AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Open Board Meeting

Wednesday, 06 April 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 31 March 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
06 April 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 **Seat at the Table Appointees** Krissi Holtz Maria Ngauamo Kirimoana Willoughby Shannon Ioane	**Auckland DHB Executive Leadership** Ailsa Claire – Chief Executive Officer Mel Dooney – Chief People Officer Mark Edwards – Chief Quality, Safety and Risk Officer Dr Debbie Holdsworth – Director of Funding – ADHB/WDHB Michael Shepherd – Interim Director Provider Services Auxilia Nyangoni – Interim Chief Financial 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**

10.02am **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?

10.05am **3.** **CONFIRMATION OF CONFIDENTIAL MINUTES 23 February 2022**

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

4.1 Digital tools related to supporting management of COVID 19.

10.20am **5.** **EXECUTIVE REPORTS**

5.1 Chief Executive's Report

5.2 Health and Safety Report

10.50am	**6.**	**PERFORMANCE REPORTS**
	6.1	Financial Performance Report
11.00am	**7.**	**COMMITTEE REPORTS**
	7.1	Hospital Advisory Committee Executive Report
	7.2	Community and Public Health Advisory Committee Executive Report
12.20pm	**8.**	**DECISION REPORTS**
	8.1	Director Appointment to the HealthSource New Zealand Limited Board
	9.	**INFORMATION REPORTS - NIL**
	10.	**GENERAL BUSINESS**
12.30pm	**11.**	**RESOLUTION TO EXCLUDE PUBLIC**

Next Meeting:	Wednesday, 18 May 2022 at 10.00am A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

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Attendance at Board Meetings

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

2021/2022

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

Seat at the Table

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

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

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

Register of Interests – Board

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

	Director – Comprehensive Care PHO Board Board Member – Yellow Brick Road Board Member – District Maori Leadership Board Iwi Affiliations – Ngati Whatua, Ngati Haua and Ngati Tuwharetoa Director - - Board of New Zealand Health Partnerships Elected Member – Ngati Whatua o Orakei Trust Board Board Member – Auckland Health Foundation Director to Emerge Aotearoa Trust and Emerge Aotearoa Limited Strategic Director, Maori – University Services (wholly owned by The University of Auckland)	
Krissi HOLTZ	Primary Employer – ASB Bank	07.07.2021
Shannon IOANE	Member – Public Service Association (PSA) Employee at Starship Children's Hospital – Allied Health/Child Health ADHB	07.07.2021
Fiona LAI	Member – Pharmaceutical Society NZ Casual Pharmacist – Auckland DHB Member – PSA Union Puketapapa Local Board Member – Auckland Council Member – NZ Hospital Pharmacists' Association Board of Trustee – Mt Roskill Primary School Vaccinator	21.11.2021
Maria NGAUAMO	Employee – NZ Ministry of Foreign Affairs and Trade (MFAT)	22.02.2022
Bernie O'DONNELL	Chairman Manukau Urban Māori Authority(MUMA) Chairman UMA Broadcasting Limited Board Member National Urban Māori Authority (NUMA) Board Member Whānau Ora Commissioning Agency National Board-Urban Maori Representative – Te Matawai Board Member - Te Mātāwai. National Māori language Board Owner/Operator– Mokokoko Limited Senior Advisor to DCE – Oranga Tamariki Engagement Advisor – Ministerial Advisory Panel – Oranga Tamariki Kura Ratapu – Radio Waatea - Wife	08.07.2021
Michael QUIRKE	Chief Operating Officer – Mercy Radiology Group Convenor and Chairperson – Child Poverty Action Group Director of Strategic Partnerships for Healthcare Holdings Limited Board Director – healthAlliance Director - New Zealand Musculoskeletal Imaging Limited	30.08.2021
Ian WARD	Director – Ward Consulting Services Limited Director – Cavell Corporation Limited Trustee of various family trusts Oceania Healthcare – wife shareholder	21.05.2020
Kirimoana WILLOUGHBY	Employer – Ngati Whatua Orakei Whai Maia Ltd Director – The Hearing House Board	01.03.2022

Minutes
Meeting of the Board
23 February 2022

Minutes of the Auckland District Health Board meeting held on Wednesday, 23 February 2022 via Zoom at 10:00am

Board Members Present Jo Agnew Doug Armstrong Michelle Atkinson Zoe Brownlie Peter Davis Tama Davis (Board Deputy Chair) Fiona Lai Bernie O'Donnell Michael Quirke Ian Ward **Also in Attendance** Heather Came **Seat at the Table Appointees** Krissi Holtz Maria Ngauamo Kirimoana Willoughby Shannon Ioane	**Auckland DHB Executive Leadership Team Present** Ailsa Claire – Chief Executive Officer Mel Dooney – Chief People Officer Mark Edwards – Chief Quality, Safety and Risk Officer Michael Shepherd – Director Provider Services Justine White – Chief Financial Officer Dr Margaret Wilsher – Chief Medical Officer **Auckland DHB Senior Staff Present** Auxilia Nyangoni – Deputy Chief Financial Officer Marlene Skelton – Corporate Business Manager Megan Wiltshire – Director Communications and Stakeholder Engagement (Other staff members who attend for a particular item are named at the start of the minute for that item)

Bernie O'Donnell led the Board in a Karakia.

1. ATTENDANCE AND APOLOGIES

That the apology of the Board Chair, Pat Snedden be received.

Krissie Holtz advised that she would have to leave the open meeting for a brief period to chair another meeting.

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

The following changes were advised:

Maria Ngauamo –is now a full-time employee of the New Zealand Ministry of Foreign Affairs and Trade and is no longer employed by MSD New Zealand.

Kirimoana Willoughby – add, Director – The Hearing House Board.

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

3. CONFIRMATION OF MINUTES 26 JANUARY 2022 (Pages 9-17)

Resolution: Moved Fiona Lai / Seconded Michelle Atkinson

That the minutes of the Board meeting held on 26 January 2022 be confirmed as a true and accurate record.

Carried

3.1 Confirmation of Open Minutes of Board – 15 December 2021 *(Pages 18-38)*

Resolution: Moved Jo Agnew / Seconded Zoe Brownlie

That the minutes of the Board meeting held on 15 December 2021 be confirmed as a true and accurate record.

Carried

4. ACTION POINTS (Page 39)

There were no action points to review.

5. EXECUTIVE REPORTS

5.1 Chief Executive's Report (*Pages 40-48)*

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

Omicron preparedness - community

In metro Auckland there are currently 15,405 active cases. There have been 1,849 cases in the last 24 hours.

Northland DHB has 390 active cases which is a high proportion for their population.

In metro Auckland 60% of the cases are from the Pasifika community. In the last 24 hours there have 949 Pasifika cases.

There have been significant outbreaks occurring in churches, ARC facilities and prisons and there have been hospital exposure events.

There is high demand in the testing stations and last night a government press release talked about moving primarily to RAT testing and using that test as a diagnostic. This is to reduce the pressure on the laboratories.

Booster vaccination rates are starting to drop which is a concern as the booster is highly protective against Omicron. There appears to be a view among the public that Omicron is a mild disease and not something to worry about as you get it and that is it, all over and done with. However, a person may catch COVID any number of times so not getting a booster is not a sensible decision. There are people being seen who are struggling with co-morbidities even when double vaccinated so a booster is a necessity.

There are 150 people in metro Auckland hospitals and half that number again in "hospital at home". The Māori Whanau and Pacific Support Teams are very busy, particularly the Pacific team. The screening tool is in place and the support being offered is largely to those in the

high risk category. High risk is a whanau ora approach. It does not just take account of a person's medical back ground but also looks at their risk in terms of housing and welfare requirements.

Omicron preparedness – hospital

Mike Shepherd advised that 65 people that are part of a mandate who have an exemption until the start of next week are being worked with to get their booster administered. Some will have a medical exemption and some will be exempt because they have had COVID. There will be another 300 people captured within the mandate over the next two months who are progressively being worked with also.

Staff Issues

Medical Physicists and Perfusionists are in strike mode and PSA Allied Health staff have indicated that they too will be striking. This is particularly a challenge because testing and vaccination have not been defined as life preserving services. The hospital is short of staff through sickness and vacancies and these strike actions are a considerable challenge to manage.

Ailsa Claire drew attention to Clinical Research Grant recipients outlined on page 44 of the agenda.

Performance of the health system statistics are as would be expected at this time. There is a particular focus being applied to immunisation for children and getting the vaccination rate for under-12's lifted from the current 55%.

The following was covered in discussion:

Doug Armstrong drew attention to page 40 of the agenda and the mention of booster vaccinations. It was his opinion that the Ministry of Health did not appear to be keeping a robust database. The Chief Executive, Ailsa Claire advised that as had been discussed before, there was no health population database available to capture this information into.

Michael Quirke asked how the COVID digital care platform, now that it had been operationalised; was performing. Ailsa Claire advised that she could not answer the question and would ensure that Shayne Tong reported on this at the next Finance, Risk and Assurance Committee or Board meeting.

Fiona Lai was advised that in relation to those 300 staff imminently due for a booster an individualised way of working with them was in place to provide them with information and access to the booster vaccine. The numbers were already reducing.

Bernie O'Donnell commented that there is a widely held view within the community that the effects of Omicron were not as serious as that for Delta. However, the Chief Executive has said that Omicron should still be taken very seriously. Bernie asked if there was a degree of complacency around Omicron and whether the key messages coming from the Ministry of Health were in alignment and the right ones for this situation. Ailsa Claire advised that there were two components to this situation. There is a difference in what it meant for the

individual as opposed what it meant for a population of people. Omicron is much more contagious, many more people will get it, it will be less serous particularly if an individual has had the booster shot and many more people will be able to self isolate. However, because so many people are going to get it that small proportion that do end up being seriously ill are a big number and will affect the health service.

There are significant communication gaps to bridge. The country has moved from a situation where people have been urged to test and now they are being told please don't have a test unless you are symptomatic, just isolate at home. Soon people will be told what is more important is how ill you are and this is what we want you to do when you are very ill.

When level three is in place there will be leaflet drops advising that if an individual has an interface with the health service then a test for diagnostic purposes is important as it affects their treatment, otherwise it is an individuals actual symptoms that are more important. If you have a family member that is ill assume your whole family will become ill. If you are symptomatic then stay at home. If you are asymptomatic then you may be able to return to work under certain conditions. If you are not that ill please do not present to the health service. Twenty-five per cent of children presenting to Starship are COVID positive and a large proportion of those cases are because parents are trying to seek assurance that it is COVID when in fact knowing that makes no difference to the treatment pathway for the child.

Action

Shayne Tong provide to the next Finance, Risk and Assurance Committee or Board meeting a briefing on digital tools related to supporting management of COVID 19.

Resolution:

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

Carried

5.2 Health and Safety Report *(Pages 49-56)*

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

There were two near miss incidents highlighted in the report. Both are making progress through the investigation and review steps with learning and improvements to come from both events. There has been good engagement from all parties.

The work being done to get all contractors on the Totika programme has been proceeding but progress has been slower than desired. There have been several attempts to get contractors to voluntarily join the programme and the next step will now be to send a more

formal request asking them to join the Totika programme or their contract with the DHB would be at risk.

The following was covered in discussion:

Bernie O'Donnell commented that he was interested to understand the ceiling collapse incident as he was curious and concerned over how this actually came to occur.

Michael Quirke commented that the contractor involved in the ceiling collapse had not completed the Totika programme training and asked for assurance that the contractor would be pulled into line and in fact that all non-compliant contractors would effectively be moved into the Totika programme.

Shannon Ioane referred to the 1200 contractors previously not identified asking how they were overlooked. Justine White advised that the DHB dealt with a multitude of contactors at different levels for a variety reasons. What the DHB currently does not have is one single contract management repository from where all contracts are managed. There are a number of disparate systems making it hard to obtain a single view of what contracts exist. There is a project due to be completed at the end of April this year that will provide a contract management system and framework running alongside it.

Shannon Ioane commented that these people would need an identity security swipe to get through the front door. If something did happen, how is Auckland DHB accountable for those people that they have given access to? Justine White replied that a variety of different ways had been employed to identify contractors. The major one is utilising the accounts payable system and the other is around who had been issued access cards. The information is held, but not in one place so staff had started with the accounts payable system and were now moving wider to capture other niche groups of contractors.

Mark Edwards advised that HealthSource contractors operate a shared service model and do not necessarily have to set foot on DHB premises to undertake their work. They were not captured initially. As a PCBU Auckland DHB do have overlapping responsibility with shared services so it is important that the DHB knows what they are doing from a health and safety point of view.

Fiona Lai noted that FIRP Tranche One and Tranche Two work would bring a number of contractors on site and that it was important that this issue was remediated quickly.

Fiona also drew attention to page 23 of the agenda and manual handling where it was said that COVID had impacted on new staff being trained and the provision of refresher training. Fiona considered that COVID was going to be around for a long while yet and some thought needed to be applied now to how to offer this training in different ways. Mark Edwards acknowledged Fiona's point commenting that it was recognised just prior to the COVID outbreak that the manual handling training was not as good as it could be and the redesign and refresh of that training had been disrupted by COVID. Outside contractor assistance was sought to identify new ideas for delivery going forward and their recommendations are being worked on now.

Mark Edwards advised Zoe Brownlie that the thing that concerned him currently was the

difficulty progressing activities aimed at strengthening systems, particularly around contractor management and workplace violence and aggression, which had been delayed though diversion of attention to other priorities such as the COVID response.

Bernie O'Donnell commented that he would be interested to see how the Totika programme really worked once it was fully in place noting that a lot of responsibility was placed on contractors to engage and it was unclear where the demarcation line or point was that Auckland DHB became involved or should be involved. Mark Edwards advised that the contractor signed up to the programme and over time audits were completed on what had been entered. It also provided a portal for Auckland DHB to look at what individual contactors were doing and their health and safety maturity data. It is designed to provide assurance that the contractor is undertaking their Health and Safety duties for Auckland DHB as a PCBU.

Jo Agnew drew attention to item 2.3.3 - staff fatigue and commented that there appeared to be a disconnect between this review, risk management and actually what was happening on the floor. Mark Edwards advised that there were a number of activities underway with a risk sitting in the health and safety risk matrix and a wellbeing risk in the regular risk register. He had asked the team to try to consolidate the information. Jacob Toner has led a workshop with a diverse number of stakeholders to obtain an overall viewpoint of the fatigue risk which will be written up from an organisation wide view and will be presented as a deep dive rather than a standard health and safety report. It will be presented to either, the Finance, Risk and Assurance Committee or Board but with the paper being made available to all Board Members.

Safe 365 Presentation

Nathan Hight Co-Founder and Director, Safe365 made a short presentation on PINs and Overlapping PCBU items. [Attachment 5.2.1]

The following was covered in discussion:

Doug Armstrong raised the issue of how Health NZ and the Māori Health Authority would be managing health and safety asking whether WorkSafe NZ would be in a position to take Health NZ to court for breaches. Nathan Hight advised that it would come down to the way these new entities were structured but in short, yes, WorkSafe NZ would be able to do this if Health NZ were the lead PCBU then they would be the one to receive the improvement notice.

Bernie O'Donnell commented that his interest was around culpability, and questioned whether in empowering contractors under the Totika programme was the DHB abdicating responsibility. Nathan Hight advised that it was never a black and white situation around apportionment of culpability. It is an overlapping responsibility within the full supply chain with the DHB's responsibility running right through that supply chain. The DHB must demonstrate to the regulator that it has taken reasonable steps to behave responsibility. Did the DHB engage contractors that can demonstrate that they have capability to manage sub-contractors, and has the contractor got a good health and safety system and can demonstrate the duty of care that they have for their workforce. What Totika does is

measure that independently utilising independent health and safety professionals to audit that data. That provides assurance and visibility over that contractor. It is really designed to work with the procurement process so that a contractor does not get a contract unless they sign up to Totika. For the initial rollout all the existing incumbent contractors have to be retrospectively on-boarded and that is the current challenge. This is a very large and complex contract framework to on-board.

The Board needs to ask itself whether it has visibility of good systems, policies and processes being in place that are reasonable and do we have the verification coming back from management that they are in place and working the way that they were expected to.

Resolution:

1. **That the Board receives the Health and Safety Report for February 2022.**
2. **That when completed a deep dive into the fatigue management risk experienced organisation wide will be presented to either, the Finance, Risk and Assurance Committee or Board.**

Carried

5.3 Human Resources Dashboard Report F22 Q2: 31 December 2021 *(Pages 57-62)*

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

The DHB has seen an increase in the number of vacancies quarter on quarter but to date this has only resulted in a relatively small decrease in the time to hire. There have been changes made to the recruitment practice to speed the process.

As a result of concern around the turnover for kaimahi Māori a specific piece of work has been commissioned to contact them and discuss their reasons for leaving.

The following was covered in discussion:

Doug Armstrong commented that staff must be worrying about what was going to happen to them in the new regime and that they would be a turnover risk. Mel Dooney advised that indeed there has been an increase in turnover in corporate services, and while the DHB was still attracting a high volume of candidates, right at this time it was a hot candidate market with a lot of movement and pay restraint guidelines are also a challenge

Zoe Brownlie asked if there was any insight around the kaimahi Māori and nursing turnover Mel Dooney advised there has been some very good work done by Margaret Dotchin, Chief Nursing Officer and her team in terms of understanding students and new graduates and ensuring that their experience is a supportive one in the first years. The reasons for leaving however are many and varied.

Zoe Brownlie drew attention to page 62 of the agenda and the “Speak Up” programme review and asked when the Board might see an update and being advised that it hadn’t made the progress expected through lack of resource and reprioritisation of efforts into responding to COVID outbreaks and that it was likely the review would be seen in the next

financial year.

Bernie O'Donnell comment that in terms of professional development for the Board he would have liked to have a workshop delivered by Mel Dooney and team in how to capture key data and construct a Human Resources Dashboard. Bernie drew attention to page 62 of the agenda and commented that it showed him that Māori and Pasifika are under-represented in the key higher paid professions and he wanted to know what as being done to address that. If it were he in that position he would be looking at a move to the Māori Health Authority to improve his position and that is not necessarily a good thing as the health sector do not want to build a silo construct they require key Māori and Pacific staff throughout. Mel Dooney commented that Anthony Hawke and team were doing some important work in this area across the directorates to improve representation.

Jo Agnew drew attention to page 59 of the agenda and sick leave noting that no data had been provided for quarter three or four and wanted to know what the DHB might expect to see. Mel Dooney replied that levels of absence had grown due to COVID sickness and this would eventually be able to be reported as special sick leave as opposed to normal sick leave. She did not have those figures at this time.

Jo Agnew asked about the voluntary turnover rate of 32% and the time period being reported, commenting that this trend provided the perfect example why people needed to be spoken to about why they were leaving and the value of an exit interview. Mel Dooney advised that this particular graph showing turnover rate for professional staff was not correct and she would need to provide reviewed figures. This was the only incorrect graph in the report.

Resolution:

The Board received the Quarter 2 People Dashboard.

Carried

5.4 Pumanawa Tangata

Mel Dooney, Chief People Officer verbally updated members on Pumanawa Tangata, advising as follows:

A separate paper had been presented at the previous Board regarding the Wellbeing activity and this work is on-going. The "Staying Connected" call centre has been re-established. Any staff that are stood down because they have COVID or are struggling with COVID related issues are called by the team. There has been a high level of appreciation expressed for this service. Kia Ora tō Wāhi Mahi and the Employee Centre remain a key focus and are doing good work, continuing to offer welfare support to the team as required.

There is good work being done by Kaimahi Māori Experience and Alexis is up for an award at HRINZ which recognises her and the approach taken with Careerforce to ensure the Rangitahi program can provide kaimahi with credits. Auckland DHB is the only DHB to do this. The leadership development programme for kaimahi Māori has been delayed but the design work has been progressed.

Communications continue to be improved through as many channels as possible. The team

have launched a new channel using Poppulo. This new channel allows contact with people who may not necessarily read emails or have access to a computer as the content is available on Smartphone.

The following was covered in discussion:

The Deputy Board Chair, Tama Davis offered congratulations to Alexis and her team for the work that they had done and he acknowledged the support through the Executive Leadership Team and Human Resources that had enabled the development through the directorates around Kaimahi Māori development.

Shannon Ioane was advised that the "Speak Up" programme timeframe had been moved out to July 2022 as there is not the resource to deliver it now. The Speak Up champions do still continue to receive questions and queries from staff but the evaluation of whether this program is working as well as it could, and indeed whether it is fit for purpose to report racism is the piece of work that needs to be completed.

Bernie O'Donnell commented that he is seeing te reo everywhere in board documents and that is good but he still does not see progress beyond that. It is now becoming annoying that while he sees positions with Māori titles he does not see an increase in Māori and Pasifika in key leadership positions nor concrete results where he can see greater benefits being delivered. Mike Shepherd advised that at the next Hospital Advisory Board meeting a more fulsome update will be provided on all the actions that have been undertaken in the Provider Arm in relation to addressing this issue in the directorates and to seek member's feedback.

Tama Davis commented that how the dashboard was translated into material gain in those particular spaces for the Māori kaimahi workforce would come via Anthony Hawke and team as it would manifest itself in the work that was being done in the directorates.

Heather Came cautioned that when Māori directors are appointed in directorates that they are at equal status and standing with their equivalent and receive the same resourcing.

Resolution:

That the Board receive the verbal report on Pumanawa Tangata.

Carried

6. PERFORMANCE REPORTS

6.1 Financial Performance Report (*Pages 63-66)*

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

December was a reasonably favourable month with that trend continuing into January.

The January month end result was $16M favourable which takes the year-to-date result to $45M favourable. The downside of this is that the favourable result is driven by the work

that the DHB is unable to undertake and the people that have unable to be employed.

That year-to-date $45M represents $48M of undelivered volume over the last seven months That has a $20M saving in people cost because they are effectively FTE that the DHB is unable to secure on a regular basis to do that work. There is another $7M in clinical supplies. The other main driver of the variances lies in pharmaceutical volumes. Pharmac recently revised some forecasts which drove another $5M of change.

The issue is in understanding what the forecast will look like for the end of the year. As at December the forecast was for a $60M deficit against a $73M budget. As at the end of January that was revised down to a $47M deficit against a $73M budget. That is assuming that some cost will come out over the remaining months as more activity comes through and this is very dependant on the impacts of Omicron.

There were no questions.

Resolution:

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

Carried

7. DECISION REPORTS - NIL

8. INFORMATION REPORTS - NIL

9. GENERAL BUSINESS

There was none.

10. OPEN COMMITTEE HOSPITAL ADVISORY REPORT

The Deputy Board Chair, Tama Davis welcomed Heather Came to the meeting as a member of the Hospital Advisory Committee joining Board to consider the following report.

10.1 Confirmation of Open Minutes of the Hospital Advisory Committee meeting – 23 June 2021 *(Pages 67-78)*

Resolution: Moved Jo Agnew / Seconded Bernie O'Donnell

That the minutes of the Hospital Advisory Committee meeting held on 23 June 2021 be confirmed as a true and accurate record.

Carried

10.2 Hospital Advisory Committee Report to Board *(Pages 79-88)*

Michael Shepherd, Director Provider Services asked that the report be taken as read.

He advised that the report was an attempt to provide assurance and information on what

was occurring with non COVID activity within the Provider Arm through the directorate structure.

The gap in delivery of $48M

It is important to note that a regional perspective is being taken to address planned care.

Mike Shepherd drew attention to pages 86 and 87 of the agenda where a view on how the region is travelling from a planned care perspective is laid out.

The ESP2 position, that is how quickly people are being sent for their first specialist appointment, appears to be positively over stated and this is because of the gap in referrals not seen coming through during lockdown, the Christmas period and then as a result of peoples concerns around COVID and access to primary care. Energy is being put into understanding this referral gap and to find these people.

Roles being appointed to

The work that the Maori Health Provider service is undertaking has been hugely valuable to and welcomed by the directorates as they embark on improving their understanding and knowledge of Te Tiriti. Teams have been asking for this advice and support and it good to see clinical teams engaging and being keen to implement positive change.

The following was covered in discussion:

Bernie O'Donnell commented that it would be good to have a timeline in future reporting for implementation of appointments of Māori and Pasifika to key leadership positions so that progress could be monitored.

Michael Quirke commented that the opportunity to come to the Board in regard to managing and addressing pain points to get through the winter months was now and urged management not to leave it too late. Michael asked how the perioperative review had been received and whether stakeholders had been supportive and receptive.

Mike Shepherd advised that a lot had been learned and would continue to be learned during the Omicron surge which would assist the DHB managing through the winter months. It is likely that a large number of Omicron cases would continue through this period and it was likely that RSV would be seen along with Influenza. Management would certainly come to Board with any requirements and requests.

The perioperative decision has been well received and those Mike has spoken to are comfortable with where things have landed. The perioperative resources related to the cardiovascular directorate have moved across and are working well. Cross leadership structures are now in place. Recruitment is going well.

Doug Armstrong referred to page 84 and drew attention to "language" emphasising that the purpose of language is communication. All the services that the DHB provides involve people who must understand what is being said to them. If Maori is used then the English translation must sit alongside. Doug thought that the Board had previously agreed that this would occur. Bernie O'Donnell agreed that it was about bilingualism and inclusivity to bring

everyone along the same journey.

Kirimoana Willoughby drew attention to page 83 of the agenda and asked whether there were any patients waiting longer than 300 days. She was advised that, yes there were a few but those people had individual plans and all were followed up in an attempt to bring this situation back to 250 days. Waiting list follow up is a key activity for all services at this time to ensure that contact is kept with these people.

Tama Davis acknowledged the work done in Cancer and Blood outlined in the Te Pūriri o Te Ora Cancer and Blood Services Equity Update. Mike Shepherd commented that this was as a result of a combination of people and opportunity. This was one of the first of four services to be a focus of equity and Te Tiriti in action and these services are now being used as learning centres with the expectation that this model would be disseminated across the other directorates.

Action

That the next Hospital Advisory report contain information about the Waitangi Tribunal report on COVID and how the DHB planned to engage with and respond to the recommendations within that report.

Resolution:

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

Carried

Late Item - Whānau HQ Model and Funding - NRHCC COVID-19 Request

Resolution: Moved Jo Agnew / Seconded Michael Quirke

That in accordance with Standing Order 3.2.9 the Board by resolution approves consideration of a confidential late item 9.3 entitled; "Whānau HQ Model and Funding - NRHCC COVID-19 Request". The reason for urgency being that expenditure between 1 February 2022 and 30 December 2022 requires endorsement to allow financial and commercial arrangements to continue.

The reason for confidentiality is that the Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public while negotiations are current.

Carried

11 RESOLUTION TO EXCLUDE PUBLIC *(Pages 89-92)*

Resolution: Moved Jo Agnew / Seconded Michael Quirke

That in accordance with the provisions of Clauses 32 and 33, Schedule 3, of the New Zealand Public Health and Disability Act 2000 the public now be excluded from the meeting

for consideration of the following items, for the reasons and grounds set out below:

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
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 made public [Official Information Act 1982	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or

	s9(2)(i)]	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	That the public conduct of the whole or the relevant part of the meeting would be likely to result in

	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)]	the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.1 Finance, Risk & Assurance Committee 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]
9.3 Whānau HQ Model and Funding - NRHCC COVID-19 Request	**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	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

	s9(2)(j)]	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]

The meeting closed at 2.50pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 23 February 2022

Deputy
Board Chair:

_____ Date: _____

Tama Davis

Provisional Improvement Notices (PIN's) & Overlapping PCBU Responsibilities

ADHB Health, Safety & Well-Being Governance.

Presenter: Nathan Hight, Director Safe365
February 23rd 2022

Workshop Agenda

1. Introducing “PINs” – what are they, how do they work and what do they mean for ADHB?
2. Overlapping PCBU obligations – update
3. Due diligence & Overlapping PCBU risks
4. Discussion – Q & A

WHS Governance – current market… still very much a work on.

Source: Safe365 maturity benchmarking NZ dataset (2021). Sample size n=2000.

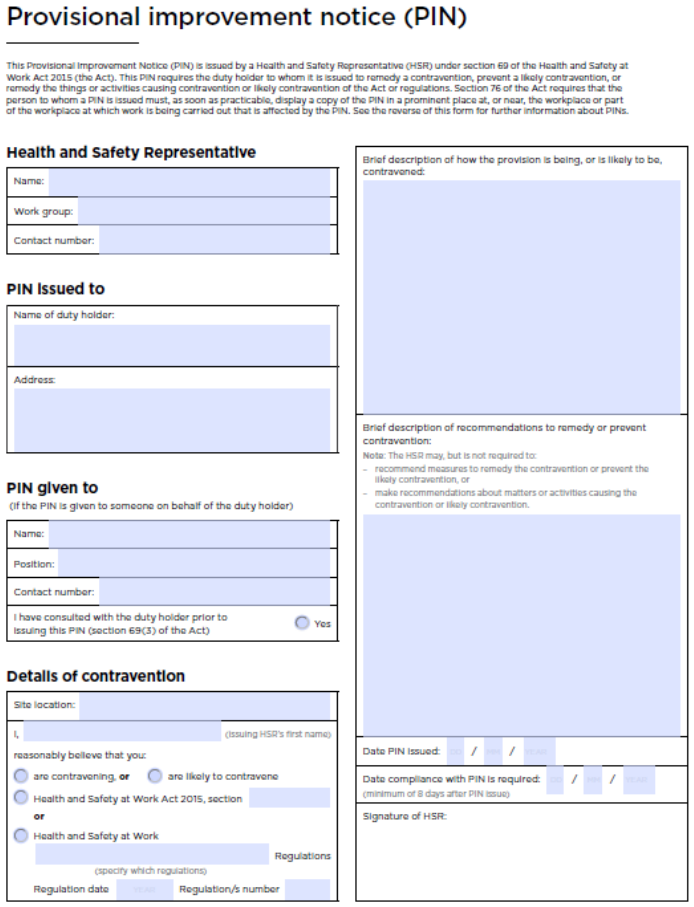
Quick Refresher – Governance role in WHS

1. The principles underpinning health and safety governance are no different than any other aspect of a governance role.
2. Good health and safety governance is about having visibility of a demonstrable plan and a pro-active approach to making the workplace as safe as it can (reasonably) be.
3. Directorship in health and safety is not about responsibility for the day-to-day granular operations of the entity.
4. It is about ensuring appropriate systems and processes are in place to support health and safety and, critically, that there is proper resourcing of, and verification of, health and safety performance at the board table.

Source: WorkSafe NZ & IoD, Health and safety guide: Good governance for directors (2016).

Provisional Improvement Notices – PINs

1. ADHB have been ‘served’ with several PINs since July 2021 for various health and safety matters of concern to HSRs within ADHB.
2. PINs are a “pre-regulator” issued improvement notice (they precede a formal improvement notice) under s69 of HSWA (2015).
3. Designed to empower trained HSRs to keep PCBUs accountable for health and safety where in the HSRs opinion, the employer (“duty holder”) is in breach of an obligation.
4. They may only be issued by a trained HSR, must only be served after a reasonable attempt to resolve the matter with the employer and must be displayed in the applicable work area the PIN relates to.
5. The ADHB must act on a PIN, if not, it becomes an enforceable improvement notice, issued under Worksafe NZ powers. The ADHB may challenge a frivolous PIN served by a HSR with Worksafe NZ (within 7 days), and it may be dismissed or confirmed.



Provisional improvement notice (PIN)

This Provisional Improvement Notice (PIN) is issued by a Health and Safety Representative (HSR) under section 69 of the Health and Safety at Work Act 2015 (the Act). This PIN requires the duty holder to whom it is issued to remedy a contravention, prevent a likely contravention, or remedy the things or activities causing contravention or likely contravention of the Act or regulations. Section 76 of the Act requires that the person to whom a PIN is issued must, as soon as practicable, display a copy of the PIN in a prominent place at, or near, the workplace or part of the workplace at which work is being carried out that is affected by the PIN. See the reverse of this form for further information about PINs.

Health and Safety Representative

Name:
Work group:
Contact number:

PIN issued to

Name of duty holder:
Address:

PIN given to

(if the PIN is given to someone on behalf of the duty holder)

Name:
Position:
Contact number:
I have consulted with the duty holder prior to issuing this PIN (section 69(3) of the Act) Yes

Details of contravention

Site location:
I, (issuing HSR's first name)
reasonably believe that you:
are contravening, or are likely to contravene
Health and Safety at Work Act 2015, section
or
Health and Safety at Work Regulations
(specify which regulations)
Regulation date Regulation/s number

Brief description of how the provision is being, or is likely to be, contravened:

Brief description of recommendations to remedy or prevent contravention:

Note: The HSR may, but is not required to:
- recommend measures to remedy the contravention or prevent the likely contravention, or
- make recommendations about matters or activities causing the contravention or likely contravention.

Date PIN issued: / /
Date compliance with PIN is required: / /
(minimum of 8 days after PIN issue)
Signature of HSR:

Overlapping PCBU Obligations (Supply Chain WHS)

Context and key thoughts – top level

- In accordance with Health and Safety at Work Act (2015), the ADHB must consult, cooperate and coordinate with other PCBUs (i.e. contractors) when working in a shared workplace, or as part of a contracting chain.
- The ADHB can't contract out of health and safety duties.
- The ADHB should always build health and safety requirements into its contracts and subsequent contract management.

"Who is undertaking work for us – or supplying us – and what is their demonstrated capability and commitment to the health and safety of theirs and any of our workers exposed to WHS risks?"

So, what does ADHB need to do?

- The ADHB needs to ensure, and verify throughout the lifecycle of the engagement, it is engaging suitable contractors with appropriate health & safety capability – it needs visibility.
- Pre-qualification, improvement, approval of safety plans for high risk operations & audit/inspection of contractors on the job.
- Take steps to resolve non-conformances, don't 'let it slide'...

How does this relate to the ADHB Board?

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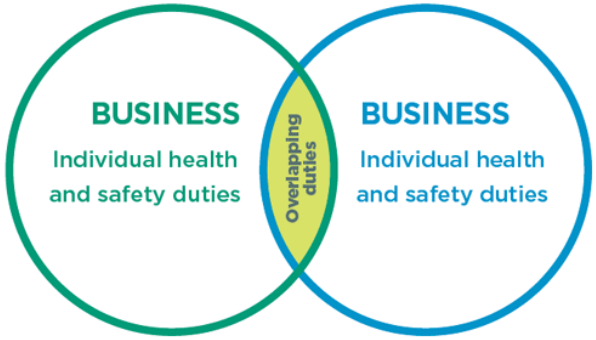
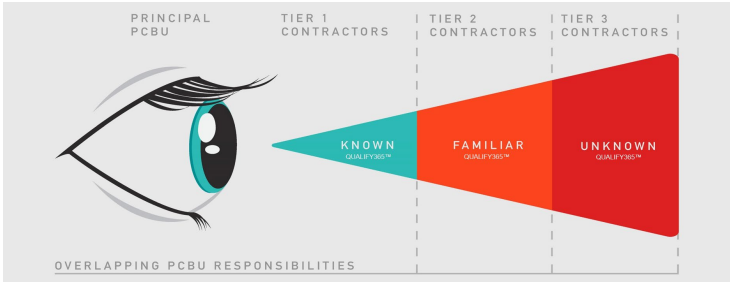


ADHB Officers (Directors and ELT) need to exercise due diligence to verify that the DHB is implementing its policies and procedures in practice (i.e. internal compliance reporting, demonstrable visibility of the supply chain WHS status). S.44 HSWA (2015).

Practical DD Questions for Directors…

1. What visibility do management have of our contractors in terms of their health and safety capability in respect to meeting ADHB's requirements? Do management feel there are any gaps?
2. Are our contractors complying with the terms of their contracts with the ADHB in respect of our health and safety requirements and, if not, what is being done to address this?
3. Do management have the resources and processes required in order to meet the ADHB's obligations in respect to supply chain health and safety matters? If not, what are the gaps and how can they be resolved?
4. What further support do management need from the Board (or ELT) to ensure our exposure to this risk is being effectively managed in accordance with our legal, moral and ethical obligations?
5. Does management have an audit and verification plan to monitor contractor performance, and what assurance can be provided to the Board to help verify it is being executed?
6. Have any steps been taken in the past month (or defined period) to address non-conforming contractors? How many non-conforming contractors have been identified in this period?



Practical DD Questions for Directors…

Use near miss scenarios that get reported as scenarios to regularly consider how the board & ELT performed… Consider:

1. Was robust due diligence applied in the lead up?
2. Did the contractor meet ADHB's contract requirements?
3. Was there sufficient audit & inspection based on the risk profile of the contractors work?
4. Do I understand enough to ask questions?
5. Do I feel assured that the process are in place and are being verified by management? What visibility have I got?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Action Points from 23 February 2022 Open Board Meeting

As at Wednesday, 06 April 2022

Meeting and Item	Detail of Action	Designated to	Action by
Item 5.1 23 February 2022	**Digital tools related to supporting management of COVID 19.** Shayne Tong provide to the next Finance, Risk and Assurance Committee or Board meeting a briefing on digital tools related to supporting management of COVID 19.	Shayne Tong	6 April 2022 [See Item 4.1]
Item 5.2 23 February 2022	**Fatigue Management** That when completed a deep dive into the fatigue management risk experienced organisation wide will be presented to either, the Finance, Risk and Assurance Committee or Board.	Mark Edwards	6 April 2022 [See item 5.2]
Item 10.2 23 February 2022	**Waitangi Tribunal report on COVID** That a future Hospital Advisory report contain information about the Waitangi Tribunal report on COVID and how the DHB planned to engage with and respond to the recommendations within that report.	Mike Shepherd/ Anthony Hawke	18 May 2022

Auckland District Health Board Board Meeting

Digital Update: Supporting Management of COVID-19

Shayne Tong
Chief Digital Officer
6th April 2022

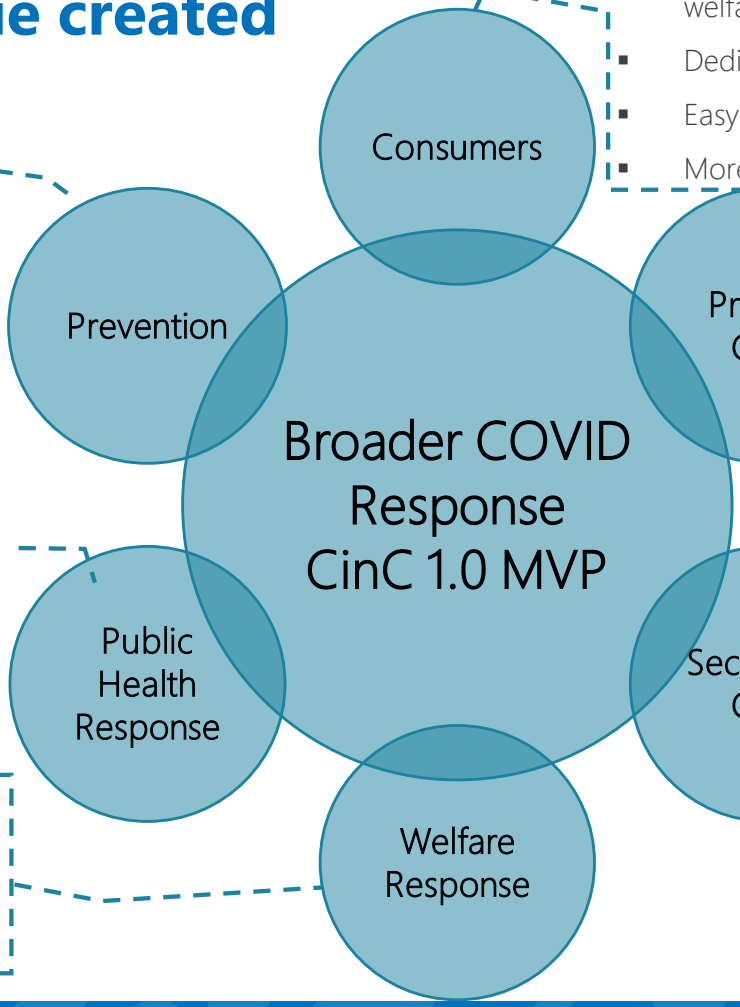
Agenda

- COVID in the Community (CinC) 1.0 MVP
- Digital has powered the COVID response
- Key workstreams
- Programme roadmap
- Primary care engagement approach

Key Messages

- After a slow start digital has driven the ability to management and support the NZ COVID-19 response
- The MOH platform approach is not to everyone's preference but has enabled true national capability for B2B stakeholders and public consumers
- Integration and connectivity into existing BAU processes and primary care: the key focus to manage COVID-19 sustainably
- Better use of digital services can change the way health engages with the public, enable data sharing, provide visibility for service coordination and equity, and shift our productivity curve

CinC 1.0 MVP – value created



- Immunisation (overall and equity focus)
- Maintaining isolation response at Border while balancing national outbreak

- Self-service tools so people can manage their own health & welfare needs.
- Dedicated assisted channel support
- Easy escalation path to Primary/Secondary Care
- More relevant and personalised communications.

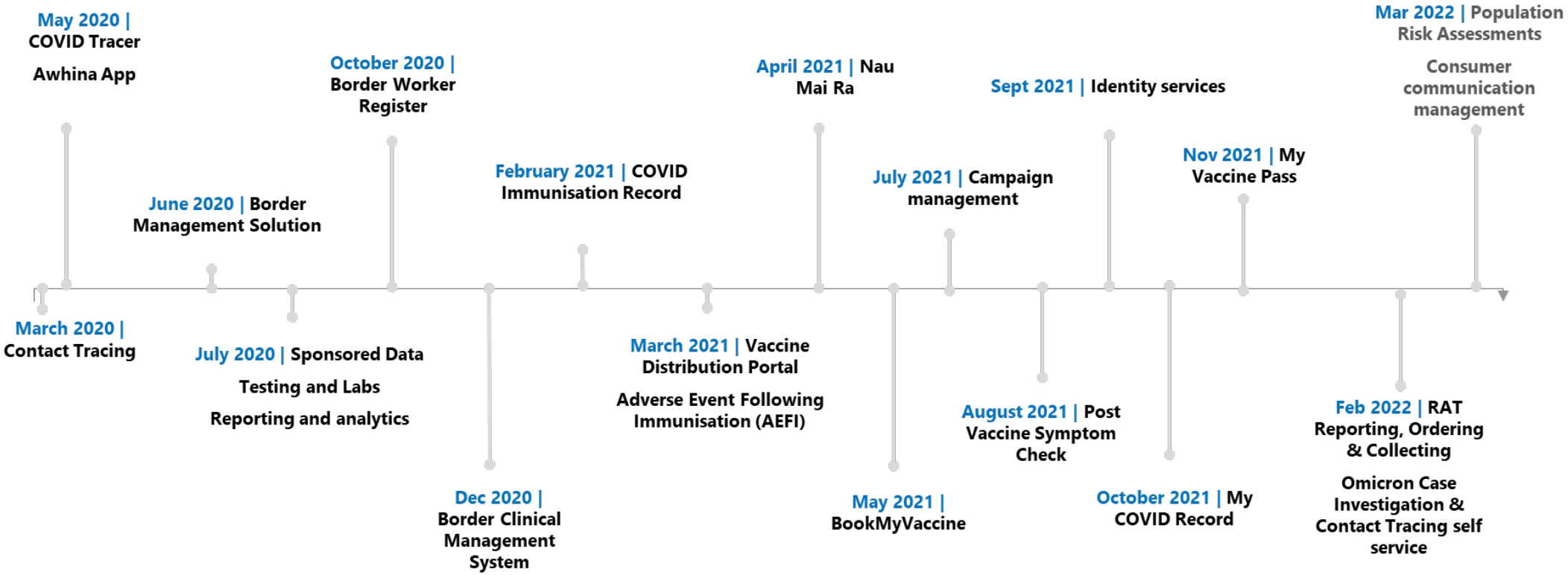
- Containing, controlling and eliminating contagion.
- Advent of social distancing tools, infection prevention and control.

- Notification and info about COVID+ patients in their care.
- Patients risk-assessed by age, vax, ethnicity to prioritise workload.
- Able to make electronic welfare referrals.

- MSD welfare referrals electronically from Contact Tracing and Primary Care
- Care Coordination Hubs capturing welfare referrals not identified initially.

- Prioritising high-risk patients reducing burden on hospitals.
- Patients risk-assessed by age, vax, ethnicity to prioritise workload.

Digital has powered the COVID response



Key workstreams

4.1

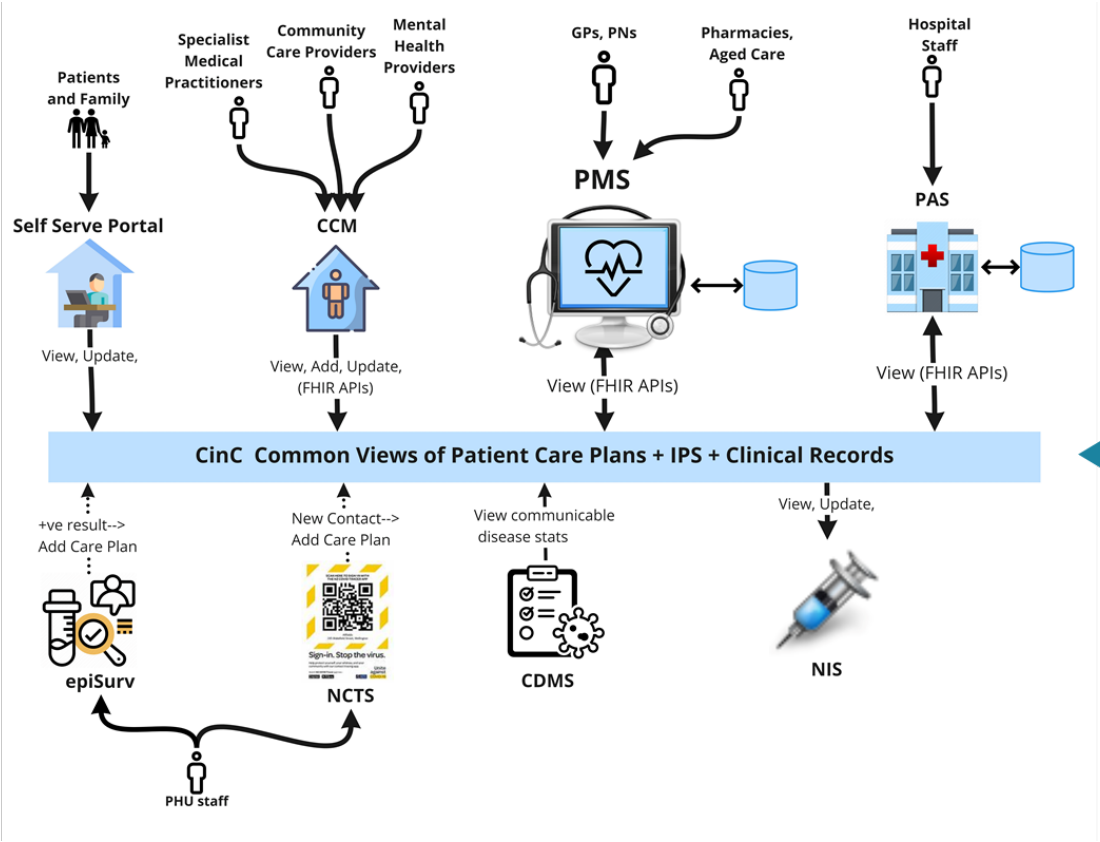
Workstreams	Scope	Key Next Activities
1. Living with COVID model	Develop a patient model which supports the broader Pandemic-Endemic response.	▪ Develop and validate customer journeys ▪ Validate supporting clinical and operational response
2. Clinical Data Store (HIRA IPS)	Provide visibility of current and scheduled medical activities, and to stakeholders across the community; to produce a more patient centric approach with a shared view of care plans and patient data.	▪ MVP – Care Plan sharing service focused on Covid Care Plans and a fledgling implementation of an IPS based on the Covid response.
3. Integration enablement	Replace the current HL7 solution with a modern FHIR-based one to: improve data quality, reduce cost and complexity, support MoH transition to modern API standards, develop reusable assets for NIS and Hira and to build out a collaborative design approach via the Ministry's developer portal. Leverage HIRA proposed API marketplace to integrate with suitable 3rd party health ecosystem providers.	▪ MVP – Publish and Subscribe capability for integration with GP Practice Management Systems ▪ Confirm participation criteria ▪ Market scan to determine suitable providers ▪ Engagement approach tbd
4. Self service roadmap	Ensure self-service portal, tools and 3rd party access is fit for purpose.	▪ Scope the breadth of the actors involved. ▪ Empathy work to understand requirements
5. Outbreak Management Support	Determine what is required to connect outbreak management tools with CinC tools and be able to flex for pandemic vs. endemic.	▪ Understand key stakeholder requirements ▪ Work with NITC and public health analysts to identify interface and other artefacts
6. CCM Partners Portal	Provide a portal solution for sector actors who don't utilise a PMS (i.e., Specialist Medical Practitioners, Community Care Providers, Mental Health Providers)	▪ Scope the breadth of the actors involved. ▪ Empathy work to understand requirements ▪ CCCM eval and future options
7. Risk Stratification	Leverage existing CHPR capability to build broader prediction and risk assessment into the system, then make available to the sector to prioritise response.	▪ Risk stratification tool ▪ Preventative health thinking ▪ Personalised engagement
8. Sector Engagement	Engage PMS vendors strategically, taking them on the Fit for Future journey. Align across product and programme roadmaps. Consistent contracting strategy. Co-design with sector partners. Transparency on upcoming support requirements.	▪ Review current contracts and payments model and determine what changes are needed to support CinC ▪ Initial engagement on Fit for Future vendor feedback and impacts.

What this means for sector systems

Patient information visible through integrated self-service portal

Primary and Secondary care settings with consistent access to the same up to date information directly from their own tools

Integrated and seamless administrative /back-office processes such as event driven payments.

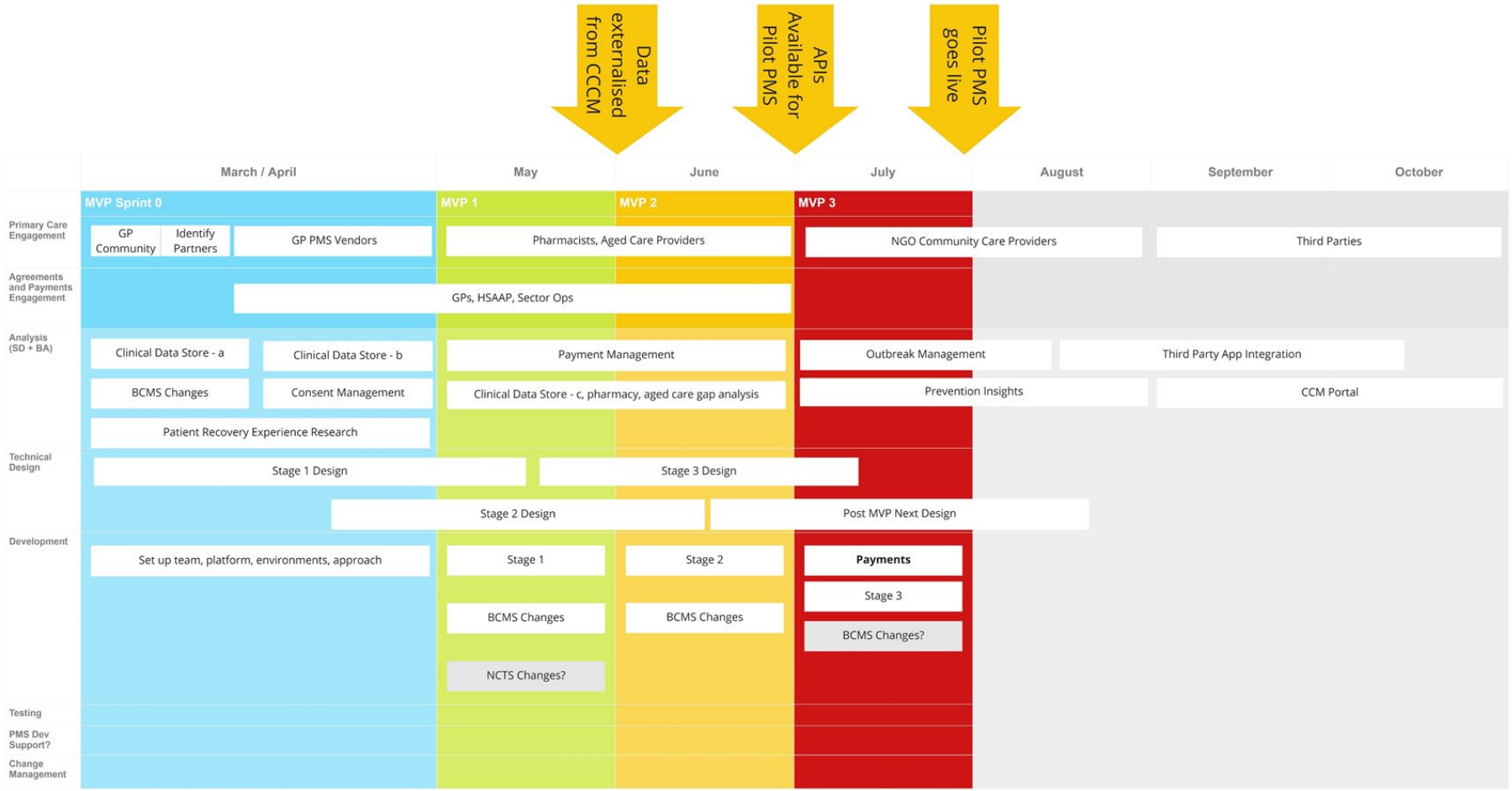


Aggregate information available to support public health initiatives

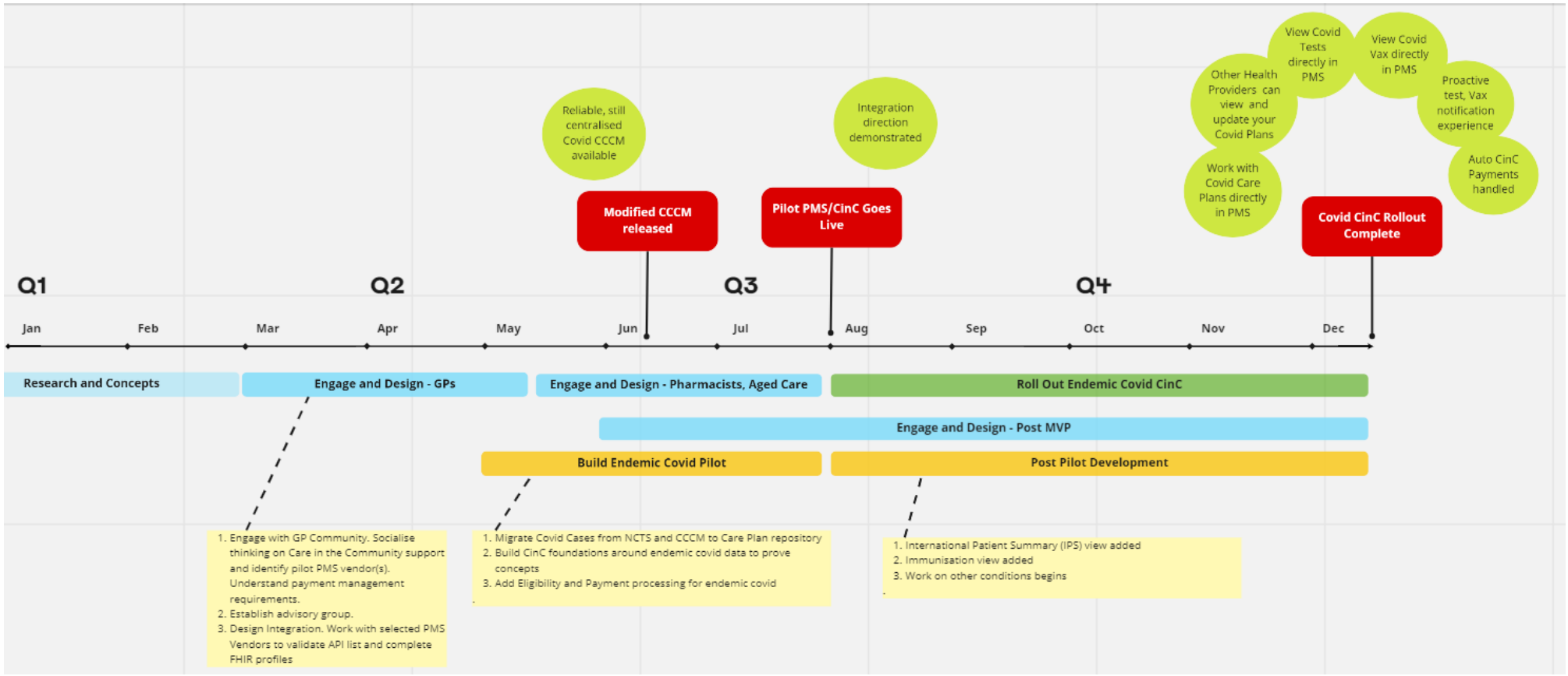
Analytics for support of public health

Access to additional clinical data (immunisation history, medical warnings etc.).

Programme roadmap



Primary care engagement approach



Chief Executive's Report

TE TOKA TUMAI
Auckland DHB

5.1

Recommendation

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

Prepared by: Ailsa Claire (Chief Executive)

1. Introduction

This report covers the period from 4 February 2022 – 20 March 2022.

2. COVID-19 updates

2.1 Dealing Omicron

We have continued to manage the impact Omicron has had in the community. Over the last few weeks we have seen an increasing number of patients with COVID-19 in our hospitals.

We have been planning for this and over the last few weeks have implemented our plans to ensure we continue to run the hospital and community services and safely care for patients.

In March, we moved to minimum service delivery across all services – both in the hospital and community.

The move to minimum service delivery has meant we have deferred a significant amount of care. We know that's hard for our patients and not a decision we take lightly. We have continued to review the minimum service delivery on a regular basis.

Whilst we are deferring planned care, our message to our public has been clear; if they need urgent care, we are here for them.

Throughout the challenges we faced, I'm incredibly proud of everything we did to make sure equity and Te Tiriti o Waitangi were at the forefront of our decision-making and action. This is a credit to everyone involved and demonstrated real leadership at all levels.

2.2 Workforce and redeployment

The biggest impact of Omicron has been on our workforce. Staff absences have been high due to illness, isolating or looking after whānau.

Some of our clinical and non-clinical kaimahi were asked to work differently to support colleagues where they were needed most.

We put in place two workforce redeployment teams:

- Ward and service supporters – staff who hold non-clinical roles volunteering to lend a hand with appropriate set tasks
- Clinical supporters who can be redeployed to areas with critical need.

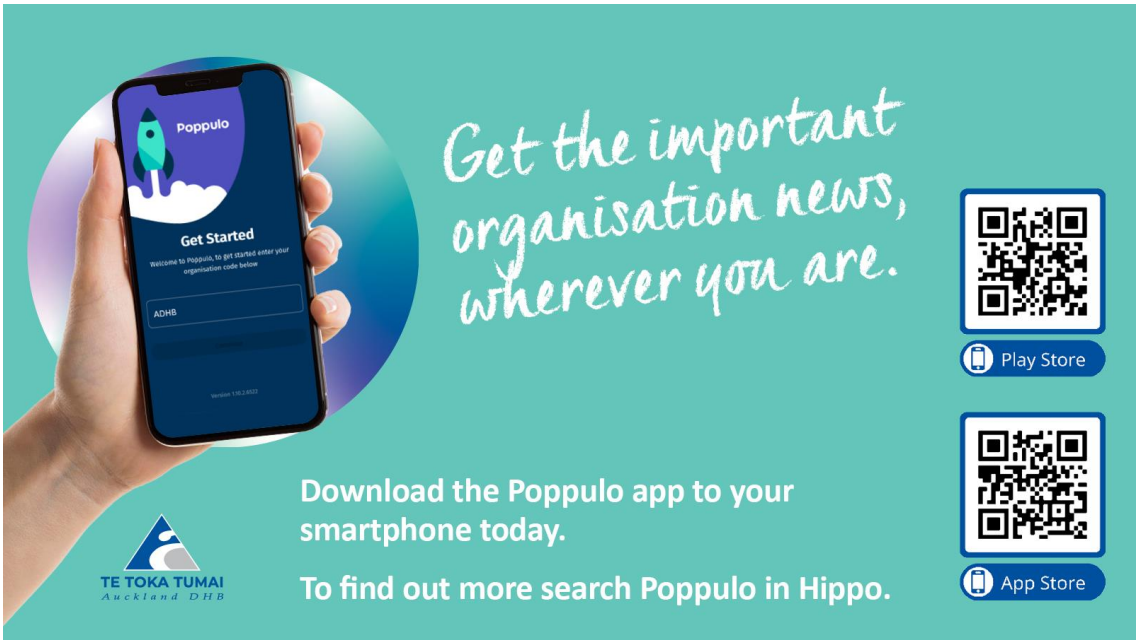
Our amazing team responded to the call. We deployed 3224 clinical hours between 23 February and 15 March, and 1362 non-clinical hours between 23 February and 20 March.

This has been another good example of our workforce coming together to support each other, ensure our patients are cared for safely and keep the hospitals functioning.

2.3 Communicating with our teams

With things rapidly changing, we needed to communicate with our workforce quickly. Listening to feedback directly from our workforce and through union delegates, we continued to improve the way we communicate through our people.

We did this through our usual communications channels and we also introduced Poppulo to get concise information to our people on the go. Poppulo is a mobile app that can be downloaded to work or personal phones from the App store or Google Play. Information can be categorised to make it easy to find and people can also comment and ask questions within the app. It looks very similar to a social media feed. To date, we've received great feedback from the people already using it.



2.6 Pride month – Manaaki through pronouns

This year for Pride Month we focused on pronouns. Whether it's He, She, They or Them - our pronouns are a part of our identity, and getting them wrong can make us feel disrespected and dismissed.

We encouraged our staff to provide better care for our patients and show manaaki to one another at Te Toka Tumai by using people's correct pronouns.

We used a series of screensavers with our people sharing what's important to them.

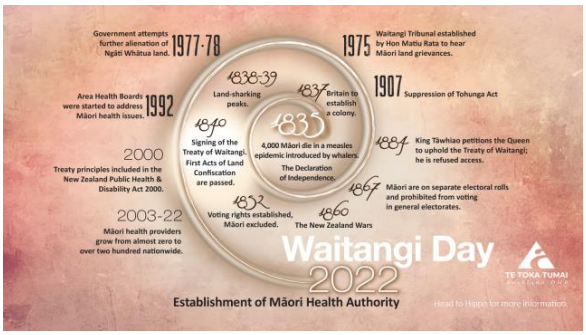
2.7 Ra Waitangi Hari

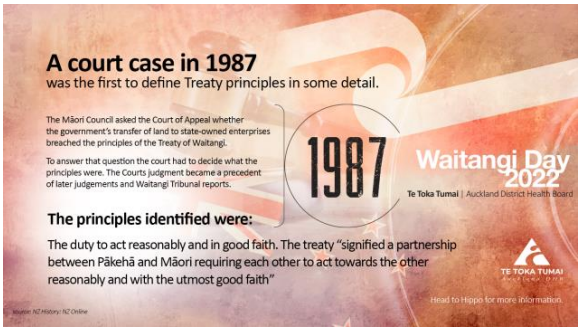
The signing of Te Tiriti o Waitangi was a pivotal moment in the history of our nation.

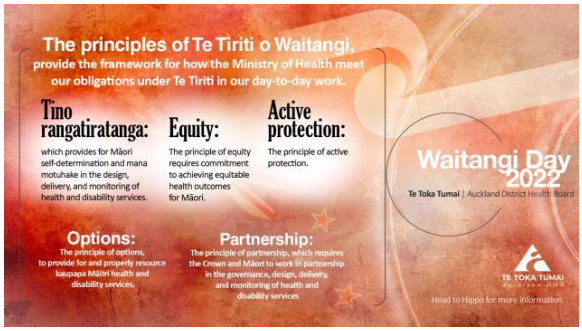
To mark Waitangi Day, we used our screensavers to offer a perspective on Te Tiriti o Waitangi.

At our sites, we displayed the flags of our nation and hosted the first Te Tepū – a forum for kaimahi Māori to discuss issues that matter takes place.

Copies of *The Treaty of Waitangi, Te Tiriti o Waitangi* by Dame Claudia Orange were given out as part of a competition.







3. Employee wellbeing

3.1 Free Raise wellbeing check-ins for staff

In February, the regional DHBs put in place some extra support to help facilitate wellbeing check-ins for teams and individuals.

The check-ins are run by a trained professional to talk about personal or work-related issues.

3.2 Coffee cards – get one, give one

We introduced Get One, Give One coffee cards to bring some joy to our people in the middle of the Omicron surge. Two coffee cards were given out when one of our leaders noticed or heard about our staff doing something amazing. One card was for the person being recognised, and the other was to pass on to someone else who is also doing something amazing.

3.3 Snack boxes

We know our teams are doing the hard mahi right now. As a small token of our aroha, we provided grab-and-go style snacks to all our teams working on-site. These were really appreciated by our amazing teams across the organisation.

3.4 Care packs for our employees impacted by COVID-19

Care packs, including tissues, disposable masks, liquid hand soap, and Rapid Antigen Tests have been provided to staff who are isolating at home.

3. Communication and Engagement

3. 1 External Communication

Between 4 February 2022 and 20 March 2022, we received 126 requests for information, interviews or access from media organisations. Most requests focused on the impact of the COVID-19 Omicron surge and included interview or information requests with pregnant women with COVID-19, postponement of planned care, COVID-19 in children and ED presentations.

Around seven 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 27 Official Information Act requests over this period.

3. 2 Internal Communication

For this period, 869 emails were received. Of these emails, 86 were non-communications-related and where appropriate, were referred to other departments and services at Auckland DHB.

- **Six** editions of Pito Pito Kōrero | Our News, the weekly email newsletter for all employees, were distributed.
- **Seven** editions of the Manager Briefing were published for all people managers, including **one** COVID-19 special.
- **Nineteen** Living with COVID-19 update emails were sent out to all employees. This includes COVID-19 booster vaccination emails.
- **Four** COVID-19 webinars.
- **Two** COVID-19 Manager's webinars.
- **One** Staff Staffing Nursing 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:

- Waitangi Day
- Kōkiri te reo Māori
- The Big Boost
- Pride – pronouns
- Heart Awareness Month
- Fact of the Week
- Thank you to our kaimahi
- International Women's Day
- Lisa Roa – Children's ED COVID-19
- Planned Care

Top performing social media posts

4. Our People

4.1 New Senior Leaders

Head of Executive Services

Congratulations to Jennie Montague who has accepted the new role of Head of Executive Services.

Jennie has been a fantastic contributor to Auckland District Health Board in a range of areas prior and through COVID-19. She is a highly experienced, qualified and committed leader and we are very pleased she has accepted this role.

Director of Cardiovascular Services

We are delighted announce Malcolm Underwood has been appointed as the new Director of Cardiovascular Directorate.

Malcolm is a Cardiothoracic surgeon and a highly experienced and committed leader. He is currently working at the Prince of Wales Hospital, Chinese University of Hong Kong.

Thank you to Joanne Bos who stepped into the role of Interim Director of Cardiovascular. She has helped guide the Directorate through a really challenging period over the last 10 months.

Also, thank you to Jo Wright and the rest of the Cardiovascular directorate leadership team who have all stepped up to assist.

Te Pūriri o Te Ora Cancer and Blood Director

Dr Fritha Hanning has been newly appointed as the Director of Te Pūriri o Te Ora Cancer and Blood. Most recently, she has been acting as Associate Director for Te Pūriri o Te Ora and prior to that was the Service Clinical Director for Medical Oncology. Fritha is inspired to lead for equity, to advance the outcomes and experience for Maori whānau, and to transform the experience within Te Pūriri o Te Ora.

5. Priority Health Outcomes Summary

	Status	Comment
Acute patient flow (ED 6 hr)		Feb 80%, Target 95%
Improved access to elective surgery (YTD)		R/U , Target 100%
Faster cancer treatment		Feb 94%, Target 90%
Better help for smokers to quit: • Hospital patients • PHO enrolled patients • Pregnant women registered with DHB-employed midwife or lead maternity		Feb 93%, Target 95% R/U, Target 90% R/U, 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 seven months ended 28 February 2022 is a surplus of $11.3M against a budgeted deficit of $42.3M, thus favourable to budget by $53.7M. The favourable position to budget was realised in the Funder arm ($20.6M favourable), the Provider Arm ($31.7M favourable) and the Governance arm ($1.4M favourable). The favourable position is attributed to Business as Usual operations ($43.7M favourable), mainly due to reduced Funder demand driven expenditure (pharmaceuticals, Aged residential care), 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 $9.9M for the year to date mainly due to favourable funded Laboratory services that fully offset unfunded COVID-19 impacts. COVID-19 funding realised for the period was $180.6M, 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 $170.7M hence the $9.9M favourable impact year to date.

7. Auckland DHB at a glance

Health and Safety Report

5.2

Recommendation

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

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

Glossary

BBFA	Blood and/or Body Fluid Accident
HSR	Health and Safety Representative
HSWA	Health and Safety at Work Act (2015)
LTI	Lost Time Injury (work injury claim)
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 February 2022.

There have been two significant changes to key health and safety risks for the reporting period. Fatigue Management is currently under review; the interim rating has been reassessed and increased to critical which allows for the potential impacts from the Omicron surge which has been modelled to peak during this reporting period. The systemic effect of this surge will have significant impact on already fatigued and stressed hospital resources. The Lone Worker risk rating has moved to high. Other key risks remain the same with ongoing monitoring and where possible a continuation of risk reduction activities that can be delivered.

One serious Workplace Violence and Aggression incident occurred in February and a further two in March. These are currently being reviewed. A near miss incident from a falling object that occurred in February had inconclusive findings as to the specific cause. All the incidents were reported to WorkSafe, who required no further information or action.

COVID management activities related to vulnerable staff, the vaccine mandate and vaccination programme, staff surveillance, N95 Fit Testing and observation and validation of controls continue 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. However, work around Workplace Violence, Manual Handling, Fatigue Management and Contractor Management continue as the impacts on our staff and our working environment are predicted to increase from these key risk areas as a result of staff shortages and heavier than normal workloads associated with the Omicron peak.

The Tōtika programme is progressing, with the final dates for all contractors/suppliers to have registration and assessment in place being 31 March 2022 and 30 April 2022 for higher risk contractors. We noted since sending out the mandated requirements 295 of the 833 contacted contractors and suppliers had completed the Tōtika assessment leaving 538 still to complete this requirement by March 31st.

The Health, Safety and Wellbeing Governance committee meeting for March was rescheduled to allow participants focus on delivery of core hospital services and has not taken place at the time of reporting.

2. Risk Analysis

2.1 WorkSafe Notifiable Events

Staff assault Te Whetu Tawera

Incident 1 (February 2022): A patient assaulted a staff member with a pen at Te Whetu Tawera (our acute inpatient unit for adult mental health services) causing lacerations to the head, ear and arm. The staff member is still off work is receiving ongoing support. At the time of writing this report, the incident review is still underway, with initial findings and key discussion points set to be discussed with Te Whetu Tawera management and staff, prior to a final report being completed with recommendations to the HSW Governance Committee for endorsement.

Staff assaults Child and Family Unit

Incident 2 and 3 (March 2022): A service user in the Child and Family Unit (CFU, our acute Mental Health Inpatient Unit for children and young people) was being managed within the High Dependency Unit (HDU). The service user was being aggressive to the nursing staff, so a security officer was present in the unit. Two different staff members were assaulted on different days. Both the staff members suffered mild concussion and were medically checked and sent home to recover. Both matters were reported to WorkSafe, who noted that these were not notifiable events. Incident investigation reports are being prepared at the time of this report being written.

Near-miss from a falling object

Incident: (February 2022): There was a reported near miss of an object falling from one of the levels above Level 3 Atrium is situated in Building 32. The object was a pressure release valve component weighing about 100 grams. Investigations have not been able to identify its source or where it may have been dislodged from. There were no contractors working in the area at the time. It is thought that the item may have been left unsecured on a ledge next the Atrium enclosure and that surrounding vibrations from work activity had caused the valve to come loose falling to floor below. WorkSafe have been notified and no further information is required at this stage. We have since reviewed all open areas around where there is a potential for dropped objects to occur.

Ceiling collapse Auckland City Hospital Site

This incident was reported to the Board at its last meeting. To date, the independent investigation report into the near miss has not been finalised. However, there were some initial observations to note, which are still subject to confirmation through the final report:

- The project was procured under a design and build contract due to work load pressures being experienced by our more familiar design consultants. The construction drawings used do not capture the office below where the slab was to be removed. The slab was determined to be on roadway gravel foundation, rather than over an office ceiling.
- Safety plans were in place and regular safety engagement on site appears to be evidenced.
- Immediately prior to the incident the construction team diverted from the original method described in their safety plan.
- The construction team did not stop works on discovery of the foundation.
- The construction team, whilst having their own permits in place, did not have the correct Auckland DHB permits required for the task.

These initial observations will be subject to further scrutiny when the independent investigation report and the Auckland DHB/FIRP investigation report are reviewed to identify any other findings, lessons to be learnt and overall recommendations to avoid similar incidents occurring.

Staff assault Assertive Community Outreach Service (ACOS)

This incident was reported to the Board at its last meeting. Investigation findings were that existing controls were compromised due to familiarity, and capacity and schedule-related pressures which increased the risk of violence for the work activity.

Some key learnings for the ACOS include:

- The importance of the daily review and raising of concerns by staff prior to off-site visits
- The need to continue with the recently implemented formal risk assessment
- Documenting risk mitigations at the daily team meeting alongside a clinical plan for all service users who are visited at their homes
- Continuously review and update high risk caseloads that will require two people to be in attendance at visits to patients in the community.

The Occupational Health and Safety (OH&S) team will work with the WPVA Steering Committee seeking to mandate the use of the Get Home Safe (GHS) Application to support remote and lone workers across DHB services. The OH&S team, with the support of the Security team will look to frame up an updated package of education, awareness and support over the next quarter, with the expectation that this will support this Service to develop or update appropriate Standard Operating Procedures (SOPs) to guide their staff members safely working in these types of environments.

2.2 COVID management

Health and Safety Advisors have been proactive across Auckland DHB sites validating COVID related controls ensuring our services are operating safely and managing this risk effectively.

Information and recommendations from the H&S Advisors observations are being reported to the weekly DHB/Unions Omicron group providing assurance that ongoing activities are being managed effectively.

Observations have been generally positive, with entry point screening operation and protocols for visitors and patients being enhanced since the initial introduction of the screening system during the Alert Level 4 situation in August 2021. Some inadequate signage was noted and rectified, and the individual visitor sticker process was identified as an area of potential weakness. The screening team have responded to this switching to using visitor bracelets (as used by entertainment venues).

PPE compliance across the hospital was good, with only minor issues noted with non-compliant mask wearing.

The Occupational Health team continue to undertake vulnerable worker assessments to support vulnerable staff members undertake duties safely during this period of heightened vulnerability.

Weekly meetings between the Occupational Health team and Health and Safety Representatives (HSRs) have been established to ensure that the most current COVID-related information to hand is shared with HSRs to support them in their roles as they, in turn, support their workplace colleagues on local Health and Safety matters. In addition, new dedicated information channels have been established to broaden our reach to HSRs. Between the weekly meetings and new information channels, it is expected that this will enable meaningful dialogue between the HSRs and the Occupational Health and Safety team to develop and evolve across the spectrum of informing,

consulting, collaborating and empowering our staff on matters pertinent to good worker participation around health and safety.

2.3 Key Risks

Summary

Since the last report to the Board, the rating for one of the key risks moved from High to Critical, with six key risks rated High and the remaining four risks rated either Medium or Low.

The risk rating for Fatigue Management is temporarily rated as Critical based on reduced staff due to the effects of Omicron. The Remote and Lone Worker risk has shifted from Medium to High based on the staff assault at ACOS and low uptake of the Get Home Safe App and other contributing factors across this Service.

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 and will continue to be the case for the foreseeable future.

Specific activities involving the occupational health and safety team include work relating to Vulnerable Staff, staff and contractor vaccine mandate requirements, staff surveillance swabbing, N95 Fit Testing, and PPE protocols.

Progress against the Key Risk Audit Schedule has been impacted by diverting resources to COVID related work and reduced Health and Safety Advisor resource. As we transition back towards BAU work we will see an increased focus towards all of the key risks.

To help refine our risk and control insights and understanding, Health and Safety Advisors meet weekly to discuss key risks and incidents to identify actions to learn from and to prevent further similar incidents that have occurred across their respective Directorates or portfolios. This information is now shared across the HSRs and will eventually be communicated across all of our management as part of H&S maturity growth.

In addition, we have asked all HSRs to immediately contact their Health and Safety Advisor directly when there is a serious incident or risk identified in their workplace, rather than the team acting upon the issue some days post the event once a Datix has been raised. This connects and engages the HSR, the Advisor and the workplace, cuts down the time to response, and focuses on developing actions and control assurance on key incidents. This supports learning and continuous improvement.

2.3.1 Workplace Violence and Aggression

The WPV risk remains high, with consequence x likelihood rated as Major and Possible. There were forty-two reported WPVA incidents in February, 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. There was one reported Lost Time Injury for February. The first draft of the WPVA Plan is currently going through a review process with the WPVA Steering Committee, with planned review to also be undertaken with our HSRs, Union partners and other stakeholders.

We are noting continued Behaviours of Concern around our satellite dialysis units. We are supporting remedial actions including assessment of patient suitability for treatment to be at

Grafton site, rather than at an isolated satellite site; providing Safety Intervention (de-escalation) training for satellite service staff; CCTV and lighting enhancements to the sites; provision of Get Home Safe (GHS) application for remote locations; enhanced facility signage and revision of security guard presence on-site.

We are also aware that with increased staff fatigue and the impact on staffing through the Omicron surge we may see an increase in staff-to-staff aggression, as well as increased patient and whānau to staff incidents. Key contributors are likely to be reduced staff numbers potentially leading to longer periods between patient care and response to patient needs resulting in increased escalated behaviours as patients and whānau react to these delays to care.

We have concluded advertising for three Safety Intervention Trainer roles to support the WPVA awareness and de-escalation training programme targeting staff in our medium risk areas across the hospital. The training will support staff to be cognisant of the risks and triggers of WPVA within the hospital environment and will help lift awareness of and embed safe de-escalation and disengagement practices for staff. It will also seek to reinforce staff feeling comfortable with calling for support or assistance from colleagues or security earlier rather than later if they encounter any WPV and aggression during their work. Over the next several months we will also work to identify how best to validate the effect and impact of training on the WPVA risk.

2.3.2 Contractor Management

Contractor Management risk remains high (Major and Possible). As noted above, there has been a serious incident involving a contractor, with the final report from the independent investigator still to be finalised. As previously noted, we continue to adopt a cautious approach in relation to construction events and undertakings while the site remains highly activated from a construction perspective. OHS are working with the Facilities team to better understand what additional areas of assurance and oversight are being undertaken while this higher level of activation and high risk activity continues.

The Tōtika programme is progressing, with the final dates for all contractors/suppliers to have registration and assessment in place being 31 March 2022 (and 30 April 2022 for higher risk contractors). Correspondence has been issued outlining the final dates for compliance, and we will be taking a closer look at the activities of contractors currently working on site. We noted since sending out the mandated requirements 295 of the 833 contacted contractors and suppliers had completed the Totika assessment leaving 538 still to complete this requirement by March 31st.

2.3.3 Fatigue Management

Fatigue Management has moved from High to Critical (Major and Likely). Review work continues, however the consequence level has been raised from Moderate to Major and the likelihood shifts from Possible to Likely. This revised rating reflects the impact of the current short staffing position across the DHB and the compounding effect of the Omicron surge across the Auckland community. While to date the hospital has managed to mitigate some of the impacts of current short staffing, the Omicron surge has further impacted staffing levels and subsequently increased the risk of staff fatigue.

There was to be a deep dive into fatigue management for this report, however there is some difficulty in this approach currently, as the team do not have the capacity to undertake the work required at this time. In addition, we know that the causes of fatigue are multi-factorial and data

capture is very difficult currently. For instance, there is no specific classification capturing fatigue in Datix (our incident management system), with the most relevant incident reporting falling under the narrative section found in safe staffing Datix reports which are mostly limited to nursing staff entries.

At this time, we will be working with the Risk and HR teams to develop a Work Plan to manage this risk that will form into a Steering Committee overseeing key activities to reduce this and other fitness for work-related risks. There is also national work currently underway around fatigue management that will be useful to review to see how it might inform and future-proof our own work plan. The steering committee will help to get the right people from the organisation around the table; will enable the appropriate datasets to be developed and obtained from across the organisation and will support a request for the resourcing required to implement the Work Plan.

2.3.4 Hazardous Substances

The risk remains high (Moderate and Possible). Recent focus has continued to be on the APS Labs in Mt Wellington regarding concerns from staff about formaldehyde exposure when work is being completed in the Cut-Up Room. Support to assist management to work through the issues which are mainly around the size of the space, equipment and ventilation continues. Our subject matter experts in environmental monitoring and Occupational Health have assessed and reported that existing controls are effective. Work on further improving controls and engagement with workers is ongoing. There have been no significant changes in trends or key contributors.

2.3.5 Working at Height

The risk remains high (Moderate and Possible). There have been no significant changes to note with this risk with respect to the environment or the controls. It is noted that construction related activity has once again resumed to higher levels of activity.

2.3.6 Manual Handling

The risk remains high (Moderate and Likely). Review of data from the past two years shows that reported incidents average around 22 per month, with the five highest reporting directorates (Adult Medical, Patient Management Services, Perioperative Services, Surgical Services and Clinical Support) accounting for two-thirds of the reported incidents. This is a key health, safety and wellbeing risk for our staff, as it is a work area where staff are most often exposed to potential risk through the frequency and continuity of their daily work activity such as patient handling, patient transfer, and moving, lifting and re-positioning of equipment, waste, laundry, materials, stores and supplies as well as high levels of repetitive movement and motion while undertaking everyday work tasks. To address this risk, a number of measures are being taken including re-establishing the Moving and Handling Steering Committee to govern a work plan and improved training programme and training delivery model. This committee was due to start at the end of February but has been delayed until the end of March due to Omicron related pressures. This committee will present a proposed Plan at the April Health, Safety and Wellbeing Governance committee seeking endorsement.

Of note, analysis of Lost Time Injury (LTIs) data for the past year across two directorates showed that three-quarters of all LTIs for these two directorates related to manual handling. This data supports the need to re-establish the Moving and Handling Steering Committee to provide the development and implementation of a cohesive and focused effort in this area.

2.3.7 Lone Worker

The risk has moved from Moderate (Moderate and Unlikely) to High (Moderate and Possible). Review work continues, however the recent assault on a staff member underlines the elevated risk to staff working alone in community settings. It is noted that usage of the Get Home Safe (GHS) app remains low and raises the risk that staff may not be able to raise an alert if under threat. The GHS app should be used by all services deploying staff undertaking remote / lone worker roles. Key actions to increase the uptake of the GHS app include a recommendation to make the GHS app mandatory for ADHB staff deployed to remote / lone worker undertakings; that an awareness, education and support package be developed through a joint effort between Health and Safety and Security Services.

There is no change to the remaining areas (noted below), which remain as either Medium or Low risk:

- HS01 - Asbestos
- HS05 - Vehicles and Driving
- HS07 - Hot Works
- HS12 – Biological Hazards (not including Covid-19)
- HS02 - Confined Spaces

3. Key Initiatives and Activities

3.1 Digital Transformation

The upgrade to our current Occupational Health Patient Management System has been delayed due to ongoing contract negotiations with Medtech (Vendor). We have managed to progress this issue where we believe a workable solution for progressing to the next stage of contract signoff and subsequent implementation to the upgraded version of Medtech in the next 2 months. This will greatly improve our information management and security resulting in timely and relevant data being extracted for analysis and reporting.

3.2 Occupational Health and Safety Work Plan

Progress remains constrained due to the diversion of resources to supporting clinical areas through the impacts of Omicron, and capacity constraints due to difficulty recruiting to key health and safety roles in a challenging market.

Current areas of focus during the minimum service delivery phase have included:

- The mandatory requirements for contractors as noted earlier
- Working in partnership with NZISM to improve health and safety leadership
- Collaborating with WorkSafe on their funded initiative to improve health and safety capability, participation and support for HSRs
- Exploring wellbeing tools to support employees and provide management with data and actionable insights

3.3 Occupational Health

The Occupational Health Steering Committee remains focussed on service and process improvement opportunities and four key risks (Pre-Employment Health Screening, Capacity, Data, and Medtech).

Rapid risk assessments for the critical risks have been completed and are being worked through with support from the Risk team. This includes prioritisation of activities required to address the risks and how progress against the action plan will be monitored.

In response to last year's PINs raised at the APS Laboratories at Mount Wellington we have provided a detailed overview (OH Protocol) to WorkSafe of our occupational health key activities (Health Surveillance, Environmental Monitoring and Pre-Employment Health Screening) across ADHB that they were supportive of. More detailed work will be required to support the OH Protocol in the coming months.

4. Auckland DHB Health, Safety and Wellbeing Governance Committee

The meeting planned for 8 March 2022 was rescheduled to 29 March. Items for discussion at the meeting were limited to critical and urgent business due to the shift to minimum service delivery.

Key areas of discussions and focus on the agenda are:

- Key Health, Safety and Wellbeing risks during the Omicron peak
- The work in progress to form a bipartite process for development of a Worker Participation Agreement
- WorkSafe notifiable events and lessons learnt from the incident review findings
- An update on what WorkSafe have learnt about the PINS process in DHBs
- Approving the reviewed interim Occupational Health and Safety Policy for Board approval in May 2022

A fuller agenda is planned for the next meeting on 19 April 2022. The key items scheduled predominantly relate to Worker Participation and Engagement. The WorkSafe Engagement Lead (Worker Engagement, Participation, and Representation) will be in attendance to present and participate in discussions.

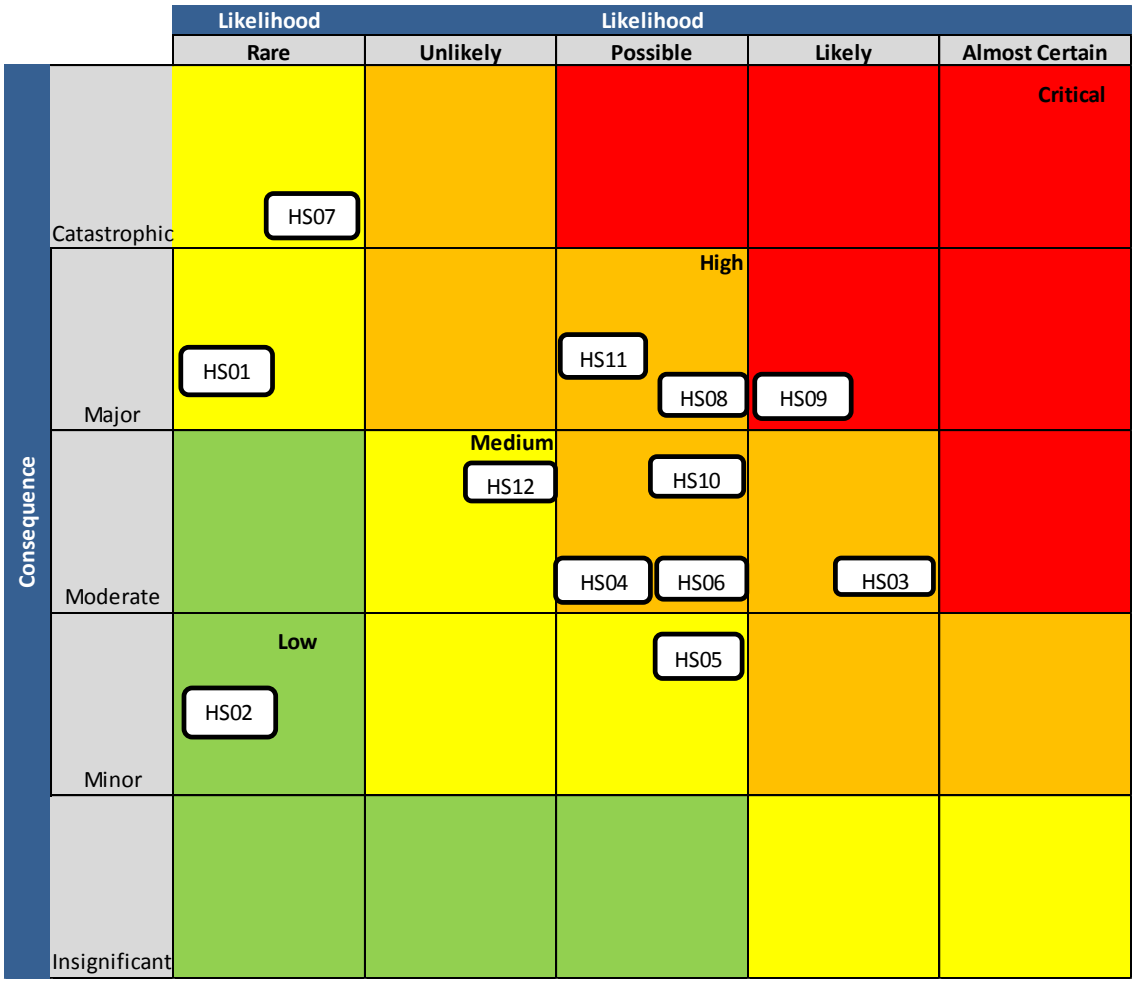
5. Internal audits

Planning is underway for an intended Health & Safety Audit by Regional Internal Audit in April. This is an anticipated timeframe but may be deferred due to Omicron peak/reducing non-clinical activities to focus on supporting the health needs of our community.

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											

Financial Performance Report for the period ended 28 February 2022

Recommendation

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

Prepared by: Angela Sinclair, Acting Deputy Chief Financial Officer
Endorsed by: Auxilia Nyangoni, Interim Chief Financial Officer
Date: 29 March 2022

1. Statement of Financial Performance for the period ending 28 February 2022

The net financial result for the month of February 2022 is a surplus of $8.2M which is $7.8M favourable against the budgeted deficit of $0.5M. For the year to date (YTD), a surplus of $11.3M was reported against a deficit budget of $42.3M, thus favourable to budget by $53.7M.

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

$000s	Month (Feb-2022)			Year to Date 2021-22			Full Year (2021-22)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Income									
Government and Crown Agency	173,830	161,109	12,721 F	1,436,355	1,289,283	147,072 F	2,056,728	1,935,832	120,896F
Non-Government and Crown Agency	7,765	8,462	697 U	64,886	67,734	2,848 U	99,354	101,508	2,154U
Inter- District Flows	62,955	66,133	3,178 U	514,221	529,063	14,843 U	780,948	793,595	12,647U
Inter-Provider and Internal Revenue	1,482	1,535	53 U	13,697	12,328	1,369 F	17,959	18,469	510U
Total Income	**246,033**	**237,239**	**8,794 F**	**2,029,159**	**1,898,408**	**130,751 F**	**2,954,989**	**2,849,404**	**105,585F**
Expenditure									
Personnel	104,660	104,152	508 U	903,805	863,939	39,866 U	1,360,802	1,307,404	53,398U
Outsourced Personnel	5,390	2,355	3,035 U	39,229	18,843	20,386 U	44,209	28,265	15,944U
Outsourced Clinical Services	4,169	3,762	407 U	28,837	30,501	1,664 F	43,629	45,652	2,023F
Outsourced Other Services	7,665	7,376	288 U	63,419	59,012	4,407 U	92,330	88,518	3,812U
Clinical Supplies	27,987	27,243	744 U	232,040	233,240	1,200 F	355,000	349,726	5,274U
Infrastructure & Non-Clinical Supplies	22,000	18,122	3,879 U	194,318	144,992	49,327 U	247,785	217,498	30,287U
Funder Payments - NGOs and IDF Outflows	65,948	73,778	7,830 F	556,183	590,227	34,044 F	854,416	885,340	30,924F
Total Expenditure	**237,819**	**236,788**	**1,031 U**	**2,017,830**	**1,940,754**	**77,076 U**	**2,998,171**	**2,922,404**	75,767U
Net Surplus / (Deficit)	**8,213**	**451**	**7,763 F**	**11,329**	**(42,346)**	**53,675 F**	**(43,182)**	**(73,000)**	**29,818 F**

Result by Division $000s	Month (Feb-2022)			Year to Date 2021-22			Full Year (2021-22)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funder	5,823	0	5,823 F	20,586	0	20,586 F	15,292	0	15,292 F
Provider	2,256	414	1,842 F	(10,673)	(42,337)	31,663 F	(58,474)	(73,000)	14,526 F
Governance	134	37	97 F	1,416	(9)	1,425 F	0	0	0 F
Net Surplus / (Deficit)	**8,213**	**451**	**7,763 F**	**11,329**	**(42,346)**	**53,675 F**	**(43,182)**	**(73,000)**	**29,818 F**
COVID-19 Net impact on bottom-line	1,712	(1)	**1,713 F**	9,927	(4)	**9,931 F**	9,927	0	**9,927 F**
Holidays Act Impact	(3,334)	(3,334)	**0 F**	(26,668)	(26,668)	**0 F**	(40,000)	(40,000)	**0 F**
BAU Net impact on bottom-line	9,835	3,785	**6,050 F**	28,069	(15,674)	**43,743 F**	(13,109)	(33,000)	**19,891 F**
Net Surplus / (Deficit)	**8,213**	**451**	**7,763 F**	**11,329**	**(42,346)**	**53,675 F**	**(43,182)**	**(73,000)**	**29,818 F**

The YTD favourable variance attributable to Business as Usual (BAU) was $43.7M and this was realised in:

- Funder Arm ($20.6M favourable)
- Provider Arm ($21.7M favourable), and
- Governance Arm ($1.4M favourable)

The favourable Covid-19 result is mainly due to the positive contribution from laboratory testing.

The full year forecast is a deficit of $43.2M, which is $29.8M favourable to the approved full year budget deficit of $73M. The forecast reflects the YTD Covid-19 favourable position, BAU favourable position expected to be sustained to year end (mainly FTE vacancies and lower consumables driven by lower volumes) and, favourable Funder position (mainly pharmaceuticals and aged residential care driven).

Commentary on Significant Variances for the Year to Date

Revenue

Total revenue YTD is favourable to budget YTD by $130.8M (6.9%). The key variances are as follows:

- Covid-19 response funding $117.9M favourable, covering vaccinations, community testing, ARPHS, laboratory testing, MIF, border control and other response costs. Offset by $20.5M adverse wash-ups for IDFs and Planned Care attributed to Covid-19.
- MOH funding for Pay Equity $34.8M favourable reflecting reimbursement of actual costs incurred.
- BAU Provision for Planned care and IDF wash-ups $8.0M unfavourable.
- MOH base revenue $5.0M favourable for one off backdated prior period IDF wash-ups.

Expenditure

Expenditure is unfavourable to budget YTD by $77.1M (4.0%). The key variances are as follows:

- Combined Personnel and Outsourced Staff costs $60.3M (6.4%) unfavourable reflecting $49.6M unbudgeted Covid-19 related costs and $10.2M unfavourable BAU personnel costs with the following underlying variances in BAU:
    - Nursing Pay Equity costs $34.8M unfavourable (offset by unbudgeted revenue from MoH).
    - BAU costs $25.6M favourable due to FTE below budget by 407.
    - Lower annual leave taken YTD than the phased assumption $5.5M unfavourable.
    - MECA costs lower than provided for $4.4M favourable.
- Outsourced Clinical Services $1.7M (5.5%) favourable reflecting lower outsourced elective surgery as a result of Covid-19.
- Outsourced Other costs $4.4M (7.5%) unfavourable, mainly greater than budgeted shared service IT costs.
- Clinical Supplies are $1.2M (0.5%) favourable to budget. Underlying this is a $5.0M Covid-19 related unfavourable variance that is offset by a $6.2M favourable BAU position. BAU is favourable due to reduced use of supplies as volumes have been lower during Covid-19 lockdown.
- Infrastructure & Non Clinical Supplies $49.3M (34.0%) unfavourable, related to unbudgeted Covid-19 expenditure $46.9M for vaccination clinic leases, urgent short-term facilities work, security, couriers, signage, etc.
- Funder payments (NGOs and IDFs) $34.0M (5.8%) favourable mainly due to net favourable funded initiatives variances, favourable prior year adjustments and net favourable utilisation variances across NGO demand driven services including Pharmaceuticals, Labs, Covid-19 costs below budget (with offsetting revenue unfavourable variance) and Aged Residential Care.

Volumes

Overall volumes are reported at 94.5% of base contract for the year to date - this equates to $57.6M below contract. $28.5M of this volume under-delivery has been provided for as this relates to IDF and Planned Care volumes that are subject to wash-ups.

FTE

Total FTE (including outsourced) for February 2022 was 10,591 which is 188 higher than budget. Covid-19 FTEs were 602 above the budgeted 90 FTEs.

2. Statement of Financial Position as at 28 February 2022

$'000	28-Feb-22			31-Jan-22	Var	30-Jun-21	Var
	Actual	Budget	Variance	Actual	Last Mth	Actual	Last Year
Public Equity	991,648	1,038,213	46,565U	987,975	3,673F	964,383	27,265F
Reserves							
Revaluation Reserve	643,988	643,988	0U	643,988	0F	643,988	0U
Accumulated Deficits from Prior Year's	(888,955)	(909,080)	20,126F	(888,955)	0F	(792,742)	96,213U
Current Surplus/(Deficit)	11,330	(22,234)	33,564F	3,117	8,214F	(96,229)	107,560F
	(233,637)	(287,326)	53,690F	(241,851)	8,214F	(244,983)	11,347F
Total Equity	**758,011**	**750,887**	**7,125F**	**746,124**	**11,887F**	**719,400**	**38,612F**
Non Current Assets							
Fixed Assets							
Land	397,089	397,089	0F	397,089	0F	397,089	0F
Buildings	599,989	659,383	59,395U	602,926	2,937U	621,314	21,325U
Plant & Equipment	83,236	97,509	14,273U	82,234	1,002F	91,861	8,625U
Work in Progress	146,158	145,566	592F	140,097	6,060F	96,596	49,562F
Total Property, Plant & Equipment	1,226,472	1,299,548	73,075U	1,222,347	4,125F	1,206,860	19,613F
Investments							
- Health Alliance	78,787	79,676	889U	78,787	0F	79,676	889U
- Health Source	271	-	271F	271	0F	-	271F
- NZHPL	6,683	7,295	612U	6,760	76U	7,295	612U
- Other Investments	617	-	617F	617	0F	-	617F
	86,359	86,971	612U	86,435	76U	86,971	612U
Intangible Assets	2,130	9,889	7,759U	2,206	76U	2,751	621U
Trust Funds	16,729	17,577	848U	16,975	246U	17,577	848U
	105,218	114,437	9,219U	105,616	398U	107,299	2,081U
Total Non Current Assets	**1,331,690**	**1,413,985**	**82,295U**	**1,327,963**	**3,727F**	**1,314,159**	**17,531F**
Current Assets							
Cash & Short Term Deposits	223,608	167,186	56,422F	229,987	6,379U	202,469	21,139F
Trust Deposits > 3months	16,716	10,707	6,009F	16,918	201U	10,707	6,009F
ADHB Term Deposits > 3 months	-	-	0F	-	0F	-	0F
Debtors	87,982	44,859	43,123F	37,829	50,153F	44,859	43,123F
Accrued Income	104,857	76,452	28,405F	131,606	26,749U	76,452	28,405F
Prepayments	8,256	5,450	2,806F	9,255	999U	5,920	2,336F
Inventory	18,827	16,275	2,552F	18,573	254F	16,275	2,552F
Total Current Assets	**460,246**	**320,930**	**139,317F**	**444,168**	**16,078F**	**356,682**	**103,564F**
Current Liabilities							
Borrowing	(3,605)	(2,828)	777U	(3,695)	90F	(2,828)	777U
Trade & Other Creditors, Provisions	(245,510)	(222,902)	22,608U	(240,011)	5,498U	(222,902)	22,608U
Employee Entitlements	(673,905)	(643,653)	30,252U	(671,148)	2,757U	(616,986)	56,919U
Funds Held in Trust	(1,410)	(1,410)	0U	(1,410)	0F	(1,410)	0U
Total Current Liabilities	**(924,430)**	**(870,793)**	**53,637U**	**(916,265)**	**8,164U**	**(844,126)**	**80,304U**
Working Capital	**(464,183)**	**(549,863)**	**85,680F**	**(472,097)**	**7,914F**	**(487,444)**	**23,261F**
Non Current Liabilities							
Borrowings	(16,227)	(19,936)	3,709F	(16,473)	246F	(13,949)	2,278U
Employee Entitlements	(93,268)	(93,299)	31F	(93,268)	0F	(93,366)	98F
Total Non Current Liabilities	**(109,495)**	**(113,235)**	**3,740F**	**(109,742)**	**246F**	**(107,315)**	**2,180U**
Net Assets	**758,011**	**750,887**	**7,125F**	**746,124**	**11,887F**	**719,400**	**38,612F**

3. Statement of Cash flows as at 28 February 2022

$000's	Month (Feb-2022)			Year to Date 2021-22		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Revenue Received	223,388	237,021	13,633U	1,966,768	1,896,665	70,103F
Payments						
Personnel	(101,904)	(97,486)	4,417U	(846,151)	(810,605)	35,547U
Suppliers	(62,326)	(50,468)	11,858U	(497,506)	(419,479)	78,028U
Capital Charge	0	(2,899)	2,899F	(17,114)	(23,195)	6,081F
Payments to other DHBs and Providers	(65,948)	(73,779)	7,831F	(556,183)	(590,232)	34,049F
GST	3,443	0	3,443F	5,366	0	5,366F
	(226,734)	(224,633)	2,102U	(1,911,588)	(1,843,511)	68,078U
Net Operating Cash flows	**(3,347)**	**12,388**	**15,735U**	**55,180**	**53,155**	**2,025F**
Investing						
Interest Income	276	219	57F	1,961	1,752	209F
Sale of Assets	4	0	4F	101	0	101F
Purchase Fixed Assets	(6,795)	(25,683)	18,888F	(60,001)	(169,138)	109,137F
Investments and restricted trust funds	200	0	200F	(5,710)	0	5,710U
Net Investing Cash flows	**(6,315)**	**(25,464)**	**19,149F**	**(63,648)**	**(167,386)**	**103,738F**
Financing						
Interest paid	(55)	(100)	45F	(614)	(801)	187F
New loans raised	(262)	0	262U	2,131	7,697	5,567U
Loans repaid	(74)	(254)	180F	827	(1,778)	2,605F
Other Equity Movement	3,673	8,709	5,036U	27,264	73,830	46,566U
Net Financing Cash flows	**3,282**	**8,355**	**5,073U**	**29,608**	**78,949**	**49,341U**
Total Net Cash flows	**(6,379)**	**(4,721)**	**1,658U**	**21,140**	**(35,283)**	**56,422F**
Opening Cash	229,987	171,907	58,080F	202,468	202,468	0F
Total Net Cash flows	(6,379)	(4,721)	1,658U	21,140	(35,282)	56,422F
Closing Cash	**223,608**	**167,186**	**56,421F**	**223,608**	**167,186**	**56,422F**

ADHB Cash	214,054	153,670	60,384F
A+ Trust Cash	9,554	11,765	2,211U
A+ Trust & Restricted Deposits < 3 months	0	1,751	1,751U
Closing Cash	**223,608**	**167,186**	**56,422F**
ADHB Short Term Investments 3 > 12 months	0	0	0F
A+ Trust Short Term Investments 3 > 12 months	16,716	10,707	6,009F
ADHB Long Term Investments	0	0	0F
A+ Trust Long Term Investment Portfolio	16,729	17,577	848U
Total Cash & Deposits	**257,053**	**195,470**	**61,583F**

Hospital Advisory Committee Report

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

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

Kuputaka: Glossary

Acronym/term	Definition
CLTC	Community and Long Term Conditions
CTO	Compulsory Treatment Order
IPS	Individual Placement Support
Kaimahi	Worker, Employee, Staff member
NRHCC	Northern Region Health Coordination Centre
PMS	Patient Management Services
Rōpū	Group

1. Executive Summary

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

- Over the past 6 weeks Te Toka Tumai has been running at 92% occupancy at our peak time at 10am, whilst under considerable pressure to resource our available bed capacity.
- We are tracking to 2019 baseline occupancy levels at the moment, and are 14% behind last year in terms of bed days. This has been affected by the impact of Covid-19 on our current inpatient volumes compared to last year.
- Workforce and resourcing available bed capacity pressures continue to be an issue.
- Transplant volumes total 67 heart, lung and liver and 92 renal transplants, totalling 159 transplants year to date. We are pleased to note maintenance of transplant activity despite the other pressures we have been experiencing.

Covid-19/Omicron Planning and Activity

Planning and activity has centred on a managing our usual essential service delivery and a surge in Covid-19 presentations, whilst our workforce was significantly reduced due to COVID infection or whanau responsibilities. As numbers of Covid-19 patients continued to increase (approximately 50% patients with another primary problem), our escalation plan was followed by moving to manage Covid-19 positive patients throughout our inpatient areas. All directorates moved to a minimum service delivery model where the sickest patients were prioritised for care. At times through the last few weeks we have dropped below minimum service delivery in some areas – particularly planned surgical care. Staff have been redeployed from non-critical to critical areas and have been supported by staff from the Northern Region Health Coordination Centre (NRHCC) and various agencies. The Living with Covid team have pivoted to meet the needs of the organisation including setting up:

- Ultra Green spaces – Neonatal ICU, Motutapu, Adult Haematology, Ward 27 A and B
- An outpatient infusion centre for the severely compromised patient

- Assisting with the redeployment of staff and the rapid recruitment of staff from outside the DHB
- The Accelerated Care Unit which supports patients triaged as not requiring hospital care
- Rapid Antigen testing support for services undertaken by non-clinical staff.

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, 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 • Extra training for donning and doffing of PPE • Distribution of Rapid Antigen testing kits to all staff
Planned Care	• Develop improved ways to deliver planned care in a Living with Covid-19 state, including outpatient programme • Safe spacing, models of care, pre-contact testing • 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 • Pathway and escalation process to reduce ambulance offload times
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
	  • Review Clinical Equipment capital plan to reprioritise

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
	  • Manage staff boosters

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
	  • Additional remuneration for night shifts and overtime

Whānau as partners in care	• Supporting whānau as partners in care to support and stay connected to their loved ones 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
	  • Maximise capacity for both Adults and paediatrics

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.)

2. Service Reports

2.1 Māori Health Provider Services

Te Toka Tumai is moving into a space of stronger and more sustainable positions associated with enacting Te Tiriti o Waitangi and Achieving Equity. The establishment of a Māori Health response leading the innovation of our clincial pathways and duty of care keeps our strategic horizon at the forefront. As a Crown agency, our business is required to support these strategic principles and are charged with finding solutions from within departments to support the expansion of the Māori Health Team network. The focus for the Māori Health Team over the next year will be:

- Continuity of influence – high trust, and high yielding relationships and engagement;
- Uniformity of advocacy – a cohesive, planned and connected voice; and
- Accountability of decision-making – monitoring, measuring and narrating performance improvement across the business.

Te Toka Tumai recognises these activities as a response to strengthen our mutual, and reciprocal partnership with Te Rūnanga o Ngāti Whātua as per our Memorandum of Understanding with the iwi. Te Toka Tumai also recognises these activities as a responsive measure to achieve equity in the care and service we provide to our patients. By supporting robust and resilient clinical pathways to prioritise better wellbeing outcomes of whānau, Te Toka Tumai acknowledges the need for greater and equitable influence over decision making within the business.

Our intention has networked the capacity and capability that exists within the organisation as a coordinated Māori-led response cognisant of a kaupapa Māori approach that centres on whakapapa, whanaungatanga and kotahitanga.

As Māori philosophies and beliefs is rooted in relational experiences and connection, the Māori Health Team network begin with a practical value approach, enabling an unbroken chain of whakawhanaungatanga from the bedside to the board room. This ensures the focussed efforts remain on patient and whānau centred outcomes.

Support from the senior leadership team in the development of their A3 equity plans and corresponding reporting documents, and the executive leadership team in advancing the networked approach, have enabled an environment with the necessary momentum to sustain the growth of the Māori Health Team network.

<u>Progress to date</u>

- July – Adoption of A3 Equity Plans across the Provider Arm directorates. This established the framework by which to enable directorates to baseline their efforts to date and set priorities determined as critical to continuing to adapt processes and systems to achieve equity.
- August – Appointment of Director Māori Health, Provider Services.
- August – Piloted the 'Pou Programme', a mobilising kaimahi response to contribute to IMT and rapid decision making. The learnings informed the networked approach we have established.
- September – Kaiārahi Nāhi is moved into the Māori Health Team and expansion of the programme in Te Pūriri o Te Ora, the Cancer and Blood directorate endorsed by the senior leadership team.

- October – IMT was replaced by the Living with Covid programme. Enacting Te Tiriti o Waitangi and Achieving Equity were embedded into the workstreams.
- November – Recruitment of Māori Health Team 'backbone' services including administration and communication support.
- November – Provider Services approval to establish Māori Health Leads within directorates.
- December – First Māori Health Lead established in Cardiovascular Services.
- February – Established Oranga Coordinator team to support Covid response. The team is non-clinical and set up within Kaiārahi Nāhi to provide support, connection and influence contributing to patient care.
- February – Executive leadership team endorse Māori Heath Team networked approach.
- February – Māori Covid representatives rōpū is established. Appointment of a Māori Health Team representative to the Living with Covid work streams.
- March – Appointment of Māori Health Leads within Clinical Services, Patient Management and Perioperative directorates.
- March – Recruitment underway for Director of Māori Nursing and Māori Engagement Specialist

2.2 Adult Medical Equity Update

A Medical Directorate Rōpū formed last year with an initial focus of seeking and responding to feedback from Māori Covid-19 inpatients. Resulting initiatives included introducing additional food options for Māori patients as well as purchasing mobile phones and iPads to lend to make it easier for patients to communicate with whānau. In February 2022, the Medical Directorate Rōpū and Covid-19 clinical teams welcomed the Oranga Coordinators from the Kaiārahi Nāhi rōpū. The Oranga Coordinators are now integrated with daily Covid clinical team catch ups and support Covid patients and whānau during their stay with us and are conduits with community providers. The Oranga Coordinators have already made a very positive impact, from identifying and coaching improved tikanga on our wards, to supporting whānau to access vaccinations and ultimately becoming vaccine-champions. Furthermore, during the current Omicron peak, we have been pleased to have the Pacific Care Navigation team supporting Covid-19 inpatients while planned care is reduced.

In the coming weeks, we have several additional initiatives. As a priority we will be advertising for a directorate Māori Health Lead. As planned care resumes, Māori and Pacific long waiting patients will be prioritised for bookings – this is already a current practice and most relevant for Gastroenterology and Neurology services. In Respiratory services, we continue to enrol Māori and Pacific patients in MyCOPD to gain feedback to further co-design the app for appropriateness. MyCOPD is an app to support those with Chronic Obstructive Pulmonary Disease to manage their disease and reduce exacerbations requiring hospital care. Additionally, we will be collaborating with the Director Māori Health Provider Services and the Kaiārahi Nāhi rōpū as they look to expand the Oranga Coordinator support to the Emergency Department, where approximately 25 Māori patients present each day.

2.3 Community Long Term Conditions Equity Update

Adult Community and Long Term Conditions directorate (CLTC) continue to make good progress towards respecting Tino Rangatiratanga. The establishment of Rōpū Ranagatira to partner with the directorate leadership team has occurred with the support of the Kaiwhakahaere Kaimahi Māori Experience. This Rōpū has focussed intially on determining the most appropriate member to be a voice of kaimahi in the directorate. It is exciting to be able to share that a preferred candidate for the Māori Health Lead for the CLTC directorate has been identifed and formalisation of the appointment is imminent. As signalled in the previous equity update, the CLTC directorate is fortunate to have kaimahi Māori and Tauiwi team members that are passionate about upholding our obligations to Te Tiriti and eliminating inequity. This is evidenced in the incremental progress thus far in terms of leadership development and will undoubtedly be accelerated in the years ahead. The consultation process with respect to Māori Health Leadership in CLTC also focused on what high quality and equitable Māori Health looks like for our directorate, with its specific needs and through a community lens. The Rōpū identified key areas to focus on while building a strong and enduring foundation for kaimahi Māori and Tauiwi within the directorate.

Capital investment has been secured for facilities projects that have been designed in partnership with Māori to serve Māori. Specifically a fit for purpose sexual health clinic in West Auckland aiming for a September 2022 open date. Mahi is also well advanced towards the creation of whānau rooms at the Adult Community Services sites at Greenlane Clincal Centre B17 and Pt. Chev Clinical Centre. Both spaces are in final stages of design which has been informed by the Community Services Māori and Pasifika staff network and Ara Manawa.

A number of key care pathway projects have been undertaken incorporating a kaupapa Māori approach. Of particular note is the development of the Hospital in the Home care pathway to support the Covid-19 pandemic response. Hospital in the Home care pathways are deliberately designed to address inequity and incorporate robust links to community Manaaki services and Te Toka Tumai Māori Health Team. Two significant care pathway improvement projects in the Adult Community Service have focussed on reducing inequity in treating lymphedema and community acquired pressure injuries. This mahi has identified tangible steps that can be taken to deliver Ōritetanga for Māori with recommendations for investment and implementation to be progressed in the near term.

2.4 Patient Management Services Equity Update

Patient Management Services (PMS) is committed to upholding Te Tiriti o Waitangi and is in the early stages of action. To support this, the new role of Māori Health Lead has been successfully recruited to. Tui Blair (Ngāti Whātua) has been appointed to this role and will be working with the directorate leadership team and kaimahi to further develop and deliver the PMS Māori health and equity plan.

PMS has been supporting the safe operating of hospital and clinical services during the recent surges of Covid-19 in the community and hospitals (both the delta outbreak and current omicron outbreak). This has required the focus of all within the directorate to support planning and response. The directorate has been heavily supporting the Living with Covid-19 work streams, including the rapid delivery of actions over the past month.

The cleaning service has been under particularly pressure due to the coinciding of high unplanned absence with increased demand on the service following high numbers of patients with Covid-19 in

hospital. The team responded well and put in place a series of actions to maintain essential elements of the service, whilst reducing overall provision particularly to lower risk areas. Support has been provided to kaimahi in the cleaning service, including targeted welfare support.

The whānau as partners in care work stream is supporting a hospital environment of whanaungatanga and manaakitanga so that patients' whānau can safely support patients in hospitals during the pandemic. This includes developing the screening team at facility entrances, supporting 'virtual visiting' and working with ward and clinical teams to address the cultural change needed.

The successful Healthcare Assistant 'earn and learn' programme continues to grow. 18 per cent of new recruits to this scheme identify as Māori. In addition, the directorate has recruited a Māori Healthcare Assistant trainer who will be working in partnership with the Kaimahi Māori Experience Team to support kaimahi enrolled in this programme. A third cohort is due to commence in May and recruitment continues for this intake.

PMS has overseen the establishment of a remdesivir infusions service for people at risk of hospital admission following Covid-19 infection. This includes referrals from primary and secondary care teams, including encouraging referrals from the Māori Regional Coordination Hub.

2.5 Starship, Child Health Equity Update

Starship acknowledges that there is progress towards actualising Te Tiriti o Waitangi within the directorate. Much of this progress is derived from charitable funding. Starship continues to make progress on:

- Developing relationships and connections with iwi Māori and kaupapa Māori providers;
- Establishing Te Tiriti based equity within the senior leadership team and all governance groups;
- Appropriately resourcing the Māori health leadership roles within Starship;
- Actualising an environment of manaaki and kaitiakitanga that will allow retention of kaimahi Māori;
- Increasing the number of kaimahi Māori currently employed within Starship;
- Increasing the percentage of rangatira Māori within Starship.

<u>Starship Māori Leadership Team</u>

Starship Foundation has provided charitable funding to establish Māori health leadership roles within the directorate. Starship's Māori Leadership Team will bring together kaimahi and rangatira Māori to support Starship to actualise equity through Te Tiriti o Waitangi. Starship recognises that this charitable funding is only a small contribution towards rectifying the chronic and pervasive inequities Māori have experienced for decades. Currently this leadership team consists of three individuals who are endeavouring to draw upon other culturally-loaded kaimahi within Starship to support this kaupapa to:

- Recruit, develop and retain kaimahi Māori;
- Collaborate to develop the cultural safety and capability of our non-Māori workforce, embedding Te Tiriti-based practice across the directorate;

- Partner with services and service designers to implement matauranga and te ao Māori innovations to improve cultural safety and quality improvement across Starship;
- Prioritise policy development to protect Māori data sovereignty and establish frameworks for the measuring, monitoring and publicising of Starship's Māori health equity status.

Starship Strategy Document

Starship's Māori leaders have consulted extensviely over the past 6 months with rangatira and kaimahi within Te Toka Tumai, Starship and iwi Māori to develop a visionary strategy for Starship. This Rautaki is nestled under the kahurangi of Pae Ora, Te Korowai Oranga and the Ministry of Health Whakamaua Action Plan. Dame Naida Glavish gifted a kauae runga kōrero and endorsed the Rautaki, with the kauae raro supported by Tama Davis, Nigel Chee and Anthony Hawke. The strategy positions Starship to actualise equity through Te Tiriti o Waitangi and commits to long overdue changes to improve the experience and outcomes for Māori tamariki and their whānau. The Starship strategy also provides navigational tools to respond as paediatric child health leaders to the most significant health reforms in the history of Aotearoa. Starship's Māori leaders have a bold plan to launch the strategy during 2022 Matariki celebrations.

Pae Ora and Oranga Tamariki Submission

Starship's Māori leadership team has lodged submissions on the Paeora (Healthy Futures) Bill and the Oversight of Oranga Tamariki System and Children and Young People's Commission Bill. These have been presented through oral submission to the respective Select Committees. We see this as part of our wider responsibility to represent and advocate for the unique needs of tamariki and rangatahi. The submissions have been well received and provided a great opportunity to colloborate with other kaupapa Māori organisations and the Paediatric Society.

Te Tiriti Critical Analysis Training

Three workshops have been delivered within the directorate since late 2021. These were attended by our Senior Leadership Team, Service Clinical Directors, Nurse Unit Managers and Operations Managers. Despite the challenges of the current Omicron response, additional workshops for 2022 are continuing as planned and will be available to anyone within the Child Health directorate. The workshops are designed to strengthen engagement with and application of Te Tiriti o Waitangi within services and pathways. The workshops also assist services to consider indigenous rights-based equity and how they can help achieve more equitable outcomes for Māori.

Māori Recruitment Strategy

Starship are commited to appointing Māori to leadership positions across the directorate. Work is underway to develop an overarching approach to recruiting Māori. One component of this is a pilot recruitment campaign specifically designed to recruit Māori to leadership positions within Starship's new Digital and Community Engagement team. Learning from this project will be extended to recruitment of additional Māori leadership roles funded through the Starship Foundation.

2.6 Mental Health & Addictions Equity Update

Within the directorate, some examples of how we continue to grow and support equity champions across our services include:

- Tino Rangatiratanga and Kāwanatanga Partnership Model: Establishment of a Lived Experience and Whānau Governance group to work in partnership with the existing Zero Suicide Governance group. To date, eight excellent candidates have been appointed through a recruitment and interview process, and a date to welcome these members has been set for late March.
- Implementing Te Tiriti o Waitangi: People leaders report on actions being taken to eliminate inequities for Māori and to be Tiriti compliant at all 2 in 1 meetings and service-wide meetings.
- Critical Tiriti Analysis Training: For people leaders in March and May, with on-going support to ensure implementation.
- Normalising Te Reo: Buchanan Rehabilitation Centre lead weekly karakia and are supporting our tangata whaiora and kaimahi to learn how to lead karakia, to learn new waiata, to observe maramataka and to learn how to mihi.
- Ngāti Whātua Ōrākei Hikoi with Tama Davis: Initially for the directorate leadership team (with other people leaders to follow) to learn the history of Ngāti Whātua Ōrākei, see Te Tiriti in action, and to gain a fuller understanding of partnership and what it means to be Tangata Tiriti.
- Online Mihi Whakatau for New Staff: Temporarily moving the pōwhiri from our Oho Ake programme to an online mihi whakatau so new staff are able to to build rapport with the directorate leadership team and get to know one another, or whakawhanaungatanga during Covid-19. Ngā mihinui He Pou Ārahi o Te Pūriri o Te Ora (Cancer and Blood Directorate) for sharing your model with us.
- Rapua Te Āhuru Mōwai: A three way partnership between Te Toka Tumai, Mahitahi Trust and CORT Housing. The pilot is funded for four years by the Ministry of Health to provide sustainable housing in the community with wrap around supports for whaiora who have been high users of mental health inpatient services and have a history of homelessness. This group have high and complex needs but are able to live independently with the right supports and housing. The pilot has a strong equity focus and Māori are prioritised for acceptance onto the programme. Mahitahi is a kaupapa Māori provider, ensuring the right cultural support is given. Since July last year 20 whaiora have entered the programme with 11 already living in their permanent homes. The key elements leading to the success achieved to date have been attributed to the strong relationships and communication built between the three partners, and whanaungatanga being prioritised with whaiora. Also important is ensuring whaiora are taking the lead in their own lives, and the support provided is able to be tailored to meet whaiora needs as they define them.
- Individual Placement Support (IPS) Service: An exciting opportunity to have Māori employment consultants from Mahitahi working in partnership with Workwise as part of the expansion of our employment services. A new steering group has been established to ensure fidelity to the IPS model and to support implementation. In line with our Te Tiriti o Waitangi focus, all parties involved including the mental health services and employment support providers are committed to meaningful partnership and collaboration, fostering shared decision-making and a commitment to the integration of all services involved in the IPS employment support programme.

- Compulsory Treatment Order (CTO) Māori Disparity Project: Staff, tangata whaiora and whānau Mental Health Act education is the primary focus for addressing CTO disparities. With our new Medical Director, we will be reviewing the Cultural Safety training for medical staff and we will also partner with with our inpatient units to ensure CTO are addressed as part of our impending advanced directives work.
- Replacement and Repeal of the Mental Health Act: People leaders and staff provided direct feedback to the MOH in a number of different forums. Ministry of Health representatives, Phyllis Tangiitu and Dean Rangihuna hosted a session for Te Toka Tumai kaimahi Māori which allowed us to share local intelligence to support the national debate. Tangata whaiora and their whānau were also informed and supported to attend the various hui and forum in Auckland.

3. Special Open Reports

Planned care position

August 2021 lockdowns leading into Christmas severely impacted planned care delivery, and although services were briefly able to return to normal capacity in late 2021/early 2022 further restrictions of planned care have been necessary due to the Omicron Surge in February and March 2022. Minimum service delivery plans were enacted which allowed staff to be redeployed to areas of need within the hospital to ensure safe staffing.

As part of the minimum service plans, services have continued delivering care to our most urgent patients, and also continued to conduct telehealth visits where appropriate.

As in previous lockdowns, referral volumes have dropped, however the lockdown in August, closely followed by the Omicron surge have significantly increased waitlists across services for both first specialist appointments and procedural planned care.

Progress on Te Tiriti o Waitangi and Equity

- Over the Omicron surge, Te Toka Tumai has been required to enact minimum service delivery plans, thus only treating our most clinically urgent patients. As capacity allows us to increase the level of planned care we provide we are extending treatment to semi-urgent Māori, and semi-urgent Pacific patients.
- We are working alongside the Kaiārahi Nāhi and Pacific Navigator teams to maintain engagement with the patients who are having to wait longer for their treatment, and to identify those patients that are ready for surgery as restrictions ease.
- Delivery of some surgery in private facilities has commenced for clinically urgent patients to reduce waiting times and mitigate clinical risk. This has been arranged over the Omicron surge mid-March up to 1 April 2022.
- Regular monitoring of patients waiting occurs at NHI level, with clinical reviews done during minimum service delivery to enable deteriorating patients to be identified and their priority to be escalated. Reporting of waiting times by ethnicity continues to be monitored weekly by service to help drive equity.
- Minimum service delivery has allowed staff to be redeployed over the Omicron surge to ensure our hospital is safe. This has included some of the Kaiārahi Nāhi and Pacific Navigators being redeployed, while planned care was reduced, to support our Māori and Pacific inpatients.

- The directorate leadership team have focussed on improving connections, being more visible on our wards, and getting to know each other within teams and across the DHB through whakawhanaungatanga so we can support each other and improve services. Covid updates via zoom have continued and through the Omicron surge the focus has been on attending rapid rounds.

Regional Equity Position

Source: Regional Waiting list as at 14 March 2022

Table 1: ESPI 2 % non-compliant by Ethnicity

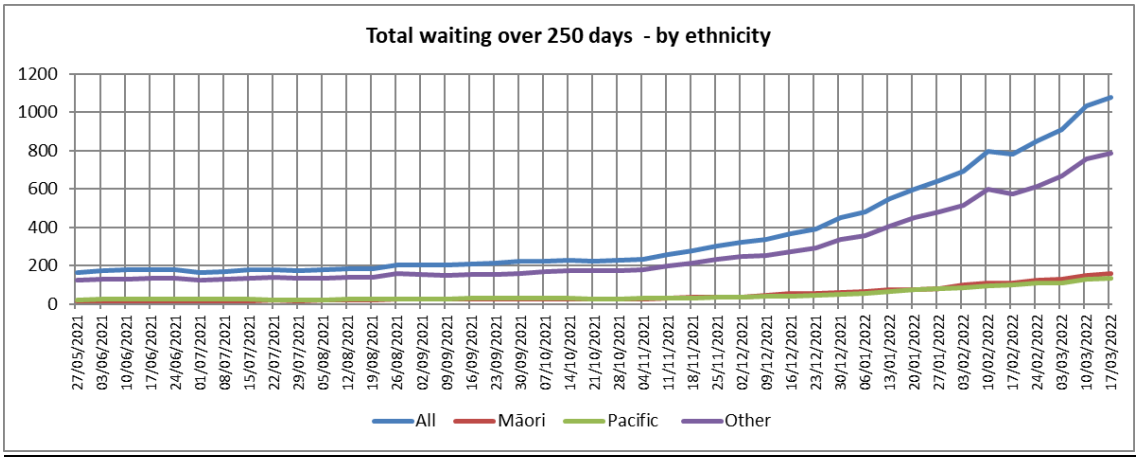
ESPI2	% Non-Compliant				
Ethnicity	**Northland**	**Waitematā**	**Auckland**	**Counties Manukau**	**Total**
Māori	51%	28%	20%	31%	35%
Pacific Peoples	50%	25%	21%	29%	26%
Asian	48%	28%	21%	28%	25%
European	45%	28%	20%	29%	29%
Other	44%	32%	18%	28%	25%
Grand Total	**47%**	**28%**	**20%**	**29%**	**29%**
Previous report (10 Jan 2022)	59%	27%	19%	37%	32%
Variance	12	-1%	-1%	8%	3%

Table 2: ESPI 5 % non-compliant by Ethnicity

ESPI5	% Non-Compliant				
Ethnicity	**Northland**	**Waitematā**	**Auckland**	**Counties Manukau**	**Total**
Māori	59%	53%	36%	30%	46%
Pacific Peoples	51%	55%	35%	26%	35%
Asian	46%	47%	37%	22%	36%
European	57%	42%	37%	25%	41%
Other	43%	52%	34%	18%	37%
Grand Total	**57%**	**45%**	**36%**	**25%**	**40%**
Previous report (10 Jan 2022)	55%	51%	39%	29%	43%
Variance	-2%	6%	3%	4%	3%

Te Toka Tumai long waiting patients

The numbers of patients waiting for surgery for more than four months, as well as long waiting patients at 200 days, 250 days and 300 days continue to be monitored at the planned care meeting weekly, along with reporting by service. The reduction to minimum service during the Omicron surge has increased the numbers of long waiting patients, although continuing to prioritise Māori patients and Pacific patients has reduced the growth in these groups of patients that would have otherwise occurred.



ESPI5 patients waiting over 250 days to 17/03/2021 produced by HIT

4. Financial Report

The Provider Arm result for YTD February 2022 is $31.7M favourable. The underlying BAU result is $21.8M favourable and the impacts of Covid-19 are $9.9M favourable.

Overall volumes are 95% of contract for the YTD - this equates to $57.6M below contract. This unfavourable contract position equates to an estimated $28.5M wash-up liability for planned care (excluding August and September which the Ministry of Health have advised will not be subject to wash-up) and IDF. This wash-up liability has been predominantly provided for under Covid-19 ($20.5M), reflecting the significant decrease in volumes during the lockdown and surge periods. The remaining $8M wash-up liability for periods outside lockdown and surge has been recognised in the BAU result.

BAU Result

The $21.8M favourable YTD BAU result is driven by the following key variances:

Favourable:

- Personnel and outsourced personnel costs are $24.5M favourable (after offsetting additional Ministry of Health funding received for the unbudgeted costs of Nursing pay equity). This is a reflection of BAU FTE averaging 407 below budget for the YTD, partly offset partly by lower levels of annual leave taken.
- Clinical Supplies are $6.2M favourable due to lower acute volumes during the lockdown periods.

Unfavourable:

- Planned Care and IDF wash-up liability $8M for periods outside lockdown and surges.

Covid-19 Result

The $9.9M favourable YTD Covid-19 result is driven by the favourable contribution margin from laboratory PCR testing. Most of the Covid-19 workstreams such as vaccinations and testing are breakeven with the positive contribution from laboratory testing offsetting the YTD unfunded impacts.

CPHAC EXECUTIVE COMMITTEE REPORT

Planning Funding and Outcomes Update

Recommendation:

Note the key activities within the Planning, Funding and Outcomes Unit.

7.2

Prepared by: Kate Sladden (Funding and Development Manager Health of Older People), Ruth Bijl (Funding and Development Manager Women, Children & Youth), Leani Sandford (Portfolio Manager, Pacific Health Gain), Shayne Wijohn (Acting Funding and Development Manager, Primary Care and Māori Health Gain Manager)
Endorsed by: Dr Debbie Holdsworth (Director Funding) and Dr Karen Bartholomew (Director Health Outcomes)

Glossary

AAA	-	Abdominal Aortic Aneurysm
AF	-	Atrial Fibrillation
ARC	-	Aged Residential Care
DHB	-	District Health Board
HCSS	-	Home and Community Support Services
HPV	-	Human papillomavirus
MMR	-	Mumps, Measles and Rubella
MoH		Ministry of Health
NA-HH		Noho Āhuru – Healthy Homes
NCHIP	-	National Child Health Information Platform
NGO	-	Non-Governmental Organisation
NHI	-	National Health Index
NIR	-	National Immunisation Register
NRHCC	-	Northern Region Health Coordination Centre
PFO	-	Planning, Funding and Outcomes
PHO	-	Primary Health Organisation
UR-CHCC		Uri Ririki - Child Health Connection Centre

1. Purpose

This report provides a brief update on Planning and Funding and Outcomes (PFO) activities and areas of priority. Note that most of the team are supporting the current outbreak response across a range of activities.

2. Primary Care

Our team remain heavily involved in the primary care COVID response.

2.1 Vaccinations

We have been working closely with the NRHCC and providers to ensure that contracts are in place and sites are prepared to maintain access to vaccinations. There are 71 general practices providing COVID vaccinations in our catchment area, and 64 pharmacies. Another nine mobile pharmacy teams are offering outreach support to communities and centres as required.

2.2 Whānau HQ

As COVID positive cases rise in our community, we have focused our resource, in partnership with the NRHCC, on preparing providers to manage cases. A metro-wide funding framework is in place for general practices to be reimbursed for care they provide to positive whānau in the community.

3. Health of Older People

3.1. Aged Residential Care

There have been 64 COVID-19 exposure events/outbreaks in aged residential care (ARC) facilities within Auckland DHB since the start of the Omicron outbreak at the beginning of February. The vast majority of ARC facilities with COVID-19 positive residents have coped exceptionally well. Most exposure events have been self-managed by the facilities with daily updates to the DHB. A small number of facilities, assessed as medium risk, have required more intensive input from the DHB. Workforce has been a significant issue although mitigating measures have been implemented including staff returning to work under the critical workers' guidance, redeployment of staff within an ARC organisation and implementing contingency care plans.

3.2. Home and Community Support Services

Home and Community Support Services (HCSS) providers have had to prioritise services to high need and socially isolated clients when there have been workforce shortages due to the Omicron outbreak. Modification of tasks has also occurred to free up the workforce. Communications were sent out to all HCSS clients at the beginning of February to prepare them for any changes in their service delivery but it is acknowledged that this has not been an ideal situation.

In recognition of the recent increase in fuel prices, which has a significant impact on the HCSS workforce, DHBs have agreed to an increase in the mileage rate. The rate has increased by five cents to 63.5 cents per kilometer for a temporary period (15 March to 30 June 2022).

4. Child, Youth and Women's Health

4.1. Immunisation

Childhood Immunisation Schedule Vaccinations

There has been a significant primary healthcare disruption due to COVID-19, which affects immunisation coverage with delays in whānau accessing childhood immunisation.

This month the hierarchy of Primary Care services was reviewed in response to the Omicron surge to support practice's prioritisation decisions. Childhood immunisations were highlighted in communications as a key service to continue delivering in all business continuity plans.

Te Manawa HealthWEST has recruited an additional 2 FTE to increase their Outreach Immunisation Service (OIS) and home-visiting teams to implement the additional OIS Funding Agreement.

The Ministry of Health has several work streams underway at pace, building on the COVID-19 tools to integrate with child, antenatal and influenza immunisation programmes. Additional funding may be allocated for MMR immunisation catch-up this financial year. Consultation is underway to increase the child vaccinating workforce by expanding the role and training for COVID-19 vaccinator pharmacists and community vaccinators working under supervision. The new immunisation register (NIS) is rolling out in stages starting with Flu immunisations from 1 April 2022.

Work has been progressing to deliver integrated immunisations (meaning co-administration of vaccines for the whole whānau) through the NRHCC COVID -19 programme across several work streams. A brief summary of the work to date follows:

- Māori and Pacific Mobile Units:
  - The funding Agreement with Providers for the COVID-19 Māori and Pacific mobile units (managed by the DHB Māori and Pacific programme managers) offers whole-of-whānau immunisations. Opportunistic child and antenatal immunisations are given in the homes they are visiting and this has been in place for several months.
  - A childhood overdue immunisation work stream is functioning with those same providers and our Uri Ririki – Child Health Connection Service (includes NIR team). Tamariki aged 2-5 years who are over-due MMR is the entry point. This is proving successful and we are looking to extend this.
- NRHCC outreach service
  - Integrated immunisation operational work is progressing with NRHCC outreach team to train staff and set up IT/NIR access. The priority is those attending special schools and emergency housing/vulnerable communities.
- NRHCC/DHB Community Vaccination Centre (CVC)
  - The first CVC site is established and functioning offering integrated immunisations at Albany.
- Community and School Vaccination Events
  - When the lead Provider requests support for administering additional vaccinations, then a collaboration is activated with PHN teams to attend and provide whole-of-whānau immunisations. This often also including oral health, vision and hearing checks too.

Note: As BAU, PHOs receive the NHI lists of children eligible for Flu vaccine annually. The OIS child referrals are flu-matched and tagged by the NIR team. There is an in-hospital vaccinator for ACH who do all child (in-patients) and antenatal (outpatients clinic) immunisations. A nurse vaccinator works with the 10 low-decile ESBHS secondary schools to offer catch-up immunisations for students in school year 9.

In response to the Omicron outbreak, PHOs and General Practices continue to offer Mama/Pepi clinics as a dedicated time and space for childhood immunisation. PHOs are supporting practices that have workforce pressures by assisting with immunisation recalls and Immunisation Coordinators are stepping in to run immunisation clinics

Auckland DHB has developed a Recovery Action Plan in consultation with Primary Health Organisations (PHOs), Māori and Pacific Health Gain teams, and regional partners to improve immunisation rates. The Ministry of Health (MoH) provisionally approved this in August since when we have been implementing the plan.

Activities completed to date include:

- The DHB funded a communication campaign to promote childhood immunisation. This included radio and retail advertising from January 2022, as well as social media posting and future posters and key messaging engagement activities.
- The successful Māori Case Review Group structure has now widened to include tamariki who are Pacific or Q5. The meeting is a collaboration of clinicians from the DHB, Māori and Pacific WCTO providers, NIR, OIS and Oral Health services. The aim is to reconnect services with children and their whānau.

In March 2022, the vaccination rates have held reasonably steady. As of 21 March, the 3-months rolling childhood immunisation coverage for **8 months of age** had remained the same for Total population at 89%, improved for Pacific 81% but fallen for tamariki Māori 68% in comparison to last month.

The coverage for **24 months of age** for tamariki Māori has been steady over the last month at 71%, while both Total 87% and Pacific 80% coverage rates had fallen for the same period.

Below is a table comparing childhood immunisation coverage over the last two weeks, including the decline/opt-off rates across Total, Māori and Pacific population.

Coverage for the Total population is consistently between 85-86% for the last 3 weeks, and Māori (69%). Immunisation rates for Pacific tamariki is slowly trending upwards with 83% fully immunised.

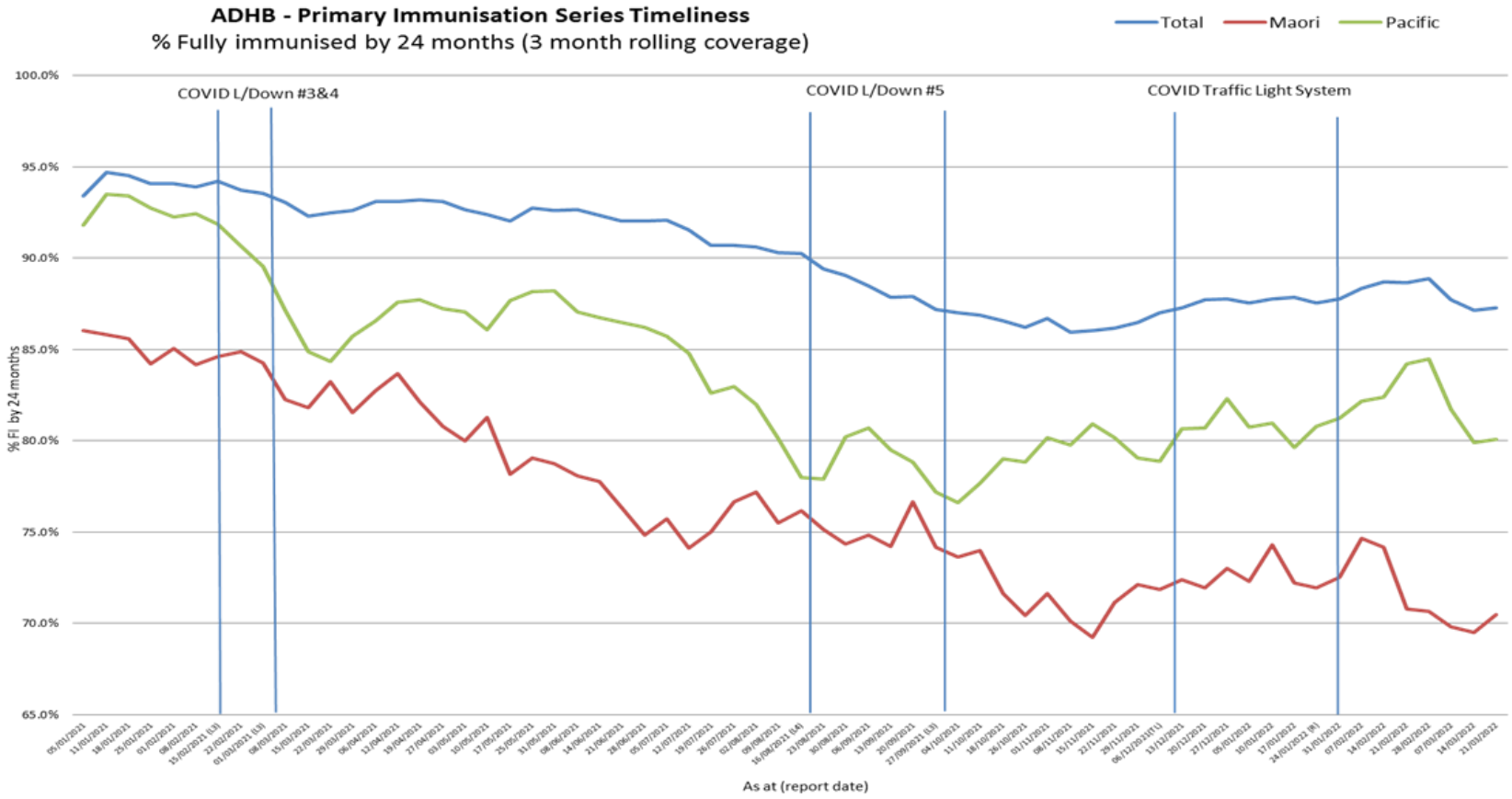
Auckland DHB Childhood Immunisation Coverage												
3 month rolling average	Week of 21/03/2022						Week of 14/03/2022					
Milestone Age	Total	Maori	Pacific	Total Decline & Opt-off Rate	Maori Decline & Opt-off Rate	Pacific Decline & Opt-off Rate	Total	Maori	Pacific	Total Decline & Opt-off Rate	Maori Decline & Opt-off Rate	Pacific Decline & Opt-off Rate
8 months	87% ↓	68% ↑	81%	2%	7% ↓	4% ↑	89%	67%	81%	2%	8%	3%
24 months	87%	71%↑	80%	3%	7%	5%	87%	70%	80%	3%	7%	5%
5 years	82%	70% ↑	83% ↑	3%	9%	2%	82%	68%	82%	3%	9%	2%

4.2. Measles

Work has continued as part of the national Measles Mumps and Rubella (MMR) catch-up focused on 15 to 30-year olds, particularly Māori and Pacific, with the Auckland strategy to increase awareness of the need to be immunised and increasing access to the vaccine. Since the campaign was launched by Minister Genter in July 2020, 2,583 new MMR doses have been recorded on the NIR for 15 to 30 year olds in Auckland DHB to the end of February 2022. Of these 282 were for Māori and 508 to Pacific. The DHB MMR team have given 1,342 MMR doses across Auckland and Waitematā, taking a holistic approach and offering a catch up of Boostrix (pertussis, 475 vaccines) and HPV (748 doses) in schools, and meningococcal (101 doses) in tertiary residential facilities.

The Ministry of Health has announced that the programme has a further extension to 30 June 2022. The programme has been impacted by COVID -19 lockdowns with planned school and tertiary vaccine events being cancelled. Activities in schools, tertiary institutes and partnerships with private occupational health providers, Family Planning and the Regional Sexual Health clinic continue.

The DHB project team is now exploring opportunities for delivering MMR alongside COVID-19 vaccination in community pop-ups and Vaccination clinics. The MMR team attended a Covid immunisation whānau event by Ngāti Whātua Orakei on Saturday 19 March and delivered 8 MMR vaccines alongside many more immunisation history checks. There is a reluctance by whanau to have multiple vaccines currently.


ADHB - Primary Immunisation Series Timeliness
% Fully immunised by 24 months (3 month rolling coverage)
Total
Maori
Pacific
COVID L/Down #3&4
COVID L/Down #5
COVID Traffic Light System
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
% FI by 24 months
As at (report date)

4.3. Uri Ririki – Child Health Connection Centre

The UR-CHCC team continue to support population health with National Immunisation Register (NIR), National Child Health Information Platform (NCHIP) and Noho Āhuru (NA-HH) during the COVID-19 Red Light setting, with a mixture of in office and working from home to ensure business continuity and provision of business as usual services. A significant number of staff were directly affected by Covid.

The National Immunisation Register (NIR) administrators are being impacted by continual NIR server outages, generally at least once per day, often for 20-30 minutes at a time. When the NIR has an outage there is a loss of connection, preventing data from being entered or reviewed, or reports being run - given the state of immunisation coverage, every minute lost to a NIR outage makes it even harder to follow up our overdue children, particularly when we run the overdue reports to our GP clinics. This has been raised as an issue with the MoH Immunisation team, however the regularity of these outages has worsened in 2022 whilst we await for the replacement National Immunisation Solution (NIS). The Ministry of Health have indicated the Minimum Viable Product is expected by late March for 'flu vaccine recording, with expansion to other vaccines later, thus we can expect to be using the aging NIR for some time to come.

Access to NCHIP has been made available through Regional Clinical Portal and also to Plunket. Our Well Child Tamariki Ora network is now also onboarding and is enthusiastic about how this system will support their service provision. NCHIP continues to support children being enrolled with a WCTO provider – a process for children aged seven weeks old without a WCTO provider results in whānau of around 5 Auckland DHB children each week being contacted by the Newborn Enrolment Coordinator to support their enrolment.

The 'Lost to Service' pathway with Ministry of Social Development (MSD) continues, however receiving data back has been a challenge during COVID-19 lockdowns. The Māori Immunisation Case review meetings have had a refresh – the group now meets fortnightly (instead of monthly) and discusses all Māori, Pacific and Q5 children who have turned 6 months of age in the last two weeks (as opposed to the monthly meeting discussing all children who have turned 6 months old) and are not fully immunised – this change expands to include all our vulnerable tamariki in a more timely manner.

NA-HH received 75 referrals in February. A series of initiatives to promote the service and increase referrals continues. The Welcome Letter sent by UR-CHCC to advise whānau of their child's enrolment on the NIR/NCHIP has been revised to include information about NA-HH and self-referral, and has already seen an increase in self-referrals as a result of this. Delivery of assessments by DHB social workers has been impacted by staff re-deployment during Covid, resulting in a significant backlog of service delivery. Services need to be re-prioritised.

4.4. Youth Health –enhanced School Based Health Services

The Enhanced School Based Health Services (ESBHS) programme is delivered in ten low-decile secondary schools, Alternative Education settings and the Teen Parent Unit in Auckland DHB. The programme provides youth friendly, confidential, and easy to access health services – the nurse is available at school every day, supported by a visiting general practitioner and clinical psychologist. Through this programme about 9,000 secondary school students have improved access to primary healthcare in Auckland DHB.

The school nurses have continued to provide the routine care they normally offer, using standing orders and the school GP support to work to the top of their scope and provide care to students. They manage this alongside a huge increase in demand for COVID related support. There are still large numbers of symptomatic students at school having to be isolated and sent home with advice

about how to isolate, test and manage. Nurses are also supporting families isolating at home with questions about COVID management and access to testing and other supports available. There has been delayed access to healthcare for some students due to isolation rules and health teams have been managing this and helping students to get the care they need. Often families and students know the health centre staff and trust them and may find difficulty accessing their own GP or not be registered with a practice. This health advice is important for them and the community.

There have been very low attendance rates at school due to students isolating, or restricted access to school for students so as to limit numbers. The ESBHS school health teams offer remote services to students having to isolate or learn remotely, in addition to the usual on-site clinics.

Nurses have also continued with HEADDSSS assessments using YouthCHAT or brief assessments when YouthCHAT is not available. They act on any issues raised as they usually would. It has been, and continues to be, a very disruptive time for students and health teams, but the teams continue to offer high quality healthcare and support to students. However, HEADSSS targets have not been met.

Through the lockdown, the psychologists have trialed various methods to engage students and support direct psychology referrals. Many of our partnering schools have praised the consistent efforts of the psychologists to engage students and support the school teams. The focus on student engagement has highlighted a need to develop a direct referral pathway from student to psychologist to address the students' requests for increased confidentiality. This is particularly important for Māori and Pasifika students who indicate a preference for in-person sessions and assured confidentiality.

Referrals for virtual therapy have remained consistent and steady. Students have highlighted the lack of privacy in the home as a barrier to participating in online sessions. The students' requests for telephone sessions have been met, with psychologists offering shorter and more frequent sessions. Overall, the school teams report the student preference for in-person sessions at school.

Psychologists have developed webinars and a library of resources in preparation for returning to school. Psychologists have recently returned to the 5 schools which can provide designated office space and an environment that reduces the risk of cross-contamination. We plan to have psychologists return to all the schools within the following fortnight. Services report on-going concerns regarding access to secondary mental health services, and capacity and acuity within primary mental health services.

4.5. Contraception

Access to contraception options, particularly Long Acting Reversible Contraception (LARC) remains a priority. Promotion of the opportunity to provide funded LARCs is ongoing within community and primary care providers. A steadily increasing number of skilled providers are now offering the service. Service provision has been negatively impacted by the COVID outbreak, with service delivery volumes notably reduced, despite increase in provider numbers among primary care. Contraception provided in hospital settings such as maternity, have continued to be important and have been provided steadily throughout.

Collaboratively with ADHB Women's Health Directorate, we have been able to support practical training for a small number of clinicians in targeted services such as youth health. This has gone well and we continue to support Ministry of Health and the Family Planning Association to strengthen training opportunities in LARC provision. Training opportunities were also negatively impacted by COVID, with a reduced number of training sessions completed.

A consumer facing resource postcard has been developed with extensive stakeholder input. The resource is intended to supplement contraception consultation discussions in a range of settings, and support consumers to be referred to a provider of free contraception. This will supplement information resources on contraception options already available, and the patient facing web based resources. We have ensured that information for all providers across Auckland and Waitematā DHBs is available, and that Counties Manukau Health information will be linked. Further feedback on the resource will be sought after it has been utilized for a period of months and refinements may be incorporated for future resources.

In addition, we are working with CMH to develop a consistent pathway to support GP to GP referral which may be able to be implemented in this programme.

4.6. Cervical Screening

Cervical Screening coverage across New Zealand including Auckland DHB is below the national performance target of 80%. Screening coverage has been persistently inequitable. The table below shows the three year coverage to end of 2021 compared with December 2019 (prior COVID).

Table: NCSP coverage (%) in the three years ending 31 December 2019 and 2021 by ethnicity, women aged 25–69 years, Auckland DHB and Total NZ Coverage:

Ethnicity	ADHB 3 year coverage, Dec 21	National 3 year coverage Dec 21	ADHB 3 year coverage, Dec 19	National 3 year coverage Dec 19
Māori	52.5%	57.2%	51.4%	67.5%
Pacific	54.8%	58.2%	58.9%	66.4%
Asian	51.4%	56.6%	50.0%	61.8%
Other	78.5%	76.0%	73.9%	75.9%
Total	**64.1%**	**68.4%**	**62.0%**	**71.7%**

NCSP analysis (unpublished) after the first 2020 lockdowns indicated that the rate of screening activity recovered to “pre-COVID” levels, we believe this reflects concerted effort in Primary Care practices. However, NCSP analysis indicates this was not equitable, with a persistently lower rate of screening among Māori and Pacific women. Pre-COVID screening participation reflected inequitable participation by ethnicity, this inequity in the recovery likely further exacerbated this.

NCSP has not released specific data on COVID impact and recovery further to the usual coverage reports that are cited above (table). As the coverage reports are for 3 year coverage, it is likely that the impact of this inequity in activity over the COVID period is yet to become clear in the reported data trends.

Primary care delivery of cervical screening is central to the current NCSP programme design. Access barriers exist in this structure, with our review of PHO enrolment for Auckland DHB indicating a significant volume of women of screening age not currently enrolled, particularly for Māori.

The shift to the new HPV primary testing programme for NCSP in 2023 will be an important opportunity to address access barriers with an equity first prioritised programme. HPV testing via self-test represents a significant opportunity to address some of these barriers in access and acceptability.

Greatest risk for cervical cancer remains among those who have never been screened, or very irregularly (therefore substantially overdue). Consequently the persistent equity issues remain the highest priority for response, despite interruptions being seen across services due to recent COVID situation.

Free and accessible cervical screening services in Auckland DHB are targeted to Māori and Pacific women specifically, to address the cervical screening equity gap and the inequity in outcomes experienced by these groups. We remain concerned that capacity across the sector has been significantly constrained and the impacts of this are recognised in screening volumes.

A trial of petrol vouchers to support women participating in screening has been undertaken in a small number of clinics. The initiative has been targeted to women who are overdue for screening with a previous abnormal result, with a focus on Māori and Pacific women. Feedback to date is positive and we will continue to evaluate the initiative and consider further extension if indicated. Although these small numbers add little to overall coverage, they are targeted to a group with a potentially increased clinical risk.

4.7. Abnormal Uterine Bleeding

The team is supporting Auckland district's contribution to the regional Abnormal Uterine Bleeding (AUB) project. This is a Pacific led initiative with the local work chaired by Dr Aumea Herman. The project is a response to high rates of endometrial cancer experienced by Pacific women. There is an expectation that the project will deliver regionally consistent services which result in earlier identification of, and treatment for, endometrial cancer.

This programme of work is progressing well, ADHB and WDHB clinical partners in the project have agreed the clinical criteria for the pathway, regional consultation on this is now underway. An evaluation programme has been commissioned for the project. Planning for training of primary care practitioners is in preparation and contracting to establish the claims mechanisms is also scoped.

5. Mental Health and Addictions

There have been 15 COVID-19 exposure events/outbreaks in Mental Health and Addiction residential facilities within ADHB since the start of the Omicron outbreak at the beginning of February. These have all been well managed by the NGOs responsible. Twice weekly forum have been set up with Northern Region NGOs to provide support and advice during the Omicron surge. Planning and Funding has also participated in the Mental Health and Addictions daily Regional Response Group meetings with the provider arms, NRA and NGO representatives to ensure a coordinated response to the outbreak.

6. Pacific Health Gain

The current focus is to encourage uptake by Pacific communities of the Covid vaccination boosters and vaccinations for children aged between 5-11years. To date the number of boosters and paediatric vaccinations is steadily increasing across the Auckland DHB area. However, to bolster the vaccination uptake, the Tongan Health Society is setting up short term vaccination sites in the community (Pop up events), an approach that was started last year. The short-term vaccination sites provide a range of settings that are culturally appropriate and accessible for Pacific communities, such as churches, community halls, and at cultural events. Between January 2022 – March 2022 the

Tongan Health Society delivered 4 Pop up sites targeting Pacific communities across metro Auckland. Two events were delivered in ADHB. Approximately more than 2000 people were vaccinated across these events.

Pacific Community Leadership Forums (Pacific ethnic specific groups –Samoa, Tonga and Cook Islands) have been established by Alliance Health Plus. Discussions are taking place to establish a combined appropriate forum for other Pacific nations including, Niue, Tokelau, Tuvalu, Kiribati and Rotuma, Fiji. The forums provide a way to engage with diverse Pacific communities quickly and efficiently about Covid response activities, information and the promotion of available resources.

Pacific Navigators are working with and amongst Pacific communities. The navigators are connectors providing communities with COVID-19 information, resources, education, linking people to welfare support and providing overall support to access COVID-19 vaccinations. The Pacific Navigators are working across the metro Auckland area which provides a regional platform to discuss current insights, convey consistent COVID-19 messages and implement similar engagement approaches when appropriate.

The Tongan Health Society is operating a Pacific Outreach Mobile health service in the ADHB area. The service provides additional focused capacity in the community to ensure COVID-19 cases are rapidly identified and managed appropriately to reduce the risk of Pacific community transmission. It also deploys primary health services to Pacific people who have an identified clinical need and who may not otherwise access primary care services.

Etu Pasifika Auckland formerly known as Mt Wellington Integrated Healthcare is delivering Whanau HQ services (COVID Care in the Community) to Pacific families in ADHB. The service is led by Pacific clinicians who work with whānau to complete a comprehensive household and detailed patient assessment. The service provides on-going engagement and monitoring and links whānau to existing social services where necessary.

7. Māori Health Pipeline

The Pipeline is one of the three prioritised areas of focus for Kōtui Hauora. The Pipeline is currently expanding in terms of project scale and staff.

7.1 Te Oranga Pūkahukahu Lung Cancer Screening Research Programme

This collaborative research programme is led by Professor Dr Sue Crengle (Waitaha, Kāti Mamoe and Kāi Tahu) with the Pipeline team; with HRC research funding.[1] In late 2021 a first offer of screening to DHB kaumatua roopu and whānau members was made via Dame Naida Glavish and the same offer was extended to Te Ha Kōtahi the Consumer Advisory Group.

Videos with Te Ha Kōtahi talking about their perspectives on screening have been loaded on the website: https://www.waitematadhb.govt.nz/healthy-living/te-oranga-pukahukahu-lung-health-check/

In December 2021 recruitment of participants into the invitation trial commenced, with two practices randomised. The research nurses report that participants are enthusiastic to talk about screening, and are keen to get to booking a CT scan. More than 30 scans have been completed so far.

The Lung Cancer Multidisciplinary Meeting (MDM) reported back to the team last week that they had seen the first ever 'screen detected' lung cancer come through the MDM, and how important a milestone they felt this was for the country.

The COPD and the biomarker components of the study are being submitted for ethical approval and participants will be offered participation in these components also. The team are working with the MMR programme to look at a mobile van to undertake a component of the COPD study, as spirometry (a breath test) is considered an aerosol generating procedure currently unable to be performed in the clinic rooms due to COVID restrictions, whereas a mobile van with a filter and ventilation make this possible. There remain challenges with recruiting general practices due to Omicron COVID impacts, however the team continues to work closely with practices to support involvement as soon as practical.

7.2 Abdominal Aortic Aneurysm and Atrial Fibrillation (AAA/AF) Screening

This programme is being extended to Northland DHB, as requested by Kōtui Hauora. An HRC DHB activation grant was successful for a project to be undertaken in parallel with Northland DHB pilot sites, this grant commenced in March. Two Northland based project members and a second AAA screener will soon join the team to progress the pilot sites depending on provider capacity after the Northland COVID peak.

The Pacific men AAA/AF programme is complete, with the team now extending the offer to Pacific women.

7.3 HPV Self-Testing Implementation Studies

Waitematā DHB and Auckland DHB have had a research programme for HPV self-testing for cervical screening since 2016. The new implementation research programme intends to focus on specific areas relevant to the national implementation of HPV primary cervical screening planned for 2023. Four interlinked studies are included. A small proof-of-concept study testing the acceptability of offer of a self-testing during the August Delta COVID-19 lockdown was completed in one suburb. This was very successful with an initial text offer followed by a single round of active follow up (text and phone call). Contactless delivery and pick up was feasible and feedback from women was universally positive. Subsequently recruitment for the main study, offering opportunistic offer of a self-test in a primary care clinic, commenced in November 2021 with more than 220 tests undertaken through

[1] Health Research Council (HRC) Global Alliance of Chronic Disease funding, HRC project grant funding for COPD, and most recently the funding for the Equitable Outcomes in Cancer partnership grant between HRC, Te Aho o te Kahu and the Ministry of Health.

two clinics so far, a third clinics is being trained at present. The telehealth phase of the study (contact and coordination centre) is currently being established.

Although not directly under the HPV self-testing programme, the Pipeline has supported a survey of Māori women's experience of colposcopy services. This is a repeat of a previous 2016 survey which reported very positive experience. Results are just being finalised, overall they show good news with the maintenance of positive experience.

7.4 Hepatitis C

This project involved appropriate data matching to enable the re-offer of treatment[2] to those with known Hepatitis C who have no record of receiving treatment, prioritising Māori. The project has worked through COVID to contact 263 non-PHO enrolled people and 117 PHO enrolled people so far, and has undertaken a further data match to identify and address key data errors in the MoH dataset. This is now finalised and audited, and the project will recommence to complete the work.

A service user evaluation for Māori patients who have been treated for Hepatitis C have also been completed, in parallel, led by Pharmacist Dr Jo Hikaka (Ngāruahine). A paper has been submitted to the New Zealand Medical Journal. Findings can be used to enhance the development of further Hepatitis C treatment services, based on Māori experiences of treatment and self-identified solutions for improvement in hepatitis C care.

[2] Currently Māori have a higher burden of infection than non-Māori with more significant complications and poorer outcomes. It is estimated that approximately 50-60% of people with Hep C are not aware that they have the disease. Maviret, the Hepatitis C treatment, has > 95% cure rate with a new short 8 week oral course. Treatment prevents cirrhosis, liver cancer and premature death from liver disease.

Decision Paper
Director Appointment to the HealthSource New Zealand Limited Board

MARCH 2022

8.1

Recommendation

That the Board

(a) **Note** the requirement to appoint a new shareholder director to HealthSource New Zealand Limited, in place of Justine White.

(b) **Resolve** Auxilia Nyangoni (ADHB Acting CFO) is appointed as the Auckland DHB shareholder director of HealthSource New Zealand Limited and the company be notified accordingly.

(c) **Delegate** authority to the Auckland DHB Chair to execute all documentation necessary to formalise this appointment.

Prepared by:	George Smith, GM Corporate Services Richard Aldous, CEO HealthSource
Reviewed by:	Justine White, CFO ADHB Ailsa Claire, CEO ADHB

1. Background

Auxilia Nyangoni (ADHB Acting CFO) is the nominated replacement for Justine White who has resigned from the HealthSource New Zealand Limited (HealthSource) Board by virtue of her resignation from Auckland DHB.

The HealthSource Constitution provides that shareholder DHBs each appoint one shareholder director by notice in writing to the company.

2. HealthSource Board Composition

The HealthSource Board composition, following approval of this recommendation, is set out below:

	HealthSource Board of Directors
Independent directors	• Paul Harper (Chair)
Shareholder directors	• Andrew Brant (WDHB Deputy CEO), with Robert Paine (WDHB CFO) as Alternate Director • Michael Kelly (NDHB CFO) • *Auxilia Nyangoni (ADHB Acting CFO) – proposed director* • Margaret White (CMH CFO)

3. Next steps:

The next steps are:

1. Notify HealthSource of the appointment (Notice of Appointment at **Appendix 1**); and
2. HealthSource Management to complete registration with the Companies Office.

NOTICE OF APPOINTMENT OF DIRECTOR

TO: HealthSource New Zealand Limited (**Company**)
585 Great South Road
Penrose
Auckland

Notice is hereby given by the Shareholders pursuant to the Company's constitution that the following person be appointed as a director with effect from 30 March 2022.

1. Auxilia Nyangoni

DATED _____ 2022

SIGNED on behalf of Auckland District Health Board by:

_____
Signature of authorised signatory

_____
Name of authorised signatory

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
2.0 Conflicts of Interest	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3.0 Confirmation of Confidential Minutes of the Board – 23 February 2022	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3.1 Circulated Resolution – Auckland District Health Board – Facilities Infrastructure Remediation Programme Variance Request to CIC – 17 March 2022	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3.1 Circulated Resolution – NRHCC Whanau HQ Budget Addendum for Metro DHB Board Approval – 30 March 2022	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4.0 Action Points- Nil	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for

		withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Risk Management Update	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 Chief Executives Confidential Verbal Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 Human Resources Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.1 Finance, Risk & Assurance Committee l Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.2 Hospital Advisory Committee Executive	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for

Report	disadvantaged if that information was 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]
9.1 Capex Variation Whanau Room Rejuvenation Project and Starship L5 Refurbishment	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
10.0 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]