BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Agenda

Bay of Plenty District Health Board

Venue: Conference Hall, Clinical School, Whakatane Hospital
Date and Time: Wednesday 19 February 2020 at 10.00 am

Please note: Board Only Time, 9.30 am

Minister's Expectations

- Primary Care Access
- Mental Health
- Improving Equity
- Public Delivery of Health Services
- Health and Wellbeing of Infants, Children and Youth
- Improving Population Health
- Long Term Capital Planning
- Workforce
- Climate Change
- Accountability for Improved Performance

Priority Populations

- Māori
- First 1000 Days of Life
- Vulnerable Children and young People
- Vulnerable Older People
- People with Long Term Severe Mental Health and Addiction Issues

The Quality Safety Markers

- Falls
- Healthcare Associated Infections
- Hand Hygiene
- Surgical Site Infection
- Safe Surgery
- Medication Safety

Strategic Health Services Plan Objectives:

- **Live Well:** Empower our populations to live healthy lives
- **Stay Well:** Develop a smart, fully integrated system to provide care close to where people live, learn, work and play
- **Get Well:** Evolve models of excellence across all of our hospital services

Compassion All-one-team Responsive Excellence
Manaakitanga

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	**Presentations** 2.1 Recovery Plan – Whakaari White Island Jo Peters, Emergency Planning Team Leader 2.1.1 Recovery Plan – Whakaari White Island 2.2 Health Consumer Council Update Sue Horne, Chair, Lisa Murphy and Adrienne von Tunzelmann	**4**
3	**Apologies**	
4	**Interests Register**	**22**
5	**Minutes and Chair Report Back** 5.1 Board Meeting - 15.1.20 Minutes 5.2 Matters Arising 5.3 CPHAC/DSAC Meeting - 5.2.20 Minutes	 **26** **31** **33**
6	**Items for Discussion / Decision** (Any items that are not standing reports must go via the Committees and will include the Chair's report and Committee recommendation) 6.1 Research and the Equity Gap 6.2 Maori Attendances through ED 6.3 Chief Executive's Report	 **38** **62** **75**

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	6.4 Primary Health Organisation Reports 6.5 Maori Health Dashboard Report 6.6 Dashboard Report (to be circulated)	**87** **97**
7	**Items for Noting** 7.1 Board Work Plan 2020	**98**
8	**Correspondence for Noting** 8.1 Letter from Australian High Commission re Whakaari White Island Patient Care – 28.1.20	**99**
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 March 2020	

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Whakaari White Island Recovery Plan	
Prepared by:	Josephine Peters
Prepared for:	Simon Everitt – Interim CE

Contents

Section 1 Executive summary

Recovery is defined as: *The coordinated efforts and processes to effect the immediate, medium and long term holistic rehabilitation of a community following a disaster."* Recovery is a developmental and remedial process encompassing the following activities:

- Minimising the escalation of the consequences of the disaster
- Rehabilitating the emotional, social and physical wellbeing of staff and individuals within communities
- Taking opportunities to adapt to meet the physical, environmental, economic and psychosocial future needs. Reducing future exposure to hazards and their associated risks

The purpose of this Recovery Action Plan is to establish and plan for effective recovery and subsequent demobilization arrangements for the Bay of Plenty District Health Board (BOPDHB) after the Whakaari White Island Eruption on 9th December 2019. The Recovery Plan outlines the principal aspects of the transition from response to recovery; establishes timeframes for implementing recovery activities and assigns responsibility. The Recovery Action Plan is a document that will change over the course of the recovery process to properly reflect the recovery needs as they evolve.

Recovery objectives include the following:

- Coordination of Psychosocial/Wellbeing Coordination for BOP DHB staff and community residents affected by the Whakaari White Island Eruption
- Provision of effective and timely communication to staff and external stakeholders
- Conducting passive surveillance of staff and responders based on potential exposure to toxic ash
- Provision of opportunities for organizational learning to inform changes and improvements from a clinical, process and systems perspective.

The BOPDHB has a legislated responsibility to support the Civil Defence Social Section through the coordination of psychosocial support to the community. For that purpose the BOPDHB Recovery Team is integrated into the Bay of Plenty Civil Defence Emergency Management Group Recovery Plan. The BOPDHB is also managing the coordination of psychosocial support to employees with the dual goals of supporting staff after this event and for building resilience in staff and the organization.

Section 2 Emergency and response summary

At 1411 on Monday 9th December Whakaari /White Island erupted. At the time 47 people were in or around the island. Whakatane Hospital began to receive patients beginning at 1606 coming by both helicopter and ambulance. In total the hospital received 31 patients: 4 of who were deceased; 3 who were discharged; and 24 who received care to stabilize their condition to allow transfer to other hospitals where they could receive specialty care. By 1200 on Tuesday 10th December all patients were transferred to specialty hospitals around New Zealand including Christchurch, Hutt Valley, Waikato and Middlemore. Tauranga Hospital received a total of 7 patients, 3 of those made their own way to the Tauranga Hospital Emergency Department and were subsequently discharged. The remaining 4 were cared for in ICU and subsequently transferred to Middlemore for specialty care on Wednesday 11th December.

The Whakatane Hospital set up and staffed the Secondary Emergency Operations Centre to support hospital operations and to meet its obligations for psychosocial coordination. The Tauranga EOC temporarily activated to support Whakatane but closed later on the evening of 9th December. On Monday evening 9th December two Counsellors were sent to Mataatua Marae to support the community. The DHB EOC deployed a Health Liaison to the Whakatane Council EOC to support communication and situational awareness and support psychosocial coordination.

The DHB coordinated with the Whakatane Council EOC Welfare Group on the provision of community based psychosocial support through the Welfare Centre. The Welfare Centre was subsequently closed on 17th December 2019. Support to psychosocial planning has been given through the expertise and experience of Christchurch events including consultation with the Christchurch Psychosocial Lead for Recovery and with the Ministry of Health's Psychosocial Coordinator and a Maori Advisor. The Psychosocial Coordinator also reached out to the community to ensure support of emergency responders, local helicopter pilots and other potentially affected by the event.

Psychosocial support to staff was initiated on the evening of the response through a session held in the Emergency Department the evening on 9th December. In the following days both group and one on one sessions were held throughout the hospital via a counsellor from Benestar and by Anne Griffiths of Soul Care. In addition the Counsellors walked around the hospital to check in on staff including staff in Podville who supported the retrieval of patients from the helicopters.

To support an integrated approach for both Maori workers in the DHB and for Maori in the community the Psychosocial Coordinator has worked with Maori Health Gains and Development. Maori Health has provided a liaison for the coming month to facilitate understanding and action for the support of the psychosocial response for the Ngati Awa and staff. Maori Health has provided karakia across the hospital in support of tikanga Maori needs.

The Communications Office provided and continues to provide regular updates to staff. They also responded to media requests for information. In addition the Communications Lead supported preparations for visits from the Prime Minister and the Minister of Health.

In recognition of the potential exposure to toxic ash a registry has been initiated for the purpose of having a record of who responded during the event and may been potentially exposed. Toi Te Ora-Public Health Service advised the exposure was secondary with health effects likely to be minimal. Recommendations from the Fire Service Scientific Advisory Committee states: *"there is no need for health monitoring in the*

absence of symptoms." The Whakatane GP Liaison facilitated the sharing of information about ash exposure to local GP to support evaluation and monitoring as needed.

The BOPDHB has now transitioned to Recovery with a Recovery Team and Recovery Advisory Group planned.

Section 3 Recovery arrangements

3.1 Group structure

The Recovery Group structure includes both dedicated staff to support the recovery and a Recovery Advisory Group. The Recovery Advisory Group includes services internal to the DHB and external partner stakeholders. Additional sub groups may form to meet specific short term needs.

The Recovery Advisory Group role is to advise and support the Recovery Team in the implementation of the plan and includes but is not limited to the following responsibilities:

- Support to meet milestones and identified outcomes within the identified timeframe
- Problem solving as challenges and need arise
- Identifying and providing resources in an environment of waning interest
- Being advocates and a voice for a safe and healthy recovery process that builds resilience for both staff and the community

Internal DHB stakeholders include but are not limited to representatives from the following:

- BOP DHB Executive team
- Maori Health Gains and Development
- DHB Communications Team
- Whakatane Hospital Coordinator
- DHB Service Improvement
- DHB Emergency Planning Team
- DHB Corporate Services
- DHB Provider Arm
- GP Liaison - Whakatane

External stakeholders include but are not limited to the following:

- Whakatane Council/Emergency Management Recovery Group Management Team
- St. John
- Ngati Awa
- Ministry of Health
- Emergency Management Bay of Plenty
- Whakatane Council
- Eastern Bay PHA
- External non-governmental agencies providing care

3.2 Recovery Staff

Role	Name	FTE	Backfill
BOP DHB Recovery Manager	Josephine Peters	.8 FTE	.5 FTE to sustain critical projects
Psychosocial Coordinator for Response to Wellness	Liz Gourlay	.9 FTE	.5FTE
Psychosocial Coordinator-Maori Health Gains and Development	To be named	1 FTE	1 FTE
Recovery Communications Lead	Communications Team	.5 FTE	.5 FTE
Clinical Psychologist	To be identified	.5 FTE	New supplier
Occupational Health Support	To be identified	.5 FTE	.5 FTE
Administrative Support	Jane Buet	.4 FTE	Increase hours of Emergency Planning Team Administrative Support to .8FTE
Budget consultation support	Kimberley Reed	.1 FTE	In kind support
Data management and analysis	To be named	.2 FTE	In kind support

A variety of strategies are being used to manage the existing workload of staff supporting the recovery including the following:

- Deferral of projects
- Reassignment of some responsibilities
- Changes in delivery timelines

To support ongoing situational awareness and decision making for effective recovery management an Executive Liaison Team will be formed

3.3 Ongoing support activities

- The Civil Defence Welfare Centre closed on Wednesday 18th December. Psychosocial services for the community continue to be managed from the Mataatua Marae through Ngati Awa (NASH). The DHB continues to support those efforts through the Maori Liaison, the Psychosocial Coordinator and in partnership with the Whakatane Council and Emergency Management.
- One free visit to the GP for those DHB staff and first responders involved in the response has been made available by the DHB through the PHOs through to 31st March 2020.
- Additional clinical staffing resources sourced from multiple areas across New Zealand and Australia to allow Whakatane staff to rest and rehabilitate (to end 31st January 2020).
- Counselling services remain available to DHB staff through Soul Care and Benestar.

3.4 Expenditure and funding

3.4.1 Expenditure

The Ministry of Health has advised that the BOP DHB will need to fund the recovery process from base funding. The emergency cost code is being set up and will be used to track costs incurred from the response and into the recovery.

3.4.2 Funding

Ngati Awa have been provided a fund from the Ministry of Social Development ($90,000.00) from which they will provide psychosocial support and other services to the community to build resilience.

To meet community, staff and logistical needs for the period of 1st January 2020 to 30th June 2020 (the end of the fiscal year) the Recovery Team has prepared a draft budget. As yet costs are unknown so maintaining flexibility within the understanding of a constrained budget environment is suggested. Budget tracking is in place.

Approval for expenditure using the emergency cost code (8006) will be by the Chief Executive.

3.5 Information management and Reporting

All documentation pertaining to recovery will be kept in a shared docman folder – link below:

http://docman/org/Emergency/Recovery/Forms/aByName.aspx

The Recovery Team will identify outcomes, indicators, milestones and timelines to track progress through the recovery process. These will be communicated through, at first weekly reporting and then monthly as we move through the recovery process.

Reporting from the BOP DHB will also be integrated into the Whakatane Group Recovery reporting process.

3.6 Meetings and Forums – To be determined

The need for meetings and forums will be assessed as the situation evolves and action is required.

Name of Group/Forum	Who attends	Dates
Executive Liaison/Advisory Group	CE and designees	To be determined
BOP DHB Psychosocial Interagency Coordinator Group	• Psychosocial Coordinator • Maori Health Psychosocial Liaison • Ngati Awa • Whakatane Council • Pou Whakaaro • Victims Support • Eastern Bay PHA • Recovery Manager as needed	Two weekly through March and then re-evaluate

Name of Group/Forum	Who attends	Dates
Workforce Support Advisory Group	• Clinical Psychologist • Business Partner Lead • Occupational Health • Business Leader • Psychosocial Coordinator • Recovery Manager	

Section 4 Recovery goals, principles and objectives for this recovery

4.1 Recovery principles

The BOPDHB Recovery process will be inclusive and responsive seeking to support community and employees psychosocial recovery through active engagement with stakeholders for the purpose of supporting recovery and building community and employee resilience. The Recovery Team seeks to integrate our work with a Kaupapa Maori approach to ensure that people are served in a way that is best for them.

Recovery will be flexible and scalable to meet identified needs across all environments. A return to a past normality may not be possible for many because of the nature of the event and this may impact on the length of time that recovery initiatives are required.

The Recovery Plan will be reviewed by the BOP DHB Executive Team every 3 months to evaluate outcomes, resource needs and support decision making.

4.2 Recovery goals

To support and provide an effective recovery following the Whakaari Eruption and build resilience for both the community and employees.

4.3 Recovery objectives

1. To support Whakatane community and BOP DHB staff in the psychosocial recovery.
2. To support Whakatane community and BOP DHB staff to build resilience and understanding regarding the new normal after the eruption of Whakaari White Island.
3. To return the BOP DHB to business as usual in the provision of health care services to the community.
4. To maintain passive surveillance for the health effect of potential exposure to ash in the environment.
5. To collect and incorporate lessons learned into existing policy, plans and protocols for system learning.
6. To maintain internal and external communications.

4.4 Recovery strategies – under development

Measurable steps to achieve the goal and objectives:

- Assessment of community and staff needs regarding psychosocial support and building resilience
- Review of best practices and coordination with partners internal and external to the DHB to determine strategies and tools to support the community and staff
- Development of expected outcomes, indicators, milestones and timelines to measure progress for the purpose of determining need and resources

- Implementation and evaluation of strategies and tools to support psychosocial support
- Coordination with Emergency Management/Whakatane Council Recovery Team to ensure integration of goals and work
- Ongoing communication with DHB employees and external stakeholders to provide awareness of services available and to maintain an understanding of ongoing work
- Ongoing passive surveillance of BOP DHB staff and responders potentially exposed to toxic ash
- Conduct operational and clinical debriefing opportunities for those who were part of the response
- Analysis of debriefing input to create an Improvement Plan and the implementation plan to support improvement work
- Determine resources needed to implement the Improvement Plan and make assignments to those work areas/services affected

4.5 Indicators

Outcomes and indicators will be determined by the DHB Recovery Advisory Group in partnership with internal and external stakeholders. Indicators may be quantitative or qualitative including anecdotal information provided by employees and partners. Quantitative indicators will be chosen to best characterise an understanding of the following with regard to interventions:

- How much is being done
- How well is it being done
- How effective is the intervention i.e. are the recipients better off

Indicators are evaluated within the context of the environment and circumstances in which they have been collected. Indicators will be used to inform decision making.

Section 5 Recovery actions

Action #	Task / Project	Outstanding response action	Expected outcome	Indicator	Lead Organisation	Responsible person	Priority	Timing	Expected completion date	Status
1.	Executive Liaison/Psychosocial Advisory Group	Continued engagement with Advisory Group participants	Advisory Group providing support and advise to the recovery process	Regular meetings and action steps	BOPDHB	Recovery Manager in collaboration with Executive Team	High	Short term	Complete	Ongoing meetings
2.	Community and staff needs assessment related to psychosocial needs	Work with community partners to plan and implement assessment	Community needs assessment, expected outcomes and indicators of success	Community needs assessment report	BOPDHB Maori Health Gains and Development and Ngati Awa	Psychosocial Coordinator with support from Emergency Planning Team and Maori Health Liaison	High	Short Term	3rd March	Ongoing
3.	Whakatane Community and Staff Wellbeing Coordination Plan development	Completion of plan development with implementation strategies, outcomes, indicators, milestones and timelines	Final plan with implementation strategies and partner commitments	Plan **NB: psychosocial support will continue during the assessment and plan development stage**	BOPDHB	Psychosocial Coordinator with support from Emergency Planning Team	High	Short term	14th February	On track
4.	Ongoing coordination and tracking the implementation of the psychosocial plan	Indicator development, system for data collection and analysis	Data set that informs the progress of psychosocial support for future decision making	Number of group and individual encounters measured against baseline	BOPDHB, Maori Health Gains and Development and Ngati Awa	Psychosocial Coordinator and Iwi Liaison Coordinator	High	Long term	Review monthly	On track

Action #	Task / Project	Outstanding response action	Expected outcome	Indicator	Lead Organisation	Responsible person	Priority	Timing	Expected completion date	Status
				encounters, did the encounters meet standard (how well) and effectiveness of the encounters						
5.	Identifying training needs	This may emerge as a result of work done	Training appropriate to support managers and staff and community	Trainings completed and numbers attended	BOPDHB	Psychosocial Coordinator with support from the Recovery Advisory Group	Low	Long Term	Ongoing	To be initiated.
6.	Debriefing and organizational learning	Debriefing schedule, analysis of existing data, initiate report writing	After Action Report and Improvement Plan	Improvement plan with assignment of responsibilities and timelines	BOPDBH	Emergency Planning Team	Low	Medium Term	May 2020	On track
7.	Communications	Ongoing communication	Timely communications	TBD	BOPDHB Communications Group	Recovery Communications Lead	High	Long Term	Ongoing	On track
8.	Passive Surveillance	Verification of potentially exposed persons	Completed registry	Completed registry	BOPDHB	Recovery Manager	Medium	Short Term	Ongoing	On track
9.	Budget Management and Tracking	Collections and management of budget information and budget planning	Budget tracking mechanisms	Monthly reporting	BOPDHB	Recovery Manager	High	Long Term	Ongoing	On track
7.	Recovery	Ongoing	Weekly then	Reports	BOPDHB	Recovery	Medium	Long Term	Ongoing	On track

Action #	Task / Project	Outstanding response action	Expected outcome	Indicator	Lead Organisation	Responsible person	Priority	Timing	Expected completion date	Status
	Reporting		monthly reporting			Manager				

Section 6 Resource analysis

6.1 Analysis of resource needs

To meet the ongoing needs of the community and BOPDHB staff, activities to support the recovery remain ongoing with those coordinating and managing the implementation of the Recovery Plan coming from internal resources because of their existing knowledge, skills and partnerships with stakeholders.

Each member of the Recovery Team is working on an analysis of their pre-event workload to identify priorities and the resources needed to sustain them. Some projects will be placed on hold and others will have extended timelines or be reassigned.

An addendum to this plan lays out a proposed budget for a one year period spanning fiscal years 2019/2020 and 2020/2021. Support to meet the resource needs will come from Executive Leadership and assigned workgroups.

Section 7 Risks

Key risks and issues arising because of the emergency and in moving from response to recovery, and actions proposed and underway to reduce the impact.

Risks are **potential** future problems and issues are **current** problems. A **risk** is something that hasn't happened yet but has some probability of occurring. An **issue** is a risk that has happened.

Risk/issue	Action needed	Responsibility	Result
Issue: staffing rosters gaps because some staff my not be able to resume their previous jobs creating added stress to staff on the job	Monitoring of staff to identify needs. Support to ACC claims Removing barriers for staff to access the care they need	Psychosocial Coordinator	Staff are rested and supported to be able to return to work
Risk: long term staff and community need for psychosocial support	Work with staff and community to evaluate and identify need	Social environment Lead Whakatane Recovery Group and BOPDHB Recovery Team	Community and staff have needs met
Risk: future health issues as a result of exposure to toxic ash	Passive Surveillance by DHB. GP awareness of potential risks to support monitoring as needed	Recovery Team	Complete records to support any future ACC claims
Risk: loss of interest and support for recovery from internal and external stakeholders	Maintain good communication about actions, progress and resources needed	Recovery Manager and DHB Executive Team	Progress in recovery is consistent and well communicated

Section 8 Engagement and communications

8.1 Engagement plans

BOP DHB continues to engage with Ngati Awa through the Maori Liaison to support psychosocial coordination.

BOP DHB is working with Whakatane Recovery Group to identify emerging issues and facilitate a response

8.2 Iwi Partnership

Engagement with iwi is being undertaken to recognise and provide a practical commitment to the principles of the Treaty of Waitangi. The principles are often referred to as partnership, participation and protection. The BOP DHB wishes to develop a psychosocial response that integrates the kaupapa Maori approach.

Iwi engagement to be planned: Regular meetings with Ngati Awa to support and track initiatives and progress

Initiatives underway: Maori counsellors and traditional healers are being made available to staff. NASH is following up on approximately 25 persons who had sought services after the Whakaari Eruption.

Initiatives to come: TBD

Iwi contacts: Rachel Morris

Iwi	Name	Contact Details
Ngati Awa	Rachel Morris	

8.3 Other key stakeholders - TBD

Internal DHB stakeholders include but are not limited to representatives from the following:

- BOP DHB Executive team
- Maori Health Gains and Development
- DHB Communications Team – Recovery Communications Lead
- Whakatane Hospital Coordinators
- DHB Service Improvement
- DHB Emergency Planning Team
- DHB Corporate Services
- DHB Provider Arm
- GP Liaison - Whakatane

External stakeholders include but are not limited to the following:

- Whakatane Recovery Group Management Team
- St. John

- Ngati Awa
- Ministry of Health
- Emergency Management Bay of Plenty
- Whakatane Council
- Eastern Bay PHA

8.4 Communications plans

Maintain responsive and efficient communications both internally and externally with messages coordinated with key stakeholders.

8.4.1 Strategy

- Maintain a responsive stance to the need for internal and external communications
- Respond to media requests as is appropriate
- Ensure resources are well communicated internally and externally

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

Bay of Plenty District Health Board
Board Members Interests Register

(Last updated February 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
BOPDHB MHAS	Employee	Mental Health & Addictions	MED	22/10/19
BOP ANZASW Branch	Member & Kaumatua	Executive Leadership	LOW	22/10/19
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
CULLEN, Michael				
Te Kotahitango o nga hapu o Ngati Tuwharetoa (TKNT)	Lead Claims Negotiator	Treaty,other claims	LOW	1/9/2010
Retirement Income Group	Director	Annuity	VERY LOW	1/6/2017
Earthquake Commission (EQC)	Chair of the Commission	Disaster Insurance	VERY LOW	1/11/2018
Lakes DHB	Board Member	Health	LOW	7/12/2019
Te Pae Maunga	Chair	Iwi/Commercial Development Relationship	LOW	
EDLIN, Bev				
Institute of Directors – BOP Branch	Board Member	Membership Body	LOW	Member since 1999
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

INTEREST	NATURE OF INTEREST	CORE BUSINESS	RISK OF CONFLICT	DATE OF INTEREST
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
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
Lakes DHB	Wife Sue works in Clinical Quality and Risk, previous Director of Midwifery	Health Management	LOW –Health Management MOD- Midwifery	Jan 2020

GUY, Marion				
South City Medical Centre	Employee	Health	NIL	06/1996
Bay of Plenty District Health Board	Employee	Health	LOW	03/10/2016
NGAROPO, Pouroto				
Maori Health Runanga	Chair	DHB Health Partner	LOW	25/02/2005
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
Volunteering Bay of Plenty	Chair	Volunteer organisation	NIL	October 2019
SHEA, Sharon				
Health Care Applications Ltd	Director	Health IT	LOW	18/12/2019
Shea Pita & Associates Ltd	Director & Principal	Consulting	LOW	18/12/2019
Manawaroa Ltd	Director & Principal	Service Provider	LOW	18/12/2019
Alliance Health Plus PHO	Board Member	Pacific PHO	LOW	18.12.2019
MAS Foundation	Board Member	Philanthropic Funder	LOW	18/12/2019
HealthShare	Consultant	Strategy	MEDIUM	18/12/2019
Maori Expert Expert Advisory Group (MEAG)	Chair	Health & Disability System Review	LOW	18.12.2020
Iwi	Whakapapa		LOW	
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	Directo	Kiwifruit	LOW	15/12/2019
Waikeke Farms Ltd	Director	Dairy Farm	LOW	15/12/2019
Oranga Marae Lotteries	Committee Member	Lotteries	LOW	25/12/2019
Toi EDA	Committee Member	Eastern bay Evonomic Dev	Low	15/12/2019
Lotteries Americas Cup	Committee Member	Lotteries	LOW	15/12/2019
Whakatohe Pre Settlement Claims Trust	Project Manager	Negotiate Whakatohea Settlement	LOW	15/12/2019

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

Minutes

Bay of Plenty District Health Board

Venue: Tawa Room, Education Centre, 889 Cameron Road, Tauranga
Date and Time: 15 January 2020 at 9.30 am

Board: Michael Cullen (Chair), Sharon Shea, Hori Ahomiro, Mark Arundel, Bev Edlin, Geoff Esterman, Ian Finch, Marion Guy, Ron Scott, Leonie Simpson, Arihia Tuoro, Annabel Davies, Pouroto Ngaropo

Attendees: Simon Everitt (Interim Chief Executive), Owen Wallace (GM Corporate Services) Bronwyn Anstis (Acting Operating Officer), Mike Agnew (Acting GM Planning & Funding and Population Health), Marama Tauranga (Acting Manukura /Executive Director Toi Ora), Graham Cameron (Pou Tikanga, Maori Health Gains & Development) Debbie Brown (Senior Advisor Governance & Quality), Jeff Hodson, (GM Facilities & Business Operations), Sarah Mitchell (Director, Allied Health, Scientific & Technical), Julie Robinson (Director of Nursing),

Item No.	Item	Action
1	**Powhiri** A Powhiri to welcome new Board Members had been undertaken prior to the Board Meeting, followed by morning tea.	
2	**Apologies** There were no apologies	
3	**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. The Board Chair had an additional interest to add which he will email through.	
4	**Minutes** 4.1 <u>Minutes of Board meeting</u> **Resolved** that the Board receive the minutes of the meeting held on 20 November 2019 and confirm as a true and correct record. Moved: M Guy Seconded: B Edlin 4.2 <u>Matters Arising</u> Matters Arising were either in progress or completed. Those in progress will be followed up. 4.3 <u>BOPHAC Meeting – 4.12.19</u> BOPHAC Chair advised that the correspondence re Bowel Screening/ Colonoscopy wait lists was a feature item for the meeting. There are challenges and positives around the proposed new programme. Urgent cases have been caught up on. It is the non-urgent and surveillance cases which still require to be caught up on.	CEO

	A Business Case on the new Screening programme will go to the Executive Team in February, followed by submission to the Board. The difference in the makeup of population in the Eastern Bay of Plenty will require a different approach. **Resolved** that the Board received the minutes of the BOPHAC meeting of 4 December 2019 Moved: G Esterman Seconded: B Edlin 4.4 <u>BOPALT Meeting – 1.12.19</u> CEO advised the Board that alliances were set up some years ago with primary care partners on how the DHB and Primary Care could work together. There has been a recent process of resetting BOPDHB's relationship with the Bay of Plenty Alliance Leadership Team (BOPALT), with a new Charter. The minutes are submitted to the Board to provide regular updates. The alliance meets on a six weekly basis. BOPALT makes decisions on such things as models of care from a primary and secondary perspective and allows joined up conversations. Query was raised on the Te Haeata item which was indicated as being on hold pending the new BOPDHB Board Chair. Te Haeata was formerly known as the Strategic Partnership Group (SPG) and has fairly recently changed to Te Haeata. The query may be whether Te Haeata is to continue. The Board noted the minutes	
5	**Items for Discussion / Decision** 5.1 <u>Enhancements to Out-Year Planning</u> GMCS provided update since submission to the Board. The Ministry advised of a change in timelines. Advice had been given that the Annual Plan was required for March, which is now set at 28 January. The Annual plan is now also required to have a view two years out as well as for what is required for the current year. The request is in parallel to current work, which has been confusing. The work required for 28 January is for the first 6 months actual results and the following 6 months planned budget. Out-years are not approved. BOPDHB will submit a forecast on 28 January complying with the Ministry request, with flags. **Resolved** that the Board notes; 1. Ministry of Health's requirements of DHBs to provide more comprehensive medium term financial and workforce planning over a three year window; 2. Potential timing issues with the 2020/21 Annual Planning process where assumptions and the 2020/21 funding envelope are still to be released. Moved: A Tuoro Seconded: B Edlin 5.2 <u>Chief Executive's Report</u> The Chief Executive highlighted: *Strategic Priorities.* CEO acknowledged that discussion is required with the Board on how the Strategic Priorities have been arrived at.	

There has been six months of work to develop Te Toi Ahorangi (TTA). The diagram encapsulates the priorities of TTA and BOPDHB's Strategic Health Services Plan priorities and key actions.

Child Health Services. There are impending changes to Child Development Services (CDS). There is an exciting opportunity and positive change for an integrated service approach for the future. A report will come back to the Board on CDS after the transition to the DHB and the opportunities for improved integration.

Keeping me Well. This is work in the integration space and is a rehabilitation and enablement project in the community. The programme will be launched in February, trialling in Te Puke.

Query was raised on Nga Mataapuna Ora (NMO) missing their target by 50% on high needs for Before Schools Checks. Acting COO will follow up and report back.

Mental Health and Addiction Services (MHAS). For the last 6 months there have been discussions with the Board on the pressures on MHAS. There has been more resourcing applied to the Crisis Service in Tauranga and Whakatane and in Whakatane some FTE services are sitting with Iwi Alliances.

Breast Screening. There has been work being undertaken on improving equity and access for Maori women for the last 12 months. There has been dedicated resourcing using IHI methodology. There is good progress being made to reduce health inequalities as reflected in the latest results.

Student Placements. Query was raised on placement options. There has been an increase in student numbers. This year 30 have progressed to the next year. Placements will go to Whakatane.

Contraception Service. The Ministry has approached BOPDHB to share / show case their approach and service model with other DHBs

Papamoa A/Hrs Services. Papamoa has been expanding with significant population growth. There has been pressure over the last year for afterhours services in that area. Review of data and when people are accessing services does not reflect that it is in the afterhours space. Western Bay PHO is consulting with their provider network to look at a weekday and weekend after hours service.

Measles Outbreak. This has been a significant piece of work which has started to plateau with no new cases in the BOP in recent weeks. Toi Te Ora (TTO) will monitor. Focus is on timely immunisation. Community Pharmacy is now part of the response and a selected number of Community Pharmacies are able to offer immunisations.

Clinical Campus. An invitation is extended to Board Members for a Noho Marae experience. This has been successful in attracting students to the Bay of Plenty. Next opportunity is 19 January 2020.

Health Research Council (HRC) has invited DHBs to partner in additional research funding. HRC are taking a different approach with their CEO engaging with DHBs. BOPDHB would look at whole of system research funding opportunities

Care Capacity Demand Management (CCDM). Director of Nursing (DON) provided the Board with background on CCDM.

	BOPDHB is a leader in CCDM. There has been Nursing resource added according to the requirements of this programme. The Board has been supportive of the requirements of the CCDM initiatives. *Orientation*. There were 100 employees at this month's orientation which included the new 47 NETP nurses. CEO canvassed the room on the DHBs CARE values and new values based recruitment process. New employees felt this was a useful process. . *Clinical School.* It was considered the new Board should be informed of the success of the Clinical School and its activities. 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. **Resolved** that the Board receive the report Moved M Arundel: Seconded: R Scott 5.3 <u>Primary Health Organisation Reports</u> The Board noted the reports 5.4 <u>Dashboard Report</u> Query was raised on Did Not Attend (DNA) rates which have been a focus for a long time. Indication is of general improvement mainly in Orthopaedics, however what progress was there in other areas, eg paediatrics and O&G?. Acting COO advised some of the success is because of outreach clinics. There are opportunities working with GP practices and Iwi and with good communication, to improve performance. Query was raised as to whether telemedicine is an option. Telemedicine is considered a good opportunity. Discussion is required on the Dashboard and linking it to the DHBs strategic priorities and actions so progress can be monitored. . Board Chair queried availability of information on inequity. There is a Maori Health Dashboard that comes to the Board. Next report is due in February. Board Chair considered the dots need to be connected from the information contained within the Dashboard and how to implement improvements. The reporting does not give a strategic approach. CEO advised that a report will be brought back to the Board **Resolved** that the Board receives and notes the content of the BOPDHB Dashboard Report for December 2019 Moved: G Esterman Seconded: L Simpson	Board Secretariat Manukura
6	**Items for Noting** 6.1 <u>Board Attendance – July – December 2019</u> 6.2 <u>Board Work Plan</u> The Board noted the reports.	
7	**Correspondence for Noting** Nil	

8	**General Business** Nil	
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: Confidential Minutes of last meeting: Board Minutes AFRM Minutes BOPHAC Minutes Chief Executive's Report Financials Central Sterilising Equipment Replacement and Upgrade Hospital Food Service Procurement Contract Award Ministry of Health DHB Balanced Score Card 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: Simon Everitt Owen Wallace Pete Chandler Debbie Brown Hugh Lees Jeff Hodson Julie Robinson Sarah Mitchell **Resolved** that the Board move into confidential. Moved: M Cullen Seconded: S Shea	
10	**Next Meeting –** Wednesday 19 February 2020	

The open section of the meeting closed at 12.40 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

Bay of Plenty District Health Board

Matters Arising (open) – February 2020

Meeting Date	Item	Action required	Action Taken
19.6.19	6.3	**Chief Executive's Report – Research** Query was raised as to whether the research we do, widens the equity gap. CEO to request HOD Clinical School to provide feedback to the Board – HOCS	Report to Board - 19.2.20 – Completed
19.7.19	2.1	**New CIO – Richard Li** The Board will look forward to the results of having Richard as CIO and requested that Richard return with an update in 3 months - GMCS	To report back early in the New Year – March 2020
18.9.19	6.1	**CEO's Report – Maori presentations through ED** GMMHGD advised that the information shown should generate more questions than answers. COO advised that there more Maori who present at ED who are then admitted. The Board requested clarity of the graph for next month's meeting. It was suggested that Dr George Gray should be invited to critique the graph and offer his opinion - GMMHGD	Verbal update provided to Board 20.11.19 – report to Board 19.2.20 Completed
16.10.19	6.2	**Primary Health Organisation Reports** NMO to be invited to the February 2020 CPHAC/DSAC meeting together with the new PHO entity. – Acting GMPF	Invitation extended NMO Presentation to CPHAC /DSAC 5.2.20– PHO to April 2020 - completed
16.10.19	6.3	**Dashboard Report** Whilst ED drop is disappointing, this is in the context of industrial action and continued high demand. A plan needs to be formulated which will come back to the Board.- COO	In progress
16.10.19	6.3	**Dashboard Report – Ash Reports** Community Health 4 kids is working with WINZ. Query will be raised with them as to what information they are sharing – Acting GMPF	In progress

15.1.20	4.2	**Matters Arising** Those in progress will be followed up. CEO	Completed
15.1.20	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	In progress – followed up with HOCS – tentatively to March Board Meeting
15.1.20	5.4	**Dashboard Report – Maori Health Dashboard** Board Chair queried availability of information on inequity. There is a Maori Health Dashboard that comes to the Board. Next report is due in February. Board Chair considered the dots need to be connected from the information contained within the Dashboard and how to implement improvements. The reporting does not give a strategic approach. - Manukura	In progress – will be consideration for next Maori Health Dashboard, May 2020

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: 889 Cameron Road, Tauranga
Date and Time: 5 February at 10.30 am

Board: Arihia Tuoro (Chair), Michael Cullen, Hori Ahomiro, Mark Arundel, Bev Edlin, Ian Finch, Paul Curry, Sue Horne

Attendees: Simon Everitt, (Acting CEO), Mike Agnew (Acting GM Planning & Funding and Population Health), Sarah Davey, (Service & Innovation Manager P&F), Graham Cameron (Pou Tikanga), Sarah Mitchell, (Executive Director, Allied Health Scientific & Technical)

Item No.	Item	Action
	Karakia	
1	**Presentation** Tuapapa Jacky Davis,Project Manager and Rewiti Te Meti, Nga Mataapuna Oranga. Tuapapa –4 key parts, Tangata Whenua Values, Nuka System of Care, Te Tiriti o Waitangi, Whanau Voice. The name Tuapapa was given to NMO by its Kaumatua Council. The name means a bedrock or foundation which can link to the landmark, Te Kuia, North Rock at the Mount, a sacred place to the people of Tauranga. Acknowledgement is given to people who planted the idea of an indigenous model of care, originally from Alaska which has given the strength to go forward. It is a kaupapa Maori system of care. Key values, Pono, speaks about and communicates about honesty, truth and integrity, Tika, is to be right or correct and appropriate and Aroha, is love and compassion, empathy, kindness, non-judgemental. Listening to the voices of whanau is a top priority. A survey was conducted across NMO network, 5 providers. 746 responses. There were 3 priority areas, • Whanau felt they were listened to but not heard, • Whanau felt that they were being told their needs • Whanau wanted simple English. 70% of responses were from Maori, 30% non-Maori. There was no distinction between responses. A huge response was for the desire to be able to do things for themselves, move from dependency to independence with support and wanting a professional caring workforce that talks to Whanau in simple English. This also relates to IT and quality and contracting systems to meet the needs and care for Whanau.	

	Query was raised as to how the survey got to the whanau. All staff were involved and the survey was incentivised between practices. Staff took the survey to their own Whanau. Engagement was made with the Community. Social media was also utilised. NMO is a claimant in Wai1315 and "first cab off the rank". Equity plays a huge part. It is considered Wai1315 will support NMO with its Tuapapa approach. NMO will select the best parts of any model if it will benefit whanau. eg they have selected components of the Nuka programme and Health Care Homes. Workforce challenges have been the catalyst for change. eg Waitaha GP shortages where enrolments have moved to Papamoa and Waitaha has become a mini Nurse led Hauora undertaking many preventative measures in eg mental health, smoking cessation etc The impacts are in terms of equity, workforce (working at the top of their scope), engagement, partnerships (local iwi, Hapu, PHOs MSD, Oranga Tamariki, DHB), IT (collecting information can isolate reasons for ED attendances), contracting (looking at high trust contracts, contracts can be prescriptive, and they would like to open contracts up more), GP efficiencies (lean thinking, GPs engaging, huddles) Te Reo me nga tikanga (a kaupapa organisation). The complexity of Tupapa is in its simplicity. Indicators of success - Action Research, Patient Portals, Patient Experience, Whanau Ora Plans, Meaningful Data, Whanau Narrative. The survey is to be repeated at year's end. *X Factors* • High trust contracting environment • Whanau and staff are ready for change • Funding for equity • Project tenure. Project was for 2 years. NMO want to be in for the long haul. *Summary* • Whanau feedback is essential\Co-designing "what works well". CEO advised of origins of Tuapapa. Nuka and Healthcare Homes were investments by the Board and are co-funded by the DHB. There are 7 - 8 Healthcare homes. Tuapapa is different as an ownership model. It is acknowledged how far NMO have come since 6 months ago. NMO is keen on outcomes contracting and wants to be involved in Maori Workforce development in the future. CPHAC/DSAC Disability Rep felt the Disability Strategy and Tuapapa have good alignment. The Committee thanked Rewiti and Jacky for their informative and inclusive presentation.	
2	**Apologies** Apologies were received from Janine Horton. **Resolved** that the apology from J Horton be received	

	Moved: G Esterman Seconded: I Finch	
3	**Interests Register** The Committee was asked if there were any changes to the Register or conflicts with the agenda. Ian Finch advised of an addition to his interests, with regard to his wife's role at Lakes DHB. No other changes or conflicts were advised	
4	**Minutes** 4.1 Minutes of Previous CPHAC/DSAC Meeting **Resolved** that the minutes of the meeting held on 6 November 2019 be confirmed as a true and correct record. Moved: B Edlin Seconded: P Curry	
5	**Matters Arising** There were no outstanding Matters Arising	
6	**Matters for Discussion / Decision** 6.1 Disability Action Plan 2019 – 2023 Comment was raised as to whether the word Disability was the correct word. "Inclusion" was put forward as a more appropriate term. Those termed "disabled" do not always feel disabled. DHBs do not fund Disability. Comment was made that under PBFF, the Disabled are a part of that population. Local Councils have a close involvement with the Disability Advisory Committee in Tauranga. Discussion about local versus regional approach to planning - a local Disability strategy with local strength was expressed as important. Acting GMPF queried whether the Committee considered a regional or local plan was preferable. Comment was made that the things required were the same in all areas and reproduction for local takes time and resource for the same thing. Engaging with the Disability sector was considered critical. A local flavour can feed into a regional approach. . Query was raised on funding implications. There will be some upfront funding. Ongoing funding is yet to be determined. It was felt regional discussion needs to be had. Timing coincides with preparation of the Annual Plan. It was agreed to explore a regional approach but with a local bottom up engagement process. GMPF & PH and EDAHST tasked with developing. **Resolved** that the Committee: • Note the implications for DHBs arising from the lead health actions. • Note the intention for the Ministry to plan workshops early in 2020. • Feedback with a view on the proposed planning package and how to engage in the process Moved: B Edlin Seconded: M Arundel	GMPF & PH and EDAHST

6.2 Funded Family Carer Policy Changes 2020

There has been historical unmet need under these proposed changes.

Acting GM P&F has asked that baselines be established in terms of funded carer costs pre the introduction of new policy so that the DHB can track impact/difference made.

Query was also raised on the monitoring of home care provision. Monitoring is by way of bi-annual assessment through InterAI.

Pou Tikanga provided a view that for Maori the funding received for care is important however more important to whanau is whanau caring for whanau.

Resolved that the Committee

- Notes the changes to the funded family carer policy and legislation.
- Provides feedback on the changes.

Moved: B Edlin
Seconded: M Arundel

6.3 Integrated Healthcare Bundle

Sarah Davey , Manager Innovation and improvement, gave background and update. The brevity of the report is not reflective of the journey. The term integrated healthcare has been used for some time. It is good to see it coming to life.

Initial vision was that by 2020 the BOP health services will be centre of family and whanau. Efforts have been made to bring the vision to life, through the SHSP. There are threads that are more effectively captured through TTA.

The paper shows some of the initiatives being developed to indicate a more planned system of care for those who find navigation through the health system difficult . There have been efforts made to share information, data, eg Primary care to upload their patient info into DHB systems. There is ability to identify those at most risk of hospitalisation so that intervention can be made appropriately at the right time to support that person to manage their care at home. Keeping Me Well is an enablement programme which allows people to stay in their own homes with multidisciplinary support.

The DHB is proud of what has been achieved thus far. System change does take time. The question is how do those working on the system ensure that the system level changes are informed by those using the system. There are a number of linked in measures and co-design techniques. Patient experience is a key metric.

Resolved that the Committee

- Notes the progress in the range of initiatives that are being progressed in the Strategic Priority of Integrated healthcare;
- Provides feedback on any identified opportunities, risks or gaps with the implementation approach.

Moved: A Tuoro
Seconded: P Curry

6.4 He Ara Oranga Update

Acting GMPF requested feedback on representation at a Mental Health governance level by late February.

	There is work being undertaken to initiate a whole of system Mental Health and Addictions service. Funding has recently been approved for the building of inpatient facilities. Delivery of future Mental Health services for best effect needs to be considered around those facilities prior to build to allow for best design. It was considered the new model of care needs to have consideration of Maori and Maori workforce. There needs to be a joined up approach to the new model of care. **Resolved** that the Committee receives the update regarding the Mental Health and Addiction (MH&A) Sector transformation work programme. Moved: A Tuoro Seconded: B Edlin	
7	***Matters for Noting:*** 7.1 Te Teo Herenga Waka & Toi Te Ora report CEO requested feedback from the Committee as to continuation of the report. The Committee considered the report gave a good overview of activities in the community and should be continued. 7.2 CPHAC/DSAC Work Plan 2020 The plan needs a stronger Disability focus. The Committee noted the papers	
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: Confidential Minutes of last meeting: This knowledge will be of assistance in relation to the matter to be discussed: Simon Everitt Mike Agnew Graham Cameron Sarah Davey Sarah Mitchell **Resolved** that the Board move into confidential. Moved: A Tuoro Seconded: I Finch	
9	**Next Meeting –** Wednesday 1 April 2020	

The meeting closed at 12.35 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

Research and the Equity Gap

SUBMITTED TO: Board Meeting 19 February 2020

Prepared by: Charlie Stratton, Clinical Research Development Manager
Marama Tauranga, Pou Haumanu - Clinical Director

Endorsed by: Marama Tauranga Interim Manukura - Executive Director Toi Ora
Prof. Peter Gilling, Head of BOP Clinical Campus

Submitted by: Simon Everitt, Interim Chief Executive

Introduction: This paper was requested at a Board meeting in 2019 following a query raised by Dr Anna Rolleston.

RECOMMENDED RESOLUTION:

1. That the Research Office, Maori Health Gains and Development in collaboration with other key stakeholders, develop a DHB research strategy that is aligned with the BOPDHB strategic priorities, including those targeting Maori health gains and inequities.

2. That Equity for Tangata Whenua in Bay of Plenty District Health Board (BOPDHB) and responsiveness to Māori in health research will be achieved by aligning research with our strategic priorities and by the articles of Te Tiriti o Waitangi; Article 1: Kawanatanga (governance), Article 2: Tino Rangatiratanga (self-determination), Article 3: Oritetanga (equity), Article 4: Te Ritenga (right to beliefs and values).

3. Ngā Pou Rangahau - The Strategic Plan for Māori Health Research (HRC, 2010-2015) provides important guidance to the organisation in terms of maximising the commitment to improve Māori health. Investing in research and enhancing the capacity and capability of the health research workforce are goals which align to Te Toi Ahorangi priorities.

4. Target selection as a Health Research Collaboration pilot site to access Health Research Council (HRC) funding, and identify other funding options, to support the needs assessment, development and delivery of health research initiatives that are aligned to the BOPDHB strategic priorities, particularly those targeting Maori health gains and inequities.

5. That a Centre of Toi Ora Excellence and Innovation is established by 2024 in alignment with the strategic currents in Te Toi Ahorangi: Te Rautaki a Toi Ora 2030, endorsed by the board on the June 19th, 2019.

Note: A Board paper submitted by Tricia Keelan, GM Māori Health Gains and Development in October 2018: Board Paper 181008 – Equity in Research projects within the Bay of Plenty District Health Board (attachment 1) further outlines the issues and actions to make progress on the recommendations above.

BACKGROUND and ANALYSIS:

Whilst there are a diverse variety of research projects undertaken within Bay of Plenty DHB institutions, locally developed health research activity within the DHB is relatively low, including research that specifically targets issues surrounding equitable delivery of health services or gains in Maori health outcomes. The majority of health research that currently occurs within the DHB is generally collaborative or commercially sponsored. The ICU /CCU and Women's health teams are particularly active in collaborative research, whilst the Oncology, Haematology, Gastroenterology and Urology teams are actively engaged in clinical trials. These types of research are currently suitable for BOPDHB as they are generally well funded and allow us to engage in well designed, scientifically robust research that addresses areas of significant unmet need.

The gap however is evident for locally developed research that specifically targets the health care needs of our local population. It's generally accepted that the major factors affecting local health research within DHBs includes funding, resources and expertise in trial design and implementation. To date insufficiencies in these areas have hindered the opportunity to deliver locally designed health research projects that are intended to address local health care needs in regional DHBs such as the Bay of Plenty. Our system relies on DHB staff and Services to identify research needs and activities and then to develop, secure funding and conduct research projects using Service approved resources. The role of the Research Office is to ensure proposed projects are in line with the DHB Research Policy and national regulations, as well as providing general guidance related to project development and funding applications.

These issues are not exclusive to BOPDHB. The National Health Research Strategy recognises that research is required to specifically focus on health care disparities experienced with certain over- represented populations such as Māori and Pacific Peoples.[1] Two of the Strategic Actions outlined in the National Health Research Strategy specifically target research in Māori and Pacific Peoples:

- ACTION 2: Invest in research for healthy futures for Māori; and
- ACTION 3: Invest in research that results in equitable outcomes for Pacific peoples and helps them to lead independent lives.

The Health Research Council (HRC) manages the Government's investment in health research and they are actively engaging with DHBs to discuss the challenges, opportunities and priorities for research and innovation within DHBs. Two initiatives have recently been rolled out:

i. The New Zealand Health Research Prioritisation Framework

This framework aims to ascertain the priority research characteristics, which will drive health research investment in New Zealand. This was released in late 2019 to work alongside the New Zealand Health Research Strategy (2017-2027).

ii. HRC Health Sector Research Collaboration Grants.

The HRC's Health Delivery Research Investment Round. This includes a pilot project to test a new way of delivering research funding to HDBs in the form of Health Sector Research Collaboration Grants.

[1] http://www.health.govt.nz/publication/new-zealand-health-research-strategy-2017-2027

This grant is a negotiated funding opportunity focused on upskilling and empowering health care or health service delivery organisations to engage in health delivery research within health delivery settings and ensuring that this research adequately responds to health sector, patient and community needs. Two of the key criteria required for this grant are:

- How organisation vision and research activities will contribute to Māori health gains; and
- How organisation vision and research activities will contribute to improving equity.

The grant structure within the pilot scheme allows for activities that will inform and prioritise research needs, upskill new researchers as well as for the delivery of specific research projects. In order to be successful with the application a collaborative cross-functional approach is required to identify research initiatives that address areas of unmet need. The Research Office is currently working with services across the DHB with a view to securing selection as a pilot site for the collaborative grant funding.

In the long term the DHB would benefit from an overall Health Research Strategy that is aligned with the strategic priorities of the DHB. Review of strategies and learnings from other DHB's, such as the Waitemata and Auckland DHB Maori Health Research Strategy, (attachment 2), and other relevant papers such as Achieving health equity in Aotearoa: Strengthening Responsiveness to Maori in Health Research[2] should be undertaken to assist with the development a DHB research strategy that meets the need of our population and includes consideration of measures designed to target health inequities, such as a Toi Ora Research network.

SUMMARY:

Health disparities are real and the evidence base is large and irrefutable. In light of an international and national shift away from solely documenting the pervasive health disparities for Māori, the Research Office and Māori Health Gains and Development will begin to work collaboratively to focus on a BOPDHB Health Equity Research agenda from 2020 onwards.

We are committed to this work because it aligns with our joint aspirations for Excellent Research and because it is essential for good health outcomes, services and systems for the communities the DHB serves.

Excellence in Research for Aotearoa requires our DHB to undertake deliberate and intentional research that has potential to address Māori health needs and priorities. It may require a paradigm shift that explicitly addresses social, political and economic processes that influence population health.

Selection as a pilot site to secure HRC grant funding will go some way to help achieve these goals, however alternative funding sources will need to be considered in order to ensure appropriate resources are available, particularly if selection as a pilot site is unsuccessful.

ATTACHMENTS:

Attachment One – Board Paper 181008: Equity in Research projects within the Bay of Plenty District Health Board

Attachment Two – Waitemata and Auckland DHB Maori Health Research Strategy, Tino Rangahau: Māori Health Research Centre of Excellence.

[2] Reid P, Paine SJ, Curtis E, et al, *Achieving Health Equity in Aotearoa: Strengthening Responsiveness to Maori in Health Research,* N Z Med Journal. 10 Nov 2017, Vol 130, No. 1465

EQUITY IN RESEARCH PROJECTS
WITHIN THE BAY OF PLENTY DISTRICT HEALTH BOARD

SUBMITTED TO:

Board Meeting 17 October 2018

Prepared by: Tricia Keelan, Māori Health Gain and Development

Endorsed by: Dr George Gray, Specialist Public Health Physician
Sarah Strong, Clinical School Business Leader

Submitted by: Helen Mason, Chief Executive

RECOMMENDED RESOLUTION:

That the Board note the contents of the paper

ATTACHMENTS:

Progress Report on TOW and Equity in Research Projects

BACKGROUND:

At his presentation to the Board in January 2018, Clinical Research Development Manager, Charlie Stratton, was asked to report back to the Board on progress on Equity in Research Projects. Charlie provided a report to the July Board meeting at which time the Board asked for a further report on equity in research projects from Tricia Keelan General Manager Māori Health Gain and Development. This report provides Tiriti o Waitangi and Equity Māori perspectives on research in the DHB.

TE TIRITI O WAITANGI AND EQUITY IN RESEARCH PROJECTS WITHIN BOPDHB

INTRODUCTION

This report provides a view on the role of Te Tiriti o Waitangi and the importance of equity for Māori in our research approach within the DHB. In this report we are interested in not only the review of research but also the determination of research priorities from foundation to execution. I posit some next steps and identify potential systems and procedural level changes that will positively contribute towards Māori health gains and development. It is intended that this paper is viewed as part of a larger whole of system approach that is giving effect to the necessary changes required to best support health equity for Māori and the realisation of Toi Ora.

Note that this month I have also provided the Board with a copy of the submission that I led for Te Tumu Whakarae, on the Government Mental Health and Addictions Inquiry. It would be helpful if the Board is cognisant of the concepts, evidence and power principles discussed in that submission document when reviewing this paper.

RESEARCH CONSULTATION WITH MĀORI

How does BOPDHB currently provide for Māori consultation in research projects?

Structurally in the past, a Māori Research Committee was in place consisting of the Director Regional Māori Health, Nurse Leader, and their choice of a local iwi representative. The committee were expected to meet monthly and to also invite the lead researcher or representative of each proposal considered to discuss the research project. At present there are four levels of Māori consultation in regards to BOPDHB clinical research[1]:

1. No Māori participants will be involved in the research project – Māori subjects are excluded.
   No consultation will take place
2. Possibility that Māori participants will be involved in the research project – Māori subjects will be occasionally involved.
   Regional Māori health services notified
   (Research team to provide a lay summary of the project.)
3. Probability Māori participants will be involved with the research project – The disease process being studied is highly prevalent in Māori.
   Consultation required with regional Māori health services
   (Research team to include summary of the project and a copy of the Patient information sheet and consent form. If the Research Proposal Coordinator has not been contacted within two weeks of the initial email, it is assumed that Regional Māori Health Services have no concerns with the research project.)
4. Definite involvement of Māori participants with the research project – The project is a study of Māori patients.
   Full consultation with the Māori research committee
   (Research team to include summary of the project and a copy of the Patient information sheet and consent form to be discussed at a monthly meeting.)

In the event that Level 3-4 Māori consultation is required, the following questions are posed:

1. How do you plan to recruit Māori participants?
2. What is the benefit to Māori?

1 Māori Consultation Guidelines. Retrieved from https://www.bopdhb.govt.nz/education-research/clinical-trials-unit-and-research/research-approval/guidelines/

3. How will the results be disseminated?

This process is administered and facilitated by the Research Office and as described within Charlie Stratton's report[2] 'the primary role of the Research Office is as a support function to ensure that research that is conducted at BOPDHB is scientifically valid, has been assessed for resource capacity, has appropriate regulatory and ethics approvals and has been signed-off by the DHB. In addition the Research Office provides access to statistical support, scientific review, and advice on ethical and regulatory review pathways. This service is readily available to all DHB employees involved in research but it is up to the individual clinicians and services to pro-actively drive their own research projects.'[3]

Improvement

There is opportunity to improve our approach so that we are more deliberate in setting an agenda for research that contributes to achieving Toi Ora. For example this can be achieved through the establishment of a Toi Ora Research Agenda that strategically navigates towards impactful research that aims to address Māori health needs and realise iwi aspirations. We can also strengthen the framework for reviewing research projects toward Toi Ora.

As outlined within Charlie Stratton's report[4], a total of 34 projects were registered in 2017, many of which originated from centres outside BOPDHB. It is unknown during this period the number of projects that were considered levels 2-4 as this would indicate potential and anticipated contributions to Māori health gains and development.

Although we do not have a thorough analysis of research projects registered over the last ten years, a surface level review of projects indicates that the majority of research is derived and initiated from other districts with low involvement and focus on Māori.

It provides us with an important opportunity to build on the current structure to grow Māori Health research capability and capacity toward Toi Ora, something that the Clinical School is very supportive of.

DATA INSIGHTS AVAILABLE

What is the number of research projects across all four levels of Māori consultation over the last ten years?

Types of research and levels of Māori involvement in DHB research projects were recently reviewed in a project in 2015[5]. This report highlights variances across DHBs and identifies differences in the level of involvement of Māori as participants and as researchers, as well as consultation methods, research design, control, analysis and the selection of research tools utilised (Table 1).

Table 1 Types of research and levels of Māori involvement in a research project

2 Stratton, C. (2018). Equity in Research: Bay of Plenty District Health Board Report July 2018.

3 ibid

4 Stratton, C. (2018). Equity in Research: Bay of Plenty District Health Board Report July 2018.

5 Simmons, S (2015) A framework for Māori Review of Research (Draft). Retrieved October 3 2018 from https://www.ccdhb.org.nz/working-with-us/carrying-out-research-at-ccdhb/research-advisory-group-maori/framework-for-maori-review-of-research-final-9nov15.pdf

	Non-Māori initiated research			Māori-centred research	Kaupapa Māori Research
Level of Māori involvement: • as participants	(1) No expected involvement	(2) Possible involvement	(3) Probable involvement	(4) Definite involvement	(5) Significant involvement, possibly exclusive
• on research team	No expected involvement	Possible involvement as junior researcher positions	Probable involvement as researchers and/or advisors	Definite involvement as researchers, senior researchers and advisors	Significant involvement, possibly exclusively Māori researchers and advisors
Type of consultation recommended	DHB Māori review	DHB Māori review	DHB Māori review and possible engagement with DHB Māori reviewers (face to face meeting)	Full and ongoing engagement and collaboration with appropriate Māori community group(s)	Full and ongoing engagement and collaboration with appropriate Māori community group(s), Māori are kaitiaki of project
Description of research	• Māori have not been included in the design of the project • There are still possibilities to contribute to Māori development	• The research topic is not designed to be analysed by ethnicity • Not a topic of particular relevance for Māori. • There are still possibilities to contribute to Māori development	• the contribution of the research to Māori health and equity is detailed • an area of health that Māori have high representation • a topic of particular relevance for Māori (nationally or locally)	• Clear aims for the contribution of the research to Māori Health and equity • Māori knowledge produced, but non-Māori methods may be used	• Clear aims for the contribution of the research to Māori health and equity • Māori analysis is undertaken and Māori knowledge produced
Control	Non-Māori	Non-Māori	Non-Māori	Non-Māori and/or Māori	Māori
Analysis	Non-Māori	Non-Māori	• Non-Māori and/or Māori • Ethnicity analysis • Equity analysis	• Non-Māori and/or Māori • Ethnicity analysis	Kaupapa Māori
Tools	Non-Māori	Non-Māori	• Non-Māori • Possibly some Kaupapa Māori Research methods	• Non-Māori • or Kaupapa Māori Research methods and Kaupapa Māori Epidemiology	Kaupapa Māori Research methods and Kaupapa Māori Epidemiology

Table 1 shows is that no matter the level of Māori involvement in the research as participants or as research team members, consultation that allows for the review of the research from a Māori perspective is recommended as a minimum expectation. This information provides insights into future planning and decision-making regarding Māori health gains and development and high quality Tangata Whenua Hauora Research.

What can we learn from other DHB Māori research consultation processes?

Māori review of research to be undertaken is an ethical and legislative requirement for research conducted in District Health Boards (DHBs) in Aotearoa/New Zealand. DHBs have used varying processes in the past and there have been efforts at standardising the Māori review process across DHBs. It is evident when exploring Māori research consultation processes across DHBs that the processes are tailored to each DHB, in terms of leadership and authorisation, processes and procedures.

All **Waikato DHB** research projects (excluding clinical audits) must undergo a consultation process that is based on Te Ara Tika[6] and aligns with Te Tiriti o Waitangi. Key areas of consideration include the collection of ethnicity data, consultation with Māori, dissemination of study results, cultural competency of researcher(s), recruitment, inequalities and potential issues of cultural significance. There is also a separate process/questionnaire for the use of human tissue.

Research within **Lakes DHB** is forwarded to the Māori health division from the Research and Ethics Committee which is inclusive of two iwi groups, and an iwi governance representative. The process requires a brief to also be prepared for the Lakes DHB iwi governance board to consider in order to comment on what the benefits of the research will be to Māori. This feedback is provided direct to the Research and Ethics Committee for consideration. All researchers are recommended to work with the Lakes Māori Health team.

6 Hudson, M., Milne, M. Reynolds, P., Russell, K., & Smith, B. (2010). Te Ara Tika Guidelines for Māori research ethics: A framework for researchers and ethics committee members. Retrieved from http://www.hrc.govt.nz/sites/default/files/Te%20Ara%20Tika%20Guidelines%20for%20Maori%20Research%20Ethics.pdf

Within the Hawkes Bay the Taumata Rangahau group have a direct responsibility to capture specific cultural requirements before the research application reaches the Ethics Committee approval stage. This process allows an earlier cultural intervention, and therefore allows for early engagement with the researchers and other specialists. This phase of consultation "fits" in with the initial research application process and in turn provides for Māori involvement at an earlier stage to prioritise how the research can contribute to Māori health gains.

Like other DHBs we are able to learn from each other to strengthen research processes for Māori Health improvement.

TANGATA WHENUA HAUORA RESEARCH

What is Tangata Whenua Hauora Research?

According to the Health Research Council of New Zealand (HRC), tangata whenua health research is research that values tangata whenua worldviews and builds research capacity and leadership. It is research that contributes to Pae Ora, healthy Māori futures (He Korowai Oranga) and builds an evidence base which contributes to tangata whenua hauora gains, derived from high-quality hauora research that upholds rangatiratanga and uses and advances Māori knowledge, resources and people.[7] In recent years the HRC has made a commitment to increase tangata whenua participation in health research, and for HRC-funded research to 'contribute as much as possible to the improvement of Māori health and wellbeing, while the research process maintains or enhances mana Māori.'[8]

New Zealand's own Māori Centre of Research Excellence, Ngā Pae o te Māramatanga (NPM) views tangata whenua research as research that is led, conceived and determined by tangata whenua[9]. NPM have established three key strategic research themes, ensuring that all research aligns with a collective agenda that focuses on Mauri Ora (human flourishing); Whai Rawa (Māori economies); and Te Tai Ao (natural environment). The work of NPM demonstrates a Māori determined research agenda and showcases how research can best align with the outcomes that we aim to achieve. These three key strategic themes also have strong alignment with the elements of Pae Ora as outlined in He Korowai Oranga Mauri Ora (Healthy individuals), Whānau Ora (Healthy families) and Wai Ora (Healthy environments).

The Ministry of Health acknowledges tangata whenua as a priority population for health interventions[10] and is at present working alongside the Health Research Council of New Zealand and the Ministry of Business, Innovation and Employment on the development of a New Zealand Health Research Strategy that focuses on four key strategic priorities and ten key actions (Figure 1). The importance of partnership with Māori and equity are fundamental principles for this framework and are woven throughout the strategy itself. The HRC's definition of excellent research affirms:

> *Excellent research occurs across the entire spectrum of innovation, from very basic to very applied and practical research – and across the full range of research disciplines: biomedical, clinical, health services, public health and information systems. It is performed in a wide variety of settings, including laboratories, hospitals and communities. We see excellent research as being ethical, scientifically sound, original, relevant, purposeful and impactful.* [11]

7 Health Research Council. (2010). Guidelines for Researchers on Health Research Involving Māori: Version 2. HRC, Auckland.

8 ibid.

9 http://www.maramatanga.co.nz/

10 Ministry of Health (2014) Standard Operating Procedures for Health and Disability Ethics Committees. Version 2, August 2014. Wellington: Ministry of Health www.ethics.health.govt.nz

11 http://www.hrc.govt.nz/sites/default/files/Final%20HRC%20SoI%202017-20.pdf

Figure 1 | New Zealand Health Research Strategy

The New Zealand Health Research Strategy provides direction to:

- prioritise research investments through an inclusive priority-setting process,
- invest in excellent health research that addresses Māori health needs and ensures healthy Māori futures,
- develop and sustain a strong Māori health research workforce,
- create a vibrant Māori health research environment by strengthening health sector participation in Māori research and innovation,
- build and strengthen pathways for translating Māori research findings into policy and practice, and
- advance innovative Māori ideas and commercial opportunities.

Enabling whānau, hapū, iwi and Māori to exercise control over their own health and wellbeing, as well as the direction and shape of their own institutions, communities and development as a people, is a key thread of He Korowai Oranga. He Korowai Oranga encourages:

- Investment in high-quality research and in building Māori health research capacity across the sector and within communities to further develop the knowledge base that will contribute to Pae Ora.
- Collaboration across sectors to coordinate high-quality research and information on the determinants of health to drive continuous quality improvement in the development, design and delivery of services for Māori.
- High-quality health information to inform the delivery of effective health and disability services that meet the needs of the Māori population across the continuum.

He Pou Oranga

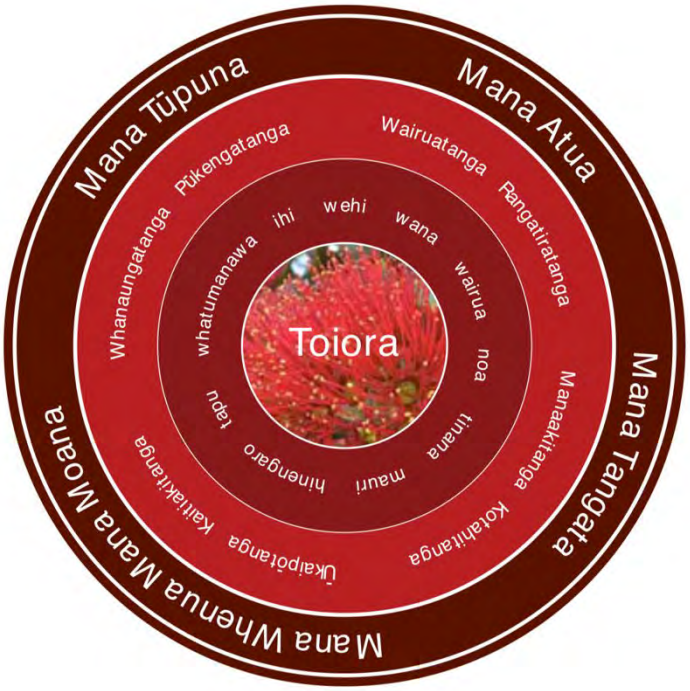


Figure 2 | He Pou Oranga Tangata Whenua Determinants of Health Framework

He Pou Oranga Tangata Whenua Determinants of Health Framework (Figure 1) provides an ultimate expression of a Kaupapa Māori approach that is embedded in the local and lived contexts of tangata whenua who have mana whenua and mana moana over their ancestral tribal lands and resources within Te Moana a Toi. Tangata Whenua research aligns with the four key domains of Ngā Pou Mana o Io; Mana Atua, Mana Tūpuna, Mana Tangata, Mana Whenua and Mana Moana, and is research that ultimately contributes towards the realisation of Toi Ora.

Although this review is specific to clinical research, the above principles and actions identified, as well as strong alignment to Toi Ora and He Pou Oranga are still very much applicable to ensure Māori health gains and development. These points are utilised within the review framework of this paper to further explore equity and Te Tiriti o Waitangi within the context of BOPDHB research projects.

EQUITY

BOPDHB is committed to ensuring that all interventions must have an equity focus to help improve Māori health outcomes. The Equity of Health Care for Māori framework[12] outlines three key areas for action that support equitable health outcomes for Māori, these are:

- Leadership: by championing the provision of high quality health care that delivers equitable health outcomes for Māori.
- Knowledge: by developing a knowledge base about ways to effectively deliver and monitor high quality health care for Māori.
- Commitment: to providing high quality health care that meets the health care needs and aspirations of Māori.

Although this framework refers to 'health care', the framework is also useful when considering the effects of 'high quality Tangata Whenua Pae Ora Research' within BOPDHB.

12 Ministry of Health. 2014. Equity of Health Care for Māori: A framework. Wellington: Ministry of Health.

TE TIRITI O WAITANGI

As partners to Te Tiriti o Waitangi, tāngata whenua have the right to self-determination, and participation in all aspects of health research – from the strategy, agenda, selection of projects, development of study aims, data collection and choice of methods for data analysis, to the interpretation, framing and dissemination of results - there are many opportunities to exercise this right.

Unfortunately while there has been a plethora of research on tāngata whenua, only a very limited proportion of research investment available in health has been deployed under tāngata whenua leadership. This is due to funded research guidelines that privilege an illness modality and western clinical paradigm and epistemologies even within research earmarked for Māori health. Researchers correspondingly undertake projects that continually try to understand why Māori are the most ill rather than undertaking research that is predicated to inform pathways to Pae Ora, and for us in Te Moana a Toi, our tangata whenua aspirations for Toi Ora.

The pervasive inequalities experienced by tangata whenua demand tangata whenua participation, partnership and protection in health research and research decision-making. It is important when we refer to Te Tiriti o Waitangi that we define what we mean by the BOPDHB's commitment to upholding its statutory obligations. Primarily, this means upholding the principles of Te Tiriti as described as follows:

- Partnership involves working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.
- Participation requires Māori to be involved at all levels of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services.
- Protection involves the Government working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

REVIEW FRAMEWORK

The following section of this paper utilises key points drawn from the following key strategic and foundational documents that support Pae Ora in order to gauge at a surface level[13] areas for continuous improvement:

- Te Tiriti o Waitangi Principles
- He Korowai Oranga
- Draft New Zealand Health Research Strategy
- Equity of Health Care for Māori framework
- He Pou Oranga Tangata Whenua

Table 2 | BOPDHB RESEARCH REVIEW – A MĀORI HEALTH GAINS AND DEVELOPMENT PERSPECTIVE

TOI ORA LENS	*CURRENT STATE ANALYSIS*

13 Note that a more comprehensive review is anticipated as part of a wider body of work to reset Toi Ora as a whole of BOPDHB system approach to Māori Health.

HE KOROWAI ORANGA

Partnership How does BOPDHB work with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain?	Tangata whenua as the Treaty partner do not participate in research decision-making or the determination of priorities within BOPDHB. Te Toi Ahorangi, the new Māori Health Strategy aims to weave both iwi and Crown aspirations in order to best realise Toi Ora within Te Moana a Toi.
Participation How does BOPDHB involve Māori in research?	Maori Health provides feedback on research proposals as per the description provided earlier in this paper.
Protection How does BOPDHB ensure that Māori have at least the same level of health as non-Māori?	Initial findings signal that with the current funding streams employed there is little investment in targeted health equity focused research for Māori.
How does BOPDHB safeguard Māori cultural concepts, values and practices?	Currently the programme and body of research does not have a foundation that values tāngata whenua wisdom and intelligence. There may be one-off ad hoc projects that value tāngata whenua wisdom and intelligence.

TOI ORA LENS	*CURRENT STATE ANALYSIS*
Pae Ora Vision How does BOPDHB invest in excellent health research that addresses Māori health needs and ensures healthy Māori futures?	The research programme in the current format doesn't have a particular focus in terms of the goals of He Korowai Oranga and Pae Ora.
Building Māori health research capacity How does BOPDHB build Māori health research capacity across the sector and within communities to further develop the knowledge base that will contribute to Pae Ora?	Building Māori health research capacity within BOPDHB is an opportunity to be explored. The GM Māori Health Gains and Development and Nurse Leader have research experience. At present the Research Office administer all research projects, with support from Māori health.
Research Collaboration How does BOPDHB support collaboration across sectors to coordinate high-quality research and information on the determinants of health to drive continuous quality improvement in the development, design and delivery of services for Māori?	There is much research that originates from outside of the BOPDHB region. This research is primarily clinically initiated it and predominantly does not include Māori as participants or as researchers. There is much potential in BOPDHB across sectors to undertake Tangata Whenua research that will demonstrate significant health gains and benefits for Māori and the vision of Pae Ora.

DRAFT NZ HEALTH RESEARCH STRATEGY

Evidence Base How does BOPDHB support high-quality health information to inform the delivery of effective health and disability services that meet the needs of the Māori population across the continuum?	There has not been a focus on robust Māori determined and driven research to date.

TOI ORA LENS	*CURRENT STATE ANALYSIS*
Prioritisation How does BOPDHB inclusively set research priorities with Tangata Whenua?	We do not yet have a Research position, strategic commitment or agenda that prioritises Tangata Whenua needs and aspirations as Tiriti partners.
Workforce How does BOPDHB develop and sustain a strong Māori health research workforce?	We do not yet have systematic processes or commitments within our DHB to build Māori research capacity and leadership.
Vibrant Research Environment How does BOPDHB create a vibrant Māori health research and innovation environment?	At present research is not well supported across the entire spectrum of innovation, from very basic to very applied and practical research – and across the full range of research disciplines as outlined in the HRC's definition of excellent research.
Research Translation How does BOPDHB build and strengthen pathways for translating Māori research findings into policy and practice?	There hasn't yet been an opportunity to translate Māori research into policy and practice. We can start to invest in this type of research so that we are able to build an evidence-base, and that we are able to effectively demonstrate the value of Tangata Whenua intelligence.
Commercialisation How does BOPDHB advance innovative Māori ideas and commercial opportunities?	Opportunities to grow Māori ideas and commercial opportunities are an untapped opportunity.

EQUITY OF HEALTH CARE FOR MĀORI

TOI ORA LENS	*CURRENT STATE ANALYSIS*
Leadership How does BOPDHB (the system, organisation and practitioners) champion the provision of high quality Tangata Whenua Pae Ora Research that delivers equitable health outcomes for Māori?	*This is not yet occuring.*
Knowledge How does BOPDHB (the system, organisation and practitioners) develop a knowledge base about ways to effectively deliver and monitor high quality health care for Māori?	We do not have robust Māori determined and driven research that is able to best meet the needs of our people across the continuum.
Commitment	

HE POU ORRANGA	How does BOPDHB (the system, organisation and practitioners) provide high quality Tangata Whenua Pae Ora Research that meets the health care needs and aspirations of Māori?	There isn't yet a research agenda.
	TOI ORA LENS	*CURRENT STATE ANALYSIS*
	Toi Ora Vision How does BOPDHB research contribute to the realisation of Toi Ora?	Most, if not all research is illness focused. Toi Ora is not signalled as a research priority as there is no set research agenda. He Pou Oranga is sometimes considered in the review of research however it does not guide decision-making.

CONCLUSION

Mā te kimi ka kite

Mā te kite ka mōhio

Mā te mōhio ka mārama

Seek and you shall see

See and you shall know

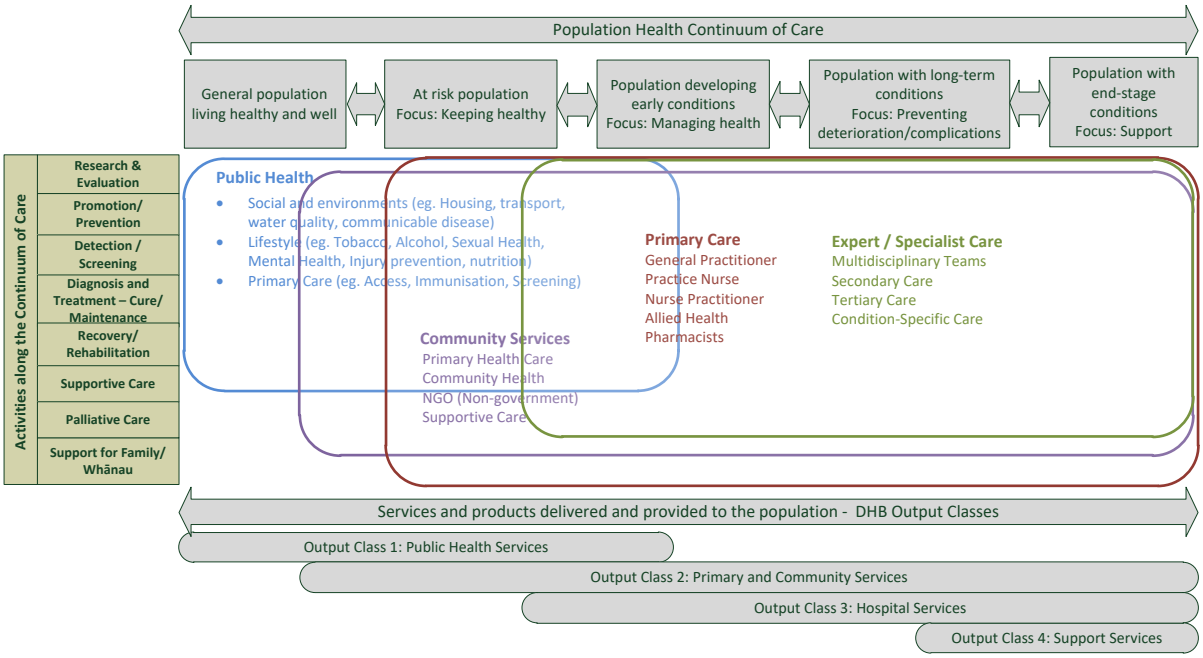
Know and you shall understand

The purpose of conducting research is toward the ultimate goal of enlightenment and Toi Ora. Our primary research endeavours are looking towards improving Māori health equity alongside the health of all people of te Moana a Toi. Maori Health Gain and Development and the Clinical Research Project staff are keen to work together on some next steps toward a Toi Ora Research Agenda.

The following list of developmental actions will be included as part of the renewal of Good 2 Great to Toiahorangi as a starting point for how we might begin to reorient research projects within the BOPDHB to better advance health equity for Māori and in a manner that upholds Te Tiriti o Waitangi partnerships with our eighteen iwi:

- Develop and appropriately resource a Toi Ora Research Agenda in partnership with iwi and Kaupapa Māori providers that activates research across the continuum of care (Figure 3);
- Determine high needs/high impact Māori focused research to be purchased as part of all Planning and Funding contracts;
- Establish arrangements for health sector organisations – both providers and funders, holding them accountable for delivering and reporting equitable health outcomes.
- Set the expectation that equity is an integral component of quality research.
- Set the expectation that health leaders have expertise in health equity as a core competency and therefore that all BOPDHB research has a Māori equity lens component as a minimum.
- Ensure collection systems have high-quality, complete and consistent ethnicity data

Figure 3 | Population Health Continuum of Care



This initial progress report demonstrates that while there is a formal research process in place for Māori consultation of BOPDHB research, we now have an opportunity to build a proactive approach to Te Tiriti o Waitangi and equity for Māori in our research approach and agenda.

In my view indigenous wisdom has the potential to address and transform the gritty challenges facing our health system and Aotearoa as a future-making country. I agree that tāngata whenua equity in health research needs to be supported at the macro level as part of a fundamental review of the way health research is developed and supported to promote DHB research activity. At the same time, BOPDHB has an opportunity to describe, create and deploy its own platform for Toi Ora research that is firmly led by Te Tiriti o Waitangi. As such Maori Health Gain and Development and the Research office in a position to explore what this could look like as a DHB with strong Māori health leadership, in partnership with our iwi partners and Kaupapa Māori providers.

The launching of Te Toi Ahorangi, the revised draft Māori Health Strategy will be presented to the Board in November prior to wider engagement. A vision for Toi Ora excellence and research will be a core strand within the strategy. My aim is to work alongside the Research office to provide a paper to the Board in its February 2019 meeting that fleshes out a staged approach to this development.

Toi ora e!

Tricia Keelan

GM Māori Health Gains and Development

Bay of Plenty District Health Board

The Māori Health Research Strategy

Development & Sign off

Writer

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Consultation Process / Circulation Round

Response date and version	The individuals/committee members listed below have been identified as the consultation group for this document	Response ✓
Version 1	Dame Rangimarie Naida Glavish	√
Version 1	Riki Nia Nia	√
Version 1	Fiona McCarthy	x
Version 1	Colin McArthur	√
Version 1	Lorraine Neave	√
Version 1	Mary-Anne Woodnorth	√
Version 1	Tereki Stewart	√
Version 1	Georgina Martin	√
Version 1	Raymond Hall	√
Version 1	Karen Bartholomew	x

The Māori Health Research Strategy

Glossary

kaupapa Māori	a philosophical doctrine, incorporating the knowledge, skills, attitudes and values of Māori society
mana whenua	local tribal authority
mātāwaka	usually urban based rōpu comprising of a collection of different iwi
Te Tiriti o Waitangi	the Māori version of the Treaty of Waitangi
tikanga	the customary system of values and practices that have developed over time and are deeply embedded in Māori social context

The Māori Health Research Strategy

Introduction

The Waitematā and Auckland DHBs aim to ensure that Māori in our region are living longer and enjoying a better quality of life by 2020 (Māori Health Plan – Waitematā and Auckland DHBs). Developing Māori health research excellence within the organisation will be a significant factor in achieving this aim. The lens through which Māori health is viewed will shape responses to Māori health challenges and the development of innovative approaches to health care that aim to enhance the health and wellbeing of Māori.

Tikanga Māori is a key driver of health service delivery and development within the Waitematā and Auckland DHBs. Ensuring that tikanga is at the forefront of our services for whānau means developing an overarching research programme that holds tikanga Māori at its core, and providing a steer for Māori research methodologies. Supporting Māori health gains through utilising Māori approaches to health service delivery and development will be reflected in a strong Kaupapa Māori research approach.

Background

The Waitematā and Auckland DHBs Māori research aspirations sit within a wider organisational commitment to research excellence. Defining research excellence from a Māori perspective means aligning Māori research planning and activities with Tikanga Māori, and supporting the implementation of the organisations Tikanga Plan. Tikanga is an integral part of service delivery at Waitematā and Auckland DHBs and is based on the principle that an understanding of Te Tiriti o Waitangi and Maori worldviews and practices are essential elements when addressing Maori health. Māori research activities will support the development of evidence that can inform service planning and delivery that is culturally responsive, implementing Māori worldviews as provided for by Te Tiriti o Waitangi. The approach to informing service planning and the implementation of Māori worldviews upholds the vision of the organisation's Tikanga Plan:

Tikanga Maori at the forefront of our services for whanau

At District Health Board level, Tikanga in governance is operationalised by the District Health Board as a partnership with Mana Whenua and mātāwaka. The Waitematā DHB has a Memorandum of Understanding (MoU) in place with Te Runanga o Ngāti Whātua and Te Whānau o Waipareira. Both parties are formally committed to improving Māori health gain and achieving demonstrable change.

Partnerships with Te Runanga o Ngāti Whātua and Te Whānau o Waipareira will strengthen the Māori research agenda within the organisation. Te Runanga o Ngāti Whātua and Te Whanau o Waipareira aspirations can help shape research activities and drive research development, including projects that focus on local Māori community development.

The Māori Health Research Strategy

Māori Research Strategic framework

The Waitematā and Auckland DHBs Māori Research Strategy has been developed to show the alignment between key strategic actions, existing DHB strategic planning activities and external research planning documents including:

- The Waitematā and Auckland DHBs Tikanga Plan
- Waitematā and Auckland DHBs Māori Health Plan
- The Auckland DHB Research Strategy
- The Waitematā DHB Research Strategy (2020)
- Ngā Pou Rangahau – The Strategic Plan for Māori Health Research (2010-2015)
- The New Zealand Health Research Strategy

1.1 Waitematā and Auckland DHB Tikanga Plan

The Waitematā and Auckland DHB Tikanga Plan (2013-2015) provides a measurable framework for the integration and implementation of tikanga best practice using Te Tiriti o Waitangi based framework. The Plan is guided by four domains that are the Articles of the Tiriti o Waitangi, including:

Article 1: Kawanatanga (governance)
Article 2: Tino Rangatiratanga (self-determination)
Article 3: Oritetanga (equity)
Article 4: Te Ritenga (right to beliefs and values)

The overall intent of the Tikanga Plan is the continual improvement of Māori health gains across the Waitematā and Auckland DHBs by enhancing tikanga leadership and as per the MoU integrating tikanga Ngāti Whātua and tikanga Waipareira across the District Health Boards.

1.2 Waitematā DHB Research Strategy (2020)

The Waitematā DHB Research Strategy reflects the DHBs commitment to Maori through committing to grow the Maori research workforce capacity to participate in all aspects of health research, contributing to the development of questions, methodology, methods of data collection and analysis, interpretation, dissemination and translation of the outcomes.

The principles that guide Māori Research development within the strategy include:

- Health partnership with Mana Whenua - partnership approach to working together at both governance and operational levels
- Health equity – ensuring the appropriate resources are applied to accelerate Māori health gain
- Self-determination - supporting meaningful Māori involvement in health care decision-making, increased capacity for self-management, higher levels of autonomy and reduced dependence
- Indigeneity - ensuring health development and decision making is based on the aspirations of Māori

- Ngā kaupapa tuku iho – including Māori beliefs, values, protocols and knowledge to guide health service planning, quality programming and service delivery
- Whole-of-DHB responsibility – accelerating Māori health gain and reducing ethnic inequalities between Māori and non-Māori is a key consideration of all activities across the health system
- Evidence-based approaches – utilising scientific and other evidence to inform policy, planning, service delivery and practice to accelerate Māori health gain and reduce inequalities

1.3 Auckland DHB Research Strategy

Auckland DHB research activities are geared towards ensuring faster translation of research to bedside care. The number of registered research projects increased from approximately 170 in 2006 to 340 in 2015. Most of the research activity within the Auckland DHB focuses on sponsored clinical research trials. Maori health research ethical reviews are a core part of the Auckland DHB research process, providing a platform to ensure that research meets expectations of cultural safety but also providing an opportunity to influence how researchers think about the potential for their work to benefit Maori including in developing future projects.

The Auckland DHB research strategy will increase key activities that have direct implications for the development and implementation of Māori health research activities. It is intended that there will be more research applications developed to maximise opportunities presented by major funding agencies that have signalled an increase in health research funding. Currently, the organisation recognises that the scope of research could be enhanced, specifically in areas that relate to health outcomes, innovation, and non-clinical research. The Auckland DHBs Māori research strategy has a significant focus on health outcomes research that identifies and develops innovative approaches to achieving Māori health gains.

1.4 National Māori Research Strategic objectives – Pou Rangahau (HRC).

Ngā Pou Rangahau - The Strategic Plan for Māori Health Research (HRC, 2010-2015) provides important guidance to the organisation in terms of maximising the commitment to improve Māori health. The plans general focus on achieving the nation's full social, economic and cultural potential. Investing in research and enhancing the capacity and capability of the health research workforce are goals that the Waitematā and Auckland DHBs shares with the Health Research Council. The strategic pathways and actions within the Waitematā and Auckland DHBs Māori research strategy are based on Ngā Pou Rangahau and mirror the strategic intent of HRCs Māori Health Research plan.

1.5 The New Zealand Health Research Strategy

The national health research strategy has four strategic priorities that include:

1. Research that addresses the health needs of New Zealanders;
2. Creating a vibrant research environment in the health sector,
3. Building and strengthening pathways for translating research findings into policy and practice,
4. Advancing innovative ideas and commercial opportunities.

The Māori Health Research Strategy

Each of these priorities has potential for advancing Māori research goals. However, the plan includes specific directives aimed at ensuring that health research contributes to Māori health gains. The strategy signals a commitment to investing in research for healthy futures for Māori and includes a health disparities lens that links variations in health outcomes with health research and policy that reflects the principles of He Korowai Oranga and Vision Mātauranga.

Developing strong partnerships with Māori is included as one of the four key components that support achieving the vision for health research at a national level. Wider Māori health research goals included in the strategy are captured within a Tiriti o Waitangi frame:

Partnership – the Crown working with iwi, hapū, whānau and Māori communities to improve Māori health and well-being through research,
Participation – actively engaging with Māori health stakeholders (whānau, hapū, iwi and community) and supporting Māori-led research initiatives,
Protection – ensuring research contributes to equity for Māori health and wellbeing.

The Māori Health Research Strategy

Waitematā and Auckland DHB Māori Research Strategy - Strategic Pathways

The strategic pathways that are included in the Waitematā and Auckland DHB Māori Research Strategy follow the goals that have been set by the Health Research Council Māori Health Committee. The application of these goals within the Waitematā and Auckland DHBs is based on the organisation's Tikanga Plan Strategic Framework.

- Māori Research Excellence
- Kaupapa Māori Methodologies
- Translating research into Māori Health Gains
- Promoting Māori ethical processes and good practice
- Extending the Māori health research workforce, and

1.6 Māori Research Excellence

The development of a Māori Research Centre of Excellence within the Waitematā and Auckland DHBs will align with national Māori research objectives that focus on increasing the scope, quantity and quality of Māori health research. Ensuring that research translates into real changes in clinical practice, community enhancement, and Māori Health Gains means building a strong evidence base that includes the development of solutions for improving health outcomes.

While there will be an expectation that the wider organisation invests in Māori research to support service planning and implementation, a key strategic action for enhancing the capacity of the Māori Research Centre of Excellence will be to secure external funding. Funding application models will favour collaborative research including co-funding of research where possible.

The emerging strategic aims include:

- Securing funding to support quality Māori led health research and research collaboration,
- Increasing the number of Māori led research within the organisation,
- Enhancing research partnerships and increase research capacity by developing collaborative research projects,
- Building an evidence base which contributes to improved Māori health outcomes through enhancing organisational data collection to support research activities and service development.

The Māori Health Research Strategy

1.7 Kaupapa Māori Methodologies

The Waitematā and Auckland DHB are in a unique position to ensure that Māori knowledge is translated into policy and practice through the Chief Advisor Tikanga role which enhances the organisations understanding and implementation of principles and practices of tikanga. The aim of building a strong evidence base to enhance Māori health gain requires that the research produces information framed by Māori worldviews and based on Māori research methodologies. Data collection and assessment frameworks must make visible Māori realities including those that offer solutions to enhance health outcomes (strengths vs deficit approach).

Kaupapa Māori research methodologies strategic aims include:

- Promoting the use of Kaupapa Māori methodologies, including an understanding of the intangible aspects of health and wellbeing.
- Using adaptable application and assessment frameworks which are responsive to the varying needs of Māori communities
- Participating in and supporting the development of internationally recognised standards for indigenous health research.

1.8 Translational Research

To support Māori Health aspirations, research must continue to develop from simply producing information and data to ensuring that research is designed to directly impact on health outcomes. Within the Waitematā and Auckland DHBs, translational research will rely upon collaborative research partnerships that engage the right mix of expertise to maximise a focus on Māori health gain. An investment in Māori research will be important to ensure that there are a growing number of research activities that directly engage with priority Māori health areas. Targeted research developed and led by Māori, can position Māori at the centre of research and in doing so target health equity effectively by developing evidence-based solutions.

The translational research strategic aims include:

- Increasing the number of research projects that include a focus on Māori health outcomes and Māori health as a central focus.
- Increasing opportunities to collaborate with Iwi to develop Māori and Iwi led research
- Effectively communicating research findings to a range of audiences through ensuring researchers have appropriate dissemination strategies.
- To effectively disseminate research outcomes to communities and partners and throughout the organisation.
- Linking projects that focus on Maori health and aim to improve Maori health outcomes to service delivery, policy and practice.

The Māori Health Research Strategy

1.9 Māori Research Ethics

The Waitematā and Auckland DHBs support the implementation of national Māori research ethics frameworks that provide guidance for researchers both within the organisation and to those in the private sector who engage with internal Māori research ethics processes. The continued utilisation of national Māori research ethics frameworks upholds Tikanga Māori as the basis of best practice ethical standards for Māori research.

The Māori research ethics strategic aims are:

- Ensuring the continued provision of Māori research ethics review to all organisational research.
- Ensuring that research values tikanga and that research protocols uphold the rights of Māori participants in line with tikanga Māori.
- Ensuring that ethics committees or research bodies external to the organisation understand and commit to internal Māori research ethics processes.
- Ensuring that research is responsive to Māori needs and includes consideration of consultation, consent, Māori researcher and community involvement and effective dissemination.
- Continuing to support the implementation of Te Ara Tika within the organisation and increase education activities to enhance understanding and application of these guidelines.
- Participating in National Māori research hui and engage in discussions aimed at enhancing ethical issue relevant to Māori.

1.10 Māori Health Research Workforce

The organisation has demonstrated a strong commitment to increasing the Māori workforce across the organisation, including increasing the total number of Māori researchers and Māori staff participation in research. While the organisation has signalled the aim to achieve a 10% increase in the number of Māori researchers within the organisation, this is seen as a baseline number that may increase as goals related to increasing Māori focused research are achieved. The aim of increasing Māori leadership in research aligns with the organisation's goals of investing in research leaders to foster research ideas and mentor new researchers. Iwi, hapū, whānau, and Māori communities must also be included in the context of increasing Māori research leadership, capacity, and capability. Wider Māori Health Workforce development goals also provide a steer for strategic actions that focus on building capacity and capability. A key aim is to target health career-related education and training which can include health research.

The Māori Health Research Workforce strategic aims are:

- Investing in the Māori health research workforce and build Māori health research capacity and capability
- Building a high quality skilled Māori health research workforce
- Promoting Māori health research as a career and support a Māori health research career pathway
- Increasing Māori led research and Māori involvement in research
- Encouraging iwi, hapū, whānau, and Māori communities to identify their own research priorities and undertake research in their own communities

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

EMERGENCY DEPARTMENT UTILISATION IN BOPDHB

SUBMITTED TO:

Board of Directors 19 February 2020

Prepared by Dr George Gray, Public Health Physician

Endorsed by: Marama Tauranga, Acting Manukura, Maori Health Gains & Development

Submitted by: Simon Everitt, Acting Chief Executive Officer, BOPDHB

RECOMMENDED RESOLUTION:
That the Board note the attendance, triage, and admission patterns described in this paper.

ATTACHMENTS:
Nil

BACKGROUND:
The Board requested detail on ED utilisation in BOPDHB, particularly among the Maori population.

ANALYSIS:

Executive Summary

1. Overall, BOPDHB has a higher rate of ED attendance than that seen nationally. This finding is consistent across different ethnic groups; both Maori, and New Zealand European and Other (NZEO groups) domiciled in BOPDHB attend ED at higher rates than their counterparts nationally. Explaining the drivers of this difference was beyond the scope of this study.
2. In 2014/15 BOPDHB had a lower proportion of triage 1-3 attendees and a higher proportion of triage 4 cases than that seen nationally. 2018/19 data for BOPDHB align with the distribution of the 2014/15 data.
3. Maori are more likely to present with issues categorised into less urgent triage categories.
4. Whakatane Hospital experiences a higher proportion of less urgent ED cases than that seen at Tauranga Hospital. This pattern is seen for all ethnic groups.
5. BOPDHB has steadily increased the proportion of ED attendees admitted to hospital. Where national data were available, the proportion admitted was decreasing.

6. Tauranga Hospital's admission proportion has increased faster than Whakatane and is driving the growth in admission proportion at BOPDHB.
7. There was a difference in the proportion of Maori ED attendees admitted to hospital in BOPDHB, but this difference reduced significantly or disappeared when stratified by triage status.
8. The differences in ED attendance rate, triage category, and admission likelihood for the Maori population are strongly associated with the deprivation profile of this group.
9. These findings may be used to identify future areas of focus related to attendance, triage, or admission, for the various ethnic, quintile, and site differences highlighted in this report. It was premature to make service delivery change recommendations within this report without greater analysis of the multiple factors influencing differences in the patient journey identified here. For example, the higher proportion of less urgent presentations at Whakatane Hospital could be entirely appropriate given the deprivation profile of the population and primary care health service capacity currently available.

Contents

Acknowledgements:

Trevor Richardson
Michelle Merrick
Hayden Eagle

Introduction

10. This Board paper seeks to summarise several key metrics related to Emergency Department (ED) utilisation.
11. These metrics have been selected based on their comparability to data published by the Ministry of Health (MoH) to help contextualise BOPDHB's performance against other DHBs, over time, and against other OECD nations.
12. The paper does not discuss the 'Shorter Stays in Emergency Departments' Health Target; this has been reported extensively elsewhere.
13. In July 2019 the Board requested information on ED utilisation; at the subsequent August 2019 meeting, the request was expanded to include information on the Maori population.
14. Further elaboration was requested by Board members regarding ED utilisation data reported to the September meeting. In November, local data were extracted to help answer these and other Board questions. These data cover 2.5 years of ED attendance, and include almost 200,000 ED attendances.
15. There were no specific questions recorded in Board minutes in relation to ED utilisation. Consequently, this paper has taken a descriptive statistics approach, highlighting key BOPDHB performance metrics and stratifying these by site, ethnicity, and presentation urgency where possible. This paper is not prescriptive or predictive; these actions would require more focused analysis.
16. Because of the multidimensionality of the ED journey it is not possible to be encyclopaedic about the ED service in a Board report. Therefore this paper has focused on summary metrics published in 2016 by the MoH, augmenting these with recent data. This approach enables time series comparison with other DHBs and national results. The aims of this analysis were to investigate:
    a. What is the ED attendance rate at BOPDHB?
    b. What patterns in presentation urgency (triage status) are evident at BOPDHB?
    c. What outcome patterns are evident at BOPDHB?
    d. Where data are available, how do the results of these queries compare with international findings, across the two local public hospitals operated directly by BOPDHB, and by ethnicity?
17. The results of these queries might be used to:

. Identify notable deviations from the performance results seen nationally that relate to site, ethnicity, or patient journey differences;
    a. Highlight summary metrics that require deeper analysis;
    b. Guide comparison of the Population Based Funding Formula's theoretical assumptions with the actual service utilisation exhibited by BOPDHB's population.

Methods

18. In collaboration with Provider Arm team members, ED attendance data were extracted for a 2-year period that included the 2017/18 and 2018/19 financial years.
19. Age-standardised rates (ASR) of ED attendance were calculated using the World Health Organization year 2000 standard population.
20. The chi-square test of independence was used to test for statistically significant differences between results where relevant (alpha = 5%).
21. Comparison data for other DHBs and hospitals in New Zealand for the period 2010/11 to 2014/15 were obtained from an Excel file published by the MoH, along with the associated report that interpreted these data.

22. The analytical methods used here replicate those applied by the MoH in its 2016 report.
23. Neighbourhood deprivation quintile values were derived from the University of Otago's NZDep2013 Index (2018 Census values had not been published at the time that analyses were undertaken).
24. Data reported here are for public hospitals in BOPDHB, and do not include private hospitals in the area. National data include a small number of private hospitals in the lower South Island (the impact of this is immaterial on overall trends).

Results

Attendance

What are the Trends in ED Attendance in BOPDHB over Time?

25. The total population usually domiciled in BOPDHB has consistently attended ED at a higher rate than the total population for the entire country. For example, in 2014/15 BOPDHB-domiciled residents were 1.3 times as likely to attend ED as the total population nationally. In addition, the rate of ED attendance in BOPDHB has increased at a faster pace than that seen nationally.
26. These differences may be due to a range of factors that are beyond the scope of this report including primary care to population ratios, population demographics, and other causes.

Table 1 ASR (per 100 population per year) of ED Attendance at BOPDHB Public Hospitals and rate ratios for the periods 2010/11-2014/15 and 2017/18-2018/19. *Data for the years 2010/11 to 2014/15 were published by the Ministry of Health. Data for 2017/18 and 2018/19 are based on local (BOPDHB) data collection and slightly underestimate the true rate of attendance at ED for those usually domiciled in BOPDHB.

Group	2010/11	2011/12	2012/13	2013/14	2014/15	2017/18*	2018/19*
BOPDHB Total Population	16.8	16.8	17.3	17.8	19.1	18.6	18.4
NZ Total Population	14.4	14.6	14.6	14.8	14.9	-	-
Rate Ratio (BOPDHB:New Zealand)	1.2	1.2	1.2	1.2	1.3	-	-

Rates are standardised to the 2000 WHO World Standard Population.

Does ED Attendance in BOPDHB Vary with Ethnicity?

27. In 2018/19, the BOPDHB-domiciled Maori population was 1.4 times as likely as the local New Zealand European and Other (NZEO) population to attend an ED within the DHB's two public hospitals. In 2018/19 24.1 per 100 Maori individuals domiciled in BOPDHB attended the ED compared with 16.9 per 100 for the New Zealand European population. The rate ratio between the two groups was steady throughout the analysis period.
    The rate of ED attendance for both ethnic groups presented in Table 2 increased over the nine years listed.

Table 2 Age-standardised rate of ED attendance (per 100 population per year) between 2010/11 and 2018/19 for individuals domiciled in BOPDHB. *Data for the years 2010/11 to 2014/15 were published by the Ministry of Health. Data for 2017/18 and 2018/19 are based on local (BOPDHB) data collection and slightly underestimate the true rate of attendance at ED for those usually domiciled in BOPDHB.

Group	2010/11	2011/12	2012/13	2013/14	2014/15	2017/18*	2018/19*
BOPDHB Maori	20.8	20.6	21.6	22.0	23.0	23.4	24.1
BOPDHB NZE	14.9	15.2	15.6	16.4	17.8	17.4	16.9
BOPDHB Total Population	16.8	16.8	17.3	17.8	19.1	18.6	18.4
Rate Ratio (BOPDHB M:NZE)	1.4	1.4	1.4	1.3	1.3	1.3	1.4

Rates are standardised to the 2000 WHO World Standard Population.
Rate ratios compare Maori with the New Zealand European or Other group usually domiciled in BOPDHB.

How Does ED Attendance in BOPDHB for Selected Ethnic Groups Compare with National Results?

28. The rate of ED attendance for the BOPDHB-domiciled Maori population and NZEO is higher than for the same groups at a national level. In 2014/15 for example, 18 per 100 Maori individuals attended an ED in New Zealand (see Table 3) compared with 23 per 100 among BOPDHB-domiciled Maori (see Table 2).
29. In addition, the Maori:NZEO rate ratio is higher in BOPDHB (1.4) than the rate ratio between these two groups at a national level (1.2).

Table 3 Age-standardised rate of ED attendance (per 100 population per year) between 2010/11 and 2014/15 for individuals in all DHBs in New Zealand published by the Ministry of Health. Data for Asian and Pacific New Zealanders can be found in the original report from the Ministry of Health but are not shown here in order to simplify comparison with the data in the previous table.

Group	2010/11	2011/12	2012/13	2013/14	2014/15
NZ Maori	17.2	17.4	17.7	17.7	18.0
NZ European or Other	13.8	14.1	14.1	14.4	14.5
NZ Total Population	14.4	14.6	14.6	14.8	14.9
Rate Ratio (New Zealand M:NZE)	1.2	1.2	1.3	1.2	1.2

Rates are standardised to the 2000 WHO World Standard Population.
Rate ratios compare Maori with the New Zealand European or Other group.

30. In summary, there are several differences in ED attendance of note:
    a. The Total Population in BOPDHB attends ED at a higher rate than that seen nationally. In 2014/15 BOPDHB's Total Population attended ED at 1.3 times the rate of New Zealand's Total Population (see Table 4).
    b. BOPDHB's usually resident Maori population attends ED at a higher rate than the DHB's NZEO population.
    c. Maori usually resident in BOPDHB attend ED at a higher rate than Maori nationally.
    d. The resident NZEO population in BOPDHB attend ED at a higher rate than the same population at a national level.

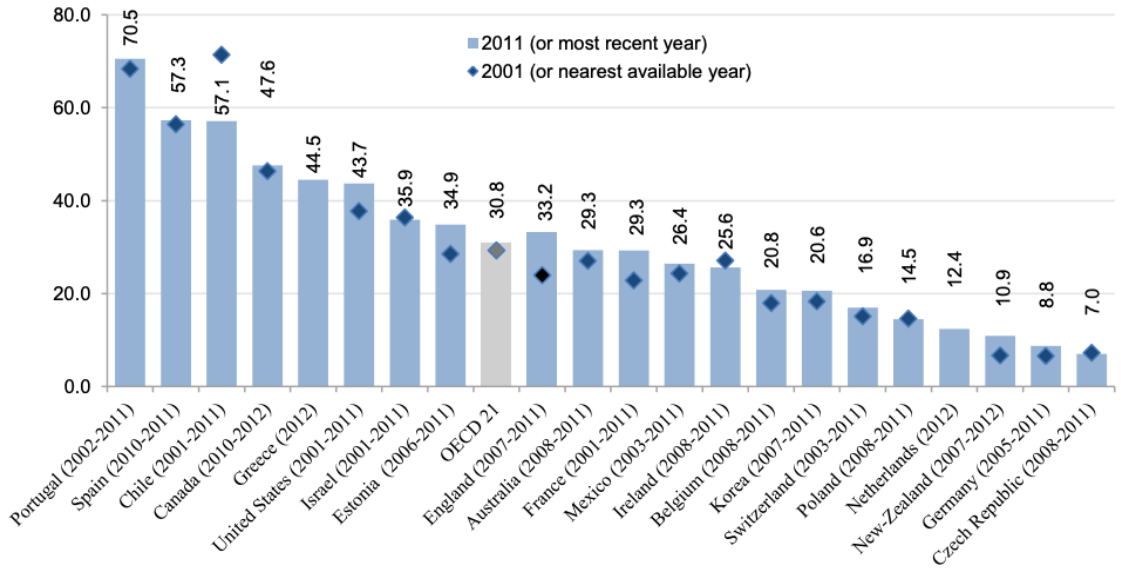
Table 4 Rate ratios comparing the rate of attendance between selected groups usually domiciled in BOPDHB with the equivalent group for all of New Zealand between 2010/11 and 2014/15. NZEO refers to the New Zealand European or Other groups (and does not include Asian and Pacific ethnicities). TP summarises data for the total population. The data are based on ASRs from the preceding tables.

Group	2010/11	2011/12	2012/13	2013/14	2014/15
BOP Maori : NZ Maori	1.2	1.2	1.2	1.2	1.3
BOP NZEO : NZ NZEO	1.1	1.1	1.1	1.1	1.2
BOP TP : NZ TP	1.2	1.2	1.2	1.2	1.3

How Does BOPDHB Compare with Other OECD Nations?

31. Though the rate of ED attendance in BOPDHB is higher than that seen nationally, New Zealand (and BOPDHB) performs well among OECD nations.
32. A comparison of ED attendance among OECD nations indicated an average of 31 visits per 100 people per year (data were not age-standardised) across the OECD members studied. The report noted New Zealand's result over the period 2007-2012 was 10.9 per 100 people.

Figure 1. Number of visits to emergency department per 100 population, 2001 (or nearest available year) and 2011 (or most recent year)



Note: Due to different definition and identification of emergency care services caution is needed when comparing OECD countries. Some countries include both ambulatory and inpatient ED visits (*e.g. Australia*), while other countries (*e.g. Switzerland or Germany*) only include inpatients ED visits (ED visits which lead to hospital admissions with a minimum of one stay and/or ED visits from patients already hospitalised).

Sources and definitions: See Table A1 and A2 in Annex.

33. New Zealand's result was based on data from the 2013 New Zealand Health Survey and is less accurate than the 14.4-14.9 per 100 population (age-standardised) reported in the Ministry of Health's 2016 report. Nevertheless, even with the higher figures drawn from the Ministry's data, New Zealand has a lower rate of ED attendance than the OECD average. There are many reasons for these inter-country differences and readers should refer to the OECD report for a discussion of these factors.
34. New Zealand Health Survey data reported for 2018/19 by the Ministry of Health are more closely aligned with the age-standardised rates reported in 2016. In 2018/19, 15% of the total population aged 15 years and over had "visited an emergency department at least once in the past 12 months"; with results of 21.3% for Maori and 15% for the New Zealand European or Other group.

Urgency at Presentation

Does Presentation Urgency in BOPDHB Differ from that Seen Nationally?

35. To provide context to the most recent triage data for 2018/19, figures published by the Ministry of Health for the period 2010/11 to 2014/15 are presented below. During this time, BOPDHB's triage mix differed from that seen nationally.
36. Overall the proportion of ED attendees in triage categories 1-3 in 2014/15 was slightly lower at BOPDHB (44.6%) than that seen nationally (53.7%).
37. Between 2010/11 and 2014/15 the proportion of ED attendances categorised into triage categories 1-3 at a national level increased. During the same period, BOPDHB's proportion of triage 1-3 attendees decreased slightly.
38. Triage categorisations for ED attendances at BOPDHB in the past two most recent financial years are consistent with preceding years and do not deviate significantly (see Table 5).

Table 5 Percentage of ED attendees categorised into various triage groups during the period 2010/11 to 2018/19 for the Total Population in New Zealand and in BOPDHB's two public hospitals.

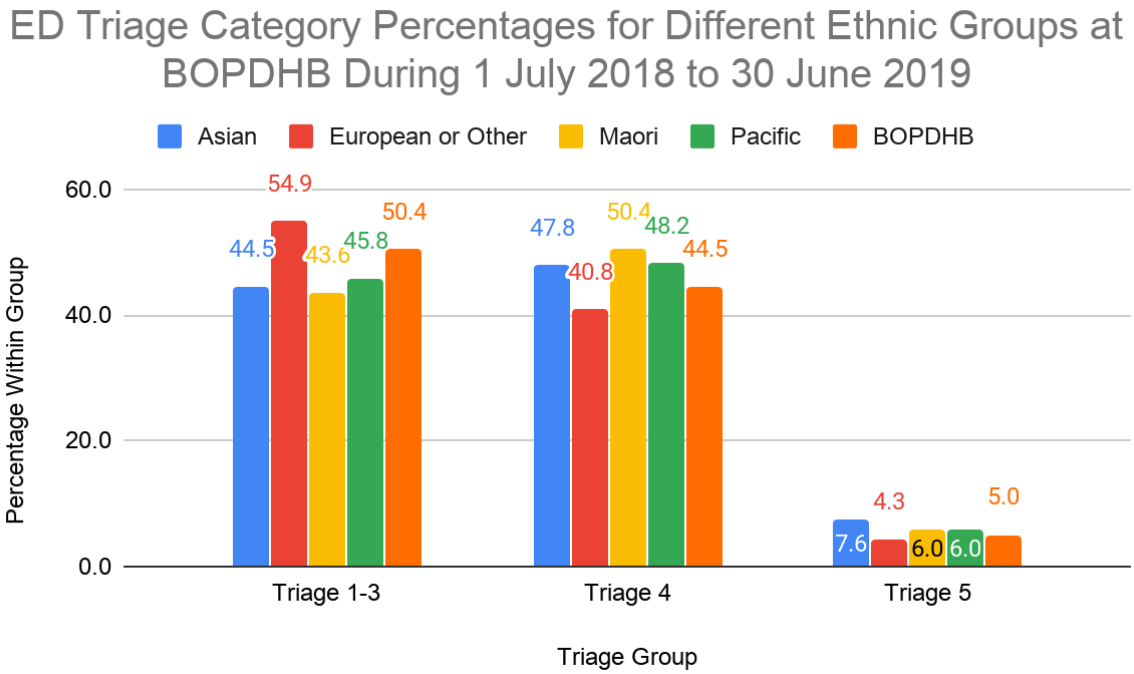
Site	Group	2010/11	2011/12	2012/13	2013/14	2014/15	2018/19
National	Triage 1-3	50.5	51.9	52.1	52.8	53.7	-
	Triage 4	39.7	39.3	39.7	39.7	39.6	-
	Triage 5	9.9	8.9	8.1	7.5	6.7	-
BOPDHB	Triage 1-3	51.7	53.2	50.8	49.2	49.6	50.4
	Triage 4	41.6	41.3	43.8	44.8	44.9	44.5
	Triage 5	6.8	5.5	5.5	6.0	5.6	5.0

Does Presentation Urgency in BOPDHB Vary with Ethnicity?

39. Presentation urgency data for the 2018/19 financial year for BOPDHB are presented below. Overall, ED attendances by Maori are less likely to be grouped within triage categories 1-3 than the proportion seen for the New Zealand European or Other group.

40. For example, 43.6% of presentations by Maori attendees were categorised into triage category 1-3 in 2018/19, compared with 54.9% of presentations by NZEO attendees. This difference may be due to a range of factors such as socioeconomic status and the associated difficulty attending primary care services.

Figure 2 Percentage of BOPDHB ED attendees from selected ethnicities categorised into various triage groups during the financial year 2018/19.



Does Presentation Urgency in BOPDHB Differ by Hospital Site?

Tauranga Hospital

41. When compared with the entire DHB, the pattern of ED attendance at Tauranga Hospital is skewed toward higher proportions within triage groups 1-3, and a smaller proportion in triage category 4.

Table 5 Proportion of ED attendees within various triage categories for BOPDHB and Tauranga Hospital for the periods 2010/11-2014/15 and 2018/19.

Site	Group	2010/11	2011/12	2012/13	2013/14	2014/15	2018/19
BOPDHB	Triage 1-3	51.7	53.2	50.8	49.2	49.6	50.4
	Triage 4	41.6	41.3	43.8	44.8	44.9	44.5
	Triage 5	6.8	5.5	5.5	6.0	5.6	5.0
Tauranga Hospital	Triage 1-3	58.3	59.9	56.6	55.2	54.3	58.0
	Triage 4	36.0	35.7	38.8	39.8	40.9	37.4
	Triage 5	5.7	4.4	4.6	4.9	4.8	4.6

Whakatane Hospital

42. In contrast, the triage profile at Whakatane Hospital is skewed toward higher proportions in triage categories 4 and 5. This pattern was already evident prior to the implementation of a hospital-based general practice service in the 2014/15 financial year aimed at seeing less urgent ED presentations. Whakatane has consistently experienced a higher proportion of less urgent ED presentations than Tauranga Hospital. This may be due to many factors such as differences in the demographic profiles of the populations in the East and Western Bay of Plenty, along with differences in health service accessibility.
43. Given the very different deprivation quintile mix of the Eastern Bay of Plenty to that seen in the Western Bay it is not advisable to use Tauranga Hospital as a benchmark of triage categorisation for Whakatane Hospital.

Table 6 Proportion of ED attendees within various triage categories for BOPDHB and Whakatane Hospital for the periods 2010/11-2014/15 and 2018/19.

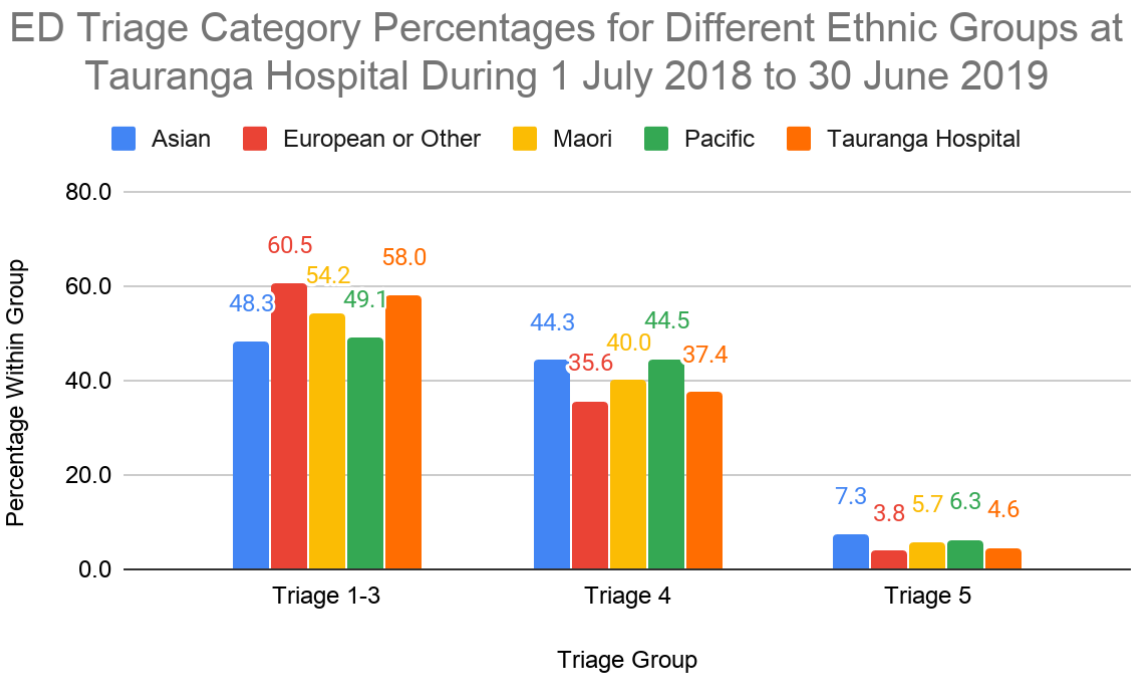
Site	Group	2010/11	2011/12	2012/13	2013/14	2014/15	2018/19
BOPDHB	Triage 1-3	51.7	53.2	50.8	49.2	49.6	50.4
	Triage 4	41.6	41.3	43.8	44.8	44.9	44.5
	Triage 5	6.8	5.5	5.5	6.0	5.6	5.0
Whakatane Hospital	Triage 1-3	41.3	42.4	41.8	39.5	41.4	33.7
	Triage 4	50.5	50.9	51.8	53.5	53.7	60.2
	Triage 5	8.2	6.8	6.4	7.0	4.9	6.1

Do Site Differences Vary with Ethnicity?

Tauranga Hospital

44. When compared with the New Zealand European and Other group at Tauranga Hospital, Maori are more likely to present with triage 4 or 5 issues, and less likely to be grouped into triage categories 1-3.

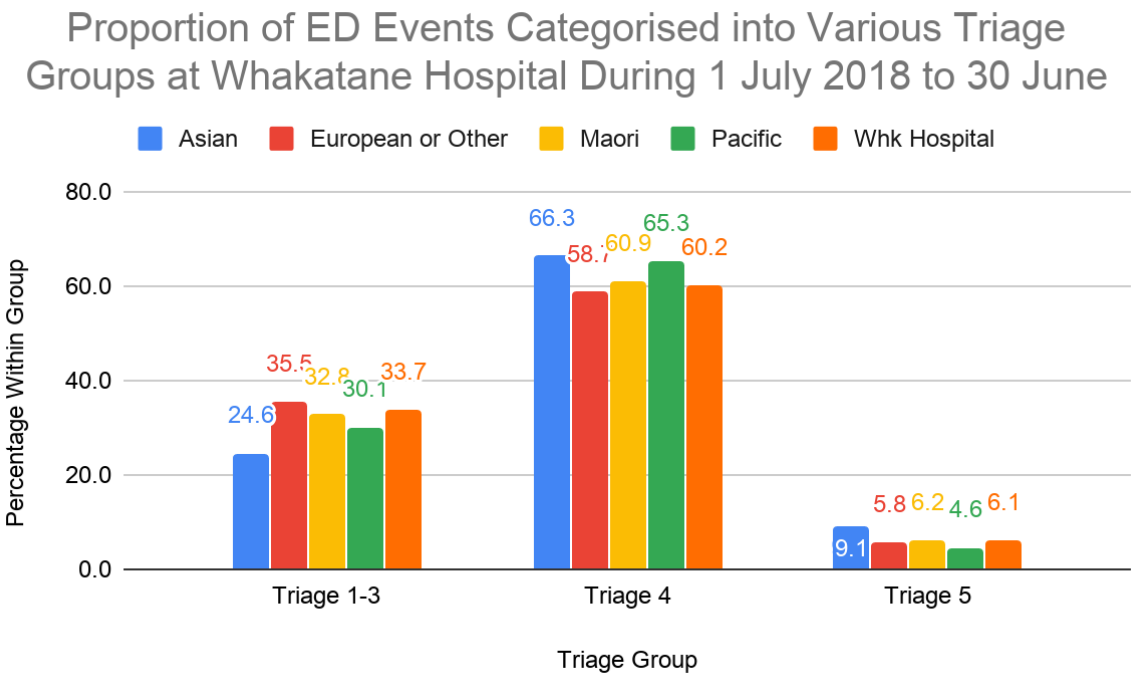
Figure 3 Percentage of Tauranga Hospital ED events from selected ethnicities categorised into various triage groups for the 2018/19 financial year.



Whakatane Hospital

45. At Whakatane Hospital in 2018/19, higher proportions among all ethnicities presented with triage 4-5 issues and fewer with triage 1-3 needs when compared with Tauranga Hospital.
46. The relative and absolute difference between Maori and the NZEO group presenting at Whakatane Hospital with triage 1-3 categorisation is less than the difference between these two groups at Tauranga Hospital.
47. However, the smaller difference between these two ethnic groups at Whakatane Hospital is statistically significant. In short, Maori are less likely to present with triage 1-3 needs than the New Zealand European and Other group at Whakatane Hospital.
48. This pattern lies within the context of all ethnicities presenting more frequently for triage 4-5 issues at Whakatane compared with Tauranga Hospital. This indicates a systemic difference in population demographics or health service accessibility in the Eastern Bay.

Figure 4 Percentage of Whakatane Hospital ED events from selected ethnicities categorised into various triage groups for the 2018/19 financial year.



Outcomes

How has Admission Changed over Time?

49. The proportion of ED attendees admitted to hospital decreased slightly during 2010/11 to 2014/15 in New Zealand. At the same time, the proportion of ED attendees admitted to hospital in BOPDHB increased from 30.0% of attendees in 2010/11 to 41.3% in 2018/19.

    Table 7 Proportion of ED attendees admitted to hospital in New Zealand (2010/11 - 2014/15) and in BOPDHB (including 2017/18 and 2018/19).

Admitted to hospital	2010/11	2011/12	2012/13	2013/14	2014/15	2017/18	2018/19
New Zealand	35.1	34.7	34.6	33.9	33.4	-	-
BOPDHB	30.9	33.4	32.6	34.2	37.6	40.9	41.3

Does Admission Vary by Site in BOPDHB?

50. The proportion admitted to hospital in BOPDHB has been increasing over time. This is driven largely by Tauranga Hospital.
51. A higher proportion was admitted to Tauranga hospital than Whakatane Hospital. This site difference is associated with the different triage profiles of the two hospitals.

52. The proportion admitted at Whakatane Hospital increased by 2.2 percentage points over the study period, while Tauranga Hospital increased by 12.5 percentage points.

Table 8 Proportion of ED attendees admitted to BOPDHB's two public hospitals for selected years spanning 2010/11 - 2018/19.

Admitted to hospital	2010/11	2011/12	2012/13	2013/14	2014/15	2017/18	2018/19
BOPDHB - both sites	30.9	33.4	32.6	34.2	37.6	40.9	41.3
Tauranga Hospital	34.3	38.1	38.2	40.1	43.8	46.4	46.8
Whakatane Hospital	27.0	26.5	24.2	24.8	25.8	28.5	29.2

Does Admission Vary by Ethnicity in BOPDHB?

53. Overall the proportion of Maori ED attendees admitted at BOPDHB in 2018/19 was lower than the NZEO population. This is associated with a higher proportion of Maori attending BOPDHB's hospitals with less urgent triage categorisation.
54. Site differences in admission for different ethnic groups are consistent with the overall differences in triage distribution observed at the two sites.

Table 9 Proportion of ED attendees among various ethnic groups admitted to BOPDHB's two public hospitals during 2018/19.

Hospital Site	Asian	European or Other	Maori	Pacific	Grand Total
Tauranga	33.1%	51.3%	39.0%	33.5%	46.8%
Whakatane	20.0%	31.9%	27.7%	20.2%	29.2%
BOPDHB	31.0%	47.0%	33.4%	31.2%	41.3%

How Does Admission Vary by Ethnicity and Triage Status?

55. When disaggregated by triage status the admission difference between ethnic groups highlighted in Table 9 reduces significantly or disappears.
56. For example, Maori and NZEO triage 1 ED attendees showed no statistically significant difference in the likelihood of admission in BOPDHB.

Table 10 Proportion of triage 1 ED attendees among various ethnic groups admitted to BOPDHB's two public hospitals during 2018/19.

Hospital Site	Asian	European or Other	Maori	Pacific	Grand Total
Tauranga	90.9%	96.6%	94.8%	100.0%	95.9%
Whakatane	100.0%	84.6%	98.0%		92.3%
BOPDHB	91.7%	94.4%	95.9%	100.0%	95.0%

Conclusion

57. Overall, BOPDHB has a higher rate of ED attendance than that seen nationally. This finding is consistent across different ethnic groups, that is, both Maori and NZEO domiciled in BOPDHB attend ED at higher rates than their counterparts nationally. Explaining the drivers of this difference was beyond the scope of this study.
58. In 2014/15 BOPDHB had a lower proportion of triage 1-3 attendees and a higher proportion of triage 4 cases than that seen nationally. 2018/19 data for BOPDHB align with the distribution of the 2014/15 data.
59. Whakatane Hospital experiences a higher proportion of less urgent ED attendees than that seen at Tauranga Hospital. This pattern is seen for all ethnic groups.
60. BOPDHB has steadily increased the proportion of ED attendees admitted to hospital. Where national data were available, the proportion admitted was decreasing.
61. Tauranga Hospital's admission proportion has increased faster than Whakatane and is driving the growth in admission proportion at BOPDHB.
62. There was a difference in the proportion of Maori ED attendees admitted to hospital in BOPDHB, but this difference reduced significantly or disappeared when stratified by triage status.
63. The differences in ED attendance rate, triage category, and admission likelihood for the Maori population are strongly associated with the deprivation quintile profile of this group.

These findings may be used to identify areas of focus for further analysis and the development of relevant interventions.

CEO's Report (Open) – February 2020

Key Matters for the Board's Attention *

STRATEGIC PRIORITIES *

The Executive Team are working on ensuring that there are better linkages to Strategic priorities, measures and outcomes in the Board reporting. This will take us a little time as we change reporting and formatting across the current suit of board reports and dashboards. However you should see positive change over the coming months as we reshape papers and agenda's to better reflect strategic priorities and work plans

Some key highlights on the four areas of focus are provided below:

1 TOI ORANGA MOKOPUA – CHILD WELLBEING *

<u>Child Development Services</u>

Assignment of the Te Whanau Kotahi contract is underway with the BOPDHB preparing to take on services in the Western Bay from 1 March 2020. A Business Lead will be appointed for a one-year period to facilitate the transition. Funding secured through an innovation fund will be used to scope current activity and recommend future services. A series of Appreciative Inquiry events will take place over the next six months to ensure true co-production of future services and provides the BOPDHB with a great opportunity to transform the delivery of child development services across the Bay.

2 TOI ORANGA AKE – INTEGRATED CARE *

<u>Keeping Me Well – An Integrated Community Enablement Approach</u>

The proof of concept test for Keeping Me Well commences Feb 17th 2020 with first 6 months testing located in two specific areas. First, a prevention of admission test in Te Puke with Nga Kakano foundation. A group of allied health clinicians has been selected to work with the General practice and health care assistants from home and community support services to form a locality team aimed at providing proactive enablement to those at risk of admission.

The group will be located at Nga Kakano with focus being on how we identify those at risk in conjunction with risk stratification data, and building of relationships/delivery of person directed interventions as a virtual team. The second aspect of the test will be focused on transitional journeys from ED/APU and medical with extension of the PARIS work being utilised to transition clients with enablement plans and access to enablement based support. This is being combined with specialist approaches such as community geriatric resource to ensure that there is a palette of services available to General practice.

Community Care Coordination

The CCC continues in its stage two expansion, (all DHB community requests through CCC by Aug 2020). Allied health requests are being integrated in preparation for Keeping Me Well, recruitment is underway of the expanded team roles with new coordination roles being formed that will support the new approached being developed in the system around health coordination and integrated patient journeys. Positive feedback is coming in about the reduction in workload for GPs and clinicians which has now been made simpler with one point of access. Data to come.

3 TOI ORANGA NGAKAU – MENTAL HEALTH *

Examples of Terms of Reference (TOR) for leadership/oversight groups established by several other DHBs have been provided to the sector for feedback and to inform thinking regarding the establishment of our own BOPDHB leadership group. A Survey Monkey has been provided to all staff in MH&A to provide opportunity for input regarding the model of group to be established and TOR for this group- 32 responses have been received to-date. A hui has been organised for 21st February for service managers and lived experience leaders from across BOP MH&A services in order to workshop and agree on the model for our BOPDHB MH&A leadership group as well as the TOR for this group, including the process of recruitment to these positions. It is hoped that this group will be fully recruited to meeting by end of April.

Hui have taken place with Lived Experience leaders across BOP, MH&A portfolio manager and Toi Oranga Ngakau Change Leader. Establishment of a lived experience network is supported as well as a commitment to informing the establishment of the MH&A leadership group. Establishment of Peer Leadership roles for WBOP and EBOP is prioritised for investment out of the 20/21 MH&A ring-fence in order to support the establishment of a lived experience network, develop a workforce development plan regarding Intentional Peer Support (https://www.intentionalpeersupport.nz/) and provide consultation for MH&A portfolio manager and Toi Oranga Ngakau Change Leader.

A full time project lead has been recruited- With a background in Mental Health and Addictions, he has extensive experience across health, education, social services and Iwi, in clinical and senior leadership in New Zealand, Australia and more recently USA. He is currently Te Kaihautu (General Manager) of Poutini Waiora – the Kaupapa Maori Health and Social Services provider on the West Coast; a West Coast PHO Board Member and United Nations Caucus member and Australasian Representative. Carl has developed a reputation for designing and delivering services that are whānau driven and has strong relationship building skills. He has a passion for ensuring Tangata Whaiora and their whānau receive services that are culturally and clinically appropriate.

4 TOI ORANGA TIKANGA – BUSINESS DESIGN *

Information Management – Integrated Sector Opportunities

Senior Executive and ICT management from the DHB and the largest primary health organisation met in January with the aim of exploring the opportunities of greater integration of ICT capabilities.

The focus of the session was to understand the appetite of the executive attendees for the organisations to "merge" the ICT capabilities to advance integrated information support across the sector for the benefit of patient care. Opportunities identified included increasing electronic document exchange, shared care system capabilities, common or federated patient scheduling systems, common patient portals and ICT staff sharing. It was agreed that the ICT leaders would work up more formal options to take to organisational Boards.

EQUITY

Te Teo Herenga Waka & Toi Te Ora

Pre School Oral Health Service

Our preschool oral health service enrolments continue to exceed the national target of 95%; 99.2% of Maori preschoolers were enrolled to the end of December 2019. For the second consecutive year, our annual report to the Ministry of Health will highlight that we've exceeded the national target

Breast Screening

For the quarter ending September 2019 BOPDHB attained its highest proportion of Maori women screened in the 50-69 years age group; 66.4% vs. the national target of 70%. We are waiting for official results from the National Screening Unit for the 24-months ending December 2019. These are due in mid-February but we expect our results to have plateaued.

Building Blocks for Under 5s

Excellent progress is being made on quality improvements to ensure our new online Building Blocks toolkit is culturally responsive. As part of this work a pūrākau (story) has been developed specifically for Building Blocks under the guidance of Ngamoni Huata (Aunty Monch), a Te Arawa raranga (weaving) expert. The tikanga associated with the meaning, values and practices behind Pā Harakeke (flax) shared by Aunty Monch, have flowed through to the pūrākau, establishing education as a journey of life-long, inter-generational learning. This pūrākau will now inform the new branding elements of the new Building Blocks website.

INTEGRATION / COMMUNITY

Te Teo Herenga Waka & Toi Te Ora

Health of Older People

The team have met with Danielle Romanes from the Department of Health and Human Services, Victoria, Australia. The purpose of the meeting was to discuss the implementation of Home and Community Support Services Responsive Model of Care. Although there are quite different structural setups between the two health agencies, there were some fundamental points that were shared to better inform how the Victorian Department of Health may approach a remodel. There were several key points through the discussion, such as:

- the deliberate strategy to improve Māori equity and how the DHB took a targeted approach in ensuring the needs of the communities could potentially be met;
- the learnings around ensuring fully informed communications planning;
- the importance of data in building an appropriate and equitable funding model that could address the inequities gap between indigenous and non-indigenous; and the impact of rurality and subsequent access to complimentary services; and
- taking a broad integrative approach to service delivery.

SYSTEM INTEGRATION

Te Teo Herenga Waka & Toi Te Ora

MMR Vaccination
BOPDHB signed a contract with 17 Community Pharmacies (16 in Western BOP & 1 in Eastern BOP) to administer MMR (Measles, Mumps and Rubella) vaccine in response to the outbreak. This was an excellent response compared to other DHBs. This was a voluntary process for those community pharmacies already administering influenza vaccines. The MMR vaccine will be free to people aged between 16 yrs and 49 yrs.

Opotiki Health Centre
Work in Opotiki now comprises two distinct streams:

1. *The Medical Care model* which has been a five year journey with local healthcare providers and is due for implementation in March. This new medical hub model is a positive development for the Opotiki community, targeting our investment to provide best value and a wider range of locally accessible care. Whilst not directly connected, we also have several services (notably ENT) who are currently working on plans to provide local specialist appointments commencing this year once the new model is in place and has the necessary GP backup.
2. *Local birthing services provision.* The interim solution has enabled local birthing services to continue from January 1st and throughout February and March whilst longer term solutions are considered. The interim solution has been well received and the various parties are working together well, albeit this is still at an early stage. Whilst the numbers of births in Opotiki are small (<50 per year), there is great significance for the local community in maintaining this service and the decisions we make over coming months will become part of our long history of healthcare service provision in the Bay.

   A further session with the midwives will be required to reach the stage of being able to identify all of the various options, which we will share with the Board once framed up.

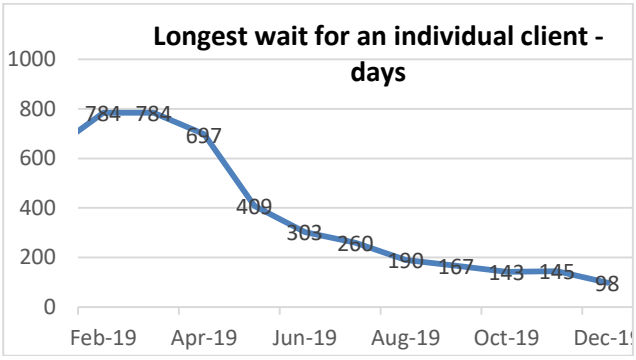
Director of Allied Health Scientific and Technology

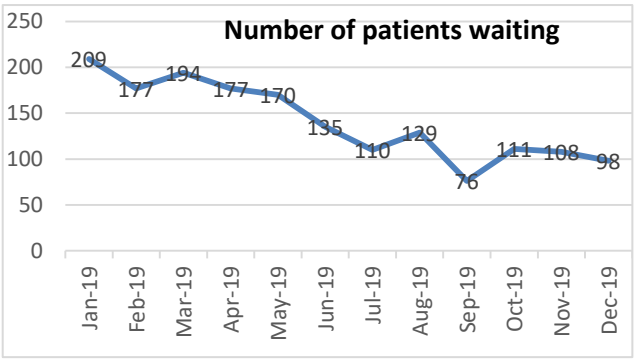
Keeping Me Well (KMW) Programme
Keeping Me Well aims to bring together community services as a virtual team with the ability to deliver enablement services tailored to the individual in a person directed way. As this model progresses, it will link to initiatives such as Health Care Homes. It is envisaged KMW will be accessed through the Community Care Coordination Centre (CCC) as the single point of access for information on responsive and early intervention in the home.

The ***Community Enablement Project*** is a workstream of the KMW programme, the focus of this project is to ensure Allied Health teams are providing responsive community services.
Current activity includes;

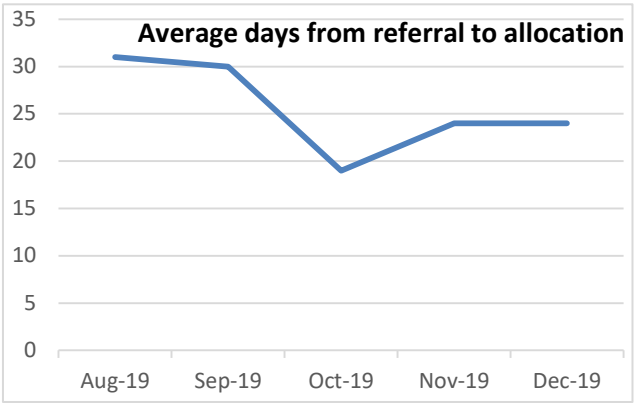
- Test pilots for community enablement with Nga Kakano recruitment in progress. Pilot to commence 17 February 2020
- Training/education/orientation plans for test pilots to be confirmed by the end of January
- Due to circumstances in the East, plans for readiness put on hold
- Community Response Team (CRT) to move to 399 Cameron Road 20 January 2020
- Community Allied Health (CAH) and Community Response Team (CRT) referrals to be managed by the CCC from February 2020
- CAH waitlist remains constant with approximately 100 waiting for a response - 57% to be seen within 21 days, 43% will be seen within 3 months (100 days).

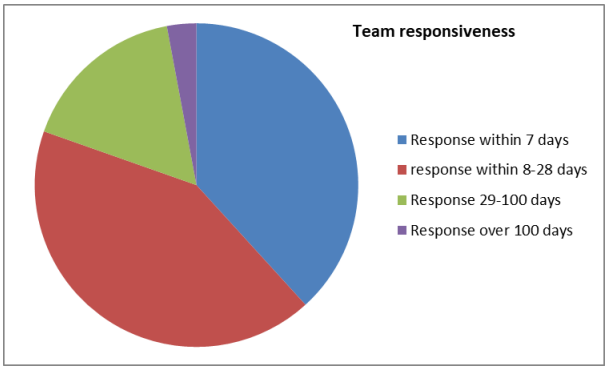
The Improvement Journey for Community Allied Health





80% of all referrals are now seen within 28days;





Orthopaedic Transformation Programme

This programme aims to have people managing their health and well-being (specifically musculoskeletal (MSK) conditions) through a proactive recovery-based pathway. The main aim is to ensure only those patients requiring surgical intervention attend hospital settings. From 29 January 2020, all MSK conditions from all GP practices in the Te Puke / Papamoa area will be included in an expansion of the project and the referral process has been improved as part of this activity. High suspicion of cancer and paediatric patients will continue to be reviewed by Orthopaedic Senior Medical Officers (SMOs).

DISTRICT HEALTH BOARD

Facilities and Business Operations

Tauranga Theatres 9 & 10 Construction

The preferred option is that the proposed Theatres 9 to 12 all be located on the existing theatre floor. This would utilise the SCBU and birthing suites space. A report on impacts and development of the Theatre 9 option to a concept stage has been commissioned.

The Health Planner has been re-engaged to complete a comprehensive report on the options, budget and impacts for the various locations for theatres 1 to 12. It is expected that the report could take 3 months to complete.

Mental Health Facility Builds

Urgent work is now underway to progress the design for two new Mental Health facilities in Tauranga and Whakatane after the announcement of $45m of Governement funding. Work is already well advanced for the Whakatane design and build process with work to commence for the Tauranga site. It is anticipated work will commence on both sites within 18 months.

BOP Clinical Campus

Education

The Advanced Study Fund has been allocated to 17 staff members who studied in 2019. There was a huge range of courses studied, qualifications ranged from grief counselling, through to Masters in Māori & Indigenous Leadership, Post Grad Cert in Medical Imaging and Sterilising Technology qualifications.

The Learning Scholarship, Hauora a Toi Scholarship and Whakatane Staff Study Fund all had their closing dates extended, and will be awarded at ceremonies in late February after various selection panels meet. There have been a good number of applications received.

The Training Plan has been written for the Microsoft Modern Workplace project, and with over 3000 staff to train in a short amount of time, this project will be the priority for the Education Team for the first half of the year. A variety of training methods will be utilised for this optional training. The Education Manager and Digital Capability Trainer are still involved with the Midland Clinical Portal eSpace project, and have raised their concerns to the programme manager around lack of resourcing for training.

The Education Manager is meeting with WBOPPHO management soon to discuss how to further align education opportunities at a strategic level, and continue the programme of work around Learning Together.

We are currently exploring opportunities for Tertiary Education Commission funded programmes that are aimed at staff with lower levels of literacy, to help support workplace communication and improve customer service.

Research - Health Sector Research Collaboration Grant (pilot)

Work has begun to identify research projects that may be suitable to support BOPDHBs application to partner with the HRC in a pilot of the new 2020 Health Sector Research Collaboration Grant. The Health Sector Research Collaboration Grant is a negotiated funding opportunity focused on upskilling and empowering health care or health service delivery organisations to engage in health delivery research in health delivery settings and ensuring that this research adequately responds to health sector, patient and community needs. Maori Health Gains and Development, Mental Health and Addiction Services, Urology and Service Innovation and Change have expressed interest in being involved in the pilot. The Research Office is working with these teams to identify the projects most suitable to support the DHB application to the HRC.

At this stage most of the activity discussed fits best with the Health Delivery Activation Grants. The aim of these grants are to establish health delivery research evidence needs or research opportunities before applying for further health delivery funding. Our application will need to identify the research activation activity as aligning with at least one of the following: relationship development, priority setting, literature review, skill/capacity building or other similar related specific activity. We are also reviewing the potential to also apply for Project Grants and Health Service Delivery Career Development Awards as part of our overall application to be a pilot site.

The registration cut-off for the 2020 Health Sector Research Collaboration Grant is Thursday 20th February. Our application must be accompanied by a letter of support from the Chief Executive (or equivalent) endorsing the content of and commitment to our application.

Provider Arm

Shorter Stays in ED Target Performance

During 2019 our performance against the '6 Hour Wait' target reduced from the 94-95% levels that we had achieved in 2018 to just over 91%. This change has broadly been similar across the country, in part due to the level of industrial action related disruption that the sector has experienced. In Quarter One (July-September) we remained at 7/20 DHBs in the national results, with a performance level of 91.4% against the 95% target.

At the end of 2019, the Board asked for feedback on our improvement plans and this update sets out what is currently underway in terms of our approach and prioritisation.

It is worth highlighting that whilst the Ministry of Health is currently refining a new set of performance measures, we maintain that the Shorter Stays target is still an important indicator of effective patient flow, but would comment that the measure as typically used is too aggregated to be of use to us as an improvement tool.

There are currently three areas of activity:

Activity Stream	Commentary	Timeline/ Completion
1. Whakatane ED	In the latter part of 2019, Whakatane ED began to experience significant pressure due to rising volumes and complexity of presentations. This was considerably exacerbated by the Whakaari eruption and our priority is maintaining and stabilising the service. Achieving this links with a wider stream of work relating to the 24/7 medical staffing model for the hospital.	Estimated June 2020
2. Equity review	The Board has asked for an equity review on the ED service and this paper has now been completed. As the teams explore the picture this paints, we want to ask ourselves about the suitability of the current model for Maori, and whether, with Wai 2575 initial findings in mind, we might consider changes to the current model.	March 2020
3. Disaggregation of data	Rather than looking at the whole DHB aggregated performance level, work is underway to split this into more usable data components to provide visibility of where the issues lie, the cause, solution and cost.	March 2020

Broadly, and aside from the disruptions of 2019, we have three core issues which are impacting on performance:

1. Volume increase (specifically the frequency and/or size of 'surge days')
2. Increasing complexity of ED presentations
3. Increased demand on specialties in other areas of the hospital, especially out of hours, adversely impacting on ED flow

The latter issue is worthy of further explanation. It is not new, but the issue is increasingly significant.

We have been actively seeking to reduce the waiting times for acute surgery as this is a patient and clinical safety issue for us, as well as an extended inpatient stay cost issue. Additional weekend acute theatre sessions are now in place to accommodate growth and this means that the surgical registrars are focussed on working through acute surgery demand in theatres, and therefore less available to support specialty referrals in ED. In terms of prioritised resource use this is an appropriate approach, however it has impacted on specialty wait times in ED. The first new dataset is due in March and will illustrate the variation in Shorter Stays performance for the various specialty presentations to ED.

Overall it does feel that the historic, NHS based model for Emergency Departments is past its use-by date and with our aspiration to move towards more community based acute care this is time to be exploring what a more suitable approach might look like in the future, rather than continue to add patch-up resource to the current model.

Provider Arm Decision Support (DSA) Team

The Decision Support Analysts are a small team of five who provide a range of finance, performance and business information services to the Provider Clusters. Historically this has been a stable team with negligible turnover, however this has changed over the last two years with notable turnover within the team. As of January 2020, we have a significant challenge due to two vacancies arising, exacerbated by two other members of the team being relatively new recruits to vacancies that arose in the previous year. It takes a new DSA in the order of two years to acquire the knowledge and skills to be able to function fully in these roles.

A discussion has commenced between Provider, Corporate Services and Funder Execs (who all have some DSA resources) on how we address this developing issue, which is important to note because there will be a capacity reduction which will restrict support to monthly reporting, data requests and other requirements for the next few months whilst annual planning takes priority. Recruitment for the new vacancies is underway.

Director of Nursing

Care Capacity Demand Management (CCDM)

Under the FTE (staffing) calculation module of CCDM, all inpatient wards have completed their calculations leading into the business planning process. Mental Health inpatient wards at both sites completed this process for the first time and have been congratulated on the significant improvement in their use of TrendCare to complete calculations. The Ministry of Health CCDM quarterly reporting including implementation of the outcomes of the FTE calculations where additional staff are required.

Community Health 4 Kids

Family Violence Intervention Programme (FVIP)

This programme seeks to reduce and prevent the health impacts of violence and abuse through early identification, assessment and referral of victims presenting to health services. Acknowledgment of the high performing BOPDHB FVIP team was recently received from the MOH;

MINISTRY OF HEALTH

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Waikato Mail Centre
Hamilton 3240
New Zealand
T+64 7 929 3600

12 November 2019

Karen Thomas
Bay of Plenty District Health Board

By email: Karen.Thomas@bopdhb.govt.nz

Dear Karen

Contract No. 360319-00 – VIP FAMILY VIOLENCE INTERVENTION COORDINATION SERVICES.

I have read your DHBs report for the above contract and have little to add by way of constructive feedback.

What carries through from this report is that BOP DHB have a VIP Coordinator team that are high performing, clearly very passionate and hardworking.

The Coordinators have had a busy six months spearheading lots of different but connected pieces of work (work occuring with clinical champions, in APU and with development of a number of proposals and resource) that will strengthen and grow BOP's response to family violence. The breadth of the work undertaken and implemented is a major achievement in six months.

It is really pleasing to read that that Coordinators have opportunities for workforce development and they have made time during this reporting period to upskill and remain current in this specialist field.

The Coordinators are to be commended for their proposal to make family violence a reportable KPI for team leaders, which was presented to the executive committee. Another outstanding achievement.

It is always a pleasure to read BOP DHB's VIP contract reports and there is little further feedback to offer. It is a stellar report.

If you would like to discuss this further please contact me either at the number listed below or via email at Helen.Fraser@health.govt.nz.

Yours sincerely

Helen Fraser
Family and Community Health
Child and Community Health
Population Health and Prevention
(07) 929 3647
021 687 549

The FVIP team were highlighted as an exemplar for other DHB's in the audit conducted by AUT University. With an average score of 91 in nine domains, the BOPDHB exceeded the national median of 80. Of particular note are scores of 100 for cultural responsiveness, reflecting the focus the team and Maori Health Gains and Development have applied and a result of 89 in the organisational leadership domain (up from 79 in 2018).

Although the BOPDHB did not meet the Ministry's child protection assessment rate of ≥ 80% for children under two years of age presenting at emergency departments, results sit just above the national mean and illustrate consistent improvement over four years.

Demand is exceeding the ability to deliver and this is reflected in a drop from 100 to 78 in the DHB Resource Funding domain.

From 2014 to 2019 the BOPDHB has had consistent results above national mean figures for Intimate Partner Violence enquiries in sexual health, alcohol and drug, community mental health and postnatal maternity services. Disclosure rates in these departments by women to a health professional met the benchmark on four of the six targets. The only exception was maternity which indicates work is needed in this area.

Overall results show an exceptional FVIP team and FVIP champions across the BOPDHB.

Chief Operating Officer addendum:
The annual plan template for 2020-21 sets a higher bar for how we as a DHB work with other state sector organisations to address this challenge. A refreshed (in January 2020) local agency working group involving senior/ Exec leads from Police, DHB, Education, Housing and Oranga Tamariki is gaining momentum in terms of a commitment to action based on a shared issue. This links wholly with our developing Child wellbeing workstream.

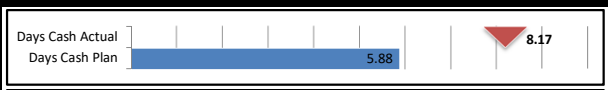
FINANCIALS
Current position is a deficit of $5.46M at the end of December which represents an unfavourable variance of $1.52m.

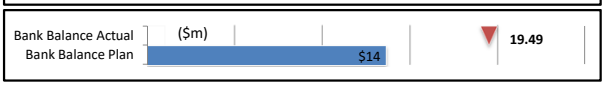
BAY OF PLENTY DISTRICT HEALTH BOARD
PRELIMINARY RESULTS FOR THE MONTH ENDED 31 DECEMBER 2019

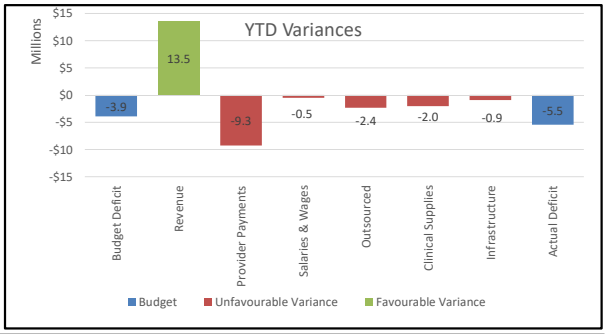
All amounts are $000s unless otherwise stated. Surplus/(Deficit)

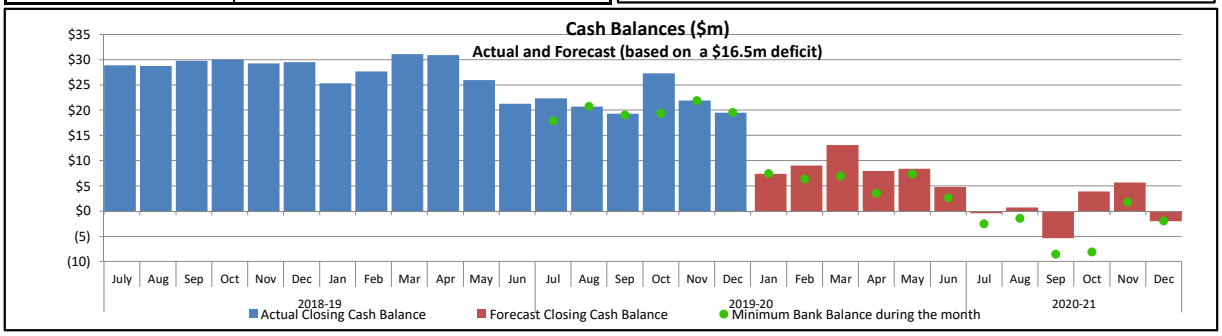
KEY FINANCIAL RESULTS SUMMARY

KEY MEASURES	Actual	AP Budget	Variance
Operating Result	**($5,463)**	**($3,942)**	**($1,521)**
FTE (accrued YTD average)	2,861	2,871	10
Provider Volumes			
Case Weights (CWD) - Acute & Arr	17,456	17,033	423
Case Weights (CWD) - Elective	4,941	5,520	(579)
Cash & Bank ($000)			
Balance	$19,490	$13,615	$5,875
Days Cash	8.17	5.88	2.29
WORKING CAPITAL ($000)	($40,577)	($42,244)	$1,668
Crown Equity ($000)	$253,851	$257,414	($3,563)

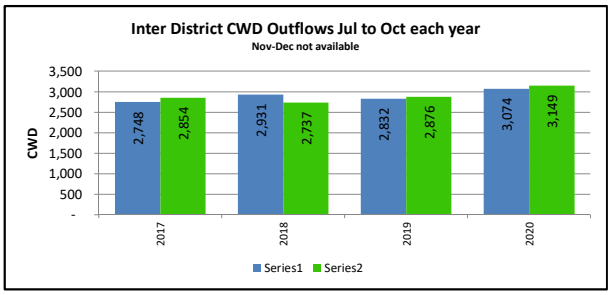


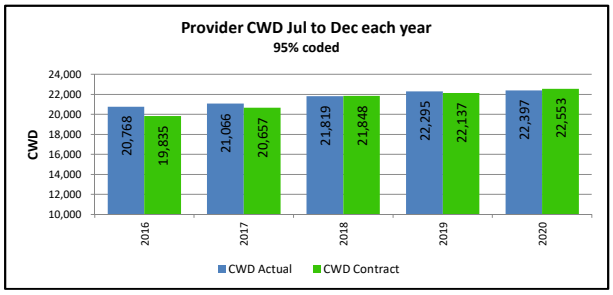


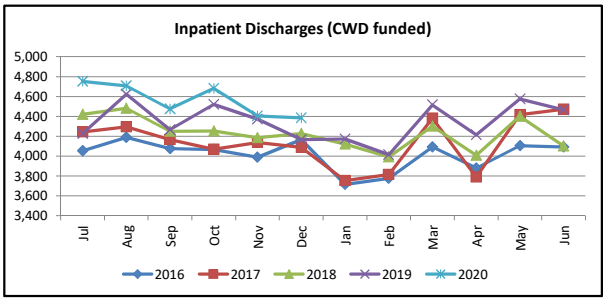


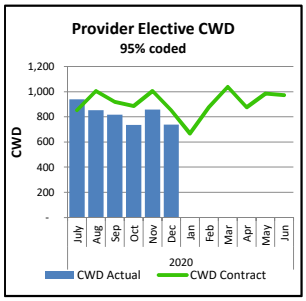


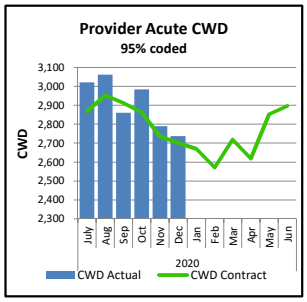
KEY ACTIVITY DRIVERS SUMMARY



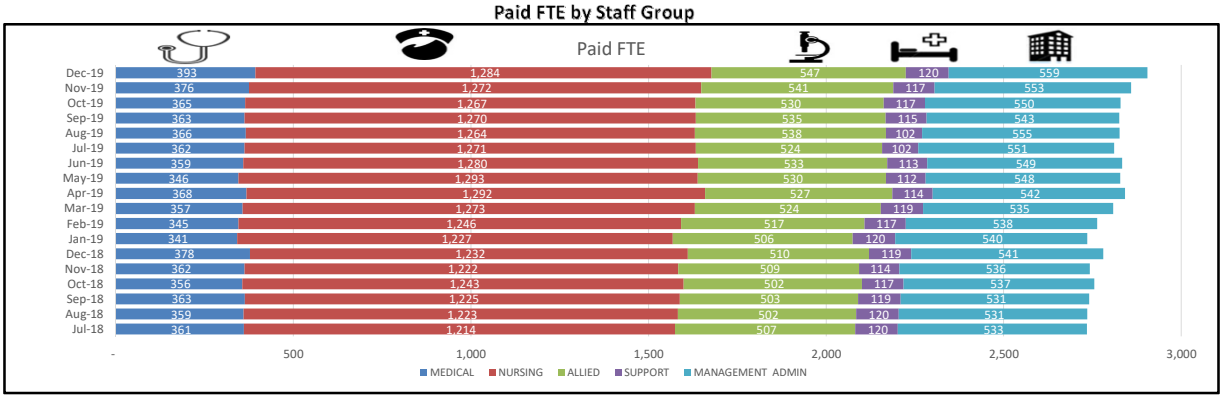








KEY STAFF FIGURES



PRIMARY CARE OVERVIEW

Key Achievements for this month:

Eastern Bay Primary Health Alliance

Opōtiki Medical Hub

The three Opōtiki general practices have an agreed model and the MOU is being finalised.

New model to start 1 March 2020. New model is for a nurse led, GP supported service covering 8am – 10pm weekdays, weekends and public holidays. Model does not include cover from 10pm-8am, nor maternity which is out of scope for the model. The model will be socialised with Opōtiki mayor and councillors Wednesday 23 January.

Service specifications developed, currently being reviewed.

Service Delivery, Target Achievement

- EBPHA achieved the Cardio-Vascular Risk Assessment target for Q2, total population reaching 93.1%. We just missed the target for Maori (88.4%)
- EBPHA achieved the Smoking Cessation target for Q2, achieving 91.34%. We reached the target for Maori and Non-Maori ESU

Whakaari

EBPHA mobilised a team of GPs to assist in ED and with several others on standby. EBPHA counselling team were also on standby, the team offered to prioritise those impacted on by the disaster. Two team members attended a session for first responders.

EPHA facilities were also offered for utilisation by the emergency team, however were not required.

Key Challenges for this month:

Opōtiki Maternity
It is unfortunate that the timing of the Opōtiki maternity service issues is overlapping with the new model development.

Single Referral Hub
The development and roll-out of a co-ordinated referral pathway for General Practice in the areas of chronic conditions, immunisation, mental health, diabetes and long term conditions.

East West Integration
The length of time and lack of progress with the integration continues to unsettle staff.

Ngā Mataapuna Oranga

Key Achievements for this month:

- NMO is currently engaging with the NMO Network staff to define the skills, knowledge and attributes of the ideal Tūāpapa Practitioner – this will enable our staff to contribute to the development of our Tūāpapa standards of practice
- A comprehensive training programme has been developed for the NMO network that aims to raise their awareness of Tūāpapa and offer lean thinking tools that support them in their roles. This training is followed by practical application and self-assessment. The NMO Network goal is to have 80% of the NMO Network trained as Tūāpapa Practitioners by the end of March 2020.

- Early morning huddles continue to be a popular option with the general practice staff (including GPs) at Tauranga Moana City Clinic. These huddles enable the general practice staff to identify any trends and potential gaps impacting on patient flow for example whānau have been able (and continue) to access same day appointments since December rather than experience the prior two week wait. NMO is cautiously optimistic that this trend will continue as a result of the access/ demand work currently in play and will continue to monitor this.
- Waitaha Hauora is working well with the nurses offering support to patients who do not need to see a GP. Additional services such as mental health will be available on this site in the very near future. Staff continue to offer support to patients transitioning to the Te Akau Clinic in Papamoa.

Key Challenges for this month:

- System transformation on a network scale is challenging with limited investment and the requirement to deliver business as usual.
- The 'go live' date for the connected care platform (Whānau Tahi) to follow 5 patients from primary care into the secondary setting has been temporarily delayed with the consenting patients now on self-management plans in the community and not requiring hospital admission. Identifying a new cohort for the pilot is currently underway.
- As lead contractor for the NMO Network, NMO is concerned at the lack of engagement and feedback post reports for the Kaupapa Maori contracts submitted to the DHB. As a result NMO are assuming reporting for these contracts are accurate and sent to the right person.

WBOP PHO
Western Bay of Plenty Primary Health Organisation

Key Achievements for this month:

- Health Care Homes progressing well in confidence.
  (See Appendix 1)

Key Challenges for this month:

- Growth in Enrolled Service Users (ESU) Western Bay of Plenty PHO

12 month Enrolled population analysis 2019-2020 for WBOPPHO

Patient Register	**Jan-19**	**Jan-20**	**Change #**	**Change%**
Patients Funded	187569	194,602	7,033	3.75%
Ethnic Group	**Jan-19**	**Jan-20**	**Change #**	**Change%**
European	142910	146,174	3,264	2.28%
Maori	29567	31,051	1,484	5.02%
Pacific Island	3040	3,269	229	7.53%
Asian	10337	12,079	1,742	16.85%
Other	1321	1,905	584	44.21%
Unknown	394	124	- 270	-68.53%
Age Group	**Jan-19**	**Jan-20**	**Change #**	**Change%**
00-04	11418	12,134	716	6.27%
05-14	25633	26,501	868	3.39%
15-24	18977	19,858	881	4.64%

25-44	41327	43,810	2,483	6.01%
45-64	49670	50,549	879	1.77%
65+	40544	41,750	1,206	2.97%
Deprivation Index	**Jan-19**	**Jan-20**	**Change #**	**Change%**
Quintile 5	29812	30,385	573	1.92%
Quintile 1 - 4	155083	159,483	4,400	2.84%
Unknown	2674	4,734	2,060	77.04%
Other PHOs*	**Jan-19**	**Oct-19**	**Change #**	**Change%**
EBPHA	27940	28,385	445	1.59%
NMO	11955	11,681	-274	-2.29%
***NB: Only for 9 month period Jan-Oct 2019 as current data not available**				

Notes:

- Projected national population growth rate is around 2.1%. Growth of enrolled population fo WBOPPHO is 3.75%
- Growth is more strongly orientated toward young families (25-44 yrs. olds) and their children
- Challenges exist around comparative growth of General Practice capacity and increased demands on constrained resources support service provision, particularly in respect to chronic condition management.
- National funding uplifts do not reflect full on-flow of demographic funding adjustments into primary care.
- Service sustainability will be compromised if a partnership approach is not adopted and new ways to manage demand are identified and implemented.

Appendix 1

HEALTH CARE HOME

Positive Aspects of Initial Health Care Home Implementation by General Practice As at January 2020

Prepared by Jeane Rossiter
WBOPPHO Health Care Home Project Lead
16 January 2020

Contents

Initial Positives of Health Care Home Implementation

Five of the seven participating general practices below have provided the following associated comments in response to your request for positive aspects resulting from the introduction of components of the Health Care Home Model of Care. ***The majority of practice comments are recorded as quoted.***

The Doctors Total Health and The Doctors Bayfair have only recently finished the scoping phase of the project. Wendy Dillon, Regional Clinical Manager Green Cross Health, indicated that it was too early into the project to approach the two practices for this information.

Chadwick Healthcare

It is important to note that Chadwick Healthcare had already implemented various components of the model prior to project commencement. This has allowed the practice to progress more quickly to implementing initiatives that would not usually fit with Year One activities.

Telephone Triage & Assessment

- Massive positive impact on acute demand;
- Positive feedback from both patients and providers;
- Allows huge flexibility for managing workload, especially when staff are away at short notice;
- Created significant capacity for clinical staff, resulting in two nurse clinics (as below).

Mental Health Nurse Lead Clinic

- Able to utilise existing qualified mental health nurse to provide service to patients of the practice;
- Internal referrals went well from the outset with massive uptake;
- Currently there are clinic three days per week, with seven or eight patients seen each day;
- Review of capacity for further clinics to meet practice patient need is ongoing.

Ear Suction Nurse Lead Clinic

- One day clinic resulting from additional nurse capacity (as above);
- 10 patients seen per day;
- Opportunity to upskill nurse staff

Primary Care Practice Assistant (PCPA) Role

- Fulltime position introduced using HCH funding;
- Good impact from role already;
- Reducing administrative workload of clinicians e.g. files normal results from GP inbox.

Equity/Patient Co-Design

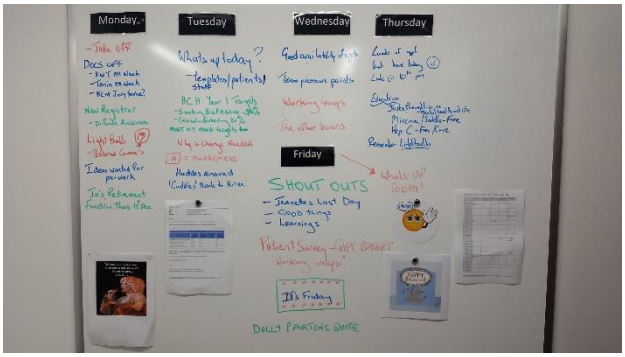
- The practice has appointed a practice champion for Māori Health from within their nursing team;
- There has been increased engagement and kōrero with the WBOPPHO Māori Health Manager, including advice for revision of their Maori Health Plan;
- Quarterly hui introduced partnering with Maori patients in system co-design. Although attendance at the first hui was lower than anticipated with just three attendees, the

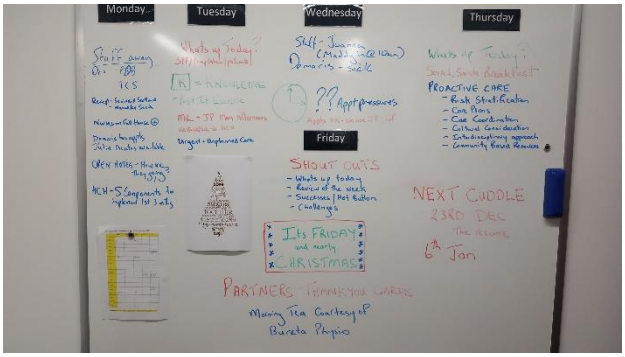
feedback gained from patients was worthwhile. The practice is confident that greater engagement will develop over time with influence from those that attended, including one prominent kaumātua.

Fifth Avenue Family Practice

Huddles

- Have had a huge positive impact on staff engagement across all roles within the practice;
- All staff feel well informed on what is happening at the practice;
- They have created opportunities for fun and laughter;
- Huddle boards working really well (photos supplied with permission to share with BOPDHB executive only).





Lean Concepts

- The practice is currently in the process of "leaning" the practice.

Off Stage Work Area

- An "off stage work area has been a huge success".
- A file storage area in the practice was renovated and purpose built (photo provided by practice);

Telephone Triage & Assessment Advanced Form

- The form to provide triage reporting for the HCH model of care was introduced and trialled by one GP at the outset of the implementation phase in December 2019;
- This has extended to four GPs by mid -January.
- Resolution rate (patients not needing to be seen) for the December to mid-January period was 76%. Two urgent same day appointments were recorded from a total of 66 patients.

Gate Pā Medical Centre

Following the initial readiness meeting between the practice and the project team, GP appointments have now been extended to include availability between 8.00am and 8.30am as well as between 12.00pm and 2.00pm.

Telephone Triage & Assessment

- Practice Manager states that since implementation of telephone triage there have not been any days where a patient has not been able to be seen;
- Patient feedback to telephone triage has been very positive;
- Although the total number of patients triaged is relatively low compared to bigger practices, the resolution rate sits at 76% to 80% for the November to mid-January period.

Equity/Patient Co-Design

- As a practice, the project has also focused the staff more on equity and their Māori patients – specifically those that are not being seen;
- The Practice Manager has worked with the WBOPPHO Manager of Māori Health to re-invigorate their Māori Health Plan to be "a living document";
- A number of whakataukī (Maori Proverbs) have been printed, with three framed and placed in the reception area each week. Already this has received positive feedback and engagement from patients, who are now sharing suggestions of other whakataukī. The ultimate aim for the practice is to also include proverbs from India, Tonga and Philippines.
- The practice sought and received input from Ngā Kākano to check for correct spelling and macron placement.

Ngā Kākano Foundation

Practice Workforce

- Inclusion in the project has supported recruitment and potential retention of new staff who are excited to be involved from the implementation phase.

Patient Portal

- Inclusion in the project has been a key driver to enable the practice to provide and fund the portal;

Lean Concepts

- The practice has resourced additional equipment to standardise rooms for clinicians;

Business Efficiency

- The practice staff see the project as a vehicle that is solution focused and will support them to make system wide improvements and facilitate team building.

Huddles

- Although the practice has not started huddles, they plan to include karakia, updates on community activities, Māori pronunciation (word of the day) and possibly waiata.
- They have asked for assistance with huddles. Fifth Avenue Family Health Centre have kindly agreed to share their learnings following attendance at their practice huddle.

GP Telephone Triage & Assessment

- The practice successfully trialled telephone triage when they were short of GP's;
- Patients are keenly waiting for it to be re-introduced as business as usual.

Ngāti Kahu General Practice Service

Huddles

- The practice has rated the initiation of daily huddles as a positive for staff;
- Information is now shared across the team which has been good for team building.

Telephone Triage & Assessment

- Practice staff have commented on the significant improvement this has made for patient access in a relatively short time;
- They have identified a significant reduction in fee for service deductions which they attribute to GP triage. (The project team will monitor this over coming months to validate that this as an outcome, but fully supports the logic applied by the practice).
- All practitioners at the practice are involved in telephone triage, including the Nurse Practitioner.
- Resolution rates for the practice sits at 40% from 115 patients triaged in the December to mid-January period.

New Extended Team Role/Realigning Roles

- Funding received from the project will be utilised to employ a part-time HCH/PCPA by upskilling an existing staff member, with cover for those hours being provided by another existing staff member.

Urgent & Unplanned Care

- Practice staff are looking forward to moving phones off front desk within the first three months of implementation;
- They are excited to use the project as a vehicle that will address patient waiting times.

Project Team Update

- A Prosci Change Management training day in October was fully attended;
- Monthly lead forums have been initiated since November 2019 with excellent attendance rates and participation from key stakeholders;
- Trello has been rolled out as the shared information portal for use by practices and the project team to share data, resources and share learnings.
- Training has been provided by Dr Pat Neuwelt in the Snakes & Ladders tool she developed which focusses on patient equity. This included staff from both PHO's and practice staff in attendance at the Practice Managers Meeting held in November

- This project lead has facilitated a discussion between the HCH Collaborative Lead and Dr Neuwelt with a view to the HCH Collaborative supporting rollout of this tool as part of their focus on equity in 2020.
- The following information is provided as an overview of Telephone Triage & Assessment for the four practices from which we receive reporting for the period 1 July 2019 to 16 January 2020:

Outcomes

Resolution:	Calls	Total	Maori	Non-Maori
Resolved in triage	1,455	55%	219 (52%)	1,236 (55%)
Not resolved in triage	1,198	45%	200 (48%)	998 (45%)
Total contacted	2,653	94%	419 (15%)	2,234 (79%)
Contact not made	181	6%	35 (8%)	146 (6%)
Total triage calls	**2,834**	**100%**	**454 (100%)**	**2,380 (100%)**

Resolved outcomes:	Calls	Total	Maori	Non-Maori
Prescription	534	37%	63 (29%)	471 (38%)
Advice Given	921	63%	156 (71%)	765 (62%)
Total resolved in triage	**1455**	**100%**	**219 (100%)**	**1236 (100%)**

Unresolved outcomes:	Calls	Total	Maori	Non-Maori
Same day face to face - not urgent	179	15%	27 (14%)	152 (15%)
Same day face to face - urgent	815	29%	135 (68%)	680 (68%)
Future face to face	170	14%	28 (14%)	142 (14%)
ED - Appropriate	5	0%	0 (0%)	5 (1%)
ED - Insufficient Capacity	2	0%	0 (0%)	2 (0%)
A&M - Appropriate	0	0%	0 (0%)	0 (0%)
A&M - Insufficient Capacity	1	0%	0 (0%)	1 (0%)
Other	16	1%	4 (2%)	12 (1%)
Total unresolved calls	**1,198**	**100%**	**200 (100%)**	**998 (100%)**

Who Did the Triage

Role	Calls	Percent
Dr	2,788	98%
Nurse	39	1%
Nurse Practitioner	7	0%
Unknown	0	0%
Total	**2,834**	**100%**

Continuity of Care

Triaged By	Calls	Percent
Patient's own GP	553	20%
Someone else	2,281	80%
Total triage calls	**2,834**	**100%**

The average time recorded for triage event was 3.38 minutes.

Maori Health Plan Dashboard — Dec-19

Monthly Results									2018/19						2019/20					
Target	Indicator	Baseline Maori*	Target	Result Maori	Result Non-Maori/Total	Numeric results	Δ from BL	Disparity	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Imms	Immunisation (8 mths)	87%	95%	78.6%	85.0%	**239 immunised** of 304 *A further 50 immunisations required to meet target*	-8.4%	-6.4%	73.4%	72.0%	70.7%	72.2%	72.9%	75.3%	77.8%	77.9%	78.8%	80.1%	78.9%	78.6%
Dental	Oral Health; Maori pre-school children enrolled in dental	65%	95%	99.2%	107.9%	**6,416 enrolled** of 6,470 *Target met*	34.2%	-8.7%	97.7%	97.5%	97.6%	97.0%	97.7%	96.8%	94.7%	96.2%	97.0%	97.2%	98.3%	99.2%
DNA	Did-Not-Attend Rate - Maori	16%	5%	15.8%	6.7%	288 **DNAs** of 1,822 *A further 197 patients needed to attend their outpatient appointment to meet target*	0.2%	9.1%	15.3%	13.9%	14.3%	11.9%	12.9%	13.3%	15.0%	14.8%	13.7%	15.9%	13.7%	15.8%
Breastfeeding	Breastfeeding at 6wks (full & exclusive)	59%	75%	60.7%	71.9%	**17 exclusive** of 28 *4 additional mothers would need to exclusively breastfeed at 6 weeks to meet target*	1.4%	-11.2%	60.4%	46.4%	59.5%	64.0%	58.9%	71.0%	51.4%	76.3%	51.0%	43.2%	60.4%	60.7%
	Breastfeeding at 3mths (full & exclusive)	47%	70%	48.3%	66.1%	**14 exclusive** of 29 *7 additional mothers would need to exclusively breastfeed at 3 months to meet target*	1.3%	-17.8%	63.4%	42.9%	46.7%	45.5%	59.3%	55.6%	48.6%	52.3%	65.7%	58.8%	41.2%	48.3%
	Breastfeeding at 6mths (receiving breast milk)	61%	60%	61.3%	74.7%	**19 receiving breast milk** of 31 *Target met*	0.3%	-13.4%	62.5%	58.8%	60.0%	62.2%	74.2%	69.7%	42.4%	54.8%	60.0%	66.7%	56.3%	61.3%
ASH Events / Acute	Maori ASH Rate per 100,000: 0-4yrs	7183	6545	6867	6104	**59 0-4 ASH discharges** **2** *Fewer Discharges Required to meet target*	-316	763	5185	4630	8148	6852	6667	6852	6325	11566	7229	6867	7048	6867
	Maori ASH Rate per 100,000: 45-64yrs	7421	7050	6026	2731	**59 45-64 ASH discharges Target met.**	-1395	3294	6051	6154	6974	6256	7590	8513	10009	8477	7455	7047	6536	6026

Quarterly Results									2018/19		2019/20	
Target	Indicator	Baseline Maori*	Target	Result Maori	Result Non-Maori/Total	Numeric results	Δ from BL	Disparity	Q3 2018/19 (Jan-Mar)	Q4 2018/19 (Apr-Jun)	Q1 2019/20 (July-Sept)	Q2 2019/20 (Oct-Dec)
PHO / Practice Enrolment	Population BOP	n/a	n/a	60,410	243,240	n/a	n/a	n/a	59,310	59,310	60,410	60,410
	Enrolled in PHOs: BOP	54,412	53,380	58,894	241,342	n/a	4,482	n/a	57,330	57,489	58,442	58,894
	Enrolled in PHOs: BOP %	97%	90%	97.5%	99.2%	n/a	0.5%	-1.7%	96.7%	96.9%	96.7%	97.5%
	Enrolled in PHOs & GP Practices: BOP	55,733	53,380	60,222	242,845	n/a	4,489	n/a	58,561	58,780	59,752	60,222
	Enrolled in PHOs & GP Practices: BOP %	97%	90%	99.7%	99.8%	n/a	2.4%	-0.1%	98.7%	99.1%	98.9%	99.7%
CVDRA	More Heart & Diabetes checks (CVDRA) within 5yrs	89%	90%	86.5%	91.2%	**14,430 checks** of 16,664 *A further 568 checks required to meet target*	-2.5%	-4.7%	86.6%	86.5%	N/A	N/A
CVDRA	More Heart & Diabetes checks (CVDRA) for Maori Men 35-44	74%	90%	72.0%	NA	**2,040 checks** of 2,822 *A further 500 checks required to meet target*	-2.1%	NA	72.3%	72.0%	N/A	N/A
Breast screening	Breast Screening Rates 50-69 Maori	60%	70%	67.5%	75.2%	**3,716 screens** of 5,505 *A further 137 screens required to meet target*	7.6%	-7.7%	65.2%	66.1%	66.4%	67.5%
Smoking Quarterly	Smoking Cessation Advice (Hospital) Maori	96%	95%	93.7%	97.1%		-2.3%	-3.4%	97.5%	93.7%	No Longer Available for BOP DHB	No Longer Available for BOP DHB
	Smoking Cessation Advice Primary Care Maori	87%	90%	87.6%	88.7%	**10,827 advised** of 12,354 *A further 292 people to be advised to meet target*	0.6%	-1.1%	86.8%	85.6%	86.0%	87.6%
	Smoking Prevalence in Pregnancy	47%	25%	26.3%	13.5%	**5 smokers** of 19 *A further 1 woman needs to be smoke free to meet target*	-20.7%	12.8%	40.5%	42.9%	40.7%	26.3%
	Smoking Cessation Advice in Pregnancy	89%	90%	100.0%	85.7%	**5 advised** of 5 *Target met*	11.0%	14.3%	93.3%	100.0%	72.7%	100.0%
Imms Flu	Influenza Immunisation (65+)	50.0%	75%	54.5%	63.7%	**2,478 immunised** of 4,550 *A further 935 immunisations required to meet target*	4.5%	-9.2%	51.3%	52.6%	54.4%	54.5%
Cervical	Cervical Screening Rates Maori (25-69)	70%	80%	73.5%	79.5%	**9,892 screens** of 13,454 *A further 871 screens required to meet target*	3.5%	-6.0%	73.5%	72.6%	72.8%	73.5%

* Note: Where possible, Maori baselines are taken from the Maori Health Plan 2016/17. All other baselines are based on actual Q4 2015/16 results.

Key to colour coding

Target Attained
Target within 10%
Target within 20%
Target outside 20%

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 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											√		

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

CORRESPONDENCE FOR NOTING

Submitted to:	Board Meeting	19 February 2020
Prepared and Submitted by:	Maxine Griffiths, Board Secretariat	

RECOMMENDED RESOLUTION:
That the Board notes the correspondence

ATTACHMENTS:

Letter from Australian High Commission re Whakaari White Island Patient Care – 26.1.20

HIGH COMMISSIONER

AUSTRALIAN HIGH COMMISSION
WELLINGTON

28 January 2020

Mr Simon Everett
Interim Chief Executive
Bay of Plenty Health Board
Tauranga Hospital
Cameron Road
Gate Pa
Tauranga 3112

Dear Mr Everett

I am writing on behalf of the Australian High Commission to express our profound gratitude to staff of Bay of Plenty District Health Board and in particular staff of Whakatane Hospital and Tauranga Hospital for their exceptional care for victims in the aftermath of the Whakaari White Island eruption.

We know it was a harrowing time for everyone connected to the tragedy and our thoughts have been with your staff since the event.

Please convey our thanks and best wishes to all involved.

Yours sincerely

Patricia Forsythe

HE Hon Patricia Forsythe AM
High Commissioner

72-76 Hobson Street, Thorndon, Wellington, New Zealand
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