BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Agenda

Bay of Plenty District Health Board

Venue: Tawa Room, Education Centre, 889 Cameron Road, Tauranga

Date and Time: Wednesday 18 March 2020 at 1.00 pm

Please note: Board Only Time, 9.00 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 Information Technology update Richard Li, Chief Information Officer	
3	**Apologies**	
4	**Interests Register**	**4**
5	**Minutes and Chair Report Back** 5.1 Board Meeting - 19.2.20 Minutes 5.2 Matters Arising 5.3 BOPHAC Meeting - 4.3.20 Minutes	 **8** **13** **15**
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 Chief Executive's Report 6.2 Dashboard Report (to be circulated) 6.3 Board Visits (verbal) 6.4 Healthy Built Environments 6.5 FARM Committee Chair attendance at Workshop	 **20** **38** **43**

Item No.	*Item*	*Page*
7	**Items for Noting**	
	7.1 Burial and Cremation Act 1964 – Submission to Ministry of Health Consultation on options to reform	**44**
	7.2 Water Services Regulator Bill – Submission to Ministry of Health, Taumata Arowai	**56**
	7.3 Board Work Plan 2020	**60**
8	**Correspondence for Noting**	
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 15 April 2020	

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

Bay of Plenty District Health Board
Board Members Interests Register

(Last updated March 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
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
Edlin Enterprises Limited	Owner/director	Business Consultancy	LOW	17/03/1987
Alleyne Trust	Trustee	Family Trust	LOW	
Phae – non trading	Director	Education	LOW	07/12/2005
NJ Family Trust	Trustee	Trustee	LOW	
Tauranga City Council	Licensing Commissioner	Local Authority	LOW	16/01/2018
Park2Park Trust	Trustee	Community Artworks	NIL	18/09/2018
Omanawa Hidden Gorge Charitable Trust	Chair	Environmental / eco-tourism Venture	LOW	December 2018
Western Bay of Plenty District Council	Licensing Commissioner / Chairperson	Local Authority	LOW	February 2019
Institute of Directors	Fellow	Professional Body	LOW	June 2019

INTEREST	NATURE OF INTEREST	CORE BUSINESS	RISK OF CONFLICT	DATE OF INTEREST
ESTERMAN, Geoff				
Gate Pa Medical Centre Ltd	Director, Manager & GP	Health	LOW – DHB does not contract directly with General Practices and as a Board Member Geoff is not in a position to influence contracts.	28/11/2013
Gate Pa Medical Centre Ltd	Practice Manager is on WBOP PHO Board	Health	NIL	December 2019
GM and P Esterman Family Trust	Trustee	Family Trust (kiwifruit)	NIL	28/11/2013
Whakatohea Health Services	Wife Penny works part-time as Nurse	Health Services Provider	Contracts to DHB LOW	Sept 2019
FINCH, IAN				
Visique Whakatane	Director	Optometry	LOW	1/11/19
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	July 2013

INTEREST	NATURE OF INTEREST	CORE BUSINESS	RISK OF CONFLICT	DATE OF INTEREST
			the position to influence funding decisions.	
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	18.12.2019
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	15/12/2019
Toi EDA	Committee Member	Eastern bay Evonomic Dev	Low	15/12/2019

INTEREST	NATURE OF INTEREST	CORE BUSINESS	RISK OF CONFLICT	DATE OF INTEREST
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: Conference Hall, Clinical School, Whakatane Hospital
Date and Time: 19 February 2020 at 10.00 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

Attendees: Simon Everitt (Interim Chief Executive), Owen Wallace (GM Corporate Services) Pete Chandler Chief Operating Officer), Mike Agnew (Acting GM Planning & Funding and Population Health), Marama Tauranga (Acting Manukura /Executive Director Toi Ora), Hugh Lees, (Chief Medical Advisor), Debbie Brown (Senior Advisor Governance & Quality), Sarah Mitchell (Director, Allied Health, Scientific & Technical)

Item No.	Item	Action
1	**Karakia**	
2	**Presentations** 2.1 Recovery Plan – Whakaari White Island Jo Peters, Emergency Planning Team Leader, Liz Gourlay Emergency Planning Team, Stephanie Baird, Communications 30 patients were received at Whakatane Hospital on Day 1 in critical condition and were transferred elsewhere by the next day. ED Staff on a normal day numbers 12. On the day of the Trauma, there were approximately 195 staff. Recovery Team focus • Psychosocial Recovery and Building Resilience • Organisational Learning for Quality Improvement – need to learn for any future events. Partnering with Canterbury because of their experience with Trauma events. • Communication • Passive surveillance BOPDHB Recovery Team are part of a wider recovery group with Whakatane District Council, working across three environments, Social, Economic, Natural environment - the island and the surrounding sea. Psychosocial support is normalising the reaction to a trauma event. Partnering in the community to assess the need and to ensure that people have a pathway to the help they need. Communities affected include our own DHB staff, Ngati Awa and Whanau, Tourism and Business Sector people and First Responders. Query was raised re learning and Canterbury DHB. How do we take the learning and ensure other DHBs are prepared for such an event.	

	There are a number of avenues to be able to do that. Staff are receiving requests for presentations etc. There are also opportunities through MOH to share the learnings. Comment was made that Whakaari was always a risk and whether we need to think about other risks the Bay of Plenty is prone to. This is part of the Emergency Planning role and is being actively reviewed and taken into consideration. Comment was also made on how the organisation's CARE values were applied naturally by staff throughout the trauma event. Exec team have been discussing resourcing and actions in preparedness for the future. <u>Corona Virus</u>. There is an Emergency team in place in conjunction with Toi Te Ora Public Health. MOH is the source of key information. Both BOPDHB EDs / hospitals have a clear process to manage suspected cases. Signage is up on both hospital sites and communication and planning has occurred with GPs. Emergency Operations Centre (EOC) is available 24/7. MOH has done a good job setting up processes for people re-entering the country. Query was raised from a GP perspective about supplies and expiry dates of supplies. Jo to liaise with BOPDHB GP Liaisons for effective feedback. A stocktake has been undertaken by PHOs. The Board thanked Jo and her team for the presentation. 2.2 <u>Health Consumer Council Update</u> Sue Horn, Chair, (Adrienne vonTunzelmann and Lisa Murphy were unable to attend) Consumer Council was established over a year ago. There are 11 members. They are a diverse group from all walks of life with links to various dimensions in the BOP. There are 4 Maori representatives. Membership has fluctuated since inception but is currently stable. It is considered the Council has the potential to be more pro-active within the organisation. A reflection on the Council by its members, was recently undertaken. A barrier has been in finding a way to connect. The Council had its first meeting of the year last week. The particular CARE value of All One Team is one that is felt needs to be embraced and fostered. The Council also recently had a day with Regional Maori Health Services which was very successful and is working on its main focus for the year. The Disability Strategy is something the Council would like to be involved in. A review of the Complaints Policy is also being undertaken. The Council has scheduled a session at their next meeting on Te Toi Ahorangi. The Person Centred Lead appointment is seen as a good conduit for the Council. The Board thanked Sue for her update and looks forward to the Council's progress. The Board sees the Council as an important avenue for consumer feedback.	
3	**Apologies** There were no apologies	

4	**Interests Register** Board Members were asked if there were any changes to the Register or conflicts with the agenda. No changes or conflicts were advised. G Esterman and M Guy registered conflicts with an item in Confidential.	
5	**Minutes** 5.1 Minutes of Board meeting **Resolved** that the Board receive the minutes of the meeting held on 15 January 2020 and confirm as a true and correct record. Moved: M Guy Seconded: G Esterman 5.2 Matters Arising Matters Arising were either in progress or completed. 5.3 CPHAC/DSAC Meeting – 5.2.20 **Resolved** that the Board received the minutes of the CPHAC/DSAC meeting of 5 February 2020. Moved: A Tuoro Seconded: B Edlin	
6	**Items for Discussion / Decision** 6.1 Research and the Equity Gap Query was raised as to whether Article 4 was an accepted article. There are three other Articles which are accepted. What has changed in terms of what we do? Comment was made that as health services have advanced, inequity for Maori has increased. The same would apply to research. It was considered research was pitched at a high level. The question is how do we close the gap? Chief Medical Advisor (CMA) gave background to benefits of research for patients. There is a need to make a start, looking at opportunities in the equity space, with an action focus. It is proposed that there can be a partnership approach with the Clinical School Research on how to engage with Maori in research. Researchers need to be up to date with their Te Tiriti learning. Te Toi Arohangi also contains research objectives as a streamlined process. Results of research are shared with the Kaumatua Council and Runanga. 6.2 Maori Attendances through ED Dr George Gray in attendance. In comparison with other OEC Nations BOPDHB is doing very well with ED attendances per 100 population which is in the top quartile. Whakatane Hospital has a higher proportion of people attending in less urgent triage categories and is associated with the vastly different deprivation between East and West. Western BOP reflects effect to a lesser degree. Opportunities to address might be through access to Primary healthcare and with Populaton Based Funding Formula (PBFF) through the MOH. There is a higher proportion of ED attendees at Tauranga admitted than the national standard.	

The Board considered the paper evidenced that increasing access to Primary Care is the pathway to reducing the ED attendance rate with Whakatane as a priority. GP capacity in Whakatane currently would be a consideration.

Resolved that the Board notes the attendance, triage and admission patterns described in the paper.

Moved: M Arundel
Seconded: I Finch

6.3 Chief Executive's Report

The Chief Executive took questions.

Funding for Mental Health and Planning for Facility Build. Resource has been committed by the Government. There is a telecon shortly with MOH. There is a design and build phase, together with modelling of care. There is leadership group being established.

Integrated Care – Keeping Me Well. Nga Kakano is looking forward to utilising BOPDHB Staff for the purpose of Integrated Care.

(*S Shea left the meeting at midday)*

CEO requested feedback on the style in which Board papers are being submitted.

Resolved that the Board receive the report

Moved: R Scott
Seconded: B Edlin

6.4 Primary Health Organisation Reports

The report from PHO practices on HealthCare Homes was highlighted. The Board requested a report on the progress with HealthCare Homes and equity.

Acting GMPF

The Board noted the reports

6.5 Maori Health Dashboard Report

Highlights:

- Ahead on PHO enrolment.
- Proportion of Maori women attending Breast screening has been trending up for some months.
- Maintained enrolments for pre-schoolers above 95% of national target for pre school dental.

Resolved that the Board receives and notes the content of the BOPDHB Maori Health Dashboard Report for December 2019

Moved: M Arundel
Seconded: H Ahomiro

6.6 Dashboard Report

Resolved that the Board receives and notes the content of the BOPDHB Dashboard Report for December 2019

Moved: M Guy
Seconded: B Edlin

7	**Items for Noting** 7.1 Board Work Plan The Board noted the reports.	
8	**Correspondence for Noting** 8.1 Letter from Australian High Commission re Whakaari White Island Patient Care – 28.1.20 The board noted the correspondence	
9	**General Business** Nil	
10	**Resolution to Exclude the Public** **Resolved** that Pursuant to S9 of the Official Information Act 1982 and Schedule 3, Clause 33 of the New Zealand Health and Disability Act 2000 the public be excluded from the following portions of the meeting because public release of the contents of the reports is likely to affect the privacy of a natural person or unreasonably prejudice the commercial position of the organisation: Confidential Minutes of last meeting: Board Minutes AFRM Minutes CPHAC/DSAC Minutes Chief Executive's Report Financial Update Capital Intentions PHO Update Chief Executive's Report 2020/21 BOPDHB Annual Plan Update 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 Mike Agnew Pete Chandler Debbie Brown Hugh Lees Sarah Mitchell Marama Tauranga **Resolved** that the Board move into confidential. Moved: M Cullen Seconded: A Tuoro	
10	**Next Meeting –** Wednesday 18 March 2020	

The open section of the meeting closed at 12.05 pm

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

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Bay of Plenty District Health Board

Matters Arising (open) – March 2020

Meeting Date	Item	Action required	Action Taken
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
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 – see below
Work is ongoing. Bi-monthly updates on progress against the planned approach set out in February Board papers will come back to the Board.			
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	See Below - Completed
ASH reports and information sharing with WINZ. The Community Health 4 Kids (CH4K) service make referrals to WINZ and facilitates clients accessing WINZ. If there is ongoing work with a client and WINZ the service may advocate on clients behalf and work with WINZ case worker. Information will be shared as needed and appropriate, with client knowledge or consent			
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 April 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 – Feedback to Board 18.2.20

19.2.20	6.4	**Primary Health Organisation Reports – Health Care Homes** The Board requested a report on the progress with HealthCare Homes and equity.	Update in Board Agenda 18.3.20 - Completed

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Minutes

Bay of Plenty Hospital Advisory Committee

Venue: Tawa Room, Education Centre, 889 Cameron Rd, Tauranga
Date and time: Wednesday 4 March 2020 at 10:30am

Committee: Sharon Shea (Chair), Hori Ahomiro, Geoff Esterman, Marion Guy, Ron Scott, Leonie Simpson (by teleconference), Lyall Thurston

Attendees: Simon Everitt, (Interim Chief Executive), Pete Chandler, (Chief Operating Officer), Hugh Lees (Chief Medical Advisor), Julie Robinson (Director of Nursing), Debbie Brown (Senior Advisor, Governance & Quality), Sarah Mitchell (Executive Director, Allied Health Scientific & Technical), Jerome Ng (Clinical Director, Quality & Patient Safety)

Item No.	Item	Action
1	**Karakia** The meeting opened with a karakia.	
2	**Presentation** 2.1 Current and Future Issues in Infection for BOPDHB Dr Kate Grimwade, Infectious Diseases Physician Kate conveyed to the Committee her background and outlined the objectives of managing Infectious Diseases in the Bay of Plenty, as understanding: • The range of infection issues • Implications for patients and communities • Risks for the future Australia has a number of avenues through the Australian Commission on Safety and Quality in Healthcare. In New Zealand there is not the same wide presence. There is minimal national leadership for guidance and direction. Infection Issues by age group Prenatally - Sexual health, Syphilis – recent epidemic especially in women of child bearing ages– produces congenital syphilis which can result in stillbirth. Infancy – major issue with vaccination programme. Childhood. Sore throats leading to heart operations, combined with decaying teeth and lots of caries Childhood pneumonia from damp houses which can develop to more serious ailments. Maori and Pacifica over-represented. TB is increasing, particularly in younger age groups. Again Maori and Pacifica hugely over-represented. HIV – in early days of HIV New Zealand responded well, however there has still been growth.	

Item No.	Item	Action
	There has been a slight fall off recently. The steps that NZ took have resulted in an ageing HIV population. Hospital associated infections, while in hospital, eg Needles, Catheters, Central Line infections, Surgical Site infections. BOPDHB sits just above mid table on the HRT data for infections. Knee and hip replacements can result in infection as can heart operations. International travel is a factor. Antimicrobial stewardship. Increasing problems with collateral damage caused, notably drug resistance. <u>What Can We Do</u> • Strong antimicrobial stewardship programmes – Safe prescribing practices – AB guidelines – Protection for most valuable agents – Education • Screening, isolation, infection control practice In BOPDHB surveys have shown 113 patients on antibiotics from 326 beds, 156 prescriptions. <u>Covid19</u> (Corona Virus) • Changing very quickly • 31 Dec - first cases • 2nd March - 90,000 cases worldwide • 64 countries • As at today 2 cases in New Zealand – Iran and Italy predominant. <u>Epidemiology</u> Rapidly changing within and outside China, daily updates from the World Health Organisation (WHO), broadly – falling numbers of new cases in Hubei province, few new cases elsewhere in China, relatively few new cases in most other countries, exceptions Iran and Italy. Over 90,000 cases worldwide, 80,000 in China. Viruses need receptors. Corona virus uses ACE2 in the respiratory system and these receptors increase with age hence Corona virus illness being more common in older people. Transmission – incubation period 2 – 14 days, secondary cases = 2.68 people (measles contamination is 14-16 people) Duration of infectivity unknown. <u>Conclusion</u> • Prevention, surveillance and management • Equity is a key issue • Fully understanding and resourcing of the work is urgently needed – primary and secondary. The Committee requested the presentation be circulated and thanked Kate for her very informative presentation.	

Item No.	Item	Action
3	**Apologies** An apology was received from Michael Cullen **Resolved** that the apology from M Cullen be accepted. Moved: R Scott Seconded: M Guy	
4	**Interests Register** The Committee was asked if there were any changes to the Register or conflicts with the agenda. No changes or conflicts were advised. BOPHAC Chair will email advice of a new interest.	
5	**Minutes** BOPHAC Meeting – 4.12.19 **Resolved** that the minutes of the meeting held on 4 December 2019 be confirmed as a true and correct record. Moved: G Esterman Seconded: R Scott	
6	**Matters Arising** The Matters Arising were in progress or had been completed.	
7	**Matters for Discussion / Decision** 7.1 Chief Operating Officer's Report Chief Operating Officer highlighted the following: *Move towards community based care* - COO advised of work in keeping well and developments with Papamoa. From Evolution, there has been discussion on acute care hubs and how primary and secondary care work together on that. It is an outflow of Health Care Homes – still at concept stage. There is renewed energy in where we are going, what we are doing and how we do that. Current environment is very different. Borders between services in secondary care are blurring in a good way. People are being drawn to changing things together, by shared cause. It is a good thing to let flow, but does need co-ordination without being restrictive. *Business Planning* - Teams are working together with Maori Health at the centre. *Bowel Screening* - Lakes rep advised of Lakes DHB hitting the target in their National Bowel Screening programme. BOPDHB collaborates with Lakes. At forefront of BOPDHB's implementation of bowel screening is engagement with Maori. Nurse Entry to Practice (*NETP) Programme* - Query was raised regarding Maori and Pacific recruit figures. DON will advise following the current intake. For Doctors, Auckland Medical School produce a number of Maori graduates consistent with the national proportion.	DON

Item No.	Item	Action
	BOPDHB's Year 1 Doctors this year met the national proportion. *Care Capacity Demand Management (CCDM*). BOPDHB is doing well. Currently at 92% implementation. Second quarter will be finalised shortly. Outstanding is the electronic core data set. There is approval to implement the outcomes which will be required to be carried out prior to Winter. The wards in Tauranga who had carried out their FTE count have smaller requirements this year. *Keeping Me Well, Social Determinants of Health* - Query was raised on how comfortable staff are in applying. BOPDHB is not in a state of readiness as yet but intent is to ensure that there is a focus on hard to reach populations. Was launched two weeks ago in two practises. *Oral Health* - Issues with equity and utilisation. An overview of the programme to come back to the Committee. **Resolved** that the Committee receive the Chief Operating Officer's report. Moved: H Ahomiro Seconded: R Scott 7.2 <u>Reporting and Linkages to BOPHAC - Discussion</u> The documents within the agenda have been developed over the last couple of months, supporting healthcare workplaces. The aim is to interface with such programmes. Query was raised as to introduction of tools and customising to New Zealand culture and how that is carried out. Health Round Table (HRT) do Australasian benchmarking which is useful. Once there is a framework it can be customised. Ethnicity data has been an issue in the past which has been raised with HRT. *BOPHAC Terms Of Reference* The Committee requested discussion at the next meeting to review against legislation and agenda compilation, as an opportunity for continuous quality improvement. It was considered this could be undertaken at Board Strategic session in March. Moved: R Scott Seconded: M Guy	COO Board Secretariat
8	**Matters for Noting** 8.1 <u>BOPHAC Work Plan 2020</u> The Committee noted the plan.	
9	**Correspondence for Noting** Nil.	
10	**General Business** • Child Development Service coming into BOPDHB. Service was previously delivered by Te Whanau Kotahi and funded by MOH.	

Item No.	Item	Action
	• Opotiki Hub is going well.	
8	**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 Chief Operating Officer's Report The Role and Core Focus of BOPHAC amid a Changing landscape 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 Pete Chandler Julie Robinson Hugh Lees Sarah Mitchell Debbie Brown **Resolved** that the Board move into confidential. Moved: S Shea Seconded: L Thurston	
9	**Next Meeting** - Wednesday 6 May 2020	

The open section of the meeting closed at 11.30 am
The minutes will be confirmed as a true and correct record at the next meeting.

CEO's Report (Open) - March 2020

Key Matters for the Board's Attention *

STRATEGIC PRIORITIES *

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

1

TOI ORANGA MOKOPUA – CHILD WELLBEING *

The Child Development Services (CDS) transition from TWK to BOPDHB is progressing well for March 2nd handover; National CDS improvement and innovation funding for BOPDHB is being planned for additional roles and implementation of additional service capacity. The appointment of Project Manager and new Business leader will assist the re-design of CDS services across the BOP for a whole of system approach, starting with the successful transition of the TWK service.

<u>BCG Vaccination in Maternity</u>

For those who meet the criteria, this vaccination can be administered before the baby and mother leave the maternity unit. However, only endorsed BCG vaccinators administer the vaccine and most are employed within Community Health 4 kids. Becoming an endorsed BCG vaccinator is time consuming, involved and not realistic for maternity staff, considering issues with staffing. Regulations changes in recent years make it difficult for maternity staff to maintain competency requirements.

Last year, the Public Health Nursing service conducted a survey of clients attending BCG clinics at CH4K for vaccination of their young babies. The survey clearly showed that parents would prefer to have the vaccination completed before leaving the maternity department.

The CH4K TB team is planning a trial in the provision of BCG vaccinations in maternity before discharge. BCG clinics run weekly or fortnightly in Tauranga and monthly in Whakatane. This is a huge increase from two years ago when clinics ran every two or three months in Tauranga and rarely in Whakatane.

2

TOI ORANGA AKE – INTEGRATED CARE *

Keeping Me Well

Keeping Me Well launched its first test site at Nga Kakano Foundation on the 17th February with a week of orientation for the DHB allied staff facilitated by the Nga Kakano team. The team were formally welcomed with a Mihi Whakatau, followed by training on aspects such as community context, population needs, services offered by Nga Kakano, introduction to and tour of local Marae.

This has already led to some significant and important learnings for the DHB team as they work with the Kaupapa and health care home model at Nga Kakano to help hape enablement services for that population. Discussions are underway to finalise funding of the Kai Awhina role that will provide support and community links for the DHB staff as we learn to braid two approaches and ensure the Kaupapa model and way of delivering services flourishes.

The focus for the next week will be on identifying those most at risk of admission that would benefit from an enablement approach and actioning the delivery. We are in the final stages of prototype negotiations with our test HCSS providers who are welcoming the opportunity to co-design the service specifications. The transition test will commence once the HCSS providers on board - estimate beginning of March. Data will follow.

Innovation and Improvement Unit

Whilst achieving the DHB's Strategic Priorities is everyone's responsibility, we are aiming to have more of a co-ordinated effort that will deliver tangible, sustainable and whole system health improvement for our Bay of Plenty communities.

To support this, two teams - Service Improvement Unit in the Provider Arm and the Service Development and Delivery team in Planning and Funding - have joined together their resource and expertise under the banner of Innovation and Improvement.

The purpose of this combined team is to provide an organisational focal point to enable, lead and support innovation, and improvement efforts across the health network. The team is organising resources and effort around the strategic priorities and helping the organisation to map out specific actions and activities that will advance achievement of these. Whilst this is a work in progress, here are some of the highlights for the month, aligned to the 4 priority areas. One of our next steps is to bring together reporting – data and narrative, across the breadth of the work programme in a succinct and meaningful way.

3

TOI ORANGA NGAKAU – MENTAL HEALTH *

Significant hui held with leaders from across BOP MH&A services on the 21st February as part of progressing the establishment of a leadership group for the sector.

The hui was attended by approximately 50 people and important steps were made in this work.

4 **TOI ORANGA TIKANGA – BUSINESS DESIGN** *

Corporate Services

Information Management – Integrated Sector Digital Services

Two meetings have been held between executive and information system staff of the DHB and Western BoP PHO to identify opportunities for sector digital service integration and to explore the appetite from key stakeholders. A draft proposal for piloting an Integrated Sector Digital Services has been developed and will be tabled in March. The pilot aims to understand whether it is possible to deliver an integrated digital service that can meet the needs of the multi entities in advancing health care in the district.

Anaesthesia, Radiology and Surgical Services

Electronic Referral Triaging

The Ear, Nose and Throat (ENT) service has successfully implemented this new process which improves the efficiency of triaging incoming referrals. Implementation across services is moving forward with the addition of Breast referrals this month.

Plans for the Orthopaedic service to adopt electronic triaging are underway with an e-grading form in development.

Electronic triaging reduces the risk of referrals getting lost in the system and is part of our Business re-design priority.

EQUITY

Te Teo Herenga Waka and Toi Te Ora

WBOP PHO has released its 2020 Health Strategy, Te Toi Huarewa. (attached FYI).

The strategy describes a whole of system partnership approach to address three key priorities, Whai Mana, Whai Ora and Whai Rangatiratanga. WBOP PHO, its general practice network, Iwi partners and stakeholders will work together to achieve equitable health outcomes for Māori and improved health and well-being for the communities we serve. Work has commenced on a number of projects and initiatives to bring the strategy to life.

Breast Screening

(DHB Performance Measure PV01)

For the quarter ending December 2019, BOPDHB attained its highest proportion of Maori women screened in the 50-69 years age group; 67.5% vs. the national target of 70%. With just 137 additional Maori women screened, BOPDHB would have reached the national target.

The screening results for Maori women in the Eastern Bay are lower than those in the Western Bay; steps taken to address this include:

1. Identification of those not enrolled in Breastscreen Aotearoa, followed by attempts to enrol these women in the programme.
2. A visit by the mobile screening unit to Kawerau from 23 March to 17 April.
3. Consolidation of the support to screening services work into one provider, WBOPPHO.

Health Workforce

Applications for Hauora Māori Training Fund 2020 are going well with 30 confirmed students taking up the study journey with interest in the funding arriving daily. The purpose is to support the non-regulated workforce to develop formal competencies in their current roles, and develop their potential to move into other health sector roles as relevant.

The courses include: Te Taupuatanga o te Whanau Bachelor of Applied Counselling, Certificate in Dental Assisting, Te Taketake Diploma in Applied Addictions Counselling, Diploma in Kaupapa Māori Public Health Whanau Violence L6, Whanau Ora Diploma, Certificate in Whanau Ora, Certificate in Health & Wellbeing - Mental health & addiction, NZ Certificate in IT.

The 2020 MOH Pacific People's Support Fund has been finalised for the regulated & non-regulated health workforce. However we now need to wait to see if the students qualify for the funding to get Māori Support.

This is an integral service that is needed for students that have taken up study, especially those students that have not studied for a number years. This service is invaluable to them and the feedback has been favourable towards it continuing.

Maori Health

Toi Te Ora and Māori Health Gains and Development attended alongside Ministry for the Environment, BOP Regional Council and Tauranga City Council, to hear the issues regarding Whareroa Marae (Ngaiterangi Iwi – Ngati Kuku and Ngai Tukairangi (Hapū)) and its surrounding community. Of main concern is the impact of Industry on the community, the degradation of its air quality; and the impact on the Moana (Sea/estuary) and its resources to feed the people of this community. There is potential for MHGD to work with BOPRC and TCC to frame a qualitative survey that will be led and co-designed with the whanau of Whareroa.
At this meeting, the hapū submitted their goals they wanted to have achieved within ten years, such as the removal of industry around the Tauranga Port and the Airport; and return of the land. It was good to see the passion but also the frustration of getting to this point as these issues have been ongoing for more than 40 years.

INTEGRATION / COMMUNITY

Te Teo Herenga Waka and Toi Te Ora

Pressure Injury Prevention

Next month we launch a Pressure Injury Prevention and Management initiative. The aim of this initiative is to reduce the incidence and severity of pressure injuries, and improve the reporting of pressure injuries across the Bay of Plenty region.

BOP Clinical School

The Education Manager met with WBOPPHO management with some positive outcomes around accrediting our Te Tiriti o Waitangi course; sharing resources; potentially co-delivering education, and better promotion of the opportunities that are available, including presenting at GP Forums in May. These discussions around collaboration and learning together continue, and will take place with Eastern Bay GP Liaisons soon.

Provider Arm

Newborn Hearing Screening (NBHS)

The aim of the national Universal Newborn Hearing Screening and Early Intervention Program (UNHSEIP) is the early identification of hearing loss to allow timely access to appropriate early intervention/s services. The early detection of hearing loss and subsequent initiation of early intervention/s via Audiology and Ministry of Education services has been shown to significantly improve long-term language and learning outcomes for children and their whanau.

Newborn hearing screening is a critical step in the UNHSEIP program as screening identifies those who are at an increased risk of congenital hearing loss. The program's core MoH target is screening of at least 95% of newborn babies within the first month of life. Achieving this target is essential for timely referral to Audiology services for completion of full diagnostic hearing assessments before the age of three months.

From 2 March, families living in the Mount/Papamoa area will have access to BOPDHB screening services from Plunket Bayfair instead of travelling to the Bethlehem Birthing Centre.

Unofficial reports from mums have been positive and include comments around the stress-free experience, easy parking, quiet and relaxing soundings. The knock-on effect affect has seen more settled babies and easier screening.

DISTRICT HEALTH BOARD

Te Teo Herenga Waka and Toi Te Ora

Acute Flow – Tauranga Site

The key aims of the programme will be to reduce hospital acquired complications and delays within Tauranga Hospital by improving flow and providing an efficient service to all acute patients.

This will be measured by a reduction in length of stay, beds occupided and a reduced stay in the emergency department for admitted patients. There will also be improvement anticipated in key quality metrics for example reduction in falls and hospital acquired conditions.

The 2020 programme will be launched following exec endorsement with an overall programme board and five workstreams reporting into it.

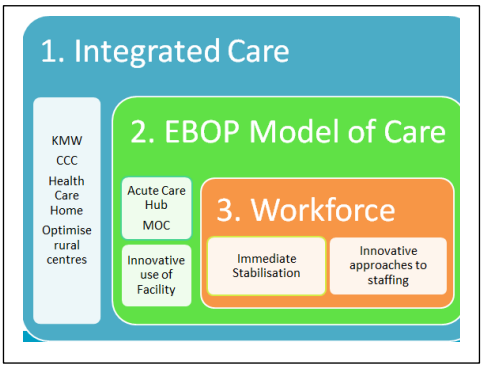
The five workstreams are:

- Acute Surgery
- Inpatient wards
- Assessment Planning Unit (APU)
- Frailty
- Health in Aging (HIA) model of care

There will be significant areas of overlap with Keeping Me Well and other strands of work within the integrated care priority. Next steps will be to determine the resource requirements and engage with the key stakeholders for each of the workstreams.

Whakatane Acute Flow- E3

The 2020 focus is building on the work of the past two year improvement focus on the Acutely Unwell Patient, Ambulatory Emergency Care and the SAFER patient bundle (Red to Green) and has three main work streams seen in the diagram below.



Progress to date:

1 Integrated Care- Action plans are being formed following the December 19 AEP audit with opportunities identified to provide equity across the Bay for three pathways DVT, Pneumonia and Cellulits and prevent admissions

2 Following the presentation of the paper 'Preparing for the Future Model of Whakatane Based Hospital Services' to the Board in July 2019 and the agreement to support exploration of models of care a Model of Care paper is being prepared which will be submitted to the E3Flow Steering group on February 27th.

3 The Acreditation visit from the RCGP's for an addition to the medical workforce was completed on 30th January with indications that Whakatane Hosptial will be acredited as a training site for Rural Hospital Generalists.

Ambulatory Care

The aim of this programme is 'To deliver Ambulatory Care with the approach of – Person and whanau driven models of care, enabling self management, digitially responsive, care closer to home for the Bay of Plenty DHB population'.

Under our workstream themes, key projects include:

- Care closer to Home: Exploring initiatives to transfer clinical activities preformed in a Secondary setting to Primary.
- IT Enablers: Investing an Enterprise Scheduling platform that will enable streamlined and agile management of our clinic and appointments, contributing to patient centred models of care, enabling self-management and being digitally responsive to the needs of our patients and operational requirements. A platform will build the foundation to move more easily to patient portal, kiosks, referral management and extending viewing of Primary and Community providers.
- Improving Equity: Developing initiatives to address the attendance rates for Maori at Outpatient appointments.
- Improving the Outpatient Experience: A cluster of improvement activities within BOPDHB Outpatient Department to improve flow, Staff utilisation, optimisation of floor space and working towards building Day Procedure spaces.
- Demand Management: Promotion of Telehealth opportunities and implementation of Zoom Business Licenses.

Toi Te Ora

Corona Virus

Toi Te Ora now has a public health response team in operation with planning well advanced for a public health response to a coronavirus outbreak. This team links to both the Bay of Plenty and Lakes Incident Management Teams through formal liaison roles. A Medical Officer of Health is a member of the joint DHB Technical Advisory Group which advises the two incident management teams.

Health Protection – Border Health

Members of our Health Protection team assisted the New Zealand Defence Force's Health Protection team with their mosquito control training.

This involved showing New Zealand and Australian Defence Force staff around the Port of Tauranga to familiarize them with port environments and for them to see a working mosquito surveillance programme. This is the second time Toi Te Ora have assisted the New Zealand Defence Force and we are working to maintain this good relationship.

Corporate Services

Health & Safety – Influenza Campaign 2020

The influenza campaign for 2020 is underway with vaccines ordered and planning of the process underway. In previous years the campaign aims to achieve 75%-80% coverage (73% achieved in 2019), however for 2020 vaccines sufficient to cover 100% of staff have been ordered. Apart from the usual drive for coverage, the higher target reflects the need to ensure a healthy workforce should Covid90 become a significant issue

People & Culture – Haeata Programme

The Haeata Interim Strategy is being transitioned into business as usual as the programme moves into the next phase with wider engagement with the workforce and several more strategic pieces of work being initiated. Earlier progress and technology updates will be operationalised by P & C leaders. A progress and closure report is being finalised for the Executive.

The Haeata team has started engagement with staff on development of the DHB People Strategy, starting with sharing the work on "Personas" which highlight the key pain points and priorities of staff (based on previous feedback and research across the DHB).

Emergency Management

The Emergency Planning team is focused on two main areas:

- Whakaari Eruption Recovery plan – implementing psycho-social support for both community and DHB staff impacted by the Whakaari eruption. A plan for the next 12 months has been developed – estimated to cost approx. $1.5m – that covers DHB and sub-contracted resources.
- COVID 19 planning and preparedness. An Emergency Operating Centre (EOC) has been established and staff rostered to undertake the role of Incident Controller. The Emergency Management team is supporting the incident controller in planning the response and co-ordinating with Toi Te Ora – which has a role across both BOP and Lakes.

Communications

Redevelopment of the DHB website continues with the goal of a presentation of the new site to the Executive Management team in early March. While the site redevelopment is on track there remains concern around the refresh and ongoing maintenance of service specific content.

BOP Clinical Campus

Students

The Rural Health Interprofessional Programme (RHIP), based out of the Clinical Campus at Whakatāne Hospital, commenced this year in January with Block 1 attending a noho marae visit to Te Rewetu Marae, Poroporo. The first group involved nine students from a range of health disciplines; medicine, pharmacy, paramedicine, speech language therapy and dietetics. While participating on RHIP students are required to work interprofessionally on projects that aim to address Long Term Conditions affecting Māori Health in the Eastern Bay of Plenty. The students presented their projects to representatives from the community, DHB and Toi Te Ora Public Health at a presentation evening in the final week of the programme. The projects were of a high quality and have been shared with Toi Te Ora.

RHIP Block 2, involving another nine students, will begin with a noho visit to Pāhāōa Marae, Te Kaha, on 1 March. Led by the team from Māori Health Gains and Development this noho will also include an additional 20 students and staff from RHIP's 'sister' programme Tairawhiti Inter-Professional Education Programme (TIPE), run by Otago University and Tairawhiti DHB out of Gisborne Hospital.

Project Lead for RHIP, Distinguished Professor Ian Reid from the University of Auckland, is visiting the RHIP team in Whakatāne on 10 March 2020 to discuss the programme. Professor Reid will also present to the Whakatāne Postgraduate Medical Society at their CME meeting that evening.

The RHIP team are expecting approximately 70 students from 14 health disciplines will complete the programme in 2020. This continues the trend of increasing number of students coming through the rural health programme, and will be the largest cohort since the programme began in 2012.

Facilities and Business Operations

The Business Operations Manager received an award from the ISS cleaning contract manager for excellent contract practice. This is the first time an award has been given to someone outside of the ISS organisation.

Provider Arm

Chief Operating Officer

Three issues that our teams often raise in relation to our time challenge are *too many emails, too many meetings, not enough information or clarity.* Within the Provider Services we are aiming to try some new approaches this year to reducing general business management time and improving information for people:

(a) Seeking to reduce meetings and avoid duplicated, circular conversations wherever we can
(b) Challenge ourselves in the email overload burden
(c) Develop a more effective communication approach to help reduce the above

Part of *improving communication* includes making it clearer for people about what's happening and who's doing it. Whilst this sounds simple, getting the right information to the right people through a means that individuals choose to use is far from easy. Communicating more can mean more emails if we apply traditional approaches and so a new weekly aggregation of easy to access information which can be shared widely is being launched this month as a trial. We're also working with the Service Improvement team to ensure that all improvement projects are easily visible for all staff by the end of this year.

Another area of expressed frustration relates to frontline clinicians who raise issues of concern through a variety of routes and are often not clear whether the concern is being dealt with, who's dealing with it and where it's at.

This is a common issue in many healthcare organisations but is something we want to change here. Starting in March, we will be implementing a new approach which will better enable frontline staff to raise concerns and have certainty that these have not become lost in our organisational systems. We piloted this last week, when a new concern was raised by an anaesthetist at Whakatane sending an email to a large group of staff because he was unsure who to go to. He was extremely and positively surprised by us trying out the new issue logging approach from his email, which has given him a reference number to follow up, a contact person to work with and a timeline for next steps.

Workforce wellbeing is one of the big conversations both locally and around the world. The national Chief Operating Officers are increasingly discussing common challenges relating to violence against staff, workplace behaviours, stress and burnout.

Within the Provider Services at the end of last year the Chief Operating Officer used a vacancy to second a project manager to begin looking at how we can triangulate information to identify service areas under pressure and monitor these, with the potential for pro-active interventional support. Multiple sources of information about our teams exist but these are disparate and not connected and so over coming months we are going to be building up a set of workplace wellbeing indicators which will provide visibility we have not had before.

One indicator which is generated but not yet purposefully used is our variance response trend. This captures daily capacity and demand across our main clinical service areas and provides a useful warning flag about demand pressures on a real time basis. The below example is from January data at Tauranga, indicating we had an extremely busy month and a number of areas which were under particular demand-related pressure.

Dept	Mauve	Green	Yellow	Orange	Red
2AMed	1.1%	83.6%	12.0%	1.5%	1.8%
2BMed	1.2%	81.3%	14.6%	2.0%	0.9%
2CMed	0.0%	84.9%	12.7%	1.3%	1.2%
3ASur	0.0%	93.7%	5.6%	0.2%	0.4%
3BSur	1.0%	93.8%	5.2%	0.0%	0.0%
3CSur	5.6%	84.6%	9.1%	0.3%	0.5%
4APaeds	3.2%	93.5%	2.8%	0.3%	0.2%
4BOrth	0.0%	92.0%	6.4%	1.0%	1.5%
APU	0.0%	69.4%	25.6%	2.6%	2.5%
CATHLAB	0.0%	81.4%	17.9%	0.0%	0.7%
CAU	0.0%	100.0%	0.0%	0.0%	0.0%
DIETITIANS	0.0%	0.0%	100.0%	0.0%	0.0%
DISTRICT NURSING VRM	0.0%	100.0%	0.0%	0.0%	0.0%
ED	0.0%	45.3%	37.2%	15.7%	1.8%
HIA	7.6%	84.8%	7.6%	0.0%	0.0%

ICU	0.7%	90.6%	8.7%	0.0%	0.0%
Mat	0.0%	76.1%	14.8%	4.3%	4.8%
MHS	3.7%	74.0%	22.2%	0.0%	0.0%
MHSOP	0.4%	92.6%	4.1%	0.1%	2.9%
OPS VRM	0.0%	80.7%	19.3%	0.0%	0.0%
ORDERLIES VRM	0.0%	100.0%	0.0%	0.0%	0.0%
SCBU	0.0%	62.6%	36.2%	1.2%	0.0%
Speech and Language	0.0%	40.0%	60.0%	0.0%	0.0%

Other key streams of work that the teams are focussing on, in addition to those in this report, in the first half of the year include:

Opotiki: The commencement of the new medical hub network and options for local birthing

Clinical Head of Department (HOD) Consultation: A refresh of our HOD model and role redefinition to enhance medical leadership

Bowel Screening: Developing the transition to go live plan, facility capacity and resourcing

Cardiology: Regional and local discussion about the timeline for equipping and resourcing a 2nd cath lab

ENT: Working to address disparities for children in the Eastern Bay

Mental Health: Developing the facility rebuild project teams, East and West Bay re-design engagement and building up a whole system governance group

MICAMHS: Assessing where the team and service are at and how we want to evolve

Whakatane: The continuation of E3 patient flow and developing the future model for 24/7 medical staff cover

BOPHAC: Re-thinking about meaningful content and best value for the Committee

Board and Committee reporting: seeking to improve quality and relevance whilst minimising duplication

Workforce Strategy: Gearing up our workforce strategy to align with annual plan objectives, Maori workforce recruitment and clinical service sustainability requirements

ENT services in the Eastern Bay

The issue of access to ENT services for children in the Eastern Bay was brought to the Board agenda in 2019 by Yvonne Boyes and resulted in a management commitment to work through the issue, which we provided an initial update on at the end of last year. Since then progress has been made in several areas:

1. *The appointment of a Clinical Head of Department for ENT.* A new appointment of an SMO has been made and this person will take on the role of Medical HOD, which we have not had for many years.
2. *Linkages between Paediatric and ENT Senior Medical Staff.* Paediatricians have been developing the dataset which identifies the details of access disparities for children in the Eastern and Western Bay areas. The team is now working with the ENT HOD to further refine data to establish what changes are going to make a positive difference.
3. *Approach to triaging.* An initial change step driven by the data is a reduced threshold for access (effectively a prioritisation) for children in the Eastern Bay coming into place this year and we would expect this to begin to show improvements over the next two to three months.

We will update the BOPHAC Committee further at the next meeting in May, including the presentation of referral and access data trends.

Director of Nursing

Care Capacity Demand Management (CCDM)
The Variance Response Management (VRM) work is progressing according to plan.
The main focus of work is refreshing the VRM indicators to align with the national standards. The other key focus is the CCDM Information Systems project to develop and implement the electronic core data set dashboard. This work is progressing albeit slowly given the detailed nature of the work related to data sources and verification of the data produced.

There has also been a considerable focus over the last six months by the TrendCare Coordinators to support departments to meet all the quality checks for use of TrendCare. There has been a significant improvement by wards which then provides greater confidence in the robustness of the Hours per Patient Day (HPPD) measure.

New Entry to Practice Programme (NETP)
Under the nurses and midwives ACCORD there is a commitment to full employment of new graduates nationally.

Twenty-nine new graduates entered the NETP programme for January 2020. Two of these were placed in Primary Care. A further 29 will commence NETP in March with one of these in Primary Care. There are two funded places remaining to be filled however this is proving challenging as the majority of the 180 nurses remaining in the national pool who have been contacted do not wish to relocate.

Mental Health placed seven new graduates into the Nurse Entry to Specialist Practice (NESP) programme. Whakatane had five new graduates across inpatient and community settings and Tauranga placed two. One of the Tauranga applicants did not pass the state final exam.

2019 New Graduate Retention
From the January 2019 new graduate intake, the retention rate for those eligible to apply for second year positions is 91%. Two are yet to have confirmed positions however both are in the interview process. Two new graduates did not meet the requirements of the NETP programme.

Anaesthesia, Radiology and Surgical Services

Accreditation of Tauranga Hospital for Anaesthetic Technician Training
Following a site visit, the Medical Sciences Council has confirmed Tauranga Hospital as an accredited Anaesthetic Technician training facility. This is excellent news for the DHB as it will enable us to grow our own anaesthetic technicians, of whom there is a critical shortage in New Zealand.

Opening of Outpatient Dental Room

Completion of fitout, opening and blessing of the Outpatient space to facilitate dental treatments in an ambulatory setting is a great accomplishment. The first patients attended for procedures from 17 February.

Woman Child and Family (WCF)

Eastern Bay Rural Maternity

There is currently no LMC midwife in Murupara and women are receiving pregnancy and postnatal care in Rotorua from Rotorua based LMC and DHB midwives. Limited GP support for pregnancy and postnatal care is available in Murupara. Support to GPs for free pregnancy testing and early antenatal care best practice has been provided along with access to maternity emergency refresher training.

An interim system for referral to the DHB (so DHB can seek to ensure provision of care is occurring) has been instituted. There are currently no access holders to the Murupara maternity unit and no births are occurring. Birthing in Murupara has become a rare event with women birthing almost exclusively in Rotorua. A long term solution is under discussion with Planning and Funding for LMC or similar services in Murupara.

Paediatrics

Preparation and planning is underway for the soon to be opened and implemented Paediatric Day Stay Unit. Meetings have begun in earnest with the setup of a governance group to implement the unit.

Costings for refurbishment of the current Whanau room are complete and commencement of the refurbishment has commenced with the more major work planned in late March. This is an exciting time for the Paediatric ward which over the years has had to manage a large influx of patients into the ward environment to perform routine “day procedures”. The Paediatric Day Stay Unit allows for this cohort of patients to be treated “away” form the ward environment.

FINANCIALS

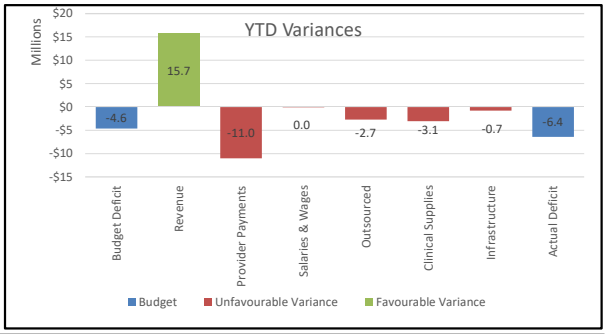
The DHB financial result for the 7 months ended 31 January 2020 was a deficit of $6.4m against a budgeted deficit of $4.6m, resulting in an adverse variance of $1.78m. The latest forecast continues to indicate a deficit of at least $16.5M at year end, although there is a growing level of concern over the provider arm’s performance

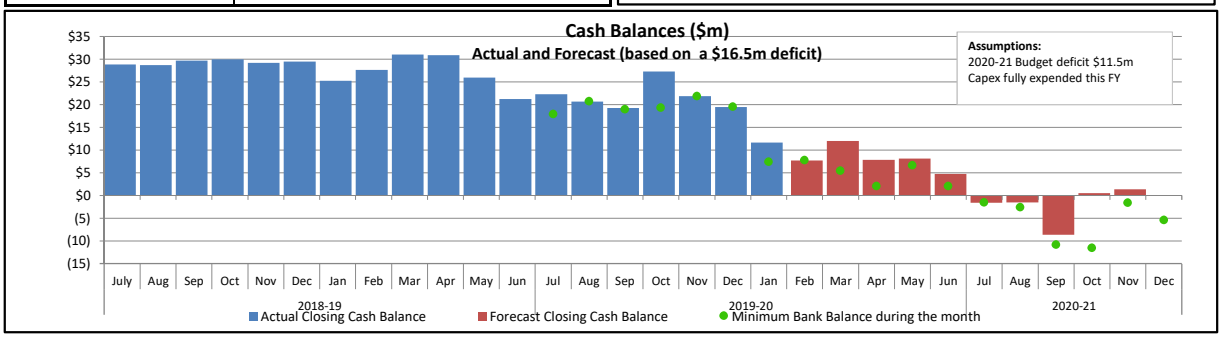
BAY OF PLENTY DISTRICT HEALTH BOARD
PRELIMINARY RESULTS FOR THE MONTH ENDED 31 JANUARY 2020

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

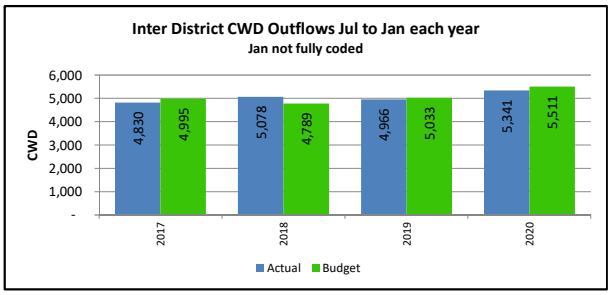
KEY FINANCIAL RESULTS SUMMARY

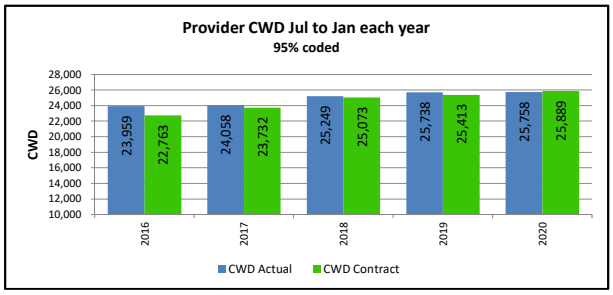
KEY MEASURES	Actual	AP Budget	Variance
Operating Result	**($6,410)**	**($4,629)**	**($1,782)**
FTE (accrued YTD average)	2,858	2,873	15
Provider Volumes			
Case Weights (CWD) - Acute & Arr	20,180	19,702	478
Case Weights (CWD) - Elective	5,578	6,187	(609)
Cash & Bank ($000)			
Balance	$11,698	$9,181	$2,517
Days Cash	4.91	3.97	0.93
WORKING CAPITAL ($000)	($41,404)	($42,522)	$1,119
Crown Equity ($000)	$252,904	$256,728	($3,824)

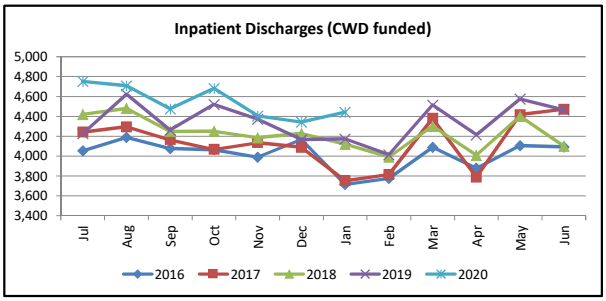


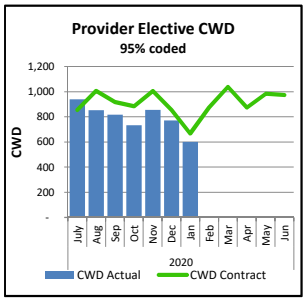


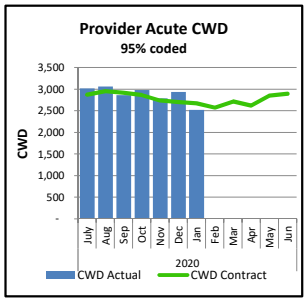
KEY ACTIVITY DRIVERS SUMMARY



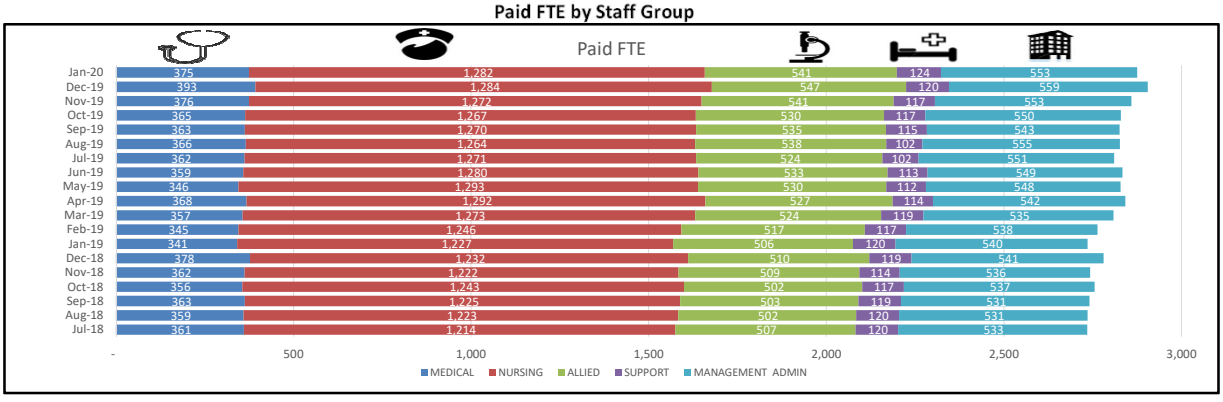








KEY STAFF FIGURES



WBOP PHO

Western Bay of Plenty
Primary Health Organisation

Tungia te Ururua, kia tupu
Whakaritorito te tupu
O te harakeke

Te Toi Huarewa

Western Bay of Plenty Primary Health Organisation Health Strategy 2020

Background

Puhi-whanake was one of the tōhunga (navigation expert) alongside Whatuira who travelled with Tamatea Ariki Nui (who was the captain) on the Takitimu waka to Aotearoa. During the voyage these men passed each night scanning the stars, in order to direct the steersmen and to be able to foretell weather conditions. Puhi-whanake travelled with Tamatea Ariki Nui all the way to the end of their journey, near the Waiau River in the South Island, and then stayed there as instructed by Tamatea Ariki Nui as ahi kaa (keeping the home fires burning, keeping a place warm through the presence of people) to serve as guardian of Tamatea Ariki Nui's wife, Turihuka, who died there.

A toi huarewa is the whirlwind path to the highest heavens.

Te Toi Huarewa o Puhi-whanake refers to a journey of striving to attain all knowledge and wellbeing under the guidance of a navigator/wayfinder who sees clearly in the darkness through all challenges.

Overview

The Board priorities are:

- Whai mana – equity
- Whai ora – quality healthcare
- Whai rangatiratanga – sustainability.

The Ministry of Health definition of equity is:

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

We will take a strong pro-equity approach, particularly for Māori, by doing the things we are doing now even better (focussing on practical and realistic improvements), by being open to looking at new ways of doing things (through best practice and what our whānau are telling us), and by challenging our own ideas about how things should work.

We know the health system is not working for Māori. In July 2019, the Health Quality & Safety Commission released a report: *A window on the quality of Aotearoa New Zealand's Health Care 2019*. The report focussed specifically on Māori health equity. The report shows a pattern of inequities between Māori and non-Māori over their lifetimes.

- Health services are less accessible for Māori compared with non-Māori over the life course
- Even when Māori access services, the evidence shows inequity in the quality of those health services and treatments for Māori
- Māori were more likely than non-Māori to cite cost as a barrier to seeing a general practitioner
- Failure to meet the requirements of Te Tiriti o Waitangi and institutional racism have established and maintained advantage for most non-Māori, and disadvantaged Māori at the same time. Examples of this are shorter consultations, fewer referrals for investigation and management, and less effective treatment for Māori.

Work is under way to provide a health status report (clinical) on our enrolled population to add to what we know already. We are starting to get a profile (Māori vs non-Māori) of data such as ambulatory sensitive (avoidable) hospital admissions, but we are also working on health needs at a primary care level, so that we can be deliberate with our actions and effort. In order to make decisions around initiatives to achieve equity, we need to be well-informed through data analysis and evidence. PHO Incentive Plans are now in their fourth year and we will review how incentive payments are made and adjust them so it is fair, realistic and, more importantly, drives change to reduce inequities.

The System Level Measures Improvement Plan 2019-2020 outlines a multidisciplinary approach and collaborative relationship with DHB and providers that addresses issues such as acute admissions to hospital. Our challenge is to work with the current *System Level Measures (SLM) Improvement Plan* whilst stretching our focus on improving outcomes for Māori. This should be central to development of subsequent plans.

Whānau, Hapu and Iwi must lead, determine and guide pathways to how best to achieve Māori health gain. *Nothing about our whānau Māori without our whānau Māori.* There needs to be a lens of mana motuhake to our service planning and investment i.e. *'how will this advance mana motuhake?'* Investing in Iwi-led and locally delivered kaupapa Māori programmes in partnership with General Practice teams will be a strategy for achieving equity in health outcomes for Māori. We need to be mindful of not stifling Māori health by stifling Māori capacity and capability by identifying opportunities best led by Iwi.

A key thread of the Māori Health Strategy: He Korowai Oranga – Rangatiratanga – captures people's right to participate in making decisions about their health and to have meaningful ways to decide how health services might be provided for their benefit. Upholding Te Tiriti o Waitangi will ensure that Māori whānau are able to enjoy at least the same degree of health and wellbeing as non-Māori. Te Tiriti o Waitangi is the most important equity tool and framework for monitoring the Crown's responsibility to ensure Māori rights to health.

Partnership approaches are important to us to address issues and ensure a positive care experience for individuals and whānau throughout their health journey. Primary care means different things to different people. As well as caring for people when they are unwell, we also want to help people to stay healthy with free programmes for eligible women such as breast and cervical screening, smoking cessation, diabetes management and immunisation. General Practice is one important layer of Primary Care and we know that strong practice/patient relationships can make a positive difference to Māori health outcomes. We need to work closely to strengthen connection with whānau by promoting the value and contribution of our General Practice teams to achieving wellbeing for whānau.

Another way we can contribute to Hauora (wellbeing) is investment in Kaupapa Māori programmes such as Mauri Ora and Koi Ora. This approach to service delivery draws upon the values, tikanga and kawa unique to their respective Iwi and is recognised as integral to whānau wellbeing. Alongside our efforts to achieve the Ministry of Health targets, we need to balance the clinical aspects with hauora (wellbeing) aspects. We will seek to understand what matters to whānau and will prioritise consumer engagement in Primary Care and co-design of services. Only about 20% of health inequities are attributed to health; the other 80% come from other social factors (poverty, cold, damp housing etc.), therefore developing meaningful relationships with other stakeholders is mahi that needs to be progressed. We need (particularly General Practice) to be better linked with local health and social providers.

We will take a strong pro-equity approach, particularly for Māori, by doing the things we are doing now even better (focussing on practical and realistic improvements), by being open to looking at new ways of doing things (through best practice and what our whānau are telling us), and by challenging our own ideas about how things should work.

We have chosen not to have a separate Māori Health Strategy but rather a strategy that focuses on Māori inequities; based on the analogy *'what is good for Māori is good for all, and what works for everyone does not necessarily work best for Māori.'* It will be a living document to enable us to respond to current and future challenges. Our commitment to achieving equity of health outcomes for Māori will remain regardless of any changes.

The pending merger of Eastern Bay Primary Health Alliance and WBOP PHO, the development of a Māori Health Action Plan (Ministry of Health) that enables a more concerted and collective approach to implementing *He Korowai Oranga* (Māori Health Strategy), the actions resulting from the Waitangi Tribunal's WAI 2575 hearings, Health and Disability System Review 2019, and BOPDHB's Māori Health Strategy Te Toi Ahorangi provide some significant opportunities to reset our Health Strategy as required.

Our organisation's values and whakatauki (gifted by respected Rangatira Dr Morehu Ngatoko Rahipere) supports and challenges us to do things differently: *Tungia te ururua, kia tupu whakaritorito te tupu o te harakeke.* (Clear the undergrowth so that the new shoots of the flax will grow. In order to change we may need to leave some ways behind in order to do things differently).

Western Bay of Plenty Health Strategy 2020

GENERAL PRACTICE

What are we trying to do and why is it a priority?

1. **Improve health outcomes for Māori and reduce the equity gap (Māori vs non Māori) for Performance Targets.**
   - We want to support General Practice to better understand why there needs to be change in the way they interact with and care for their Māori patients/whānau.
   - Empower and support Practices to grow their cultural intelligence, use data to identify issues and gaps, guide their activity and measure their improvements, be prepared to change their approach and grow connections to whānau and community.

What will we focus on?

1.1 PHO Board continued investment in health target incentivisation for achievement of performance target for Māori. An incentive plan is now in its fourth year, we need to review this plan and funding criteria.

1.2 Areas of performance focus will be reflected in the SLM Plan but largely underpin existing incentivised activity within the areas of:
- improved coverage of Māori Women for Breast and Cervical Screening, (PHO incentivised and supported by Priority Women Cervical Screening funding)
- Cardiovascular Disease Risk Assessment (CVDRA) for Māori Male 35-44, (PHO funded for target achievement of 92.5%)
- Seasonal Flu vaccinations for Māori 65+, (PHO incentivised)
- Support for Smoking Cessation for Māori (National Health Target funded under SLMs)
- Improved coverage of Māori children aged 0-4 for Childhood Immunisations (National Health Target funded under SLMs).

A platform already exists but we need to better reflect that in how we convey expectations to our Practices and support them with meaningful data and support.

1.3 Select three goals from SLM and implement the recommended actions for each.

1.4 Connect General Practice with 'interim quality improvement team' who have technical, cultural and clinical expertise (General Practice Services Team, Manager Māori Health, Health and Wellness) to support incentivisation.

How will we know it makes a difference?

We will work in true partnership with relevant Partners to agree on SMART goals i.e Specific, Measurable, Achievable, Realistic, Timely. A separate SMART Work Plan will be developed.

Continues next page ...

1.5 Work with General Practice to develop/review their Māori Health Plans and provide support with implementation.

1.6 All CME/CNE and training events incorporate relevant national and local data relating to access, outcomes and inequities to enable relevant learning and understanding.

1.7 An equity diagnostic self-assessment exercise against MOH Equity of Health Care for Māori: A framework undertaken. This exercise will also incorporate Te Tiriti o Waitangi self-assessment. Practical examples of application of the principles of Te Tiriti o Waitangi aligned to Cornerstone accreditation are developed and shared with General Practice.

1.8 Supporting whānau to engage and remain engaged with primary healthcare providers by developing targeted programmes in partnership with relevant Community Providers /Iwi. Suggested ideas are:
- Mauri Ora programme working with General Practice on a Māori mens' CVD programme i.e. holding a whānaungatanga event – barbecue with dads and daughters
- PHO-subsidised whānau consultations through Manawanui Whaiora Kaitiaki (MWOK) programme

1.9 We will invest in the development and implementation of a holistic Hauora Tāne programme for men with high health and social needs, in partnership with iwi. The programme will build on other successful initiatives e.g. Tāne Takitu Ake programme (Korowai Aroha Health Centre).

IWI PARTNERS

What are we trying to do and why is it a priority?

2. Māori will be the decision makers in their health and wellness.
- Whānau will have increased access to programmes to support them to live well.
- Our Māori men are at the heart of our communities. We want our tāne to live long and healthy lives – for themselves and for their Whānau, Hapu and Iwi.

What will we focus on?

2.1 We will invest in and support the development of existing and new roles to promote a holistic approach to improving health and social wellbeing.

2.2 Local Iwi to pilot Manawanui Whaiora Kaitiaki project.

2.3 Explore additional investment of social workers/navigator-type roles with mental health experience being located with Iwi to work alongside General Practices.

2.4 Consumer/whānau engagement in Primary Care and co-design of services. Engage co-design expertise to develop and implement workshops and training.

2.5 Explore opportunities to establish a Māori roopu (group) with BOPDHB to ensure whanau-centred care along the continuum of care (Primary and Secondary Care).

How will we know it makes a difference?

We will work in true partnership with relevant Partners to agree on SMART goals i.e Specific, Measurable, Achievable, Realistic, Timely. A separate SMART Work Plan will be developed.

Continues next page ...

2.6 For Māori who have a diagnosis of an illness such as diabetes, increase support to access all PHO and DHB-funded initiatives through referrals and set targets e.g. uptake of Diabetes Care Improvement Programme will be 40% of the total funding utilised for Māori.

2.7 We will invest in the development and implementation of a holistic Hauora Tāne programme for men with high health and social needs, in partnership with General Practices. The programme will build on other successful initiatives e.g. Tāne Takitu Ake programme (Korowai Aroha Health Centre).
Tāne will determine the space and terms of the programme – aroha ki te tangata.

PRIMARY HEALTH ORGANISATION

What are we trying to do and why is it a priority?

3. We want to create an organisational culture of equity to ensure sustainability in all our efforts to address inequities (Māori vs non-Māori). When focus shifts, improvement gains can be lost.

Data Quality

- Getting the basics right is important and we need to get our house in order to be in the best position to start to address inequities.
- Where inequities exist we will find them, prove them and then intervene to remove them to the best of our ability and capability. Annecdotal evidence is not good enough to cause change. Real change begins with information. Evidence-based decision-making first requires the evidence.

Engaged and effective workforce

- A culturally-competent workforce contributes to improved health outcomes.

What will we focus on?

3.1 Creating an organisational culture of equity using the following frameworks: *A Roadmap to Reduce Racial and Ethnic Disparities in Health Care* (Finding Answers to Reduce Racial and Ethnic Disparities in Health Care) and *The NZ Ministry of Health Equity of Health Care for Māori: A framework*.

Invest in additional quality improvement resource.

3.2 Data Quality
Diligent collection, understanding, monitoring and sharing of data both quantitative and qualitative data by ethnicity (Māori vs non-Māori). We will focus on making sure that we collect data that is complete enough to expose inequities of health outcomes and then we will proactively go looking for the evidence of where these are occurring. We will endevour to discover why these are occurring and then we will plan interventions to stop them from happening. We will continually monitor the effectiveness of interventions and adjust them when necessary.

3.3 Use data from National Work Programmes, e.g. opioid use, to develop a local programme.

How will we know it makes a difference?

We will work in true partnership with relevant Partners to agree on SMART goals i.e Specific, Measurable, Achievable, Realistic, Timely. A separate SMART Work Plan will be developed.

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3.4 Develop and implement a training programme to reflect assessment of staff and GP Practice learning needs regarding equity and quality
Possible topics are:
- introduction to quality improvement, institutionalised racism, implicit bias, unconscious bias
- cultural competence.

3.5 Hold Snakes and Ladders workshops. The aim of the workshops is professional development for healthcare teams, especially General Practice teams. It is an opportunity to have fun while exploring the experiences of patients, receptionists and practice managers involved in the patient journey to care.

3.6 Develop a contestable Scholarship and Innovation Fund for our Practice and Provider network with clear guidelines and rationale developed for making awards that seek to improve equity/health outcomes for Māori.

Useful Links

A Window On The Quality Of Aotearoa New Zealand's Healthcare 2019
System Level Measures Improvement Plan 2019-2020
He Korowai Oranga
Health and Disability System Review Report
WAI 2575 Health Services and Kaupapa Inquiry Report Hauora
New Zealand Health Strategy 2016
Te Toi Ahorangi Te Rautaki A Toi 2030

Healthy Built Environment Position Statement

SUBMITTED TO: Board Meeting 18 March 2020

Prepared by: Phil Shoemack, Medical Officer of Health (Toi Te Ora Public Health)

Endorsed by: Mike Agnew, Acting General Manager, Planning and Funding

Submitted by: Simon Everitt, Interim Chief Executive Officer

RECOMMENDED RESOLUTION:
That the Healthy Built Environments Position Statement is adopted.

ATTACHMENTS:
Position Statement – Healthy Built Environments (Final Draft).

INTRODUCTION:
This paper was initially submitted for the previous Board in November 2020. At the meeting it was agreed that the document be held over for the new Board to consider as part of determining what being a Te Tiriti based organisation means. The paper is now being resubmitted for the Board's endorsement.

BACKGROUND:
Healthy built environments are places that support equity, and where the wellbeing of people, land, water, air and living species are at the forefront of decisions.

Application of healthy built environment principles promotes community resilience, good nutrition, physical activity and quality of life. It also considers availability and access to quality and appropriate housing, employment, education, healthy food, health services, ngāhere (forest), rongoā (traditional medicines), greenspaces and other amenities. This contributes to the prevention of unintentional injury and mortality, and chronic conditions such as obesity, cancer and type 2 diabetes[2]. Furthermore, this also supports a positive impact on Papatūānuku (the environment) and the relationship to her and all living things upon her.

Due to the influence that the built environment impacts our health, especially at a time of such rapid population growth for the Bay of Plenty region, it is important we advocate for the application of healthy built environment principles across all stages of planning and development.

ANALYSIS:
The position statement reflects Bay of Plenty DHB's position as a Te Tiriti based organisation and was developed by Toi Te Ora Public Health with cultural input from Graham Cameron-Bidois, Pou Tikanga, Māori Health Gains and Development.

The position statement highlights the Bay of Plenty District Health Board commitment to advocating for the application of healthy built environment principles across all stages of planning and development to enhance community and environmental health and wellbeing.

DEFINITIONS USED:

Term	***Definition***
Position Statement	A position statement examines an issue facing the population and describes appropriate approaches and states the organisation's stance on the issue. A well-constructed position statement is an invaluable means of bringing focus and clarity to the development of an organisational response.

Bay or Plenty District Health Board is committed to improving and protecting the health of the communities in the Bay of Plenty district.

Position Statement – Healthy Built Environments

As a Te Tiriti based organisation, the Bay of Plenty District Health Board supports and advocates for the application of matauranga Māori (Māori wisdom) and evidence based healthy built environment principles throughout all stages of urban and rural planning and development. Healthy built environments are places that support equity, and where the wellbeing of people, land, water, air and living species are at the forefront of decisions.

The built environment is made up of the settings where people live, work, learn and play, and supports whakawhanaungatanga (connections) and manaakitanga (mutual respect). In both rural and urban communities, healthy built environments are places that are designed to support Toi Ora (flourishing health and wellbeing for all). Planning decisions such as zoning, transportation systems and community design significantly influence health and wellbeing. The balance of the Te Tiriti partners' unique world views incorporate concepts relating to Ngā Pou Mana o Io, He Pou Oranga Tāngata Whenua[1], Toi Ora, equity, universal design (accessible design for all), and employs mahi tahi (collaboration) and co-design to make decisions.

Application of healthy built environment principles promotes community resilience, good nutrition, physical activity and quality of life. It also considers availability and access to quality and appropriate housing, employment, education, healthy food, health services, ngāhere (forest), rongoā (traditional medicines), greenspaces and other amenities. This contributes to the prevention of unintentional injury and mortality, and chronic conditions such as obesity, cancer and type 2 diabetes[2]. Furthermore, this also supports a positive impact on Papatūānuku (the environment) and the relationship to her and all living things upon her.

The built environment encompasses a community of plants, animals, and humans that inhabit an environment. For tāngata whenua, this community is a series of relationships, of whanaungatanga, in which people are teina (the younger sibling) with a responsibility to protect and maintain the mana (power) of all of our tuakana (elder sibling) in that environment.

Many areas are physically dominated by built structures such as buildings and roads. However, the built environment also contains a rich patchwork of green spaces, including parks, reserves, backyards, street plantings, ecological corridors, streams, and rural land. These greenspaces provide the living heart of a healthy built environment and include culturally significant features such as marae, wāhi tapū (sacred sites), urupa, pā and papa kāinga (communal land), which are essential elements of Toi Ora for Māori communities.

Healthy built environments are more than the individual functional parts, and need to consider the kōtahitanga (unity) of different elements and connections between natural areas. Healthy built environments can either diminish or enhance the mana of all those within them. If planned and developed in a way that preserve the environment, enable healthy behaviours and access to where people live, learn, work and play, the communities and environment thrive and support Toi Ora.
Ko ahau te taiao, ko te taiao, ko ahau (the ecosystem defines our quality of life). A healthy

environment[3] is integral to tāngata whenua. It is a tāonga (treasure) under Article II of Te Tiriti o Waitangi, and needs to be protected as part of Treaty obligations. Iwi, hapū and whānau provide guidance to act as kaitiaki (guardians) to preserve the mauri (life force) of Papatūānuku. Any degradation of the natural environment, or our relationship with the environment, can weaken this connection and have consequences for Toi Ora.

A well-designed built environment system also supports the achievement of equity. Priority populations who are most affected and vulnerable need to be involved in mahi tahi at all levels of planning. This ensures the development is equity and Tiriti focused, which is conducive of Toi Ora and will minimise unintended consequences. In mahi tahi the voices of children, families, older persons and persons with disabilities should also be included. It is also important to hear from those who speak on behalf of those who cannot speak for themselves; plants, animals and the wider environment.

The Bay of Plenty District Health Board supports and advocates for:

- Application of matauranga Māori (Māori wisdom), He Pou Oranga Tangata Whenua, Ngā Pou Mana o Io, Toi Ora, Whakawhanaungatanga, Manaakitanga, equity and universal design to all stages of planning and development.
- Ensuring genuine collaboration, co-design and mahi tahi is utilised throughout planning and development stages particularly with priority populations and vulnerable communities.
- Consideration of the health of our people, land, water, air and living species at the forefront of planning and development.
- Application of evidenced based healthy built environment principles across all stages of planning and development, including[4]:
  - Biophilic design principles, such as protecting and enhancing natural elements across the landscape, preserving and enhancing environmentally sensitive areas, and maximising opportunities for everyone to access natural environments.
  - Healthy neighbourhood design by creating complete, compact neighbourhoods through mixed land use and efficient planning, and prioritising new developments within or beside existing communities.
  - Active transportation facilities, where street design prioritises active transportation networks which are safe and accessible by all ages and abilities, and provide connected, attractive routes that support multiple modalities.
  - Affordable and quality housing options, with diverse housing forms and tenure types, and located in sites that minimise exposure to environmental hazards.
  - Healthy food systems, by ensuring there is affordable and equitable access to healthy food options, protecting productive land and increasing the capacity of local food systems.

References

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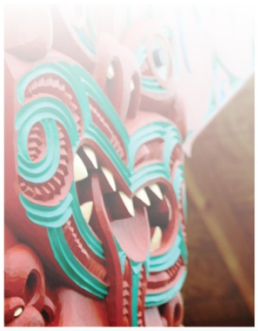
3. Ministry for the Environment (2015) Māori relationship with the environment. Retrieved from https://www.mfe.govt.nz/publications/environmental-reporting/environment-aotearoa-2015-our-new-reporting-approach/m%C4%81ori
4. BC Centre for Disease Control. (2018). Healthy Built Environment Linkages Toolkit: making the links between design, planning and health, Version 2.0. Vancouver, B.C. Provincial Health

Services Authority.

Related Position Statements
Active Transport
Disability Responsiveness
Food Security
Health Inequalities
Housing and Health
Sanitary Services
Waste Management and Minimisation

Adopted by: the Bay of Plenty District Health Board at its ___ meeting.
Review Date:


BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

FARM CHAIR COMMITTEE WORKSHOP ATTENDANCE

Submitted to: Board Meeting 18 March 2020

Prepared by: Maxine Griffiths, Board Secretariat

Endorsed and Submitted by: Simon Everitt, Interim Chief Executive

RECOMMENDED RESOLUTION:

That the Board approves of the FARM Chair's attendance at the Auditor General's Audit Workshop, 31 March 2020.

BACKGROUND:

The FARM Committee Chair has been invited to attend a Workshop, facilitated by the Auditor General, in Auckland, on 31 March 2020.

The only expense to be incurred for this forum would be travel (km) costs.

At its meeting on 4 March 2020, the FARM Committee approved a recommendation to go forward to the Board, that the FARM Committee Chair attends the Workshop.

WORKSHOP DETAILS

Working together to deliver improved value for New Zealanders.

As always each update will have a comprehensive programme of sessions including the key note session from the Auditor-General. This will be followed by sessions on procurement, a high level technical accounting update as well as an in-depth technical accounting workshop, performance reporting, an economic forecast from the Treasury and other sessions to be confirmed. We will continue running special interest options in the afternoon as the feedback from most delegates indicated they preferred this format.

Please note the programme is designed for governors, mayors and councillors, CEOs, CFOs, and senior managers. Due to venue and cost constraints this invitation is limited to senior delegates.

9am - 4pm Tuesday 31 March

Eden Park, South Stand, Level 4 Lounge, Reimers Avenue, Kingsland, Auckland

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Submission to Ministry of Health Consultation on options to reform the Burial and Cremation Act 1964 and Related Legislation

SUBMITTED TO: Bay of Plenty Board Meeting 18 March 2020

Prepared by: Phil Shoemack, Medical Officer of Health (Toi Te Ora Public Health)

Endorsed by: Mike Agnew, Acting General Manager, Planning and Funding & Population Health

Submitted by: Simon Everitt, Interim Chief Executive Officer

RECOMMENDED RESOLUTION:
Bay of Plenty District Health Board notes the attached submission to the Ministry of Health Consultation on options to reform the Burial and Cremation Act 1964 and Related Legislation.

ATTACHMENTS:
Feedback to Ministry of Health, Burial and Cremation Team

BACKGROUND
Bay of Plenty District Health Board through its public health unit Toi Te Ora Public Health, have prepared feedback to the above consultation on options for modernising the legislation to death, burial, cremation and funerals in New Zealand. This work follows the 2015 Law commission report *Death, Burial and Cremation: A new law for contemporary New Zealand*, which made recommendations to modernise the law that governs death, burial, cremation and funerals in New Zealand which Toi Te Ora Public Health made submissions to.

The attached submission responds to Ministry of Health request for feedback on the options developed on this relevant public health topic and public health regulatory requirements.

ANALYSIS:
Preparation of this submission to the consultation document is within the context of Bay of Plenty District Health Board's Health in All Policies approach to engage with government, on local authority issues.

TOI TE ORA
PUBLIC HEALTH
Bay of Plenty + Lakes Districts

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

LAKES DISTRICT HEALTH BOARD

Toi Te Ora Public Health
PO Box 2120
TAURANGA 3140

26 February 2020

Freshwater Submissions
Ministry for the Environment
PO Box 10362
WELLINGTON 6143

Submission to Death, Funerals, Burial and Cremation: a Review of the Burial and Cremation Act 1964 and Related Legislation - Consultation document 2019

Introduction

District Health Boards are required by the Public Health and Disability Act 2000 to improve, promote, and protect the health of people and communities, to promote the inclusion and participation in society and independence of people with disabilities and to reduce health disparities, by improving health outcomes for Māori and other population groups.

This submission has been prepared by Toi Te Ora Public Health (Toi Te Ora) which is the Public Health Unit for both Bay of Plenty District Health Board and Lakes District Health Board (the DHBs).

The key role of Toi Te Ora is to promote, protect and improve population health, prevent ill health and minimise the risk of disease and injury through population based interventions.

Public health approaches wellbeing and health in terms of the social, economic, cultural, environmental and political context and from a "determinants of health" perspective. Many of the factors that determine health are directly influenced by the decisions and activities of Government, which is why it is important New Zealand has fit for purpose legislation for death, burial, cremation and funerals.

Designated officers within Toi Te Ora have responsibilities to reduce conditions within the local community which are likely to cause disease. This is undertaken by assisting the Ministry of Health to select and design final policy proposals to Parliament for law reform that safeguard public health.

For these reasons the DHBs welcome the opportunity to inform changes to improve the quality, relevance and effectiveness of the laws that relate to death, burial, cremation and funerals.

Declaration of interest
The DHBs including designated officers within Toi Te Ora could not gain any financial or other interest in business that may be affected, positively or negatively as a result of the proposal contained within the consultation document.

This submission aims to provide objective and independent input to promote good health for current and future populations. By this the DHBs mean that suitable provision is provided for the disposal of the dead in a manner that is managed, respectful and protects health.

Submission
Medical Officers of Health and Health Protection Officers have had a long standing role in burial and cremation for example with exhumation, where the role is to make sure the disinterment is done in a dignified and respectful manner. Our role is not only about infection control but to ensure the psychological wellbeing of family and the public so as not to cause mental anguish or stress to the family and public.

The health risks posed by dead bodies from communicable diseases are likely to be negligible, especially if death has resulted from natural causes or trauma. When infectious disease has been the feature of the end of life, those risks are managed by other acts and regulations. However all humans may carry pathogens in their gastrointestinal tracts and therefore care needs to be taken that the burial site does not contaminate ground or surface waters. Likewise, care needs to be taken to prevent cremation polluting the air.

The disposal option can affect the psychological wellbeing of those who have lost a loved one and also the psychological wellbeing of the public and wider community.

Therefore the policy to implement the Government's decisions needs to consider the protection of public health by ensuring that:

- The disposal of the dead occurs in a managed, hygienic and dignified manner which as far as possible demonstrates respect for the wishes, as well as the cultural and spiritual beliefs, of the deceased and next of kin.
- Accurate records are kept, such as registers of death, records of burials and cremations, as well as appropriate controls to prevent the concealment of crimes.
- All matters relating to the disposal of the dead are carried out promptly.
- All planning of new facilities for the disposal of the dead are carefully scrutinised.
- Regular auditing of existing facilities and certification processes occur.

Introduction: Proposed overarching duties regarding the disposal of bodies
1. Do you agree that there should be a general duty on everybody to 'treat any dead human body or human remains with respect'?
Yes.

2. Do you agree that any breach of this duty should be an offence punishable by infringement notice, or, on conviction, by a fine?
Yes.

3. Do you agree that there should be a requirement that the person who has the duty to dispose of the body must do so without undue delay, including considering the mourning needs of the bereaved, any ceremonies to be performed, tikanga or other cultural practices, and any other relevant considerations (such as police investigations)?
Yes.

4. Do you agree that any breach of this duty should be an offence punishable by infringement notice, or, on conviction, by a fine?
Yes.

Section A: Death certification and auditing
5. What do you think are the key problems with the current system for certifying the cause of death and existing auditing systems?
That no agency has statutory oversight of the entire death certification system and that there is no national medical certificate cause of death audit system. A primary purpose of the Medical Certificate of Cause of Death (MCCD) is to inform the development of and resource allocation to public health policies and programmes in the health sector. Inaccurate population data undermines the effectiveness of public health policy and programme interventions and the primary function of the health sector to improve, promote and protect health.

6. Can you provide any evidence about the size or extent of the problems with the current cause of death certification and auditing systems?
The current situation involves running two systems; paper and electronic. This causes a lot of confusion. Funeral services not registered with the Department of Internal Affairs need to obtain electronic copies. DHB mortuary staff cannot access Medical Certificate of Cause of Death to sight prior to releasing a person unless the funeral service provider collecting the deceased person presents with the Medical Certificate of Cause of Death. Ideally, one system which provides registered funeral service providers and hospital staff that release deceased person's access is recommended.

7. What do you think about the options identified for modernising the death certification system? Do you want to suggest any additional options? If so, please provide the reasons for your alternative options.
No comment.

8. Do you agree with the presented impacts of the options identified for modernising the death certification system? Why/why not? Can you suggest other likely impacts from the three options?
No comment.

9. Can you provide any information to help the Ministry gauge the size of any potential impacts, costs or benefits that could affect you?
No comment.

10. What is your preferred option to modernise the death certification system? Please provide the reasons for your view.
Option 2: Implementing a package of changes to the current system based on most of the Law Commission's recommendations

The DHBs note that there is no evidence of misidentification for deaths certified by certifying practitioners and that existing administrative processes provide checks to reduce misidentification.

11. What do you think about the options identified regarding the auditing of death certification? Do you want to suggest any additional options? If so, please provide the reasons for your alternative options.
The options address the Law Commission recommendations. Option 2 is considered a reasonable approach when weighing up the need to audit death certification. Rather than the Ministry of

Health providing oversight and guidance to death certification auditing committees, it is suggested mechanisms be available to the Ministry of Health to require auditing committees to implement improvements and address errors when identified.

12. Do you agree with the impacts of the options regarding the auditing of death certification? Why/why not? Can you suggest other likely impacts from the three options?
Yes. While auditing death certification is necessary, option 3 is overly prescriptive for the additional accuracy likely to result. Requiring the review before the body was disposed of increases the potential risk to public health which otherwise wouldn't exist.

13. Can you provide any information to help the Ministry gauge the size of any potential impacts, costs or benefits that would affect you?
No comment.

14. What is your preferred option for auditing death documentation? Please provide the reasons for your view.
Option 2: Establishing a death certification auditing committee system.

The DHBs agree that option 2 presents lower administrative and compliance costs for both the Ministry and DHBs, however accurate information is needed because death documentation informs the development and resourcing of public health policy and programmes which are intended to prevent death and improve life.

The DHBs preference is option 2 with the addition of specific stator powers to the Ministry of Health to review where there is doubt over the validity of cause of death described in option 3.

Section B: Regulation of the funeral services sector
There is a need to improve cultural awareness of funeral services the needs and aspirations of tāngata whenua. This is particularly acute in the Bay of Plenty as coronial services are provided through funeral services rather than the hospital campus. This has seen conflict as funeral services have attempted to control access of Māori whānau to their tūpāpaku and at times even exclude them. To incorporate knowledge of tikanga and kawa, to build strong relationships with iwi and Māori communities and to have Māori leadership within funeral services will improve the quality and appropriateness of services for Māori. This will promote equitable health outcomes and reduce the likelihood of cultural offence by enabling Māori customary practices to be performed. Two minimum expectations should be that at all times services support and encourage whānau to accompany tūpāpaku at all stages from death, through preparation and to their return of their loved one to them, and that there is support of and access to traditional Māori practices of body preparation.

15. Do you agree that there are issues that could be improved with the funeral services sector? Are you aware of any other problems?
Yes.

16. Can you provide any evidence about the size or extent of the problems in the funeral service sector?
The DHBs consider the issues with the current system in the consultation document do not adequately recognise impact to public health from poor quality services. Poor services which do not treat human remains with respect or dispose of bodies in an appropriate and timely manner will harm health.

Currently there is a lack of qualification and minimum competency requirements for funeral service providers who essentially arrange for the disposal of the body of the deceased person. In doing so the funeral service sector provides services to protect public health and avoidance of offence.

17. What do you think about the options identified for regulating the funeral services sector? Do you want to suggest any additional options?
The DHBs note that only option 4 provides for the funeral service sector to demonstrate that they understand the laws and regulations which apply to handling human remains.

It is recommended that people providing funeral services to the public, commercially or not, must identify and have access to suitable premises and transportation methods for registration before being allowed to operate. Option 4 needs to include an on-the-ground premise and transport suitability assessment. Local authority environmental health officers and/or public health officers have the skillset to make this assessment.

The DHBs do not support the option for funeral directors practicing continuously for the previous three years to be deemed to have achieved the training requirements. All persons handling human remains must be competent to obtain registration and provide Medical Officer of Health and Health Protection Officers reassurance that public health will be protected.

18. Do you agree with the impacts of the options identified for regulating the funeral services sector? Why/why not? Can you suggest other likely impacts from the four options?
Yes.

19. Can you provide any information to help the Ministry gauge the size of any potential impact, cost or benefit that would affect you?
Most people are likely to be ill equipped to prepare and store the deceased before disposal. As such, the main role of funeral service providers is to arrange for the disposal of the body of the deceased person and in doing so ensure protection of public health and avoidance of offence. Due to the sensitive nature of death and post death practices, poor quality services are likely to be unacceptable and distressing to most people, which is why the funeral services sector needs to operate to minimum acceptable standards and professionalism to protect public health.

20. What is your preferred option for regulating (or not) the funeral services sector? Please provide the reasons for your view.
Option 4: Providing central regulation for funeral directors.

The DHBs acknowledge that the funeral service sector appears to be respectful of the deceased; however the DHBs' preferred option is to regulate the funeral service sector to ensure anyone undertaking funeral services and other post death practices is registered. What may be considered suitable, inoffensive and respectful to one person may not be to another person, particularly children. Locally, the location of a funeral service and disposal of deceased ashes are examples when cultural preferences differ.

The discussion document mentions, *''botched' funeral issues can be potentially traumatising'.* Unless any post death practice is undertaken in a manner that is respectful of the deceased and mindful of the public, disturbing and distressing situations are likely to arise that will impact the psychological wellbeing of family, friends of the deceased and the wider community.

The DHBs would like to see mechanisms to investigate and address issues that may pose a risk to public health to prevent future issues.

The DHBs have no preference whether registration is locally or centrally managed.

21. What do you think about the options identified for better informing consumers about the cost of funeral services? Do you want to suggest any additional options?
The DHBs have no comment on the three options; however the cost of funeral services needs to be affordable to be inclusive and available to everyone. Particularly when funeral services arrange for the disposal of the body of a deceased person and in doing so ensure the protection of public health and the avoidance of offence.

22. Do you agree with the presented impacts of the options regarding better informing consumers about the cost of funeral services? Why/why not? Can you suggest other likely impacts from the three options?
No comment.

23. Can you provide any information to help the Ministry gauge the size of any potential impact, cost or benefit that would affect you? Comments
No comment.

24. What is your preferred option for ensuring that consumers are fully informed of the component prices of funeral services? Please provide the reasons for your view.
No comment.

Section C: Burial and cemetery management
25. Do you agree that there are issues that could be improved with the current framework for burials and cemetery management? Are you aware of any other problems?
Yes. The discussion document in C1.3 explains that establishing a new cemetery, burial ground or place of burial requires resource consent. To the knowledge of the DHBs, resource consent is not always required by local authority plans and the Minister of Health may be the only avenue of regulatory oversight to the burial of human remains including taking into consideration any environmental and public health impact.

The DHBs note that Urupa (Maori Burial grounds) are regulated by the Te Ture Whenua Act 1993 and are out of scope of this Act review. The DHBs also note the issue with the current framework for burial and the inconsistent management between the different types. The DHBs share the confusion discussed in the consultation document and have had similar experiences. For example, it can be difficult to determine which Act, the Te Ture Whenua Act or the Burial and Cremation Act, a site is administered under. To the understanding of the DHBs the Maori Land Court does not hold a database of specific urupa which causes uncertainty about where and who manages urupa in the Bay of Plenty and Lakes districts. For the protection of public health it is important to know where human remains are buried so the potential risks can be identified and appropriately managed. For instance, so unlawful burial or disinterment can be identified and to allow for the assessment of health and environment impacts from land use activities.

Currently The Burial and Cremation Act require every local authority to establish and maintain a suitable cemetery only where sufficient provision is not otherwise made for burials within its district, however cemeteries and crematoria are sanitary works under the Health Act 1956 which local authorities are required to provide. Local authorities are also not required to consult with their communities over the development and management of new and existing cemeteries or seek input and direction from the Medical Officer of Health. This lack of consistency, clarity and detail means individual community's demographic, cultural and spiritual needs have not been accessible and

affordable to everyone. It also means that other provisions which will be suitable to the community's current and future needs (eg crematoria and alternative burial methods), may not be identified and therefore not meet the needs for the psychological wellbeing of the population now and into the future.

26. Can you provide any evidence about the size or extent of such problems outlined about the current framework for burials and cemetery management?
The DHBs often receive enquiries from the public about private burial grounds and places, and denominational burial grounds. This reflects a lack of recourse towards meeting the community's cultural and spiritual needs and a lack of adequate provision for people dying within the Bay of Plenty and Lakes health district, although this is a requirement of local authorities.[1] As the population ages, if suitable provision isn't made a number of burial sites throughout the district is likely to result if uncontrolled, which could have land use management issues for local authorities in the future.

Although New Zealand Standards exist for cemetery and crematoria, these are not mandatory and there is no regulatory authority to oversee compliance and require operator accountability before an issue arises, which is not protective of health. Although the Health Act requires local authorities to inspect their district this is not routinely carried out in a proactive manner.

27. What do you think about the options identified regarding a new framework for burial and cemetery management? Do you want to suggest any additional options?
The types of burial land included in the proposed cemetery management framework are supported. The provision of appropriate services needs to remain accessible and affordable to everyone. Requiring local authorities to provide facilities for the disposal of bodies will ensure the number, location and proximity of burial land will be coordinated at a district level, ensuring there is sufficient provision.

Cemeteries are core public services necessary for community wellbeing. The DHBs support the proposal to retain local authority current responsibilities to provide suitable cemeteries. The DHBs recommend that guidelines, be developed to clarify what is considered 'suitable'. From the DHBs' perspectives, suitable means sufficient provision which is affordable and acceptable to the community and meets the needs of the psychological wellbeing of the local authority community now and into the future.

The DHBs recommend that local authorities be required to assess burial and cremation service provision in their district to ensure suitable sanitary services are planned and provided in advance. The DHBs recommend that the Medical Officer of Health has the legal ability to provide advice on the adequacy of these services prior to policy approval.

The DHBs support the approval of burial on private land in accordance to the Resource Management Act process; however the DHBs recommend that local authorities must retain discretion to decline an application for burial on private land. Lawful burial within a reasonable time is necessary for the protection of public health. However, as mentioned in the discussion document, the current system lacks recognition of New Zealand's diverse needs in relation to burial. Burial on family land is an example of this, particularly for Māori for whom the whenua, the land is a familial relationship, and burial an affirmation of that relationship. Obtaining approval to bury on family land is an involved process which can take a substantial time meaning the deceased or next of kin wishes may not be met. The DHBs recommends that the process to obtain consent, particularly when death is unexpected, can occur without delay to enable burial within a reasonable period of time.

[1] Health Act 1956, Section 25.

The DHBs also recommend that the Resource Management Act process requires consultation with the Medical Officer of Health to ensure the health and psychological wellbeing of the public is taken into consideration, in addition to the benefits to a person and their family's wellbeing, in allowing burial on private land.

The DHBs recommend that consent for discharge and land use be captured as both have the potential to impact on the short and long term health of the community. The DHBs also recommend that public consultation needs to be for all post death services including cemeteries, mortuaries and crematoria irrespective of where they are located.

The DHBs support the prohibition to bury a body in places that are not approved cemeteries and recognise that there may be occasions when it is impractical to transport a body. Although burying the body with respect is necessary, so too is ensuring the body and burial is managed in a hygienic manner. Burial outside an approved cemetery should be extremely rare and when it does happen, there needs to be a site risk assessment, accurate records as well as ongoing management controls for the protection of public health.

28. Do you agree with the impacts of the options identified regarding a new framework for burial and cemetery management? Why/why not? Can you suggest other likely impacts from the three options?
Yes. The DHBs are supportive of local authority and cemetery managers approving disinterment provided a regulatory authority with an audit function oversees disinterment applications and procedures. This will provide the DHBs confidence that potential public health issues are investigated and appropriate processes are followed that respectfully manages and protects health.

29. Can you provide any information to help the Ministry gauge the size of any potential impact, cost or benefit that would affect you?
No comment.

30. What is your preferred option for a new framework for burial and cemetery management? Please provide the reasons for your view.
Option 3: Implementing a package of changes to the current system based on most of the Law Commission's recommendations.

Option 3 will ensure decisions are protective of public health by remaining appropriate and up to date with general trends in society and future population views about post death activities.

The DHBs agree that the Environment Court is not the appropriate authority for burial and cemetery management issues including disinterment. The location of any place where a body is buried needs to be managed in perpetuity and should be agreed by the community which is why the DHBs support the exclusion of independent cemeteries. Independent cemeteries may not be located in areas that are in the interests of the community, may not be affordable to everyone and are likely to pose an increased risk to public health if they are not maintained and operated properly.

Section D: Cremation regulations and the medical referee system
31. Do you agree that there are issues that could be improved with the current cremation or medical referee systems? Are you aware of any other problems?
Yes. The current cremation forms for processing requests for cremation do not appear to include radioactive material questions of the medical practitioner or nurse. There are certain isotopes and timeframes required for radioactive material to become harmless. It is suggested that the forms for cremation authorities requesting information about whether the deceased has been treated with

radioactive material, how long ago that treatment was and what isotope was used. This will ensure the clinician takes into account radioactive material, for instance when treating prostate cancer.

32. Can you provide any evidence about the size or extent of such problems outlined with the cremation or the medical referee systems?
No comment.

33. What do you think about the options identified regarding the reform of cremation and crematorium management? Do you want to suggest any additional options?
The DHBs support option 2 to move establishment and operation of crematoria into the Resource Management Act process. The DHBs note the local authority must consider the risks posed to public health and to the environment. Bearing in mind that public health approaches wellbeing and health from a 'determinants of health' perspective, consideration by local authorities must be for all the determinants of public health not only the risks to public health and environmental effects.

Dealing with unclaimed ashes or custody issues appear to be addressed, however the DHBs recommend regulatory controls about what can be done with the ashes. Although the physical public health risk from handling ashes is negligible, scattering ashes in public places needs to be managed to prevent contamination of the environment and also protect the aesthetic values of other people.

34. Do you agree with the impacts of the options identified regarding the reform of cremation and crematorium management? Why/why not? Can you suggest other likely impacts from the two options?
Yes. The DHBs wish to highlight that while the discussion document mentions that there is limited public health interest in the construction, design, or operation of a crematoria, public concern and risk perception should not be underestimated.

The reform of cremation management should ensure, as far as practicable, that cremation activities are aesthetically acceptable to all cultures and spiritual beliefs in the community. For this reason, the DHBs recommend approval for establishing new crematoria to require resource consent (both land use and air discharge), and for the application to be publicly notified. Public consultation needs to be for all crematoria irrespective of where they are proposed to be located, including rural areas. The DHBs also recommend that the Medical Officer of Health be considered an interested party to the establishment and use of new crematoria and be required to be consulted.

35. Can you provide any information to help the Ministry gauge the size of any potential impact, cost or benefit that would affect you?
No comment.

36. What is your preferred option to modernise the regulations for cremation in New Zealand? Please provide the reasons for your view.
Option 2: Adopting all the Law Commission's recommendations relating to cremation and dealing with ashes.

This view is for the same reasons mentioned in the consultation document.

37. What do you think about the options identified regarding the reform of the medical referee system? Do you want to suggest any additional options?
No comment.

38. Do you agree with the impacts of the options regarding medical referee system? Why/why not? Can you suggest other likely impacts from the four options?
Yes. No comment.

39. Can you provide any information to help the Ministry gauge the size of any potential impact, cost or benefit that would affect you?
No comment.

40. What is your preferred option for changes to the medical referee system? Please provide the reasons for your view.
Option 3: Reforming the medical referee system.

The DHBs agree that the medical referee system duplicates both the death certification and coronial systems; however controls to prevent the concealment of crimes are essential. The DHBs also recommend that a process to identify and remove potentially harmful items such as pace makers and radioactive material continues to ensure cremation adequately mitigates these risks to health.

Section E: New methods of body disposal
41. Are you aware of any particular new methods of body disposal that could be made available in New Zealand?
No.

42. Do you agree with the issues outlined regarding new methods of body disposal? Are you aware of any other problems?
Yes. The DHBs agree with the issues and are not aware of any other problems.

43. Can you provide any evidence about the size or extent of the problems regarding new methods of body disposal?
No comment.

44. What do you think about the options identified for regulating new methods of body disposal? Do you want to suggest any additional options?
No comment.

46. Do you agree with the impacts of the options identified for regulating new methods of body disposal? Why/why not? Can you suggest other likely impacts from the two options?
Yes. Regulating different methods of body disposal will better protect public health from inappropriate disposal practice and allow the opportunity for new methods to be carefully scrutinized prior to their use. This will better protect the dignity of the deceased.

47. Can you provide any information to help the Ministry gauge the size of any potential impact, cost, or benefit that would affect you?
No comment.

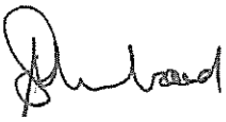
48. What is your preferred option to regulate new methods of body disposal? Please provide the reasons for your view.
Option 2: Regulating new methods of body disposal.

Body disposal must occur in a hygienic and dignified manner which as far as possible demonstrates respect for the wishes, as well as the cultural and spiritual beliefs, of the deceased and next of kin.

The DHBs wish to thank the Ministry for the opportunity to submit and share the public health perspective to death, funerals, burial and cremation.

Sir Michael Cullen
Board Chair
Bay of Plenty District Health Board

Simon Everitt
Chief Executive
Bay of Plenty District Health Board



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BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Submission to Ministry of Health Submission to Taumata Arowai – the Water Services Regulator Bill

SUBMITTED TO: Board Meeting 18 March 2020

Prepared by: Phil Shoemack, Medical Officer of Health (Toi Te Ora Public Health)

Endorsed by: Mike Agnew, Acting General Manager, Planning and Funding & Population Health

Submitted by: Simon Everitt, Interim Chief Executive Officer

RECOMMENDED RESOLUTION:
Bay of Plenty District Health Board notes the attached submission to Ministry of Health, Taumata Arowai regarding the Water Services Regulator Bill

ATTACHMENTS:
Feedback to Ministry of Health, Taumata Arowai – the Water Services Bill Review.

BACKGROUND
The Bay Of Plenty and Lakes District Health Board through its public health unit Toi Te Ora Public Health, have prepared a submission to the Health Select Committee in response to their proposed Taumata Arowai—the Water Services Regulator Bill. The attached submission responds to relevant health related topics and public health regulatory requirements within the proposed legislation.

ANALYSIS:
Preparation of this submission to the consultation document is within the context of Bay of Plenty District Health Board's Health in All Policies approach to engage with government, on local authority issues.

TOI TE ORA
PUBLIC HEALTH
Bay of Plenty + Lakes Districts

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

LAKES DISTRICT HEALTH BOARD

Toi Te Ora Public Health
PO Box 2120
TAURANGA 3140

17 February 2020

Committee Secretariat
Health Committee
Parliament Buildings
WELLINGTON

Submission to Taumata Arowai — the Water Services Regulator Bill

Introduction

District Health Boards (DHBs) are required by the Public Health and Disability Act 2000 to improve, promote, and protect the health of people and communities, to promote the inclusion and participation in society and independence of people with disabilities and to reduce health disparities by improving health outcomes for Māori and other population groups.

This submission has been prepared by Toi Te Ora Public Health (Toi Te Ora) which is the Public Health Unit for both Bay of Plenty District Health Board and Lakes District Health Board (the DHBs).

The key role of Toi Te Ora is to promote, protect and improve population health, prevent ill health and minimise the risk of disease and injury through population based interventions.

Public health approaches wellbeing and health in terms of the social, economic, cultural, environmental and political context and from a "determinants of health" perspective. Many of the factors that determine health are directly influenced by the decisions and activities of Government, which is why it is important New Zealand has fit for purpose legislation for a new regulatory body to oversee, administer, and enforce the drinking water regulatory system.

Designated officers within Toi Te Ora have responsibilities to reduce conditions within the local community which are likely to cause disease. One way in which this is done is by assisting the Ministry of Health to select and design final policy proposals to Parliament for law reform that safeguard public health.

For these reasons the DHBs welcome the opportunity to inform changes to improve the quality, relevance and effectiveness of the laws that relate to the drinking water regulatory system.

Declaration of interest
This submission aims to provide objective and independent input to promote good health for current and future populations.

Drinking Water Assessors and Technical Advisors currently employed by Toi Te Ora could seek employment with Taumata Arowai.

Submission
The DHBs support the intent of this Bill to implement the Government's decision to create a new regulatory body to oversee, administer, and enforce the drinking water regulatory system. The Bill would establish Taumata Arowai – the Water Services Regulator (Taumata Arowai) as a new Crown agent and provide for its objectives, functions, and operating principles. It would also provide for its governance arrangements, including the establishment of a Board and Māori Advisory Group.

The following comments and recommendations on the Taumata Arowai — the Water Services Regulator Bill are made on behalf of the DHBs:

The DHBs support the Taumata Arowai objective to protect and promote drinking water safety and public health outcomes. The DHBs would strongly advocate for this objective to be carried into the functions of Taumata Arowai.

Public health has been defined as the 'science and art of preventing disease, prolonging life and promoting health through the organised efforts of society' (Acheson 1988). A public health approach is about promoting wellbeing and preventing ill health. To achieve optimal outcomes for our communities, it is essential that health remains the priority for the new regulator.

DHBs are responsible for population health within their districts and are also focused on reducing health inequities. Equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically (WHO, 2014). Equity means fairness including meaningful participation of, and benefits for, all groups.

The DHBs would also advocate for an additional function of Taumata Arowai. Whilst performing any of Taumata Arowai objectives and functions, that Taumata Arowai - the Water Services Regulator facilitates, promotes, or supports the equality of outcomes for communities. Achieving equal results generally entails reducing or eliminating inequalities or inequities.

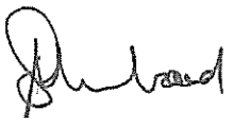
Equity seeks to ensure that everyone receives safe drinking water, recognising existing differences in community. Treating everyone the same (equality) does not mean that safe water will be provided to all, since not all start from the same place and their needs and

interests are different. If the diverse needs, roles and contexts of all different users of a water supply system are considered through the drinking water regulatory system, opportunities to address inequities will be identified, and unintended negative impacts or inadvertent discrimination can be avoided.

Priority also needs to be given to achieving equity for our populations, and working in partnership with iwi as per Te Tiriti o Waitangi obligations.

The DHBs wish to thank the Ministry for the opportunity to submit.

The DHBs do not wish to be heard on this submission.



Sir Michael Cullen
Chairperson
Bay of Plenty District Health Board

Nick Saville-Wood
Chief Executive
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BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

BOARD WORK PLAN 2020

Activity	Source	15 Jan	19 Feb	18 Mar	15 Apr	20 May	17 Jun	15 July	19 Aug	16 Sept	21 Oct	18 Nov	Dec
Venue – Tawa Room, Tga		√		√		√		√		√		√	No 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											√		