BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Board Meeting
Agenda

Wednesday, 21 October 2020
10.00 am

Please note Board Only Time 9.00 am

Venue: Conference Hall, Clinical School, Whakatane Hospital

Hauora a Toi | Our Priorities 2020-2021

Healthy, thriving communities – Kia Momoho Te Hāpori Oranga

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

A connected system

Moving care into the community

Partnering in localities

Health in all policies

Organising for the future

Transformations

Integrated healthcare

Mental health & addictions

Child wellbeing

Connecting with our communities

Equitable healthcare

Systematic addressing of inequalities

Empowering the Eastern Bay

Enacting Te Toi Ahorangi in the design and delivery of care

TE TOI AHORANGI

2030 TOI ORA STRATEGY

Transformations

Growing as Te Tiriti partners

Evolving the Eastern Bay health network

Delivering improvement against equity KPIs

Healthy, thriving workforce

Enhancing physical and psychological safety

Addressing injustice and discrimination

Evolving the new world of work

Transformations

Leadership Development

Restorative Resolution

Union partnerships

Role clarity

Reducing Bureaucracy

Sharing Information

Safe and compassionate care

Robust clinical governance and continuous improvement

Recognising the mana of each unique individual

The Quality Safety Markers

Falls

Healthcare associated

Infections

Hand hygiene

Surgical site infection

Safe surgery

Medication safety

Transformations

Culturally safe quality management

Intelligent quality monitoring & improvement

Choosing wisely

Person & Whanau-centred systems

Item No.	Item	Page
1	**Karakia** Tēnei te ara ki Ranginui Tēnei te ara ki Papatūānuku Tēnei te ara ki Ranginui rāua ko Papatūānuku, Nā rāua ngā tapuae o Tānemahuta ki raro Haere te awatea ka huri atu ki te pō (te pō ko tenei te awatea) Whano whano! Haere mai te toki! Haumi ē, hui ē, tāiki ē! This is the path to Ranginui This is the path to Papatūānuku This is the path to the union of Ranginui and Papatūānuku From them both progress the footsteps of Tānemahuta [humanity] below Moving from birth and in time carries us to death (and from death is this, birth) Go forth, go forth! Forge a path with the sacred axe! We are bound together!	
2	**Presentation** 2.1 Disability Strategy - 10.10 am Rachel Noble, Capital and Coast DHB	
3	**Apologies**	
4	**Interests Register**	**5**
5	**Minutes** 5.1 Board Meeting – 23.9.20 Matters Arising 5.2 CPHAC/DSAC Meeting - 7.10.20	**10** **20**
6	**Items for Decision** 6.1 BOPDHB Board Code of Conduct	**26**

Item No.	Item	Page
7	**Items for Discussion** 7.1 Health and Safety Strategy Update 7.2 Chief Executive's Report 7.3 Dashboard Report (to be circulated)	 **35** **41**
8	**Items for Noting** 8.1 Correspondence for Noting • Copy of a letter to Dr Hugh Lees from the Safe Staffing Healthy Workplace (SSHW) Governance Group, 13 October 2020 8.2 Board Work Plan 2020	 **83** **85**
9	**General Business**	
10	**Resolution to Exclude the Public** Pursuant to clause 33(3) of the NZ Public Health & Disability Act 2000 Mr Pouroto Ngaropo who is the Chair of the Maori Health Runanga is permitted to remain after the public have been excluded because of his knowledge of the aspirations of Maori in the Bay of Plenty that is relevant to all matters taken with the public excluded. Pursuant to clause 33(5) of the NZ Public Health & Disability Act 2000 Mr Pouroto Ngaropo must not disclose to anyone not present at the meeting while the public is excluded, any information he becomes aware of only at the meeting while the public is excluded and he is present.	
11	**Next Meeting** – Wednesday 18 November 2020.	

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

Bay of Plenty District Health Board
Board Members Interests Register

(Last updated September 2020)

INTEREST	NATURE OF INTEREST	CORE BUSINESS	RISK OF CONFLICT	DATE OF INTEREST
AHOMIRO, Hori				
Tapuika Int Authority	Board Director	Fisheries Trust	LOW	22/10//19
BOP ANZASW Branch	Member & Kaumatua	Executive Leadership	LOW	22/10/19
NZ Social Work Registration Board	Board Member	Social Workers Registration	LOW	May 2020
ARUNDEL, Mark				
Pharmaceutical Society of New Zealand	Member	Professional Body	NIL	1980
Armey Family Trust	Trustee	Family Trust	NIL	28/07/2005
Markand Holdings Ltd	Director	Property	NIL	2016
TECT	Trustee	Community Trust	LOW	July 2018
EDLIN, Bev				
Magic Netball/Waikato BOP Netball	Board Chair	Sports Administration	LOW	Member since March 2015/ Chair Sept 2017
Valeo International Limited	Co-owner/director	Education	LOW	20/12/2007
Governance NZ	Fellow	Governance	LOW	2011
Boardroom360 Limited	Co-owner/director	Education – Governance	LOW	10/3/2011
Edlin Enterprises Limited	Owner/director	Business Consultancy	LOW	17/03/1987
Alleyne Trust	Trustee	Family Trust	LOW	
Phae – non trading	Director	Education	LOW	07/12/2005
NJ Family Trust	Trustee	Trustee	LOW	
Tauranga City Council	Licensing Commissioner	Local Authority	LOW	16/01/2018
Park2Park Trust	Trustee	Community Artworks	NIL	18/09/2018
Omanawa Hidden Gorge Charitable Trust	Chair	Environmental / eco-tourism Venture	LOW	December 2018
Western Bay of Plenty District Council	Licensing Commissioner / Chairperson	Local Authority	LOW	February 2019
Institute of Directors	Fellow	Professional Body	LOW	June 2019

INTEREST	NATURE OF INTEREST	CORE BUSINESS	RISK OF CONFLICT	DATE OF INTEREST
ESTERMAN, Geoff				
Gate Pa Medical Centre Ltd	Director, Manager & GP	Health	LOW – DHB does not contract directly with General Practices and as a Board Member Geoff is not in a position to influence contracts.	28/11/2013
Gate Pa Medical Centre Ltd	Practice Manager is on WBOP PHO Board	Health	NIL	December 2019
GM and P Esterman Family Trust	Trustee	Family Trust (kiwifruit)	NIL	28/11/2013
Whakatohea Health Services	Wife Penny works part-time as Nurse	Health Services Provider	Contracts to DHB LOW	Sept 2019
FINCH, IAN				
Visique Whakatane	Director	Optometry	LOW	1/11/19
Vic Davis trust	trustee	Grants for mental illness research	LOW - DHB employee may be applicant/recipient of grants	1/9/20
BOPDHB	Midwifery – casual contract	health	Moderate	1/9/20
GUY, Marion				
Chadwick Healthcare	Casual Employee	Health	NIL	06/1996
Bay of Plenty District Health Board	Employee	Health	LOW	03/10/2016
NZNO	Honorary and Life Member	Nursing Union	LOW	
NGAROPO, Pouroto				
BOP Maori Health Runanga	Chair	DHB BHealth Partner	LOW	2018
BOP Maori Health Runanga	Member	DHB Health Partner	LOW	25/02/2005
Te Rūnanga of Ngati Awa	Deputy Chairman		NIL	1990

Te Tohu o Te Ora o Ngāti Awa	Cultural Adviser		NIL	2007
Mental Health Awareness	Trustee	Supporting families	NIL	2010
Pou Whakaaro Trustee	Trustee		NIL	2001
Golden Pond	Cultural Advisor		NIL	2009
Tūtei o Te Hau-a-kiwa	Trustee		NIL	2010
Te Kupenga-a-Irakewa	Chairman Kaumatua Council		NIL	2000
Whakatane District Council	Director	Waters Plains Committee	NIL	2004
Whakatane District Council	Director	Museum & Gallery Board	NIL	2000
Whakatane District Council	Cultural Advisor		NIL	2001
Iramoko Marae Matata	Chairman		NIL	1999
Mary Shapely Old People's Home	Cultural Advisor		NIL	2009
Ngāti Awa Research & Archives Trust	Trustee		NIL	2000
Ngāti Awa Whakapapa Committee	Trustee		NIL	2000
James Street School	Cultural Advisor		NIL	2010
Apanui School	Cultural Advisor		NIL	2006
Pāroa School	Cultural Advisor		NIL	2009
Te Umuhika Lands Trust	Trustee		NIL	2001
Pōkerekere Lands Trust	Chairman		NIL	2002
Te Awakaponga Urupa	Trustee		NIL	2004
Joint Advisory Committee	Deputy Chairman		NIL	2010
Te Ramaapakura Trust	Chairman		NIL	2003
Regional Iwi Relationship Board	BOP Representation		NIL	2010
Resource Disability Centre	Cultural Advisor		NIL	2010
Sun FM 96.9	Cultural Advisor		NIL	2010
IXX Radio Station 2008	Cultural Advisor		NIL	2008
Shea Pita & Associates	Cultural Advisor sub-contract	Sub-contracting to Shea Pita & Associates for MOH evaluation	LOW	Aug '20
SCOTT, Ron				
Stellaris Ltd and Stellaris PTE Ltd	Director	Business Education and Training organisation	LOW	2005

SILC Charitable Trust	Chair	Disabled Care	Low – As a Board Member Ron is not it the position to influence funding decisions.	July 2013
AA Bay of Plenty District Council	Council Member	Transport and Road Safety	LOW	March 2018
Establishment Board of Trustees – Suzanne Aubert Catholic School, Papamoa	Member	Education	NIL	March 2020
SHEA, Sharon				
Shea Pita & Associates Ltd	Director & Principal	Consulting	LOW	18/12/2019
Manawaroa Ltd	Director & Principal	Service Provider	LOW	18/12/2019
MAS Foundation	Board Member	Philanthropic Funder	LOW	18/12/2019
HealthShare	Consultant	Strategy	MEDIUM	18/12/2019
Maori Expert Advisory Group (MEAG)	Former Chair	Health & Disability System Review	LOW	18/12/2019
Iwi	Whakapapa		LOW	
A Better Start – E Tipu E Rea	Board Member	National Science Challenge – Auckland University	LOW	6/3/2020
EY - Department of Corrections Project	Member	Consulting - Corrections	LOW	April 2020
Interim Mental Health Commission	Consultant	Mental Health Outcomes Framework	LOW	May 2020
ACC	Consultant	Accident Compensation Commission	LOW	May 2020
Wai 2575 Claimants	Consultant	contracted via the National Hauora Coalition to support Wai 2575 claimants cost historic underfunding of Māori PHOs. Short-term project.	LOW	August 2020
Tairawhiti DHB	Consultant	support to facilitate service design and development hui linked to mental health and addictions sector. Short-term project.	LOW	August 2020
Ministry of Health	Consultant	National Evaluation of Breast and Cervical Screening Support	LOW	August 2020

		Services *Note:* BOP Maori Health Runanga Chair sub-contracting to Shea Pita & Associates for MOH Evaluation, as a Cultural Advisor		
Alliance Plus Health PHO - Pan Pacific Resilience Model	Consultant	Health	LOW	27/08/2020
Husband – Morris Pita - Health Care Applications Ltd - Shea Pita & Associates Ltd	CEO Director	Health IT Consulting	LOW LOW	18/12/2019 18/12/2019
SIMPSON, Leonie				
Te Runanga o Ngati Awa	Chief Executive	Iwi Entity	LOW	23/12/2019
Toi Ohomai	Kahui Matahanga Member	Iwi representation	LOW	23/12/2019
TUORO, Arihia				
Whakatohea Mussels	Director	Mussel Farming	LOW	15/12/2019
Poutama Trust	Trustee	Maori Economic Development	LOW	15/12/2019
Kaikou Gold Kiwifruit	Director	Kiwifruit	LOW	15/12/2019
Waikeke Farms Ltd	Director	Dairy Farm	LOW	15/12/2019
Oranga Marae Lotteries	Committee Member	Lotteries	LOW	15/12/2019
Toi EDA	Committee Member	Eastern bay Economic Dev	LOW	15/12/2019
Lotteries Americas Cup	Committee Member	Lotteries	LOW	15/12/2019
Whakatohea Pre Settlement Claims Trust	Project Manager	Negotiate Whakatohea Settlement	LOW	15/12/2019
HUDSON, Mariana (Board Observer)				
The Maori Pharmacists Association (MPA)	Vice-President	Pharmacy	LOW	26/08/2020
VALEUAGA, Natu (Board Observer)				
Pacific Island Community Trust	Board Member	Community Work	LOW	31/08/2020

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Minutes

Bay of Plenty District Health Board

Kahakaharoa Room, The Whare Whakamana 17th Ave, Tauranga

Date: Wednesday 23 September 2020, 10.00 am

Board: Sharon Shea (Interim Chair), Ron Scott, Hori Ahomiro, Mark Arundel, Bev Edlin, Geoff Esterman, Ian Finch, Arihia Tuoro, Annabel Davies, Mariana Hudson, Natu Vaeluaga (Seat at the Table observers),

Attendees: Pete Chandler (Chief Executive), Bronwyn Anstis (Acting Chief Operating Officer), Owen Wallace (GM Corporate Services), Mike Agnew (Acting GM Planning & Funding and Population Health), Julie Robinson (Director of Nursing), Jeff Hodson (GM Facilities & Business Operations), Sarah Mitchell (Exec Dir Allied Health Scientific & Technical), Debbie Brown (Senior Advisor Governance & Quality), Marama Tauranga (Manukura, Maori Health Gains & Development), Lisa Murphy (Health Consumer Council)

Public Attendee: L Tebutt (BOP Times)

Item No.	Item	Action
1	**Karakia** The meeting was opened with a Karakia. The two new Seat at the Table Observers were welcomed	
2	**Presentation** 2.1 <u>Sustainability Strategy</u> Vicktoria Blake, Sustainability Manager There are a number of pieces of legislation that move towards sustainability. The Minister's expectation is that there will be 50% carbon reduction by 2030. The recent Health and Disability review acknowledges climate change as a significant risk to health. MOH is beginning work into climate change adaptation. Benchmarking with other DHBs is occurring towards measuring the health system's environmental impact and BOPDHB is currently sitting a mid-range. Exec Committee has endorsed the Sustainability (Kaitiakitanga) Framework. Environment is the most important factor. The framework needs to be viewed in a holistic manner. Kaitiakitanga has 8 Principles. Sustainability sits under Wai Ora within Te Toi Ahorangi (TTA) The framework means BOPDHB will show internal and external leadership in Sustainability. There is an Action Plan which has 10 priorities. It is currently focussed on waste, transport, travel, and procurement with embedded leadership and accountability. Good progress has been made in the last 12-18 months. There are some current major projects underway.	

Item No.	Item	Action
	COVID has had a huge impact on the organisation, however it does bring opportunities, especially in the community eg telehealth and flexible working. Our footprint would be reduced by 57% with an active transport model. Queries were raised with regard to: • *Travel*. How would telehealth impact on that? If 30% of outpatient appointments moved to telehealth, it would reduce the footprint. Staff not having to travel for work would also mean a reduction in the footprint along with other considerations. • *Prioritisation and Targeting*. There is an Action Plan included which gives 10 priorities. This will be broken down. • *Sustainability Expense.* 93% staff support a Sustainability Strategy. Given the support is there any sense of pushback within any of the groups involved given that these people do other things as well. Do we measure time undertaken with Sustainability as an expense to the organisation? The work is being done very efficiently with minimal face to face meeting time. There are 10 staff fully engaged in progressing Sustainability. The green teams meet for 2 hours every month. Other communication is via email. • *Procurement.* Where does it fit with regard to renewable energy? As a full DHB overview we have the Tier 1 health sector. Is there engagement with those other than providers? It is currently provider centric. Once there are initiatives working well, there will be good messages to share with other groups. • *Highest User, Natural Gas and Electricity.* The highest user in the energy field is not indicated as a priority. Energy is an absolute priority. The organisation is engaging with EECA to look at how we use energy across the sites and looking at assets as they are retired to make informed decisions for replacement. Significant capital investment is required. It is considered in relation to the Steering Group that there needs to be input from the community and also Maori and Pacifica further down the track. The Board thanked the Sustainability Manager for her informative presentation and for her enthusiasm. Through the CEO the Board will be interested in reviewing progress. **Resolved** that the Board endorses the Kaitiakitanga Sustainability Strategy Moved: B Edlin Seconded: H Ahomiro	
3	**Apologies** Apologies were received from Marion Guy, Leonie Simpson and Pourotu Ngaropo **Resolved** that the apologies from M Guy, L Simpson and P Ngaropo be received Moved: M Arundel Seconded: R Scott	

Item No.	Item	Action
4	**Interests Register** Board Members were asked if there were any changes to the Register or conflicts with the agenda. No changes or conflicts were advised.	
5	**Minutes** 5.1 Minutes of Board meeting – 19.8.20 **Resolved** that with the Board receive the minutes of the meeting held on 19 August 2020 and confirm as a true and correct record. Moved: A Tuoro Seconded: M Arundel 5.2 Matters Arising All Matters Arising were in progress or completed 5.3 BOPHAC Meeting 2.9.20 The Committee Chair advised of key points: • ICU was stressed but being addressed • COTS is going well • Pharmacy strikes • BOPDHB had received outstanding ratings for CCDM The Board received the Minutes of the meeting held on 2 September 2020.	
6	**Items for Decision** 6.1 Position Statement on Te Tiriti o Waitangi, Health Equity and Racism The paper was taken as read It was considered there were three issues that needed to be separated out with regard to BOPDHB's position. MHGD had debated having 3 separate position statements however with debate and due diligence, together with discussions that had been had with others and Public Health, there was clear rationale for one position statement. There is a disconnect in separation but momentum in one position. The opportunity of implementing the three different views is not lost with one position statement. Te Toi Ahorangi (TTA) is woven into the document. Strong policies will be developed going forward aligning the position statement and what occurs at the grass roots. It was considered that racism covers many different ethnicities. The position keeps a focus on responsibility to the Tiriti however the position has a flow on effect – a culture change. Operationalising will enable the position to be wider encompassed. TTA has many statements. He Whakaputanga relates to others. Some specific queries had been circulated prior to the meeting: • There needs to be alignment with the number of Te Tiriti articles the organisation accepts. In Governance, papers 1-3 have been accepted. The position statement covers 1-4. Governance may need to be aligned. • Direct relationship with iwi and hapu. There hasn't been a discussion with the Board in that regard. The position proposes a relationship and direct engagement with individual hapu, iwi.	

Item No.	Item	Action
	Is this practical, how do we resource, or is it through the Runanga. The position statement should not go into operational aspects. There should a revised governance level position and another to operationalise. The paper has been written from a Tangata Tiriti and Tangata Whenua perspective however there is an obligation for whole of population wellbeing. The supporting information is valuable and should be linked. The revised paper should reflect that and be short, sharp and to the point. The Board notes the paper and supports the direction. An amended paper to be circulated and discussed via Zoom prior to next Board Meeting. If it is considered the paper should come back to the Board thereafter, it will be submitted to next Board meeting.	Manukura
7	**Items for Discussion** 7.1 <u>Inquiry into Health Inequities for Maori</u> The paper was compiled in response to a Board request regarding the Maori Affairs Select Committee paper. The paper has been considered and compared to what is happening in the BOPDHB environment. It aligns with the Te Manawa Taki Equity Plan. Board Chair declared her conflict of interest with the work she is undertaking for MOH. Attention was drawn to the table at the back of the paper and the column to advise best lead. CEO considered the organisation should challenge itself on the table and the responsibility as to where lead sits. For Bowel Screening, as go live is impending, further discussion should occur with regard to local drive and initiatives. Point 17 advises that health workers be annually assessed for cultural safety training to retain a medical practicing certificate. It is suggested that people may become overburdened with training if required on an annual basis. The Board noted the paper 7.2 <u>Indicators of District Health Board performance (IDP) Quarter Four Summary</u> CEO advised that last quarter's data was fascinating in COVID times. Over the next year a different lens for improvement in performance is likely to be applied. BOPDHB is looking forward to MOH steer on the post COVID environment. There is space to think about from the long lists of things we measure, what are the things that triangulate to where improvement should be applied, aligned to equity and other important issues. Application to what can be easily achieved is an important aspect. Query was raised as to what capacity can be had locally under current COVID level to determine what current priorities are. It is considered this will probably be clearer post election. The Board noted the paper	

Item No.	Item	Action
	7.3 Chief Executive's Report The CEO advised that the report is compiled in line with the Board's desire for different or improved Board papers. Feedback is requested. It is considered papers should align with strategic goals at Board level. The Chief Executive highlighted: The current big focus under COVID is the Port testing. There has been tremendous work in collaboration with WBOPHO and operationalisation from Ngati Ranginui. The work will be ongoing for quite some time The Comms report on social media indicates what the public is interested in. The financial position in Month 2 saw a shift as it requires separation out of COVID costs. We are awaiting from MOH a Letter of Comfort relative to COVID and the Port Testing. It is expected imminently. Query was raised on Disability Support Services costs. ARC costs indicate a significant increase over the last few months which was not expected and is being reviewed. Transformational activity is included in the report which is important going forward. Health and Safety has a new focus with the new Health and Safety Manager. There is a partnership being formed with WorkSafe. There is a strategic plan for the next 12 months being developed which will come to the Board soon. Health Consumer Council (HCC) rep advised that HCC have completed updated Terms of Reference (TOR). HCC is available to participate in more co-design projects. Board Members conveyed that the HCC's voice is welcomed at the table. Query was raised with regard to indication that Toi Te Ora (TTO) reduced BAU work over the COVID period and whether that is of concern. The Team at TTO have prioritised workload really well however with COVID efforts some Business as Usual (BAU) has had to be set aside. TTO is actively recruiting into the required COVID spaces which will free up return to BAU. Mandatory responsibilities are being maintained. With regard to ESPIs, there are three specialties that are currently not compliant for ESPIs. There is good progress being made. There has been some increased outsource to assist. It is considered it will take 18 months to reach compliance following COVID. The pressure is in wait times which is a focus for the team. A request was made for those waiting to be represented as a percentage. It is considered the report is hospital centric and it would be interesting to know of whole of system approach and data. Where does the barrier lie. The Power BI displayed this morning will give a better view. Query was raised on MICAMHS move and whether that had proved positive. It has addressed space constraints and paved the way for a better model, with better connections to eg Paediatrics. The Child Service space is going very well.	GMCS COO

Item No.	Item	Action
	An update will come to the Board. There is a bigger opportunity than envisaged initially. **Resolved** that the Board receive the report Moved: R Scott Seconded: A Tuoro 7.4 Primary Care Overview The Board noted the paper 7.5 Dashboard Report Jerome Ng in attendance The content of the report illustrates the framework and the need to bring together the groups and measures that currently exist. It displays what has been developed, partially developed and those areas which need new KPIs based on strategies. The test model is the start of the journey. Power BI is a tool to visualise data. The ability to tap into iwi data has been a discussion point nationally. What is currently reported was the starting point for the new framework. Where we need to progress are the operational processes, Care Process, Our People, Financial, Hospital Care, Primary care and Community Care. The Board indicators have been simplified and are shown in red and green. Query was raised with regard to the absence of orange. It is important to know which are close to either red or green. Decision on red /green or traffic light red/orange/green needs to be made going forward. Query was raised as to whether there are filters within the live dashboard to be able to slice and dice. The dashboard includes the data we have access to. Trying to leverage other information is a view going forward eg New Zealand Health Survey Data. Queries were raised: • As to how to connect things eg financial, fiscal, operational, to be able to gauge cost savings or effectiveness of initiatives. There is a data technical component and then there is consideration as to what you do with the data. • As to whether PHO Data is included. It is considered BOPDHB has more PHO information than other DHBs. PHO representatives are included in the process. • With regard to data sovereignty and non-breach. BOPDHB purchases through PHOs. Is that captured? Information comes in through Planning & Funding however does need to be extracted. It is considered the process could be used for data collection on other areas, eg lifecurve, whanau data. The Board considered the opportunity to be able to incorporate better data and means of reviewing was exciting. The community and client voice is important. HCC advised that HCC has a rep on the Clinical Governance Committee, however filtering down of data would also be helpful to the HCC. The Board thanked Jerome for the informative presentation.	CEO

Item No.	Item	Action
8	**Items for Noting** 8.1 Te Toi Ahorangi Action Plan and Investment / Annual Plan Alignment Update The paper is in response to queries from the last Joint Board Meeting. The budget that has been afforded to TTA is included. The connection points for the Equity Plan and how that connects with TTA is also addressed within the paper. The key focus is to work with the Board and Runanga. Internally there is a Toi Ora workshop series for people to become Toi Ora change leaders. MHGD is continuing to support the balanced scorecard. There will be incremental improvement in target areas. The big shifts will take a little longer. 8.2 Board Work Plan 2020 The Board noted the reports	
9	**General Business** There was no General Business	
10	**Resolution to Exclude the Public** **Resolved** that Pursuant to S9 of the Official Information Act 1982 and Schedule 3, Clause 33 of the New Zealand Health and Disability Act 2000 the public be excluded from the following portions of the meeting because public release of the contents of the reports is likely to affect the privacy of a natural person or unreasonably prejudice the commercial position of the organisation: Confidential Minutes of last meeting: Board Minutes FARM Meeting - 2.9.20 BOPHAC Meeting - 2.9.20 IWI MOU Briefing Confident Disability Employer Capex Risks Update MCP Hybrid Workshop COVID-19 Recovery Dashboard Board Strategic Plan Outline That the following persons be permitted to remain at this meeting, after the public have been excluded, because of their knowledge as to organisational matters or for the purpose of legal records. This knowledge will be of assistance in relation to the matter to be discussed: Pete Chandler Owen Wallace Mike Agnew Debbie Brown Julie Robinson Jeff Hodson Marama Tauranga Sarah Mitchell **Resolved** that the Board move into confidential.	

Item No.	Item	Action
	Moved: B Edlin Seconded: I Finch	
11	**Next Meeting –** Wednesday 21 October 2020	

The open section of the meeting closed at 12.00 pm

The minutes will be confirmed as a true and correct record at the next meeting.

RUNNING LIST OF ACTIONS

Key	Completed on time	Work in progress, to be completed on time	Not completed within timeframe

	Task	Who	By When	Status	Response
15.1.20 Item 5.2	**Chief Executive's Report – Clinical School** CEO advised that it would be good for the Head of Clinical School, Prof Peter Gilling to meet with the Board at a future meeting. One of the Clinical School's priorities was to give students an experience that made them want to work for BOPDHB. – Board Secretariat	HOCS	Nov		Scheduled for Nov Face to Face Board.
19.8.20 Item 7.1	**Chief Executive's Report – HQSC Certification Audit** A report will come to the Board in September.	SAGQ	Sept		In progress – report due from HQSC October Preliminary Results on Board Agenda October - Completed
23.9.20 Item 6.1	**Position Statement on Te Tiriti o Waitangi, Health Equity and Racism** The Board notes the paper and supports the direction. An amended paper to be circulated and discussed via Zoom prior to next Board Meeting. If it is considered the paper should come back to the Board thereafter, it will be submitted to next Board meeting.	Manukura	Oct		Next version progressing to Runanga meeting 14.10.20
23.9.20 Item 7.3	**CEO report – Health and Safety** There is a strategic plan for the next 12 months being developed which will come to the Board soon.	GMCS	Oct		Update to Board – October – Completed
23.9.20 Item 7.3	**CEO report – ESPIs** A request was made for those waiting to be represented as a percentage.	COO	Oct		

	Task	Who	By When	Status	Response
23.9.20 Item 7.3	**MICAMHS** The Child Service space is going very well. An update will come to the Board. There is a bigger opportunity than envisaged initially.	CEO	Oct		Update in CEO's Report to Board 21.10.20 – Completed

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

CPHAC/DSAC COMMITTEE
MINUTES 7.10.20

SUBMITTED TO:

Board Meeting 21 October 2020

Prepared and
Submitted by: Arihia Tuoro, Chair, CPHAC/DSAC Committee

☐ **For Decision** √ **For Discussion** √ **For Noting**

RECOMMENDATION:
That the Board received the minutes of the CPHAC/DSAC meeting held on 7 October 2020

ATTACHMENTS:
CPHAC/DSAC Committee Minutes 7 October 2020.

KEY POINTS:

1. Received Integrated Care / SHSP Enablers Update –progress ,issues ,opportunities
   - Community Care Coordination
   - Keeping me well
   - Information Systems to enable Integrated Care
   - Pilot Community Orthopaedic Triage Services
   - Telehealth

   Committee Query – whose roll is it to advocate / lobby for connectivity ?

2. Received PHO – Healthcare Homes Update –progress , issues ,opportunities

3. Papers for noting only
   - Mental Health and Addictions Transformation Update
   - Toi Te Ora Update

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Minutes

Bay of Plenty Combined Community & Public Health Advisory Committee/ Disability Services Advisory Committee Meeting

Venue: Daniels in the Park, 53 11th Avenue, Tauranga
Date and Time: 7 October at 10.30 am

Board: Arihia Tuoro (Chair), Hori Ahomiro, Mark Arundel, Bev Edlin, Ian Finch, Natu Vaeluaga, Punohu McCausland (Runanga Rep), Lindsey Webber (PHO Rep),

Attendees: Pete Chandler (Chief Executive), Mike Agnew (Acting GM Planning & Funding and Population Health), Hugh Lees (Chief Medical Advisor), Sarah Mitchell (Executive Director, Allied Health Scientific and Technical), Janet Hanvey (Business Leader, Toi Te Ora)

Item No.	Item	Action
	Karakia	
1	**Presentation** Nil	
2	**Apologies** Apologies were received from Sharon Shea, Paul Curry and Rob VIgor-Brown **Resolved** that the apologies from S Shea, P Curry and R Vigor-Brown be received Moved: B Edlin Seconded: I Finch	
3	**Interests Register** The Committee was asked if there were any changes to the Register or conflicts with the agenda. No changes or conflicts were advised.	
4	**Minutes** 4.1 Minutes of Previous CPHAC/DSAC Meeting **Resolved** that the minutes of the meeting held on 5 August 2020 be confirmed as a true and correct record. Moved: B Edlin Seconded: H Ahomiro	
5	**Matters Arising** Matters Arising are in progress for 2 December meeting There has been some work on the Disability Action Plan which has been pleasing, with inclusion of BOPDHB being a Confident Disability Employer. BOPDHB is working with Lakes DHB as the organisations have a common Planning Manager.	

	Query was raised as to what is received from the MOH by way of funding and whether the funding is sufficient to deliver what is required. Disability is funded directly from MOH. It is a separate line of funding, similar to Public Health. It is considered that funding for such issues is not keeping pace currently. Query was raised as to whether there is a place that BOPDHB can speak up. BOPDHB needs to look for opportunities. The Disability Action Plan is an opportunity.	
6	**Matters for Discussion / Decision** 6.1 <u>Integrated Care / SHSP Enablers Update</u> Sarah Davey, Service Delivery and Development Manager, Planning & Funding, in attendance The cover paper denotes the desire for more metrics, being more realistic about forecasts, especially with disruption of COVID this year. The sections within the paper are around integration and co-dependent improvements that are linked with common threads. *Community Care Co-ordination (CCC)* CCC evolved with District Nursing but is expanding with other referral options. CCC is staged and there is currently a finite list of services. Long term, it is envisaged joining up with other providers such as the PHOs. There is a suite of services that PHOs co-ordinate. People who are receiving services from multiple touchpoints would come through CCC as a single point of entry. There is real value in taking a locality approach. BOPDHB has been working on this approach for a little while. There may be different approaches needed for different localities. It is also recognised that one model cannot be applied to Western and Eastern Bay of Plenty. It is important to note that a lot of BOPDHB's population do access services through District Nursing, Support Net, and Community Allied Health. Short term home and community support following a hospital event have a lot of commonality. The feedback from General Practice is that some patients are quite complex and have historically needed referrals for a number of different areas. Query was raised on collaboration with Maori providers. It is important to have a Maori workforce working with Maori. There is concern with Maori workforce numbers. It is considered that the people coming through Te Awanuiarangi would fit well with this programme. PHOs are working with GPs to look at services as an outreach provision. There is a model that has been tested in other places which is being looked at. If a GP is worried about a patient they can refer to the outreach team. WBOPPHO is working in partnership with Ngati Ranginui to launch. When looking at local, there needs to be review of what is fit for purpose for local. If DHBs do not have expertise, the providers will have the expertise. It's about working together. Patients in the BOP are given the option of being referred to a Kaupapa provider.	

	CCC contacts all who have identified as Maori to follow up and offer the choice of Kaupapa services for Community Nursing referrals as part of the Regional Maori Health Services. The graph shown indicates this is working well. Approximately 20-25% of requests were resolved at the point of triage. The introduction of Lifecurve will also have a positive effect with identifying other community service providers and ensuring that those requiring enablement services are directed in a timely manner. *Keeping me Well – pilot in Nga Kakano* 152 clients have been through the pilot so far. It is a good demonstration of bringing together a number of threads. Keeping Me Well is anchored on a person directed approach. Goals are set by patients and whanau and the team that is working in the first test site with Nga Kakano in Te Puke is a multi-disciplinary team, integrated into the holistic approach Nga Kakano delivers. Level 4 COVID offered the opportunity of connection via food parcels and visiting people, helping where they could which was a great induction for the Nga Kakano team. They are using data to identify people most at risk of hospitalisation but who may not be engaged with traditional services. What matters to the person is taken into account with the clinical diagnosis. People have their goals and plans need to be designed around that, empowering the person to do. eg a person's goal may be to be able to walk to the letterbox or look after their Mokupuna. Advice was given of good feedback from Nga Kakano who considered that for their people, showing up to DHB services and not having their needs met had been the norm. The initiative has created faith that the DHB is committed to addressing Maori disparity and that the relationship is on the right pathway. Trust has also been developed between the DHB clinicians, team and the community. The Leadership at Nga Kakano is acknowledged for the success of the programme. Their willingness to embrace it has been important. The next area to focus on is Kawerau. Work is being undertaken with providers to determine the approach. Electronic shared care planning is also a next step. The Lifecurve is a critical enabler of Keeping Me Well. The app and software is currently being tested. The tool is being adapted to a more New Zealand feel as it is English based. Functionality will be the same but the look and feel will be different. Testing through the hospital has seen improvements and better outcomes. COTS is progressing very well. Query was raised on the financial gains from the project. This is currently being analysed. It is looking very positive. The next area of focus on the Orthopaedic pathway is to expand access of COTS to other practices to ensure reduced waiting times across the Bay. CEO updated on recent conversations, one this morning with MidCentral DHB and yesterday a meeting with MSD to investigate how to work better together with locality as a consideration.	

	Teleheath Telehealth has been slightly impacted resource-wise. There has been some funding from MOH for secondary and primary care. Telehealth had been used during COVID and query was raised as to whether there was appetite to continue. Telehealth is much more than a tool and there is a whole workflow that needs to be co-ordinated to support the clinicians to deliver the best care for their patients. A raft of things need to work seamlessly. Some people are more comfortable with technology than others. The patients also need to have the technology. It is a culture change. Secondary and primary care link is also important. Query was raised as to whether there is an organisational role to be played in advocacy. It is considered that this is important. Local approaches and partnerships work well. Debunking myths is also important, looking at the evidence and assessing what is working well. The Committee encouraged management to continue with these Gold Star initiatives and considers that Public Health and connectivity is an important aspect. The Committee notes the progress in the range of initiatives that are being progressed in the Strategic Priority of Integrated healthcare and enablers. 6.2 <u>PHO Activity Update</u> The paper was taken as read. Attention was drawn to the metrics regarding healthy homes. Practices are making a difference in the key measures. There have been some issues in the Eastern Bay. Some practices had opted in initially and found they were not prepared. Outcome measures are required to determine benefits to approach for more funding to allow further rollout. The Committee looks forward to ongoing statistics at next meeting.	Acting GMPF
7	***Matters for Noting:*** 7.1 <u>Mental Health and Addiction System Transformation</u> 7.2 <u>Planning and Funding /Toi Te Ora Report</u> 7.3 <u>CPHAC/DSAC Work Plan 2020</u> The Committee noted the information	
8	**General Business** There was no general business	
9	**Resolution to Exclude the Public** **Resolved** that Pursuant to S9 of the Official Information Act 1982 and Schedule 3, Clause 33 of the New Zealand Health and Disability Act 2000 the public be excluded from the following portions of the meeting because public release of the contents of the reports is likely to affect the privacy of a natural person or unreasonably prejudice the commercial position of the organisation:	

	Wai 2575 Response That the following persons be permitted to remain at this meeting, after the public have been excluded, because of their knowledge as to organisational matters or for the purpose of legal records. This knowledge will be of assistance in relation to the matter to be discussed: Pete Chandler Mike Agnew Hugh Lees Sarah Mitchell Janet Hanvey **Resolved** that the Committee move into confidential. Moved: B Edlin Seconded: I Finch	
9	**Next Meeting –** Wednesday 2 December 2020	

The meeting closed at 12.05 pm
The minutes will be confirmed as a true and correct record at the next meeting.

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

CODE OF CONDUCT - GOVERNANCE

SUBMITTED TO:

Board Meeting 23 October 2020

Prepared by: Debbie Brown, Senior Advisor Governance and Quality

Endorsed and Submitted by: Pete Chandler, Chief Executive

√ For Decision ☐ **For Discussion** ☐ **For Noting**

RECOMMENDATION:

That the Board endorse the Code of Conduct – Governance which has been reviewed and updated.

ASSURANCE:

The Code of Conduct aligns with the Te Kawa Mataaho Public Service Commission Standards of Integrity and Conduct. All Board Members have had the opportunity to review and provide feedback on the Code of Conduct.

ATTACHMENTS:
Code of Conduct – Governance
Note links to referenced documents included in the paper.

BACKGROUND/ANALYSIS:

In order to operate effectively in our communities and make a difference, the Board need to have the trust and confidence of our people. To maintain this trust and confidence, Board Members need to be able to show they are trustworthy, that they act in the interests of the people of the Bay of Plenty District Health Board, and never for their own personal gain.

The Code of Conduct was last reviewed and updated in 2012. The latest version reflects current best practice.

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

CODE OF CONDUCT - GOVERNANCE

1. Code of Conduct

This Code of Conduct has been developed and agreed to by all Board Members of the Bay of Plenty District Health Board (DHB). The Code sets out key principles that govern our conduct as Board members, both individually and collectively.

In developing the Code, we recognise the unique nature of the DHB, which embraces the disciplines and accountabilities expected of best practice governors. We acknowledge that we are ultimately accountable for the successful performance of the DHB, and that our actions, both public and private, should support the decisions and activities of the organisation.

It is noted that:

- Some sections of the Code will be further supported in time by organisation policies - (e.g. Media Relations, Consultation)
- the DHB has a separate (and aligned) Code of Conduct policy for staff.
- Board members should also be guided by the expectations outlined in their letter of appointment from the Minister of Health.

2. Te Tiriti o Waitangi

The Board recognises that Te Tiriti o Waitangi is a founding document of Aotearoa/New Zealand. The Board also recognizes that as a Crown agent, the DHB has an obligation to actively implement Te Tiriti through its role, scope and function.

Te Tiriti is interpreted via the Articles and the Principles. Appendix 1 outlines both and the Board is committed to applying genuine effect to Te Tiriti through its conduct and implementation of agreed strategies and actions aligned with Te Tiriti.

3. Principles

a) Fiduciary Responsibility

We each have a duty to ensure that the DHB is properly governed. To meet this obligation, we will:

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[2] United Nations Declaration on the Rights of Indigenous Peoples, Articles 23 & 24 - https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf

[3] The MOH definition is "In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage *require different approaches and resources* to get equitable health outcomes."

- Comply with the NZ Public Health and Disability Act 2000(NZPH&DA) and the Crown Entities Act 2004 (CE Act);
- Act in good faith and lay aside all private and personal interests in our decision-making.
- act with honesty and integrity;
- exercise reasonable care, diligence and skill in our duties at all times;

b) Accountability

Members are accountable to the Minister of Health (through the Board Chair) for the performance of the DHB.

To ensure ongoing confidence of the wider community we serve, we must all be fair, impartial, responsible, and hold ourselves accountable for our behavior.

4. Commitment

In accepting the position of Board Member we have made a commitment to undertake the work of the Board, and to commit the time required to carry out these responsibilities. We will make every effort to attend scheduled meetings, but recognise that there will be occasional conflicts which require the courtesy of notice to the Board/Committee Chair.

- We agree to be diligent in preparing for and attending Board meetings.
- We will endeavour to be as informed and as knowledgeable as we can be, about the responsibilities of the DHB and the issues presented to us, in order to arrive at the best decisions possible.

Training needs will be identified through Board evaluation processes and all training expenditure approved by the Board Chair and Chair of the Finance, Audit & Risk Committee.

5. Collective Responsibility

We agree to the following principles:

- We will clearly express our views at Board meetings, and endeavour to achieve a collective decision and course of action. We accept that once a decision has been formally reached by the Board, this decision becomes the policy of the Board.

- We acknowledge that it is inappropriate for a Board Member to undermine a decision of the Board, or to engage in any action or public debate which might frustrate its implementation and will refrain from this.

- We will not attempt to re-litigate previous decisions at future meetings of the Board, unless the majority of Members agree to re-open the debate.

- We are mindful that our personal actions should not bring the Board into disrepute or cause a loss of confidence in the activities and decisions of the DHB.

6. Clarity of Roles

We are responsible for the governance of the DHB, and delegate to the Chief Executive the power to make decisions on management matters relating to the DHB on whatever terms and conditions it sees fit. To this end, the Board approves a Delegation of Authority Policy that is reviewed on an annual basis.

The Board delegates to the Chief Executive responsibility for implementing the decisions of the Board, and the day to day management of the organisation. The Chief Executive is expected to provide the Board with relevant and appropriate information and with free and frank advice to assist it in reaching high quality decisions on strategy, policy and other governance matters

We agree that, for the purposes of accountability, clarity between the roles of governance and management is essential and we must not become involved with management's activities.

- We will endeavor to comment publicly only on policy and governance matters for which we are responsible, and to leave public comment on operational and management matters to the Chief Executive and Management according to the DHB's media policy.
- Members will not make commitments for work or expenditure by the DHB that have not been previously approved by the DHB, nor create any obligation or liability for the DHB beyond authorised delegations.

7. Employment Relationship

We recognise our role as the employer of the Chief Executive and indirectly of all staff within the DHB. We will exercise this employment responsibility professionally and responsibly. To that end:

- We will be supportive of employees of the DHB, and will not criticise employees or the service provided by the DHB in public. Any concerns we might have will be raised with the Board and/or Chief Executive, as appropriate.
- We will exercise judgement and courtesy in respecting the protocol of communicating through the Chair and/or Chief Executive, (as appropriate), in raising matters with the Chief Executive and/or senior staff.
- We will not attempt to influence any employee of the DHB to present material in a particular way, such that it might affect the outcome of a decision to be made by the Board.
- We will exercise care in communicating privately with employees of the DHB, and will refer any staff with complaints or concerns back to the Chief Executive.

Contact with Individual Staff Members

In some circumstances it will be quite appropriate for members to communicate directly with individual staff to further their knowledge/understanding of organisational issues relevant to their governance role. Such communication needs to be carried out in an open and considerate manner. As a general rule, requests to individual staff should be governed by the following protocols:

- In the first instance, such approaches should be made "through the management line", either via or with the knowledge of the Chief Executive (and Chair) and subsequently through the appropriate management levels (i.e. top down);

- E-mails (or other written requests) and subsequent communication should be copied to the Chief Executive and Chair;
- Consideration should be given to staff pressures and workloads and requests should not impose unreasonable burdens on staff;
- Any concerns about responsiveness to Board member requests should be taken up directly with the Chair/Chief Executive.

8. Complaints Procedures

We appreciate our role as Board Members in providing a community voice to the activities of the DHB. Equally, however, we recognise that the organisation through the mandate of the Board will have processes in place to manage engagement with our staff and community.

- We will advise residents / health consumers, who desire personal matters to be brought to the attention of the DHB, to follow the proper procedure for raising issues and registering complaints.
- We will not advocate on behalf of an individual beyond advising them of the complaints procedure and later checking that the matter has been addressed satisfactorily by the organisation. ('Satisfactorily' refers to the procedures followed by the organisation in addressing the matter, not necessarily whether the outcome is as the individual would wish.)

9. Legislative Compliance

We are mindful that the position of a Board Member brings with it an obligation to act at all times as a responsible member of society.

- We will be familiar with the New Zealand Acts and Regulations that govern our responsibilities as Board Members of the Bay of Plenty DHB, and will obey the law, be aware of and respect the processes of the law.
- We will comply with the health and safety policies and procedures operating within the sites and facilities owned by the DHB.

10. Confidentiality

We recognise that we will receive information that is both public and private and that the release of information, and access to and handling of personal information, about any individual are governed by the Official Information Act 1982 and the Privacy Act 1993. In order to protect the organisation and ourselves from inappropriate use and disclosure of information:

- We will make ourselves familiar with this legislation, and refer any requests for 'Official Information 'or information about individuals to the Chief Executive.
- We will not disclose publicly any business discussed while the public is excluded from a meeting, and/or information for which good reason exists (under the terms of the Official Information Act) for it to be withheld from the public, unless the Board decides by resolution to make such information public.
- We accept that we may acquire information of a confidential nature, for example about health and disability providers and/or other local and national organisations.
- We agree not to use any such information for personal advantage, nor to disclose it to any other person unless first authorised by the Board.

11. Conflict of Interest

We note that the NZ Public Health and Disability Act sets out the definition and procedure for disclosure of Members' interests. This states that:

A Board Member who is '*interested in a transaction'* of the DHB must, as soon as practicable, disclose the nature of the interest to the Board. This duty of disclosure is ongoing and is additional to any disclosures made at the time of election/appointment of the Board member. Some interests may only become apparent over time or as certain transactions arise, so members should supplement their standing disclosures with further disclosures as and when such interests become apparent. In addition, the 'nature' of the interest should be considered on a case by case basis with regard to the matters before the Board

Note that one of the most important things when dealing with interests and conflicts is openness and transparency;

- The Board Member must not take part in any deliberation or decision of the Board relating to the transaction.
- The disclosure must be recorded in the minutes and entered in a separate interests register.

  "interested in a transaction" is defined within the NZHDA (Interpretation Section) as: *"if the Board Member:*

  (a) is a party to, or will derive a material financial benefit from, the transaction;
  (b) has a material financial interest in another party to the transaction; or
  (c) is a director, Member, officer, or trustee of another party to, or person who will or may derive a material financial benefit from, the transaction ….;r
  (d) is the parent, child, or spouse (or de facto partner) of another party to, or person who will or may derive a material financial benefit from the transaction; or
  (e) is otherwise directly or indirectly materially interested in the transaction.
- We recognise that at times there may arise a 'perception of interest' which is a wider interpretation than that defined in the legislation. We agree that the appropriate procedure is to raise such matters of interest in the first instance with the Chair, who will determine an appropriate course of action.
- We agree that the Board may, where appropriate, decide that a Board Member who has declared an interest in matters to be discussed by the Board should leave the meeting room for the duration of discussion on such matters.
- We will not use our official position for personal gain, or solicit or accept gifts, rewards or benefits which might be perceived as inducements and which could compromise our integrity.
- We will exercise care and judgement in accepting any gifts, and advise the Chair and/or Board of any offer received.

12. Media and Public Comment

We recognise the freedom of Board Members to communicate with the media, but agree that we should do so in a manner consistent with this Code of Conduct. Primarily we seek to ensure that the Board can function successfully and make informed decisions in the best interests of the public.

- In accepting that we are each entitled to our own views, we agree to exercise care and judgement when commenting on policy or matters of public debate.
- In particular we will distinguish clearly to our audience whether we are speaking personally and communicating our own views, or whether we are speaking on behalf of the Board and conveying policy decisions taken by the Board.
- We may comment on matters relating to existing policy and practice which align with what has been formally decided by the Board. The Board Chair shall be kept informed to ensure "no surprises".
- We agree to refer the media to official spokespeople, where these have been appointed by the Board to respond to specific issues.
- We will refrain from acting in public in a manner that undermines other Board Members, and will not act for self-promotion purposes at the expense of the image of the DHB itself.
- We agree that our individual activities and contribution to any public debate or discussion should be consistent with the objective of maintaining a non-partisan work environment for the Board.

13. Consultation and Participation

We note our legislative obligations to engage with the community to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services. It has a special responsibility to establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement. We will endeavor to keep an open mind during formal consultation with the public and be prepared to listen, to develop our understanding, and if appropriate to change our view.

- We will ensure that the consultation process provides the public with an effective opportunity to give their views.
- We will be respectful and attentive to members of the public.
- We note that the judgement from the Court of Appeal decision in Wellington International Airport v Air New Zealand Limited outlines the Court's view of consultation:

  "Consultation does not mean negotiation or agreement. It means setting out a proposal not finally decided upon, adequately informing a party of relevant information upon which the proposal is based, listening to what others have to say with an open mind (in that there is room to be persuaded against the proposal), undertaking that task in a genuine and not cosmetic manner, reaching a decision that may or may not alter the original proposal."

Election Period Behaviour

We will abide by State Services Commission and Ministry of Health guidelines on conduct during election periods.

I have read and understood the code of conduct and agree to abide by it.

Name:

Signature: Date:

APPENDIX 1: TE TIRITI O WAITANGI

Articles

Te Tiriti o Waitangi has three articles and the Ritenga Māori Declaration. These articles and the declaration underpin our code and how we act.

Article I: Kāwanatanga
This article reflects tangata whenua's agreement to enable tangata Te Tiriti to govern in New Zealand. The right to govern was linked to governance that was honourable and supported mutual benefit. The Ministry of Health interprets this as enabling them to be a kaitiaki or steward of the health and disability system. The DHB is an agent of the Crown; we too have an obligation to act as a responsible kaitiaki[1]. The DHB accepts this responsibility and opportunity.

Article II: Tino Rangatiratanga
This article recognises the importance of tangata whenua authority and autonomy. The Ministry of Health states that they have a responsibility to enable Māori to exercise authority over their health and wellbeing. The DHB accepts this responsibility and opportunity.

Article III: Ōritetanga
This article supports equitable outcomes for tangata whenua. The Ministry of Health states that it supports achieving equitable health outcomes for Māori. The DHB accepts this responsibility and opportunity.

Ritenga Māori Declaration: Wairuatanga
This declaration upholds the importance of tangata whenua belief systems, worldviews and values. The Ministry of Health states that it supports Māori to live, thrive and flourish as Māori. The DHB accepts this responsibility and opportunity.

Principles

The principles of Te Tiriti o Waitangi have most recently been re-articulated by the Waitangi Tribunal[2]. These principles are applicable to the wider health and disability system. The principles are:

- **Tino rangatiratanga:** The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of *health and disability services*.
- **Equity:** The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Māori.
- **Active protection:** The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents, and its Treaty partner are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.
- **Options:** The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori *health and disability services*. Furthermore, the Crown is obliged to ensure that all *health and disability services* are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
- **Partnership:** The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of *health and disability services*. Māori must be co-designers, with the Crown, of the primary health system for Māori.

Meeting our obligations under Te Tiriti is necessary if we are to realise the overall aim of Pae Ora (healthy futures for Māori) under He Korowai Oranga (the Māori Health Strategy) and our health strategies for Māori.

[1] Ministry of Health (2020) Whakamaua Māori Health Action Plan 2020-2025. Ministry of Health: Wellingotn.
[2] Wai 2575 Claim: https://waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/. Accessed 4 September 2020.

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

2020/21 Health & Safety Planning 2020

Submitted to:	BOARD	21 October 2020
Prepared by:	Linda Browne, Health and Safety Manager Owen Wallace, General Manager Corporate Services	
Endorsed by:	Owen Wallace, General Manager Corporate Services	
Submitted by:	Pete Chandler, Chief Executive	

☐ **For Decision** ☑ **For Discussion** ✓ **For Noting**

This paper serves to provide a brief commentary on the current status of the Helath and Safety Planning and associated activities.

Executive Summary

The DHB has recently appointed a new Health & Safety Manager after a period of that position being vacant. The Board has asked that the Health & Safety Manager present to the Board on the plan for improving Health & Safety across the DHB.

The new Manager is currently developing the Health & Safety Plan for the coming 12 – 24 months – although a high level approach has been developed. The H&S Manager is currently on leave and unable to attend the October Board Meeting. It is recommended that this issue is either brought to the November FARM Committee (4/11) or Board meeting (18/11) to enable the attached presentation to be gone through and Board member questions addressed.

In addition to the H&S plan the Manager will be able to provide greater detail on a number of key activities:

- the recent ACC Accredited Employer Programme audit - focus on Injury Management
- progress around key action areas – Risk 75 Violence Towards Staff and Lone Worker initiatives
- progress on the development of Safety dashboards to enable improved reporting of key metrics

Health & Safety

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

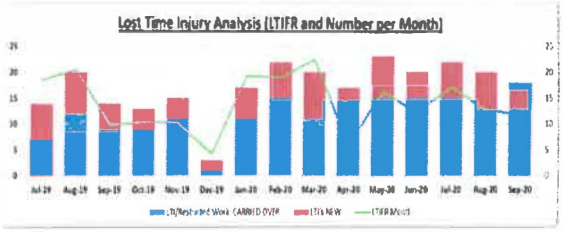
Agenda

- Strategic – Short Term Plan
  - How are we tracking
  - Measured progress against Strategic Plan
- Business statistics
- National Bipartite proposed Work Stream
  - Linkage into BOPDHB Strategic Plan
- Health and Safety Calendar
- Project Update
  - AEP Injury Management Audit
  - Risk/Lone Worker
- General Business

Progress to Strategic Plan

STRATEGIC PILLAR	DETAILS	High Leve Update
Building Engagement	Advisory Group/Operations Group • Schedule regular meetings	Advance meetings scheduled – Advisory/Reps/Operations Annual Safety calendar has been developed, scheduling meetings, standard and protocol reviews etc
	• Review group make up/Terms of Reference	To be reviewed next month
	• Monitor/track attendees to understand engagement	Continue to be monitored as lead indicators across various stakeholders ie Unions/Executives
	Safety Walks/Conversations • 2 per month H&S team with Rep involvement	20 walks were conducted over TDH and WHK sites in September, the process is still being developed, where corrective actions will be assessed in terms of risk and also a process to monitor whether the corrective actions have been actioned (envisaged that Vault will be utilised) – this scope of work is planned for November
Health & Safety Team	• Align/streamline Health and Safety Advisors practices • Define roles/organisational requirements	Organisation and team requirements still being understood and dynamics with external parties
	• Develop team capability by increasing understanding of key principles [illegible]	Progress has been made (particularly) in the [illegible] reporting space with data and reports being refined for BOPDHB specific requirements Training & [illegible] with DHB practices continues
	• Increased visibility	• Safety walks continue as discussed above • There has been increased safety profile with 3 x daily news items for all staff highlighting safety issues/initiatives • Plans for team video have been scoped, introducing the H&S Team, has been scheduled for 3rd November with communication [illegible]
Reporting Systems Create efficiency and removal of silos	[illegible] Docman • Create/agree high level structure with IT • [illegible]	Some progress in relation to this. IT resourcing have delayed this in this area – not issue at this stage
	• Datix	Limitations of the system in regard to H&S reporting are being worked through; data will be exported out of Datix and power BI tool proposed to be used for Safety Dashboards H&S Team require Datix and excel training to produce reports allow data to be analysed in depth (planned for November)
Add Value	Policies Key policies currently under review • Health & Safety Statement/Policy	• [illegible] statement and H&S Policy complete, to be presented to the Ops/Advisory and then planned advisory group/Executive Team – refer to safety calendar for new schedule plan re protocol A number of other protocols are in draft, with planned review as per the safety calendar
	Safety Dashboard	– There has been significant progress in this area – to present draft safety dashboard to the Executive Team in November
	Communications/[illegible] • Safety daily news [illegible] • OnePlace landing page	Good progress in this area with new initiatives such as shared safety learnings commencing and [illegible] displayed on Daily News
	Safety Walks/Conversations	As above

Business Statistics



LAG INDICATORS	SEPTEMBER actual	YTD	2019 FY AVERAGE
Lost Time Injury Frequency Rate (LTIFR) per 1,000,0000 hrs worked	11.8	13.9	14.3
Days lost/ Lost Time Injury (severity rate)	9.6	85.2	108

National Bipartite proposed Work-Stream

Health and Safety Work Programme

Principles

- Cross sector
- Consistency
- Collaboration
- Pragmatic/ solution focused
- Principles and framework based
- Ease of implementation
- Keeping it simple

✓ INDICATES THAT THIS PROPOSED WORKSTREAM of BOPDHB IS IN ALIGNMENT WITH THIS FRAMEWORK/PROGRAM OF WORKS
NOTE NEEDS TO BE TAILORED AS ACTIONS WILL VARY DEPENDING ON MATURITY ACROSS THE VARIOUS DHB'S

Annual H&S Calendar for Advisory Group
"Under Development"

ANNUAL H&S CALENDAR	2020						2021					
ITEM	MONTH JULY - JUNE											
	J	A	S	O	N	D	J	F	M	A	M	J
Bipartite Meeting	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
Advisory Group Meeting	☒		☒		☒		☒		☒		☒	
Operations Group Meeting – 2nd Thursday of every month	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
Workwell Group Meeting – 1st Monday of every month (3-4pm)				☐	☒	☒	☒	☒	☒	☒	☒	☒
H&S Rep meetings – every 2nd month		☒		☒		☒		☒		☒		☒
• WHK (1-2pm)		17th		20th		14t		18th		20th		18th
• TGA (10.30 – 11.30)		25th		29th		9th		24th		29th		23rd
Documentation Review/Consultation:												
• Wall Statement, H&S Policy					☒							
• 5.3.1 – P2; Roles & Responsibilities							☒					
• 5.3.1 – P3; Worker Participation (due for review 2021)												
• 5.3.1 – P4. Contractors, Volunteers & Visitors									☒			
• 5.3.1 – P5; Orientation, Training & Supervision									☒			
• 5.3.1 – P6; Accident Claims and Return to Work							☒					
• 5.3.1 – P7; Workplace Surveillance					☒							
Advisory Group Terms of Reference Annual review												☒

Key Project Update

ACCREDITED EMPLOYERS PROGRAM AUDIT 5/6TH OCTOBER:

- Maintained Tertiary accreditation
- No critical issues
- Employee Focus Group – Union & H&S reps involvement

- Planned future involvement with Unions & Reps for external audit in June 2021

LONE WORKER

- Steering Group Meeting is scheduled to meet 28th October

RISK PROJECT– VIOLENCE TOWARD STAFF

- Data being collected – Datix and security guard
- Late October/November – project focus by reviewing previous plan and create updated Violence & Aggression to staff project

SAFETY DASHBOARDS

- Underway 60% complete – to be presented at the next meeting

General Business/Questions

Engagement and alignment of work DBH/WorkSafeNZ

- Planned meeting via zoom 29/10/20
  Between Linda Browne and Catherine Epps WorkSafe NZ

Catherine Epps is the General Manager Health and Technical Services, reporting to the CE.

WorkSafe's National Advisor Māori Mohi Apou now also reports to the CE. "The changes signal an increased focus on tackling work related health and improving work health and safety outcomes for Māori.

QUESTIONS/END

Chief Executive's Report

This report covers the period 16th September 2020 to 14th October 2020.

1. Chief Executive's Overview

September has been an extremely busy month for the DHB's clinical services with hospital bed occupancy at times being the highest since our 2016 peak. Much of this peak relates to surgical acute activity but a more detailed overview of specific trends is included in the Provider Services section in this report.

Work has progressed on refining our Equity KPIs and Equity Improvement commitments for this year and these are included as a first draft in the Confidential section of the Board meeting for discussion.

Further work has continued on re-framing our current strategic priorities to better illustrate what's in our plans for this year and how the various components fit together. This will be shared for discussion in the CEO presentation in the Confidential section of the Board meeting and part of the overview one pager has been included in the front page of the Board papers this month.

Reporting against quality indicators has been an area of required improvement and work has been undertaken this month to bring together new, consolidated reporting to the Board from the various indicator owners. This information is included in the performance pack and is a new development.

The most significant event of this month is that we finally went live with the full Midland Clinical Portal functionality on 14th October. After over five years of planning, design, training and preparation this is a very significant achievement for us and paves the way for our digital transformation journey. Despite many challenges along with way and the considerable disruption on the design team from COVID this year our IM and training teams, in conjunction with Healthshare, have been unwavering in their commitment to achieve this and we celebrate their tremendous effort in doing so.

The MCP Support Team ready to provide support to staff on MCP Go Live Day

MICAMHS Update

In October 2019 issues were raised in relation to our MICAMHS service in Tauranga. A combination of historic underlying issues, exacerbated by workload pressures, restricted space and a phase of experienced leavers being replaced by less experienced new staff were all contributors. Unfortunately a small group of staff, encouraged by their Union, decided to use the media to air their concerns and the resulting imbalanced reporting added to the team distress.

In the year since, very significant work has taken place to understand the things that needed to change and to set about putting changes into place. There has been considerable listening, learning and understanding of perspectives between staff groups, staff and management, and with guidance and support from our unions. A specialist (external) workplace psychologist and counsellor was made available to staff and this has been extremely valued and beneficial in supporting team members.

Some of the elements which were significant in staff minds but relatively small were easily resolved – for example upgrading mobile phones, providing laptops instead of desktop PCs to allow mobile access to our systems. Other elements were more challenging such as finding ways to address the physical space constraints of the MICAMHS buildings.

Turnaround needs such as these are not easy, requiring much time, openness, vulnerability and commitment from all stakeholders with some extremely challenging phases which can make or break the collective healing journey. However, it is pleasing to report that excellent progress has been made and whilst the workload pressure is higher than ever due to COVID related referral increases, the service has moved forward significantly.

In April we took the decision to seek alternative premises and to split the child and adolescent functions, thereby allowing each function to grow and develop in conjunction with their own networks and this has been extremely well received. This step has also helped to pave the way for the wider re-modelling of our Tier 2 child services which is reported on in the Child Wellbeing section of this paper.

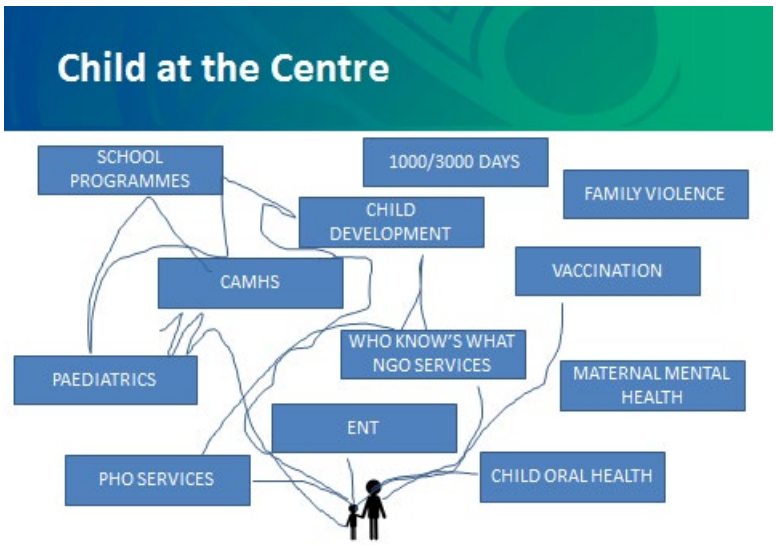
Turnaround processes usually take 9-18 months of hard work before there is a broad acknowledgement that things have changed, and that the change is being maintained. Whilst there is more yet to do and an extremely challenging workload to navigate, the current state was summarised by one of the staff last week in the following email content:

"Well I did not think that I would be writing this email but here it is.
Since the difficult times experienced in the MICAMHS service I would like to acknowledge the positive changes that have been made. Our team of managers have gone above and beyond to make huge improvements by listening and supporting us.
Yes the workload remains stressful and relentless but we have hope, we have a new and appropriate working environment and our leading managers are there just to listen.
Jen has been present, Anja has been amazing and my team leader Sean is a trooper. They have all rolled up their sleeves and made themselves available at all times to support us.
Thank you all for the changes, I am now proud again to be a part of the team and the new changes".

As Chief Executive I'd like to acknowledge the MICAMHS team for trusting that we would be true to our word in supporting change, the wise leadership and hard work by our management teams and the support of our unions in this improvement journey.

Child wellbeing

At the end of April we had planned to commence explorations on our next tangible steps in the child wellbeing priority area however COVID both got in the way, and also helped us as the same time. With an inability to meet and workshop as originally

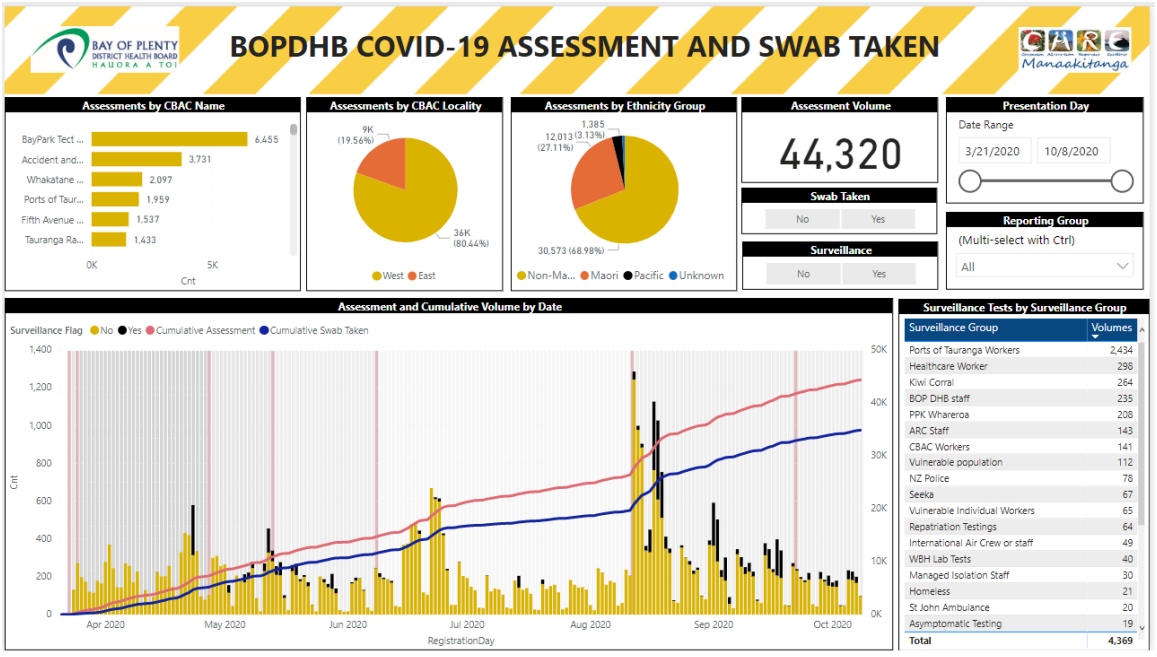


planned, but with a strong keenness from our teams to progress, we held three half an hour Zoom sessions ("The Child at the Centre") with a small group to explore current issues and opportunities within the DHB's own child services.

The group agreed that we have some pressing needs to address and that it would be appropriate to progress these as a foundational step before having a wider conversation about future service models with stakeholders. The issue that has been raised often by families, referrers and clinicians relates to the historic disconnected nature of our children's services, especially for children that require multiple specialty support. Children often zig-zag between services as if the services were part of different organisations and so we agreed that this was something we needed to address within the DHB before looking at the interfaces with the wider system. The proposed model is close to release and will be shared with the Board in November.

2. News and key events

2.1 COVID-19 Key Updates October 2020



Key information for the month:

- The Bay of Plenty remains in alert level 1 and has no active cases in its region.
- With effect from the 1st October, PPE is being supplied only to general practices that are carrying out swab testing, and Pathlab. Communication has been sent to all providers to advise them of this change.

- TPOOM is still providing a testing service for people not enrolled with a general practice. They are in discussion with the Pacifica community to explore what support they need specifically.
- Pahi Tahi mobile services to rural communities continues.
- There is funding being made available to DHBs to assist with testing costs. This will be allocated to DHBs using a mixed model based on population and testing volume. Whilst helpful, it is unlikely that this will cover more than a 2-3 week busy testing period.
- An event is being planned for 29 October to provide an opportunity for people to discuss the impacts of COVID to date and share ideas of how we could progress with this in the future.
- Implementation of a new sustainable Port testing service which is a Joint Ventrure between Western Bay of Plenty PHO and Ngati Ranganui is going well and has been in place since the end of September. Since the 8th October 2020, 2434 Port workers have been tested by this service. This service ensures compliance with all Port Order and Maratime Order requirements.
- A reporting framework for COVID-19 (assessment and Swabbing) using the Power BI tool continues to be refined and developed. The team in business intelligence have done a great job putting it together. It is possible to quickly drill down into different groups i.e. by ethnicity, surveillance group, eastern or western BOP, using this tool. The link for the tool is; http://powerbiportal/Reports_PBIS/powerbi/Pandemic/EOC_COVID19/COVID%20Assessment%20and%20Swab%20Taken

Toi Te Ora (TTO) Response:

- A current risk for this region is Te Te Ora's (TTO) capacity to carry out case and contact tracing should a community outbreak occur over the December/January holiday period. They plan to roster higher than usual staffing levels the Christmas/New Year period. In addition they are working with both Bay of Plenty and Lakes DHBs to ensure there will be sufficient staff from each DHB available to be called back at short notice to assist should we need to activate our surge plan. These are staff who will already have already been trained in case and contact tracing.
- The Ministry of Health have also initiated discussions with the public health units regarding the possible establishment of a national COVID-19 response team to support New Zealand's response, with the priority being the summer 2020/21 break. Local planning will need to progress while this discussion is had.
- The need to develop specialist expertise within Toi Te Ora to manage complex setting outbreak (for example in aged residential care) has been identified. The capacity for the DHBs alongside the facilities to manage an outbreak in an aged residential care facility in this region is seen as an area of risk.
- COVID-19. Toi Te Ora has stood up two Māori liaison roles to support the public health response across Bay of Plenty and Lakes. In addition, Toi Te Ora is now supporting each DHB's Māori health teams by staffing the new single point of contact roles required of every DHB to assist both the national and local response with connecting Māori to local welfare providers as needed.
- A Māori health equity tool has been used by the service to audit the public health response in this region to the first wave of pandemic. The audit report will outline opportunities to improve the response moving forward, which we will seek advice from the Māori health teams on how to progress.
- Toi Te Ora commissioned a community health needs assessment, which is now complete and the report is being released.

The findings from the report will inform our work, and that of the two DHBs in the areas of recovery and in supporting the strengthening of the communities' resilience. We propose to present the findings of the health needs assessment to the Lakes and Bay of Plenty Boards later this year.

Hospital Response:
The Integrated Operations Centre (IOC) function continues to take responsibility for the hospital response to the national COVID 19 situation. To maintain a sufficient number of Covid-19 testing numbers nationally, BOPDHB public health nurses offered testing for asymptomatic DHB staff across both sites. The uptake has dwindled to very small numbers as BOPDHB moves into alert level one with all staff now being directed to their GP for this service.

Planning & Funding & Response:

- COVID -19 impacts have been felt this month, primarily in the transformational rather than transactional space. The Improvement and Innovation team has been most impacted with staff diversion stopping or slowing transformational efforts, particularly in the acute flow space. The Toi Te Ora involvement in the COVID-19 effort has been continuous since March; however with the support of dedicated funding the team has been able to gather resource in this area that is enabling a reasonable level of return to business as usual. This element of progress is particularly important to ensure responses to other Public Health issues are possible.
- Health care providers across the system are continuing to struggle between the balance of supporting the COVID response, managing their usual operations and progressing improvement that was already required in a system that was experiencing increased demand and expectations pre COVID. This is leading to some providers experiencing 'response fatigue'.
- A proposal for a single COVID data collection system outside the context of general practice is being developed. This will save time and money if the need to stand up dedicated testing sites arises. It also has application for non-COVID related mobile service delivery.

Kaumatua Experience of Covid-19:

- These are very moving short video clips of kuia and kaumatua sharing their experience of COVID-19. These provide some excellent insights for us around our communications and touch on a range of key themes. They have been produced by Ngā Matauranga Taonga, by Rauawaawa Kaumataua Charitable Trust and are a series of six short videos capturing Kaumatua in different living situations sharing their experiences of COVID-19 lockdown and what they did to overcome difficulties and keep themselves well. Please access via the following link https://www.hpa.org.nz/covid-19-kaumatua-videos

Key Ministry of Health Updates:

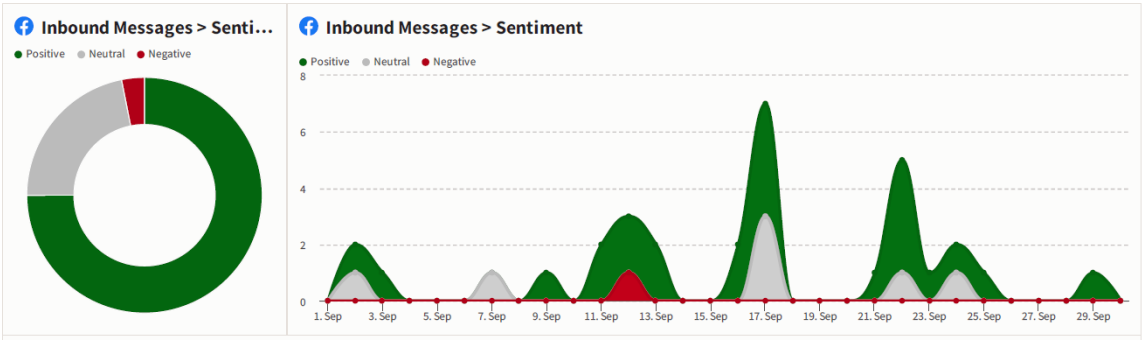
Identifying Positive change over the early stages of COVID-19:
As you will be aware, during the initial outbreak of COVID-19 in March this year DHBs moved quickly to innovate the way services were delivered. In order to capture these innovations and challenges, the Ministry commissioned a small piece of work to compile what was learned during those early months. (*Refer to appendix 1*). Please note this paper was simply developed to share the learnings of the early COVID-19 period and will not be formally published. BOPDHB will be reviewing these learning and looking for opportunities to fine tune its COVID-19 response going forward.

2.2 Communications

Social media activity has been notably lower this month with much less information to share with the public in relation to COVID19 and most postings relating to job opportunities.

We have a new suite of analytics now coming through which will be extremely useful to us as we increasingly take a more intentional approach to the use of social media in the year ahead.

The infographic below shows the general tenor of feedback and comment on our Facebook pages (which remain the most viewed of all the platforms we use). The negative phase in early September related to further reaction to the August posting on hospital busyness which was perceived as the DHB knowing something about imminent hospital service demand but not sharing it (i.e. it was perceived, incorrectly, that we had a sudden COVID issue which we were not telling the public about).



Our top 5 postings during September were as follows:

Post Message	Posted	Total Reach	Engaged Users
Spring is in the air. 💐 60 bunches of daffodils were delivered to our Whakatāne Team yesterday from an anonymous person – thanking our people for their hard work caring for those from the Whakaari/White Island eruption. Thank you kind person ☺ #gratitude #CARE #Manaakitanga #BOPDHB #WhakataneHospital	16/09/20	3705	501
Today is World PT (Physiotherapy) Day and I would like to thank the entire physiotherapy workforce for their dedication in supporting and enabling the well-being of people who come into contact with our services. It has been inspiring to see how responsive and flexible the teams have been in meeting the needs of the system during this pandemic. There are many exciting initiatives across the Bay of Plenty where physiotherapists are leading the way in the prevention and early intervention space.	07/09/20	3134	272

	Our physiotherapists are amongst the first across New Zealand to transform musculoskeletal pathways, which are focused on enabling people to manage their health and wellbeing through proactive recovery-based pathways. Other areas of innovation include: first point of contact practitioners in the Emergency Department, seven day working in the acute setting, early supported discharge for neurological patients to name just a few. Dr Sarah Mitchell Director of Allied Health, Technical and Scientific #BOPDHB #worldptday			
	Tauranga Hospital Mental Health Registered Nurse Sandra Zammit is a strong woman, and it's proven! In August she not only won but set records at the National Championships for New Zealand Powerlifting League. She came first overall in her age group and weight class under 67.5kgs and she achieved two personal bests! Well done Sandra and good luck with the training for the 2021 world championships □🏆	10/09/20	2405	156
	"We want to thank the Welcome Bay Lions for their hard work in raising the funds and their generosity in using them to purchase pyjamas for our children on the ward," said Karyn. Bringing comfort to children and families in need is one of the main drivers behind the Welcome Bay Lions annual donation of pyjamas to Tauranga Hospital's Children's Ward. Read our full story http://ow.ly/MOPz50BjsLd #BOPDHB #TaurangaHospital	06/09/20	1937	158
	There's no Mondayitis for our Whakatāne team when the All Blacks are in town. Some of our team spent the afternoon with the ABs – a gesture of support for those who worked 'above and beyond' after the eruption. Thank you ABs it's a big thumbs up from us! #gratitude #care #manaakitanga	21/09/20	1890	167

Post engagement is the number of unique people who engaged with content from our Facebook post (clicked, liked, shared, or commented).
Post reach is number of unique people who have been exposed to the post (having it display on their screen).

2.3 Notable Visits

Te Aho o Te Kahu | Cancer Control Agency Site Visit
Professor Diana Sarfati and Chief Advisor Dawn Wilson from Te Aho o Te Kahu, the Wellington-based Cancer Control Agency, visited the BOPDHB 22 September meeting with members of the Cancer Service and the Executive Team.

The Cancer Control Agency was established in December 2019 to provide strong national leadership for, and oversight of, cancer control in New Zealand. It is equity-led, knowledge-driven; person and whānau-centred and outcomes-focused, taking a whole-of-system focus on preventing and managing cancer.

From left Clinical Director from the Midland Cancer Network and Haematologist Dr Humphrey Pullon, Regional Hub Manager from Midland Cancer Network Jan Smith, Cancer Control Agency Chief Advisor Dawn Wilson and Chief Executive Professor Diana Sarfati, General Medicine Specialist and Respiratory Physician Pierre de Villiers and Acting Business Leader for Anaesthesia, Radiology and Surgical Services Dot McKeown.

HAPAI SUDI prevention coordination service
Bay of Plenty DHB featured in the HAPAI SUDI prevention coordination service newsletter following a recent visit.

The full report can be read at https://mailchi.mp/71fbf71726d1/sudi-prevention-newsletter-september-2020?e=9fdbc23509

A short excerpt as below:
At the end of August Nari and I visited the BOPDHB in Tauranga and their wānanga wahakura facilitator. We were privileged to visit Bobbe Elliot, a kairaranga wahakura in Te Teko, and pick up six of these beautiful taonga for whānau in the region.

Raewyn Lucas & Bobbe Elliot

3. Our People

3.1 Senior Management Changes

Chief Financial Officer
The new Chief Financial Officer, Simon den Bak, commenced his position with us in October and we welcome him to the DHB.

General Manager, Planning and Funding
Simon Everitt is leaving the DHB at the end of October and will be taking a well earned break before commencing consultancy work. We wish Simon all the very best in his new endeavour. Mike Agew, Acting GM Planning and Funding, will continue in his current acting role for the next six months.

Acting Medical Director/ Chief Medical Officer
Dr Joe Bourne has taken on the position of Acting CMO to cover after Dr Hugh Lees retires this month whilst the recruitment process for the re-designed role is progressing.

3.2 Education and Training

The Education Manager spoke at the Western Bay of Plenty PHO Provider Forum to highlight and publicise the education opportunities available to the wider health sector. This was received well and has resulted in a number of queries and requests for online learning accounts. At the same time, we are working with the PHO to get a Registered Nursing Community Prescriber course up and running. This has been developed by Counties Manukau and signed off by the Nursing Council. We are also working closely with the PHO around endorsement from the Royal GP College, as well as exploring options for more integrated education around life support. Staff from Kathleen Kilgour Centre have recently all had accounts created for accessing Te Whāriki ā Toi.

Midland GMsHR have approved, in principle, the employment of an Instructional Designer for regional courses to contribute to collaboration and consistency for online courses. The Education Manager will be taking the regional lead on working with HealthShare to prepare the papers for regional CEOs and the governance of this group. At a national level, we are also part of the team looking at a national learning solution and data sharing.

The Digital Capability Trainers have started producing a newsletter on computer tips and tricks. This has been a huge success so far with some areas having an open rate of 94%. Feedback has been positive, and people have engaged with the newsletter, both by opening, but also sending in tips and tricks and requests for further topics. They have also been working closely with IT around the changes to Zoom, and have produced a number of resources on both Zoom, and other IT topics, based on an online course from Taranaki DHB.

A series of Zoom sessions on ‘engaging effectively via video conference’ were delivered, with overwhelmingly positive feedback from attendees. Another series will be arranged as there were people interested who could not attend on the pilot sessions.

A formal evaluation of MedApps will be presented in mid-October. There are 50 users across Whakatane, mainly students and House Officers. The feedback is positive, though there is interest in being able to access OnePlace for documents such as rosters and Controlled documents. The vendor is currently preparing quotes for a wider roll out if there is the appetite for this.

Health Leaders Advanced has been confirmed to continue in 2021 with Midland colleagues. The format has changed again since the 2020 delivery, and an evaluation will be completed to determine if it still meets the needs of the organisations. BOP Health System will have seven places out of twelve for attendees.

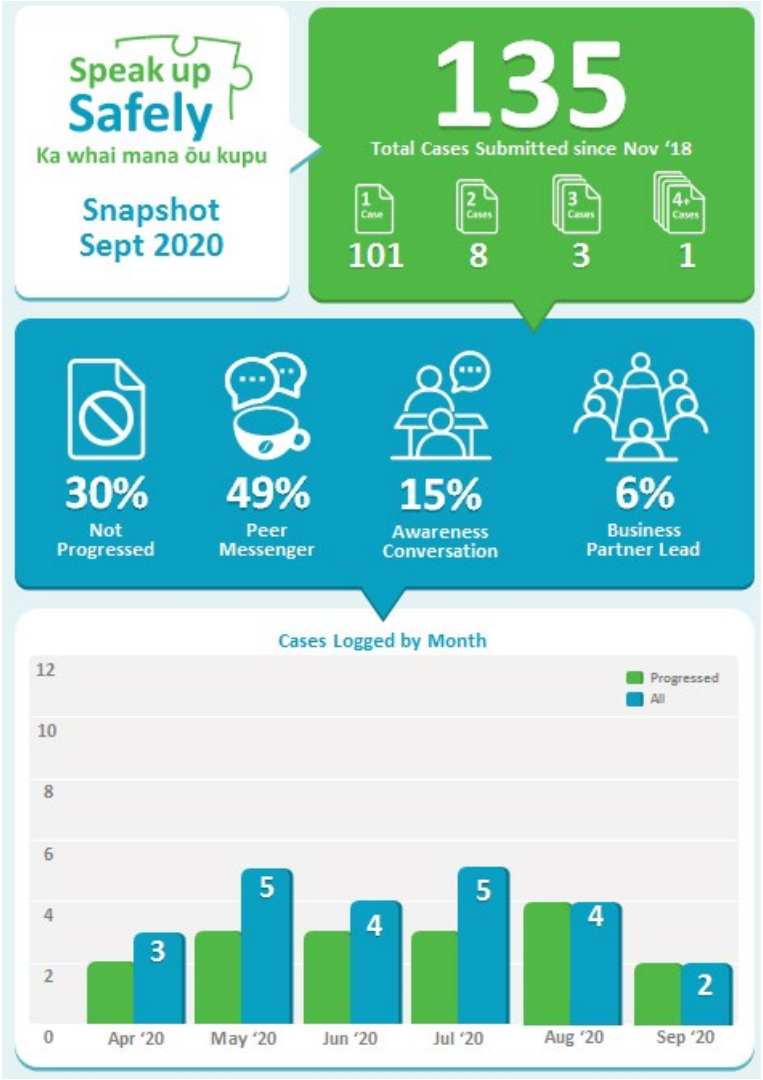
3.3 Speaking up Safely

Speaking Up Safely (The Cognitive Institute model of low level addressing of inappropriate behaviour) has now been running for two years. This commenced as part of our Creating our Culture initiative and transferred into People and Capability in 2019.

The below infographic provides an overview of the number of reports received to date and the resulting actions and this is notably lower than might be expected. I have undertaken several recent tests where teams have raised issues about individuals to ask whether Speak up Safely had been used and the response has been that is has not.

We still believe that the model, which is in principle supported by our Unions, is a good one but if this is something we want to continue with then it may need some process amendments and definitely requires much greater awareness amongst staff groups.

During October and November a phase of discussion with staff and Unions will commence to establish comprehensive feedback on Speaking Up Safely in order to determine whether we continue with this as a key toolkit item and whether any changes in approach need to be made.

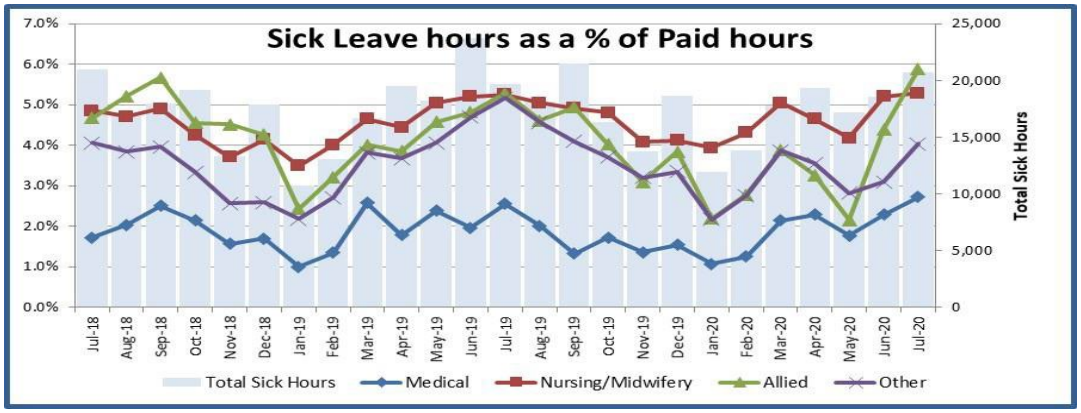


3.4 CCDM

Care Capacity Demand Management (CCDM)

In Ministry feedback from Quarter 4 performance, BOPDHB received an outstanding rating for CCDM implementation.

Monitoring of the CCDM programme takes place through the Core Data Set and the Staff Report. Following are further examples of the measures. Sick has a seasonal variation and rates were slightly higher than usual in winter as staff followed advice to remain at home if there is any suggestion of coughs or colds.



Reduction in Nursing Overtime Initiative

Nursing has initiated work to reduce overtime hours. Working long hours is strongly associated with adverse outcomes for staff. Increased staff tiredness, results in loss of goodwill.

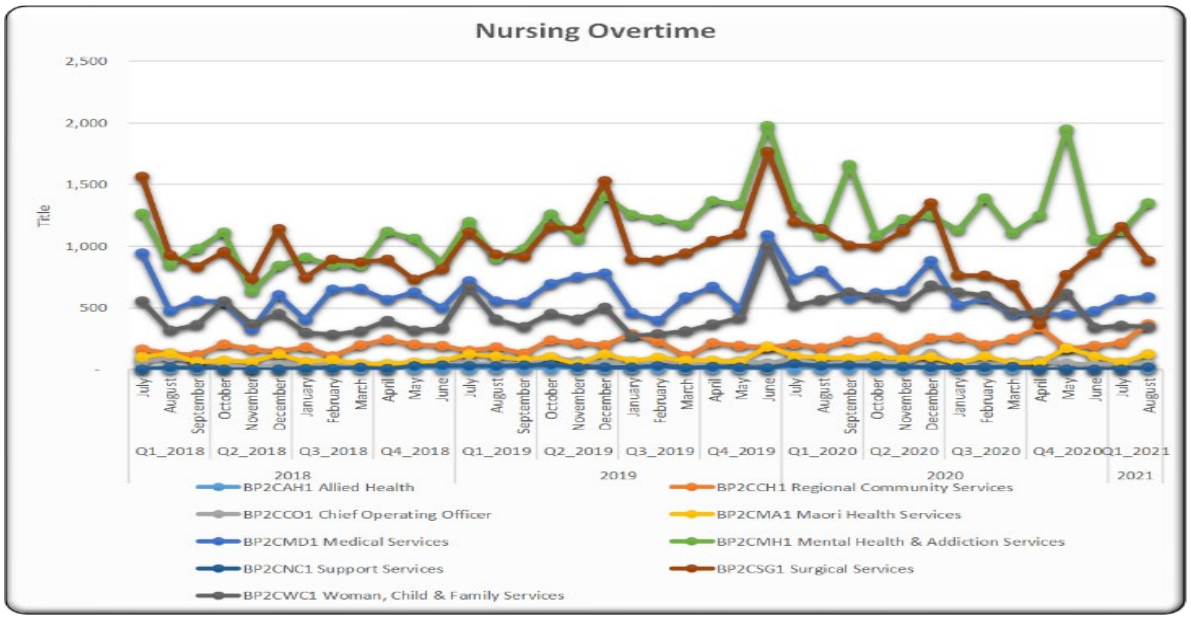
As the base Nursing, Midwifery and Health Care Assistant (HCA) FTE has increased as an outcome of the Care Capacity Demand Management (CCDM) FTE calculations, the reliance on overtime as a response to variance should decrease.

The aim is to reduce Nursing, Midwifery and HCA overtime hours by 17,000 hrs this year.

Mental Health is the first service to commence this initiative and Surgical Services will follow as two areas of the highest overtime. Understanding the key drivers for the use of overtime will help determine various solutions. Learnings will be shared where there are similar drivers.

The following graphs show Mental Health and Addictions with the highest overtime in the organisation. The Business Leader is to lead this project to explore key aspects leading to overtime and strategies to address.

BOPDHB Nursing Overtime by Cluster



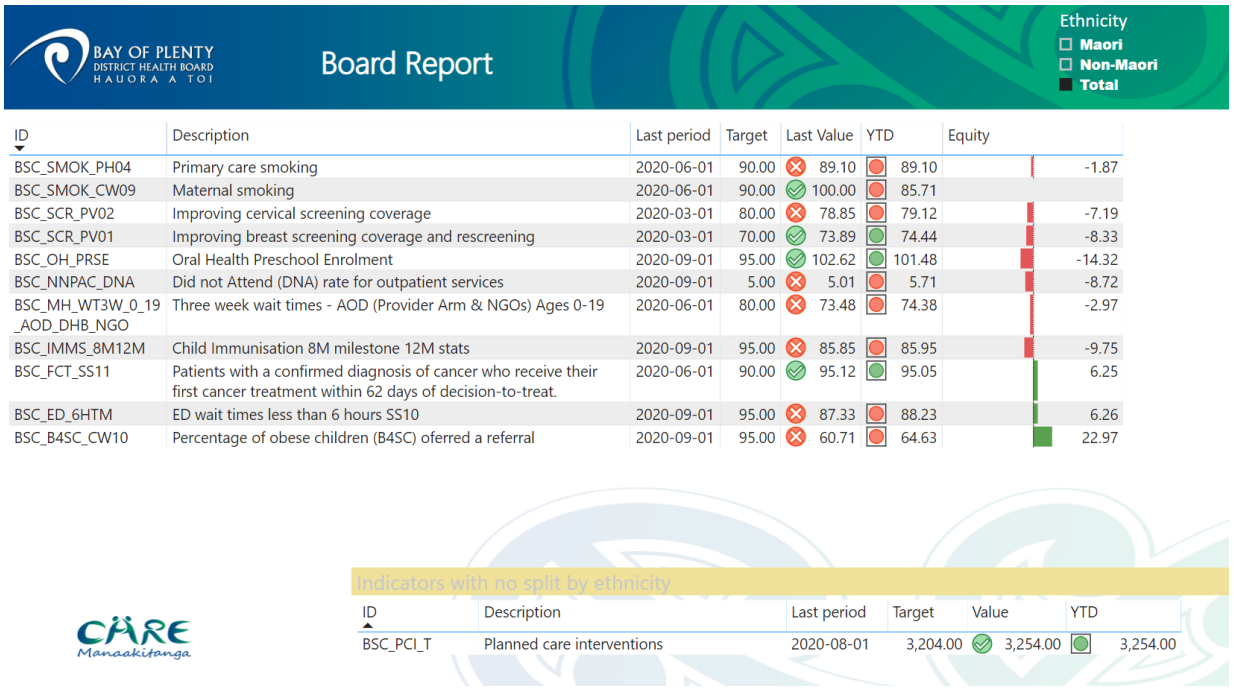
3.5 Whakaari Recovery

A range of activities occurred as part of the post Whakaari recovery programme

- A Hauora/Wellness Coordinator position has been established and the recruitment process has commenced – application process is open until 2nd October
- Whakatane Staff Wellness strategies – survey underway with staff on strategies and outcomes
- A team from Canterbury DHB visited and delivered a presentation and two workshops on the recovery processes they adopted post the Christchurch mosque shooting and the Canterbury earthquakes.
- Communication and public relations activities including a key staff member providing an interview to a NZ On Air documentary, 10 employees attending the meet and greet with the Prime Minister on 9th September, and 8 employees attending the All Blacks practice session in Whakatane and meeting with players afterwards. The Australian High Commissioner has indicated a desire to reschedule her visit, post-poned as a result of COVID, but at this stage this is yet to happen.
- Emergency Management BOP Whakaari Recovery Leaders Group – continues to meet monthly. Ngati Awa are planning a day of recognition with different activities – no detail available yet

4. Bay of Plenty Health System Performance

The Board presentation session on dashboards unfortunately did not take place last month but is planned and will enable confirmation of the key indicators for inclusion in this section however our current high level indicator dashboard is included:



ID	Description	Last period	Target	Last Value	YTD	Equity
BSC_SMOK_PH04	Primary care smoking	2020-06-01	90.00	89.10	89.10	-1.87
BSC_SMOK_CW09	Maternal smoking	2020-06-01	90.00	100.00	85.71	
BSC_SCR_PV02	Improving cervical screening coverage	2020-03-01	80.00	78.85	79.12	-7.19
BSC_SCR_PV01	Improving breast screening coverage and rescreening	2020-03-01	70.00	73.89	74.44	-8.33
BSC_OH_PRSE	Oral Health Preschool Enrolment	2020-09-01	95.00	102.62	101.48	-14.32
BSC_NNPAC_DNA	Did not Attend (DNA) rate for outpatient services	2020-09-01	5.00	5.01	5.71	-8.72
BSC_MH_WT3W_0_19_AOD_DHB_NGO	Three week wait times - AOD (Provider Arm & NGOs) Ages 0-19	2020-06-01	80.00	73.48	74.38	-2.97
BSC_IMMS_8M12M	Child Immunisation 8M milestone 12M stats	2020-09-01	95.00	85.85	85.95	-9.75
BSC_FCT_SS11	Patients with a confirmed diagnosis of cancer who receive their first cancer treatment within 62 days of decision-to-treat.	2020-06-01	90.00	95.12	95.05	6.25
BSC_ED_6HTM	ED wait times less than 6 hours SS10	2020-09-01	95.00	87.33	88.23	6.26
BSC_B4SC_CW10	Percentage of obese children (B4SC) oferred a referral	2020-09-01	95.00	60.71	64.63	22.97

Indicators with no split by ethnicity

ID	Description	Last period	Target	Value	YTD
BSC_PCI_T	Planned care interventions	2020-08-01	3,204.00	3,254.00	3,254.00

Once our new Equity Performance Improvement commitments are agreed with the Board these will be included in this section.

5. Financial Performance

Financial performance to the end of September is yet to be available.

As at the end of August, the DHB had a year to date deficit of $0.976m which represented a $1.652m unfavourable variance against the phased Annual Plan budget.

COVID related costs accounted for $1.1m of the deficit meaning that the "business as usual" operating result was $0.5m adverse to budget at the end of August.

6. Bay of Plenty Health System Transformation

Our re-defined overarching priorities are being proposed to the Board this month and subject to endorsement, this section of the report will be re-defined in line with the refreshed model but will continue to set out the transformation activity which is underway.

Currently the CEO is working with the Improvement & Innovation, Quality, Funder and Provider Teams to bring together a visually appealing integrated overview of the key organisational workstreams by December, following which discussion will expand to include our PHO partners. This development will enable wider awareness and engagement across the whole DHB, as well as the wider health system and this in turn is preparing us for the development of a Bay of Plenty Healthcare System Transformation Hub. This concept takes the learnings from our Integrated Operations Centre model and translates into an execution model to drive change, improve performance and deliver on our commitments to our communities.

6.1 DHB Operating System: How we work

Business Systems – eRecruitment Replacement

The project to replace the DHB's use of Taleo as its recruitment system is nearing completion with the aim of go live date of 3 November. The new recruitment platform provides full system integration with the DHB's current HRIS system allowing for a more streamlined workflow and the adoption of a full service recruitment process from initiation through to onboarding of applicants. Apart from improving the process for applicants and DHB users, the system will enable improved understanding of the overall recruitment process with enhanced metrics around vacancies, turnover, time to hire etc.

Integrated Operations Centre (IOC)

Hospital Capacity at Tauranga is still under pressure with Intensive Care Unit (ICU)/High Dependency Unit (HDU) constraints causing further disruption to planned care operations. A maximum of two planned care cases are able to be scheduled on any given day which require an ICU/HDU bed to allow capacity for acute patients.

The IOC is undertaking long length of stay reviews and re-implementing a red and green bed day process at Tauranga Hospital. This was one of the initiatives during the acute flow improvement Frances Health programme to identify patients without any value-added activity.

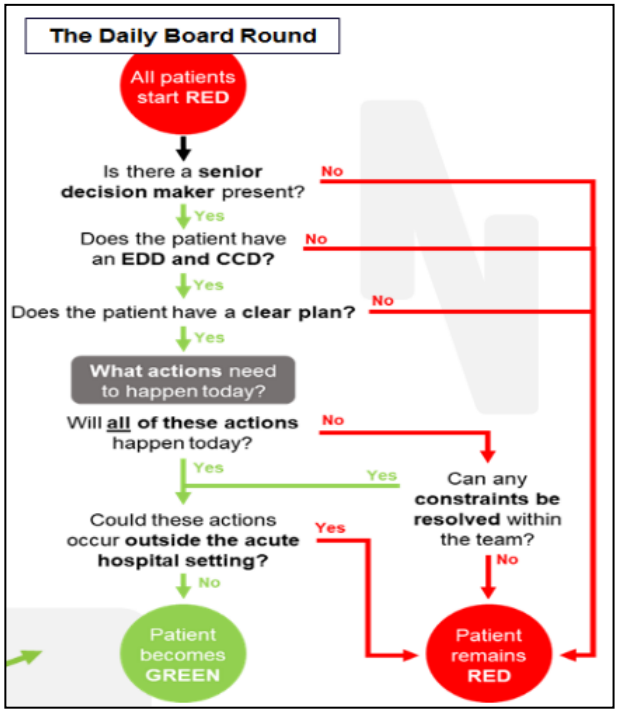
Work is underway with Tauranga Admission Planning Unit (APU) to develop information that would be useful to clinicians to help reduce unnecessary delays. This will focus on the patient journey including current location and delays to discharge. Christchurch and Waitemata DHBs have this functionality and their systems and information are providing the basis for the BOPDHB development.

Perioperative Services are developing a Variance Response Management (VRM) set customised to their particular pressure points and the IOC will give visibility to this. A walk through the patient journey is planned with the aim of mapping, agreeing and identifying key time stamps. This background work is essential to record and report delays and timeliness.

Surgical Wards Length of Stay

Discharge delay reasons weekly snapshot of patients with a length of stay greater than 7 days commenced 25th August.

Using criteria for 'red day' or 'green day' the weekly audit captures themes for patient delays to discharge. Escalation includes summary of delay themes to IOC and follow up action by Nurse Leader.



For the first 3 weeks of September the key themes for delay to discharge:

- Patients waiting for Allied Health interventions. Solution: The Service Leaders are working together to track and respond to demand. Services are considering increasing Allied Health presence across the seven-day week.
- Orthopaedic patients between surgical interventions and are not deemed safe to discharge home or to a community care facility. Solution: orthopaedic patients that meet clinical criteria wait in another facility and are actively managed. An assessment of the average requirement for beds in the community occurred in 2019, additional beds are available from time to time with the preferred provider.
- Patient without Enduring Power of Attorney (Court process). Solution finding: A legal opinion from DHB Legal Advisor was requested and provided.

Planned Care Improvement Initiative Funding Proposals

BOPDHB submitted the following suite of proposals for the Ministry of Health Service Improvement and Workforce Initiatives funding ($7.75 million) and Capital funding ($50 million). The selected proposals focused on equity, quality and agile change principles that will contribute to substantially reducing waiting times, providing alternative models of delivery and increasing equity for Māori:

- Community Orthopaedic Triage Service
- Enterprise Scheduling Platform
- Community-based Ultrasound Services at Kawerau and Ōpōtiki
- Increased Radiology engagement for Māori
- Electronic Shared Care Planning
- Telehealth: Workflow Integration
- Telehealth: Programme of Sustainability
- Digital Transcription

- Care closer to home for Refractory Glaucoma patients

It is expected that the Ministry will provide a response of the selected proposals mid-October.

Digital transformation

Digital Strategy Development

The development of the BOP Digital Transformation Strategy has commenced with initial presentation to the Executive of the planned programme of work. The strategy is expected to be completed by February 2021 is led by the Chief Information Officer, Richard Li, and utilises the specialist skills of the DHB and SPARK Health who have successfully undertaken a similar exercise at other DHBs. The outcome of the work will be a Digital Health Vision/Strategy and high-level roadmap that will enable the delivery of BOP Strategic Health Service Plan 2017 – 2027, Te Toi Ahorangi and other key strategies.

In aiming to develop a sectorwide shared Digital Strategy, key stakeholders across the District will be engaged with and links will be developed to relevant sector Digital Health Strategies (e.g. MoH Digital Strategy, MoH Information Services Strategic Plan, Midlands Region ISSP and BOP Providers plans). This all sounds like a complex web of strategies, which indeed it is, hence the need to bring together our locally consolidated version.

Clinical Systems - Midland Clinic Portal (MCP)

With the Midland Clinical Portal going live in October, work is now developing in relation to the subsequent development roadmap.

Existing primary and community provider access to BOPDHB data will be unaffected by BOP's transition to MCP. Enabling work has been undertaken to ensure clinical data created and held in the regional MCP can be viewed by our community users via their existing CHIP for Primary access.

As part of the regional data sharing. BOP's team is also working with HealthShare on bringing Tairawhiti results into Éclair to broaden the existing sub-regional repository of diagnostic data. This aspect of the work is expected to compete around December.

Business Systems – Microsoft Modern Workplace

The programme to adopt the Microsoft cloud based product suite as part of the DHB's digital transformation was paused in August on request of the EOC due to Covid-19 response impacting the business. Restarting in late September, the programme currently has over 1200 of the DHB's device fleet migrated (approx 46%). Other aspects of the migration such as transitioning email and shared documents are not as advanced – expecting to be substantially complete by last quarter of 20/21.

Overall confidence level for this project is Medium due to the potential technical issues being dealt with and the complexity of the DHB environment. As aspects of the migration are delivered this confidence level will increase.

Workforce and People Strategy

Flexible Working/Modern Workspace

As part of the People Strategy and in line with capturing the innovation gains post-COVID, a set of principles for implementing flexible working arrangements and workspace environments has been developed. The flexible arrangements workstream looks to define work role types and identify the key elements of the "working style" of those roles. This is then used to define the mobility, technology and physical location requirements of the roles and the consequent workplace arrangements.

Our People Strategy is now in the final phase of construction with a deadline for release in November. This will be shared at the November Board meeting and sets out, for the first time, principles and approach in supporting a flourishing workforce.

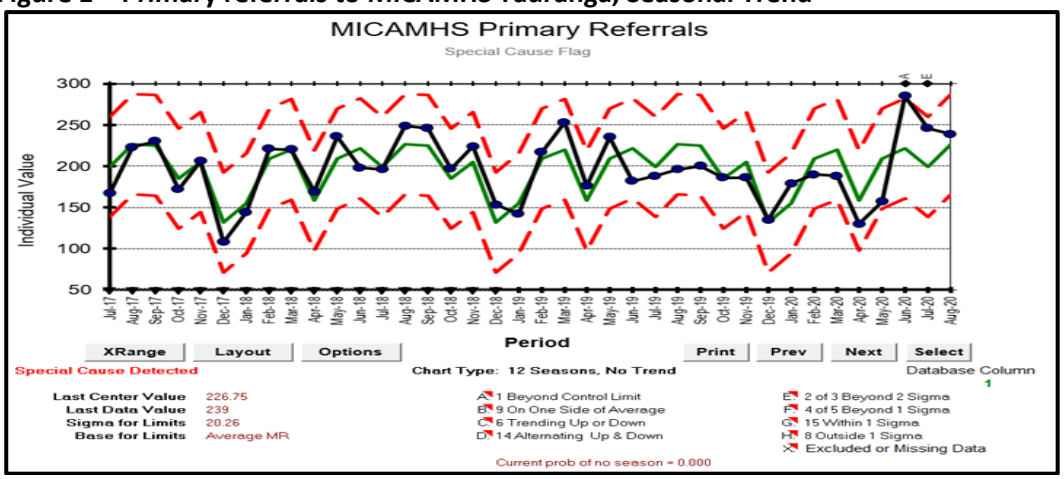
6.2 Mental Health and Addictions Services

Maternal Infant Child and Adolescent Mental Health Service (MICAMHS) Redevelopment

The move of the Adolescent, SORTED and Duty teams to 290 Cameron Road was completed on the 26th of August. The focus will now move to the development of the Service Improvement Plan for the two teams – Youth Service (Adolescent Team and SORTED Team) and Child Team. Team Leader for the Child Team has been seconded to a Project Management role to co-ordinate the Service Improvement Plan with support from the Nurse Leader and Business Leader.

Teams been challenged by the volume and complexity of the clinical work (Figure 1) with volumes in the last three months being significantly higher than previous periods at the same time. The demand at this time of year is usually higher than other times.

Figure 1 – Primary referrals to MICAMHS Tauranga, Seasonal Trend



Mental Health and Addiction Crisis Support (MHACS) Capability Planning and the establishment of a Mental Health and Addiction Crisis Support

A national group has been convened of interested parties from the General Managers Mental Health and Addictions to share ideas and progress on this project. Resources will be shared as appropriate. Focus at this stage in the Bay of Plenty will be in the Emergency Departments and management of mild to moderate presentations to develop pathways and ensure appropriate and consistent follow up for ED presentation.

6.3 Integrated Healthcare

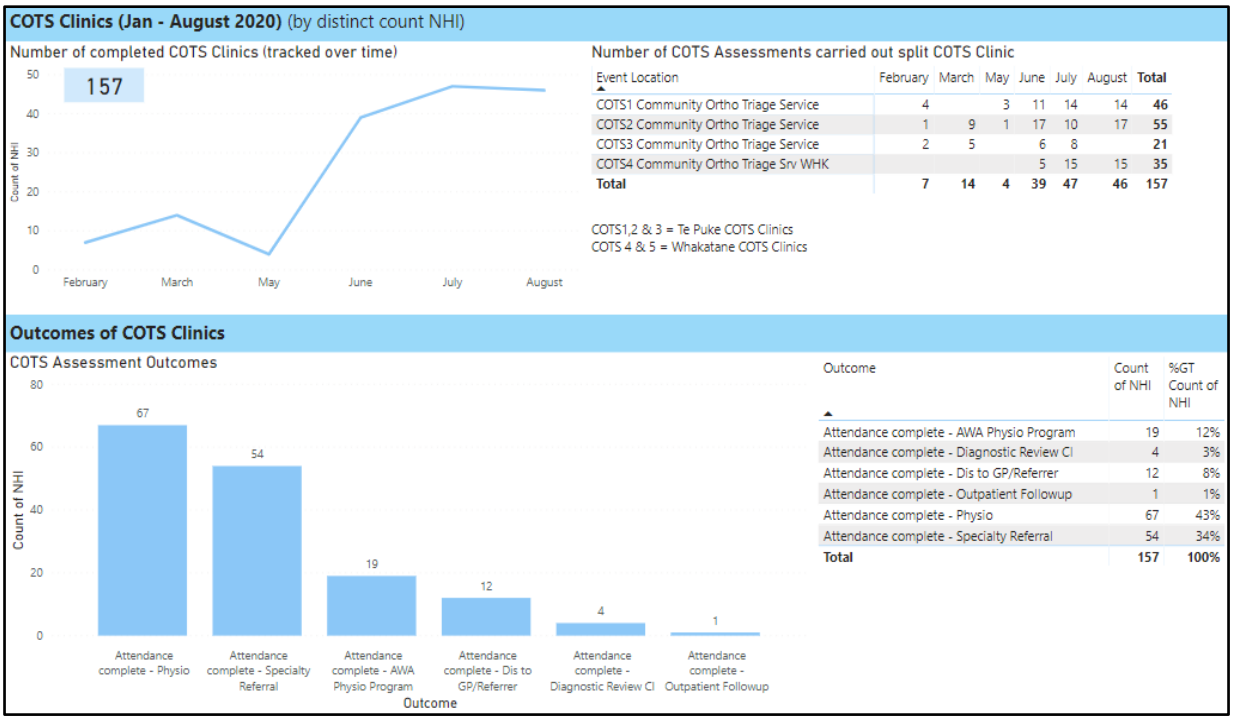
Orthopaedic Transformation

Community Orthopaedic Triaging Servicing (COTS)

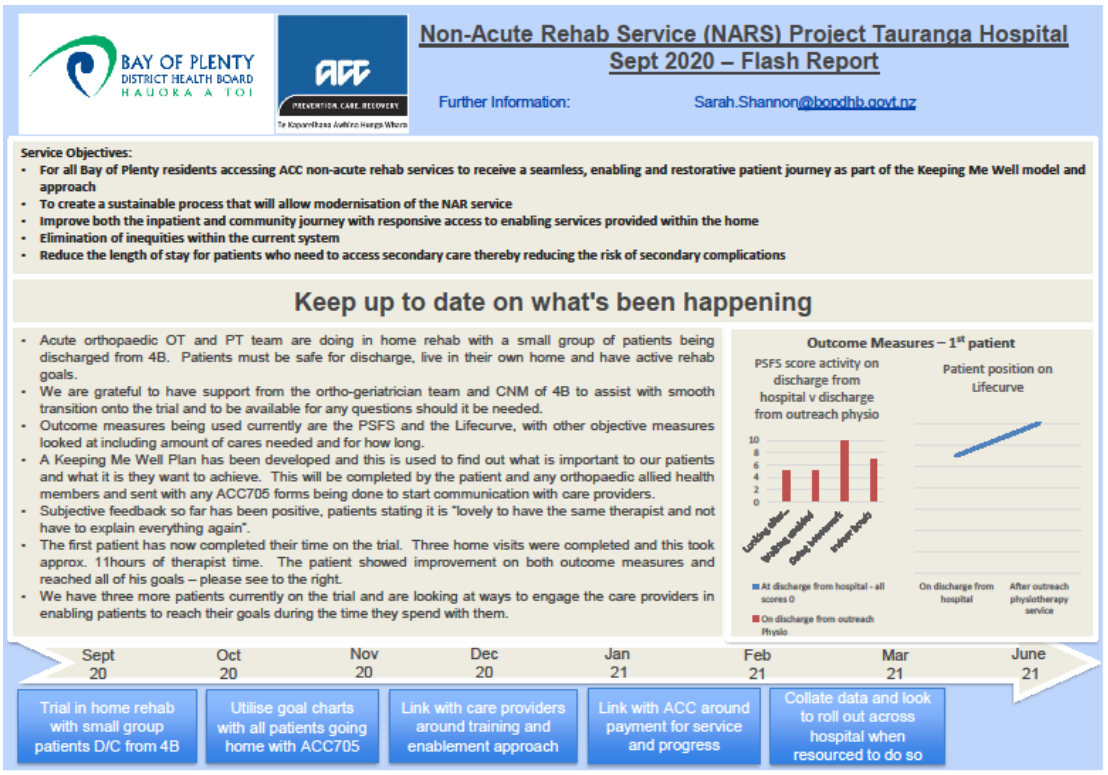
This service continues to develop and expand as shown in the following dashboard. The inclusion of visual wait-time data for the service will be included in next months report.

Only a third of COTS assessments result in on-referral for surgical opinion and On-referral to DHB Physiotherapy (43%) is the most common pathway for patients seen. This will naturally create additional demand to the existing service or needs to be closely monitored and respond to.

All of these referrals have been graded for orthopaedics by the COTS physiotherapist with the patient's appointment booked according to grade.



The following dashboard provides a summary of the NARS programme which focuses on progressing greater post admission to hospital rehabilitation enabled in the patients' home environment.

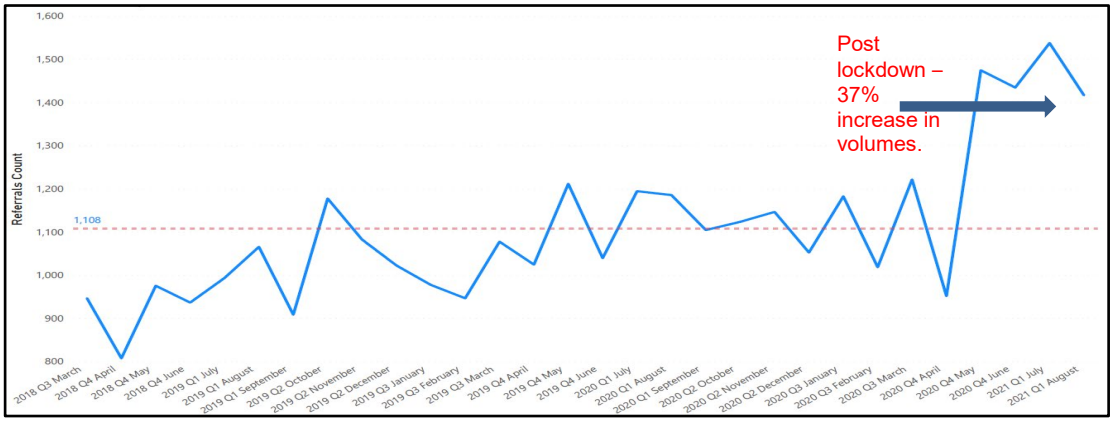


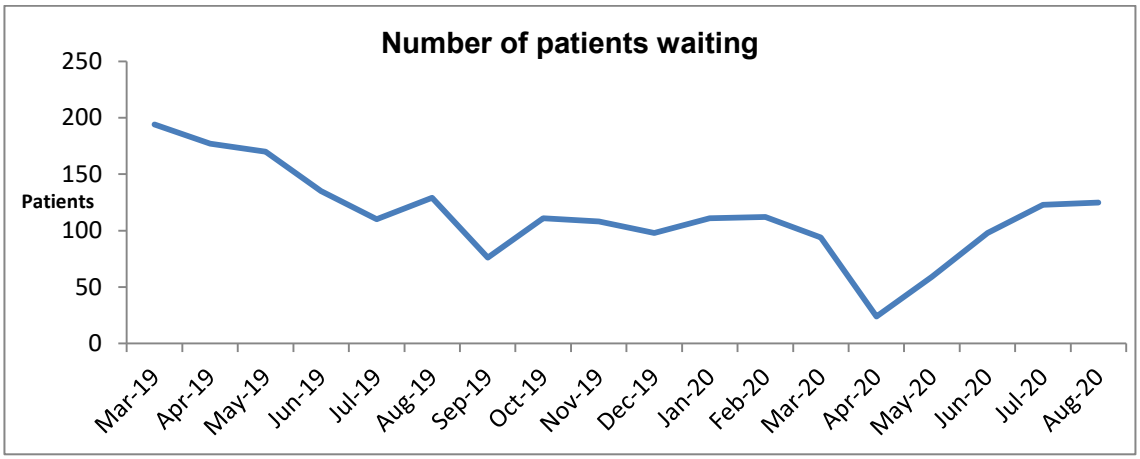
Keeping Me Well

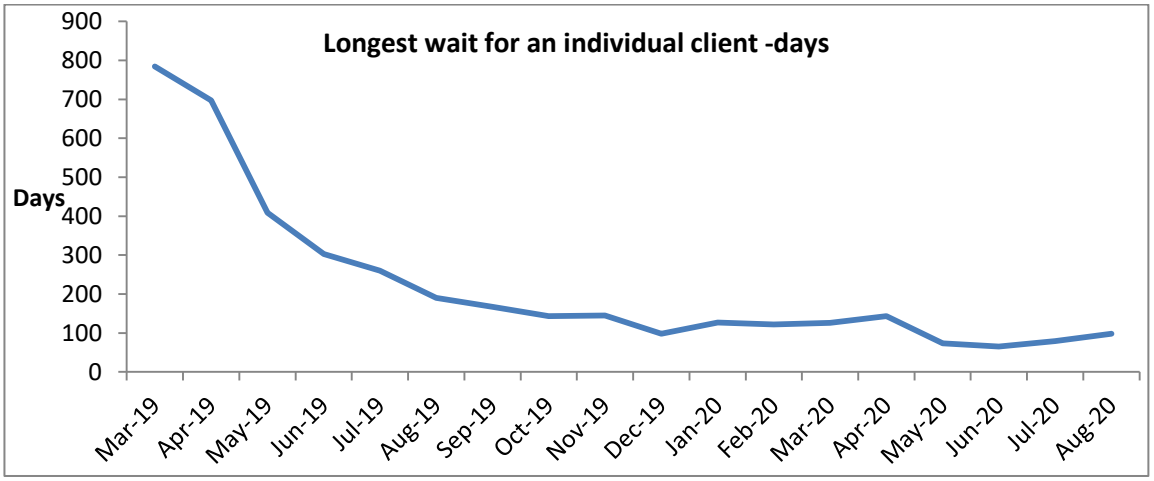
Community Care Coordination (CCC)

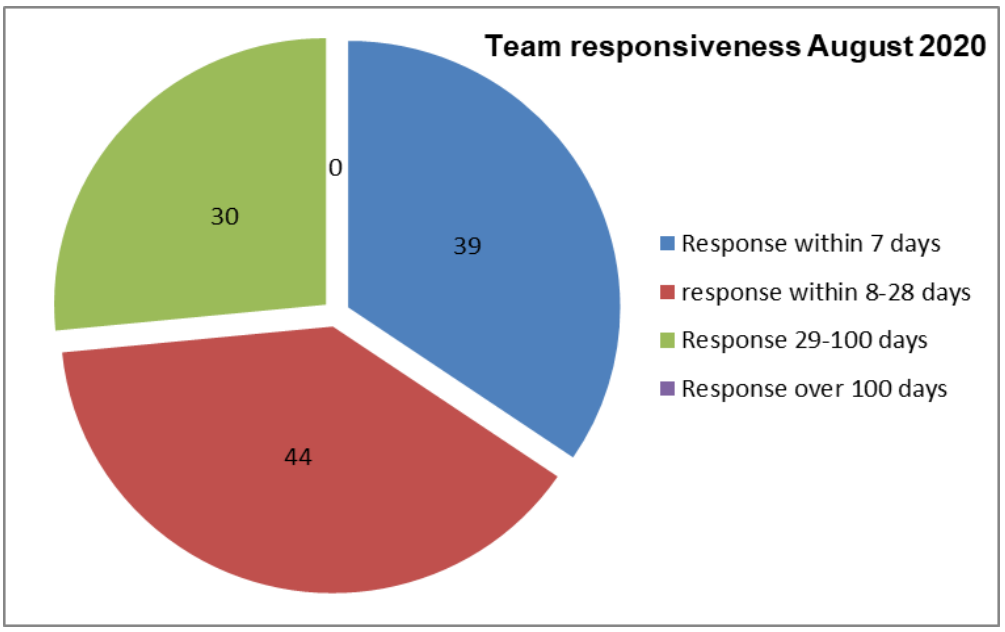
The Community Care Coordination Centre aims to provide a single point of access, navigation and coordination, for people requiring community based short term health and enablement services across the Bay of Plenty.

The following graphs provide a high level summary of activity and of note a marked increase in referrals during and post Covid lockdown in March.









Support Net

The CCC team is making good progress in conjunction with PHOs regarding wound care packages for simple wounds now being managed by GP practice. A good number of practices are now on board with this process.

More Social Workers in the Eastern BOP are trialling the CCC Short Term services format where services are modified to suit the client's needs. Casual Allied Health staff are supporting the CCC team and making an impact on Community Allied Health referrals.

Avoiding errors due to the increased pressure and demand on the current staff is challenging. Education required for staff within the DHB regarding the differences between short term and long term packages of care. Plan to address this at Clinical Nurse Managers meeting CCC Operations Manager

LifeCurveTM

- One-year fixed-term Project Manager commenced 31 August.
- Currently in testing phase, meeting with all five partners/testers to facilitate and support using the LifeCurve™ App
- Next steps are to increase testing, collaborate with MHGD regarding changes to the App to make it relevant for Maori and all NZ, and look at mapping of services to positions on the LifeCurve™
- Tauranga Orthopaedics NARS trial good news story with LifeCurve™ testing: one patient moved up three levels (discharge from Tauranga Hospital to six-weeks post with outreach physio input at home); now only one level away from being off the LifeCurve™

6.4 Child Wellbeing

Child Development Services (CDS)

The Child Development Service (CDS) project is progressing well. The CDS advisory group convened for the first time on 30 September, bringing together members from a range of DHB departments, Oranga Tamariki, MOE, and service users. The advisory group creates a platform for cross-sector collaboration and will consider service development opportunities for CDS based on learnings from co-design with whānau. The advisory group received a mention at the Disability Sector Election Event which can be viewed here
https://www.youtube.com/watch?v=59YM4LiinZg, a quote from the event is included below.

"…committed to changing how disabled people and whānau are supported by working on the planning and design processes that would have Health New Zealand and DHBs working differently than they do today. In Tauranga… these discussions are happening now and I'm part of a newly formed advisory group that's looking for ways that we can redesign the current system and move away from the pockets of funding we're all fighting over and bring them together for the benefit of the individual or the family. "

The project has documented an initial understanding of CDS which is being reviewed by the CDS teams before wider circulation. The document brings together feedback from our teams on what the service is, what's working well, and what are the opportunities ahead.

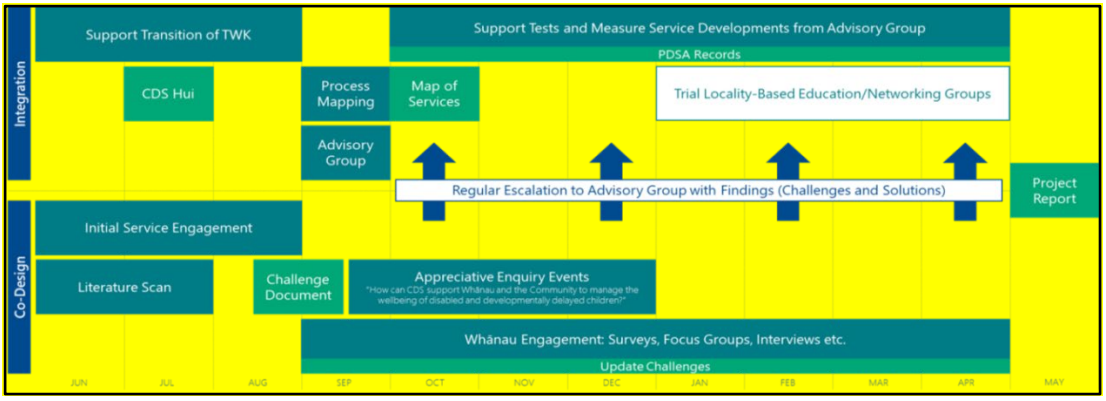
Next steps for the project include process mapping for CDS, and hosting whānau engagement events such as focus group with the first one planned for 21 October in Tauranga.

Feedback on the joint application by Hutt Valley DHB and BOPDHB to fund the creation of a CDS website is expected this month. The idea was raised in the Te Manawa Taki (Midlands) CDS meeting and was well received by the other providers in the group, with a couple offering their time and support if the application is approved.

A document summarising feedback from the CDS hui and individual meetings is nearing completion. This is intended to give a service-based view on current state and trigger further thinking and ideas to come from providers and the community.

The project lead has reached out to Iwi Provider Alliance to start discussions on community engagement in the Eastern Bay of Plenty, and will submit a paper to the Rūnanga to discuss engagement in the Western Bay and areas in the East not covered by the Provider Alliance.

The Project Initiation Documentation has been finalised along with the Project Plan (following). The project is about to commence wider community engagement and has drafted questions and information for focus groups, and the appreciative enquiry topic for events with other service providers. Feedback from these events will be considered by the Advisory Group and will inform future service changes**.**



7. Health and Safety

Health & Safety Representative Training

The signed Worker Participation Agreement, which is effectively a national agreement, notes that union partners prefer WorkSafe to be the training provider. BOPDHB has utilised a company called Coachio to provide this training.

An issue at the recent H&S Advisory Group has arisen with the training provider for H&S representatives. The issue was raised by PSA, a response is being prepared for discussion with Executive as a number of factors need to be considered in the response – cost being the key one (WorkSafe Reps) appearing to be significantly more at first glance.

ACC Accredited Employer Programme (AEP) Audit

The new Health & Safety Manager has embarked on a process of reviewing current state, planning a programme of improvement and leading the preparation for the ACC AEP audits. As an accredited employer the DHB faces a full audit of its compliance with the programme on a biannual basis and an audit of aspects of the programme in the intervening year. This year the DHB faces an injury management audit in October and the full audit in June 2021.

Significant work has been undertaken to prepare for both these audits with ongoing activities planned to ensure the major audit in June 2021 is passed.

7. Clinical Campus

Students

The academic year is fast coming to an end with Year 5 medical students finishing at the beginning of October, some are staying on to complete compensatory time that was missed during COVID lockdown. Year 4 students will finish on 6 November and again some will stay on to complete compensatory time.

Year 6 finish on 29 October, most of the cohort have been offered house officer roles in their chosen DHB and will take these up in either November 2020 or January 2021.

The new academic year starts again on 11 January 2021 with the arrival of 30 University of Auckland year 6 students.

The Rural Health Interprofessional Programme (RHIP) in Whakatāne has an additional cohort commencing 12 October 2020 for those students who missed out on placements during COVID lockdown. The first cohort in 2021 will commence on 25 January.

A huge thank you to all the supervisors who look after these students that go above and beyond

HRC Health Sector Research Collaboration Grants

HRC Health Sector Research Collaboration Grants are undergoing final review in September. We are expecting to hear whether we have been successful in our application for HRC collaboration grants in October. The grants are to support development activities relating to service delivery research for BOPDHB integrated health projects.

- Mid-September – Portfolio Panel meet to discuss applications and make recommendation to HRC Council
- October – HRC Council consideration of funding recommendations
- October – discussion and contract negotiation with HRC and DHB pilot partners
- November/December – contract commencement

Clinical Trials

Recruitment to clinical trials has begun to pick up again after a slow period of activity following various impacts from COVID -19. We have approximately 16 patients on active treatment across all trials currently. We have been awarded 10 new trials in the last 2 months, most of which will be open by the end of Q4 2020. The majority are oncology trials.

8. Te Teo Herenga Waka and Toi Te Ora

Planning

Transactional

- The Annual Plan has been submitted for sign-off.
- Savings plan work has been started with a review of Inter-district flows yielding savings potential initially in the order of $750k related to Planned Care.

Next steps will include intensive monitoring, revised target setting and advice thereof to DHBs of service and a tripartite approach to referral management involving the Provider Arm.

Transformational

- Work is underway for the DHB to become a Disability Confident Employer. This effort is in line with the expectation that the DHB prepare a disability action plan by the end of June 2021. This may become a sub-regional effort with Lakes DHB. Discussions will occur in October.

Funding

Transactional

- Performance to budget is $0.1M better for the month of August. Health of Older People is an area for investigation with high levels of volume growth.
- Contract renewals and variations are on track for completion by the end of September 2020.
- Admin resource is being trained to enhance contract administration.

Transformational

- A workshop is planned for November to decide on Performance Monitoring and how fit for purpose the current approach is. P&F will continue to push for consideration of Community data collection and management as part of the DHBs data management strategy. At present data formats are inconsistent and not amenable to simple management and review.

Personal Health

Transactional

- A sub-regional agreement to manage Urology services is under consideration. This could see a single contract across Lakes and BOP and would lead to improved coordination and relationships with the Provider. A decision is targeted for the end of the calendar, during which time remedial audit and contractual work must be completed before BOP would contemplate taking a lead contractual role.
- Hypofractionation techniques in treating cancer (breast and urology) with radiotherapy have been developed which will change the cost structure of service delivery. Service provider KKCLP is prepared to negotiate impacts as part of the 20/21 contract negotiation, further illustrating the positive turn in its relationship with the DHB.

Transformational

- Service shifts into the community have been scoped for Iron infusions. Procurement strategy remains the final matter to be resolved.
- A different, capacity-based funding model Routine Wound Care in the Eastern Bay Primary care space is under consideration. This would see the PHA play a greater role in referral management and enforcement of the principle that once a referral is made to Primary Care it is managed by Primary Care.
- Whakatane Acute Flow. Staffing business case is out for review. The aim is a 4 year rotational Rural Hospital Medicine Programme.

Mental Health

Transactional

- Grief Support Services are now running two peer led support groups. One in Papamoa in response to the increased number of suspected suicides in this area over the past 9 months and an evening group at their premises in Greerton. In addition to this their peer lead support service is due to become operational mid- October.

Transformational

- Tauranga Community Housing Trust continues to actively work with tenants from the RSA flats. All but two of the tenants have been relocated.
- Accommodation service contract reviews are taking place to move towards more flexible service options and intentional pathways of care.

This is a precursor for a more in-depth review currently being planned for all MH&A facility-based services as part of the model of care design for our inpatient rebuilds.

Health of Older People

Transactional

- **ACC Falls Prevention Live Longer for Stronger**: Funding ceases as of the 31 of December 2020 for both contracts. ACC will be submitting their business case for the continuation of funding beyond 2020, however, the DHB is also preparing a case if the funding bid proves unsuccessful.

Transformational

- The Palliative Care project to reshape services has been rekindled and the project Team enhanced with the addition of SMO, MHGD and a Person-Centred Experience representative.
- Keeping Me Well pilot is extending to a second Te Puke Practice. Fulfilment scores have improved from 2.4 initially to 9.0 post intervention.

Child, Youth and Dental

Transactional

- COVID impacts involving diversion of Public Health Nurse resource are being assessed in terms of Annual Plan commitments and BAU catch-up potential.

Transformational.

- Child Development Service/ CDS projects on track for Implementation of new resource and Innovation project investigation of a new model; regular consultation in place with Midland regional providers group and MoH for national direction.

Women and Population Health

Transactional

- Dr Rachel Shouler has agreed with BOPDHB to support nurses working in Ngati Awa and Tuwharetoa Ki Kawerau Hauora to perform Jadelle Implants under the Protected&Proud contraception contract. This includes supervision and standing order support.
- A Tamariki Ora nurse from Ngati Awa has recently completed the LARC training and has since been supporting local women with successful LARC insertions conveniently in the community. Enabling Tamariki Ora nurses the ability to offer their clients Mothers with this option for contraception provides an opportunity for whānau to have a long-term contraception available to them by a practitioner that they are already engaged with and trust.

Transformational

- The Systems Level Measure initiated project for improving access to STI self-testing for youth is underway. This is a partnership between Tauranga Youth Development Trust and the Sexual Health Clinic. It is proposed that 100 quick test kits are tested by youth and men who have sex with men to gather insight as to if this sort of testing is acceptable in the Bay of Plenty.

Primary Care

Transactional

- Teams at EPHA and WBoPPHO have been working together to prepare our regional Primary Mental Health proposal ready for the next round of MoH RFPs.
- Proactive community engagement with Motiti and Matakana Island residents has resulted in some significant collaborative achievements including First Aid Training (18 residents) Telehealth and supply of medical equipment.

Transformational

- Three Healthcare Home practices are undertaking HQSC training in co-design. The co-design project is a pre cursor to quality improvement; what to focus on, problem to solve, working with their team and the community.
- WBoPPHO is supporting an Iwi and general practice led programme for patients with Long Term Conditions (LTCs). Five practices are taking part in the 12 month pilot. The programme provides outreach support for patients living with LTCs and their whānau through a mobile nursing and kaiāwhina team, operating as an extension of the general practice team.

Public Health Toi Te Ora

Transactional

- COVID-19. Toi Te Ora has stood up two Māori liaison roles to support the public health response across Bay of Plenty and Lakes. In addition, Toi Te Ora is now supporting each DHB's Māori health teams by staffing the new Single Point of Contact roles required of every DHB to assist both the national and local response with connecting Māori to local welfare providers as needed.
- COVID- 19. An increase in food insecurity has been identified as a significant issue and a key priority of our COVID-19 recovery work. Some of the work undertaken includes leveraging of work out of Auckland to inform our local work with food banks and improve food security.
- Healthy Food and Drink Policy Audit. Audits for both the Tauranga and Whakatāne sites have been completed and a report will be presented to the Executive Group next month.
- Communicable Disease. The public health management of TB in the community has been challenged by both the COVID response and staff shortages. Recent cases are being reviewed to ensure that all necessary steps have been taken and supports are in place.

Transformational

- COVID-19 A Māori health equity tool has been used by the service to audit the public health response in this region to the first wave of pandemic. The audit report will outline opportunities to improve the response moving forward, which we will seek advice from the Māori health teams on how to progress.
- Toi Te Ora supported Te Kura Kaupapa Māori o Te Matai, Te Kura o Te Moutere O Matakana, Te Kura Kaupapa Māori o Whakarewa I Te Reo Ki Tuwharetoa and Rotorua Girls High School with menu development and basic nutrition advice for their Lunch in Schools initiative.

Data / Digital

Transactional

- A proposal for a single COVID data collection system outside the context of general practice is being developed. This will save time and money if the need to stand up dedicated testing sites arises. It also has application non-COVID related mobile service delivery.
- eLabs orders. Work is underway to make electronic lab orders easier and faster for GPs and then in secondary care. This will reduce both errors and the use of faxes. Form testing will commence in November 2020.
- Centralised Diagnostic Results. The WBoPPHO clinical committee and others have contributed to a list of diagnostic results currently kept in community repositories that would be useful for clinicians if they were gathered and viewable from a centrally accessible location. Examples of these types of results are Retinal screening, Community INRs, Spirometry, LMC Maternity information, Hospice letters, Audiology results, Plunket records and Podiatry information.

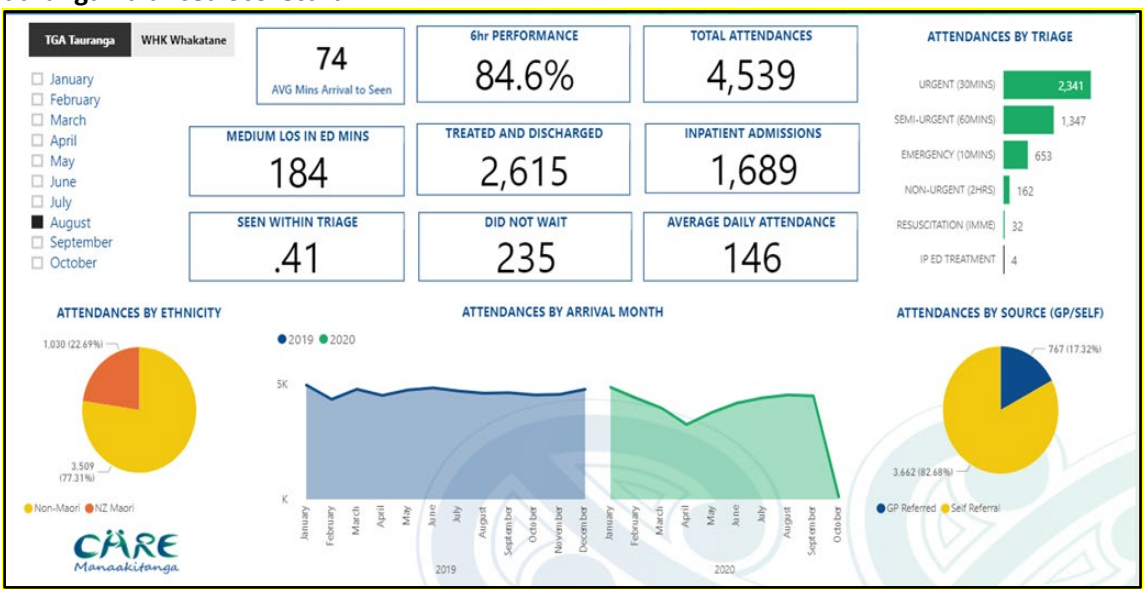
9. DHB Provider Services

Shorter Stays in ED

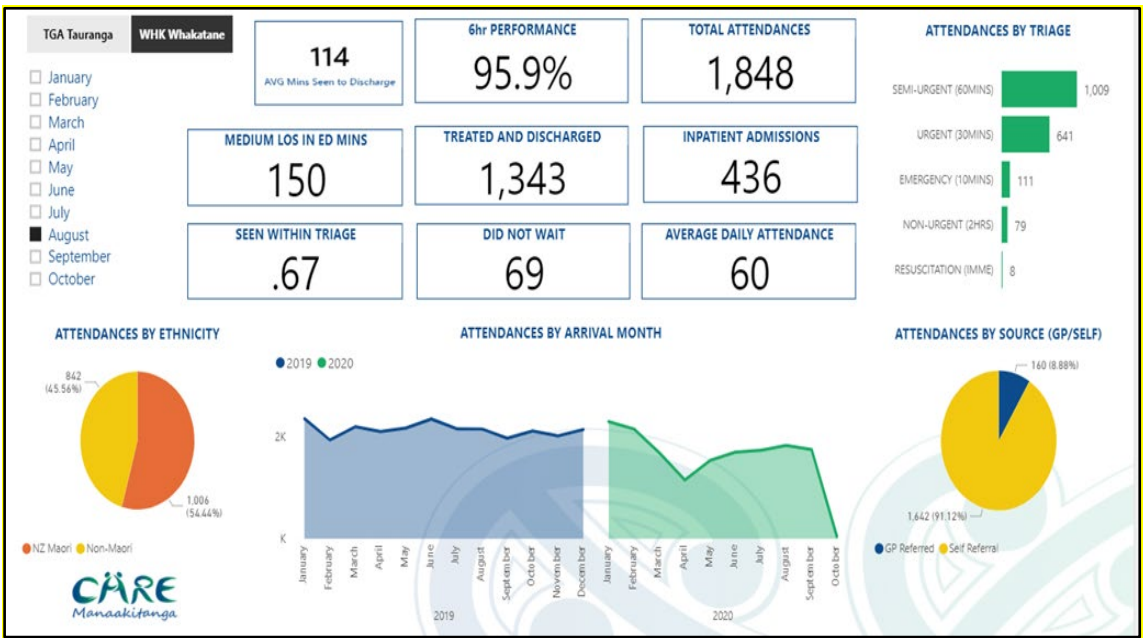
The following graphs highlight the challenge in our performance of shorter stays in ED for Tauranga. A key factor has been the high level of complexity of presenting patients evidenced across the hospitals and reflected in admission rates from ED to the hospital. Availability of the acute teams to respond is a significant contributing factor particularly out of hours.

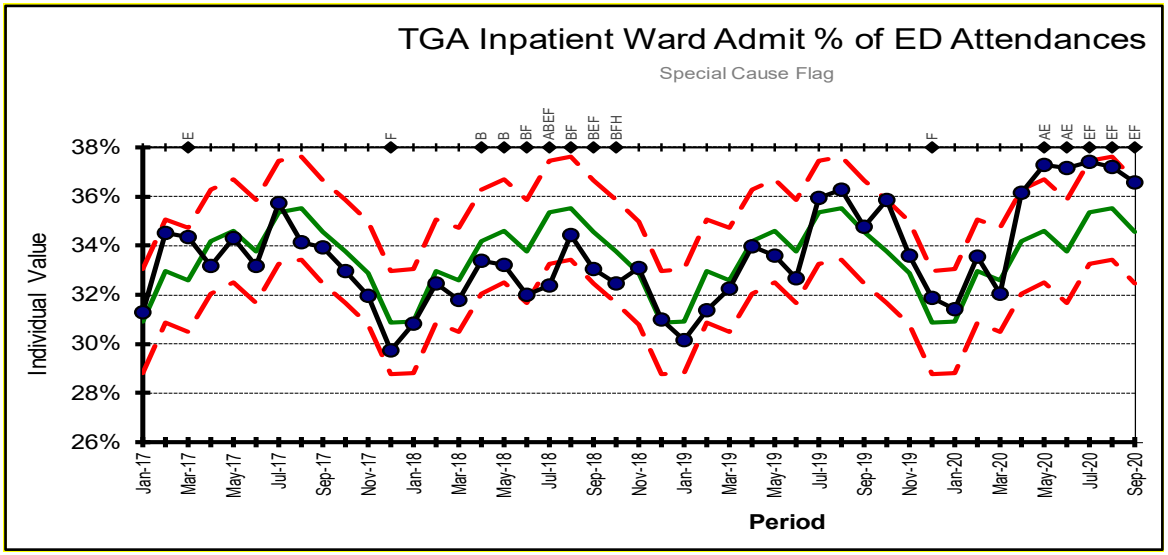
A recent review has shown increase presentations in the evening and at night. This is being investigated further.

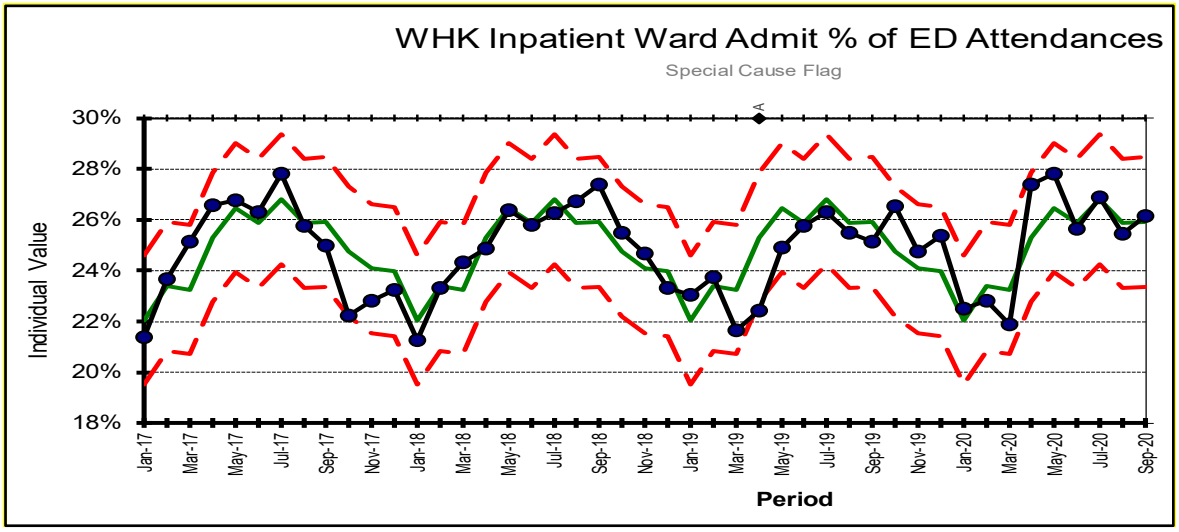
Tauranga Balanced Scorecard



ED Whakatāne Balanced Scorecard

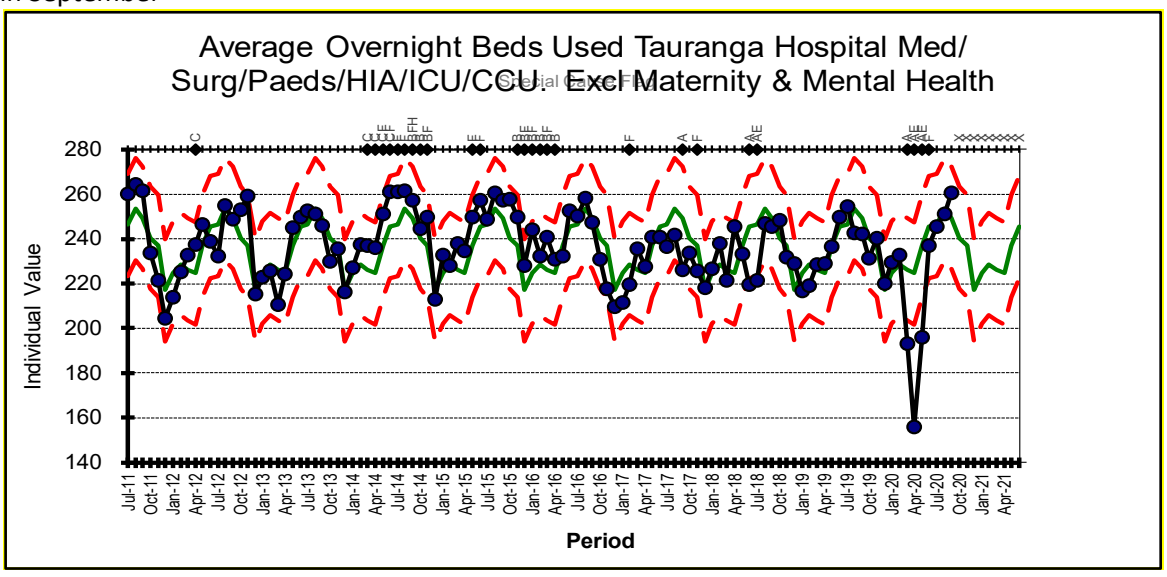






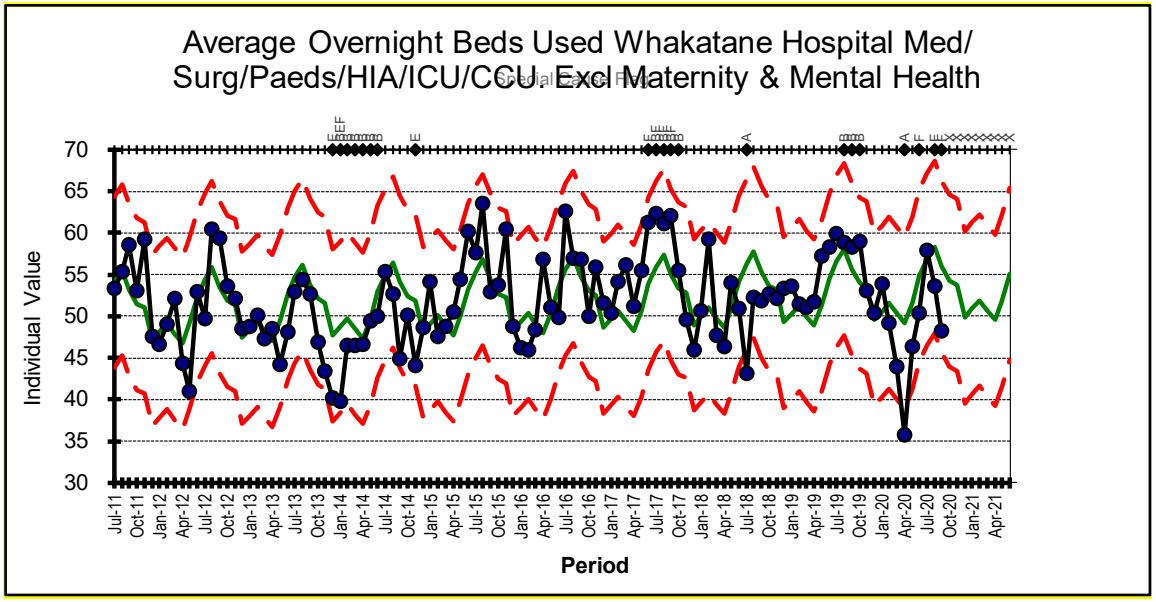
Tauranga Hospital Occupancy

Tauranga Hospital used an average of 11 more overnight inpatient beds than normally expected in September



Whakatane Hospital Occupancy

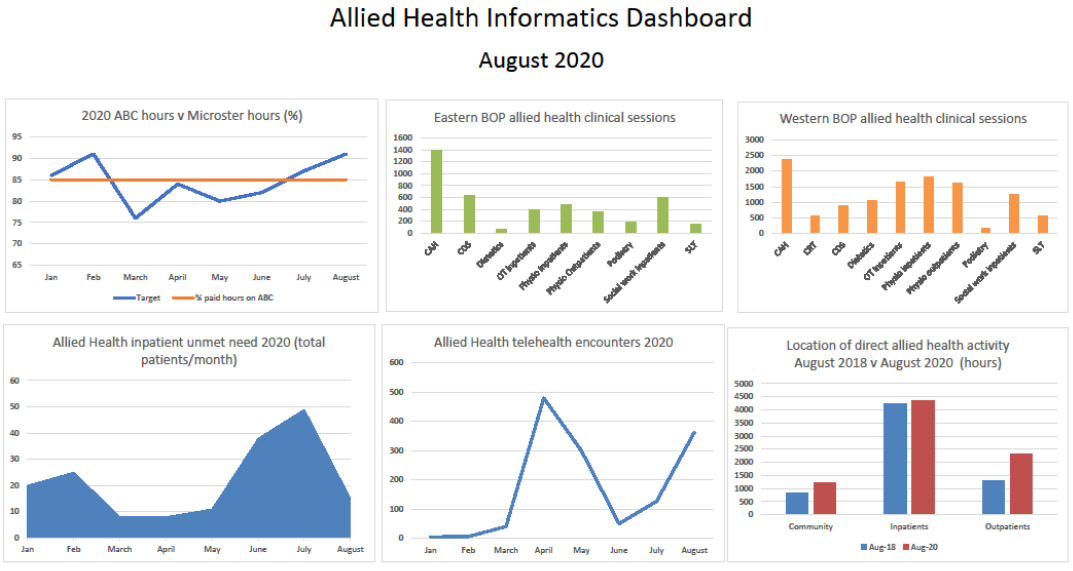
Whakatane Hospital used an average of four fewer overnight inpatient beds than normally expected.



Allied Health Informatics

Key points from the following graphs:

- Increase activity in out-patient setting. Work underway to identify if this activity can be undertaken off hospital site.
- Increase since level 2 of telehealth which had dipped. Need to hold these gains



Paediatrics

The Tauranga Hospitals children's day stay unit is up and running with positive feedback from whanau. There is an emphasis on reducing the waiting list for food allergy testing.

Faster Cancer Treatment

Results for Quarter 1

31 Day Indicator –91% patients with a confirmed cancer diagnosis receive their first cancer treatment (or other management) within 31 days of a decision to treat

62 Day Indicator – 97% patients referred urgently with a high suspicion of cancer receive their first treatment (or other management) within 62 days of the referral being received by the hospital

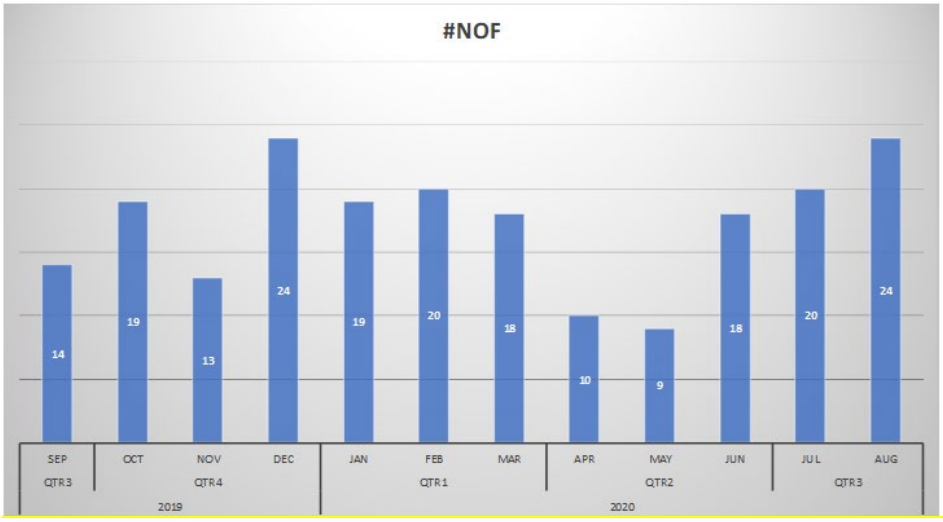
Preassessment

There is a significant backlog of patients waiting for preassessment in Tauranga. Work is underway with the preassessment leadership group to improve flow of these patients through the service which includes after hours and weekend clinics.

Fracture Neck of Femur (#NOF) Admissions

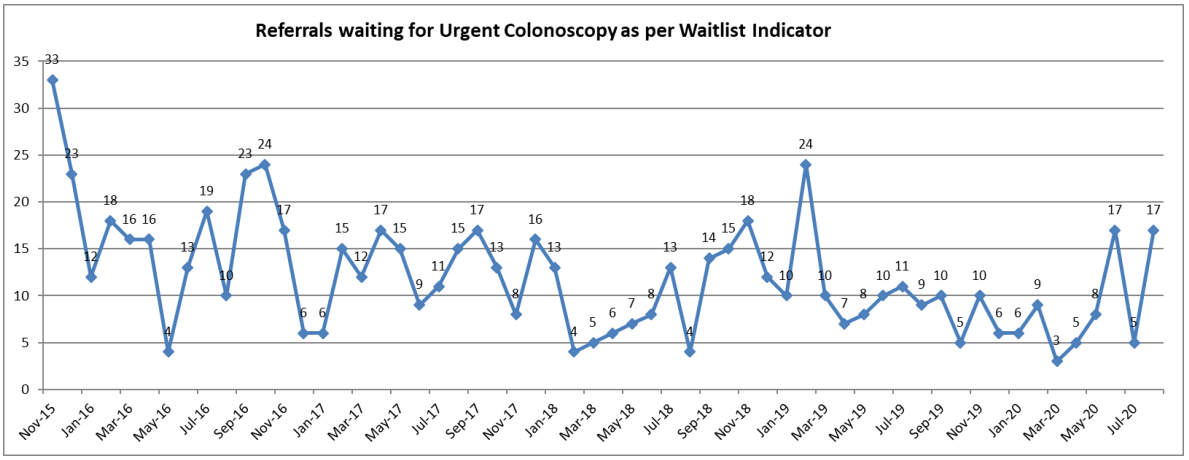
The month of August 2020 has shown a peak of 24 patients across both Hospitals presenting with fractured neck of femur. This number of presentations places increased pressure within acute orthopaedic pathway and services downstream. The inpatient ward length of stay is being monitored as an indicator of effectiveness of care, discharge planning processes and the availability of community based resources.

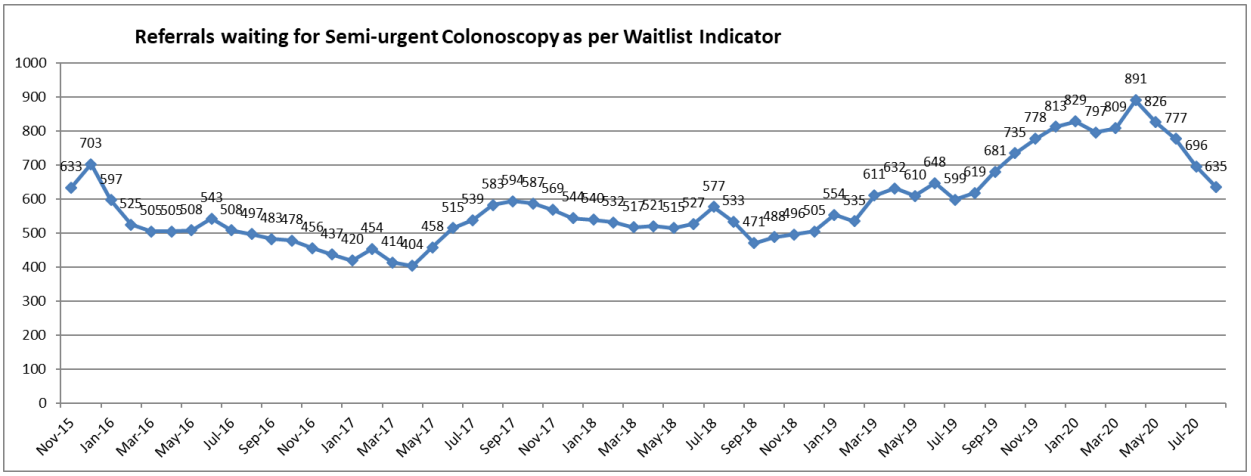
Number of patients admitted to BOP hospitals with #NOF

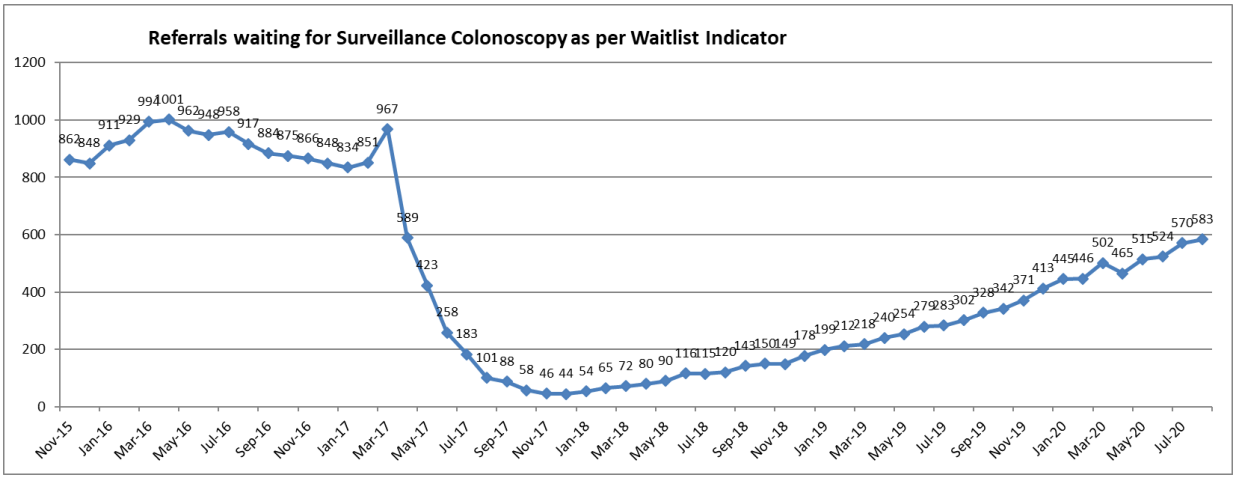


Colonoscopy

The following graphs show the current state of colonoscopy waiting lists by indicator noting the reduction in semi urgents due to extra endoscopy sessions and a reduction in staff leave. Growth in the number waiting for surveillance continues. An outsourcing contract for colonoscopy has been finalised and will provide 150 colonoscopies per month commencing November 2020.







Cardiology

The service is currently working through the detail of cost and revenue for the approved second cath lab with both FBO and Procurement. Meanwhile, elective angiography continues to be of concern as previously identified. This is as a result of PCI and Pacemaker insertion being prioritised however there is no solution to the capacity pressure issue until the second Cath Lab opens.

COMMUNITY HEALTH 4 KIDS (CH4K)

Pre-school Oral Health Enrolment

Total population enrolments are 101.9%, with Maori increasing to 93.6% (95% target), Ministry of Health have also provided NHI level data that showed 1,400 pre-schoolers not enrolled with Community Dental (CDA) and preschool enrolment co-ordinators are continuing to work through the list contacting parents/caregivers to enrol. Overall this is showing an improvement towards the 95% target for Maori and addresses enrolment equity and commences engagement with whanau.

Community Dental Services – Failed to Attends (FTA's pre-schoolers)

A co-design project with Maori Health Gains and Development and Community Dental Service (CDS) is progressing towards designing a position description for a dental Kaiawhina role. The HOD Oral Health and CDS manager are working on guidelines for the intent and outcome of roles to target non-engagement of whanau Maori and high Failed to Attend (FTA's).These roles will be implemented in early 2021. FTA's for Maori were 40% compared with non-Maori at 17%.

Failed to Attends is a target we are aiming to reduce as this is currently 28%, with pre-schoolers over represented.

	July 2020	Difference/ Change	August 2020	YTD Result	2020/2021 Target
Total enrolled YTD	43,832	649	44,391	N/A	N/A
Total Preschool Enrolment (0-4yrs)	99.9%	1%	101.9%	101.9 %	95%
Preschool Maori (0-4yrs)	92.4%	1.2%	93.6%	92.4%	95%
5yr olds caries free – Total Pop.	40.0%	3%	43%	49%	58%
5yr olds caries free - Maori	30.0%	3%	33%	31%	58%
Total Yr. 8 DMFT ratio	0.9	0.1	1.0	1.1	1.6
Maori Yr. 8 DMFT ratio	1.4	0.2	1.6	1.6	1.6
Yr9-Y13 Adolescent Rate Year End 2019	Not available	Not available	Not available	68%	85%

The biggest issue for community dental continues to be overdue examinations (arrears.) Post-COVID figures are now at 46% (20,419) and the service has a prioritisation framework emphasising Maori and Pasifika, high risk children and those most behind for an annual examination. The COVID recovery plan to reduce arrears will not allow CDS service to return to pre-COVID performance until the end of 2021. Pre-COVID arrears were escalating due to the focus on enrolling Maori pre-schoolers in recent years was at 25% and the Ministry of Health (MoH) target is 10%.

Murupara Dental Services

The third year of the joint partnership with Absolute Dental, Murupara Area School and CDS is going well, with improved engagement. The majority of teenagers have been examined. This will enable the dentist to focus on treatment till the end of school term three. The service to adults from 3pm-5pm daily is also going well and WINZ is actively involved in approving quotes over the phone so adults can receive treatment within days of their examination.

Family Violence Intervention Programme (FVIP) and Vulnerable Unborn (VU)

The FVIP had an excellent audit from SHINE on the DHB FVIP staff training programme, with the only recommendation relating to updating training information as this changes rapidly with legislation.

Chief Executive's Report
COVID – 19 Appendix 1

Identifying Positive Change that Occurred Over the early COVID-19 Period:

A review of the District Health Boards response in New Zealand

FINAL REPORT

Executive Summary

During the period of time that the New Zealand health system was preparing for the anticipated onset of a pandemic and the surge of patients relating to the COVID-19 virus changes, there were anecdotal reports of significant change to models of care and the agility of change implementation. In order to maximise the learnings to be gained and understand the changes effected across the system, an opportunity was taken to gather information from across the District Health Boards (DHBs) nationwide.

A cross sectional survey of purposively sampled executive team members was undertaken across the District Health Boards nationwide. District Health Boards were targeted as key sources of information due to the leadership role taken during the pandemic preparatory period. Each participant was asked five questions addressing; changes to models of care, processes used, barriers overcome, benefits to the changes and sustaining change.

There were 'bright spots' identified within the preparation activity, they included;, relationships, governance, training, mode of contact, workforce and facilities. There were also sticking points identified by the participants, often as obstacles to the preparation underway. These included; resistance to change, facilities, Information Technology (IT), people, networks and communication. To move forward and sustain change, participants reported numerous ideas under consideration. The dominant themes were; new pathways, change engagement, digital health, vulnerable population focus, a 'lighter touch' ethos, relationships and workforce potential.

This review has provided a unique opportunity to gather information from across the system in a way that has never been done before. Using interviews and thematic analysis, the application of an informal interpretive-descriptive methodology has gifted us with stories of rich detail, reflective learnings and unique insights. Our health organisations across the system responded to the anticipation of COVID-19 with, agility, compassion and expertise, providing quality services under extreme circumstances. The dominant themes identified within this review emphasise the opportunities and areas for growth that our health system has the potential to step into. Each organisation continues to reflect, evaluate and identify their focus for growth at this time. Through the examples and shared ideas in this report, it is intended that our organisations might choose to use them as a spring board for opportunity.

Background

During the period of time that the New Zealand health system was preparing for the anticipated onset of a pandemic and the surge of patients relating to the COVID-19 virus changes, there were anecdotal reports of significant change to models of care and the agility of change implementation. In order to maximise the learnings to be gained and understand the changes effected across the system, an opportunity was taken to gather information from across the District Health Boards (DHBs) nationwide.

Methodology

A cross sectional survey of purposively sampled executive team members was undertaken across the District Health Boards nationwide. District Health Boards were targeted as key sources of information due to the leadership role taken during the pandemic preparatory period. The executive team members identified, included all clinical leads; Chief Medical Office, Chief Nurse or Director of Nursing and Directors of Allied Health; operational leads including Chief Operating Officers; and the planning leads, General Manager Planning and Funding or their equivalent. Each post holder was identified, contacted and invited to participate in an interview via phone or video meeting platform. Participants chose to either contribute individually or jointly in a team interview, occasionally additional team members were present in order to provide detailed information not held by the identified post holder.

Five questions were developed and validated against a selected number of executive post holders in order to refine them and ensure validity and reliability of findings. These five questions were then used in each interview process, the interviewer sought clarification or further detail using identified prompts:

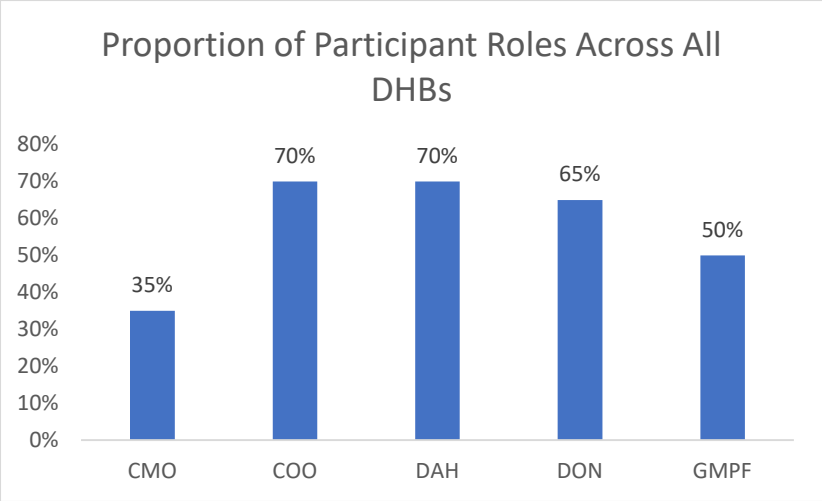
1. Can you describe the model of care changes you have implemented in anticipation of the COVID-19 surge?
2. What was the process or processes you used/went through to make these changes?
3. Are you able to recall the specific barriers you have had to overcome to implement these changes?
4. Can you articulate the benefit of implementing these changes?
5. What thoughts do you have on how to sustain the benefit of these changes?

Data Collection and Analysis

A team of 4 collected the information provided by the participants using hand written or typed notes to capture the detail and any specific quotes provided. The team collaborated and discussed data collection in order to reduce bias and increase rigour. Thematic analysis and coding was completed in collaboration by two team members to identify recurring themes under each question/heading. For the final report the themes were grouped from 30-50 into 5 or 6 dominant themes for each question. The dominant themes are grouped again and discussed under three headings; What were our ‘bright spots’? What were our sticking points? and What do we need to keep doing?

Findings

We have achieved a significant degree of participant contribution from across the District Health Boards. The final response rate was:



Due to the intensity of the workload during the pandemic and other contributing factors we were notified that occasionally staff were unavailable for interview at the times they were sought.

Model of Care Changes Implemented

The most prevalent model of care change was the implementation and uptake of *Telehealth* provision. The need to retain and sustain contact with vulnerable clients and their whanau drove services to roll out and accelerate the implementation of alternative modes of contact. Methods identified included phone calls, videos and text messaging. Key examples provided were;

- Outpatient services providing all follow up appointments by phone or video across mental health, medical and surgical as well as NGOs and PHOs
- Community allied health services utilising video platforms to review environmental needs
- Community care services using phone calls to check in on chronic/long term patients
- Whanau Waka initiative for Māori and Pasifika complex and high needs were proactively contacted via telehealth to support and manage their care.
- The evolution of a 'lighter touch' approach to providing care impacting on dependency and intensity of service use.
- "GPs went virtual overnight"

Many of these changes were *clinician driven* and as a theme this was particularly evident across the interview information provided.

The adoption of *New Pathways* was identified across a number of DHBs. These were either driven by the reduction in contact, geographical location or timeliness of services required. Key examples include;

- The implementation of a new Acute Medical Assessment Unit – provided safe streaming and supported reduced admissions
- Increasing local lab capacity for testing eliminated the need to send tests outside of the region and provided a much faster diagnostic response time (<1 day).

The majority of the DHBs physically altered their facilities to prepare for the appropriate flow of patients, to ensure safe streaming and an increase in available capacity. There were also flow on impacts from the directives to reduce contact;

- The reduction in visitors was found to be "less disruptive on the workflow" of staff
- External temporary buildings were positioned in front of ED sites to contain and manage potential COVID-19 positive patients.
- Temporary walls were built to divide physical spaces in ED
- "CBACS were stood up overnight" and "Theatres and PACUs were converted to ICUs"
- Negative pressure rooms were installed where required

Many of the participants also mentioned how they worked to creatively use their *workforces more broadly*. The key drivers for this were identified as needing to reduce contact, prevent secondary care service use and manage patients effectively in the community. Key examples provided include:

- The creation of a 'SWOOP' team out of a community nursing team who focussed on supporting COVID-19 positive and provided input to manage their care at home. Received referrals from ARCs and GPs.
- Allied Health staff were refocussed into the referral and triage process of patients prior to admission from primary care in order to reduce admissions and sustain patients at home.
- The development of new community teams to for 'early supported discharge' of patients from secondary care services.

Processes

The responses addressing the *framework/s in place to support executive decision making* were very mixed. Most commonly the CIMs Structure was identified as the primary framework in use, taking the command and control approach. However many of the DHBs also reported that whilst this worked in the first few weeks it did not support the managed and sustained period following the immediate response required. DHBs did positively feedback about the use of *Clinically Led* change and the use of technical and or clinical advisory groups. One DHB commented where "fantastic collaboration was exhibited it did not fit with the command and control model".

The phrase *'common goal'* was regularly mentioned in the participants information, it was identified as the unifying factor that promoted team work, collaboration across organisational, professional and service boundaries and trust. One DHB highlighted that they developed a mission statement;

> 'To stop people getting COVID-19, provide good care for people with COVID-19, maintain acute services for those who need it, support community for community based response and plan to return to a long term sustainable health system'.

One participant strongly identified that having 'the right people around the table at the right time' was the priority. Whilst a second participant contended;

> "Professional managers need to be aware that if you speak to one professional group then you don't have the full picture. We do have a bias towards doctors, and we need our pharmacists, physios etc around the table as well. If we asked the people what does the patient need to make their journey better or safer? Then you come up with the solution - then you cascade it out to those who need to understand it."

The participants also identified a number of key factors as being instrumental in managing the response process. These include;

- Trust
- Consistent communication
- Whole of System consideration
- Expedited decision making
- Frequent short meetings
- Open and transparent communication

Barriers Overcome

Four main themes stood out clearly when the participants provided their answers.
Communication – Examples were provided of communication challenges within and without of the DHB organisations. They identified that a lack of consistent and coordinated communication caused confusion and delay within their workforce and services, whilst the same issues for information coming out of the MOH and NHCC caused parallel confusion and uncertainty of how to be proactive rather than reactive. Positive examples of how DHBs overcame these challenges include;

- Co-location of essential staff
- Use of Comms team
- DHB set up own 0800 number
- Māori Health leading their own services
- Daily stand up meetings across services
- Use of national professional networks

IT and Digital Solutions – The main challenges were, setting up the workforce to work from home (software and hardware); facilitating shared access to online information; purchase of equipment and managing facilities to support IT. These were overcome or managed in different ways and rural locations often didn't find suitable solutions. Examples of positive change include; a facility Wi-Fi upgrade 3 years in the waiting was completed within 24hrs; finances were prioritised and equipment was purchased from local commercial sources; IT teams worked long hours to collaboratively solve interoperability issues and established access across digital platforms.

PPE – There appeared to be two main contributing themes to this barrier, firstly staff anxiety and secondly the information communicated about it. The level of staff anxiety around COVID-19 appears to have compounded the impact of the difficulties with PPE. A number of the DHBs provided focussed support to staff who were managing their anxiety with a use of PPE. The provision of liaison staff including microbiology and infection control specialists, is a positive example where peer communication goes a long way to allaying fears and heightened anxiety that drives a behavioural reaction. However there were also a number of responses from participants who felt strongly that the communication about volume and distribution of PPE was misaligned to the information they had and undermined their management of PPE. One participant also suggested that the guidance on use of PPE from the MOH could have been quicker.

Working Together – There were a significant number of comments from participants positively extolling the benefits and value that collaborative work brought to the process. However there were also significant issues identified with patch protection, PHO engagement, NGO engagement and inequity of service implementation. In one region, the PHO reported that their after-hours clinic would close completely where upon the DHB's IMT met with and talked through the process of staying open – providing advice, guidance and practical support. This led to the clinic remaining open and providing essential services.

Benefits of Change

There are four main themes identified as Benefits of Change and many examples of the tools or strategies that evidence them.

Resources being use to potential – A change in rosters, the ability to 'simplify and intensify' services, utilising telehealth and prioritising SMOs to frontline assessments were all examples provided that identify existing resources being maximised.

A reduction in waitlists and admissions due to efficiencies in connecting and prioritising. The re-design of service provision and engagement from staff led also led to a positive recognition of workforce development need for the future.

Relationships – Significant feedback was received on the benefit that as changes were negotiated and decided relationships were established, strengthened and grown. This occurred across all sectors including Māori Health, PHOs, NGOs, ARCs. The whole of system approach appeared to require a level of coordination and regularity of contact that relationships were dependent on mutual communication and trust. Where the services were delayed or fractured in their response feedback was provided to evidence that relationships with the providers were often the source of the issue.

Decision Making – It was clearly evident from the analysis of information that rapid, expedited and empowered decision making had a significant impact on staff. To ask, recommend or suggest an idea was progressed rapidly through a governance process and a response provided far more quickly than it would usually take. Feedback suggested that this process encouraged engagement from clinical staff, an ability to think creatively and to respond to the community at need.

Willingness to continue ways of working – The majority of participants commented that staff were willing to continue working differently, to take their new confidence and apply their learnings, but were keen to ensure their practice was supported clear guidance and governance with the changes in place. There was also feedback to suggest that a change in culture had occurred in some areas towards hand hygiene and self-care, one participant commented, 'we have staff who were adamant anti-flu vaccine in the past who have been complaining that they hadn't been offered their jab yet.'

Sustaining Change

A number of themes were generated and then identified as key drivers towards sustaining change.

These include;

- *Collaborative Working* – community based teams working across primary and secondary, leadership training for clinicians, taking a 'lighter touch' approach, working in partnership across organisations and developing networks, meeting vulnerable population needs.
  "(we)want to create environments to sustain change"
- *Using the Workforce more fluidly* – reviewing roster models, contracting to support ongoing delivery of changed service, coordinating the planned care response, looking after fatigued staff, using early intervention opportunities i.e. SMOs and to increase the use of mobile services to reach vulnerable populations.

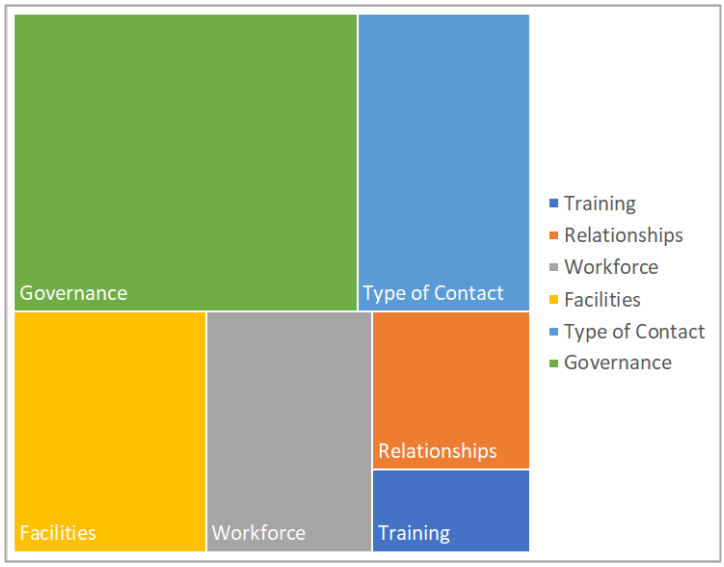
- *Removing the Executive as a Barrier* – a desire not to return to the level of bureaucracy previously experienced, suggested use of guiding principles in future decision making, regular reporting on state pf preparedness to MOH.

- *Embedding Telehealth and Digital Solutions* – to offer the patient appropriate options for contact via phone, video or text, to minimise patient and staff time consumption in travel and waiting, to continue shared access platform development across systems, to prioritise equipment provision and software integration.

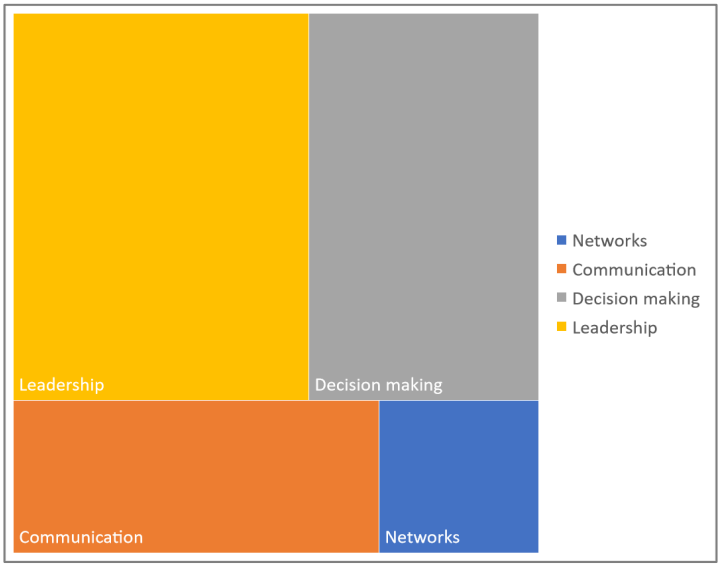
Dominant Themes

Following the final analysis of themes, grouping and interpretative description was completed. This identified theme weighting and the most prevalent theme within each group. The following graphs emphasise the proportional emphasis of themes per question:

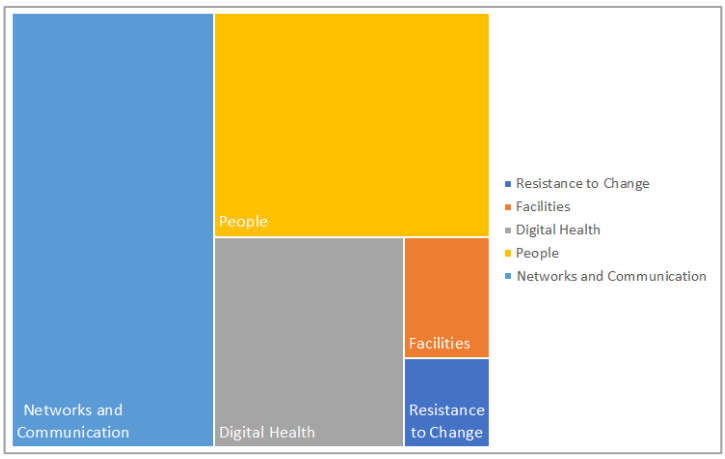
1. Can you describe the model of care changes you have implemented in anticipation of the COVID-19 surge?



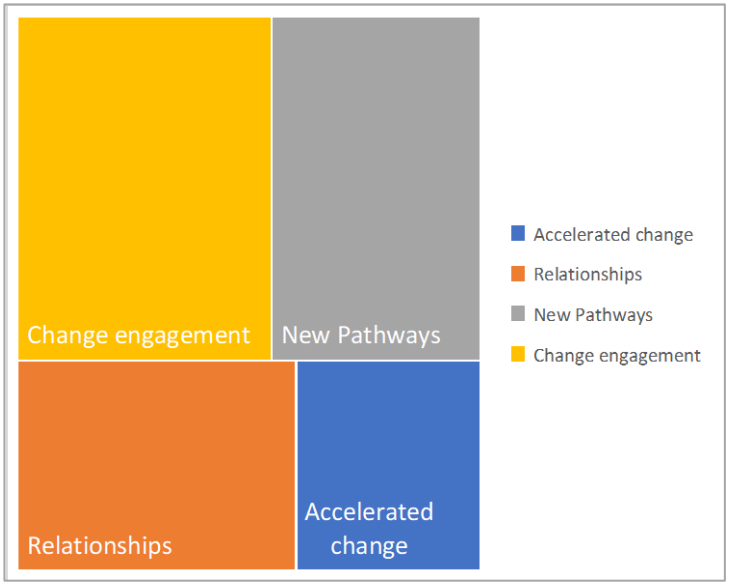
2. What was the process or processes you used/went through to make these changes?



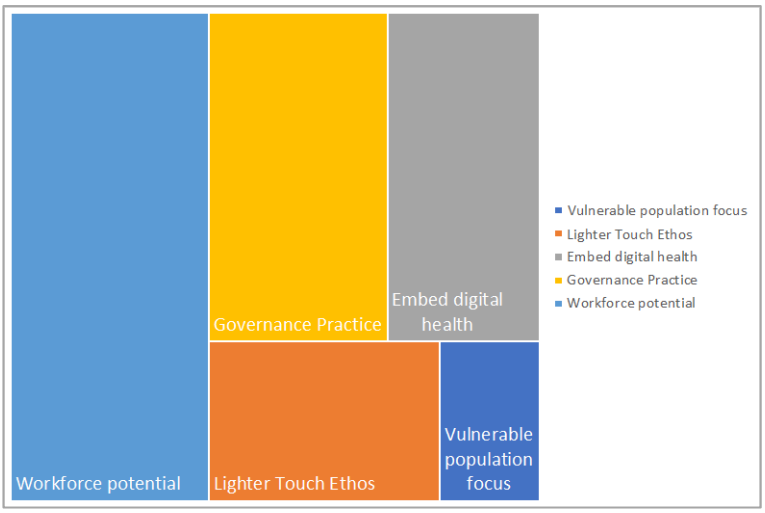
3. Are you able to recall the specific barriers you have had to overcome to implement these changes?



4. Can you articulate the benefit of implementing these changes?



5. What thoughts do you have on how to sustain the benefit of these changes?



Discussion

Before the discussion it is important to acknowledge key factors that influenced the context of preparation for COVID-19. These factors were identified by participants as concerns for sustaining change. Key factors identified were; the reduction in barriers to financial expenditure, altered governance processes and the redirection of workforce resource away from existing services. The participants identified that these changes were unsustainable regardless of the positive impact or successful outcomes they generated.

What were our 'Bright Spots'?

Training – rapid and novel training methods were employed to ensure that staff were upskilled in PPE use, ventilation techniques and clinical skills required for managing COVID-19 positive or suspected patients. A number of examples were given of expedited training provided online, reaching an exponential number of staff and facilitating competency of practice to be effectively managed.

Relationships - there were a significant number of positive reports detailing the creation, development, building and deepening of relationships during the preparation phase. These occurred across services, providers and between team members. Stories were shared and gifted to the interviewers of events and situations where compassion, trust and collaborative behaviour instigated not only positive outcomes but perpetuated positive behaviour in outgoing ripples.

Type of contact – A number of novel methods were employed to reach out to consumers, the workforce and partner providers at this time. Examples that clearly reported a positive impact include the set up and implementation of an 0800 direct line. This supported the local community and health providers, providing a central point of contact to resolve concerns and queries with the DHB. Mobile services were increased and redirected to reach out proactively to identified vulnerable populations. These proved very effective in meeting intended and unintended needs e.g. Swab testing alongside vaccinations and welfare checks. The use of social media was reported to be an effective tool for informing the community and workforce and saw significant increase in use as community networking platform. Overall the shift of services off site from DHB facilities and into the community provided opportunities to meet consumers in their context of need. Whilst promoting the opportunity to address issues tailored to the individual, this also provided an increase in health care access for our vulnerable and less engaged populations.

Workforce – The overwhelming theme identified by many of participants was the way in which our workforce was used more broadly. Though this did not always mean clinical staff working beyond their scope of practice. Clinicians were asked to fundamentally change how they delivered their care, when they delivered it and to be available to change at short notice. Centralised rostering of nursing staff, reallocating medical staff into teams, DHB staff working within CBAC and ARC sites, and staff working from home were all identified as successful measures that provided effective outcomes.

Facilities – A number of the DHB's undertook to physically change their environments in order to manage the streaming of patients for assessment and treatment. They also made use of community locations including schools and maraes for CBACs.

Governance – The predominance of a 'whole of system' response was evident in the participants feedback. Many examples were given of the colocation of Incident Management Teams and how they led community focused solutions using an inclusive provider approach. New pathway adoption was the most prevalent theme and examples were ranged across clinical, administrative and governance processes. Ensuring that the 'right people were around the table' was a reoccurring attitude. Clinical Advisory Groups and clinically led decisions were reported to be effective in making rapid and successful decisions for the system's response. Whilst the clinicians felt included, heard and able to implement an effective service response.

What were our sticking points?

Resistance to Change – A lack of knowledge and shared understanding across ARC facilities and DHBs required active negotiation to manage the transfer of patients back into ARC facilities. There were examples of both patch protective behaviours and a few rural services challenged to adapt. An episode of discrimination towards Infection Protection Control (IPC) staff sadly highlighted evidence of 'discipline superiority' that was believed to be outdated in a contemporary health system.

Facilities – Inflexible physical environments and limited available space were examples provided of the restriction in facilities. This caused significant challenges for the workforce to social distance, manage the streaming of patients and meet the anticipated requirements. A number of DHBs invested in adapting their facilities and installing negative pressure environments. Whilst these investments retain their value the DHBs facilities will continue to challenge IPC requirements.

Digital health – Nearly all the DHBs reported initial or ongoing challenges with their technology systems. These issues included the urgent purchasing of hardware, rapid installation and implementation of software programmes, environmental upgrades for internet connections, and the training and change engagement for staff. Despite positive feedback on the response to this challenge rural services and facilities where digital services are not sufficient continue to have difficulties. The limitations of our IT infrastructure is a source of inequity in the provision of health services and in the consumer's receipt of health and disability care.

People – Despite people's positive and effective collaboration there were difficulties when behaviour limited service integration and prevented connections across the sectors. Feedback provided clearly indicated the value of 'whole of system' and cross sector engagement, but when this did not occur there were fractured care pathways and a lack of coordinated service provision. In addition the anxiety of staff was a significant factor that required active management and support in a number of DHBs. The DHBs implemented their own strategies to manage this effectively but the behaviour had a significant ripple effect within organisations and impacted on the preparation response.

Networks and communication – It was reported that a number of established networks became temporary impediments for the DHBs in their preparation for the pandemic. These networks included the Unions, St Johns, PHOs and the MoH. Either by negotiation or agreement a resolution was found and the requirements were progressed. The participants however reported that timely communication and clear direction from the MoH would have supported these networks to respond quickly with reassurance of time to review afterwards.

What do we want to keep doing?

New pathways – A number of new pathways were developed during the preparation phase. Feedback identified that these new pathways and services; supported consumers in the community and deferred admissions, provided early supported discharge services, offered a choice of how services were delivered, housed the homeless and decreased the risk for immuno-compromised patients. It is apparent that the focus of these new pathways is on the preventative emphasis of health care. The shift in emphasis to community based services was significant and there was an initial positive consumer response reported by the participants.

Change engagement – Participants regularly reported the desire to try and 'bottle' the momentum and attitude of the situation. Although they recognised how unique the 'common goal' was in uniting people together. The willingness of people to engage and their acceptance of decisions made was often identified as enablers to the change required. Particular DHBs sought to foster that with an overt vision and mission statement for the preparation. The focus this provided on the immediate context was evident in the outcomes reported.

Relationships – The benefits of relationship building across organisations and sectors was evident in the participants' stories. Sustaining those relationships was a desire articulated often and some of the forums that had begun in the preparation phase are continuing to connect. The majority of participants reported the value of new connections and the potential for impact on the health services.

Vulnerable population focus – The outreach across vulnerable populations was evident in the model of care changes and the value was demonstrated in the benefits of those changes. Mobility of services, telehealth use and the proactive outreach in contacting high risk consumers, impacted on the system. Deferred admissions, increased vaccination rates, appropriate referrals and increased levels of engagement across the Maori and Pasifika communities were all positive outcomes.

'Lighter Touch' ethos – A number of the stories provided spoke to a 'lighter touch' style of service provided by clinicians. Anecdotally, staff had experienced similar outcomes to usual service and were reflecting on whether their services could be changed as a result. These changes would reflect a less intrusive or intensive style of contact and when appropriate, offering the choice to the consumer if a follow up was required.

Digital health – The rapid investment into and acceleration of digital solutions, systems and hardware proved its value in the coverage of telehealth capability, the sharing of information across platforms and the capability of staff to work from home. However there were many examples provided where additional factors acting on digital health continue to limit our health service provision. The workforce worked with these challenges but continue to deal with them on a daily basis. These include broadband internet connections, access to devices, and the interoperability of system platforms to enable data visualisation. There was a clear drive from the participants to continue embedding digital health solutions and to support them with robust procedures and guidance on training for staff.

Workforce potential – A number of participants were interested in the possibilities of using the workforce more fluidly in the future. Collaborative working, partnership models of service and multidisciplinary teams were all identified as opportunities for growth across the systems. New teams temporarily created for the response, provided opportunities to trial different models of care. Shared stories also highlighted the value observed in having clinicians involved in governance and opportunities to develop leadership potential are being considered.

Conclusion

This review has provided a unique opportunity to gather information from across the system in a way that has never been done before. Using interviews and thematic analysis, the application of an informal interpretive-descriptive methodology has gifted us with stories of rich detail, reflective learnings and unique insights. Our health organisations across the system responded to the anticipation of COVID-19 with, agility, compassion and expertise, providing quality services under extreme circumstances. The dominant themes identified within this review emphasise the opportunities and areas for growth that our health system has the potential to step into. Each organisation continues to reflect, evaluate and identify their focus for growth at this time. Through the examples and shared ideas in this report, it is intended that our organisations might choose to use them as a spring board for opportunity.

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

CORRESPONDENCE FOR NOTING

SUBMITTED TO:

Board Meeting 21 October 2020

Prepared by: Maxine Griffiths, Board Secretariat

Endorsed and
Submitted by: Pete Chandler, Chief Executive

☐ **For Decision** ☐ **For Discussion** √ **For Noting**

RECOMMENDATION:
That the Board note the correspondence

ATTACHMENTS:
Copy of letter to Dr Hugh Lees from the Safe Staffing Health Workplace Unit, dated 13 October 2020.

15 October 2020

Hugh Lees

Medical Director
Bay of Plenty District Health Board
(via email)

Dear Hugh

Further to the vote of thanks at the meeting of the Safe Staffing Healthy Workplaces (SSHW) Governance Group yesterday, as the Co-chairs we want to formally extend to you our appreciation, and that of the Governance Group, for the tremendous contribution you have made to SSHW and its Care Capacity Demand Management (CCDM) programme during your tenure on the group, representing the DHBs' Chief Medical Officers.

As you will remember you were appointed to the Governance Group in September 2015. Since then you have participated in multiple meetings and over the years you have made several Governance Group visits to DHBs. Whilst the focus of these visits has always been the provision of nursing services the interest and commitment you have shown has been highly valued by your governance colleagues, the DHB and Union nursing leaders with whom you have interacted.

Throughout your tenure the advice you have given to the Governance Group and the SSHW Unit has always been well considered, respectfully provided and importantly in the best interests of patients and staff. It is fair to say that for your nursing and allied colleagues it has been very special to have a senior medical officer so committed to this important work, over such a long period.

For all this we thank you. Your presence and contribution to SSHW work will be missed but we wish you the very best for your retirement.

Yours sincerely

Julie Robinson

Co-chair SSHWU Governance Group

Memo Musa

Co-chair SSHWU Governance Group

CC Nick Baker Chair of the DHB SMO Group
Pete Chandler CEO Bay of Plenty DHB

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BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

BOARD WORK PLAN 2020

Activity	Source	15 Jan	19 Feb	18 Mar	15 Apr	20 May	17 Jun	15 July	19 Aug	16 Sept	21 Oct	18 Nov	Dec
Venue – Tawa Room, Tga		√		√		No Mtg		√		√		√	No Meeting
Venue – Conference Hall, Whk			√		√		√		√		√		
Board only Time (*with CEO)		√*	√	√*	√		√	√*	√	√*	√	√*	
Board Strategic Sessions				√			√			√			
Joint Bd/Run – Te Waka O Toi			√						√			√	
Patient Experience / Story	Bd Sec	√	√	√	√		√	√	√	√	√	√	
Manaakitanga Visits (2.30 pm)	Bd Sec	√		√			√	√		√	√		
Approve Committee Resolutions	Bd Sec	√	√	√	√		√	√	√	√	√	√	
Monitor Interest Declarations	Bd Sec	√	√	√	√		√	√	√	√	√	√	
Midland CEOs Meeting Minutes	CEO		√	√	√		√	√	√	√	√	√	
Reports from Reg / Nat Forums		√	√	√	√		√	√	√	√	√	√	
6 monthly Board Attendance	Bd Sec	√						√					
CEO Report	CEO	√	√	√	√		√	√	√	√	√	√	
Dashboard Report	GMPF	√	√	√	√		√	√	√	√	√	√	
PHOs Report	GMPF	√	√	√	√		√	√	√	√	√	√	
Maori Health Dashboard Plan	GMMGD		√				√		√			√	
Employee Health & Safety Report	GMCS	√			√			√			√		
Quarterly IDP Ratings	GMPF	√		√			√			√			
Risk Report	GMCS			√			√			√			
Draft Annual Plan 19/20 – Minister's Priorities			√										
Annual Plan – approve Draft	GMCS				√		√						
SHSP and Annual Plan 2018/19 6 month progress report	GMPF			√					√				
Annual Report										√			
Exec/Board/Runanga Planning Workshop											√		