland DHB at a glance

Patient Experience

1,594 patients completed our patient experience survey in January 2022

89.5% rated their experience very good or excellent

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

- Communication
- Care and compassion
- Organisation and correspondence

Patients

In January 2022 across Auckland DHB:

101,711 outpatient appointments took place

8,312 presentations to the Adult and Children's Emergency Departments

4,835 surgeries discharged

In January 2022 the mean occupancy for the Adult hospital at 12am was **604**

Communications

from 10 January - 3 February 2022

53 media requests

18 Official Information requests

335 emails to the generic communications inbox

123,979 page views on the Auckland DHB website

There's been a **17%** increase in people coming to the Auckland DHB website from Google compared to 2021.

Health and Safety Report

Recommendation

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

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

Glossary

TRIFR	Total Recordable Frequency Rate (# of Lost Time (LTI), Medical Treatment (MTI) and Restricted Work (RWI) Injuries x 1000000/total personnel hours)
LTIFR	Lost Time Injury Frequency Rate (# of Lost Time Injuries x 1000000/total personnel hours)
AIFR	All Injury Frequency Rate (# of All LTI, MTI, RWI & First Aid Injuries x 1000000/total personnel hours)
BBFA	Blood and/or Body Fluid Accident
EY	Ernst and Young Limited
HSR	Health and Safety Representative
HSWA	Health and Safety at Work Act (2015)
LTI	Lost Time Injury (work injury claim)
MFO	Medical Fees Only (work injury claim)
MOS	Management Operating System
PCBU	Person Conducting a Business or Undertaking
PES	Pre-employment Health Screening
SI	Safety Intervention (previously MAPA)
SMS	Safety Management System
SPEC	Safe Practice Effective Communication (SPEC)
SPIC	Safe Practice in the Community
WPV	Workplace Violence
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 January 2022.

There have been no significant changes to key health and safety risks for the reporting period. However, this may change as we continue to monitor and assess the effects of Omicron within the community over the next several reporting periods with any subsequent consequence and impacts on the hospital environment.

Two incidents occurred in January, both of which are currently being reviewed. They were notified to WorkSafe New Zealand, who did not require any further information.

COVID management activities related to vulnerable staff, the vaccine mandate and vaccination programme, staff surveillance, N95 Fit Testing and observation and validation of controls continues daily.

Progress against the Key Risks Audit Schedule has been impacted by the diversion of resources to COVID related work and limited availability of Health and Safety Advisors over the Christmas/New Year period. However, key pieces of work around Workplace Violence, Manual Handling and Contractor Management continues.

Since its remodel, the H&S Governance committee has met four times and is progressing well. The involvement of HSRs and union partners alongside senior leaders on the committee makes for meaningful and productive discussions that support collaborative and constructive health, safety and wellbeing governance. As we evolve this committee further, other key activities supporting it will be developed. These should help raise the overall organisational focus and commitment towards health, safety and wellbeing.

2. Risk Analysis

2.1 WorkSafe Notifiable Events

Staff assault

There was a serious event involving an Auckland DHB employee delivering care in the community to a High and Complex Needs and Rehab Services patient. An outpatient physically attacked the staff member causing moderate injuries. The staff member has returned to work and is being provided with additional support. The incident is currently being internally reviewed and has also been reported to WorkSafe who have responded noting that they require no further information.

Ceiling collapse Auckland City Hospital Site

There was an event involving building damage which was a serious near-miss event involving an Auckland DHB staff member. A contractor undertaking demolition work on the Grafton site was using a hydraulic concrete breaker to create a cable hole and pathway next to the occupied sub floor offices below for building A01. The hydraulic concrete breaker broke through the slab and dropped concrete debris and dust into the office below. The office was unoccupied at the time as the staff member had left the office to take a break from the noise of the demolition work. Initial reports suggested that there was incorrect information about the location of the offices in relation to the work being carried out. The incident is currently being reviewed and has been reported to WorkSafe who have since responded requiring no further information. Ongoing work in the vicinity of the incident has been paused until the incident review has been completed and the issues understood. We also noted the Contractor had not completed the Totika assessment we requested from them last year.

2.2 COVID management

Health and Safety Advisors have proactively been out across Auckland DHB sites validating environmental and other controls to seek assurance and ensure our services are able to operate safely and manage risks related to Omicron. Information and recommendations from their observations are being reported to the weekly DHB/Unions Omicron group to ensure effective monitoring, management and governance, with any items for immediate improvement escalated daily to relevant people to action.

We observed generally good practices around distancing and PPE use. Exceptions to this were raised back to staff concerned and where relevant, management. We also noted that it is difficult for our people to eat and drink outside their work areas, particularly with public areas having “no eating and drinking” signage. Some of this issue has been due to designated eating and drinking areas being too far away for staff to access in a timely manner. We are currently working on improving this.

We are continuing to engage our HSR’s weekly for the foreseeable future to facilitate effective and timely sharing of information relating to Omicron management.

2.3 Key Risks

Biological hazards risk remains moderate as noted on the heat map provided in Appendix 1. The Covid-19 risk is not reflected on the heat map as part of the biological hazards rating. We note it is an issue under active management and has had sustained and active focus across the DHB. This

includes any health and safety aspects. Its impact is being widely reported . This will continue to be the case for the foreseeable future. Specific activities involving the occupational health and safety team include activities relating to Vulnerable Staff, staff and contractor vaccine mandate requirements, staff surveillance swabbing, N95 Fit Testing, and PPE protocols.

Progress against the December / January Key Risk Audit Schedule has been impacted by diverting resources to COVID related work and reduced Health and Safety Advisor resource over the Christmas/New Year holiday period.

There are six key risks with a residual risk rating of High.

2.3.1 Workplace Violence and Aggression

The WPV risk remains high, with consequence x likelihood rated as Major and Possible. There were forty-nine reported WPV&A incidents for January, compared to the current three month average of sixty-six, with the majority of incidents occurring in Adult Medical and Mental Health and Addictions directorates. The first draft of the WPV Plan is currently going through a review process with the WPV Steering Committee, with planned review to also be undertaken with our HSRs, Union partners and other stakeholders.

2.3.2 Contractor Management

Contractor Management risk remains high (Major and Possible). While the Totika programme is underway, it is noted that progress remains slow and, in addition, a further 1200 contractors not previously identified have come to light following receipt of a recent HealthSource list of contractors who were contacted for the vaccine mandate. It was also noted previously that with a more activated site due to the FIRP activity, a more cautious approach in relation to the construction related contractor events (and undertakings) is being adopted. The building damage and near miss reported earlier also reflects this risk rating from an assurance perspective where we do not have enough evidence from contractors completing high risk work on how they would manage their work activities against a Standard. This will continue to be a problem unless we can instruct contractors through our Procurement to complete the Totika assessments which will give us some visibility of the risk contractors are managing on our behalf.

2.3.3 Fatigue Management

Fatigue Management remains high (Moderate and Possible). Review work has commenced, with the support of the Risk team and is expected to be completed over the next two month period. It is likely that this risk may shift over the next several reporting periods as we see the impact of Omicron on the community and its potential flow-on consequences across our workforce, significantly impacting our current level of staff resources.

2.3.4 Hazardous Substances

The risk remains high (Moderate and Possible), with no significant change in trends or contributing issues.

2.3.5 Working at Height

The risk remains high (Moderate and Possible). Construction activity across the hospital sites has recently re-started following the Christmas/New Year period, with no significant change in activity trends or contributing issues.

2.3.6 Manual Handling

The risk remains high (Moderate and Likely). Manual handling risk is rated high on the basis that this is a work area where our staff are most often exposed to potential risk through the frequency of their daily activity such as patient handling, patient transfer, and moving, lifting and re-positioning of equipment, waste, laundry, materials and supplies as well as high levels of repetitive movement and motion while undertaking everyday tasks. To support risk mitigation, patient manual handling training is a primary control provided to support staff with appropriate lifting and handling technique and to ensure familiarity with specialised equipment. However, Covid has impacted the training programme and this has seen a reduction in new staff being trained, as well as having an impact on refresher training. The reduction in training is seen as a contributor to the risk rating. The rejuvenation of the Moving and Handling (M&H) Steering Committee will support a revamped training programme geared to ensuring increased levels of staff training with support from staff moving and handling 'champions' focused on higher risk areas with more immediate support at a local service level.

3. Key Initiatives and Activities

3.1 Digital Transformation

Occupational Health Patient Management System: The ongoing delays in progressing to a signed agreement have been escalated to the Medtech CEO. A meeting will take place with Medtech to address and resolve the outstanding questions and concerns posed by Health Source. This has significantly impacted on our ability to deliver workflow improvements for our staff and process improvements to service delivery. We have readjusted our original timeline for delivery to April from December based on these delays.

3.2 Occupational Health and Safety Work Plan

The activities in progress as at December 2021 remain unchanged. The arrival of Omicron has meant some of the work has been delayed or unable to progress whilst key stakeholders divert to urgent service and workforce continuity planning.

There has been positive collaboration with unions, WorkSafe and other external agencies to start discussions about the development of capability and training plans for governance, leadership and HSR roles and good progress made in activities relating to our HSR engagement plans. Improvement processes relating to the way our Health and Safety Advisor team work engage and support their services are moving to implementation in the coming month.

Work relating to the Contractor Management framework and certification requirements remains a risk due to lack of engagement and availability of resources. Concentrated effort will need to be placed on engaging with the recently identified additional HealthSource contractors to meet a 31 March 2022 deadline for these requirements. Positively, Totika have recently implemented a COVID assurance feature in their listing service which provides further assurance to clients such as Auckland DHB that suppliers are complying with the COVID-19 order.

3.3 Occupational Health Service Review

The Occupational Health Steering Committee has begun exploring options for short term improvements in service delivery and capacity. Resources recently approved as part of the Fit for the Future project will address some of the existing clinical risks and enable additional work related to COVID management to be supported. Currently there are four key risks being worked on which are Pre-Employment Health Screening, Capacity, Data, and Medtech.

4. Auckland DHB Health, Safety and Wellbeing Governance Committee

Since its remodel, the committee has met four times and is beginning to function well. The involvement of HSRs and union partners on the committee makes for meaningful and productive discussions that support collaborative and constructive health, safety and wellbeing governance.

Items considered by the committee at its 25 January 2022 meeting included:

- Refining the Directorate Performance reporting for implementation informed by feedback received from pilot groups
- Communication, engagement and support for workers through Omicron
- Process for development of a draft 3-Year Workplace Violence Prevention Work Plan
- HSR engagement activities and events being planned
- Progress towards shaping up a calendar of training events focussed on developing leadership capability
- Improvements and changes being made to the Observations and reporting process
- Planned improvements relating to Health and Safety Advisor ways of working to better support and engage with Directorates
- An interim updated Occupational Health and Safety Policy
- HSR Representation Vacancies to fill on the Health and Safety Working Group
- A revised approach to progressing the draft Worker Participation Agreement

The key areas of discussion and focus for our union partners were:

- The work around Omicron preparation, including improved communication and support for staff
- The anticipated increases in workplace violence and aggression as a result of worker and patient stress and anxiety about Omicron and capacity issues
- Staff safety and workforce sustainability
- Worker participation, engagement and representation
- The interim updated Occupational Health and Safety Policy.

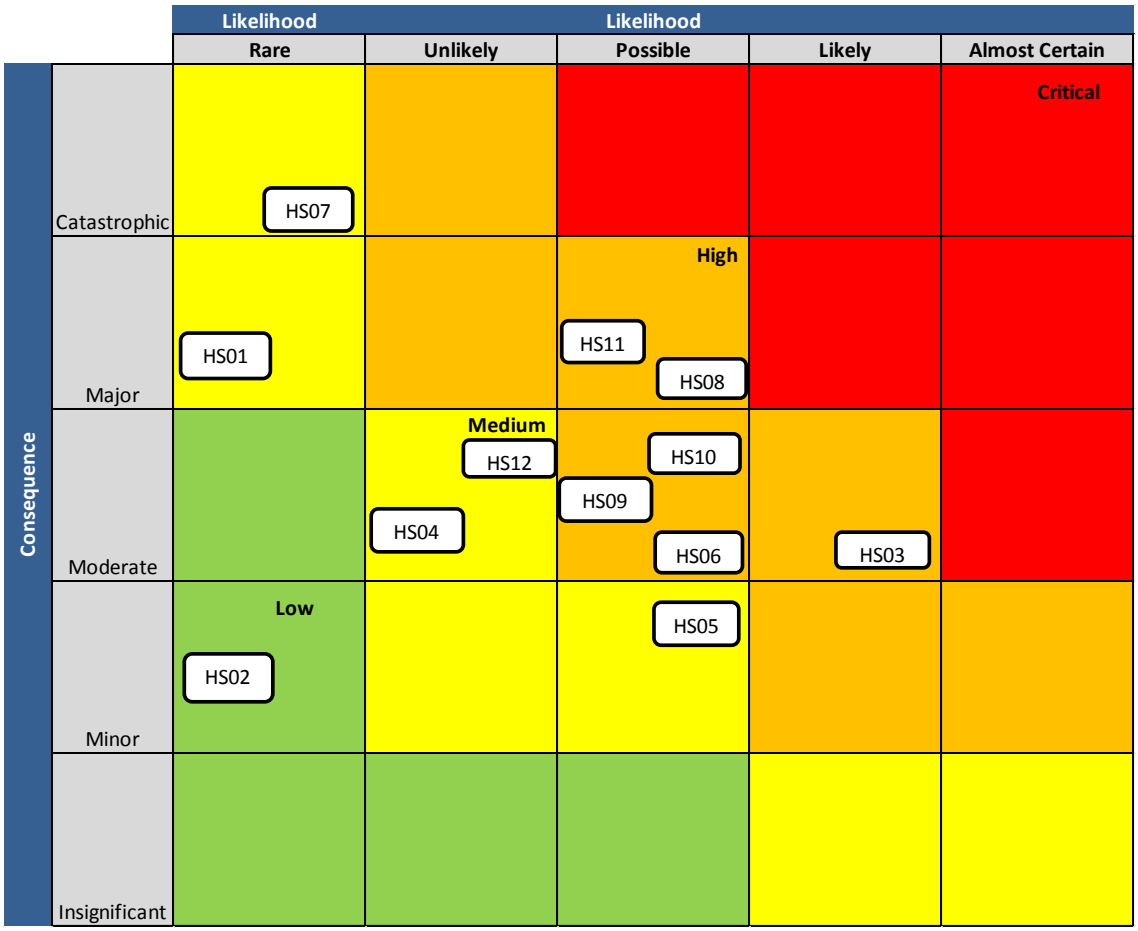
5. Internal audits

Planning is underway for an intended Health & Safety Audit by Regional Internal Audit in March/April.

Appendix 1

Health and Safety Risks

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



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

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												
HS07 - Hot Works			x		x												
HS09 - Fatigue Management			x	x	x	x											
HS10 - Hazardous Substances				✓	x	x											
HS05 - Vehicles and Driving				✓		x											
HS02 -Confined Spaces				✓		x											

Open Meeting: Human Resources Report

Auckland DHB People Dashboard – Quarter 2 2021/22

Recommendation

That the Board:

1. **Receives the Quarter 2 People Dashboard.**

Prepared by: People & Culture Senior Leadership Team
Endorsed by: Mel Dooney (Chief People Officer)

This Paper is presented for the Board's information and presents the key data & metrics for the second quarter of the year across Pūmanwa Tāngata – the Te Toka Tumai People Plan.

Pūmanawa Tāngata Plan 2020-2023

Strengthening Culture & Building Capability

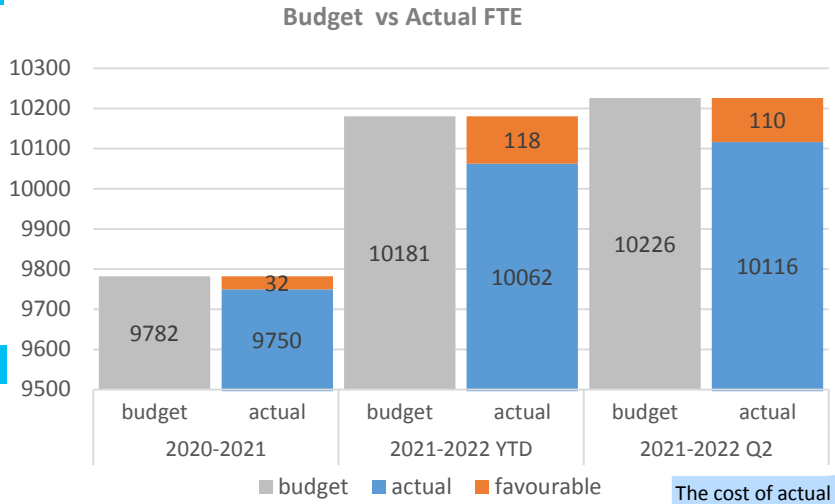
Quarterly ADHB People Analytics Dashboard - F22 Q2: 31 December 2021

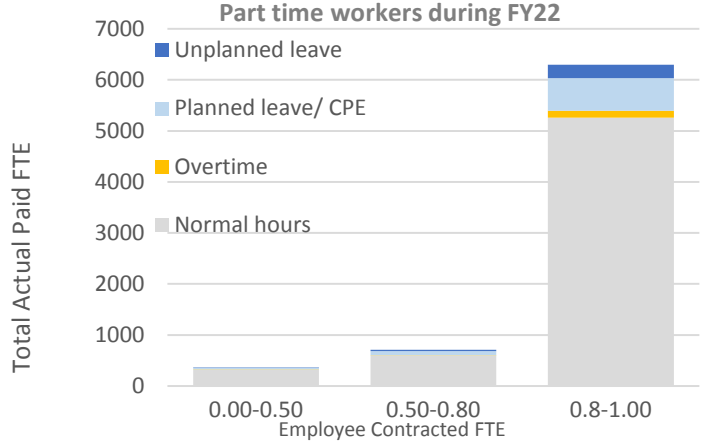
Strengthen our workplace culture | Building capability to achieve equity | Grow and develop ngā kaimahi Māori | Kia Ora tō Wāhi Mahi | Fit for the future | Make it easy

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

What does our workforce look like?

- As at 31 December 2021, there are 10,116 employees (FTE) at Auckland DHB, excluding staff on casual contracts or those on extended leave.

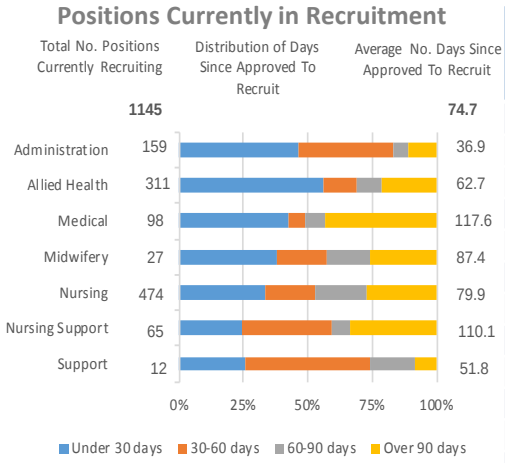




The cost of actual hours is paid to casual, part time, and full time staff. Full Time staff (those contracted to work between 0.8 and 1.0 FTE) account for 85% of the total paid hours.

Attracting talent to our workforce

- Vacancies have again increased this quarter from 917 at the end of September to 1145 at the end of December.
- Our average time to hire is trending similarly to last year however this is masking some increased time to hire in key groups such as Nursing.
- We are investigating options to support managers to speed up the process which we hope to have in place by the end of the next quarter.



Midwifery figures are under reported, as they aren't all being recruited to cover vacancy levels.

Reasons for Recruitment Activity	Nursing	Admin	Other	Total Count (FTE)
Replace resignation	50%	10%	31%	372.1
Cover for staff on leave	53%	8%	38%	88.9
New / increased FTE	48%	23%	20%	196.4
Internal Staff Movement	42%	22%	38%	69
Change in hours	67%	10%	34%	57.8
Secondment/Backfill	56%	4%	27%	26.2
Project	21%	18%	53%	44.1
Other	76%	7%	47%	28.2
Training	8%	0%	94%	15.8
Temporary cover	41%	27%	54%	3.7
Fellowship	0%	0%	100%	5.3
Total for all reasons	48%	13%	36%	**1129.5**

The time to hire represents the time taken from approving recruitment to commence, to extend an offer to a desired candidate.

Pūmanawa Tāngata Plan 2020-2023

Strengthening Culture & Building Capability

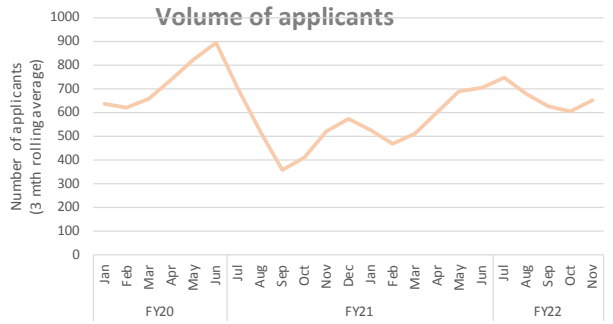
Quarterly ADHB People Analytics Dashboard - F22 Q2: 31 December 2021

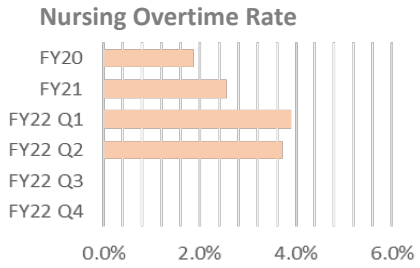
Strengthen our workplace culture | Building capability to achieve equity | Grow and develop ngā kaimahi Māori | Kia Ora tō Wāhi Mahi | Fit for the future | Make it easy

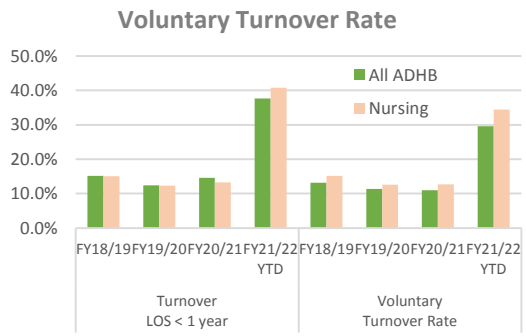
AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

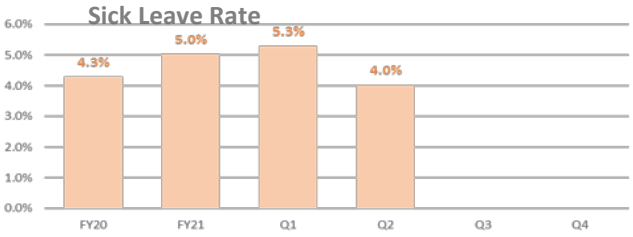
Focus on Nursing Workforce

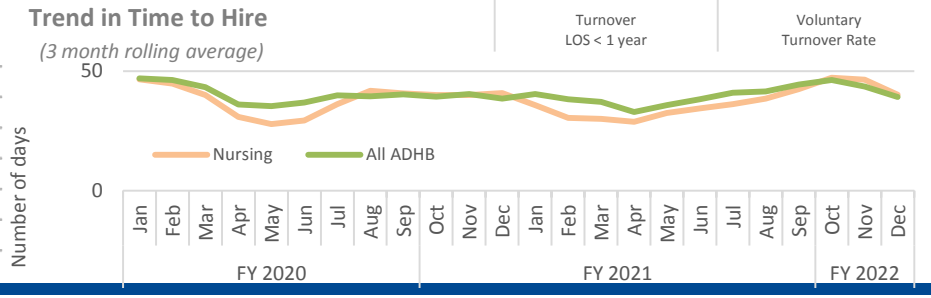
- We are still seeing reasonable numbers of candidates applying for our nursing vacancies and our time to hire has reduced a little this quarter which is pleasing.
- Of concern, is our retention of nurses specially those who have been with us less than a year.
- Overtime and sick leave has reduced slightly across this quarter.





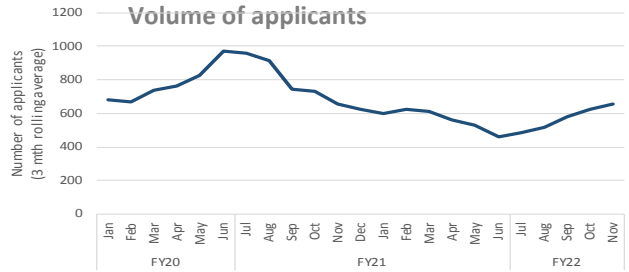


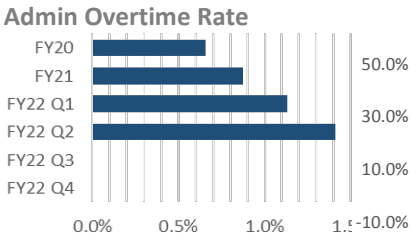


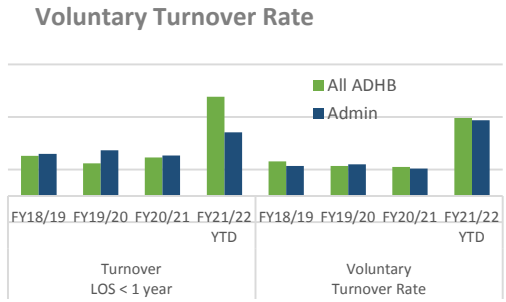


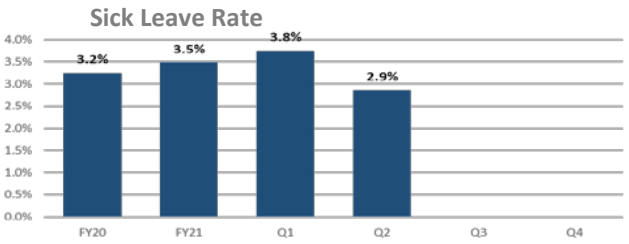
Focus on Corporate/Admin workforce

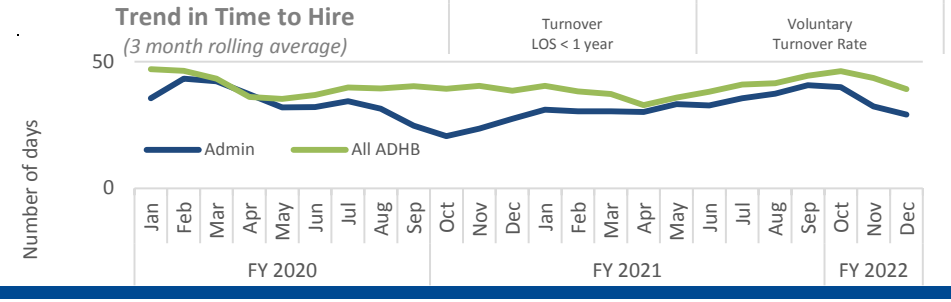
- Our Corporate / Admin workforce turnover has increased from 5% to over 20% this quarter.
- This is likely due to factors which include a buoyant labour market for many of our enabling functions, pay restraint having an impact, and concern from people as to the change impacts of HealthNZ on their functions.
- Work to keep the enabling functions engaged across the next six months, will being in early 2022.











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

Pūmanawa Tāngata Plan 2020-2023

Strengthening Culture & Building Capability

Quarterly ADHB People Analytics Dashboard - F22 Q2: 31 December 2021

Strengthen our workplace culture | Building capability to achieve equity | Grow and develop ngā kaimahi Māori | Kia Ora tō Wāhi Mahi | Fit for the future | Make it easy

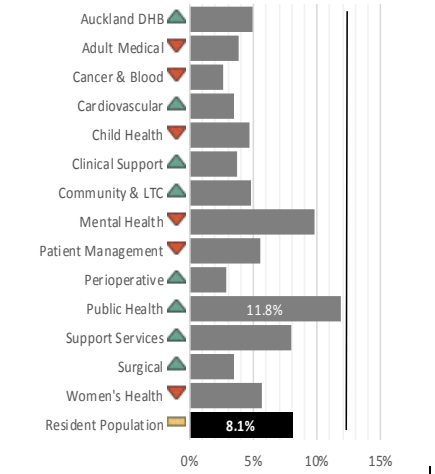
AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

5.3

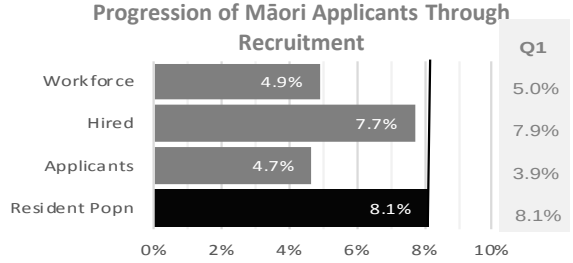
Māori in the workforce

- Current YTD turnover is significantly high particularly within the first year. A focus on supporting kaimahi Māori to connect in to Kaimahi Māori Experience team kaupapa as well as any specific directorate/department initiatives is a must. Robust links to the Māori Health Leads will be made as they are established across the provider.
- The Māori Leadership Development Programme will launch in 2022 with a cohort of rangatira Māori previously nominated by their respective provider director.
- Talent management pilot centred on kaimahi Māori continues in mental health (Manawanui) and women's health (Te Manawa o Hine) with view of a directorate supported phased roll out in due course.
- The Kaimahi Māori Experience Team are currently focused on elevating kaimahi Māori voice and storying the journey of that pātai (question) to an outcome remaining visible and accountable to kaimahi Māori .
- These are some immediate examples of we are addressing kaimahi Māori experience and thus retention.

Māori Representation by Directorate



Progression of Māori Applicants Through Recruitment



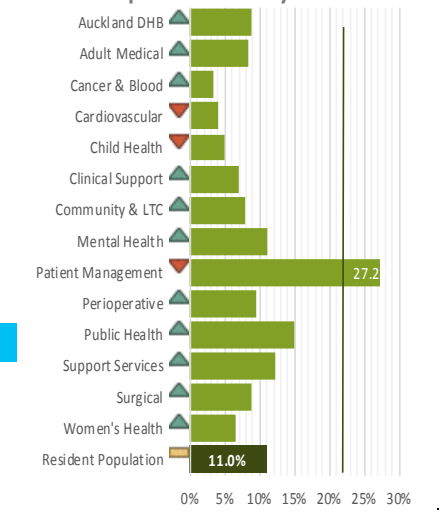
	Percent of Shortlisted Applicants to Interview		Hired : Unsuccessful Applicants Ratio	
	Māori	All Staff	Māori	All Staff
FY22 Q2	62%	42%	1 : 2.5	1 : 4.8
FY22 Q1	75%	48%	1 : 1.2	1 : 3.4
FY22 YTD	69%	45%	1 : 1.7	1 : 3.9
FY21	62%	43%	1 : 2.6	1 : 5.8

Voluntary Turnover Rate

Pacific in the workforce

- Our numbers for Pacific staff recruitment have remained relatively stable
- Of note is that retention of Pacific staff has improved over the last quarter.

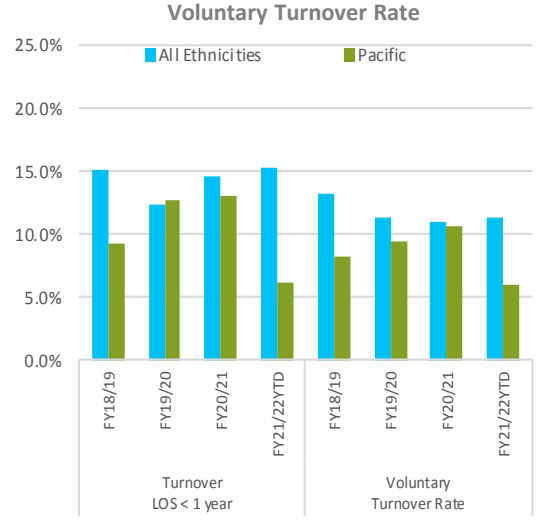
Pacific Representation by Directorate



Progression of Pacific Applicants Through Recruitment

	Percent of Shortlisted Applicants to Interview		Hired : Unsuccessful Applicants Ratio	
	Pacific	All Staff	Pacific	All Staff
FY22 Q2	54%	42%	1 : 4.4	1 : 4.8
FY22 Q1	56%	48%	1 : 2.4	1 : 3.4
FY22 YTD	55%	45%	1 : 3.1	1 : 3.9
FY21	57%	43%	1 : 4.4	1 : 5.8

Voluntary Turnover Rate



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% of Shortlisted to Interview shows what % of applicants that were shortlisted get an interview.
The hired ratio represents how many unsuccessful applicants per hire.

Pūmanawa Tāngata Plan 2020-2023

Strengthening Culture & Building Capability

Quarterly ADHB People Analytics Dashboard - F22 Q2: 31 December 2021

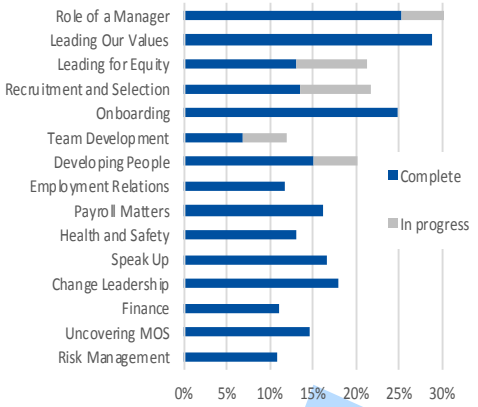
Strengthen our workplace culture | Building capability to achieve equity | Grow and develop ngā kaimahi Māori | Kia Ora tō Wāhi Mahi | Fit for the future | Make it easy

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Strengthen Culture & Build Capability

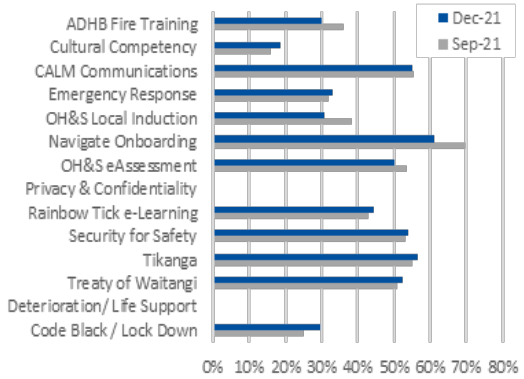
- We continue to see a number of MDP modules being completed by Managers on top of the mandatory training. A reminder in the Manager Briefing around the development programmes on offer will occur this coming quarter.
- Good traction is occurring with Mandatory Training this quarter which can be contributed to better reporting. It is great to see Tikanga and Treaty of Waitingi increase from last quarter as staff complete these important modules to better understand Tikangi and the Treaty and enable better patient care.
- Performance & Development conversation reporting appear to be lagging and could be due to conversations not occurring as Managers prioritise Omincron planning. This is an area that is crucial to staff feeling valued and being heard, further work to address this decline is underway with HR Managers reminding their services of the importance of these conversations and the reporting on them.
- While the borders remain closed we continue to see leave accrual climb as well as excess annual leave. Once the borders open we do expect a number of staff will seek to go on leave. Depending on Omicron we will look to push taking time out again, as staff continue to report feeling fatigued.
- Annual leave balances continue to climb from 1> years onwards which again can be contributed to staff not looking to take holidays at this time.

Management Development Programme

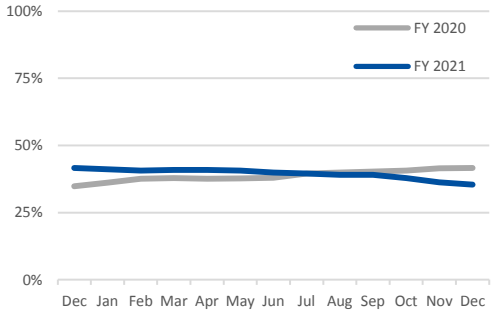


The MDP module completed by People managers as at 30 June 2021.

Mandatory Training

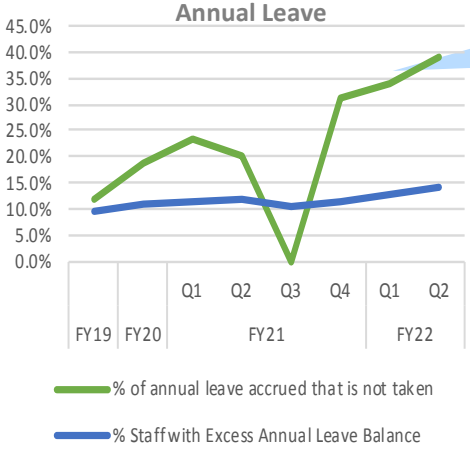


Performance & Development Conversations



This graph indicates the completion of our requirement to document performance conversations in kiosk. We are aware more performance conversations have taken place but have not been entered as complete in Kiosk.

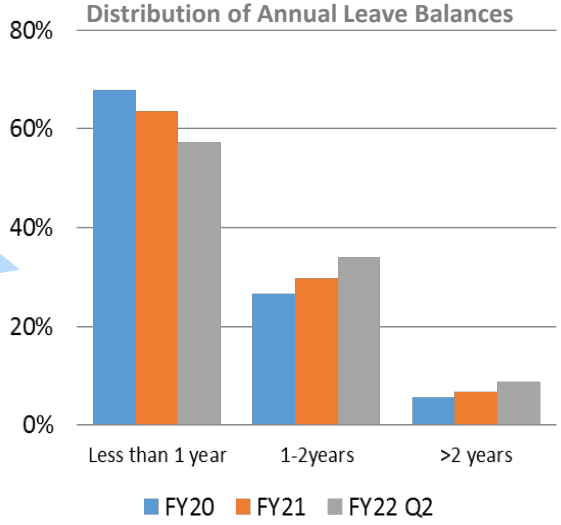
Annual Leave



11,243 weeks of leave was accrued by staff in FY21 Q3 with 13,278 weeks of leave taken. That means that on average, there was no annual leave accrued during Q3 that was not taken.

The year-to-date % of employees taking less than their annual leave entitlement (63.5%) is currently very similar to FY20. A concerted effort to have staff continue taking leave through Q4 will be needed to establish a trend of decreasing the % of staff not taking their full annual leave entitlement.

Distribution of Annual Leave Balances



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AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

5.3

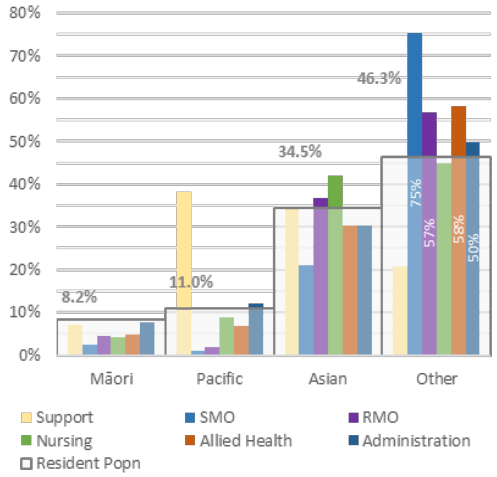
Diversity & Inclusion

- In December we receive full accreditation in the Hearing Accredited Workplace Programme
- In partnership with Counties Manukau DHB we have implemented a Research project which focuses pm 'organisational inclusiveness for people impacted by disability'. This work will help to drive a blueprint action plan of work to progress.

Wellbeing

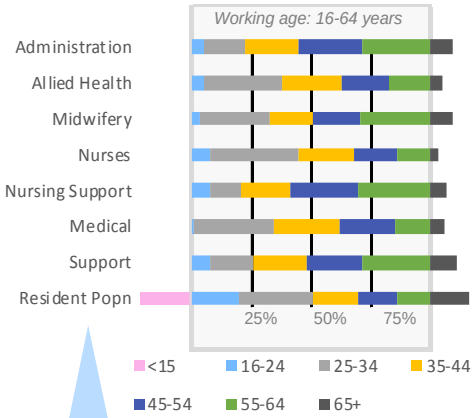
- Although ER cases remain steady, we are working hard to ensure managers have conversations with staff where behaviours may not be in line with the company values, instead of tracking a more punitive approach. We are also using facilitation to fix working relationships where needed.
- Work continues around review of the Speak Up programme. We are listening to our people who have used the programme to see what we can do better or change.

Ethnicity by Profession



Grouped as per national guidelines. Staff cannot be more than one ethnicity. Staff with no ethnicity data are included as other.

Age by Profession



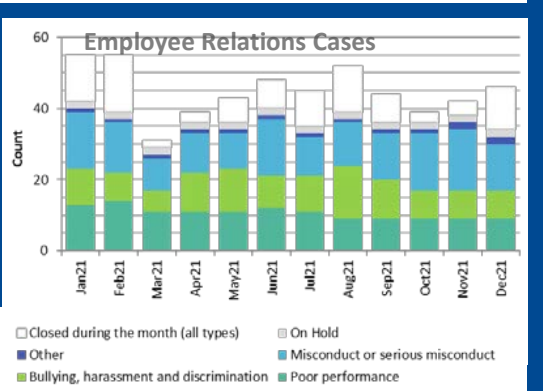
Resident population supplied by Stats NZ, based on 2018 Census.

Disability Data

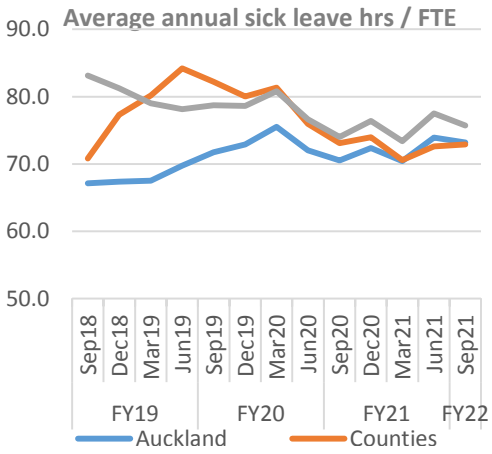
Type	Count
Cognitive/Learning	1
Head Injuries	1
Hearing loss	9
Invisible	15
Mobility Physical	6
Vision	5
Total	37

According to Stats NZ Disability survey from 2013, approximately 10% of New Zealand's workforce has a disability or impairment. 0.3% of ADHB workforce have self-identified as having a disability.

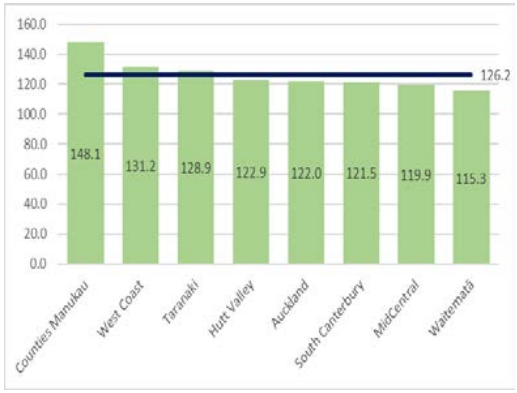
Employee Relations Cases



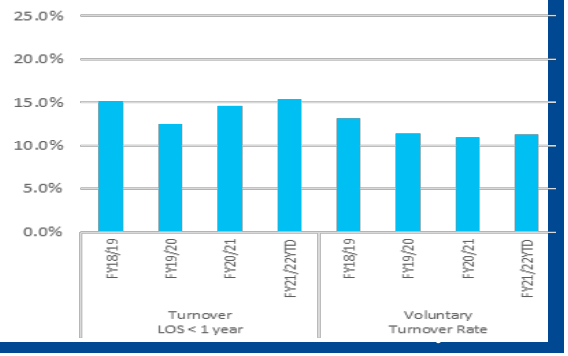
Average annual sick leave hrs / FTE



Ratio of AL bal to entitlement per FTE (%)



Voluntary Turnover Rate



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Financial Performance Report for the period ended 31 December 2021

Recommendation

That the Board Receives the Financial Report for the period ended 31 December 2021

Prepared by: Auxilia Nyangoni, Deputy Chief Financial Officer
Endorsed by: Justine White, Chief Financial Officer
Date: 14 February 2022

1. Statement of Financial Performance for the period ending 31 December 2021

The net financial result for the month of December 2021 is a surplus of $539K which is $13.5M favourable against the budgeted deficit of $13M. For the year to date (YTD), a deficit of $4M was reported against a deficit budget of $33.8M, thus favourable to budget by $29.9M. The YTD favourable variance is attributable to Business as Usual (BAU) operations ($23.8M favourable) and was realised in the Funder Arm ($10.7M favourable), Provider Arm ($18.2M favourable) and Governance Arm ($920K favourable).

The forecast for the full year has been updated to a deficit of $60.9M, which is $12.1M favourable compared to the approved full year budget deficit of $73M. This is an improvement on the year end forecast in November (a deficit of $69.9M), with the improvement reflecting improved YTD Covid-19 impacts and also improved BAU position. The forecast includes YTD Covid-19 impacts up to December 2021, with no further future impacts included due to the variable nature of these costs.

The summary financial performance for the month, YTD and year end forecasts are summarised in the Table below:

$000s	Month (Dec-2021)			Year to Date 2021-22			Full Year (2021-22)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Income									
Government and Crown Agency	199,262	162,289	36,973 F	1,094,615	967,020	127,594 F	2,035,000	1,935,832	99,168F
Non-Government and Crown Agency	8,675	8,451	223 F	49,096	50,826	1,730 U	99,112	101,508	2,396U
Inter- District Flows	68,355	66,133	2,223 F	387,770	396,797	9,027 U	784,178	793,595	9,417U
Inter-Provider and Internal Revenue	1,741	1,535	206 F	10,787	9,257	1,530 F	17,959	18,469	510U
Total Income	**278,033**	**238,409**	**39,624 F**	**1,542,268**	**1,423,901**	**118,367 F**	**2,936,249**	**2,849,404**	**86,845F**
Expenditure									
Personnel	123,237	116,239	6,998 U	697,238	645,656	51,582 U	1,360,855	1,307,404	53,451U
Outsourced Personnel	5,484	2,355	3,129 U	29,490	14,132	15,358 U	42,419	28,265	14,154U
Outsourced Clinical Services	4,168	3,805	363 U	21,845	22,949	1,103 F	44,086	45,652	1,566F
Outsourced Other Services	7,967	7,376	591 U	48,560	44,259	4,301 U	92,330	88,518	3,812U
Clinical Supplies	30,965	28,796	2,168 U	177,251	179,334	2,083 F	352,000	349,726	2,274U
Funder Payments - NGOs and IDF Outflows	77,350	73,778	3,572 U	423,952	442,670	18,718 F	865,143	885,340	20,197F
Infrastructure & Non-Clinical Supplies	28,322	19,054	9,268 U	147,889	108,746	39,144 U	240,310	217,498	22,812U
Total Expenditure	**277,494**	**251,404**	**26,089 U**	**1,546,225**	**1,457,746**	**88,479 U**	**2,997,143**	**2,922,404**	**74,739U**
Net Surplus / (Deficit)	**539**	**(12,996)**	**13,535 F**	**(3,957)**	**(33,845)**	**29,888 F**	**(60,894)**	**(73,000)**	**12,106 F**

Result by Division $000s	Month (Dec-2021)			Year to Date 2021-22			Full Year (2021-22)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funder	2,456	0	2,456 F	10,740	0	10,740 F	8,102	0	8,102 F
Provider	(2,073)	(12,989)	10,915 F	(15,596)	(33,824)	18,227 F	(68,996)	(73,000)	4,004 F
Governance	156	(7)	163 F	899	(21)	920 F	0	0	0 F
Net Surplus / (Deficit)	**539**	**(12,996)**	**13,535 F**	**(3,957)**	**(33,845)**	**29,888 F**	**(60,894)**	**(73,000)**	**12,106 F**
COVID-19 Net impact on bottom-line	5,003	(1)	**5,003 F**	6,102	(4)	**6,106 F**	6,102	0	**6,102 F**
Holidays Act Impact	(3,334)	(3,334)	**0 F**	(20,001)	(20,001)	**0 F**	(40,000)	(40,000)	**0 F**
BAU Net impact on bottom-line	(1,130)	(9,661)	**8,531 F**	9,942	(13,840)	**23,782 F**	(26,996)	(33,000)	**6,004 F**
Net Surplus / (Deficit)	**539**	**(12,996)**	**13,535 F**	**(3,957)**	**(33,845)**	**29,888 F**	**(60,894)**	**(73,000)**	**12,106 F**

Commentary on Significant Variances for the Year to Date

Revenue

Total Revenue is favourable to budget YTD by $118M (8.3%). The key variances are as follows:

- Covid-19 response funding $105.0M favourable covering vaccinations, community testing, ARPHS, laboratory testing, MIF, border control and other response costs.
- MOH Nursing Pay Equity funding $31.6M favourable reflecting actual costs incurred.
- $17.0M unfavourable variance due to a provision for Planned Care and IDF revenue wash-up, reflecting significantly reduced volumes during the level 4 Covid-19 lockdown period.
- MOH base revenue $6.0M favourable for one off backdated prior period wash-ups.
- $5.5M unfavourable Funder NGO revenue due to adverse funded initiative variances with corresponding expenditure variances.

Expenditure

Expenditure is unfavourable to budget YTD by $88.5M (6.1%). The key variances are as follows:

- Combined Personnel and Outsourced Staff costs $66.9M (10.1%) unfavourable variance reflecting $40M unbudgeted Covid-19 related costs and $26.6M unfavourable BAU personnel costs, mainly pay equity payments and MECA settlements provisions.
- Outsourced Other costs $4.3M (9.7M) unfavourable, mainly unbudgeted healthAlliance IT related costs.
- Clinical Supplies are $2.1M (1.2%) favourable to budget. Underlying this is a $2.8M Covid-19 related unfavourable variance that is offset by a $4.9M favourable BAU position, reflecting reduced use of supplies as volumes have been lower during Covid-19 lockdown.
- Funder payments to NGOs and IDFs $18.7M (4.2%) favourable mainly due to net favourable funded initiatives variances, favourable variances from budgeted initiatives not committed, favourable prior year adjustments and net favourable utilisation variances across NGO demand driven services including Pharmaceuticals, Primary Health Organisations (PHO), Aged Residential Care and Carer Support.
- Infrastructure & Non Clinical Supplies $39.1M (36.0%) unfavourable, related to unbudgeted Covid-19 expenditure $38.4M for vaccination clinic leases, urgent short-term facilities work, security, couriers, signage, etc.

FTE

Total FTE (including outsourced) for December 2021 was 10,673, which is 308 higher than budget at a total level. There were 674 unbudgeted FTE for Covid-19 in the month of December, meaning the underlying BAU position is 366 below budget, mainly driven by Nursing FTE vacancies.

2. Statement of Financial Position as at 31 December 2021

$'000	31-Dec-21			30-Nov-21	Var	30-Jun-21	Var
	Actual	Budget	Variance	Actual	Last Mth	Actual	Last Year
Public Equity	987,975	1,018,511	30,536U	982,879	5,096F	964,383	23,592F
Reserves							
Revaluation Reserve	643,988	643,988	0U	643,988	0F	643,988	0U
Accumulated Deficits from Prior Year's	(888,955)	(878,633)	10,321U	(888,955)	0F	(792,742)	96,213U
Current Surplus/(Deficit)	(3,956)	(44,181)	40,225F	(4,496)	539F	(96,229)	92,273F
	(248,923)	(278,826)	29,903F	(249,463)	539F	(244,983)	3,940U
Total Equity	**739,052**	**739,685**	**633U**	**733,417**	**5,635F**	**719,400**	**19,652F**
Non Current Assets							
Fixed Assets							
Land	397,089	397,089	0F	397,089	0F	397,089	0F
Buildings	605,864	654,505	48,641U	608,771	2,908U	621,314	15,450U
Plant & Equipment	85,042	96,097	11,055U	85,516	474U	91,861	6,819U
Work in Progress	133,634	122,515	11,119F	126,121	7,513F	96,596	37,039F
Total Property, Plant & Equipment	1,221,629	1,270,205	48,577U	1,217,498	4,131F	1,206,860	14,769F
Investments							
- Health Alliance	78,787	79,676	889U	78,787	0F	79,676	889U
- Health Source	271	-	271F	271	0F	-	271F
- NZHPL	6,836	7,295	459U	6,913	76U	7,295	459U
- Other Investments	617	-	617F	617	0F	-	617F
	86,512	86,971	459U	86,588	76U	86,971	459U
Intangible Assets	2,282	8,105	5,822U	2,361	78U	2,751	469U
Trust Funds	17,444	17,577	133U	17,220	224F	17,577	133U
	106,238	112,653	6,414U	106,169	69F	107,299	1,061U
Total Non Current Assets	**1,327,867**	**1,382,858**	**54,991U**	**1,323,667**	**4,200F**	**1,314,159**	**13,709F**
Current Assets							
Cash & Short Term Deposits	361,381	179,566	181,815F	194,307	167,074F	202,469	158,912F
Trust Deposits > 3months	17,418	10,707	6,711F	18,423	1,006U	10,707	6,711F
ADHB Term Deposits > 3 months	-	-	0F	-	0F	-	0F
Debtors	89,262	44,859	44,403F	45,613	43,649F	44,859	44,403F
Accrued Income	124,502	76,452	48,050F	165,799	41,297U	76,452	48,050F
Prepayments	9,932	5,568	4,364F	10,735	803U	5,920	4,012F
Inventory	18,660	16,275	2,385F	17,744	916F	16,275	2,385F
Total Current Assets	**621,154**	**333,427**	**287,728F**	**452,621**	**168,533F**	**356,682**	**264,472F**
Current Liabilities							
Borrowing	(3,421)	(2,828)	593U	(3,179)	242U	(2,828)	593U
Trade & Other Creditors, Provisions	(426,933)	(222,902)	204,031U	(238,884)	188,049U	(222,902)	204,031U
Employee Entitlements	(668,409)	(636,986)	31,423U	(689,511)	21,102F	(616,986)	51,423U
Funds Held in Trust	(1,410)	(1,410)	0U	(1,410)	0F	(1,410)	0U
Total Current Liabilities	**(1,100,174)**	**(864,126)**	**236,048U**	**(932,984)**	**167,190U**	**(844,126)**	**256,048U**
Working Capital	**(479,019)**	**(530,699)**	**51,680F**	**(480,363)**	**1,344F**	**(487,444)**	**8,425F**
Non Current Liabilities							
Borrowings	(16,528)	(19,158)	2,630F	(16,619)	91F	(13,949)	2,579U
Employee Entitlements	(93,268)	(93,316)	48F	(93,268)	0F	(93,366)	98F
Total Non Current Liabilities	**(109,796)**	**(112,474)**	**2,678F**	**(109,887)**	**91F**	**(107,315)**	**2,481U**
Net Assets	**739,052**	**739,685**	**633U**	**733,417**	**5,635F**	**719,400**	**19,652F**

3. Statement of Cash flows as at 31 December 2021

$000's	Month (Dec-2021)			Year to Date 2021-22		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Revenue Received	410,520	238,191	172,329F	1,592,408	1,422,593	169,814F
Payments						
Personnel	(143,826)	(109,571)	34,255U	(645,080)	(605,655)	39,425U
Suppliers	(49,277)	(52,066)	2,789F	(369,544)	(319,087)	50,457U
Capital Charge	0	(3,834)	3,834F	0	(17,396)	17,396F
Payments to other DHBs and Providers	(77,350)	(73,779)	3,572U	(423,952)	(442,674)	18,723F
GST	31,757	0	31,757F	29,231	0	29,231F
	(238,697)	(239,250)	553F	(1,409,346)	(1,384,813)	24,533U
Net Operating Cash flows	**171,823**	**(1,059)**	**172,882F**	**183,062**	**37,780**	**145,282F**
Investing						
Interest Income	295	219	76F	1,383	1,314	69F
Sale of Assets	18	0	18F	97	0	97F
Purchase Fixed Assets	(11,260)	(21,564)	10,304F	(45,753)	(120,683)	74,930F
Investments and restricted trust funds	1,000	0	1,000F	(6,409)	0	6,409U
Net Investing Cash flows	**(9,947)**	**(21,345)**	**11,397F**	**(50,682)**	**(119,369)**	**68,687F**
Financing						
Interest paid	(49)	(100)	51F	(431)	(601)	169F
New loans raised	151	0	151F	2,471	6,427	3,956U
Loans repaid	0	(240)	240F	901	(1,269)	2,170F
Other Equity Movement	5,096	10,663	5,567U	23,591	54,128	30,537U
Net Financing Cash flows	**5,199**	**10,323**	**5,124U**	**26,532**	**58,686**	**32,154U**
Total Net Cash flows	**167,075**	**(12,081)**	**179,156F**	**158,912**	**(22,903)**	**181,815F**
Opening Cash	194,306	191,646	2,660F	202,469	202,469	0F
Total Net Cash flows	167,075	(12,081)	179,156F	158,912	(22,903)	181,815F
Closing Cash	**361,381**	**179,566**	**181,815F**	**361,381**	**179,566**	**181,815F**

ADHB Cash	353,855	166,050	187,805F
A+ Trust Cash	7,185	11,765	4,580U
A+ Trust & Restricted Deposits < 3 months	340	1,751	1,411U
Closing Cash	**361,381**	**179,566**	**181,815F**
ADHB Short Term Investments 3 > 12 months	0	0	0F
A+ Trust Short Term Investments 3 > 12 months	17,418	10,707	6,711F
ADHB Long Term Investments	0	0	0F
A+ Trust Long Term Investment Portfolio	17,444	17,577	133U
Total Cash & Deposits	**396,242**	**207,850**	**188,393F**

Minutes
Hospital Advisory Committee – Provider Equity Meeting
23 June 2021

Minutes of the Hospital Advisory Committee – Provider Equity meeting held at A+ Trust Centre, Auckland City Hospital and via a Zoom meeting commencing at 2:30pm

Committee Members Present Tama Davis (Chair) Bernie O'Donnell Fiona Lai Heather Came Michael Quirke **Zoom** Jo Agnew (Deputy Chair) Doug Armstrong Michelle Atkinson Peter Davis **Board Observers** Krissi Holtz Shannon Ioane	**Auckland DHB Executive Leadership Team Present** Dr Michael Shepherd – Interim Director Provider Services Dr Mark Edwards – Chief Quality, Safety and Risk Officer Justine White – Chief Financial Officer Margaret Dotchin – Chief Nursing Officer Meg Poutasi – Chief of Strategy Mel Dooney – Chief People Officer Sue Waters – Chief Health Professions Officer **Auckland DHB Senior Staff Present** Jo Brown – Funding and Development Manager, Hospitals Dr Barry Snow – Director, Adult Medical Directorate Dr Richard Sullivan – Director, Cancer and Blood Dr George Laking – Medical Oncologist Alex Pimm – Director Patient Management Services Nigel Robertson – Interim Director Perioperative Services Duncan Bliss – Interim Associate Director Surgical Services Kay Sevillano – EA to Deputy Board Chair (minutes) (Other staff members who attend for a particular item are named at the start of the minute for that item)

10.1

KARAKIA

The Karakia was led by Meg Poutasi, Chief of Strategy.

1. APOLOGIES

That the apologies of Zoe Brownlie, Board member be received.

That the apologies of Executive Leadership Team members Ailsa Claire (Chief Executive), Dr Debbie Holdsworth (Director of Funding – Auckland and Waitematā DHBs), Karen Bartholomew (Director of Health Outcomes – Auckland and Waitematā DHBs), Dr Margaret Wilsher (Chief Medical Officer) and Shayne Tong (Chief Digital Officer) be received.

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

Michael Quirke, Board Member advised that he is on the Health Alliance Board, representing Auckland DHB.

There were no other conflicts of interests to any items on the open agenda.

3. CONFIRMATION OF MINUTES 21 April 2021 *(Pages 9-23)*

Resolution: Moved Jo Agnew / Seconded Michelle Atkinson

That the minutes of the Hospital Advisory Committee meeting held on 21 April 2021 be approved.

Carried

4. ACTION POINTS *(Page 24)*

a) Guidance on reports (socialising the use of Te Reo Māori; use or readable fonts, graphs and illustrations; defining acronyms consistently; and inclusion of framework with intention that defines process and completion)

Dr Michael Shepherd, Interim Director Provider Services confirmed that the guidance provided by the Board have been noted and included in report writing guidelines. He requested that the Directorate A3 be the way in which to measure progress, as the document will include outcome measures and narrative around provider directorate activities. Directorate Business Plans will be presented at the next meeting.

b) Māori leadership involvement in different directorates

Tama Davis, Hospital Advisory Committee Chair advised that the matter is to be discussed further with Bernie O'Donnell, Board Member.

Director Equity Update – Clinical Support

Bernie O'Donnell has discussed Māori pathways with Ian Costello, Director Clinical Support. However, Tama Davis and Bernie O'Donnell agreed that recommendations around creating Māori pathways at Auckland DHB through the three major Wānanga would need to be taken to the Board for consideration.

5. PERFORMANCE REPORTS

5.1 Provider Arm Operational Exceptions Report (*Pages 25-28)*

Dr Michael Shepherd, Interim Director Provider Services asked that the report be taken as read, opening the floor to questions from the committee.

There were no questions raised nor points to consider

Resolution:

That the Hospital Advisory Committee receives the Provider Arm Operational Exceptions

Report for June 2021.

Carried

5.2 Financial Update *(Pages 29-38)*

Justine White, Chief Financial Officer, asked that the report be taken as read.

Justine explained that Auckland DHB is on track as expected, with a forecast of $42 million deficit by the end of 2021. The organisation will be $3million above budget, which relates to donations received earlier in the year.

She explained further that the organisation is currently in its first deficit year after a significant period of not being in deficit. Previous finances were in deficit as a result of a one-off Holidays Act provision. Over the last three years, approximately $260 million has been accrued due to the Holidays Act and the organisation continues to accrue $40 million per annum.

There were no other questions raised.

Resolution:

That the Consolidated Statement of Financial Performance for June 2021 be received.

Carried

5.3 Director Equity Update – Cancer and Blood *(Pages 39-46)*

Dr Richard Sullivan, Director Cancer and Blood and Dr George Laking, Te Whakatōhea, Medical Oncologist, Kaihautū – Pou Ārahai, asked that the report be taken as read.

Dr Laking reported that Te Pūriri o Te Ora was the name gifted to the service by Dame Naida Glavish, Chief Advisor Tikanga – Auckland DHB. Considerable work within the directorate is being undertaken around alignment with the organisational strategy, particularly in terms of Te Tiriti o Waitangi in Action, and embedding foundational changes in workplace culture.

The service introduced a series of Wānanga (workshops), which commenced on 16 April 2021, which was attended by Pat Snedden, Board Chair and Tama Davis, Deputy Board Chair. The purpose of the programme is to provide learning and facilitate a better understanding of history to be able to work in a manner that is culturally safe. The programme takes place fortnightly and alternates with fortnightly powhiri to welcome new staff and whānau into the service. Staff who leave the service are accompanied to their new mahi and handed over in person. This practice will be included as part of the directorate's work programme.

There was successful engagement with Te Whetu Mārama marae in relation to whānau who had a poor experience with the service. Huis with the whānau and health care team provided learnings that will be documented and used to improve services going forward.

Dr Laking expressed gratitude and acknowledged the support of Ngāti Whātua in enabling the development of Maturanga and Tikanga in the service. He also thanked the committee,

staff and whānau for contributing to the improvement of Te Pūriri o Te Ora.

Jo Agnew, Hospital Advisory Committee Deputy Chair queried the presence of Māori leadership in the directorate to support the initiatives specified in the report. Dr Laking identified himself by way of his own whakapapa (his mother is from Whakatōhea in the Eastern Bay of Plenty), the Kaimahi Māori (the team) whose kaupapa is Te Pou Ārahi (the Guiding Post). The Te Pou Ārahi leadership consists of Dr Laking (Chair of Te Pou Ārahi), Tame Hauraki (kaumatua), Troydyn Raturaga (Auckland DHB Provider Services), and Ingo Lambrecht (Ngati Whatua by adoption).

Bernie O'Donnell, Board Member acknowledged the humility in which the report was presented and congratulated the team on the progress. He noted it was important to establish the right Māori framework and to create a pathway that addresses the needs of other constituents.

Michael Quirke, Board member queried the warranty period for linear accelerators that resulted in increased cost of service contracts. He asked whether the expense of $2 million over the next 10 months and possibly another $400,000 in the next 2 months would be budgeted for in the next financial year. Dr Sullivan explained that linear accelerator contracts are for a 10-year period. Two accelerators are to be replaced in the next 6 to 12 months. Future service contracts will be budgeted.

Peter Davis, Board Member queried the concept of disseminating key clinical skills beyond the medical workforce to achieve necessary increase in geographical range and to remedy burnout. Dr Laking explained that this concept was in line with a different model of care that involves training people to gain the right skillset and providing the necessary support to allow them to do their job, as opposed to a model of quality assurance that focuses on paper-based processes, supervision and oversight. Dr Shepherd further explained that this was an organisation-wide approach aimed at ensuring staff were able to work at top of their scope as well as partnering with whānau to deliver improved quality of care. Michelle Atkinson, Board member mentioned that nurse practitioners, nurse prescribers and nursing-led primary care practices are examples of new ways in which certain tasks originally done only by doctors and are now diversified.

Dr Sullivan explained the scorecard results, particularly the metrics for patient-centered ratings that were marked red (refer to page 45). He said that the demand for services increases between 15% to 18% annually, which places a constant strain on ensuring that the appropriate service model and workforce is in place to meet demand. There is also need to ensure that services are community-focused and patient-centered. Although the goal is to see patients within 4 weeks or less under the faster cancer treatment pathway, making this happen is a challenge. However, the service has set targets that they are working to meet to improve ratings. Tama Davis, Chair Hospital Advisory Committee said that it is the committee's duty to ensure that targets are being met, but to also to ensure that directorates are setting achievable targets.

Resolution:

That the Director Equity Update – Cancer and Blood for June 2021 be received.

Carried

5.4 Director Equity Update – Patient Management Services *Pages 47-52)*

Alex Pimm, Director Patient Management Services asked that the report be taken as read.

Alex advised that the report focuses on staff and the support provided to them. The service's initiatives and improvement of patient support will be discussed the next time he presents to the Hospital Advisory Committee meeting.

Fifty-one Auckland DHB staff are graduating on 25 June 2021 through the Thrive programme. Forty-two of those will be graduating with level 2, 3 or 4 NZQA qualifications. Nine people who have English as their second language are being supported through digital literacy and use of English in the workplace to help them achieve NZQA qualifications. The programme has been in place for a couple of years and has resulted in people moving into other roles within the organisation (e.g. reception and health care assistant roles).

Auckland DHB has about 200 volunteers that regularly work at the hospital to support patients. The service is taking steps to change the demographic of volunteers, identifying more flexible ways of volunteering. Current volunteers are in the hospital wearing blue coats and green vests. The companionship volunteer programme has also been expanded and has been the service's biggest success over the past year. The programme provides patient support in a variety of settings and across the different wards (e.g. Adult Health, General Medicine), and through the Grandparents programme in Starship. The service is looking to provide support to the Surgical ward particularly for short-stay patients who might benefit from having companionship while in hospital**.** All volunteers have been offered the Covid-19 vaccine.

Jo Agnew, Deputy Chair Hospital Advisory Committee queried the volunteer uniforms and the way in which the organisation acknowledged volunteers for their contribution. Alex Pimm explained that volunteers are involved in the modernising and standardising of volunteer uniforms across the organisation. The goal is also for volunteers to able to cover a number of different roles across the hospital. The service hosts Volunteer Christmas parties and morning teas as a way to express gratitude for their service. Senior leaders spent time with volunteers this year to personally acknowledge their contributions. The volunteer centre has also been refurbished.

The directorate is in the early stages of integrating Te Tiriti o Waitangi into their work programme and with the support of Māori leadership and experts from other parts of the organisation, they will utilise a Te Tiriti analysis tool to review policies and practices.

Although the directorate's leadership team is diverse it does not currently have Māori representation. The service has a total of 1,100 staff of which 6% are Māori and belong to tier 4 roles along with Pacific people. A number of developmental opportunities and the

Thrive programme are in place to support staff progress to other roles within the organisation.

Fiona Lai, Board member queried whether younger volunteers were being recruited as the organisation works to provide a safe workplace and provide possible career pathways for rangatahi. Alex Pimm said the age range of volunteers are between 18 and 88 years of age. As a result of working with educational institutions, a number of young nurses and allied health students work as volunteers in the hospital. Blue coat and reception roles tend to be filled by senior volunteers who are more flexible and can offer more of their time. Younger volunteers have less time so flexible volunteering schedules are provided.

Bernie O'Donnell, Board member queried the presence of Māori or mana whenua intelligence to help inform the work that the service is doing to uphold Te Tiriti o Waitangi and address equity issues. Alex Pimm said that support for equity-focused initiatives are gained through engagement with Māori teams and clinicians within the organisation. However improvements are to be made in this space going forward.

Michael Quirke, Board member commended the favourable audit performance of cleaning services delivered during the Covid period and queried whether these costs could be factored in when having discussions with the Ministry of Health. Justine White, Chief Financial Officer explained that costs that are clearly Covid-related are brought forward for discussion however routine services (e.g. cleaning services) are difficult to identify as direct Covid-related expenses. Alex Pimm further explained that cleaning services have stepped up over the past 18 months and have made a significant effort to meet the demand of a Covid environment. The cost impact is however not proportionate and some savings are available from efficiencies made elsewhere as well as through Covid allocations from the Ministry of Health. These activities were undertaken without significant additional cost, which reflects the agility and responsiveness of the team.

Shannon Ioane, Board Observer queried the directorate's guaranteed interviews to Māori and asked if it needed to be reframed to protect the mana of these applicants. She also asked what focused support under the Thrive programme looks like for Māori and Pacific people.

Alex Pimm explained that the organisation offers guaranteed interviews for Māori and Pacific applicants that meet the essential criteria for the role. There is a high number of people joining the service and all are valued for the skills and knowledge they bring. Focused support relates to providing assistance to employees who have high rates of absence. Coaching, EAP access and green prescriptions reviewed by the occupational health service are provided to these staff members as required.

Resolution:

That the Director Equity Update – Patient Management Services for June 2021 be received.

Carried

5.5 Director Equity Update – Perioperative Services *(Pages 53-68)*

Dr Nigel Robertson, Director – Perioperative Services asked that the report be taken as read.

Dr Robertson explained that work around embedding Te Tiriti and addressing equity continues through collaboration with the Kaiārahi nāhi and Pacific Care Navigator teams. The purpose is to facilitate patient pathway through the perioperative treatment for Māori Pacific people.

Staff are supported to be able to understand and respond appropriately to a diverse community, particularly Māori and Pacific communities, and support patients who come through the Perioperative service during a stressful and challenging time.

The service has achieved significant uplift in the ability to deliver planned care, filling in sessions during the week. There is also significant uplift in weekend work and acute weekend coverage.

Michael Quirke, Board member queried whether tikanga practices in operating rooms might bring complexity and disruption in terms of surgical safety. Dr Roberston said that the service is focused on safety and communication in the operating room and they have undertaken work in the last 5 to 10 years to strengthen their surgical safety processes. The team are thus comfortable with incorporating Tikanga Māori in the operating room as it does not impact on their ability to provide safe and effective patient care. Team briefings take place before the first patient is brought in. This is a chance for everybody to introduce themselves to one another and it is then where the decision is made to have a karakia or not.

Welcome signage in Te Reo Māori and karakia in all meetings are now becoming part of normal practice and is welcomed by staff.

Peter Davis, Board member queried whether the 85% theatre utilisation (refer to page 66) is sufficient. He wanted clarity around whether theatre utilisation meant 5 days a week from 9:00 am to 5:00 pm. Dr Robertson explained that there are a number of ways to look at utilisation. One measure is session utilisation which means 85% of resource time is used while the patient is in the operating room being cared for. The other measure is the number of available sessions that are utilised. In this report, utilisation means the in-session patient contact time, with 85% resource time as a nationally agreed acceptable figure. Resource time spent at level 8 operating rooms is over 91% at present. These all relate to planned care utilisation where a percentage of the resource time is allocated for the planning sessions during the week. There are a number of Saturday lists on occasion that result in slightly extended theatre days in certain areas and staffing mix is required, noting that it doesn't take account of the acute provision.

Michael Quirke, Board member asked about the average time patients spend in theatre. He queried whether patient cases (average or complex) could be categorically recorded through coding or pricing, to understand the drivers that result in longer stays and to identify ways to improve efficiencies.

ACTION: Perioperative and Surgical services will report on case complexity and operating time by procedure to further explain length of stay in theatre.

Resolution:

That the Director Equity Update – Perioperative Services for June 2021 be received.

Carried

5.6 Director Equity Update – Surgical Services *(Pages 69-80)*

Duncan Bliss, Interim Associate Director Surgical Services asked that the report be taken as read.

Duncan advised that the report acknowledges the lack of Māori representation in the Surgical Directorate Lead Team. The directorate has since taken initial steps to address the gap by having Kaiārahi nāhi representation on the team who attend meetings on a weekly basis, and Pacific Care Navigators in attendance on a fortnightly basis.

The report also provides an update on current DNA levels where there has been a marginal improvement in Māori and Pacific patient DNA rates. The service has recently engaged with the surgical bus based at Counties Manukau DHB that has been delivering dental services to predominantly Māori and Pacific children for the last 6 weeks. Three hundred children have since been attended to and the DNA rate is under 1%. Auckland DHB's Performance Improvement staff are working in the service to evaluate the programme.

Peter Davis, Board member asked whether having stand-by patients to fill slots of cancelled patients appointments could be put in place. Duncan Bliss explained that that is the current way in which the standby list works and is an opportunity for utilising spare capacity. Patients are contacted a day prior to surgery to confirm their attendance. When scheduled patients choose not to come to surgery or an operation is cancelled or rescheduled, more operating space is available. Patients who are on stand by are then contacted, however this may be challenging for the person in terms of uncertainty of when they will be contacted, and having to stay 'nil by mouth'.

Peter Davis, Board member asked about learnings from the Covid experience where alternative ways of communicating with patients were utilised. Dr Shepherd explained that this question is not specific to just Surgical services but applies to all directorates. There is an opportunity to deliver more services through Telehealth, virtual platforms and other modalities, but more work is required to develop the process and methodology. Post Covid, there was an increase of patients who opted for in-person consults with clinicians. Most surgical patients need to be seen prior to surgery as they require examination and assessment.

Duncan Bliss said that day surgery admission rates are at 80% in comparison to the nationally-set target rate of 68%. There is an opportunity within the Neurosurgical service to improve current surgery admission rates because the service has a high proportion of patients coming from the region and out of town. These patients require imaging prior to operation and could be provided hotel accommodation.

Day surgery means the patient comes in and goes home after their operation on the same day. Day of surgery admission means the patient does not require admission prior to the day of operation.

There are also opportunities to improve diagnostic patient pathways in Urology that will involve streamlining of processes and working closely with patients and whānau adopting a patient and whānau-centered approach.

Low feedback rate from patients is another priority of the directorate to be able to understand patient and whānau experience of Auckland DHB's services. If patients report poor experience, the complaint is handled by services making individual contact.

Action: Dr Mark Edwards, Chief Quality, Safety and Risk Officer will share the different ways patient data is collected at the October 2021 meeting.

Resolution:

That the Director Equity Update – Surgical Services for June 2021 be received.

Carried

6. RESOLUTION TO EXCLUDE THE PUBLIC (*Pages 81-83)*

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Karakia Attendance and Apologies	N/A	N/A
2. Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Confidential Minutes 21 April 2021	**Commercial Activities** **Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public** [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

4. Confidential Action Points	**Commercial Activities** **Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public** [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Community Anatomical Pathology	**Commercial Activities** **Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public** [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.2 Provider A3 Business Plan	**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]
6.1 Major Risks & Issues – 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)] **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]
6.2 Mental Health Facilities Plan	**Commercial Activities** **Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public**	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

	[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)]	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 Expert Advisory Review Panel – Women's Health 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.** **Privacy of Persons** **Information relating to natural person(s) either living or deceased is enclosed in this report.**	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.2 Winter Plan	**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.** **Prejudice to Health or Safety** **Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.**	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.3 Clinical Quality and Safety Report	**Prejudice to Health or Safety** **Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.**	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

The meeting closed at 4.00 pm.

Signed as a true and correct record of the Hospital Advisory Committee meeting held on Wednesday, 23 June 2021

Chair: _____ Date: _____

Tama Davis

Hospital Advisory Committee Report

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

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

Kuputaka: Glossary

Acronym/term	Definition
Hui	Meeting
Kaimahi	Worker, Employee, Staff member
Māmā	Mother, mum
MOH	Ministry of Health
Rōpū	Group
Te Papakāinga Atawhai o Tāmaki	Auckland City Hospital

1. Executive Summary

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

- Te Toka Tumai had another busy holiday period and has been running to 95% occupancy. Whilst plans are in place to respond to forecasted demand, it is likely that the hospital will maintain high rates of occupancy throughout the winter period. Planning is underway given the additional likely impact of COVID-19.
- Currently, overall year to date hospital midnight occupancy is running at approximately 7 per cent behind previous years; however our workforce situation has made this difficult to manage.
- Transplant volumes total 64 heart, lung and liver and 79 renal transplants, totalling 143 transplants year to date. We are pleased to note maintenance of transplant activity despite the other pressures we have been experiencing.

Year to Date	14/15 YTD	15/16 YTD	16/17 YTD	17/18 YTD	18/19 YTD	19/20 YTD	20/21 YTD	21/22 YTD
Heart	7	6	5	17	14	9	11	10
Lung	7	13	10	14	24	16	16	20
Liver	27	27	30	36	31	34	36	34
Total Nat Funded	**41**	**46**	**45**	**67**	**69**	**59**	**63**	**64**
Renal	44	54	65	74	77	77	85	79
Total	**85**	**100**	**110**	**141**	**146**	**136**	**148**	**143**

Surgical and Perioperative Directorate Review

The Surgical and Perioperative Directorate review which commenced in March 2020, has now been completed. The revised leadership structure to the Surgical and Perioperative Directorate teams aims to better align along the patient pathway and provide a governance board structure to ensure the Directorates will be fit for purpose now and in the future. New roles within the revised structure include: Director Adult Surgery – General Surgery, Transplant, Trauma, National Intestinal Failure & Rehabilitation Service, Urology; Director Adult Surgery – Otorhinolaryngology, Head and Neck, Oral & Maxillofacial Surgery, Auckland Regional Hospital and Specialist Dentistry, Neurosurgery, Orthopaedics, Ophthalmology; Nurse Unit Manager, Greenlane Surgical; and Associate General Manager, Greenlane. Two leadership groups have also been established,

including an Operating Room Management Group (coordinating operating room use and professional perioperative issues across the Provider arm) and a Perioperative/Surgical Directorate Leadership Group.

COVID-19 / Omicron Planning and Activity

We are continuing to adjust our approach to be able to serve our people, while living with COVID-19 in our community. We have been operating an improvement programme with a number of work streams to move us forward, the focus areas of these work streams are summarised below.

Work streams	Work stream focus
Clinical Pathways and Guidelines	• How we manage patients who are here because they are sick with COVID-19 related illness • How we manage patients with other illnesses or injuries who have COVID-19 (incidental) • This is across all directorates, including community, mental health and diagnostics and covers both acute and electives • As part of this we'll also be working closely with the Northern Region DHBs • Developing resources and flows so that this becomes part of business as usual
Infection Prevention and Control	• A fit for purpose IPC response for a range of scenarios • The right skills and knowledge around PPE systems. This includes rolling out a 'spotter role and other staff education and resources • A safe and sustainable N95 respirator protection programme • Exposure management process
Planned Care	• Develop improved ways to deliver planned care in a Living with COVID-19 state • Safe spacing, models of care, pre-contact testing • Includes outpatient programme • Maximise telehealth/virtual work • Agile operational process to outsourcing or maximise delivery, that can flex up and down quickly, depending on external and internal factors • Link to regional and national response, in particular supporting Northland
Acute Flow	• Activities that need to continue to improve acute flow for COVID-19 and Winter 2022 in the Adult Hospital • Assess current projects that support acute flow and discharge • Adult Emergency Department facilities work and implications • Clinical pathways will inform this work, including regional rapid discharge work
Facilities	• Prioritised facilities works across Auckland DHB to reduce the risk of transmission of COVID-19. This is closely aligned to the pathways work • Focused on reducing the risk for our staff, our patients and their whānau and includes: airflow review and enhancement, allocation of portable HEPA filters, permanent facilities projects, physical controls which support staff and patient flows identified by the pathways work stream, temporary physical controls • The refocus for facilities will mean some other work is paused or stopped
Supply chain and Equipment	Monitor and manage risks and issues in supply chain. Current focus includes: • Respond to supply chain issues as they arise • Plan ahead to procure equipment as needed • Look at a more regional approach to Labs • Review Clinical Equipment capital plan to reprioritise • This refocus means some equipment will be de-prioritised
Workers	Look after the health, safety and wellbeing of workers. This includes: • COVID-19 Vaccination and Booster • Supporting vulnerable workers • A surveillance testing framework • Supporting the wellbeing of all our people • Appropriate pre-employment screening
Workforce	Ensure we have an available and flexible workforce with the right skills. This includes: • Consider alternative models of care • Surge capacity • National and regional links • Overseas workforce and immigration • Managing and supporting students
Whānau as partners in	• Supporting whānau as partners in care to support and stay connected to their loved ones

care	in hospital • Manage visitor screening at the front door • Develop a more sustainable screening function • Introduce testing in some specific areas
Hospital at Home	Develop capability to reduce admission and length of stay where appropriate. Current focus: • Patients with COVID-19 illness • Virtual enabled care • Liaison with NRHCC and Primary Care
IT Enablers	Rapidly implement enablers to support how we work in a COVID-19 environment and support wellbeing. Includes: • Data and analytics requests • Requests to support COVID response using digital tools (e.g. visitor registration, Regional Clinical Portal template requests) • IT equipment and mobile phone requests (e.g. laptops, etc.)

Omicron Outbreak Organisational Operating and Decision-Making Model

We have developed a more formalised operating model and aligned regional service delivery approach. The aims of the operating model include:

- Widely shared understanding of the situation
- Decision making as close to the clinical floor as possible
- Transparency around who is tasked with fixing issues or addressing risks
- Feedback loops and information available to be able to learn and change as needed.

Overall decision-making principles follow the strategic intention of Te Toka Tumai. Areas that specific focus is also needed include:

- Patient focus – both COVID and non-COVID-related safety and quality of care is optimised
- Using Te Tiriti o Waitangi in action: The potential risks of breaching Te Tiriti o Waitangi and amplifying health inequities are considered in decision-making
- Worker engagement and participation: where appropriate workers who are impacted by decisions are engaged and participate in the decisions

Minimum service delivery expectations have been agreed by the Regional Provider Group. The aims of this care delivery approach include:

- Regionally consistent DHB provider approach to ensure equitable access to services that cannot be reduced
- Maintain the well-being and welfare of workforce
- Daily decision making occurring at clinical interface in accordance with established Business Continuity Plans
- It is acknowledged that there is some clinical activity that cannot be reduced.

2. Service Reports

2.1 Māori Health Provider Services

The Māori Health Team is currently working with Directorates to appoint Māori Health Leads across the Provider. Cardiovascular and Patient Management Services have appointed their leads, and Perioperative Services and Clinical Support are in negotiation with shortlisted candidates, two of whom identify as Ngāti Whātua. Adult Medical Services and Adult Community and Long Term Conditions are working in partnership with their kaimahi Māori to identify leaders.

We welcome the addition of four Oranga Coordinators to the Kaiārahi Nāhi team who will support COVID patients and whānau during their stay with us and become the conduits with community providers. This unit has been developed as part of our legacy approach to employment for kaimahi Māori recruited into our vaccination centres. All four kaimahi identify as Ngāti Whātua.

To ensure uniformity of our 'Living with COVID' programme in response to equitable influence of decision making, all workstreams have been delegated Māori representation. This approach is underpinned by He Kāmaka Waiora as the primary authority of tikanga and underpinned by the Māori Strategic Approach A3, and the DHB's Te Tiriti o Waitangi position statements.

2.2 Āhua Tohu Pōkangia Perioperative Services Equity Update

The last few months have been exciting for Āhua Tohu Pōkangia, with the selection of a Māori Health Lead to join the Māori health leadership network for Te Toka Tumai. Dr Jack Hill from the Women's Health Department of Anaesthesia has been nominated by Tika Rōpū, the Directorate's equity committee. Jack is of Ngāti Whātua, Ngāpuhi, Ngāti Kahungunu, Ngāti Tuwharetoa and Ngāti Raukawa descent and has recently completed a sabbatical that included an immersion course in Te Reo and Te Ao Māori. Discussions with the Director of Māori Health Provider Services continue in order to progress the appointment and breadth of work that Jack is going to be involved with – a great step forward for us.

Planned care continues, and with the daily review of planned care we make sure that we are applying the equity adjuster to the cases that we do, within the current constraints of staffing. Long wait patients who are Māori or Pacific are identified in our booking system and we prioritise their surgery.

Tika Rōpū continues to work on patient pathways, working with the Kaiārahi Nāhi and Pacific Navigator teams, to ensure that our patients are not disadvantaged in the interaction with the health system. Upcoming work includes enhancing our patients' experience in the pre-assessment clinic and improving how we interact with Māori whānau. We also are working to lengthen the operating room planned care day and reduce cancellations and overruns in the Women's Health operating rooms, with particular emphasis on the gynaecological oncology service, where Māori and Pacific women are over-represented in the caseload.

2.3 Cardiovascular Directorate Equity Update

The directorate welcomed the appointment of Willy Bhana as Māori Health Lead, starting in January (0.6 FTE). Willy is of Ngāpuhi, Ngāti Kahu and Tainui descent and is a long serving and highly experienced Clinical Nurse Specialist at Te Toka Tumai. We are now working on a work plan to deliver the Te Tiriti o Waitangi and Equity priorities of the directorate business plan. A key focus will be review of outpatient services to improve access for Māori and Pacific patients and increasing the number of Māori staff in the directorate. To inform this work, a hui is scheduled for our kaimahi Māori in February to identify priorities to improve recruitment and retention.

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 directorate Māori Health Lead will now be engaged in this planning.

The directorate savings plan is tracking to be achieved and whilst PVS achievement has been impacted by COVID, it was fully achieved in December.

Cardiothoracic Surgery (as at 2 Feb)

Priority	Māori	Other	Pacific	Grand Total
P1	4	6	3	13
P2	8	42	9	59
P3	16	67	11	94
Grand Total	**28**		**23**	**166**

The cardiothoracic waitlist is unfortunately at an historical high, with many P2 and P3 patients waiting longer than MOH recommended timeframes. The total cardiac bypass patients on the waitlist has exceeded the MOH maximum since mid-January (currently 118 vs a target of 113) and there were 31 (19.25%) ESPI breaches in December. The service is outsourcing cardiac cases where possible however private capacity is very limited with only one provider in Auckland (Mercy). We are carrying out additional Saturday lists when resources are available. The Thoracic waitlist is also very high but lung cancer patients are generally receiving their surgery within the recommended timeframe (21 days). CVICU capacity continues to be a constraint.

The Echocardiogram TTE outpatient waitlist is very high and has been raised as an organisational risk. 1987 (88%) patients are waiting over the target timeframe of 6 weeks and the average wait time is 210 days. All DHBs in the region have similar waitlists and there is a similar picture nationally. The region has agreed a work plan to address this with issues including access to training, retention of staff, lack of capacity in the private sector and very high demand.

2.4 Clinical Support Directorate Equity Update

Leadership talent mapping and leadership development pathways have been completed across the Directorate, with a particular focus on our Māori staff, to actively support development into leadership positions and to create leadership and career progression opportunities for our Māori staff. An example of this is a newly created leadership role approved by the directorate called the Therapy Assistant Co-ordinator role, where a person identiifed on this talent map was succesfully coached to prepare for, and was successful in attaining, the role. The Directorate is in the process of appointing a Māori Health Lead, in conjunction with the Director of Māori Health Provider Services. Two candidates have been interviewed and an appointment is imminent.

As a Directorate we see an opportunity to support our teams to be involved in Te Tiriti o Waitangi in practice training sessions which are available through Te Toka Tumai. All services have achieved the target of ensuring their staff have completed the training and the leadership team of each service has developed a strategy for implementation.

All services are engaged in the Rangatahi programme, with active participation in school visits, career open days and work experience for students. This was delivered via a virtual approach at COVID alert levels. A joint approach to recruitment has been developed with Patient Management Services to enable career development and career change from entry pathways. Pathways have been agreed, prioritising Māori and Pacific staff recruitment. Initial advertisement for appropriate positions will be to the Patient Management To Thrive groups only.

Pharmacy intern interviewing is taking place in March/April 2022. In conjunction with the School of Pharmacy, University of Auckland, Māori candidates have been prioritised to attend the assessment centre, supported by University of Auckland Māori advocates. From 2021 onwards one of the intern positions has been identified for a Māori candidate only and our first pharmacist intern is starting training this year.

Champions for Māori patient and staff experience and support across the Directorate have been identified. The role of our champions includes suggesting improvement in our Māori patient/whānau experience, monitoring Māori workforce participation and progression in our Directorate and applying Te Reo and Tikanga across our Directorate which includes the capability of our workforce to correctly pronounce Māori names and words.

A Greenbelt project has been completed in Radiology with some recommendations made to better support patients to attend diagnostic imaging appointments, with a particular focus on Māori patients. These recommendations are being implemented including changing hours and options for access, changing the approach to booking appointments and a review of navigation support. The equity adjuster has been applied to all radiology waiting lists

Dame Nadia Glavish has been working with the Contact Centre team to provide greetings messages on all automated phone messages in Te Reo Māori. This will be expanded as switchboard functionality allows.

A review of Māori language options has been completed in the Patient Administration Service, with the aim of enabling all patients and whānau to converse in the language of their choice with our contact centre and bookers and schedulers. A strategy to recruit staff continues.

As a Directorate we see an opportunity to support our teams to be involved in Tikanga in Practice and Te Tiriti o Waitangi in practice training sessions which are available through Te Toka Tumai, and to encourage the use Te Reo Māori routinely in our business.

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

Within Te Pūriri O Te Ora, the Pou Ārahi leadership team meets weekly with Service Clinical Directors and Managers. Our work in the last 6 months has been shaped by the Delta and Omicron phases of the pandemic.

The pandemic has compounded issues of access to our service, with infection control measures requiring us to reduce the number and size of in person meetings. This has meant a delay in the introduction of whānau Pōwhiri. Instead we have stood up a pathway called Āwhina te Tangata, a project that endeavours to achieve equitable healthcare inclusive of Te Ao Māori tikanga. A Kaupapa Māori, by Māori for Māori, approach is undertaken with a senior member of our Cancer Support Team who contacts whānau by telephone in advance of their first clinic attendance. Furthermore tikanga is observed such as importantly whakawhanaungatanga (relationship building), manaakitanga (the process of showing respect, generosity and support to others) and acknowledging mana/aroha ki te tangata (respect/love-compassion to the person). Tikanga is observed when phoning patients to verify their ability to attend an appointment, or that it is a telehealth session. When speaking to the patient or their whānau it may become clear that a zoom is requested or taxi chits required; then those needs are addressed and organised. Gains are tangible that Maori whānau are provided with appropriate service and support so they can become more self-managing. Intangible gains are that they are heard and are acknowledged – tino rangatiratanga: self-determination, autonomy.

We are grateful to the Māori Health Provider Services Team for deploying two Kaiārahi Nāhi Māori Clinical Nurse Navigators into Te Pūriri o Te Ora. The pandemic has required us to step up our use of information technology. We are impressed by the ServiceNow platform used by Kaiārahi Nāhi for monitoring productivity and are exploring the utilisation of this. At the end of last year we trialled the Zoom platform for remote clinical review. This was generally welcomed by clinicians and whānau alike. We generated valuable qualitative feedback that is being evaluated by our University colleague Dr Rob McNeill. We look forward to the coming adoption of Zoom on an organisation-wide basis, and its integration into clinical booking systems.

We have put together a leadership program that brings in external educators. The start date has had to be set back due to Omicron but we plan to progress this in June, to time the launch with Matariki. We continue with pōwhiri to welcome new staff, and have taken this onto Zoom.

Te Pūriri o Te Ora, with the assistance of Pou Ārahi, continues to bring a Māori lens to directorate projects. We are mindful of significant pressure on the Haematology Bone Marrow Transplant service, and have engaged from the equity perspective in the working group to resolve this. Bone Marrow Transplant wait times, particularly for Allogeneic transplant (a supra-regional service), are too long. We have an improvement plan in action and further investment in this area is likely to be necessary.

We are also engaged regionally with community Māori stakeholders in respect of the Integrated Cancer Service and forthcoming cancer centre rebuild.

2.6 Surgical Services Equity Update

Surgical Services has advanced the outcome of the Surgical and Perioperative review in December 2021 with the successful appointments of Dr Richard Sullivan and Mr Duncan Bliss to the Director roles in the Directorate. Substantive recruitment is now underway for the key leadership roles of Māori Health Lead, Nurse

Director, General Manager and Allied Health Director. It is hoped that all these appointments are made prior to March 2022.

Operationally, Surgical Services have spent the last quarter attempting to return to normal levels of services following reduced capacity through COVID-19 lockdown. This has resulted in increased waiting times for patients. As services have returned, priority has been given to longest waiting Māori and Pacific patients. The Directorate is currently planning minimal service levels with the forecast impact of the Omicron outbreak however presently are committed to deliver as much planned care activity for as long as resources allow.

2.7 Women's Health Directorate Equity Update

Maternity services continue to be under significant pressure, primarily because of on-going midwifery workforce issues.

The Women's Health engagement process has continued to be impacted by the COVID-19 outbreak however the work continues. Moana Research and staff engagement have identified some general themes and the team are developing plans to address these as well ask seeking further ways to gather Māori intelligence.

Other key pieces of work that continue in the Directorate include:

- Establishing a Directorate Governance model which is a Te Tiriti based model to ensure equity lens is applied to projects and service development;
- Working to increase access to Te Manawa o Hine for Māori and Pacific māmā;
- Actively growing Māori leadership within the midwifery leadership team;
- Improving the Discharge process in maternity. This work is in response to feedback to feedback and adverse outcomes associated with whānau not having timely and appropriate followup after birth and discharge communication. We are working to increasing capacity for community midwives to undertake face to face handover for discharge from both Te Papakāinga Atawhai o Tāmaki and Birthcare to ensure discharge planning and communication is optimal.

3. Special Open Reports

3.1 Planned Care Update

Planned care position

In the August COVID lockdown delivery of outpatient face to face appointments was restricted to urgent FSA and follow up appointments that could not be delivered via telehealth or a non face-to- face method. Work was done to put in additional waiting spaces to attempt to increase the physical space for patients waiting and different ways of working were implemented to limit the waiting times between diagnostic testing and FSAs. As restrictions were able to be slowly lifted services have worked on delivery of FSA and follow up appointments in outpatient clinics returning back to 100%.

Lockdown has allowed services to trial and streamline how we provide telehealth/virtual appointments. Where clinically appropriate to do so, services have maintained this mode of delivery to allow more flexibility for patients. There is a significant increase in telehealth delivery in FY22 compared to FY21. Adult Surgical Services have delivered 1,888 FSAs as telehealth YTD FY22 compared to 571 in the whole year FY21. 8,863 follow-ups have been delivered by telehealth YTD FY22 compared with 4,722 in the whole year of FY21.

Te Toka Tumai has attempted to complete as many FSAs as possible, to ensure we maintain the safety of our patients. The resulting waitlisting of patients for surgery, as appropriate, provides a more accurate picture of our ESPI5 waitlist. Continuous clinical review of clinical risk within these waitlists is occurring.

As in previous lockdowns, referral volumes have dropped and this has had a flow on effect to our waitlists. Due to the four month ESPI measures this drop in referrals is now causing a drop in our ESPI2 and ESPI5 numbers. With the community spread of Omicron it is difficult to predict when referrals will return to pre-COVID levels.

Progress on Te Tiriti o Waitangi and Equity

- We continue to work alongside Kaiārahi Nāhi and Pacific Navigator teams. Our focus for planned care is prioritisation of clinical urgency, long waiting patients over 200 days, and long waiting Māori and Pacific patients over 120 days.
- Regular monitoring of patients waiting occurs at NHI level, with equity adjusted reporting to ensure appropriate prioritisation.
- All line managers have been asked to prioritise kaimahi Māori wellness/safety at work, including being able to ensure that kaimahi Māori are able to attend Māori networking hui and wellness zoom meetings throughout lock down. Care packages have been provided by Te Toka Tumai and line managers were asked to support team members get access to these where possible.
- Where clinically appropriate to do so, services have maintained telehealth/virtual appointments as the mode of delivery to allow more flexibility/choice for Māori patients and reduce barriers to attending appointments.
- Te Toka Tumai has maintained its visitor policy to allow support people and whānau to attend planned care appointments, acknowledging the significance of this as part of improving patient experience and outcomes for Māori patients.
- An increase in weekend and evening clinics to reduce barriers and improve access and outcomes for Māori.
- Phone calling and reminders of surgery and PCR testing requirements, providing RAT tests on site for patients who cannot access testing sites in the days leading up to surgery.

Regional Equity Position

Source: Regional Waiting list as at 10 January 2022

Table 1: ESPI 2 by Ethnicity

	% Non Compliant				
Ethnicity	**Northland**	**Waitematā**	**Auckland**	**Counties Manukau**	**Total**
Māori	62%	26%	16%	35%	39%
Pacific Peoples	66%	24%	17%	38%	29%
Asian	57%	28%	21%	39%	29%
European	57%	26%	19%	37%	33%
Other	52%	32%	17%	39%	28%
Grand Total	**59%**	**27%**	**19%**	**37%**	**32%**
Previous Report **(6th Dec)**	54%	31%	21%	42%	34%
Variance	5%	-4%	-2%	-4%	-2%

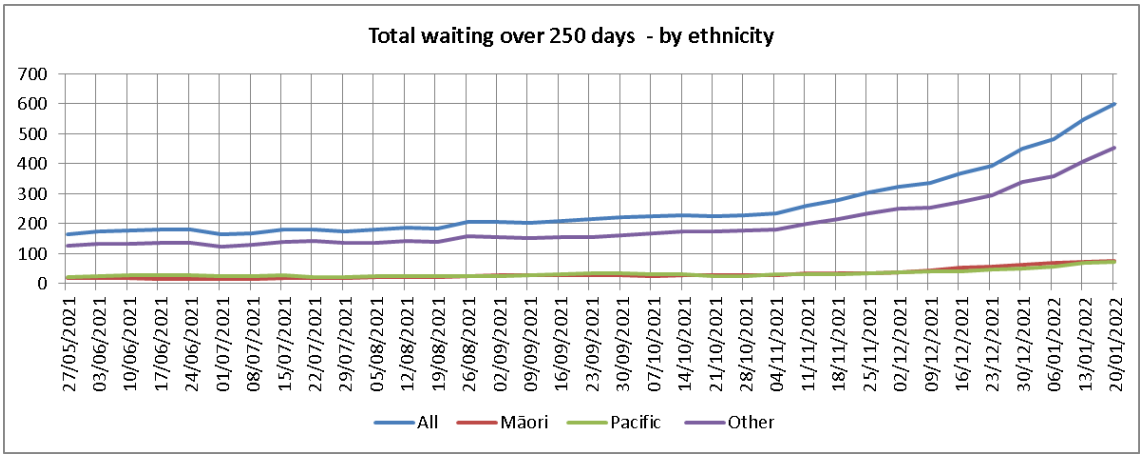
Table 3: ESPI 5 by Ethnicity

	% Non Compliant				
Ethnicity	**Northland**	**Waitematā**	**Auckland**	**Counties Manukau**	**Total**
Māori	57%	55%	38%	33%	47%
Pacific Peoples	62%	58%	33%	30%	36%
Asian	54%	52%	41%	28%	41%
European	54%	50%	40%	27%	44%
Other	45%	57%	38%	22%	41%
Grand Total	**55%**	**51%**	**39%**	**29%**	**43%**
Previous Report **(6th Dec)**	57%	49%	45%	33%	46%
Variance	-2%	2%	-6%	-4%	-3%

Te Toka Tumai long waiting patients

As well as monitoring numbers of ESPI5 patients, long waiting patients at 200 days, 250 days and 300 days are monitored at the planned care meeting weekly, along with reporting by service as to weekly changes in patients being removed due to having their surgery (or removed from the waitlist) or being added as they exceed 200 days waiting.

Services review these patients at NHI level, and are asked to report on plans for their top 20 longest waiting Māori patients and top 20 longest waiting Pacific patients. These patients are also supported by the Kaiārahi Nāhi and Pacific Navigator teams to facilitate their admission for planned care.



ESPI5 patients waiting over 250 days to 20/01/2021 produced by HIT

4. Financial Report

The Provider Arm result for YTD December 21 is $18.2M favourable. The underlying BAU result is $12.2M favourable and the impacts of COVID-19 are $6.1M favourable.

Overall volumes are 95% of contract for the YTD - this equates to $42.8M below contract. This unfavourable contract position equates to an estimated $17.0M 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 provided for under COVID-19, reflecting the significant decrease in volumes during the lockdown periods.

The $12.2M favourable BAU result is driven by three key variances:

- Personnel and outsourced personnel costs are $5M favourable (after offsetting additional MOH funding received for the unbudgeted costs of nursing pay equity). This is a reflection of BAU FTE below budget, partly offset partly by lower levels of annual leave taken.
- Clinical Supplies are $4.9M favourable due to lower acute and planned care volumes during the lockdown periods.
- ACC revenue is $2.3M favourable due to one off backdated funding received for the non acute rehabilitation (NAR) contract.

The $6.1M favourable COVID-19 result is driven by the favourable contribution margin from laboratory testing. Most of the COVID-19 workstreams such as vaccinations and testing are breakeven with the positive contribution from laboratory testing offsetting the unfunded impacts.

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
0.0 Confirmation of Confidential Hospital Advisory Committee Minutes 23 June 20212	**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]
0.1 Confidential Hospital Advisory Committee Report to Board	**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]
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 – 26 January 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 Confirmation of Confidential Minutes of Board 15 December 2021	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for

	made public [Official Information Act 1982 s9(2)(i)]	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]
3.2 Confirmation of Confidential Minutes of a Special Sub-Committee of the Auckland District Health Board – 16 December 2021	**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	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 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	**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**	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

	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)]	1982 [NZPH&D Act 2000]
8.1 Finance, Risk & Assurance Committee Referral 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 Health Information Technology: NHI Format Change – Tranche Two Business Case	**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]
9.2 Capex Variation Approval for: MRI Replacement – Level 5, ACH	**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]
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]