BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Board Meeting
Agenda

Wednesday, 18 November 2020
10.00 am

Please note Board Only Time 9.00 am

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

CARE Manaakitanga

Hauora a Toi | Our Priorities 2021-2022

Healthy, thriving communities – Kia Momoho Te Hāpori Oranga

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

Enablers

- Flourish at Work
- Population health plan
- Campus Plan
- Digital Transformation
- Environmental Sustainability
- Nursing & Midwifery
- Health Intelligence
- Clinical Governance
- Health & Safety
- Planned Care

Drivers

- Te Toi Ahorangi
- Strategic Health Services Plan
- Minister's Expectations
- Annual Plan
- Regional Equity Plan
- Financial Sustainability

A connected system

Moving care into the community

Partnering in localities

Health in all policies

Organising for the future

Transformations

Integrated healthcare

Mental health & addictions

Child wellbeing

Connecting with our communities

Equitable healthcare

Identifying unfair and unjust disparities

Systematic addressing of inequities

Enacting Te Toi Ahorangi in the design and delivery of care

Transformations

Growing as Te Tiriti partners

Evolving the Eastern Bay health network

Delivering improvement against equity KPIs

Healthy, thriving workforce

Enhancing physical and psychological safety

Addressing injustice and discrimination

Evolving the new world of work

Transformations

Leadership development

Restorative resolution

Union partnerships

Role clarity

Reducing bureaucracy

Sharing information

Growing a sustainable Māori workforce

Safer and compassionate care

Robust clinical governance and continuous improvement

Recognising the uniqueness of each individual

The Quality Safety Markers

Falls

Healthcare associated infections

Hand hygiene

Surgical site infection

Safe surgery

Medication safety

Consumer engagement

Transformations

Culturally safe quality management

Intelligent quality monitoring & improvement

Choosing wisely

Person & whānau-centred systems

Item No.	Item	Page
1	**Karakia** Tēnei te ara ki Ranginui Tēnei te ara ki Papatūānuku Tēnei te ara ki Ranginui rāua ko Papatūānuku, Nā rāua ngā tapuae o Tānemahuta ki raro Haere te awatea ka huri atu ki te pō (te pō ko tenei te awatea) Whano whano! Haere mai te toki! Haumi ē, hui ē, tāiki ē! This is the path to Ranginui This is the path to Papatūānuku This is the path to the union of Ranginui and Papatūānuku From them both progress the footsteps of Tānemahuta [humanity] below Moving from birth and in time carries us to death (and from death is this, birth) Go forth, go forth! Forge a path with the sacred axe! We are bound together!	
2	**Presentation** 2.1 Professor Peter Gilling, Head of BOPDHB Clinical School – 11.30 am	**5**
3	**Apologies**	
4	**Interests Register**	**11**
5	**Minutes** 5.1 Board Meeting – 21.10.20 Matters Arising 5.2 BOPHAC Meeting - 4.11.20	 **15** **23**
6	**Items for Decision** 6.1 Smart Growth Nominations 6.2 Child Health Services 6.3 Position Statement – Joint Ventures / Fund Raising	 **29** **31** **35**

Item No.	Item	Page
7	**Items for Discussion**	
	7.1 Chief Executive's Report	**37**
	7.2 Dashboard Report	**65**
	7.3 CCDM	**75**
8	**Items for Noting**	
	8.1 Correspondence for Noting • Letter from Minister Hipkins to Midland Regional DHBs re Te Manawa Taki Regional Equity Plan 2020/2021, 16 October 2020	**85**
	8.2 Media Releases • Tauranga Hospital Prostate Cancer World First • International Trauma Course • Bay Organisations COVID response – past, present, future	**88**
	8.2 Board Work Plan 2020	**97**
9	**General Business**	
10	**Resolution to Exclude the Public** Pursuant to clause 33(3) of the NZ Public Health & Disability Act 2000 the Chair of the Maori Health Runanga is permitted to remain after the public have been excluded because of their 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 the Runanga Chair 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 27 January 2021.	

Bay of Plenty
CLINICAL CAMPUS

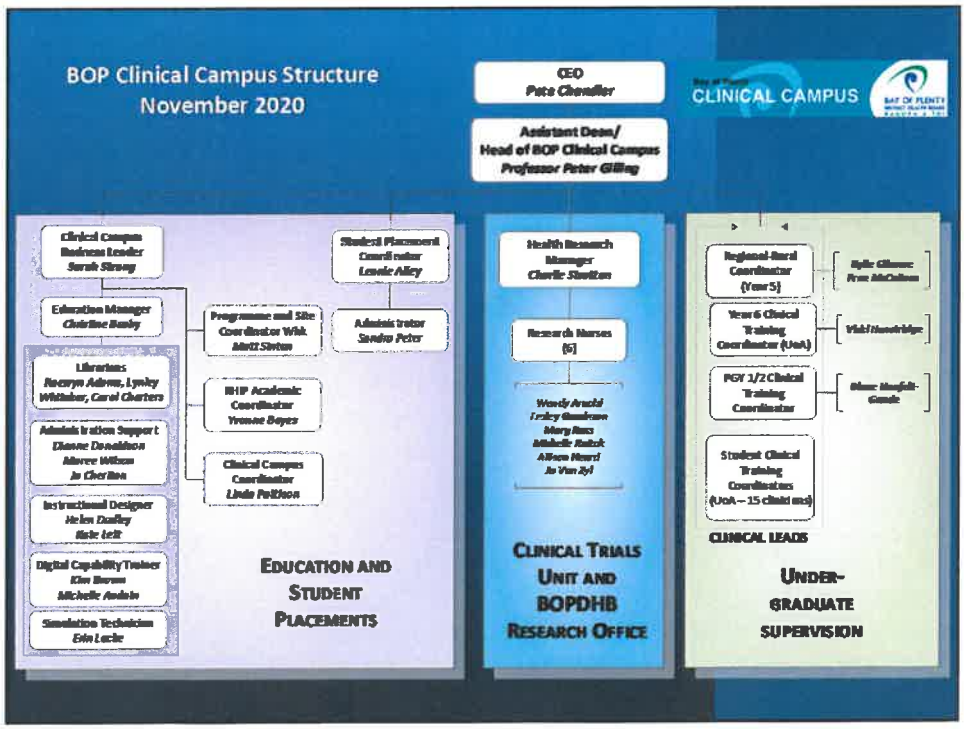
BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

Presentation to BOPDHB Board

18 November 2020

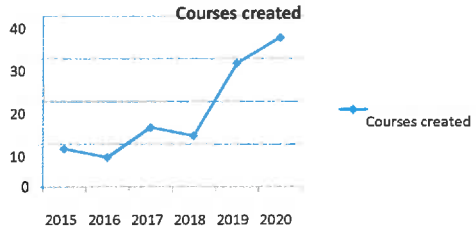
Professor Peter Gilling
Head of BOP Clinical Campus
Deputy Dean, University of Auckland

Content:
- Structure BOP Clinical Campus
- Online learning and education
- Students
- Clinical Trials Unit and Research Office



Online Learning

- Online learning platform Te Whāriki ā Toi available to all health workers in Bay of Plenty.
- Work closely with online learning teams from other DHBs to share content and collaborate.
- 254% increase in courses completed between 2015 and 2019



Bay of Plenty Clinical Campus

Education Centre

2019 - **30,516** attendances at training including clinical education, Treaty of Waitangi; digital capability, communication and leadership, and online learning (24% increase from 2018).

Over 2,000 different events offered both face to face, and online in 2019 – 11% increase from 2018.

Opening up education opportunities to **whole of system**, including library services, facilities, face to face training and opening up the free qualifications we offer.

Manage study funding, awards, simulation, library and leadership programmes.

Work closely with Maori Health Gains and Development around suite of education on equity, unconscious bias, cultural intelligence and Te Tiriti o Waitangi.

Over 50 people have completed Level 2 Certificate in Computing Fundamentals through EIT, with 30 currently studying and 34 about to start. This is a fully subsidised course to enhance digital capability.

Bay of Plenty Clinical Campus

Student Placements

MEDICAL AND HEALTH SCIENCES

2020 is the sixth year of University of Auckland (UoA) **Year 4** students and has consistently been a cohort of 24 students for the academic year.

UoA **Year 5** cohorts began in 2017, we have up to 18 students across Tauranga and Whakatane, 18 students projected in 2021.

The first UoA **Year 6** cohort in 2012 started with 10 students and has projected to grow to 29 students in 2021.

In 2020, **10 of the 12 Year 6 BoP cohort students** that applied for a PGY1 position were accepted.

Bay of Plenty Clinical Campus

Learning Together

- **Aged Residential Care project –** looking at the opportunities for providing more and better education for the Aged Residential Care sector. This is a project in conjunction with Planning & Funding, and WBOP PHO
- **Life support –** investigating options around providing access to Basic Life Support and Advanced Life Support classes for Primary care, who currently pay individual private providers
- **Leadership programmes –** 50% subsidy provided for primary and community care partners to participate in BOPDHB leadership programmes
- **Online Learning –** RN Community Prescribing course provided, through partnership with WBOP PHO. Access to any courses deemed appropriate is available to the wider community. Working on a Fundamentals of Diabetes course
- **Royal College of General Practitioners –** Investigating option to have a Bay of Plenty wide accreditation for CME. Currently WBOP PHO are the only provider accredited.

Bay of Plenty Clinical Campus

Allied & Other Students

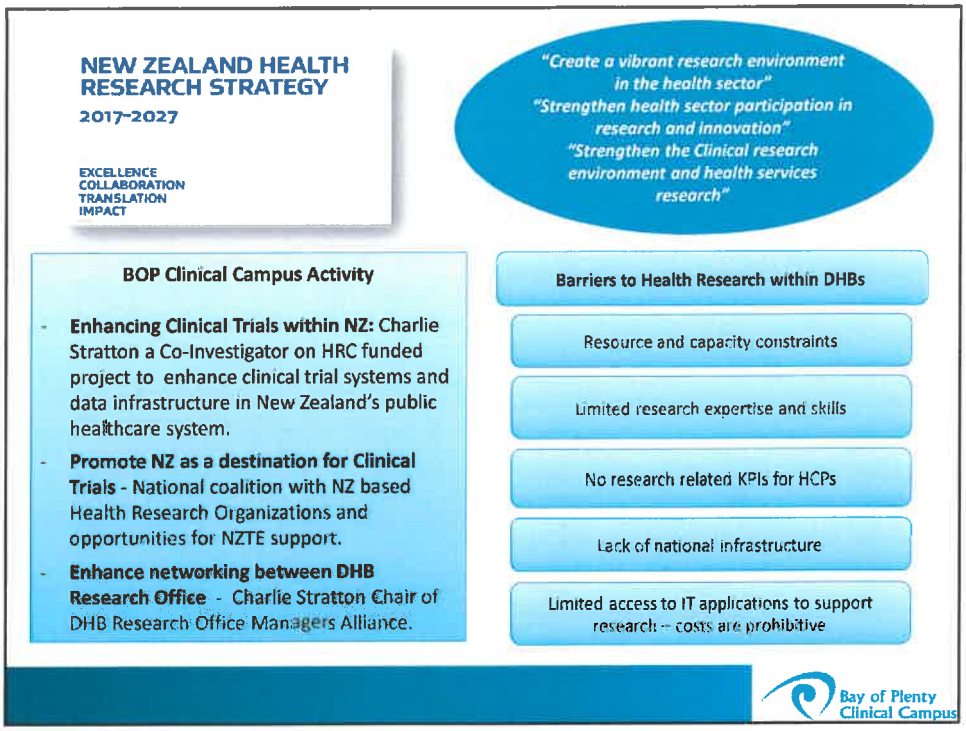
- Orientation for 60 to 70 Allied students each year, including Physiotherapy, Occupational Therapy, Audiology and Dietetics to name a few.
- Midwifery students also come under the umbrella of the Clinical Campus.
- Overseas medical students from Australia, the UK and Ireland are welcomed (where we can fit them in) for 4 to 8 week placements, although this is on hold with our borders currently closed.
- In addition, NZ students from Otago and Auckland are also placed in BOP for electives (8 weeks) and selectives (6 weeks).

Bay of Plenty Clinical Campus

RHIP – Rural Health Inter-professional Programme

- Commenced in 2012 with a small pilot involving 3 disciplines and 7 students, now over **400 students** have completed the programme
- Now includes students from **optometry, nutrition and dietetics, medicine, pharmacy, social work, physiotherapy, occupational therapy, podiatry, paramedicine, nursing, midwifery, speech language therapy and oral health therapy**
- Improves the recruitment and retention of health professionals in rural areas. Funded by HWNZ via UoA. **2 sites in NZ**, the other in Gisborne via UoOtago
- **6 cohorts per year, for 5 weeks each**, commencing with a noho marae and finishing with presentations to improve Māori Health based on local demographics and environment
- Students live, study and work together in Whakatāne. RHIP runs concurrently with, and forms part of, the student's clinical placement in the **Eastern Bay**

Bay of Plenty Clinical Campus


NEW ZEALAND HEALTH RESEARCH STRATEGY
2017-2027
EXCELLENCE
COLLABORATION
TRANSLATION
IMPACT
"Create a vibrant research environment in the health sector"
"Strengthen health sector participation in research and innovation"
"Strengthen the Clinical research environment and health services research"
BOP Clinical Campus Activity
- Enhancing Clinical Trials within NZ: Charlie Stratton a Co-Investigator on HRC funded project to enhance clinical trial systems and data infrastructure in New Zealand's public healthcare system.
- Promote NZ as a destination for Clinical Trials - National coalition with NZ based Health Research Organizations and opportunities for NZTE support.
- Enhance networking between DHB Research Office - Charlie Stratton Chair of DHB Research Office Managers Alliance.
Barriers to Health Research within DHBs
Resource and capacity constraints
Limited research expertise and skills
No research related KPIs for HCPs
Lack of national infrastructure
Limited access to IT applications to support research – costs are prohibitive
Bay of Plenty Clinical Campus


Investigator-led Research
Health Sector Research Collaboration Grant
BOPDHB selected as a Pilot partner with the Health Research Council (HRC) – one of only four DHBs selected.
Activities target service delivery and integrated health care models that meet the needs of our Māori Communities.
Led by Allied Health (Sarah Mitchell) in collaboration with RMHS (Marama Tauranga) and the BOP Clinical Campus (Charlie Stratton).
$280K of HRC funding for an Activation Grant and two Research Career Development Awards:
➢ Research Activation Grant:
He Pou Oranga: Developing a Framework for Integrating Technology and Health Research
➢ Career Development Awards:
Exploring the use of technology (LifeCurve App) to promote wellbeing among Māori
Developing skills and expertise in Kaupapa Māori research methodology
Bay of Plenty Clinical Campus

Collaborative Research

BOPDHB staff are involved in multiple collaborative research initiatives across many services:

- ✓ Women Child and Family – On track Network
- ✓ Medical – Infectious Disease, Oncology, ICU / CCU
- ✓ Allied Health
- ✓ National and International Registries

The Research Office supports our local Investigators with:

- Contracting and MOUs
- Locality approval
- Ethics submissions

Bay of Plenty Clinical Campus

Clinical Trials @ BOPCTU

DHBs access trials at no cost to public services and can generate revenue for the promotion of locally developed health research initiatives.

Promotes innovation within the DHB and contribute to the development of modern medicines.

Provide alternative treatment options where standard treatments are not working or where there is no treatment alternative available.

Access to innovative medicines that may not be currently available or are not funded by Pharmac.

Attract and retain high achieving staff and enhance capacity and capability.

Bay of Plenty Clinical Campus

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

Bay of Plenty District Health Board
Board Members Interests Register

(Last updated November 2020)

INTEREST	NATURE OF INTEREST	CORE BUSINESS	RISK OF CONFLICT	DATE OF INTEREST
AHOMIRO, Hori				
Tapuika Int Authority	Board Director	Fisheries Trust	LOW	22/10//19
BOP ANZASW Branch	Member & Kaumatua	Executive Leadership	LOW	22/10/19
NZ Social Work Registration Board	Board Member	Social Workers Registration	LOW	May 2020
ARUNDEL, Mark				
Pharmaceutical Society of New Zealand	Member	Professional Body	NIL	1980
Armey Family Trust	Trustee	Family Trust	NIL	28/07/2005
Markand Holdings Ltd	Director	Property	NIL	2016
TECT	Trustee	Community Trust	LOW	July 2018
EDLIN, Bev				
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
ESTERMAN, Geoff				
Gate Pa Medical Centre Ltd	Director, Manager & GP	Health	LOW – DHB does	28/11/2013

INTEREST	NATURE OF INTEREST	CORE BUSINESS	RISK OF CONFLICT	DATE OF INTEREST
			not contract directly with General Practices and as a Board Member Geoff is not in a position to influence contracts.	
Gate Pa Medical Centre Ltd	Practice Manager is on WBOP PHO Board	Health	NIL	December 2019
GM and P Esterman Family Trust	Trustee	Family Trust (kiwifruit)	NIL	28/11/2013
Whakatohea Health Services	Wife Penny works part-time as Nurse	Health Services Provider	Contracts to DHB LOW	Sept 2019
FINCH, IAN				
Visique Whakatane	Director	Optometry	LOW	1/11/19
Vic Davis trust	trustee	Grants for mental illness research	LOW - DHB employee may be applicant/recipient of grants	1/9/20
BOPDHB	Midwifery – casual contract	health	Moderate	1/9/20
GUY, Marion				
Chadwick Healthcare	Casual Employee	Health	NIL	06/1996
Bay of Plenty District Health Board	Employee	Health	LOW	03/10/2016
NZNO	Honorary and Life Member	Nursing Union	LOW	
SCOTT, Ron				
Stellaris Ltd and Stellaris PTE Ltd	Director	Business Education and Training organisation	LOW	2005
SILC Charitable Trust	Chair	Disabled Care	Low – As a Board Member Ron is not it the position to influence funding	July 2013

INTEREST	NATURE OF INTEREST	CORE BUSINESS	RISK OF CONFLICT	DATE OF INTEREST
			decisions.	
AA Bay of Plenty District Council	Council Member	Transport and Road Safety	LOW	March 2018
Establishment Board of Trustees – Suzanne Aubert Catholic School, Papamoa	Member	Education	NIL	March 2020
SHEA, Sharon				
Shea Pita & Associates Ltd	Director & Principal	Consulting	LOW	18/12/2019
Manawaroa Ltd	Director & Principal	Service Provider	LOW	18/12/2019
MAS Foundation	Board Member	Philanthropic Funder	LOW	18/12/2019
Maori Expert Advisory Group (MEAG)	Former Chair	Health & Disability System Review	LOW	18/12/2019
Iwi	Whakapapa		LOW	
A Better Start – E Tipu E Rea	Board Member	National Science Challenge – Auckland University	LOW	6/3/2020
EY - Department of Corrections Project	Member	Consulting - Corrections	LOW	April 2020
Interim Mental Health Commission	Consultant	Mental Health Outcomes Framework	LOW	May 2020
ACC	Consultant	Accident Compensation Commission	LOW	May 2020
Wai 2575 Claimants	Consultant	contracted via the National Hauora Coalition to support Wai 2575 claimants cost historic underfunding of Māori PHOs. Short-term project.	LOW	August 2020
Ministry of Health	Consultant	National Evaluation of Breast and Cervical Screening Support Services *Note:* BOP Maori Health Runanga Chair sub-contracting to Shea Pita & Associates for MOH Evaluation, as a Cultural Advisor	LOW	August 2020
Alliance Plus Health PHO -	Consultant	Health	LOW	27/08/2020

INTEREST	NATURE OF INTEREST	CORE BUSINESS	RISK OF CONFLICT	DATE OF INTEREST
Pan Pacific Resilience Model				
Counties Manukau DHB	Consultant	Mental Health & Addicitions project	LOW	November 2020
Counties Manukau DHB	Consultant	Maori Health project	LOW	November 2020
Husband – Morris Pita - Health Care Applications Ltd - Shea Pita & Associates Ltd	CEO Director	Health IT Consulting	LOW LOW	18/12/2019 18/12/2019
SIMPSON, Leonie				
Te Runanga o Ngati Awa	Chief Executive	Iwi Entity	LOW	23/12/2019
Toi Ohomai	Kahui Matahanga Member	Iwi representation	LOW	23/12/2019
TUORO, Arihia				
Whakatohea Mussels	Director	Mussel Farming	LOW	15/12/2019
Poutama Trust	Trustee	Maori Economic Development	LOW	15/12/2019
Kaikou Gold Kiwifruit	Director	Kiwifruit	LOW	15/12/2019
Waikeke Farms Ltd	Director	Dairy Farm	LOW	15/12/2019
Oranga Marae Lotteries	Committee Member	Lotteries	LOW	15/12/2019
Toi EDA	Committee Member	Eastern bay Economic Dev	LOW	15/12/2019
Lotteries Americas Cup	Committee Member	Lotteries	LOW	15/12/2019
Whakatohea Pre Settlement Claims Trust	Project Manager	Negotiate Whakatohea Settlement	LOW	15/12/2019
HUDSON, Mariana (Board Observer)				
The Maori Pharmacists Association (MPA)	Vice-President	Pharmacy	LOW	26/08/2020
VALEUAGA, Natu (Board Observer)				
Pacific Island Community Trust	Board Member	Community Work	LOW	31/08/2020

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Minutes

Bay of Plenty District Health Board

Conference Hall, Clinical School, Whakatane Hospital

Date: Wednesday 21 October 2020, 10.00 am

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

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

Item No.	Item	Action
1	**Karakia** The meeting was opened with a Karakia.	
2	**Presentation** 2.1 <u>Disability Strategy</u> Rachel Noble, General Manager Disability, Wairarapa, Hutt Valley and Capital and Coast DHB (via Zoom) Rachel is employed by the DHB as General Manager for Disability and has a team of 8 part time people (3FTE) who meet weekly. She has been in her role for 18 months. 50% of her team have a disability. In the beginning, there was a blank piece of paper and Rachel and her team have developed the Disability Strategy from scratch. There were six months of networking and discussions. Every second year there is a forum where people from various sectors come together as an opportunity to reflect on where they've been and where they are going. It also allows the building of relationships with disability in the community. The Strategy needs to be redone next year, the forum this year was delayed by COVID. The forum has one Maori and one non-Maori Chair Query was raised as to the top two enablers to success and top two barriers • They have a great team which is strongly connected in the community • The DHB wants to do the work and supplies resources and ability to connect within the DHB. Lack of data on disability is a barrier. Query was raised regarding disability in the workforce. In New Zealand there is a long way to go with disability issues in the workforce. An environment needs to be created where people feel welcome to apply for roles and confident that organisations will accommodate them. The Interim Chair thanked Rachel for stepping into such a leadership role, bringing her skills and lived experience and for talking with the Board today.	

Item No.	Item	Action
	Rachel explained that the work that she and her team are doing is something that can be shared and she is happy to help. She also offered to send some links to information she thinks may be of interest.	
3	**Apologies** An apology was received from Pouroto Ngaropo **Resolved** that the apology from P Ngaropo be received. Moved: I Finch Seconded: M Arundel	
4	**Interests Register** Board Members were asked if there were any changes to the Register or conflicts with the agenda. No changes or conflicts were advised.	
5	**Minutes** 5.1 Minutes of Board meeting – 23.9.20 **Resolved** that the Board receives the minutes of the meeting held on 23 September 2020 and confirms as a true and correct record. Moved: B Edlin Seconded: A Tuoro 5.2 Matters Arising All Matters Arising were in progress or completed 5.3 CPHAC/DSAC Meeting 7.10.20 The Committee Chair advised of key points: The meeting focusses on Strategic Objective 2. • There was a presentation on Allied Health Integrated Care, Keeping Me Well which is running a pilot scheme with Nga Kakano. It is transformational work which takes time and systems and practices need to change. • COTS is another proactive initiative through an Orthopaedic Triage System. • Telehealth was discussed. • PHO HealthCare Homes is also a pilot scheme to reduce demand on ED and Hospitalisation and improve Maori Health. Readiness in the community is an issue. General Practice will need to think differently. The measures are exciting. The Board received the Minutes of the meeting held on 7 October 2020.	
6	**Items for Decision** 6.1 BOPDHB Board Code of Conduct The Code of Conduct has been agreed to. **Resolved** that the Board endorses the BOPDHB Board Code of Conduct. Moved: B Edlin Seconded: M Arundel	
7	**Items for Discussion** 7.1 Health and Safety Strategy Update The new Health and Safety Manager has done a great job in developing the strategy, with a key aspect of bringing a structured way of approaching health and safety. There has been an absence of leadership in this area recently.	

Item No.	Item	Action
	The presentation provides a snapshot of the approach she is taking, a starting point is building engagement. The team is out and about across the organisation which is making a difference, particularly with health and safety representatives feeling better supported. FARM will see an improved way of reporting of key elements. The Health and Safety Manager will attend next FARM meeting to go through the presentation. BOPDHB has recently been through the ACC accredited employer programme audit and has maintained its tertiary accreditation status. One of the improvements was involvement of the unions and employee groups who didn't consider they were adequately involved in the last audit. The Interim Chair requested feedback on Board specific health and safety walkrounds and also having Board Health and Safety representatives. This can be discussed further at next FARM meeting Query was raised on DHB benchmarking injury management. How we measure where we are will be key for the Health and Safety Manager. There are no national benchmarks available. There are national and regional health and safety meetings convened which the Health and Safety Manager is in the progress of joining. There is a national Datix system which records information, however the interpretation of the information may be different. A connection is being strengthened with WorkSafe with the Health and Safety Manager's commencement. Query was raised as to whether there are WorkSafe prosecutions. There have been prosecutions elsewhere. 7.2 <u>Chief Executive's Report</u> The Chief Executive highlighted: *MCP* - went live with no major roadbumps. The team has done an amazing job. *MICAMHS*. - is going well albeit still a work in progress. The workload pressure has not gone away however is being monitored and there is a much healthier environment within the service. The leadership team is to be complimented. They have showed maturity to stand back from the adversity and reflect, support and led wisely through the challenges of the last year rather than reacting. *Child Wellbeing* There is a proposed connectedness of Child Development, MiCAHMS, Child Dental and Paediatrics who want to work together to solve historical issues. It will bring together a model of co-ordination and holistic care. *COVID.* Query was raised as to a lack of availability of testing over weekends. Testing can be ramped up quickly over the weekend if required. There is a point of contact through the normal contacts of General Practice and the Emergency Departments, in the current environment. Acknowledgement was conveyed to Dr Joe Bourne for the amazing job he and his team have done during the recent phase of COVID work.	GMCS GMCS

Item No.	Item	Action
	Query was raised on Port Workers and recurrent testing. Mon – Fri workers can obtain a test. Legal responsibility for enforcing testing does not sit anywhere currently. There is an expected update in legislation soon where it will fall to the employer to ensure their workers are tested. *Child at the Centre* - The possibility of obtaining HRC funding as investment to progress the integrated model was raised. *Speaking Up Safely* - This was initiated a couple of years ago and came from the Cognitive Institute in Australia. There are four steps to managing an adverse employment situation. Nationally it is supported by Unions as a pathway to address inappropriate behaviours. It is time to review the data, feedback and our approach from the last two years and see whether any changes are required. The Cognitive Institute requires those signed to the programme to follow it through and 'not blink' when dealing with difficult people. *CCDM* – highlights overtime. BOPDHB is ahead of other DHBs with CCDM. The Board considered the benefits and return on investment from fiscal, patient and worker wellbeing would be good to see. *Performance* - There are some good dashboards coming through and lots of data which now needs to be brought together. Whole of System performance is important and discussions will be held with BOPDHB's PHO partners. Query was raised on the IOC and how it is tracking. The first version (10 years ago) made a huge difference as a fundamental shift in working, primarily in nursing care. The additional tools required going forward need to be considered as a whole of system view. Critical to progression to the next level will be the introduction of the IOC Manager. The information produced needs to be available to see in each ward and the issues indicated, addressed. Having Primary Care linked into that information is the next step. It is envisaged it will be a year of development before evidence of real progress is seen. *Education* - There are 15 Summer Students coming in, taking on great portfolios of work. There is always meaningful outcome from this work. Query was raised as to whether there has been disruption with COVID. There has been some nursing disruption with exams but won't impact on recruitment. The clinical placement hours for nursing will have been challenging. There has also been a little disruption to RMOs. Query was raised on BOPDHB's role in developing the workforce over the next 5 years. BOPDHB sits on Advisory Councils which allows influence. It was advised that Awanuiarangi is struggling with tutors. Query was raised as to whether BOPDHB has a role to support. BOPDHB does assist where they are able to. The Eastern Bay can be challenging for workforce within the hospital and finding people with the time to teach is an extra challenge. Collaboration between BOPDHB and the tertiary providers to progress is considered a requirement. *Planning & Funding and Population Health* - Acting GM gave background to the new format of his section of the report. The transaction and transformational aspects of the report were well received.	DON

Item No.	Item	Action
	Indication of outcomes is considered something that would be good to have within the report. Query was raised on indication within the CEO's report that Tauranga A&E and 9% of patients at Tauranga Hospital ED do not wait. It is a flow problem with the hospital at capacity recently. **Resolved** that the Board receive the report Moved: G Esterman Seconded: M Arundel 7.3 Dashboard Report The report was taken as read.	Acting GMPF
8	**Items for Noting** 8.1 Correspondence for Noting • Copy of letter to Dr Hugh Lees from the Safe Staffing Health Workplace (SSHW) Governance Group, 13 October 2020 8.2 Board Work Plan 2020 The Board noted the papers	
9	**General Business** There was no General Business	
10	Resolution to Exclude the Public Resolved that Pursuant to S9 of the Official Information Act 1982 and Schedule 3, Clause 33 of the New Zealand Health and Disability Act 2000 the public be excluded from the following portions of the meeting because public release of the contents of the reports is likely to affect the privacy of a natural person or unreasonably prejudice the commercial position of the organisation: Confidential Minutes of last meeting: Board Minutes – 23.9.20 FARM Meeting - 7.10.20 BOPHAC Meeting - 7.10.20 Holidays Act Liability update FPIM Equity KPIs Whareroa Marae Hospital Certification Results CEOs report Patient Safety Correspondence for noting That the following persons be permitted to remain at this meeting, after the public have been excluded, because of their knowledge as to organisational matters or for the purpose of legal records. This knowledge will be of assistance in relation to the matter to be discussed: Pete Chandler Owen Wallace Mike Agnew Debbie Brown Julie Robinson Jeff Hodson	

Item No.	Item	Action
	Marama Tauranga Sarah Mitchell Resolved that the Board move into confidential. Moved: R Scott Seconded: M Guy	
11	Next Meeting – Wednesday 18 November 2020	

The open section of the meeting closed at 12.20 pm

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

RUNNING LIST OF ACTIONS

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

	Task	Who	By When	Status	Response
15.1.20 Item 5.2	**Chief Executive's Report – Clinical School** CEO advised that it would be good for the Head of Clinical School, Prof Peter Gilling to meet with the Board at a future meeting. One of the Clinical School's priorities was to give students an experience that made them want to work for BOPDHB. – Board Secretariat	HOCS	Nov		Presenting to Board 18.11.20
23.9.20 Item 6.1	**Position Statement on Te Tiriti o Waitangi, Health Equity and Racism** The Board notes the paper and supports the direction. An amended paper to be circulated and discussed via Zoom prior to next Board Meeting. If it is considered the paper should come back to the Board thereafter, it will be submitted to next Board meeting.	Manukura	Oct		Next version progressing to Runanga meeting 14.10.20
23.9.20 Item 7.3	**CEO report – ESPIs** A request was made for those waiting to be represented as a percentage.	COO	Oct		
21.10.20	**Health and Safety Strategy Update** FARM will see an improved way of reporting of key elements. The Health and Safety Manager will attend next FARM meeting to go through the presentation.	GMCS	Nov		Health and Safety Manager presented to FARM 4.11.20 – Completed
21.10.20	**Health and Safety Strategy Update** The Interim Chair requested feedback on Board specific health and safety walkrounds and also having Board Health and Safety representatives. This can be discussed further at next FARM meeting	GMCS	Nov		

	Task	Who	By When	Status	Response
21.10.20	**CCDM** BOPDHB is ahead of other DHBs with CCDM. The Board considered the benefits and return on investment from fiscal, patient and worker wellbeing would be good to see.	DON	Nov		Update to Board 18.11.20 – Completed
21.10.20	**CEO's report – Planning & Funding** The transaction and transformational aspects of the report were well received. Indication of outcomes is considered something that would be good to have within the report.	Acting GMPF	Nov		

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

BOPHAC MEETING – 4.11.20
HIGHLIGHTS

SUBMITTED TO:
Board Meeting 18 November 2020

Prepared by: Geoff Esterman Chair, BOPHAC

Endorsed by: Sharon Shea, Interim Board Chair

Submitted by: Pete Chandler, Chief Executive

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

RECOMMENDATION:
That the Board notes the highlights from the BOPHAC Meeting of 4 November 2020

ATTACHMENTS:
Draft BOPHAC minutes, 4 November 2020

HIGHLIGHTS:

- **Community Dental**
  - High rates of enrolment but difficulty seeing patients due to growing population / reduced capacity because of COVID 19 restrictions / high DNA rates (Maori patients 45% , non -Maori 18%)- refocus and prioritisation based on Ethnicity now occurring
  - Issue of ageing workforce with preferential (historic) employment contracts discussed – Management to explore this issue
  - Committee considered whether dental services could be provided external to the DHB – Management to explore this issue

- **Focus on Effective Workforce**

- **Capacity Issues**
  - Current capacity issues which will be worsened with upcoming renovations –plans are underway to manage through this

- **Heads of Department Engagement**
  - A process has been started, with some energy, at educating and enabling medical leaders with a more structured approach to meetings – it is hoped this will result in clinicians proposing better models of care – the committee asked for progress reports on this

- **COO Report**
  - Highlighted the increasing complexity and unwellness of patients presenting,
  - Eight of our planned care Proposals will be funded by the MOH- which should assist

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 November 2020 at 10:30am

Committee: Geoff Esterman (Chair), Hori Ahomiro, Marion Guy, Ron Scott, Lyall Thurston, Lindsey Webber

Attendees: Pete Chandler (Chief Executive), Bronwyn Anstis (Acting Chief Operating Officer), Julie Robinson (Director of Nursing), Sarah Mitchell (Executive Director, Allied Health Scientific & Technical), Joe Bourne (Acting Chief Medical Advisor)

Item No.	Item	Action
1	**Karakia** The meeting opened with a karakia.	
2	**Presentation** 2.1 Community Dental Martin Steinmann, Regional Manager, Community Health 4 Kids Dr Rudi Johnson, Principal Dental Officer Martin and Rudi introduced themselves and explained their roles within the organisation. The School Dental Service has been in existence since 1921. Photos were shown of children attending by horseback in those days, through to the latest mobile Dental Units. It is now known as the Community Dental Service. There is currently an enrolled child population of around 42,000 in the Bay of Plenty. The core number is pre-schoolers and school aged children. There is a fleet of 14 mobile units. There is also a diagnostic unit in Eastern Bay and 6 fixed site clinics. The biggest challenge is trying to see all children and meet their needs in the Western Bay, with population growth. Since 2011, there have been 14,000 additional children. Prevalence of dental caries is high. Ideal ratio per Dental Therapist is 1350, currently in Western Bay ratio is 1750. Eastern Bay is not as difficult. Children are automatically enrolled at birth, so the system works as one of opt-out for parents. It is desirable to see children from the time they get their first teeth, around 6-9 months old. BOPDHB works collaboratively with Te Manu Toroa who have a contract with BOPDHB. Query was raised as to why BOPDHB provides a service that PHOs may be able to provide.	

Item No.	Item	Action
	Te Manu Toroa work with Maori to reduce inequity. The Committee requested consideration be given to examining reasons that Dental Services may not be able to provided externally to BOPDHB. It may be that we are currently providing the best method, however it was considered worth review. Advice was given that this has been considered previously, however recruitment of Dental staff is more difficult outside the DHB and smaller entities tend to result in Therapists working in isolation. A report will come back to the Committee COVID lockdown added extra pressure to a burdened system, especially with regard to DNAs. Dental surgery rooms have had to be adapted due to aerosol water and drill sprays. Supply of dental products which predominantly come from overseas, have been restricted. The service model has required to be changed, moving to prioritisation. Emergencies and overdue children are priority. There are usually around 7,000 visits per month which reduced to 4,000 in June under COVID circumstances. Patient liaison roles have been introduced to address DNA rates which number around 4-5,000 per year. Kaiawhina roles are to be introduced to assist also. Query was raised on percentage of DNAs for Maori and non-Maori which was advised as 45% for Maori and 18% for non-Maori. Query was raised regarding liaison with GPs and whether that could assist with DNAs. Liaison is primarily with schools. GPs do see under 5 year olds. There is a "Lift the Lip" programme which gives an overview of Community Dental to Practice and Hospital Nurses. Enrolment rates have increased significantly which is part of the reason that DNAs are high. There is a lot of work being done with adolescents to get them involved in dental care, engaging with high schools and WINZ. There has been a project in Murupara for the last 5 years, connecting adolescents with enablers and work is scheduled for next year in Te Kaha. Opotiki High School has been another area of focus. After COVID lockdown a refocus of the service was undertaken. Prioritisation is now also undertaken on ethnicity. Gaps in equity have been long standing. There are a number of ageing Dental Therapists in the workforce who tend to reduce their FTE rather than retire, which can create difficulty in recruitment. There are also issues with old Dental contracts and leave allocation during school holidays. The Committee requested that the Executive consider review of the contracts and report back to the Committee. Query was raised as to where the Fluoridation issue lies. It is currently with MOH. BOPDHB has a position statement of support for Fluoridation.	Acting GMPF / COO COO

Item No.	Item	Action
	Query was raised as to whether the biggest challenge was workforce or equipment. Recruitment is difficult, however it is both. Query was raised as to whether the Provincial Growth Fund could assist with funding of equipment and mobile clinics. The Committee thanked Martin and Rudi for their informative presentation which the Committee found very interesting.	
3	**Apologies** An apology was received from Leonie Simpson **Resolved** that the apology from L Simpson be received. Moved: R Scott Seconded: H Ahomiro	
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.	
5	**Minutes** BOPHAC Meeting – 2.9.20 **Resolved** that the minutes of the meeting held on 2 September 2020 be confirmed as a true and correct record. Moved: M Guy Seconded: H Ahomiro	
6	**Matters Arising** Termination of Pregnancies (TOP) update. There has been new legislation. FOR BOPDHB currently 1st trimester is delivered by Lakes DHB, 2nd trimester is delivered by Medical. Terminations post 18 weeks has not been addressed. Close access is a consideration. The numbers of those requiring access to TOP post 18 weeks are small in the BOP. There are also ethical considerations for some clinicians. The Matter Arising can be closed.	
7	**Matters for Discussion / Decision** 7.1 Addressing Capacity Issues Acting COO outlined some initiatives being undertaken and challenges in addressing current capacity issues. Query was raised as to whether there was a Communications Plan for changes that will be required. GP Liaisons work with GPs with regard to matters such as hospital capacity. PHOs and their GPs can manage expectations in the community. The COTS programme has been well relayed to primary care. It was considered that communication to the community on current situations and conditions is important. 7.2 Head of Department (HOD) Engagement An induction day has been held for the new Medical HODs on new contracts and with a better understanding of their roles.	

Item No.	Item	Action
	There had been good feedback from attendees. A more structured approach to HOD meetings is planned. There will also be professional development for the role they play. HODs have a 3 year tenure. Query was raised on the relativity of medical staff numbers and their admin support. Review is being undertaken and there will be discussion on how staff can support clinicians. Electronic usage and the ability of immediate input, means that clinicians do now undertake a higher volume of admin work themselves than previously. Query was rasied as to how success will be measured in the new model. This will be linked to Clinical Governance however ultimately it will be in the quality of care being delivered. Equity, quality of care and patient outcomes will be measures. Query was raised on how clinicians competence is monitored. There is a credentialling process which reviews clinical competence. The Committee requested feedback as the model evolves. It was considered it would take 12 months to gain a good view. The first milestone could be to measure engagement with Clinical Governance which could be within 6 months.	COO / Acting CMA
	7.3 <u>Chief Operating Officer's Report</u> The Acting COO highlighted: *Planned Care Proposals* - Eight Planned Care proposals have been endorsed and supported by MOH. *New Graduate to Entry Practice Changes*. There has been a change which has involved MHGD and making entry more culturally appropriate. Feedback will be sought once the new graduates are in placements. There will be 59 new placements next year, plus Mental Health. *Performance for October* - reflects high admission rates and high acuity. Comment was made on the low percentage of GP referred patients and whether there is a way of encouraging people not to approach ED directly. There has been a dropoff in Triage 4s and 5s and an increase in Triage 3s. Physios in ED are seeing a lot of Triage 4s and 5s which is taking some burden off ED. Primary Care data to compare would be good to be seen alongside the secondary data. *Planned Care* - is tracking reasonably well despite capacity issues. *Bowel Screening Programme* - has started with planning community engagement and education. *Mental Health Builds* – GMFBO is working with MOH. Business Cases are being prepared. *Child Development* - There is now an Advisory group with involved partners. **Resolved** that the Committee receive the Chief Operating Officer's	COO

Item No.	Item	Action
	report. Moved: R Scott Seconded: M Guy	
8	**Matters for Noting** 8.1 BOPDHB Three Year Planned Care Strategy All the aspects of the Planned Care are part of the Annual Plan. If all asepcts are achieved in three years, we will have done very well. Query was raised on some aspects in comparison to those included in the Annual Plan. Infusions and the Acuity Tool do not seem to be included in the Planned Care Strategy. The document is a living document so this can be reviewed. Iron infusions have been commenced. There is an agreement with Primary Care. Progress will be reported back to the Committee. 8.2 BOPHAC Work Plan 2020 The Committee noted the plan.	COO COO
9	**Correspondence for Noting** Nil.	
10	**General Business** The Committee considered that there has been some really great work going on in the organisation throughout a difficult year.	
11	**Next Meeting -** Wednesday 26 January 2021	

The open section of the meeting closed with a karakia at 12.30 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

SMARTGROWTH

SUBMITTED TO:

Board Meeting 18 November 2020

Prepared and
Submitted by: Pete Chandler, Chief Executive

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

RECOMMENDATION:
That the Board:

- **notes** the information regarding SmartGrowth
- **supports** the proposal to nominate a Board member to join the SmartGrowth Governance Group

ATTACHMENTS:
Website reference for further information: https://www.smartgrowthbop.org.nz/

BACKGROUND:
SmartGrowth provides a unified vision, direction and voice for the future of the western Bay of Plenty as we help develop a great place to live, learn, work and play. Taking into account a range of environmental, social, economic and cultural matters, the strategy identifies opportunities for building our community.

Ensuring a balanced approach to growth management is an important part of planning for the future and connecting the spaces and places that create communities where we live, learn, work and play. Not just now, but in the future.

The Strategy is focused on implementation and Future Thinking. It has a 50-year horizon with particular focus on the next 20 years.

DHB PARTICIPATION:

The DHB is officially a member of the SmartGrowth leadership however our ability to be actively involved has been limited, not least by meetings clashing with Board meeting dates. With the changes to our Board schedule in 2021 this issue resolves.

In October we were approached by SmartGrowth in relation to increasing our input as a DHB which is seen as very important at this time of unprecedented growth in the area.

There are three levels of input:

1. Operational: This role is covered by Sarah Davey

2. Executive: The new CEO has been asked to join the group alongside other council and agency CEOs

3. Governance: SmartGrowth have asked if the DHB would consider nominating a Board member to attend this group, which now has two Ministers and local politicians involved

The Board is asked to consider this request and if supported to propose a Board member for management to feedback to SmartGrowth.

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

CHILD HEALTH SERVICES

SUBMITTED TO:

Board Meeting 18 November 2020

Prepared and
Submitted by: Pete Chandler, Chief Executive

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

RECOMMENDATION:
That the Board notes the information and endorses the Proposed Service Models for Child Health Services

ATTACHMENTS:
Child Health Services Proposed Services Models

BACKGROUND:
As advised at last Board Meeting, there is intent for Child Health Services to be progressed in a more integrated manner. The attached information outlines Phase 1, for Child Health Integrated Response Pathways (CHIRP) which lays the foundation for integrated practice within healthcare.

Child Health Services

Proposed Service Models

CARE Manaakitanga

Child Health Integrated Response Pathways (CHIRP)

Child Health Integrated Response Pathways (CHIRP) is the DHB's answer to children bouncing between services and falling between gaps. To the left, CHIRP is visualised as a model for Child Development Services, Child Mental Health, and Paediatrics but this is just a starting point. The model recognizes the unique contribution each team makes to the care of children and whānau. The model also recognizes spaces where services can work together to address complex needs, as well as where services could reconfigure to address needs which more than one team could manage on their own.

Currently there are children under the age of 12 with different developmental needs being referred to Child Development Services, Child Mental Health, and Paediatrics. For example a school may refer a child with possible ASD to Child Development Services, Paediatrics, and Child Mental Health at the same time as different services respond to different needs. The coordination of care becomes very complex with children often left waiting in multiple queues.

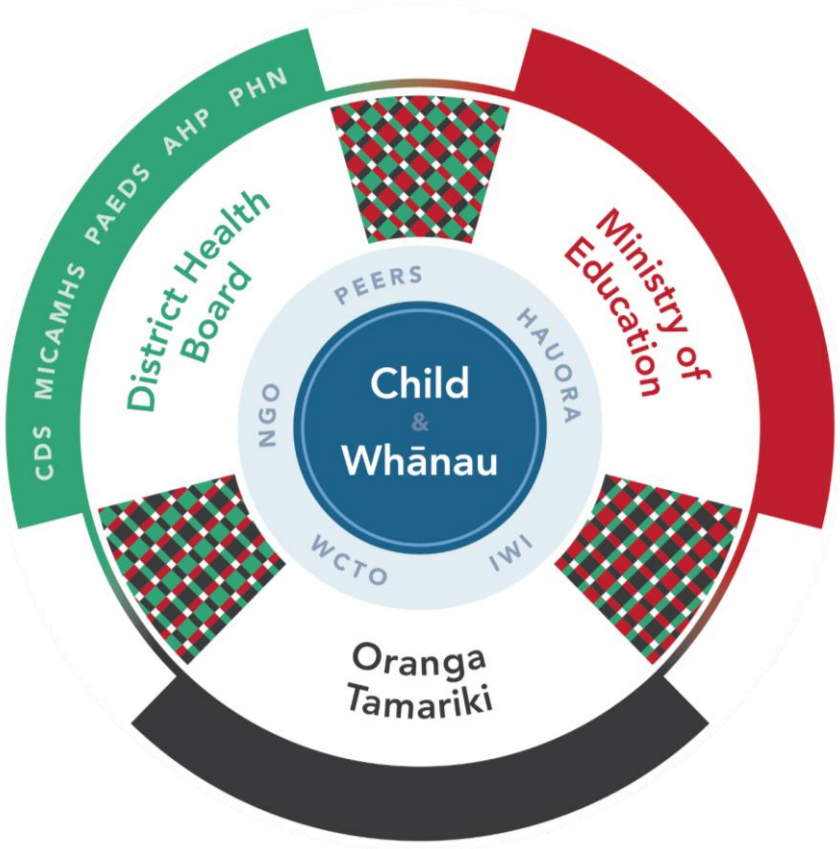
The CHIRP vision would be to create a child at the centre model. This will mean that young people will be assessed by a team of professionals consisting of members from the different child facing services and that their needs would be addressed by the best clinician rather than the best department. This will mean a significant reduction in waiting time, more efficient care and coordination by reducing overlap and debate, and improved access to services that can't be provided in silos, for example a child accessing CDS won't require another referral to access Mental Health.

There will always be children who only require one team's support for their needs to be met. For CDS this may be feeding plans for school-aged children, or for Child Mental Health this may be therapy following trauma.

There are also children with more complex needs who require our services to weave together to give them a good start in life. Open lines of communication mean that our teams can provide the best quality of care by being fully informed of a family's situation.

CARE Manaakitanga

Kids' Network for Integrated Teams (KNIT)



As phase 1, CHIRP lays the foundation for integrated practice within healthcare. KNIT realises health is only one aspect of wellbeing for children and whānau and expands integrated practice to multiple agencies.

KNIT encourages crown entities to work together in an integrated manner to meet the wellbeing needs of children and whānau. For this model to be successful, we envision 3 different workstreams.

1. Child Health DHB services working together in a CHIRP model (teams around the outside)
2. Bolstering services and supports in family natural networks such as NGOs, peers etc. This means giving them the skills and oversight needed to manage wellbeing needs without whānau needing to come to a crown entity. The commissioning model would need to be reconsidered in this space.
3. MOE, Oranga Tamariki, and BOPDHB (CHIRP) working together in real time such as joint meetings and shared plans.

Support and Education moves inwards through the circle to the child and whānau.

- Distinct health teams support and educate each other to manage needs they may have otherwise referred on.
- Crown Entities readily work together and provide education and support to community groups/service providers to manage wellbeing needs of children and whānau in their natural networks and environments.
- Crown entities work directly with children and whānau to provide expert level care and support where this is not safe or otherwise able to be delivered by another agency or group.

Requests for help and education moves outwards through the circle. It is recognized that children and whānau want their natural network such as peers to support them. This model requires specialised services such as education and health to empower natural networks to be responsive to these needs. Specialised services will still exist and be there for those who need care or support that cannot be safely or otherwise provided in the natural network.

CARE Manaakitanga

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

BOPDHB. POSITION STATEMENT
JOINT VENTURES / FUNDRAISING

SUBMITTED TO:

Board Meeting 18 November 2020

Prepared by: Debbie Brown, Senior Advisor, Governance & Quality

Endorsed and Submitted by: Pete Chandler, Chief Executive

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

RECOMMENDED RESOLUTION:
That Board endorses the Position Statement, Joint Ventures/Fundraising.

ATTACHMENTS:
BOPDHB Position Statement, Joint Ventures / Fundraising

BACKGROUND:
Transformational change requires resources and collaboration. To enable our future direction Bay of Plenty DHB supports collaboration and strategic partnerships with organisations which enhance the financial viability of initiatives in order to improve the health outcomes for our community/population

The attached position statement provides a foundation for managing partnerships that may arise as a joint venture or fundraising opportunity.

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

Position Statement - Joint Ventures/Fundraising

Bay of Plenty DHB supports collaboration and strategic partnerships with organisations which enhance the financial viability of initiatives in order to improve the health outcomes for our community/population

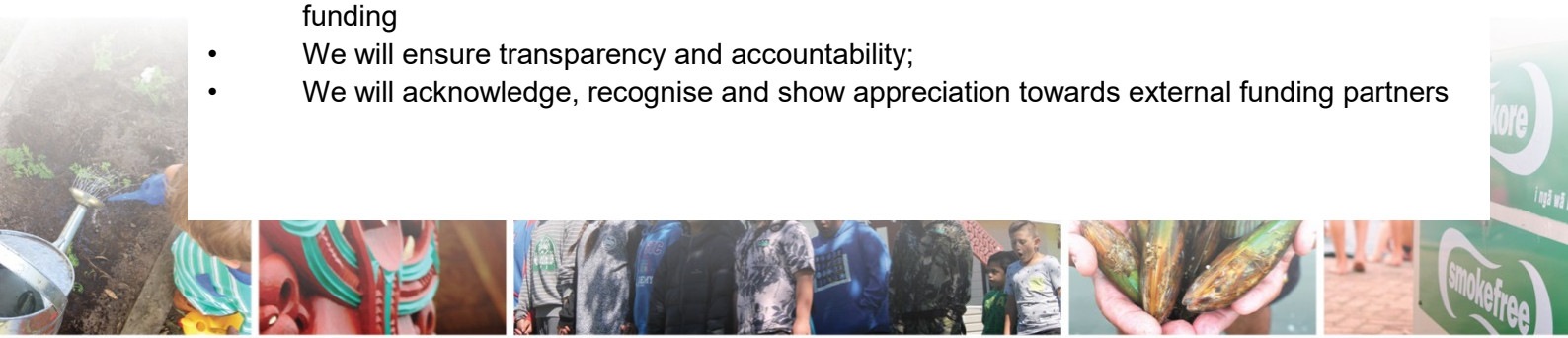
Traditionally health care investments have been managed within the funding envelope received from the Ministry of Health. However in constrained times and with significant need across our communities this is becoming more and more challenging. Providing innovative, transformational healthcare which allows people to live well, get well and stay well comes at a cost. Our purpose as a DHB is not solely to provide basic, essential healthcare but to be a contributor to societal wellbeing and to work in partnership with others to achieve this.

Historically, BOPDHB had done well at living within its means however demands of population changes, higher cost treatments and new technology require considerable investment to provide the very best health services we can to our people and communities.

Partnering with other state sector, NGO and voluntary organisations as well an appropriate businesses and philanthropic investors who share our aims to pool funding on shared initiatives is an effective way to ensure value for money.

Principles:

- Funding partnerships are advancing our aims in the transformation of heath and wellbeing care provision.
- Partnerships align with and enhance the DHB vision, mission and our CARE values
- Partnerships will supplement Government funding rather than being seen as an alternative
- Partnerships will not provide favouritism or expectations in other areas of goods and services procurement
- External funding will be treated responsibly in the same was as taxpayer sourced health funding
- We will ensure transparency and accountability;
- We will acknowledge, recognise and show appreciation towards external funding partners



Chief Executive's Report

This report covers the period 14th October to 11th November 2020.

1. Chief Executive's Overview

Strategic Development

The one pager strategic priorities overview feedback from the Board was immensely valuable last month. Subsequently the CEO met with the Runanga for further discussion. The Runanga were pleased with the over-arching essence of Te Toi Ahorangi being symbolised and made some further suggestions which have been incorporated. Zoom sessions have been held with the Unions and whilst the revised document has now been released to the organisation via the CEO newsletter we'll be sharing in more detail with staff at the November Grand Round.

Sarah Mitchell is moving into her new role in November and will be working with subject matter leads to bring together our detailed execution plans, capturing top priorities, timelines and execution lead details so that we have a clear and visible owned plan. Note that much of this is work underway already and the aim is to achieve collective visibility at this point, with a framework for prioritised sequencing emerging for future work.

This month we have a new report, sent by email as the format does not work well in Stellar, from our Innovation and Improvement team which has not been seen before. This shows the range of work (some of which Board members are aware of, but not all) currently underway which is supported by this team. For future months we will be looking to integrate the Innovation and Improvement updates into the transformation sections of this CEO report.

With each of our Executives having their own business groups to run there is little additional capacity for the CEO to draw on. With Exec time being diluted by COVID and with Simon's departure from the team this has created a notable capacity reduction. To address this in the short term we have contracted one of the senior leaders from Francis Health who has been key in our acute flow transformation work previously, to work with the CEO and Executive for the next four months. Naila Naseem will provide some expert capacity and an objective fresh lens to helping us in our development. She will take on some specific areas of work as an extension of the CEO, mirroring a similar arrangement at Mid Central DHB who have also been similarly struggling with Executive level execution capacity to deliver their vision.

Hospital activity

October continued to be a month of high volume and high acuity ED presentations and admissions, requiring the use of an average of 12 additional overnight beds this month to meet essential needs. Perspective from our frontline hospital co-ordinators suggest that this is reflective of:

- The lack of residents travelling overseas of work or holidays
- An increase in people travelling to Tauranga for holidays
- Increased frailty and falls after lockdown
- Delayed access to care linked to COVID

Additionally, with 2.8% population growth now formalized for the 12 months to 30th June our population is growing by almost 10,000 people a year. The Executive are currently re-thinking our normal Christmas holiday season plans and the potential need for an extra level of acute demand provision.

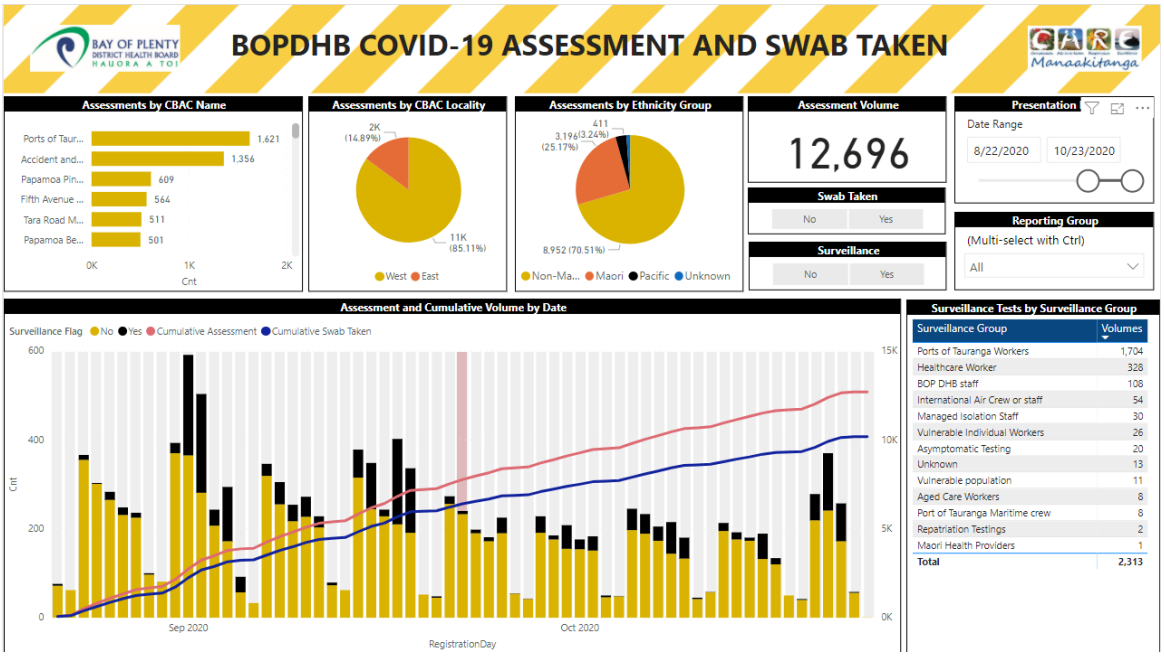
Pharmacy Negotiations

It was good to achieve settlement with the APEX Union and Pharmacy staff.

The planned strike action for October was withdrawn and this matter is now closed.

2. News and key events

2.1 COVID-19 Key Updates November 2020



Toi Te Ora

- It was pleasing to see the timely mobilisation of additional staff to assist with the response to a case at the Port of Tauranga with a quick response from both the BOPDHB EOC and Community Health 4 Kids. This was good test of our plans and provided an opportunity to identify areas where we can fine tune some of the processes. The response itself was further assisted by the strong relationships the health protection team have developed with the Port companies over recent years, alongside the excellent swabbing service that is now operating at the Port.
- Members of the Toi Te Ora Incident Management team have reviewed its surge planning with the Manager of the National Investigation & Tracing Centre, Ministry of Health, who is pleased with the approach for this region, and the progress being made. Work is continuing to ensure there are sufficient trained staff available across both DHBs should we need to stand up the surge plan over the summer holiday break.
- Toi Te Ora is working with its two DHBs to ensure there are good processes in place around accessing transport, accommodation and welfare needs in the event of a community outbreak. At this stage the direction from the Ministry of Health is that any positive cases would be transferred to the Jet Park Hotel for quarantine.
- The Toi Te Ora Māori Liaison team are supporting the Waikato Māori Incident Management team to organise a national symposium to enable others to gain insight into their processes around engaging iwi in their response following wide interest from public health units. The Auckland Regional Public Health Service will also support the event.
- One of the Hapū Hauora kaimahi met with Ngāti Ranginui to gain insight into their experience through COVID-19 and to support them on the development of their pandemic plan for their Hapū. An identified gap is the need for the iwi to have ready access to information on the various Māori Providers. There is also potential for reintroducing '*Te Pa Harakeke*' network which would enable the strengthening of relationships across a range of providers.

COVID - Data Collection & Reporting

Improvements in data collection and reporting related to COVID activities continue. New Ministry of Health based reports have been developed for data captured from Ports of Tauranga swabbing centres and are being sent through to the Ministry. Internal reporting processes are also being redeveloped to provide improved COVID data intelligence. A proposal for a new COVID specific application platform has been designed and is moving to implementation stage.

COVID - Communications

COVID-19 – continual internal and external communications. The Staff Bulletin is now published once a week with the shift to COVID-19 Alert Level 1 and continued collaboration to maintain the BOP COVID-19 (TTO, Lakes and BOPDHB) initiative and digital release of a regular stakeholder panui.

2.2 New Radiation Treatment for Breast Cancer

Local Radiation Oncology provider Kathleen Kilgour Centre have been publicly recognised for their new treatment regime available for breast cancer treatment. This will mean fewer repeat visits for radiotherapy for women across the Bay.

2.3 Hand Hygiene Promotion

To reinvigorate the profile of hand hygiene new posters, stickers and banners have been developed. The banners will be displayed at both hospitals. The posters and stickers have been distributed to all departments. The auditing for the current quarter ends 31 October 2020.

2.4 Communications

Key areas of internal communications focus this month have been:

- Emphasis on producing digital educational material and social media posts for service teams
- Communicating the Whakaari wellness at work and support options
- Supporting the Canterbury Mental Health lead visit. This was a two-day event across both sites including smaller workshops to share learning from Disaster Recovery, Christchurch Earthquakes, Mosque Terrorist Attacks, COVID-19.
- Communications in support of the Midland Clinical Portal launch

Key areas of external communications focus this month included:

- World first in prostrate treatment at Tauranga Hospital,
- Internationally renowned trauma course at Tauranga and
- Breakthrough treatment in Tauranga (Kathleen Kilgour Centre) which reduces breast cancer radiation treatments

Our top 5 social media postings during October were as follows:

Post Message	Type	Posted	Lifetime Post Total Reach	Lifetime Engaged Users
Eastern Bay Microbiology Service. We are aware that over the last few weeks there has been heightened interest in the Eastern Bay Microbiology Service, with historic claims regarding it being revisited. As a DHB we are concerned about the potential for misinformation to cause public anxiety and so want to provide some reassurance to all users of this service and the Eastern Bay community in general. Since reading about alleged microbiology service issues in local media we have asked our doctors and other staff teams at Whakatāne Hospital, a range of rural GPs, and Pathlab (who provide the service for us) to advise us of any service issues being experienced or any complaints having been made over the last five years. Five years was the period chosen because we felt this was a sufficiently lengthy timeframe to be able to undertake a clear assessment. We can confirm that no complaints have been registered by Eastern Bay GPs or practices at any time during this period. In addition, and despite asking the question widely, we've so far not been able to identify any cases of dissatisfaction and no examples of patients being put at risk. Therefore, we have to conclude that the various allegations being made have no basis in fact and are being promoted and pursued for unknown reasons. However, if GPs do experience any service issues in the future, or have any concerns but have not reported them, I would remind you to please use the complaint reporting process provided to each practice so that these can be addressed. I would like to re-iterate, as BOPDHB Chief Executive, that the Microbiology Service	Photo	22/10/20	3182	273

which serves the Eastern Bay and has done for so many years is an exceptional one with very high standards of practise and some of the most sector-leading equipment in Australasia. I can assure the Eastern Bay communities that if any issues are reported at any time in the future they will be thoroughly investigated and addressed. Pete Chandler BOPDHB Chief Executive #WhakataneHospital #BOPDHB				
A world first surgery at Tauranga Hospital could represent a major advance in the treatment of prostate cancer. The surgery was part of a clinical study using slow-release technology called Biolen. Get the full story here http://ow.ly/g9Eo50BY2Yj #TaurangaHospital #BOPDHB	Photo	20/10/20	2899	287
Summer is on its way, a great opportunity in the Bay! Diabetes Clinical Nurse Specialist. Please click here for more details…. http://ow.ly/Th5750BK8lw	Photo	05/10/20	2795	71
An internationally recognised trauma course at Tauranga Hospital for the first time is great news for both the Bay of Plenty District Health Board and the community it serves say medical experts. Get the full story http://ow.ly/51Qh50C5Lcb #TaurangaHospital #BOPDHB	Photo	29/10/20	2150	224
Tauranga Osteoporosis Nurses Nicola Ward and Juanita Berridge encourage people to love their bones on World Osteoporosis Day. knowyourbones.org.nz #knowyourbones #worldosteoporosisday #BOPDHB	Photo	19/10/20	2057	200

2.5 Tauranga City Council Executive Meeting

Last month the Executive met with the MSD Executive to explore shared areas of opportunity for the future. This month a meeting was arranged with Tauranga City Council Executive. This was an extremely beneficial session as both teams exchanged information on current pressure points arising from our population growth and shared areas of opportunity for the future, with a key focus on health in all policies.

There emerged a strong desire to work together in the interests of the wellbeing of our communities in Tauranga and the Western Bay and the conversation will develop further early next year.

3. Our People

We are a very proud service to have Nicola Davis - Breast Surgeon and strong advocate for women in surgery as part of our BOPDHB team. Nicola graced the cover of the Focus magazine this month and discusses breast cancer and treatment and also encourages women to get involved in a medical career – Ka Rawe Nicola!

Dr Richard Forster - Paediatrician at Whakatane - has announced his intention to retire in January 2021. He joined the team in Whakatane 12 years ago following a long career in the South Island. Richard has been a highly vocal advocate for the Eastern Bay, especially for children in the East and the need for local access to MRI. His ongoing challenges to the management teams have been instrumental in the increasing priority focus of developing our Eastern Bay network. Recruitment has commenced for his replacement.

Dr John Malcom has been appointed as a Clinician Emeritus in recognition of the esteem with which he is held by his colleagues and the significant contribution he has made to the development of Paediatrics in the Bay of Plenty during his career. The appointment is unpaid and specifically excludes clinical work in the DHB, but recognises his ability to provide wise advice, mentoring and teaching to his Colleagues, especially Junior Medical Staff and Paediatric Trainees as agreed with the Head of Department .

Five of our senior staff contributed to a recent successful New Zealand Society of Anaesthesia conference presenting on the following topics:
CDP, POPs, Unconscious bias, Serious Illness conversation, Whakaari.
Heidi Omundsen, Graham Cameron and Nick Hulme presented and Renee Franklin formed part of organising committee (on Right)

Senior management changes

- The new Chief Financial Officer, Simon den Bak, started in early October, filling the vacancy that had been open since the end of June 2020.
- The new executive Director People & Culture, Joe Akari, will start on 23rd November.

- With Sarah Mitchell stepping into our Strategic Architect role Judi Riddell has agreed to support as part time Acting Director of Allied Health.
- Neil Mckelvie, Business Leader of the Medicine Cluster, is relocating with his family and his colleague Sandra Fielding will take on this role in the interim.

Nursing New Graduate Entry to Practice Programme (NETP & NESP)

The interview process for next year's intake of new graduates changed this year based on feedback and to align with the nursing strategy action to review recruitment strategies to positively support Māori. Interview sessions are facilitated and delivered in a Wananga style. The session is 3.5 hours in length and includes a Mihi Whakatau, Whakawhanaungatanga, group activities, and a 20-minute individual interview/korero with a Clinical Nurse Manager and a member of the Maori Health Gains and Development team. The Mental Health service also participated in the process this year. The new format will be evaluated next year once the graduates are in place.

3.1 Education and Training

Education

Quarterly statistics show that July-September this year was our biggest in terms of new users in Te Whāriki ā Toi (our online learning resource) since early 2019. More online courses were completed than face to face sessions attended, which is becoming a slight trend. Eleven new courses were created or updated, including a Digital Literacy course from Taranaki DHB, a Health Literacy course from Hawkes Bay DHB, and Pressure Injury Management and Prevention. There were also three courses created to complement face to face training, with IV and Oral Analgesia replacing a face to face session, and Male Catheterisation halving the time spent in face to face training.

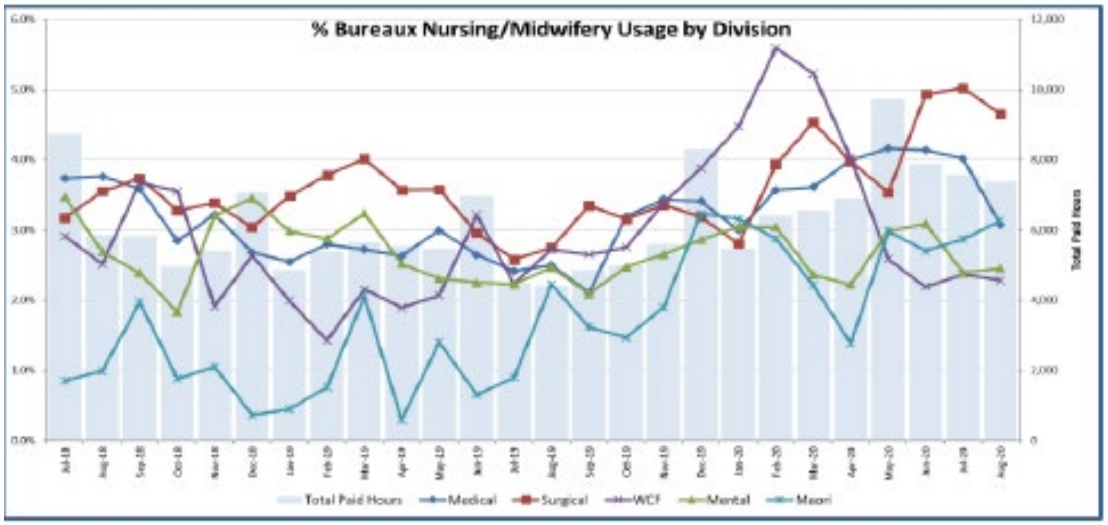
The Education Manager is working with our PHO and PHA colleagues around credentialing for the Royal College of GPs to enable our education sessions to be accredited. We are also working with Philippa Jones around how basic life support/CPR education that is currently delivered privately (mainly around life support and CPR) could be incorporated to provide networking opportunities and reduce the expenditure that individual practices spend on private providers.

3.2 CCDM

The use of overtime is one of the CCDM core data set (CDS) measures reflective of system activity and should decrease as base staffing improves. Reduction of overtime is a focus of savings opportunities. As noted, there is a downward trend with overtime currently 1.8% of worked hours. This is from a peak of 2.6% in June 2019.

Casual staff use

While it is pleasing to see the reduction in use of overtime, casual staff usage is high reflecting the requirement to respond to increased demand. Casual staff are an important variance response tool however high levels of causal staff impact on the efficiency of the team as they may not be as familiar with the environment or have the same skill set as the staff they are replacing. The continued high occupancy at Tauranga required Medical Day Stay to be used for overflow patients more nights than any previous record in the last five years. This requires additional nursing staff and impacts on the medical day stay throughput. ICU also required high levels of additional staff for ventilated patients.



Allied Health Variance Response Management (VRM)

A national Allied Health CCDM expert advisory group has been established under the Safe Staffing Unit.

Allied Health now have visibility of their VRM forms via the Integrated Operating Centre (IOC) site. Previously they have been doing this manually and reporting verbally at the daily operations meeting. The proportion of time in Orange at Tauranga again reflects the sustained high occupancy.

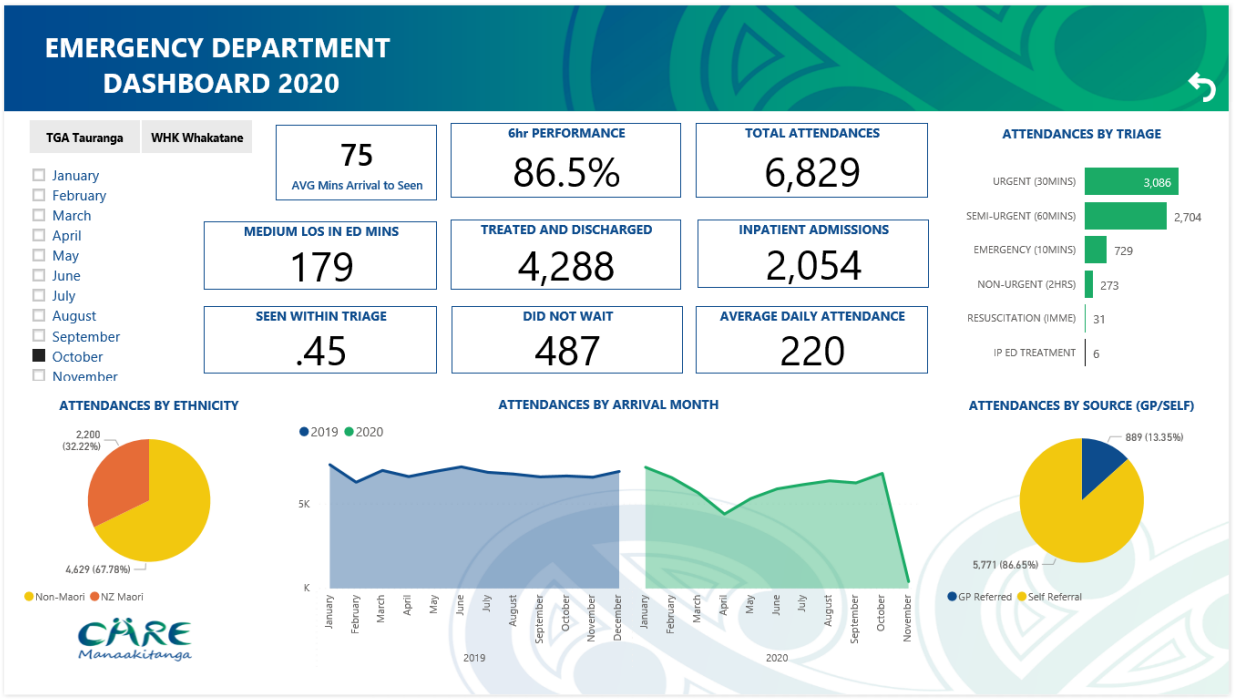
3.3 Whakaari Recovery

The major focus during October was on the recruitment process for the Hauora/Wellness Coordinator position which saw interviews of candidates in late October and early November. Appointment expected to be made in mid-November.

As part of the post-Whakaari recovery process a survey underway is underway with staff on strategies and outcomes aimed at improving staff wellness.

4. Bay of Plenty Health System Performance

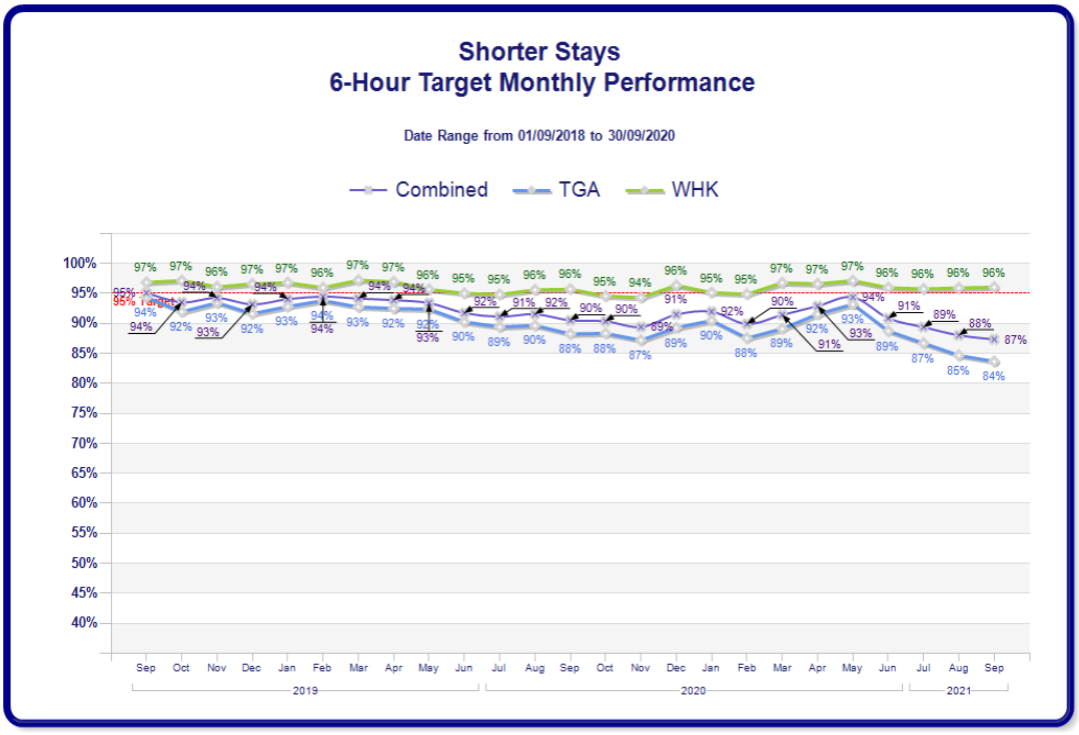
Emergency Department Presentations

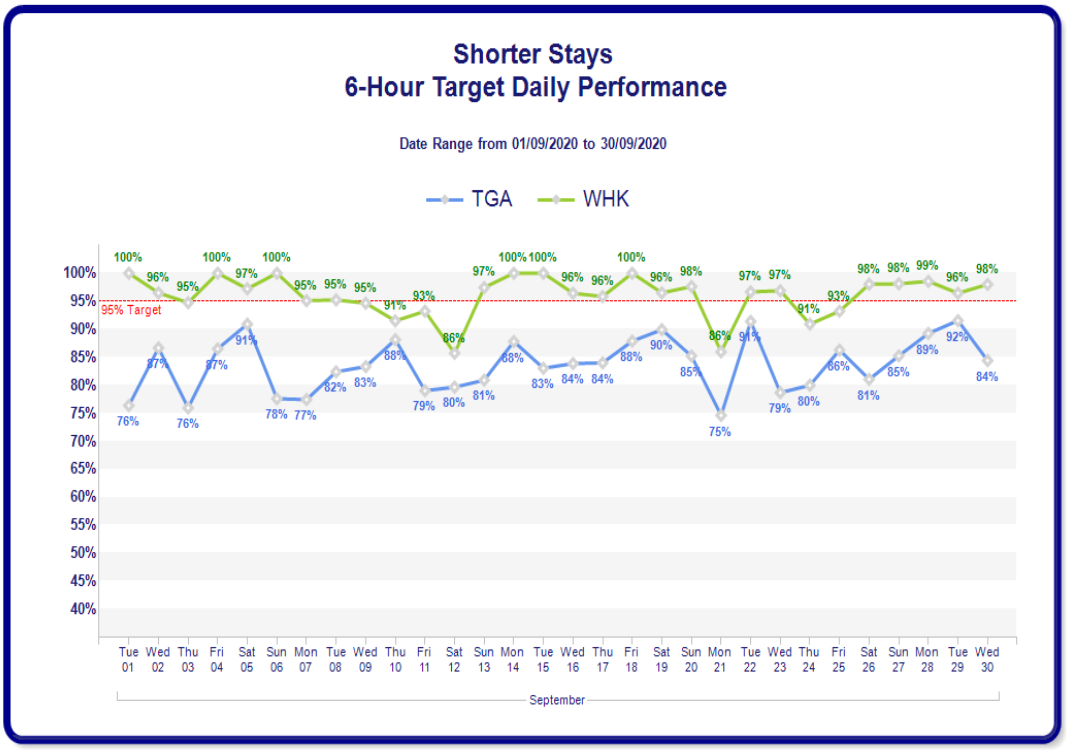


Shorter Stays in ED September Result: 87%

Work continues with the focus on the acute flow journey, bed management via the Integrated Operations Centre is a key part of this activity. Allied services are now an integral part of the ED front of house response taking direct access to triage (in "normal" hours) patients.

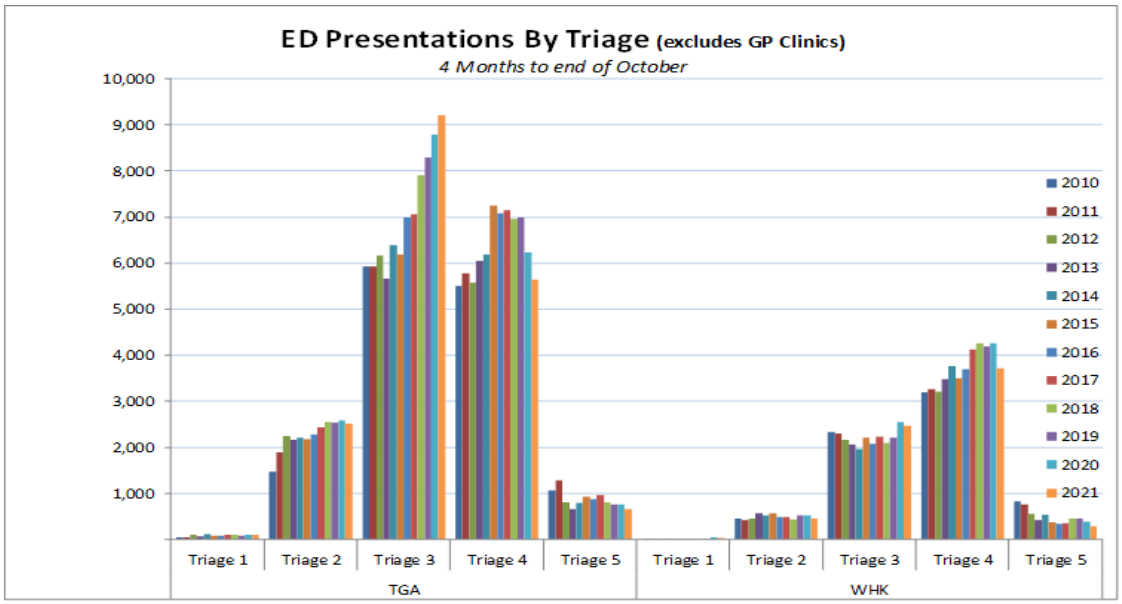
Whilst these are positive developments that will result in benefits over time, the current trending is a cause for concern being it indicates that our services are becoming gridlocked at this time of peak demand.



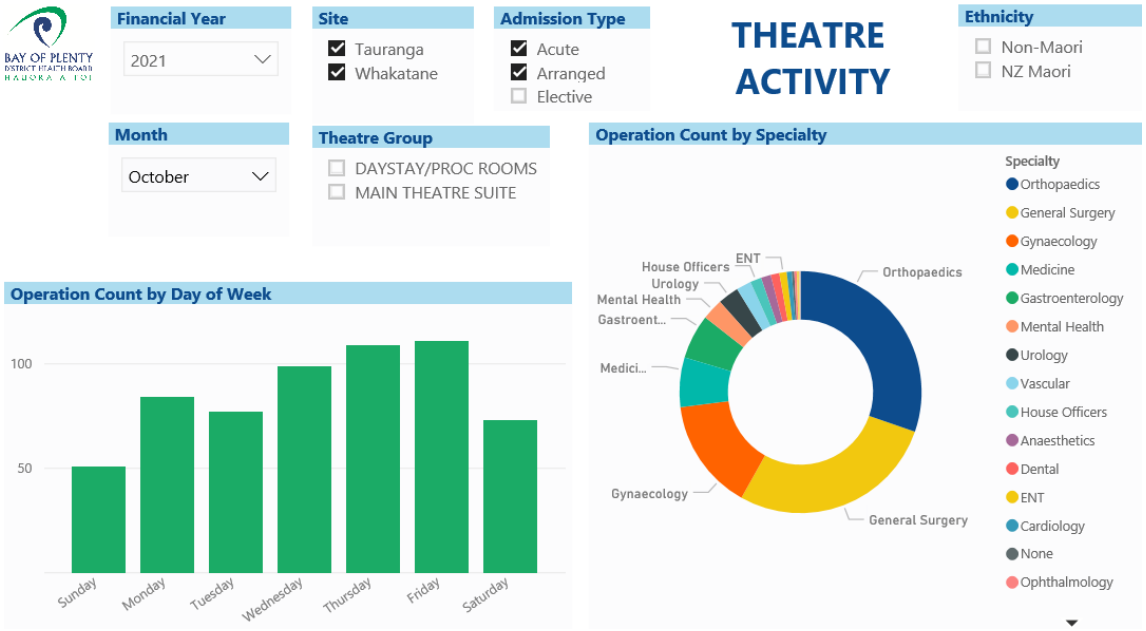


There have been a number of issues which have contributed significantly to the deterioration of the indicator

- Increased admission rates from ED – a review of these highlighted that these were appropriate admission. The evidence shows that across both sites acuity of patients has increased since the same time last year and in comparison the pre Covid. This leads to increase demand for beds and limited ability to respond.
- Presentations to ED particularly in higher triage categories have significantly increased in the out of hours time periods when general staff in ED is less but more importantly other sub specialty and allied resources are significantly reduced.



Acute Surgical Theatre Activity



Total Acute Operations October 2020

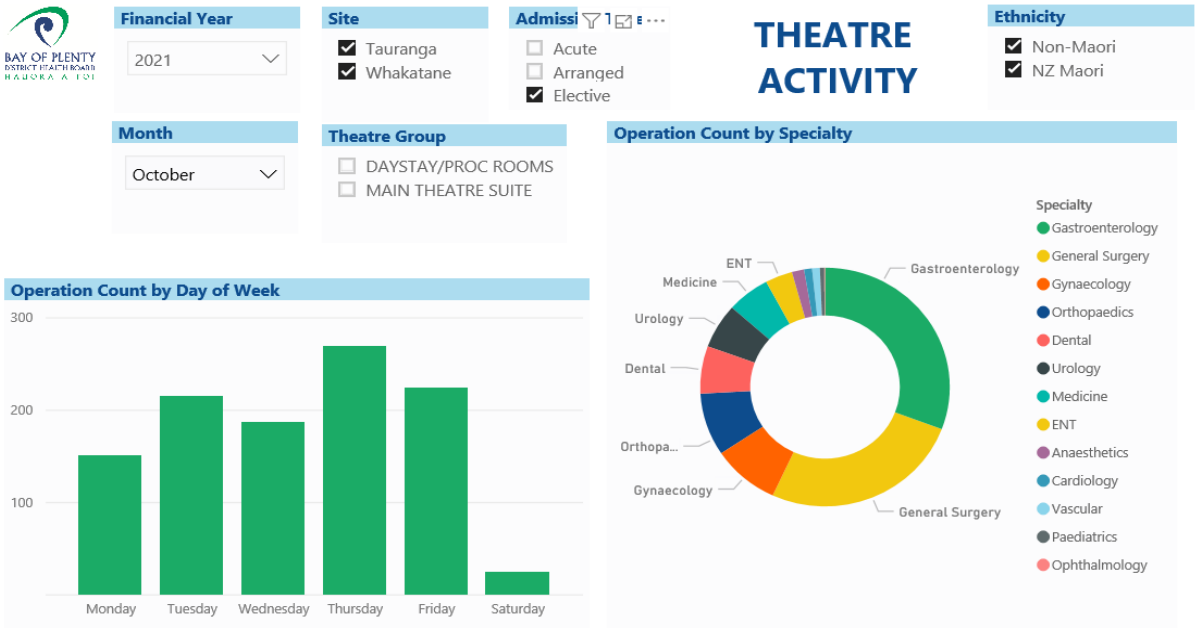
Ethnicity: All

Operation Count	Theatre Minutes	Patient Count	Admission Count
604	50,328	539	559

Ethnicity: NZ Maori

Operation Count	Theatre Minutes	Patient Count	Admission Count
388	27,153	360	373

Elective Operations October 2020



Total Elective Operations October 2020

Ethnicity : All

Operation Count	Theatre Minutes	Patient Count	Admission Count
230	14,084	228	229

Ethnicity : NZ Maori

Operation Count	Theatre Minutes	Patient Count	Admission Count
1,074	63,138	1,059	1,070

Faster Cancer Treatment

BOPDHB tracking to 99% for the 62 Day Indicator and 93% for the 31 Day Indicator for Quarter 1 - this is great news.

The Te Manawa Taki MDM Solution is a database developed by a company called Dendrite which will streamline, standardise and where possible automate the admin business processes that support the MDMs (Multidisciplinary Meetings for Tumour Streams). The system is in the final stages of preparation and will go live at Waikato first, followed by BOP in coming weeks. This system will improve safety and care by ensuring to robust and consistent approach to supporting people through their cancer journey.

Tauranga Paediatrics

The Tauranga Paediatric ward has recently experienced high numbers of children with mental health issues. This has presented challenges that has required debriefing and coaching for staff and is going to require ongoing monitoring as we do not have a children's mental health ward and this may be something that needs to be considered.

Te Haumaru Kohangahanga (Children's Day Stay Unit) is progressing well. There will be continued drive to use it to full efficiency, ensuring that as many children as possible receive care as day treatments rather than being admitted overnight.

5. Financial Performance

October was a positive month in terms of financial performance with a mix of internal and external movements contributing to a $2.3m positive budget variance for the month.

Lower than budget staff costs, a reduction in the capital charge (reduced to 5%) and higher than budget Pharmac revenue were all contributors to the improved monthly result. This is in sharp contrast to the previous two months and has led to a year to date result of approximately $2.4m adverse, including impact of COVID.

With four months of the year complete, the DHB will shortly commence reporting an estimated year-end forecast position. As neither COVID nor Holidays Act costs were included in the 2020/21 budget, these will drive a year end adverse variance.

6. Bay of Plenty Health System Transformation

6.1 Digital transformation

Following sign-off of from the Executive Committee, the initiation stage of the Digital Strategy programme commenced in October involving the identification of key stakeholders prior to embarking on engagement meetings & workshops. Richard Li and Dr. Will Reedy (CEO of SPARK Health) will deliver a joint presentation to the November Executive Committee meeting to outline the next steps of this work.

Development of e-Referrals; eTriage and Pathways

eTriaging (a key component of the Midland Clinical Portal) is Progressing with the following services now online:

- Paediatric
- Ear Nose and Throat
- Dental
- Renal
- Infectious Disease
- Breast
- General Medical
- Dermatology
- Health in Ageing
- Respiratory

The following services have planned Go Live dates over the next month:

- Sleep Service
- Outreach Clinic for ENT

eReferral has been developed for Clinical Physiology that enables DHB services to refer electronically.

Data & Digital Programme – MoH Quarterly Update

The DHB has six key areas of focus under its Data & Digital Programme and is required to report quarterly on progress against those areas.

Key Focus Area		Assessment
Integrated Sector Digital Services	Development of sector wide federated digital services capability including, shared leadership, care planning/scheduling, digital strategy.	On Target
Telehealth	Further development of telehealth capability with particular focus on specialist services delivered into the community and opportunities for iwi led initiatives.	On Target
Digital Maturity Assessment	Working with MoH to assess digital maturity across primary, community and secondary care services.	Delayed
Midland Clinical Portal	Transition off local clinical workstation onto regional portal.	On Target
Digital Maternity System	Identification and implementation of digital solution to support maternity service delivery across the DHB.	On Target
FPIM	Implementation of the national Finance Procurement Information Management system.	On Target

Business Systems – eRecruitment Replacement

The project to replace the DHB's use of Taleo as its recruitment system was virtually complete by the end of October. The planned go live of 3rd November meant that in the last week of October all electronic recruitment processes were "paused" in preparation for the system changeover.

Workshops with hiring managers have demonstrated the new system is more intuitive and easier to use than the legacy Taleo system and, to date, feedback has been positive, although the real test will be once the system is rolled out in early November.

Business Systems – Microsoft Modern Workplace
The programme to adopt the Microsoft cloud based product suite as part of the DHB's digital transformation has recommenced after a pause due to COVID impacts. At the end of October, 57% of the fleet had been transitioned over to the new operating system and cloud based product suite – up from 46% at the end of September. The completion of the transition is timetabled for end of March 2021.

Overall confidence level for this project is currently Medium due to the potential technical issues that are being encountered and dealt with due to the complexity of the DHB environment. As the migration progresses this confidence level is expected to increase**.**

Business Systems - Project Portfolio Overview (Proof of Concept)
The Information Management team has developed a proof of concept project portfolio dashboard that enables easy reporting of the programmes of work currently planned and underway. The proof of concept is an improved mechanism for reporting projects and their status as captured in the Cherwell service management toolset.

Business Systems – FPIM/Health System Catalogue
BOPDHB has been approached by NZ Health Partners Ltd (NZHPL) to be an early adopter of the national Health System Catalogue project along with three other DHBs (Mid-Central, Wairarapa and Tairawhiti) - a reflection of the work done to date as a Wave 1 DHB and recognition of the skillset of the DHB's procurement specialist. While the opportunity to influence the direction of this national programme is useful, it is unclear whether there would be any financial assistance to backfill FPSC team members. As we are in no position to expend additional resources on this national programme, at this stage we have not agreed to participate.

6.2 Planned Care Improvement Initiative Funding Proposals

BOPDHB has been successful in receiving funding for eight of the nine submitted suite of proposals for the Ministry of Health Service Improvement and Workforce Initiatives. (Total funding of $4,071,300). This will enable faster progression and implementation of these activities that enable our BOP Health system transformation intentions.

These selected proposals focus on equity, quality and agile change principles and will contribute to substantially reducing waiting times, providing alternative models of delivery and increasing equity for Māori:

He Pou Oranga Tangata Whenua Model of Care
Community Orthopaedic Triage Service
Enterprise Scheduling Platform
Community-based Ultrasound Services at Kawerau and Ōpōtiki
Increased Radiology engagement for Māori
Electronic Shared Care Planning
Telehealth: Workflow Integration
Telehealth: Programme of Sustainability

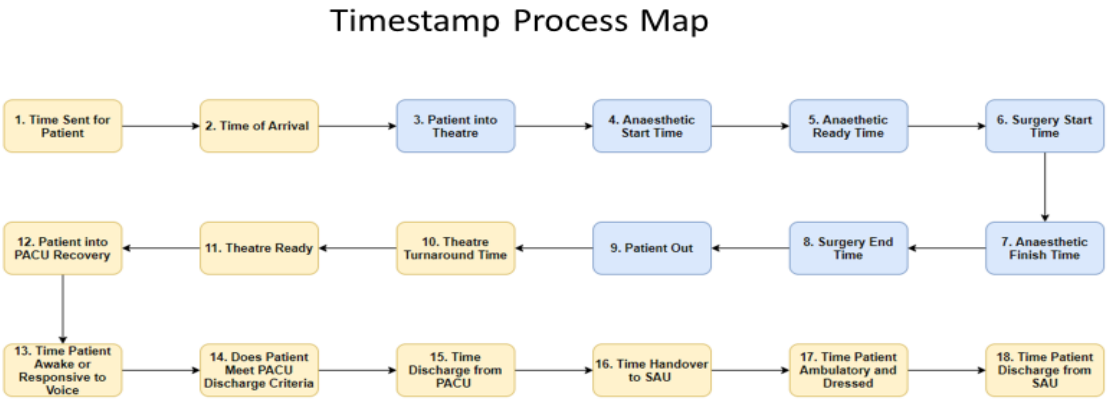
6.3 DHB Operating System: How we work

Integrated Operations Centre (IOC)
Hospital Capacity at Tauranga is still under pressure with ICU / HDU constraints causing further disruption to planned care operations. To address this capacity issue no more than two planned care cases are booked on any given day requiring an ICU/HDU bed.

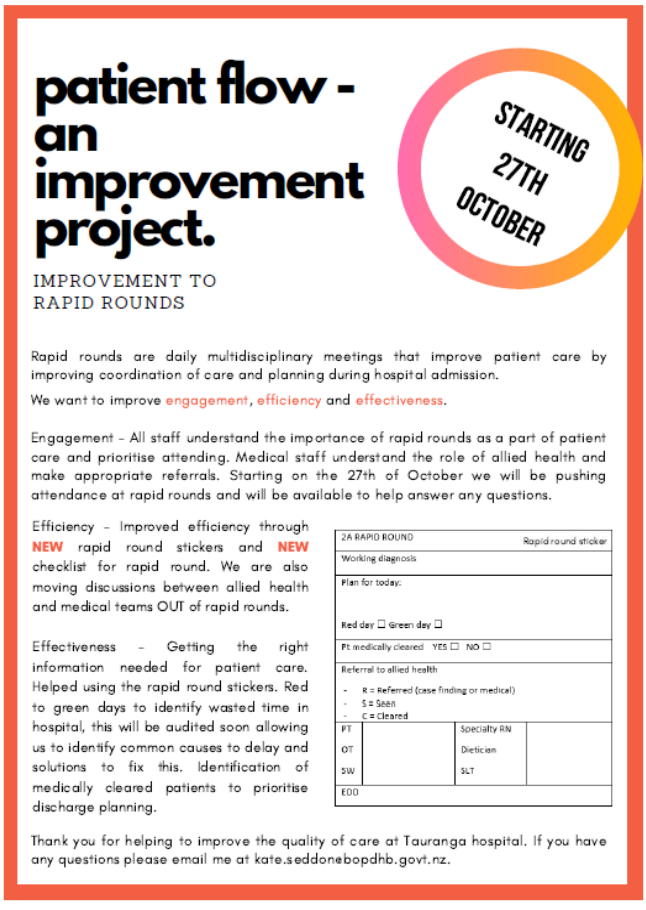
The IOC continues to take responsibility for the hospital response to the national COVID 19 situation.

In order to maintain a sufficient number of COVID- 19 testing numbers nationally our public health nurses offered testing for asymptomatic staff across both sites. The uptake has dwindled off to very small numbers and as we move into alert level one, we will cease to provide that testing and direct all staff to their GP.

Process Mapping of Peri-operative Patient Journey (Tauranga) is completed with agreed timestamps to be recorded (see following table). This will enable the more accurate recording and reporting of delays from which improvement work can commence and align the current Theatre Hospital at a Glance screens with Theatre timestamp definitions as agreed by Theatre staff.



The Red to Green project, aimed at improving patient flow through identifying local trends (ward level) in discharge delays has been relaunched. Whakatane Hospital have already completed a two week focus and are currently actioning their findings. Dr Kate Seddon supported by the IOC, is leading this at Tauranga Hospital



patient flow - an improvement project.

STARTING 27TH OCTOBER

IMPROVEMENT TO RAPID ROUNDS

Rapid rounds are daily multidisciplinary meetings that improve patient care by improving coordination of care and planning during hospital admission.

We want to improve engagement, efficiency and effectiveness.

Engagement - All staff understand the importance of rapid rounds as a part of patient care and prioritise attending. Medical staff understand the role of allied health and make appropriate referrals. Starting on the 27th of October we will be pushing attendance at rapid rounds and will be available to help answer any questions.

Efficiency - Improved efficiency through NEW rapid round stickers and NEW checklist for rapid round. We are also moving discussions between allied health and medical teams OUT of rapid rounds.

Effectiveness - Getting the right information needed for patient care. Helped using the rapid round stickers. Red to green days to identify wasted time in hospital, this will be audited soon allowing us to identify common causes to delay and solutions to fix this. Identification of medically cleared patients to prioritise discharge planning.

2A RAPID ROUND			Rapid round sticker
Working diagnosis			
Plan for today: Red day ☐ Green day ☐			
Pt medically cleared YES ☐ NO ☐			
Referral to allied health - R = Referred (case finding or medical) - S = Seen - C = Cleared			
PT OT SW		Specialty RN Dietician SLT	
EDD			

Thank you for helping to improve the quality of care at Tauranga hospital. If you have any questions please email me at kate.seddonebopdhb.govt.nz.

Workforce and People Strategy

Self Service Leave Applications
As part of the process of replacing legacy processes with digitally enabled ones, the roll out of automated leave using roster self-service application will recommence in November. This workstream had been paused because of the eRecruitment project and to allow any findings from the HAC project to be addressed. The HAC project identified that the process for application of leave in the DHB was non-compliant as leave was being applied for and approved in multiple ways. Utilising the self service module will assist in making the leave application process compliant. Currently approximately 1300 staff are using the self-service process for leave applications.

6.3 Integrated Healthcare

Orthopaedic Transformation Programme
Currently within this programme there are 4 strands of work:

1. The Community Orthopaedic Triaging servicing (COTS)
2. The Musculoskeletal Emergency Department project
3. The Orthopaedic In-patient ankle / foot pathway project
4. The Non-Acute Rehabilitation Services Project

Reporting this month will focus on projects 1, 2 and 4

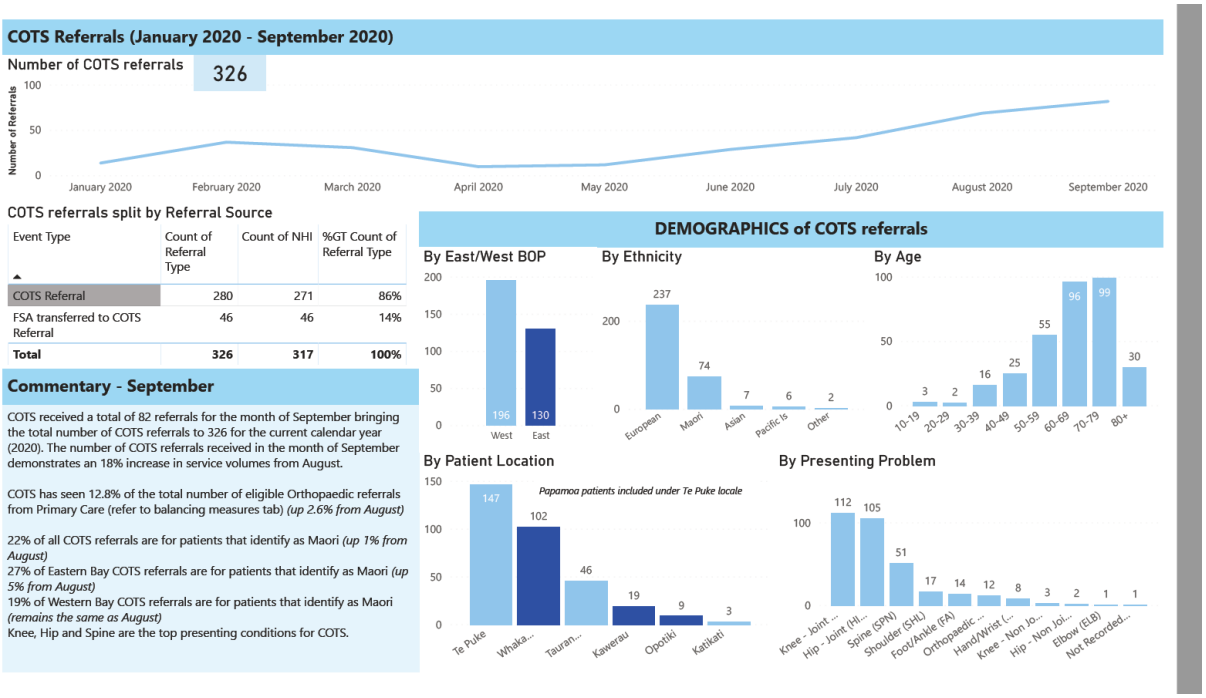
The Community Orthopaedic Triaging Servicing (COTS)
During the month of September COTS continued to gain momentum and has started to attract national attention.

COTS received 82 new referrals (12.8% increase on last month) and assessed 58 patients in clinic (26% increase on last month) due to increasing service demand; a second COTS clinic was opened in Whakatane.

The project team presented the COTS service model and progress to date to Canterbury and Waitemata DHBs, Bay of Plenty Hospital Advisory Committee (BOPHAC) and the Ministry of Health (MoH).

COTS wait times and radiology utilisation rates have been added to the data collection to support robust evaluation of COTS.

As a result of on-going collaborative work and trusting relationships, COTS have obtained support from Orthopaedics to grade direct to FSA as required, therefore bypassing the need for Orthopaedic SMO to grade, unless the decision is uncertain.



The Musculoskeletal Emergency Department (ED) project

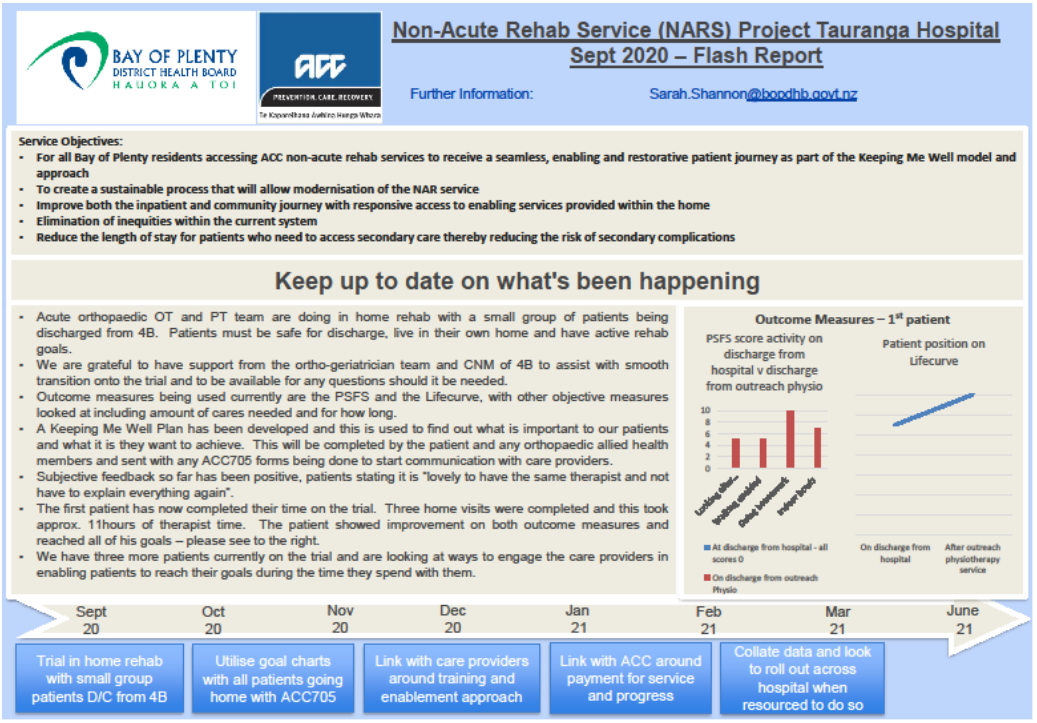
The ED process maps for triage 4 and 5 patients have been finalised, the 2 ED MSK physiotherapists (PT) are now embedded into ED, have developed effective working relationships with the team and seen as business as usual. The ED SMO liaison has been instrumental in this change in ED and has invited the PTs to radiology training and has agreed with proposed changes to the standing order process for simple analgesia. Changes now to be formalised in controlled documents.

Total triage 4 and 5 MSK patients seen by MSK physio in ED (Feb-Sept 2020)	606
Total patients admitted after seen by MSK physio in ED	33 (5.4%)
Number of patients imaged (after MSK Physio Assessment)	383 (63%)
Number of +ve imaging results	146 (38%)
Number of cases escalated to medical team	39 (6.4%)

Non-Acute Rehabilitation Services (NARS) Project Tauranga Hospital

This project is progressing and patients managed in this way have reduced impact on the intensity and frequency of inpatient allied health orthopaedic care.

Staffing levels and VRM status have made it challenging to provide this service



Keeping Me Well – Western Bay Nga Kakano Practice Test Team

The aims of this pilot include:

- Provide clinically and culturally safe care to Māori, in an environment where Māori patients, whānau and staff feel valued, and where the team/ leaders actively seek to eliminate inequities
- Reduce barriers and improve access to community allied health services, closer to home for Te Puke based Ngā Kākano patients through delivery of Poipoia te Pā Hārakeke in the home or any other location that the client choose.
- Test how best to support health professionals to deliver a Person-Directed approach, change rigid health structures and practices, and advance health equity
- To prevent admissions to hospital and improve client wellbeing through delivery of enablement programmes in the home.
- To reduce ED presentations through responsive enablement programmes in the home.

The LifeCurve™

The aim of the project:

- To support healthy aging in our Bay of Plenty communities
- To facilitate early intervention
- To link communities to support services available closer to home
- To work alongside Professor Ngaire Kerse in support of the AWESSoM research programme

Some high level messages around benefits of using the LifeCurve™ across the Bay

- Service Users receive a set of outcomes tailored to their stage on the LifeCurve™ to improve their ability or maintain it for as long as possible
- Commissioning Organisations and Partners can assess the impact of their services on healthy ageing using the LifeCurve™ as a measurement tool
- Commissioning Organisations and Partners can promote services and target them to those with relevant areas of need.
- Supports gap analysis in provision of services
- Supports scaling of services, to see where further/extra provision is needed

Progress to date:

- Project manager for LifeCurve, Kathy Everitt, commenced in new 1 year fixed term role.
- Regular meetings via Zoom with ADL SmartCare UK for support to Bay of Plenty launch of LifeCurve™ App
- Currently in testing phase, meeting with all 5 partners/testers to facilitate and support using the LifeCurve™ App with plans to increase testing, collaborate with MHGD regarding changes to the App to make it relevant for Maori and all NZ, and look at mapping of services to positions on the LifeCurve™
- Tauranga Orthopaedics NARS trial good news story with LifeCurve™ testing, 1 patient moved up 3 levels (discharge from Tauranga Hospital to 6 weeks post with outreach physio input at home); now only 1 level away from being off the LifeCurve™

BOP Community Care Coordination (CCC)

- BOPCCC continue to develop the service and have recently met with the Whakatane Social Work team and providers which was very productive. These meetings are to continue on a regular basis to ensure appropriate networking and information sharing.
- A recent meeting with GPs in Tauranga to discuss the BOPCCC role and function has also been very useful.
- Additional funding has been approved for a short term staff member to assist with the increasing work load and increasing number of complex referrals that BOPCCC is managing.

Radio-isotope injections

Currently BOPDHB domiciled patients travel to Waikato DHB for a minimum 3 hour return drive for patients requiring sentinel node biopsy as part of their treatment - predominantly Breast and Melanoma surgery. Our operational teams are working with Nicola Davis, General and Breast surgeon, to scope out the feasibility and logistics of providing a radio – isotope injection service locally for these patients.

ENT Outreach Clinic Kawerau

A recent study was undertaken to determine if remote clinics improved access to healthcare by assessing the trend of clinic attendance over time. In summary the study found that the ENT Outreach Clinic Kawerau clinics has improved access to ENT healthcare for the children of Kawerau and the iwi have been an invaluable partner in achieving equitable access to healthcare.

6.4 Child Wellbeing

Child Development Services

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

"…committed to changing how disabled people and whānau are supported by working on the planning and design processes that would have Health New Zealand and DHBs working differently than they do today.

In Tauranga… these discussions are happening now and I'm part of a newly formed advisory group that's looking for ways that we can redesign the current system and move away from the pockets of funding we're all fighting over and bring them together for the benefit of the individual or the family. "

The project has documented an initial understanding of CDS which is being reviewed by the CDS teams before wider circulation. The document brings together feedback from our teams on what the service is, what's working well, and what are the opportunities ahead. Next steps for the project include process mapping for CDS, and hosting whānau engagement events such as focus group with the first one planned for 21 October in Tauranga.

Pre-school Oral Health Enrolment

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

Community Dental Services

The biggest issue for community dental are overdue examinations (arrears) post COVID which are now at 44% (19,677), a 2% increase on August figures. The service continues its prioritisation framework with an emphasis on Maori and Pasifika, high risk children and those most behind in their annual examination. This will framework will continue through the 2021 calendar year.

Community Dental staff in Whakatane have hosted the first two rural health immersion programmes, with two students from Otago University.

B4 School Check Programme (B4SC)

The B4 School Check programme performance is improving and statistics are showing an improvement in the number of nursing checks.

The B4SC co-ordinator is focussing on training new B4SC nurses in CH4K and delivering training for Te Manu Toroa nurses. This has resulted in Te Manu Toroa performance improving dramatically. Plunket are behind in their contracted service delivery due to sick staff and COVID recovery plan. The co-ordinator is working with the vision and hearing technicians to improve the lag time between the nursing check and VHT check. This is impacting our performance. Administration processes also being targeted for improvement in regards to Plunket. Innovation being pursued relates to electronic referrals and on-line documentation.

National Immunisation Register (NIR)

New national reporting, along with new reporting programme has rolled out, with a range of issues that are impacting NIR being able to provide Providers with reports on performance and targeting specific children for immunisation. This is slowly being resolved, including BOPDHB IT providing "work arounds".

Public Health Nursing (PHN)

A preschool PHN is to be seconded to Child Development Services for a fixed term, which will be great for both services and build alignment and service capacity.

The PHN service is being contracted to co-ordinate the 15-29yr old MMR (measles catch-up) over the next 12 months. This roll will be a 0.5FTE and work across primary, secondary and community care including Hauora Maori. The PHN service will be contracted to deliver the MMR programme in the high schools to target the 15-18yr olds with one dose.

The clinical nurse manager has met with MiCAMHS to work on improving the working relationship between the PHN's and MiCAMHS staff and to form multidisciplinary teams.

The only COVID related work PHN's are undertaking on rotation is providing 1 PHN to Toi te Ora per week as part of the ongoing COVID response. DHB staff swabbing clinics have ceased and PHN's supporting Lakes DHB are now back in their roles in Tauranga and Whakatane.

Extending vaccination services with Maternity is under discussion and beginning to move forward again. This has 2 focuses:

- BCG vaccination programme for immunising new-borns against TB. Who and where will this be delivered from 2021 is under review. PHN service is delivering this all by clinics currently and not in Maternity ward
- Training 20 midwives and midwife co-ordinators to become Independent Vaccinators so as they can deliver good advice to mothers on childhood vaccination, vaccinate high risk pregnant women in their third trimester who attend DHB antenatal clinics plus the flu vaccination during flu season.

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

The Family Violence month programme is set to roll out shortly and is being funded through the BOP Health Trust.

Family Violence cases continue to increase in complexity and the advice and time needed by the FVIP team is significant. The team is being called about to advise staff in regards to elder abuse which is not a funded part of the MoH FVIP programme.

The VU co-ordinator has identified some gaps in identifying vulnerable mothers when mothers are attending ED, so is working with ED currently on "work around" processes, while an VU alert system is developed for BOPDHB by IT.

7. Health and Safety

ACC Accredited Employer Programme (AEP) Audit

The new Health & Safety Manager has undertaken a programme of stakeholder communicating of the plans for the next six months as the service moves towards a clear strategic plan to take the DHB forward and to prepare for the ACC audit to be undertaken in June 2021.

The ACC Accredited Employer Programme (AEP) audit for 2020 which focused on injury management has been completed and the DHB has retained its tertiary level accreditation under the AEP programme.

8. Clinical Campus

Students

The 2021 Academic year for medical student commences as follows:

- Monday 11 January 2020 with 29 UoA Year 6 students.
- Monday 25 January 2020 for Year 5s
- Monday 15 February 2020 for Year 4s.

These students will be confirmed once the Board of Examiners have met for each year, in the next month. We will have around 70 University of Auckland students over the three cohorts.

Mock year 4 exams were held on 28 and 29 October, many registrars, house officers and consultants helping with these. The real exam will be held in Auckland in a couple of weeks. Special thanks to James Chancellor and Nazley Youssef for all their organisation and guidance for students with the mock exams.

Research

HRC Health Sector Research Collaboration Grants
The Health Research Council of New Zealand (HRC) has completed assessment of our applications to the Health Sector Research Collaboration Grant. I am very pleased to advise that the following applications have been approved:

Research Activation Grant

- Sarah Mitchell (co-investigators: Marama Tauranga, Charlie Stratton) – He Pou Oranga: Developing a Framework for Integrating Technology and Health ($89,708)

Research Career Development Awards

- Leigh Haldane – Exploring the use of technology (LifeCurve App) to promote wellbeing among Māori ($109,600)
- Mariana Hudson – Developing skills and expertise in Kaupapa Māori research methodology ($83,000)

The grants are allocated for a 12-month period from Now / Dec 2020. The advertising/marketing of these will firstly be announced by HRC and is embargoed until then. A DHB communications article will be developed once formally announced.

Clinical Trials
Two new Clinical Trials were initiated in October:

KEYNOTE-641: A Phase 3, Randomized, Double-blind Trial of Pembrolizumab (MK-3475) Plus Enzalutamide Versus Placebo Plus Enzalutamide in Participants with Metastatic Castration-Resistant Prostate Cancer (mCRPC). Principle Investigator: Dr Elliott Brenman.

SKYSCRAPER 7: A Phase III, Randomized, Double-Blind, Placebo-Controlled Study Of Atezolizumab With Or Without Tiragolumab (Anti-TIGIT Antibody) In Patients With Unresectable Locally Advanced Oesophageal Squamous Cell Carcinoma. Principle Investigator: Dr Richard North.

Two new trials are due to open in November.

9. Te Teo Herenga Waka and Toi Te Ora

Planning
Transactional
Indicators of DHB performance (IDP) is poised to change over the next two reporting cycles. The aim is to vest more control and responsibility in the "feeder" divisions and at the same time raise the profile of this activity. A subset of critical indicators will be undertaken by the GMs P&F and Allied Health, in the latter's role of System Architect.

Transformational
GM P&F and the Exec Director Allied Health have committed to jointly working up the DHB's first disability strategy. Other DHBs and their Allied Health units are being canvased. An offer has been extended to Lakes DHB to work on a joint strategy.

Personal Health
Transactional

Inter district flow reviews have been completed as part of the current year savings plan initiative, and in preparation for the 20/21 financial year. Next steps will involve resetting production level expectations, noting Alma's advice that greater budget/target visibility for both referrers and providers is key to managing production volumes.

Work done in the 20/21 financial space has identified outliers in inter-district flows that should not form part of next year's budget. Negotiating volume adjustments with other DHBs will take place in November.

Transformational

Urology workforce planning is underway with options in negotiation that will future-proof the service and flesh out succession planning. The prospect of supporting Tairawhiti with its Urology needs is also being considered. The East Coast is currently reliant on service provision out of Auckland. Links to the Lakes/BOP service may provide a better, more convenient level of service coverage.

Governance of Laboratory testing is about to get a refresh with the reformation of the Laboratory Clinical Board. The timing is perfect, now that DHB clinical governance is also being refreshed. Also on the lab agenda is enhancing ethnicity data. The Data Architect role, currently in Planning and Funding, is working with the lab to be able to track ethnicity, particularly in cases where patients do not go through with their lab tests. The aim is to identify this cohort and report back to General Practice to follow up.

Mental Health and Addictions

Overview

MHA awareness event - 'Fluro Fest' ran very successfully on Sunday 18th Oct at Memorial Park. Initially part of Mental Health Awareness week the event had to be delayed due to Level Two restrictions however the event was extremely popular with a large crowd attending throughout the 3 hours of activities and up-front performances. The event was hosted by radio Hits MC Will Johnston who was also part of the pre-event media releases with reference to his own journey re*g*arding struggling with depression.

Transactional

Cost-neutral changes have been made to two NGO contracts, shifting non-clinical roles into clinical ones, in order to provide increased clinical capacity in the community and support the Navigate collaborative outlined below, as well as recognising changes to practice across non-clinical roles post-lockdown.

Outcome measures have been included in these agreements to ensure that patients progress and recover on their care Journey, rather than becoming dependent on care and support.

Transformational

- Work continues to establish processes including the terms of reference for the steering group to support the Navigate collaborative initiative across five NGOs and MHA NASC- https://www.bopdhb.govt.nz/services/a-z-hospital-services/mental-health-addiction-services/navigate/. This has had an exciting start with an increase in referrals and growth across the collaborative MDT that is providing the support for the NGOs to work with quite complex cases they would otherwise likely not feel comfortable managing in isolation. This initiative is providing a new option for support that has not existed outside of secondary services previously.
- BOPDHB's four Housing and Recovery provider contracts have been reviewed and changes made to their contract in order to contract more intentionally for the desired outcomes for Tangata Whaiora from this service. These changes will have a 6-12 month bedding in period and will require ongoing review meetings with the PM, service and NASC, including a more formal review after 12 months.

Primary Care

Overview

The new skin infection service (Kia Ora project) has launched in 10 community pharmacies in Eastern Bay and Te Puke where trained pharmacists can diagnose and treat children and young adults for skin infections and lice. This is unique to BOPDHB and should prevent serious conditions and hospitalisations through early diagnosis and treatment. Already good news stories are emerging where hospitalisation of two children has been potentially avoided by excellent work by community pharmacists and in conjunction with local GPs.

Opotiki Pharmacy has worked with one large family treating and educating about lice. The family's mother has come in several times for advice. GP practices have welcomed this new service.

Healthpoint are working with GP practices and community pharmacies to enter their specific details into the BOPDHB Healthline informatics.

The DHB made up and sent PPE Grab Kits to all pharmacies, in the event there was another community COVID outbreak, to enable pharmacies to deep clean their premises to a high standard. These parcels were delivered by the BOP Community Pharmacy Group and were much appreciated.

The Specialist Review Service has been operating in the Eastern Bay for several years and has been acknowledged internationally as an innovative approach that addresses equity with actions.

Transactional

- All 56 Integrated Community Pharmacy Services Agreements (ICPSA) have been varied with agreed updated funding uplift and terms from 1 October 2020.
- Excellent news, from 28 October, the MMR vaccine is being temporarily classified as "prescription-only medicine", except when administered by a vaccinator who has completed a Ministry of Health-approved training course. This means that intern and pharmacist vaccinators providing the MMR Immunisation Service will be permitted to provide the vaccinate outside of the pharmacy site.
- Primary Mental Health RFP – NMO have indicated they will join with WBOPPHO and EBPHA to prepare a BOP wide proposal for the roll out of the Te Tumu Waiora Integrated mental health and wellbeing programme. Work has progressed on the methodology for an equity focused phased rollout to ensure maximum breadth of reach for Māori.

Transformational

- EBPHA has been funded, by the Provider Arm, to undertake a 12-month cellulitis management pilot in primary care. This is a result of the excellent collaborative work by the E3 group in the East.
- A fund of $1.7 m enabling workload relief for overstretched community pharmacy teams, has been set up. The MoH is funding this via the Pharmacy Council and it is targeted to community pharmacy teams providing services to Māori and/or Pacific peoples, possibly working as a sole practitioner, and those in independent, or independent franchise-held pharmacies.
- At its recent strategic planning workshop, the WBOPPHO Board committed to establishing a local Māori health commissioning agency that would be responsible for commissioning services initially through allocation of WBOP PHO retained earnings. The commissioning agency would support Rangatiratanga for Māori and uphold Māori values in the design and development of health and wellbeing services. There is an opportunity for the commissioning agency to also become a service integrator and coordinator for Māori through accessing funding streams across health and social services and commissioning integrated services.

Child, Youth (Family) and Oral Health

Overview

This first monthly report (new template) is an opportunity to reflect and comment on activities that are aligned to BOPDHB organisational priorities and govt policy guiding transformational change.

The organisational construct for BOPDHB to deliver on the Govt `Child and Youth Wellbeing` policy will be to orientate our systems delivery and service improvements to a `whole of system` (and Integrated/client centred) approach; inclusive of `Woman, Child, Youth & family`, this recognises the life course continuum for timely intervention.

At this level an important approach is to update the health service framework (internal and external for BOPDHB) so that the Annual Plan actions and client/clinical pathways are connected through appropriate decision making, advisory and operational workforce delivery.

Useful examples this month are; the first `Child Development Service` (CDS) Advisory Group meeting, established to advocate and advice the CDS Innovation project. This group includes internal BOPDHB, external cross sector partners OT and MoE and clinical specialties. The group will meet regularly and as needed.
We have also this month met with MSD/OT staff consulting on Youth issues for their beneficiary client population in BOP who are expressing difficulty accessing health services; specifically they identified medical assessment, emergency housing and public health/prevention. We have agreed to establish baseline data known for the youth cohort from the MSD/OT and health views.

Consistent improvement in Childhood Immunisation achieved

The vaccination support service have concentrated efforts on missed children to improve timely vaccination and this has supported our improved consistency of coverage 87% Total and 84% Maori at 12 months; the NIR team have worked closely with the PHO Outreach services (OIS) to secure actions for the cohort of children each month. To the extent that all WBOP and EBPHA (PHO) missed children this month have outcomes – the majority non-responding to OIS and GP or delaying/hesitating due to Covid-19 heightened concerns.

Transactional

- Childhood Immunisations; meeting the health target remains frustrated by decline rates ranging from 8.6 to 11.2% for ages (12 months to 5 yrs) this will continue to be a focus for Immunisations co-ord staff working with GP practices
- Influenza coverage for >65 yrs has plateaued at 74% and 67% for Maori, this result although below target 95% is in the top 5 DHB results for the season
- Raising Healthy Kids (RHK) obesity (BMI) assessment performance to target, has short-term risks to be mitigated by actions with GP practices, for referral acknowledgement
- RHK - we also have a high decline rate for referral due to family perception that the test and need is not present; this is particularly present with Maori rate of referral decline at 72% (6 month profile) compared to 62% for total population.
- School Based Health Service (SBHS) coverage has been planned for extension to Alternative education and Kura schools to ensure equitable primary care intervention for school youth, this is progressively improving.
- SLM update on working groups for child and youth; have not met in quarter 1 due to the system `lag` effects of COVID 19 responses required by working group members.

  Currently there is no Alliance with active coverage for youth matters; negotiations with the BOPDHB primary care alliance `BOPALT` are stalled at present but other forums are being investigated
- WCTO - Two Quality Improvement hui with kaupapa maori providers completed with identification of reporting and PMS system improvement required, also a need to better capture (Whanau) mahi done and resource needed.

  Provider staff has also identified the need for assistance with professional development in the key priority area of family violence (FV) as another quality indicator for assessments and understanding.

Transformational

- First 2000 Days Project is re-starting in November, focused on reviewing the programme priorities and assessing project trials working with pregnant woman who live with complex lives.

- Measles Mumps and Rubella/MMR catch up campaign Plan submitted with MoH, an `Implementation schedule` has been populated and in progress; local communication plan drafted for roll out with national resource from HPA

Toi Te Ora Public Health

Youth of Kopeopeo

Youth of Kopeopeo is proud to present '*Ko mātou nei – Toimanawa Kopeopeo'* (This is Us – The heartfelt art of Kopeopeo). '*Ko mātou nei*' is a multimedia exhibition which is now showing at Te Kōputu A Te Whanga A Toi within the Whakatāne Library. Over the course of four months, Youth of Kopeopeo conducted interviews with the students of the Trident High School Arts Trade class who were working on abstract self-portraits. These self-portraits have been paired with audio recordings of interviews that can be accessed by a QR code. The opening was supported by Te Iramoko Marae Trust, Trident High School, Whakatāne District Council, and members of the public. The opportunity to share this exhibition within Bay of Plenty District Health Board will be explored in the future.

Food Security

- Toi Te Ora have joined the *Everybody Eats - Ōpōtiki* kaupapa as a project partner. Led by Healthy Families East Cape, this is a collective impact project based in Ōpōtiki.

  The project partners are working with the community to look at innovative ways for making Ōpōtiki a place where everyone has access to affordable and nourishing food all of the time.

- Toi Te Ora has linked with the Fonterra Relationship Manager- KickStart Breakfast regarding their Milk for Schools and early learning services programmes operating in our region. This will assist with our scoping the Healthy Active Learning programme work Toi Te Ora will be undertaking around the food and drinks environment in schools and early learning centres.

Workplace Wellbeing

- Healthy Families Rotorua attended the WorkWell Advisor National Mentoring Zoom session and provided an update with the progress they have made with the WorkWell/Maramataka approach, including the new tools and resources they have developed. The presentation showed the strong link between the two approaches to workplace wellbeing.

  The majority of the national WorkWell advisors have committed to supporting the Mental Health Foundation's Working Well – Mental Wellbeing in the Workplace Workshops in the eight WorkWell regions across Aotearoa New Zealand.

Community Action for Safe Drinking Water Project

- A Hapū Haoura kaimahi is leading a project to raise awareness of Iwi authorities regarding the new Water Services Bill. This month a letter was sent to Iwi from the Medical Officer of Health along with a map of regional marae and kura.
- The establishment team for Taumata Arowai (the new regulator) presented to iwi, marae and hapū, with several Māori small water suppliers present. Follow up actions will be to support the direct lines of communication with Taumata Arowai and small drinking water suppliers, and to develop a submission template in partnership with Healthy Families Rotorua.
- In addition, Toi Te Ora will have input into the work Healthy Families Rotorua is doing to develop a Te Mana o te Wai proposal for the 2020 COVID-19 equity response fund.

  The National Policy Statement For Freshwater Management 2020 describes Te Mana o te Wai as follows:

  Te Mana o te Wai is a concept that refers to the fundamental importance of water and recognises that protecting the health of freshwater protects the health and well-being of the wider environment. It protects the mauri of the wai. Te Mana o te Wai is about restoring and preserving the balance between the water, the wider environment, and the community.

Population and Women's Health

BOPDHB supported the Murupara and surrounding communities to host a series of Women's Health Wananga. The First wananga was in Minginui and attracted over 50 local women. Whilst they were there a nurse was able to check who was overdue their cervical screening and performed 29 cervical screening (smear) tests on the day. This is a great example of a grass roots approach and taking the services to the community. Te Ika Whenua Hauora coordinated and led the day. There are 3 more planned for the rest of the year.

The Portfolio Manager (Sarah Stevenson) presented at the UX Healthcare international (web-based) conference. Sarah shared about how to design and develop health services using co-design principals and drew on the Protected&Proud contraception service as a key example. You can view the live recorded presentation here: https://www.youtube.com/watch?v=tNOo9exaf9c

BOPDHB consent for sub-contract established between Nga Kakano and Poutiri Trust for the Integrated Breastfeeding Service ' Mama Maia'.
Mama Maia has been delivering the Integrated Breastfeeding Support Service for one year and has embedded well the community breastfeeding support service across the Western Bay of Plenty:

- 363 Māmā engaged with Māmā Maia
- One third of Māmā were Māmā Māori and 32% of Māori pēpi

The majority of referrals were for first time Māmā or Māmā without previous breastfeeding experience (63%).

Funding Bid

The DHB has submitted 6 projects to the 'Community for Change' funding opportunity. These projects are required to improve social wellbeing outcomes and are to be within the TCC or WBOPDC boundaries. If successful this work, valued at over $1M, will have a substantial impact of the social determinants impacting the health of our most vulnerable in the Bay of Plenty.

Health of Older People

Supported transition testing from hospital has been running over the last 6 months with the PARIS team who are focussed on those at risk of increased stay in the hospital, this incorporates an early supported discharge element due to be tested from August 2020.

This work forms part of the Keeping Me Well concept that seeks to join providers, DHB/primary care staff as an integrated team to support enablement in the home. The learnings from this initial testing in August will inform a service specification due for completion in December 20202 which will also include the plan for ESB within the NARs programme, funded by ACC.

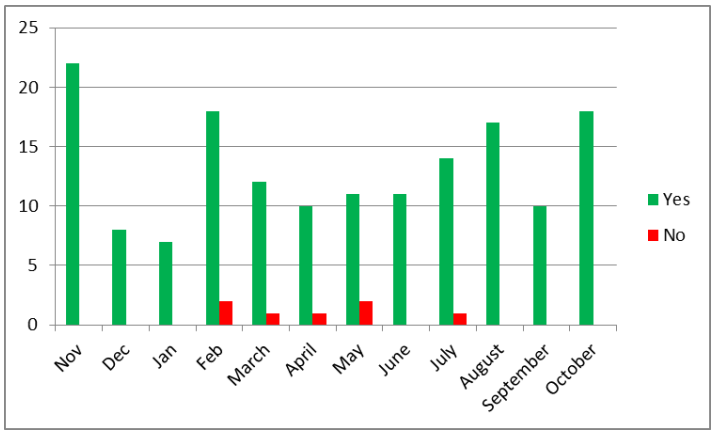
10. Governance and Quality

OIA's (Responded to 1 – 31 October 2020)

	OIA	Requester Type	Due Date	Response Date	Met on time
1	Transgender Health Services	Individual	08.10.20	02.10.20	Yes
2	Gender Affirming Healthcare Services	Media	15.10.20	02.10.20	Yes
3	Colonoscopy Services	Media	05.10.20	05.10.20	Yes
4	HDC, CCU Beds	Union	08.10.20	07.10.20	Yes
5	Endoscopies	Student	13.10.20	08.10.20	Yes
6	Occupational Therapists	Union	13.10.20	09.10.20	Yes
7	Psychotherapists	Union	23.10.20	09.10.20	Yes
8	Pharmacy Contract Policy	Business	11.11.20	16.10.20	Yes
9	Children's Teeth	Media	23.10.20	20.10.20	Yes
10	Pathology and Laboratory Services	Councillor	11.11.20	21.10.20	Yes

11	Costs of Covid Hospitalisations	Business	04.11.20	21.10.20	Yes
12	Fit Testing	Individual	30.10.20	21.10.20	Yes
13	GP Referrals Declined	Media	29.10.20	22.10.20	Yes
14	Alcohol ED Admissions	Media	04.11.20	22.10.20	Yes
15	MOH Funding Applications	Media	30.10.20	23.10.20	Yes
16	STI Diagnosis	Media	09.11.20	27.10.20	Yes
17	DHB Specialist Locum Costs	Media	29.10.20	28.10.20	Yes
18	Mental Health Prescriptions	Media	05.11.20	29.10.20	Yes

Compliance by Month



Health Consumer Council
Key Topics:

- DHB future planning - would like more HCC member involvement;
- Council to share meeting summaries with community groups;
- Consumer Engagement Quality and Safety Marker and current projects;
- Consumer feedback on hospital referrals.
- Finalised Terms of Reference.

The DHB Executive sponsor spoke about the DHB's planning for the future and the intention to have more involvement with the Council members. The HCC members are looking forward to meeting the recently appointed CEO, Pete Chandler. This meeting is scheduled for December.

Summaries of monthly meeting minutes are currently being developed by the HCC to share with community groups. Feedback is being sought from these community groups to ensure the summary statements are informative and relevant to the community audience. The summaries could also be put on the DHB website.

A health sector report was provided by the Kaewhakahaere Takawaenga a Hāpori (Person Centred Experience Lead) informing the Council of his areas of focus. An update was given on the Consumer Engagement Quality & Safety Marker. In addition, there was some discussion around the Whānau centred co-design project, with HCC members invited to attend a ZOOM hui to provide feedback on this concept.
Consumer feedback was shared with members on what consumers think of the referrals to Whakatane Hospital.

The HCC Terms of Reference were finalised to be sent to the CEO and Board Chairperson for consideration

Monthly Indicators report

From Board Dashboard and Balanced Scorecard

October 2020

CARE Manaakitanga

From Balanced Scorecard on PowerBI Indicators on Annual Report

CUSTOMER/WHANAU FACTORS

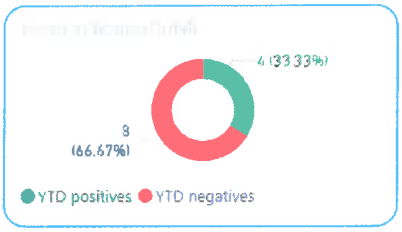
Area	YTD positive total	YTD negative total	YTD positive maori	YTD negative maori	Indicators No Ethnicity
Wai Ora	25	18	7	11	27
Whanau Ora	6	11	3	10	4
Mauri Ora	3	13	1	14	1

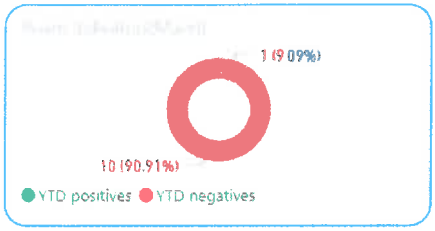
These are the indicators from the Annual Report(Statement of Performance)
From a total of 76 indicators, we can see that 34 indicators are in green, which represents 45%.
From a total of 46 indicators with split by ethnicity Maori, only 11 are in green which represents 24%
From the 76 indicators, 32 do not have split by ethnicity, which represents 42%.

OBS: There is an ongoing restructure in the indicators based on 2020-21 published Annual Plan.

CARE Manaakitanga

From Board dashboard on PowerBI





From a total of 12 indicators, 4 indicators are in green, which represents 33%. From previous month indicator "Percentage of obese children offered a referral" switched from green to red.
From a total of 11 indicators with split by ethnicity Maori, 1 are in green which represents 9%
From the 12 indicators, 1 do not have split by ethnicity, which represents 8%.

OBS: These are the indicators from the previous excel dashboards that were sent to the Board monthly by Planning and Funding.

CARE Manaakitanga

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

Board Report

Total population

Ethnicity
- Maori
- Non-Maori
- Total

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

CARE Manaakitanga

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

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

Board Report

Maori

Ethnicity
- Maori
- Non-Maori
- Total

ID	Description	Last period	Target	Last Value	YTD	Equity	
BSC_SMOK_PH04	Primary care smoking	2020-06-01	90.00	88.07	88.07		-1.87
BSC_SMOK_CW09	Maternal smoking	2020-06-01	90.00	100.00	86.96		
BSC_SCR_PV02	Improving cervical screening coverage	2020-03-01	80.00	73.21	73.17		-7.19
BSC_SCR_PV01	Improving breast screening coverage and rescreening	2020-03-01	70.00	67.02	66.97		-8.33
BSC_OH_PRSE	Oral Health Preschool Enrolment	2020-09-01	95.00	94.31	93.46		-14.32
BSC_NNPAC_DNA	Did not Attend (DNA) rate for outpatient services	2020-09-01	5.00	11.65	13.02		-8.72
BSC_MH_WT3W_0_19_AOD_DHB_NGO	Three week wait times - AOD (Provider Arm & NGOs) Ages 0-19	2020-06-01	80.00	72.41	69.19		-2.97
BSC_IMMS_8M12M	Child Immunisation 8M milestone 12M stats	2020-09-01	95.00	79.97	80.26		-9.75
BSC_FCT_SS11	Patients with a confirmed diagnosis of cancer who receive their first cancer treatment within 62 days of decision-to-treat.	2020-06-01	90.00	100.00	97.06		6.25
BSC_ED_6HTM	ED wait times less than 6 hours SS10	2020-09-01	95.00	91.56	92.00		6.26
BSC_B4SC_CW10	Percentage of obese children (B4SC) oferred a referral	2020-09-01	95.00	70.97	73.42		22.97

CARE Manaakitanga

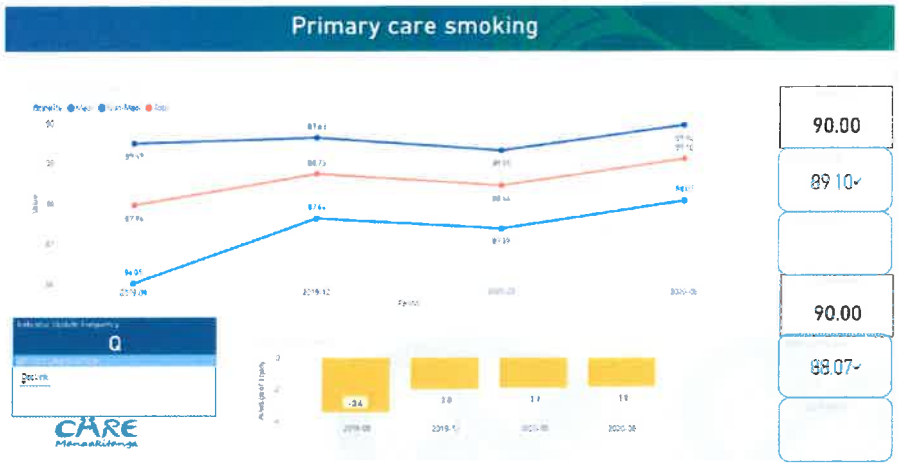
ID	Description	Last period	Target	Value	YTD

Individual Indicators

On the following slides, the indicators from the Board report will be shown individually, with the definition on top of the page and comments on the right hand side.

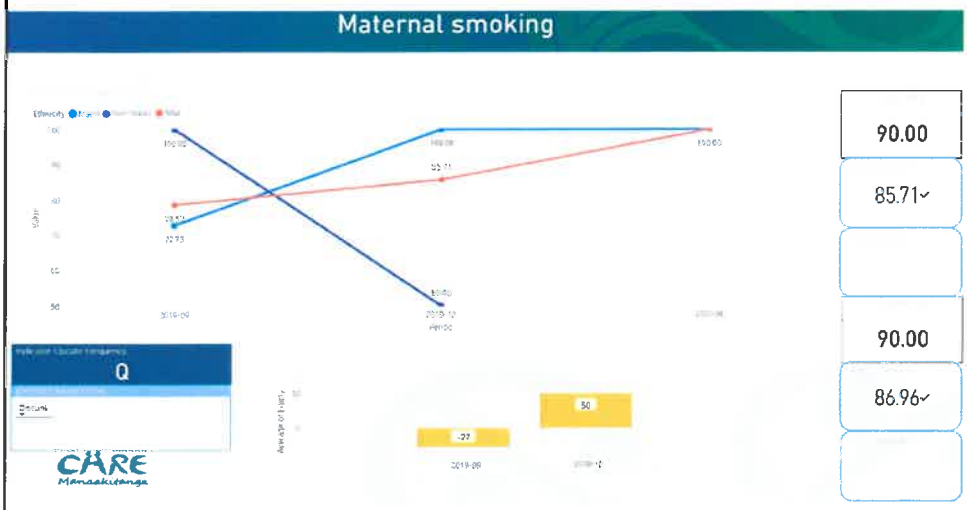
CARE Manaakitanga

Definition
MOH Indicator PH04 Better help for smokers to quit (primary care) :
90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.



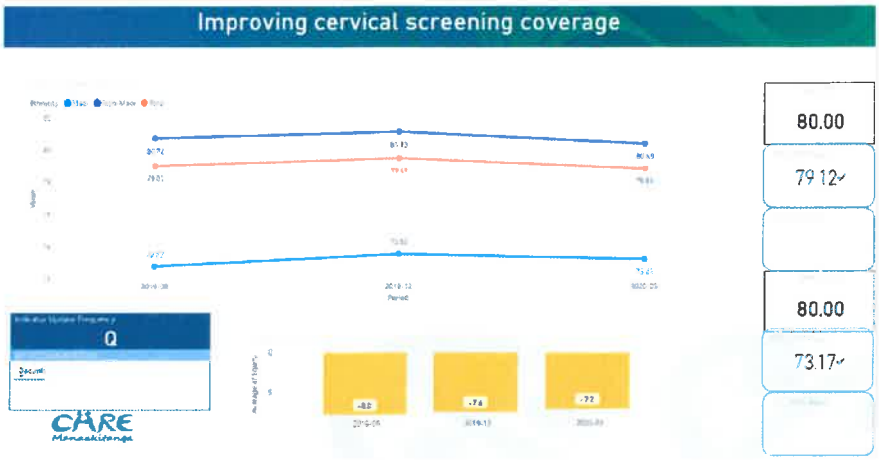
Comments:
The Primary Care target was missed in Q3 for both Total and Māori populations, but is improving in Q4. Disparities in smoking prevalence for Māori remain a concern in all areas - primary, secondary and maternity.
Data for Sep2020 is not available yet.

Definition
MOH Indicator CW09 Better help for smokers to quit (maternity):
90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.



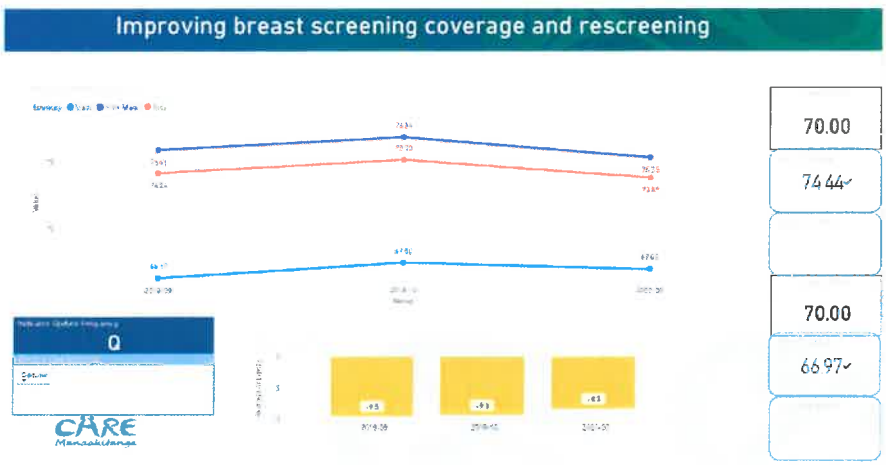
Comments:
Maternity smoking advice results were not available before this report was created.
Data for June was adjusted since there was no data for non-maor. Due to small numbers data does not look very clear, therefore we cannot see a trend.
There was a meeting in August re Well Child Tamariki Ora providers to discuss data challenges, MOH was leading.

Definition
MOH Indicator PV02 Improving cervical screening coverage:
80% coverage for all ethnic groups and overall.



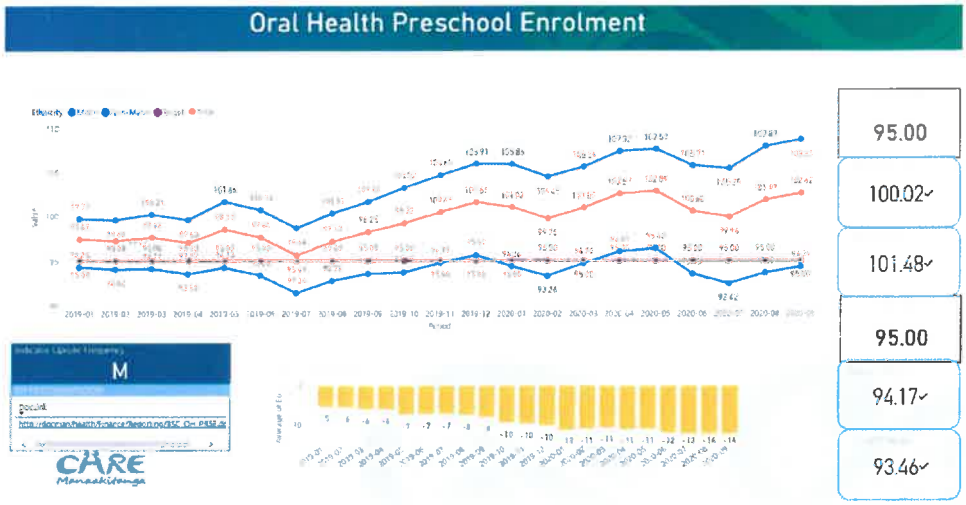
Comments
No new data has been released after March 2020. The result for the Total population has remained below the 80% cervical screening coverage target in Q3 2019/20 (data for the three year period ending March 2020).
The result for Māori this quarter is 73.2% with a negative equity gap for all periods between 8% and 7% points.

Definition
MOH Indicator PV01 Improving breast screening coverage and rescreening:
70% coverage for all ethnic groups and overall.



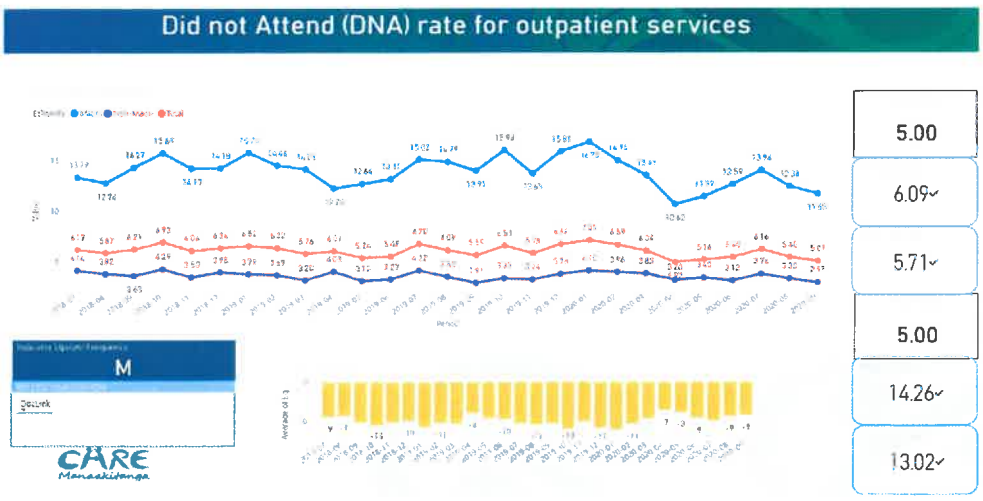
Comments
No new data has been released after March 2020. The Total breast screening coverage rate have dropped slightly to 73.9% in the latest reporting period (the two year period ending 31 March 2020). Māori coverage remains slightly below the 70% target at 67.0% with a negative equity gap for all periods between 8% and 9% points.

Definition
MOH Indicator CW03 Improving the number of children enrolled and accessing the Community Oral health service :
Children (0-4) enrolled ≥95%



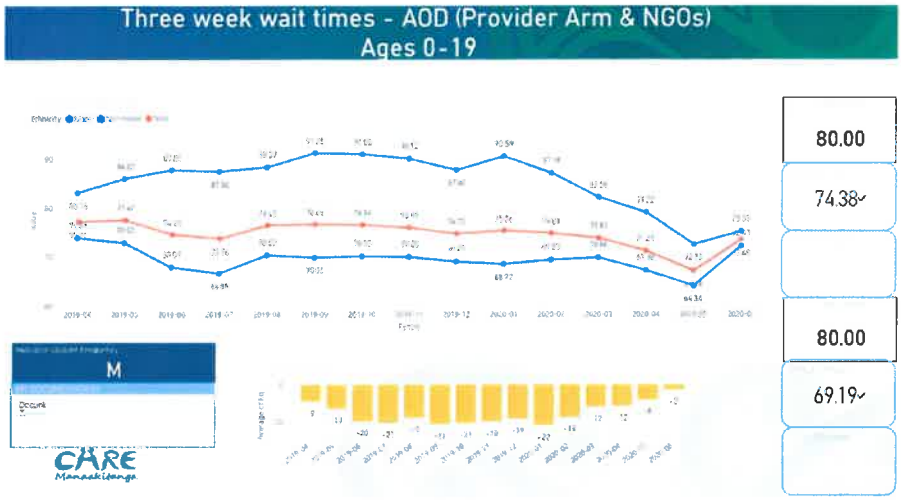
Comments
Māori preschool enrolment is recovering.
The equity gap for this indicator is increasing monthly.

Definition
Internal Indicator:
Did not attend rate for outpatient services, Target 5%.



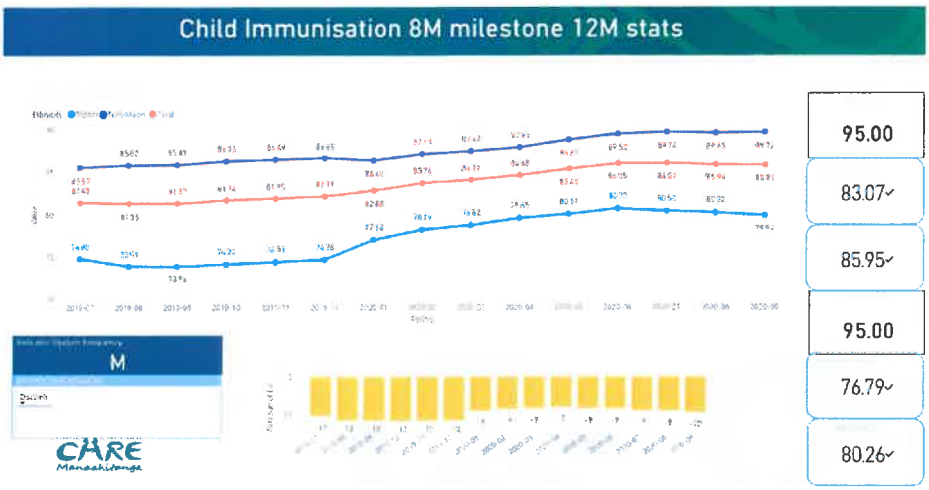
Comments:
DNA rates for May 2020 have increased again from the lower levels seen in April, returning to similar levels seen during the earlier part of the year.
YTD 2020 for Maori is 13.02%.
Negative Equity gap between Maori and non-Maori has been around 9% points for the lasts few months.

Definition
MOH Indicator MH03 Shorter waits for non-urgent mental health and addiction services :
Addictions (Provider Arm and NGO) 80% of people seen within 3 weeks.



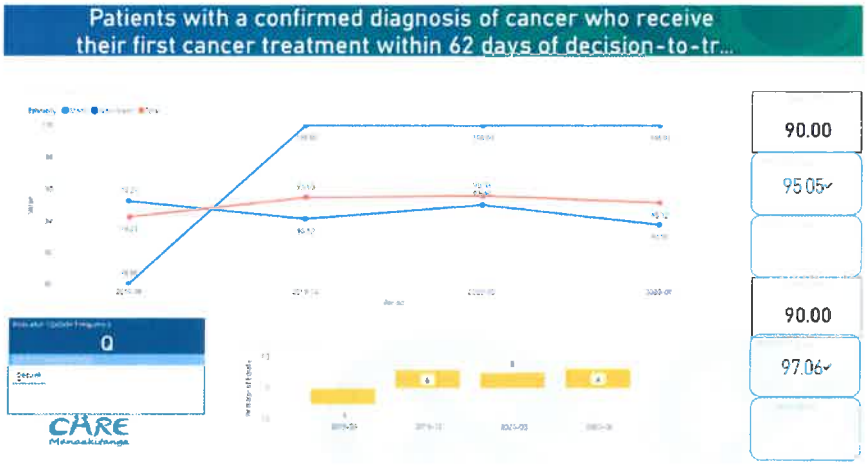
Comments
This measure is 4 months behind from the latest update received from MOH this month.
The latest figures show an improvement on June.
The equity gap for this measure has been decreasing in the last two months.

Definition
MOH Indicator CW05 Immunisation coverage at eight months of age(12 month stats):
≥95% of eight months old for each of the Maori, Pacific (where relevant) and total populations fully immunized. The equity gap, if any, between Maori and non-Maori populations is no more than 2%.



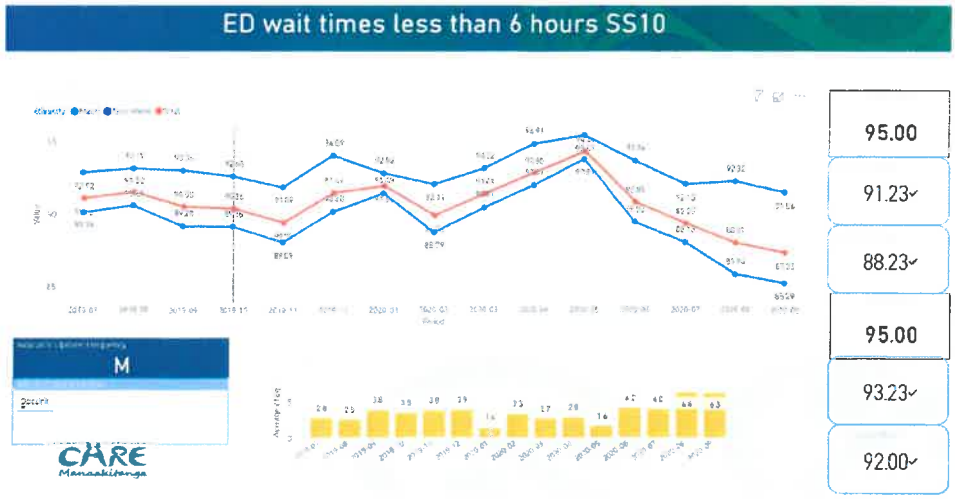
Comments
This indicator has changed, we are monitoring 12 months stats instead of previous 3 months stats. To align with AP and IDP.
Immunisation coverage has improved since June 2019, although equity gap between Māori and Non-Māori has been steady, although showed some improvement at the beginning of the year.

Definition
MOH Indicator SS11:
90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.



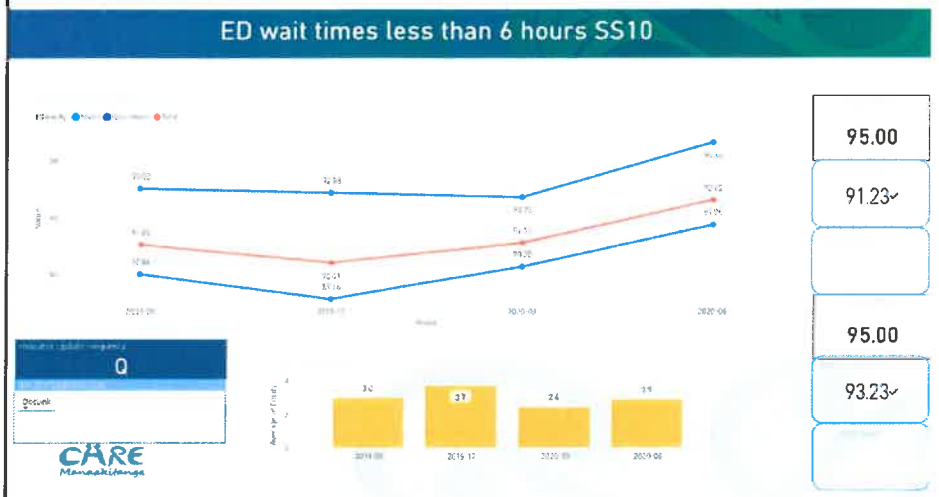
Comments:
Updated data for this indicator is not available yet. Performance has remained over the target for all ethnicities. It is worth noting that the number of patients in this 62 day KPI are very low for Māori, only 9 in this most recent quarter from a total of 39.

Definition
MOH Indicator SS10: 95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.



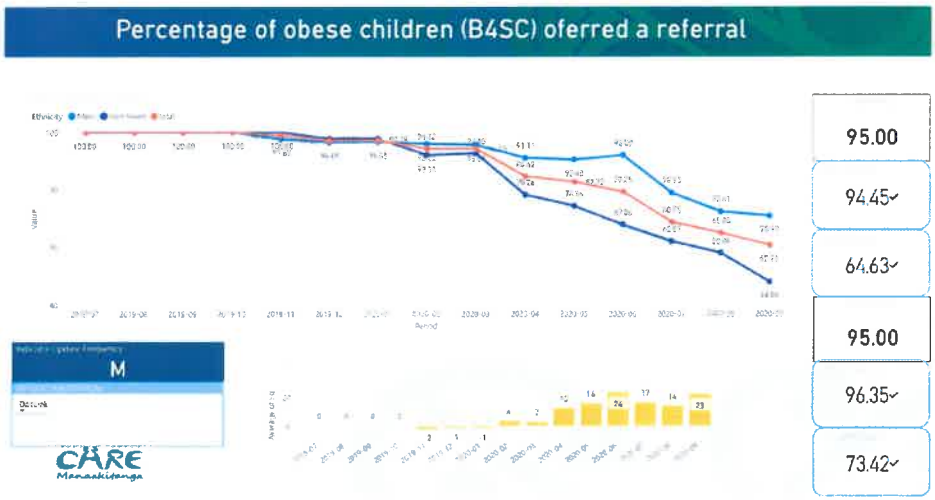
Comments:
Performance against the shorter stays in ED target has been decreasing during the recovery after covid19. On the last three months we are back to the normal number of presentation seen from last year, to over 5 thousand per month. **The official indicator is measure quarterly by MOH and reflected on the IDP reports.**

Definition
MOH Indicator SS10: 95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours. Quarterly from MOH



Comments:
This is the official indicator is measure quarterly by MOH and reflected on the IDP reports.
If we compare YTD2019 Total and Maori, we have the same results, the difference is how "on time" we would like to have the data.

Definition
MOH Indicator CW10 Raising healthy kids:
95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.



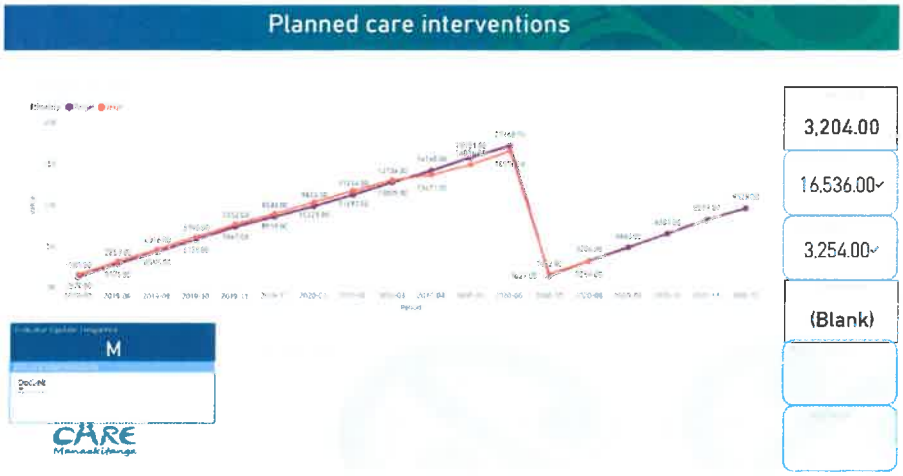
Comments
This measure is the percentage of children identified as obese in the B4 School Check programme offered a referral.
On previous month this indicator included "referral sent" but does not mean that the patient/whanau has acknowledge the referral.

Definition

MOH Indicator SS07 Planned Care Measures PCM 1 - Planned Care Interventions:

Each DHB will identify, and agree with the Ministry of Health, a minimum level of Planned Care interventions to be provided for their population through the Annual Plan and the Planned Care Funding Schedule.

DHBs will provide 100% of their agreed Planned Care interventions for each quarter.



3,204.00
16,536.00
3,254.00
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Comments:
Planned care interventions for 2020/21 is 19050. The number of interventions planned until Dec 2020 is 9579. Until August there is a total of 3254 PCI performed against a target of 3204.

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Care Capacity Demand Management (CCDM) Benefits

SUBMITTED TO:
Board Meeting 18 November 2020

Prepared by: Julie Robinson, Director of Nursing

Endorsed by: Bronwyn Anstis, Chief Operating Officer

Submitted by: Pete Chandler, Chief Executive

☐ **For Decision** ☐ **For Discussion** ☒ **For Noting**

RECOMMENDATION:
That the Board notes the response to the request to identify the benefits of CCDM.

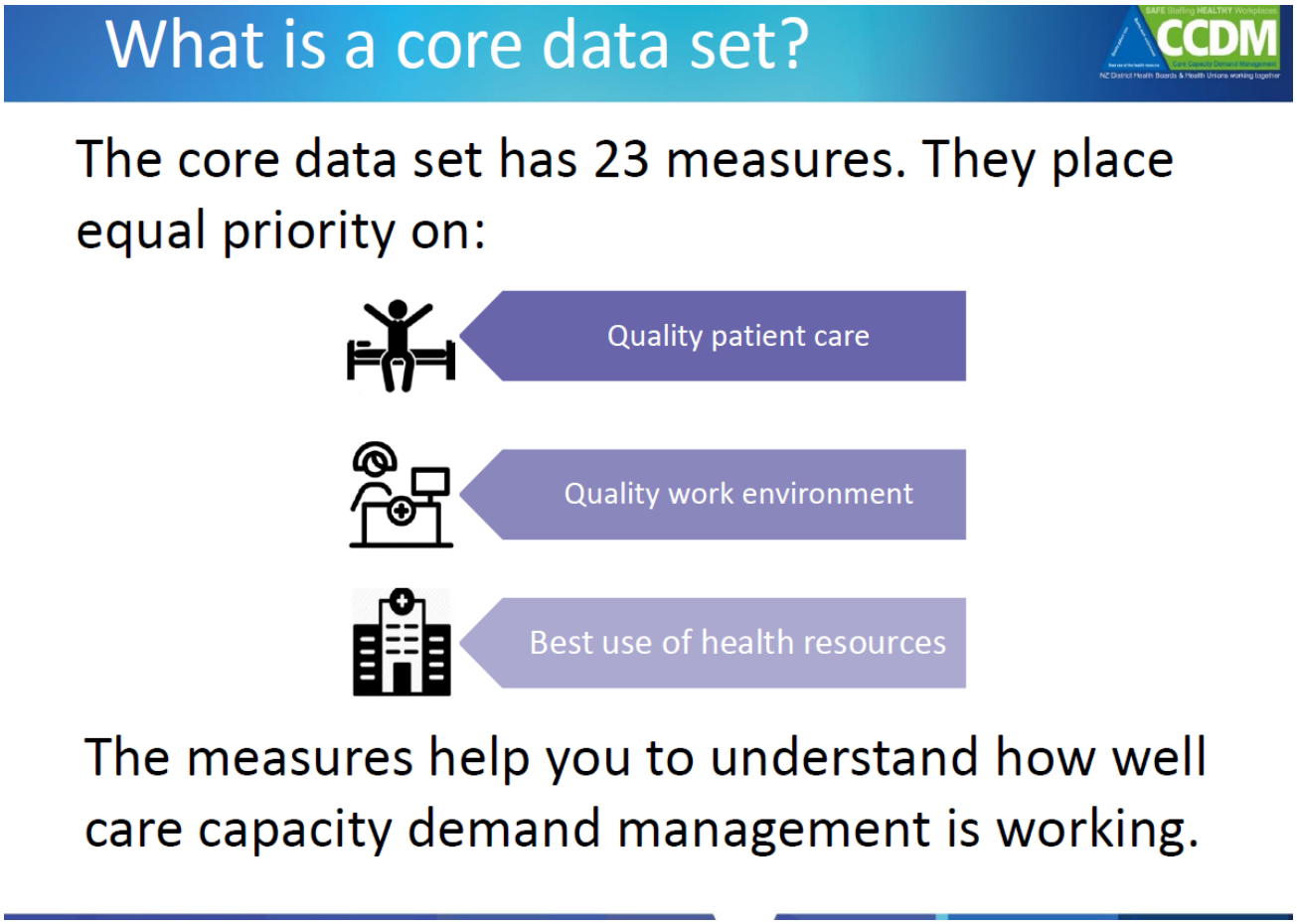
ATTACHMENTS:
National CCDM Core Data Set definitions.

BACKGROUND:
Given the investment in nursing FTE to better align the base staffing requirements to patient acuity and demand the Board wished to understand the benefits fiscally as well as to patients and staff.

Benefits of Care Capacity Demand Management (CCDM)

In response to the Board request to understand the benefits of CCDM the Core Data Set (CDS) information is provided.

The 23 measures in the Core Data Set relflect the key goals of CCDM of quality patient care, quality work environment for staff and efficiency or best use of health resources. All goals are of equal importance.



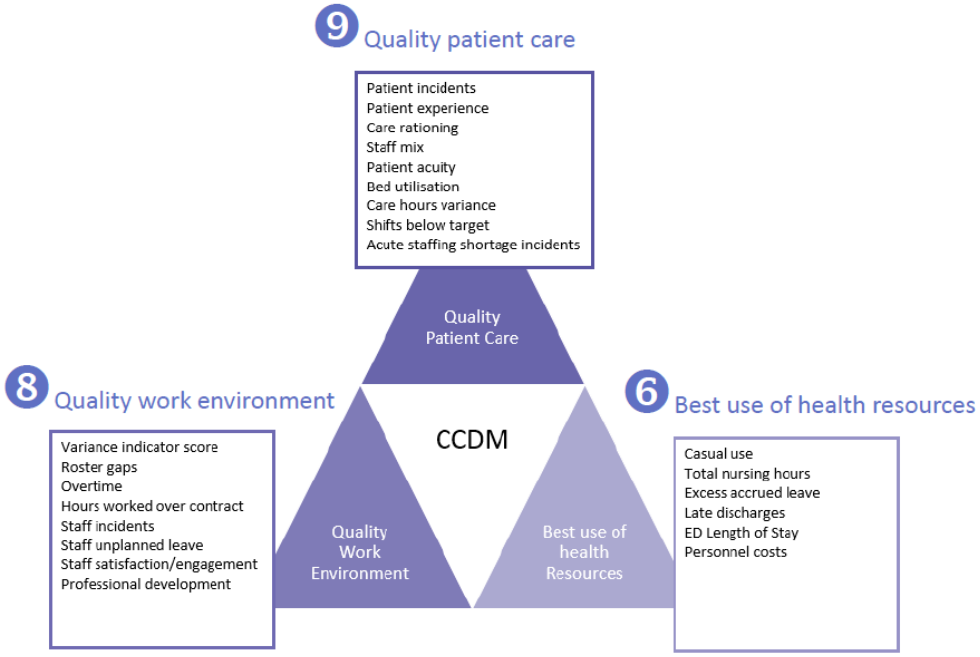
Each measure identified below is accompanied by a descriptor and the rationale for selection. The full document is available for those who wish to understand the detail.

BOPDHB is currently completing the work to have the measures electronically via Power BI. Managers will then have access to their own unit level data in a more timely manner.

A selection of measures will be progressed for improvement. A reduction in the use of overtime is a current focus.

What are the 23 measures?

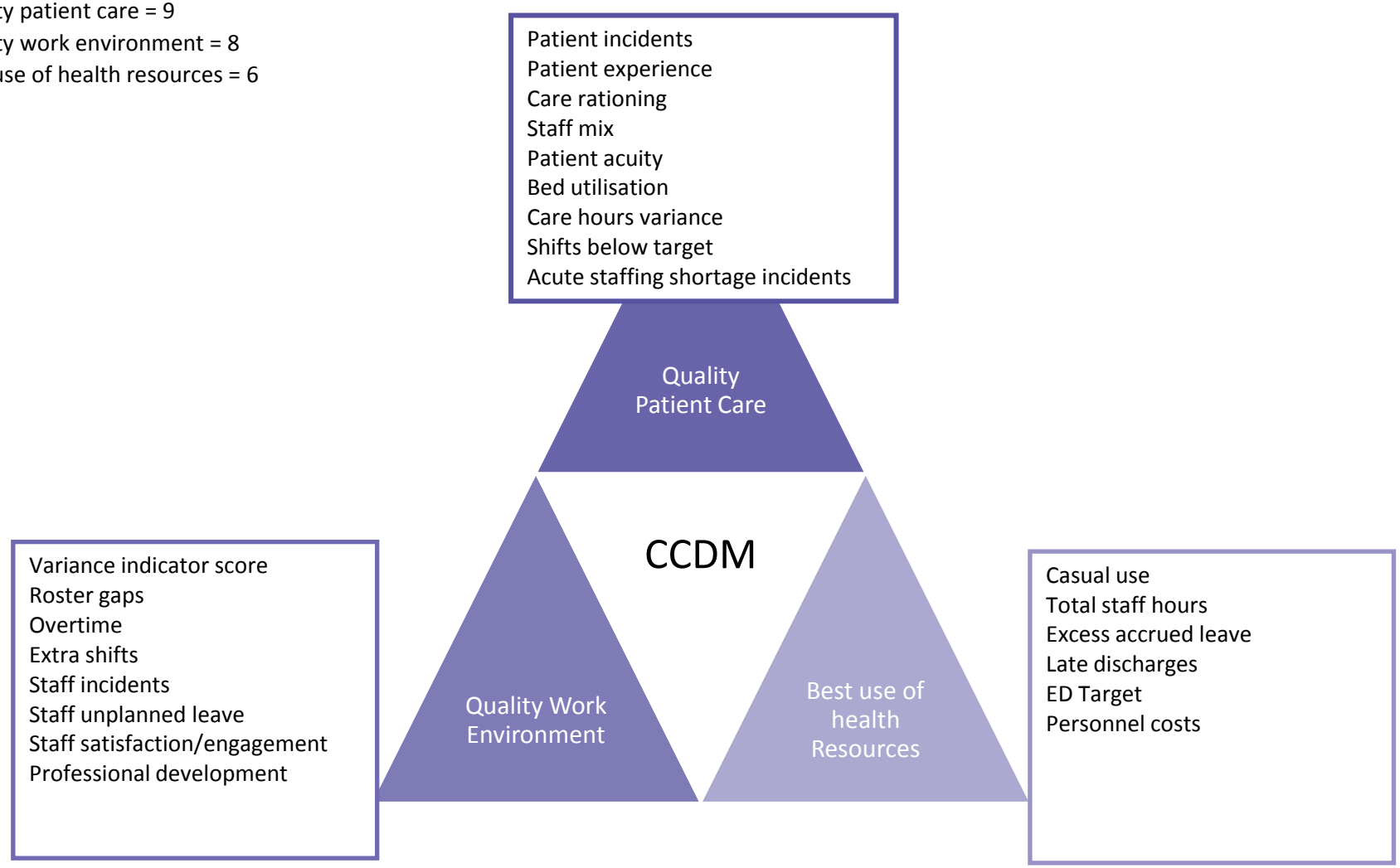
This diagram shows how the 23 measures are balanced around the CCDM triangle.



Core Data Set Balanced Set of Measures

This diagram shows the complete set of measures and how they are balanced around the three sides of the CCDM triangle.
The measures are listed under the following headings based on research findings that support this arrangement.

1. Quality patient care = 9
2. Quality work environment = 8
3. Best use of health resources = 6



CCDM Core Data Set

Version: FINAL DRAFT | Last updated: 24 July 2017 | By: Colette Breton

Note the measures:

1. Are a recommended minimum set. Wards/unit/services can add additional measures.
2. Include inpatient areas with a validated patient acuity tool.
3. Do not exclude other areas depending on the DHBs ability to collect and calculate the measures as described.
4. Should be trended over time using run charts or control charts.
5. Should be reviewed together to establish relationship or correlations between measures.
6. The 'Interpretation' column (and the 'If this, then' tab) provides some guidance but is not limited to these notes.
7. Should be reported for each ward/unit, aggregated by directorate/service and aggregated for the hospital.
8. For a local data council may only include 4-6 of the measures reported for the ward.
9. Assume data sources are correct, including integrity and quality of the validated patient acuity system data.
10. Assume comparison of like staff groups e.g. RNs, EN & HCAs with RNs, ENs and HCAs. So the word 'staff' where used, needs to be defined by the DHB.

Programme Goal	Measure	Description	Rationale	Interpretation	Calculation	Unit of measure	Frequency	Data Source
QUALITY PATIENT CARE	Patient incidents	A patient incident is any event that could have or did cause harm to a patient (adverse event, near miss, reportable event). **Source:** https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/Reportable-Events-Policy-Final-Jan-2013.pdf) **Examples include:** falls, pressure injury, hospital acquired infection, patient collapse/777, medication error etc.)	Patient incidents are an indicator of the quality of care provided to patients, the quality of the work environment and staffing (37, 38). Lower nursing staff levels are associated with increased patient mortality (4, 5, 39), failure to rescue (6, 7, 40), medication errors (8, 9, 10), falls (10, 11) and missed care (12, 13).	Trending ↑ = Negative/ Flag Higher patient incidents may be caused by inadequate staffing levels, poor skill mix or poor staff mix (2) negative care hours variance and shifts below target. Higher patient incidents have a negative impact on patient experience, length of stay and increase costs of care.	The sum of all inpatient incidents reported.	Number for the date period, by ward, directorate and hospital.	Monthly	DHB incident reporting system
QUALITY PATIENT CARE	Patient experience	Results from the patient experience survey as defined by the Health Quality Safety Commission. Reported as a total score (/10) from each of the four domains. **Source:** http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/2812/. **Note:** This can not be drilled down to a ward level - reported by DHB only.	Patient experience is an indicator of the quality of care provided to patients. There is evidence that quality work environments and higher levels of registered nurses are associated with higher patient satisfaction (14, 37, 38). The is a significant association between positive nursing leadership styles, behaviours and practices and increased patient satisfaction (18).	Trending ↑ = Positive/ Improving Review with caution against other core data set measures as patient experience domains are not specific to nursing care. This data is not available by ward or directorate/service level.	As per Health Quality Safety Commission.	Number for each of the fours domains, by DHB	Quarterly	Health Quality Safety Commission
QUALITY PATIENT CARE	Care rationing	All care that was missed, delayed, sub optimally delivered or inappropriately delegated as reported by staff. Also defined as care left undone due to lack of time, material resource, poor communication or teamwork.	Care rationing impacts on the quality of care provided to patients, patient experience and staff satisfaction/ engagement. Lower levels of staffing are associated with missed care and failure to rescue (5,12,13). Care rationing impacts on nurse satisfaction and causes moral distress (36).	Trending ↑ = Negative/ Flag Review along side care hours variance, shifts below target, staff mix, acute staffing shortage incidents, variance indicator score, patient incidents, patient experience and staff satisfaction/ engagement.	Number of staff reporting care rationing / number of staff returning a survey x 100.	Percentage for the date period, by shift for the ward, directorate and hospital.	Quarterly	Work Analysis 'End of shift survey' or equivalent
QUALITY PATIENT CARE	Staff mix	The number of regulated staff (RN, RM and EN) that worked compared with all staff that worked expressed as a percentage for AM, PM and N shift.	Higher levels of RNs have been associated with better patient outcomes (2). Higher RN levels are associated with lower mortality rates (31, 35, 39) and failure to rescue (5). The majority of patient care requires RNs (2). RNs also contribute to the provision of coherent, quality nursing services through supervision, patient flow, team organisation and delegation (2). Monitoring the percentage of regulated nurses (RN, RM and EN) is a logical step towards ensuring the delivery of quality patient care.	Trending ↑ = Positive/ improving. Poor staff mix may be caused by increased patient acuity, unplanned leave or roster gaps. Poor staff mix should be reviewed with acute staffing shortages incidents, variance indicator scores, care rationing, patients/staff incidents, patient experience and staff satisfaction/ engagement.	The number regulated staff / total number of staff x 100.	Percentage by AM, PM, N for the date period by ward, directorate and hospital.	Monthly	Validated Patient Acuity System or DHB pay roll or human resources system
QUALITY PATIENT CARE	Patient acuity	Patient Acuity is the patient's level of dependence on nursing staff due to their care requirements. This is described as nursing hours required by patient acuity. **Source:** TrendCare Glossary of Terms (2016).	There is a strong association between patient acuity and dependency and nursing requirements (8, 10, 11, 28, 30, 31 & 32).	Trending ↑ = indicates increased patient acuity and/or volumes. Useful to chart with bed utilisation and total nursing hours or personnel costs. Review with staff mix, care hours variance and shifts below target, acute staffing shortage incidents, variance indicator scores, care rationing, casual use, overtime, hours worked over contact, and cancelled professional development.	The sum of hours required by patient acuity (clinical hours only).	Hours for the date period for the ward, directorate and hospital.	Monthly	Validated Patient Acuity System

Programme Goal	Measure	Description	Rationale	Interpretation	Calculation	Unit of measure	Frequency	Data Source
QUALITY PATIENT CARE	Bed utilisation	Bed utilisation reflects the throughput of patients during a calendar day – accounting for all discharges, deceased patients, admissions and transfers for the shift on which the patient received care. By shift AM, PM, N. **Source:** TrendCare Glossary of Terms (2016)	Bed utilisation is more sensitive to nursing workload than occupancy because it counts all admissions, discharges and transfers. The process of admitting or discharging a patient requires nursing hours in addition to those hours required to care for a patient already occupying a bed. Increasing patient turnover is associated with diminishing nursing hours (26, 27) and failure to rescue (28).	Trending ↑ = Positive or negative (depends on starting point) Bed utilisation is best interpreted with patient acuity and total nursing hours. Increasing bed utilisation means more nursing workload and usually more nursing hours required.	The total throughput of all patients on a shift divided by the ward/units funded beds x 100.	Percentage by AM, PM and N for the date period by ward, directorate and hospital.	Monthly	Validated Patient Acuity System
QUALITY PATIENT CARE	Care hours variance	The difference between the hours required by acuity for inpatient care versus the clinical hours available to provide care by shift (AM, PM, N). This is clinical hours or direct patient care hours only. **Source:** TrendCare Glossary of Terms (2016)	Matching nursing hours with the required patient care hours is a simple strategy for minimising care rationing, ensuring workloads are fair and reasonable, and efficiently using resources. Nursing hours have a significant impact on patient morbidity, mortality (4,7, 39) and incidents (10). Staffing levels must be set and assessed on a shift by shift basis (2).	Trending ↑ = Positive or negative (depends on starting point) For the most effective results workloads should be neither too high, nor too low (also see 'shifts within target'). High workloads where care hours variance is low or negative indicates insufficient care hours for patient demand. This may be due to increased patient acuity, bed utilisation, roster gaps or unplanned leave. The consequences of insufficient care hours may include high casual use, overtime, hours worked over contract, acute staffing shortage incidents, care rationing, poor patient experience, increased patient incidents, higher staff unplanned leave, staff disengagement, high excess accrued leave, and staff turnover. Low workloads (where nursing hours variance is positive) indicates surplus nursing hours, minimum staffing levels or minimum staff/skills mix.	Hours required by patient acuity minus clinical hours available calculated for AM, PM and N.	Hours for the date period by shift for the ward, directorate and hospital.	Monthly	Validated Patient Acuity System
QUALITY PATIENT CARE	Shifts below target	The percentage of shifts by AM, PM, N where the difference in the care hours provided and the care hours required was greater than negative 8.5% (or 40 minutes per FTE). **Worked example:** if there are 30 days in the month (or 90 shifts in total) and 25 shifts had more than negative 8.5% difference in hours between required and supplied, then the percentage of shifts outside of target = 25/90 x 100 = 27%.	Patient mortality increases with exposure to increased number of shifts below target (4, 10). Shifts below target is the companion measure to nursing hours variance. Nursing hours variance may be 400 hours for the month on PM shifts. However 9 of the 30 shifts may have had a negative variance of greater than 8.5% (or 40 minutes per FTE). Once 40 minutes per FTE has been breached there is increasing risk to patient safety, staff meal breaks, working overtime etc.	Trending ↑ = Negative/Flag The 'shifts below target' measure reflects the effectiveness of the base roster and variance response management. Shifts below target and care hours variance are both needed to determine if care capacity was matched to patient demand. Increasing numbers of shifts below target should be reviewed alongside roster gaps, unplanned leave, patient acuity, bed utilisation, acute staffing shortage incidents, variance indicator scores, care rationing, patient/staff incidents, patient experience and staff satisfaction/engagement.	Count of shifts within target/total number of shifts x 100	Number by AM, PM and N for the ward, directorate and hospital.	Monthly	Validated Patient Acuity System
QUALITY PATIENT CARE	Acute staffing shortage incidents	When a nurse or midwife considers they have reached the limits of safe practice (NZNO MECA Clause 6.0). This includes, short staffing, inappropriate staff mix, influx of patients and/or unexpected increase patient acuity.	Reporting of acute staffing shortages is a MECA requirement. In these circumstance emphasis is placed on professional judgement. Poor perceptions of staffing adequacy and perceived psychological strain are linked to increased patient mortality, falls, medication errors and missed care (12, 15).	Trending ↑ = Negative/ Flag Acute staffing shortage incidents may be caused by inadequate staff mix, care hours variance or shifts below target. The consequence of increasing staffing shortage incidents may include increased patient/staff incidents, poor patient experience and staff dissatisfaction.	Sum of all acute staffing shortage incidents reported by staff working in inpatient wards/units.	Number for the date period by ward, directorate and hospital.	Monthly	DHB incident reporting system

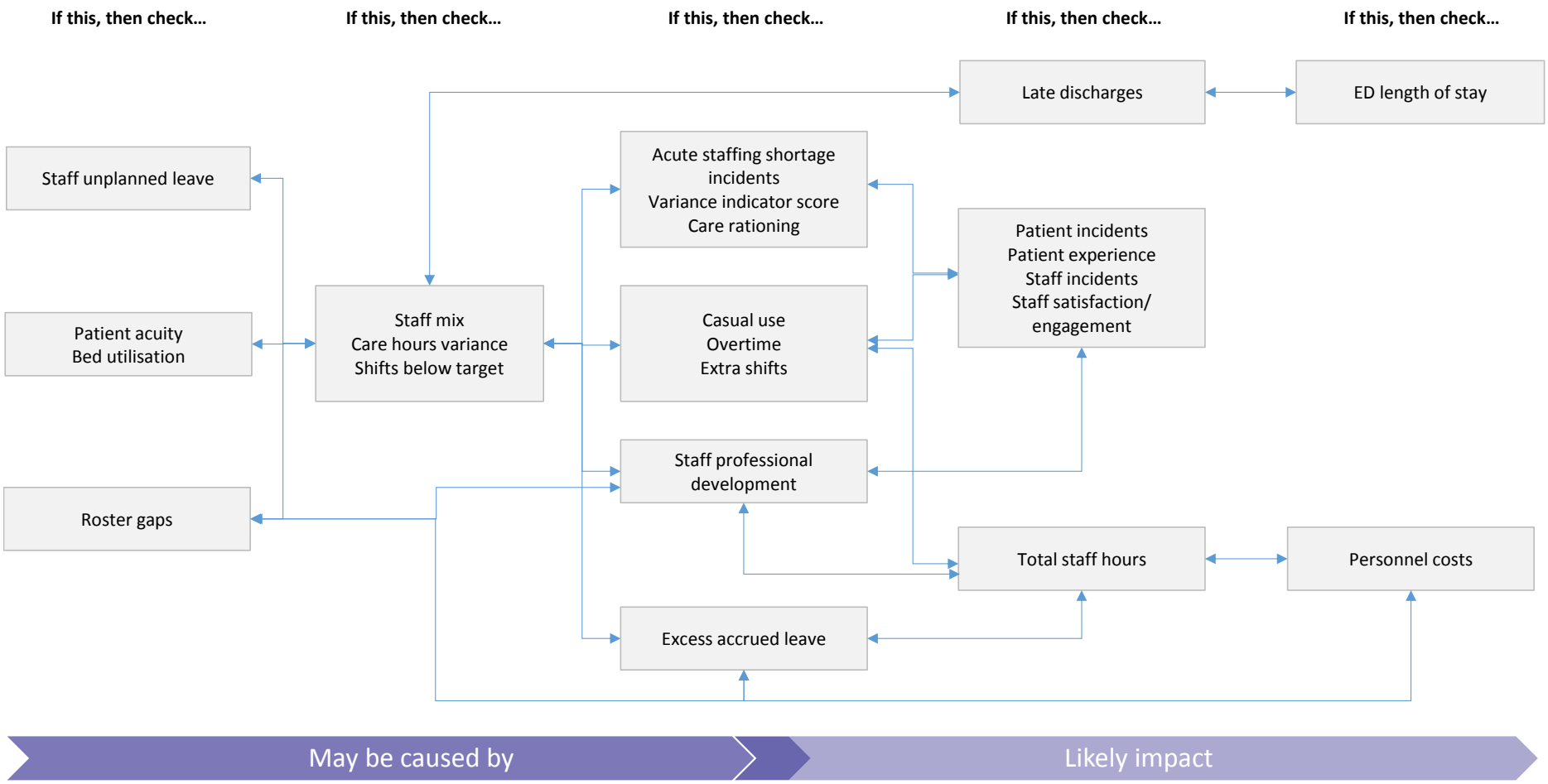
Programme Goal	Measure	Description	Rationale	Interpretation	Calculation	Unit of measure	Frequency	Data Source
QUALITY WORK ENVIRONMENT FOR STAFF	Variance indicator score	An early warning score alerting the hospital to a care capacity demand mismatch (surplus or deficit) in a ward/unit. There are 5 colours that indicate the ward's current state from surplus capacity (mauve) to serious shortfall in capacity (red).	The variance indicator scoring system is a combination of subjective and objective measures set up by the DHB. The critical factor for shift safety is RN professional judgement (42). Poor perceptions of staffing adequacy and perceived psychological strain are linked to increased patient mortality, falls, medication errors and missed care (15, 42).	Trending ↑ = Negative/ Flag Increasing variance indicator scores for red + orange may be caused by poor staff mix, negative care hours variance, shifts below target, increased patient acuity or bed utilisation, roster gaps and late discharges. Increasing red + orange variance indicator scores should also be viewed for impact i.e. care rationing, acute staffing shortages, patient incidents, staff incidents, patient experience and staff satisfaction/ engagement.	The sum of the number of times in 'red + orange' and the number of times in 'mauve' for the month, calculated separately for each by AM, PM and N.	Number for the date period, by shift for ward, directorate and hospital.	Monthly	DHB variance indicator system
QUALITY WORK ENVIRONMENT FOR STAFF	Roster Gaps	Roster gaps are the degree to which the posted/planned roster matches the roster model. The roster model (established from the Staffing Methodology) is the best match of FTE to demand by shift and by day of the week. The posted/planned roster is the roster that is published not less than 28 days prior to the commencement of the roster (MECA clause 6.5). **Worked Example:** Roster model = 384 shifts for the calendar month. (Calculated by adding up all FTE for each shift and each day of the week for the calendar month). Posted roster = 372 shifts rostered 384 - 372 = 12 i.e. there is a gap of 12 shifts in posted roster.	The roster model affords the best starting point for right staffing. The posted roster should therefore match the roster model. Having a posted roster that matches the roster model provides the best plan for having the right staffing on the day. If you start with a mismatch then you are planning to need a variance response. This is neither efficient nor effective care capacity demand management. Posted rosters that have too few or two many staff are costly.	Trending ↑ = Positive/ improving Trending ↓ = increasing mismatch between the posted roster and the roster model. This is commonly due to inadequate budgeted FTE, vacancy, long term sick leave or poor rostering. This means more variance response will be required every day, every shift. This is avoidable time spent by the ACNM, CNM and DNMs looking for and/or moving staff. It may also mean greater risk to patients from inadequate staffing (numbers, staff mix or skill mix).	Total shifts on roster model minus the total shifts on posted roster.	Number of shifts for the date period, by ward, directorate and hospital.	Monthly	Roster audit or summary from DHB roster system
QUALITY WORK ENVIRONMENT FOR STAFF	Overtime	Overtime includes any extra paid hours that a nurse is required to work beyond their contracted hours at either end of their shift (2). Overtime is as defined as per the MECA. Includes payment for missed meal breaks. Example from NZNO *Overtime is time worked in excess of:* *(i) eight hours per day or the rostered duty whichever is greater or* *(ii) 80 hours per two week period*	Overtime should be for exceptional circumstances only. Working long hours is strongly associated with adverse outcomes for nurses and increased risk of error (16, 17). Increased staff tiredness, results in loss of goodwill and paying overtime costs more money.	Trending ↑ = Negative/ Flag Routinely working overtime at either end of the shift indicates a shortfall in nursing care hours at the right time of the day. It may also be due to inappropriate staff mix (or skills mix). This measure is useful to interpret with care hours variance, shifts below target, late discharges, hours worked over contract, patient/staff incidents, patient experience and staff satisfaction/ engagement.	The sum of all hours paid as overtime.	Hours for the date period by ward, directorate and hospital.	Monthly	DHB pay roll system
QUALITY WORK ENVIRONMENT FOR STAFF	Extra shifts	All staff hours worked that are additional to their normal contracted hours of work. This applies to part time staff only. **Example:** a nurse may be contracted to work 24 hours per week but actually works 32 hours. **Note:** This differs from the NZNO definition of overtime as the nurse may not exceed 8 hours per day or 80 hours per fortnight, but is still working additional hours to contract.	Additional shifts worked by part time staff is an important and valuable part of the variance response management system. There is a strong positive relationship between working long hours and adverse outcomes for nurses (17). Working additional shifts may place the staff member under undue pressure to support their team in times of need and adversely effect work-life balance resulting in tiredness, reduced resilience and increased stress (2). Increased perceived psychological strain on nurses is associated with higher rates of patient mortality, falls, and medication errors (15).	Trending ↑ = Negative/ Flag Staff routinely undertaking extra shifts indicates a shortfall in nursing care hours on the base roster. The cause its likely to be increased bed utilisation, patient acuity, roster gaps, staff mix, care hours variance and shifts below target. The consequences may include patient/staff incidents, poor patient experience and staff dissatisfaction or disengagement. Working over contract costs more. The part time staff member accrues more annual leave and is paid at a higher average salary for annual leave. There may also be a legitimate challenge to the contracted hours when compared with custom and practice.	Sum all paid hours (excluding paid overtime) minus sum all contracted hours.	Hours for the date period by ward, directorate and hospital.	Monthly	DHB pay roll system

Programme Goal	Measure	Description	Rationale	Interpretation	Calculation	Unit of measure	Frequency	Data Source
QUALITY WORK ENVIRONMENT FOR STAFF	Staff incidents	A staff incident is any event that is reported and could have or did cause harm to a staff member (adverse event, near miss, reportable event). Examples include: accidents, needle sticks, back injuries, slips, verbal abuse etc. **Source:** 1. Work Safe Notifiable Events: http://www.worksafe.govt.nz/worksafe/notifications-forms/notifiable-events e.g. death, serious injury, illness or incident where person exposed to serious or immediate risk to health and safety 2. Reportable Events Guidelines (MoH, 2001): https://www.health.govt.nz/system/files/documents/publications/reportableevents.pdf 3. MECA Clause 30.3	Staff injuries cause significant individual and workplace impact. Staff incidents are more likely to occur when staff are under time pressure, tired or inexperienced or in the presence of increased workplace hazards (hours, complexity and workload) (1,3).	Trending ↑ = Negative/ Flag The causes of staff incidents are multifactorial. Contributing factors include increasing workload (bed utilisation, patient acuity) without the right resources (staff mix, care hours variance, shifts below target) resulting in increased work effort (overtime, hours, worked over contract).	Sum all reported staff incidents.	Number for the date period by ward, directorate and hospital.	Monthly	DHB incident reporting system
QUALITY WORK ENVIRONMENT FOR STAFF	Staff unplanned leave	The total unplanned or short notice leave hours taken by staff e.g. sick, domestic, bereavement, ACC. This includes sick leave hours paid, unpaid or paid as annual leave. Includes staff on permanent contracts only.	Sick leave is one indicator of the health of the workplace. Burnout and job stress increase staff absenteeism due to sickness (19).	Trending ↑ = Negative/ Flag Staff unplanned leave should be interpreted with staff satisfaction/ engagement, nursing hours variance, shifts below target, excess accrued annual leave, casual use, overtime, and working above contracted hours.	Sum of hours taken for unplanned leave.	Hours for the date period by ward, directorate and hospital.	Monthly	Validated Patient Acuity System or DHB pay roll system
QUALITY WORK ENVIRONMENT FOR STAFF	Staff satisfaction/ engagement	Staff experience of the work environment is measured by staff satisfaction or engagement surveys, as per the DHB staff survey process.	Staff satisfaction/engagement is an indicator of a healthy workplace. Engaged staff are high performing staff. Engaged staff provide better care to patients (2, 20). Evidence shows that work environments are associated with patient outcomes (11, 21). Perceptions of good organisational climate are associated with positive employee outcomes such as reduced burnout, depression and anxiety (22). Nurses reporting better staffing are less likely to report emotional exhaustion and job dissatisfaction (23). Workplace empowerment has a positive relationship to job satisfaction (24).	Trending ↑ = Positive/ improving. Staff satisfaction/engagement should be interpreted with care rationing, variance indicator score, acute staffing shortage incidents, overtime, hours worked over contract, casual use, care hours variance, shifts below target, staff mix, staff and patient incidents.	Number staff stating overall satisfaction or engagement / number of staff survey responses x 100	Percentage for the date period, by ward, directorate and hospital.	Quarterly	Work Analysis 'End of Shift Survey' or DHB specific survey
QUALITY WORK ENVIRONMENT FOR STAFF	Staff professional development	All paid hours for staff to attend professional development activities which are additional to mandatory training and hospital training. 'Paid leave to meet organisational and service requirements, ….shall be granted in addition to provisions [for professional development leave]. The employer will meet any associated costs (MECA clause 27.3)'. Includes staff working in inpatient areas only.	Readily available staff training and ongoing development are key aspects of a healthy workplace (1). Ongoing training and education are also fundamental to providing safe and effective patient care (2). Higher levels of education are associated with fewer falls (21) and lower mortality (38). The risk of patient adverse outcomes is lower in clinical areas with professional models of care and higher nurse skills levels (25). Attending paid professional development activities is a MECA entitlement.	↑ = Positive for staff and patients. May be negative for roster and personnel costs. The hours paid for professional development should be assessed against the established budgeted plan. Variance to plan should be assessed for cause e.g. care hours variance, roster gaps, staff mix, shift below target. Low levels of professional development should also be reviewed for impact on staff satisfaction/engagement, patient incidents and engagement.	Sum of paid professional development hours.	Hours for the date period by ward, directorate and hospital.	Monthly	DHB pay roll system
BEST USE OF HEALTH RESOURCES	Casual use	Hours paid to staff working in inpatient areas on casual contract (e.g. RN, HCA, EN) compared with total hours worked by staff on permanent contracts (e.g. RN, HCA, EN). As percentage of total hours of care.	Casual staff play an important role in the hospitals variance response management system. However, increasing or persistently high casual use is of concern for several reasons. Casual staff may not be familiar with the environment or have the same skill set as the staff they are replacing. Team function can be altered by high levels of casual staff. Casual labour may also directly and indirectly cost more.	Trending ↑ = Negative/ Flag Regular use of casual staff indicates a shortfall in budgeted FTE, roster gaps (e.g. persistent vacancy or long term sick leave) i.e. the posted roster does not match the roster model or significant unmatched increase in bed utilisation or patient acuity . High casual use may impact on patient/staff incidents patient experience and staff satisfaction/engagement. This may in turn exacerbate unplanned leave.	Sum of all hours worked by staff on casual contract. Sum of all hours worked by staff on casual contract/all hours worked x 100.	Hours and %	Monthly	Validated Patient Acuity System DHB pay roll system

Programme Goal	Measure	Description	Rationale	Interpretation	Calculation	Unit of measure	Frequency	Data Source
BEST USE OF HEALTH RESOURCES	Total staff hours	The total hours includes all productive (clinical and other productive hours) and non-productive (annual, sick, bereavement) hours . Includes casual staff.	It is important to see the total hours so that the dollar spend can be accounted for in terms of productive and non-productive hours. Nursing hours have a significant impact on patient outcomes such as morbidity, mortality (4, 7, 39) and incidents (10).	Trending ↑ = Positive or negative (depends on cause and source of increase e.g. productive or non-productive) The total nursing hours is useful in comparison to nursing personnel costs, bed utilisation, patient acuity, professional developed and accrued annual leave. Significant increases/ decreases from one month to another require further investigation of the cause e.g. an increase in patient one to one care.		Hours for the date period by ward, directorate and hospital.		Validated Patient Acuity System
BEST USE OF HEALTH RESOURCES	Excess accrued leave	Excess accrued leave is an annual leave balance in excess of 24 months worth of the current annual entitlement (MECA, clause 13.4). **Example:** Total Annual Leave balance = 240 hours. Annual entitlement 160 hours with FTE of 0.60 equates to an annual entitlement for this employee of 96 hours per annum (160 x 0.60) With a current balance of 240 hours, this equates to 48 hours excess accrued leave (240 - (96 X 2) = 48)	A healthy work environment has the health and wellbeing of the person as its primary objective (1). Annual leave entitlements exist to support staff take adequate breaks from work. Excess annual leave indicates staff are not taking or unable to take their annual leave. Excess annual leave is a financial liability for the DHB.	Trending ↑ = Negative/ Flag Excess annual leave accrual may be due to insufficient budgeted FTE, roster gaps (vacancy, long term sick leave) i.e. the posted roster does not match the roster model. The impact of excess accrued leave can be seen in total nursing hours personnel costs. Excess accrued leave may also impact on staff tiredness, satisfaction and engagement.	Total annual leave balance - (annual entitlement x 2 x FTE)	Hours for the date period, by ward, directorate and hospital.	Monthly	DHB pay roll or human resource system
BEST USE OF HEALTH RESOURCES	Late discharges	The DHB sets discharge time for inpatient areas. Late discharges are therefore after the pre-set time. E.g. Patients discharged after 1100 on their expected date of discharge. **Source:** TrendCare 2017	Late patient discharges impact in two ways. They result in bed-blocking and a peak in nursing workload. In both circumstances there is often no additional capacity (beds or staff). Efficient and timely discharge processes are key to patient flow (29).	Trending ↑ = Negative/ Flag Late discharges may be caused by staff mix, care hours variance or shift below target. Late discharges may falsely elevate the care hours required resulting in 'surplus' once the patient leaves. Late discharges impact on the ED target and operating theatre.	Sum of patients discharged late on their expected date of discharge / total number of patients discharged that day x 100	Percentage	Monthly	Patient Management System or Validated Patient Acuity System
BEST USE OF HEALTH RESOURCES	ED length of stay	The ED Length of Stay Target is the 'Shorter Stays in Emergency Department (ED)' i.e. Patients admitted, discharged, or transferred from the ED within six hours. The target is 95%. Can only be reported by specialty e.g. general surgery, gynaecology **Source:** http://www.health.govt.nz/new-zealand-health-system/health-targets/about-health-targets/health-targets-shorter-stays-emergency-departments.	This is a national DHB performance measure. The target is a measure of the efficiency of flow of acute (urgent) patients through public hospitals, and home again.	Trending ↑ = Positive/ improving Where ED target is not being met, review against late discharges, bed utilisation, staff mix, casual use, care hours variance and shifts below target.	Sum of patients admitted, discharged, or transferred from ED within six hours / total number patients seen x 100	Percentage for the date period by specialty and hospital.	Monthly	DHB reporting system
BEST USE OF HEALTH RESOURCES	Personnel costs	The dollar amount spent per month on personnel costs (e.g. nursing, allied health, midwifery, HCA). Includes personnel costs for casual staff.	Nursing is the largest workforce and therefore one of the biggest investments in providing healthcare services. DHBs are responsible for best value for public health system resources. A logical step in achieving this is to monitor the spend on nursing personnel costs. Some studies suggest higher staff costs are off set by better patient or system outcomes (4,7). Higher staffing levels are associated with lower hospital use in terms of length of stay (30, 32, 33) and re-admission (34).	Trending ↑ = Negative/Flag if not justifiable. Personnel costs are best interpreted with a number of other measures including unplanned leave, professional development, annual leave accrual, bed utilisation, patient acuity, staff mix, casual use, hours worked over contract and overtime.	Sum of all dollars paid to staff	Dollars for the date period, by ward, directorate and hospital	Monthly	DHB pay roll system

Interpreting the Core Data Set

The following flow chart assists with interpreting the core data set. By working through 'if this, then check' each of the measures can be reviewed against the others.
The flow chart can be read from left to right, or right to left, or you can start in the middle and work out.
The arrow at the bottom shows the flow of 'may be caused by' and 'likely impact' from right to left.



BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

CORRESPONDENCE FOR NOTING

SUBMITTED TO:

Board Meeting 18 November 2020

Prepared by: Maxine Griffiths, Board Secretariat

Endorsed and
Submitted by: Pete Chandler, Chief Executive

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

RECOMMENDATION:
That the Board note the correspondence

ATTACHMENTS:

- Letter from Minister Hipkins to Midland Regional DHBs re Te Manawa Taki Regional Equity Plan 2020/2021, 16 October 2020
- Email to all staff re the Privacy Act and Privacy Week, from Privacy Co-ordinator, Sheryl Shearer, 1 November 2020

Hon Chris Hipkins

MP for Remutaka

Minister of Education
Minister of Health
Minister of State Services

Leader of the House
Minister Responsible for Ministerial Services

16 October 2020

Nick Saville-Wood
Lead Chief Executive for
Midland Region District Health Boards
nick.saville-wood@lakesdhb.govt.nz

Dear Nick

Te Manawa Taki Regional Equity Plan 2020/21

This letter is to advise you that I have agreed the Te Manawa Taki Regional Equity Plan.

Your region has produced a Regional Equity Plan this year which demonstrates an excellent collaborative approach between Māori and Iwi leaders working in unison with DHBs. I acknowledge that this is a significant milestone for the region and is the direct result of an enhanced Te Tiriti o Waitangi based partnership between Iwi and the five DHBs. In addition to this, the COVID-19 pandemic has presented extraordinary challenges to the health system, and your region has responded well with rapid escalation and early engagement in the early stages, laying the foundation for recovery and a transition to the “new normal”.

My approval of your plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health (Ministry). Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

I would like to thank you and your staff for your valuable contribution and continued commitment to delivering quality health care to your population and wish you every success with the implementation of the 2020/21 plan.

Please ensure that a copy of this letter is attached to the copy of your signed plan held by each DHB Board and to all copies that are made available to the public.

Ngā mihi nui

Chris Hipkins
Minister of Health

+64 4 817 8706 | Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand | c.hipkins@ministers.govt.nz | beehive.govt.nz

From: Cheryl Shearer
Sent: Sunday, 1 November 2020 9:42 a.m.

Subject: MONDAY OF PRIVACY WEEK - 2 November 2020

GOOD MORNING

[Managers/Team Leaders – please place a copy of this email on your staff noticeboard to ensure your staff who do not have easy access to emails or OnePlace have an opportunity to see this message – thank you.]

The Privacy Act 2020

The updated Privacy Act 2020 – comes into force on 1 December 2020 (current legislation is Privacy Act 1993). There are ten changes – but for us as a Healthcare Provider the **six** significant changes are:

- New notifiable privacy breach regime (for details see Wed, 4th November email)
- Amendments to information privacy principles (for details see Thurs, 5th November email)
- Cross border protections relating to the transfer of personal information to an entity outside NZ (for details see Thurs, 5th November email)
- Service provider responsibilities (for details see Thurs, 5th November email)
- Access requests (for details see Thurs, 5th November email)
- New criminal offences and penalties (for details see Thurs, 5th November email)

The other four changes relate to: extra-territorial reach; clarification and amendment to the scope of the news media exemption (including bloggers); removal of public register privacy principles; and changes to the Privacy Commissioner's power to make access requests, compliance notices and investigatory powers.

Although the new Privacy Act doesn't include changes related to data portability or anonymisation and has not introduced a specific concept of sensitive data – ***we should always treat healthcare information and employee information as being sensitive data in relation to the person the information is about.***

If you have any queries regarding this Privacy Week information – please don't hesitate to email me.

Cheers
(Mrs) Cheryl Shearer MBA
Privacy Coordinator
cheryl.shearer@bopdhb.govt.nz | PO Box 241, Whakatane, 3158 | Direct Dial 07 306 0890 | 027 205 8551
Live Well, Get Well, Stay Well – for a health community
Do you need to print this e-mail?

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

MEDIA RELEASES FOR NOTING

SUBMITTED TO:

Board Meeting 18 November 2020

Prepared by: Maxine Griffiths, Board Secretariat

Endorsed and
Submitted by: Pete Chandler, Chief Executive

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

RECOMMENDATION:
That the Board notes the Media Releases

ATTACHMENTS:

- Tauranga Hospital Prostate Cancer World First
- International Trauma Course
- Bay Organisations COVID response – past, present, future

Media Release

FOR IMMEDIATE USE

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Wednesday 21 October, 2020

World first surgery at Tauranga Hospital could pave way to new way of treating prostate cancer

A world first surgery undertaken at Tauranga Hospital could represent a major advance in the treatment of prostate cancer say medical experts.

The surgery, successfully conducted by urologist Dr Mark Fraundorfer, uses a pioneering localised drug delivery technology to deliver slow release drugs (e.g. bicalutamide) directly into cancerous tumours. The surgery was part of a clinical study being carried out by US-based company Alessa Therapeutics, which has developed the slow-release technology called Biolen.

“I am honoured to be the first in the world to enrol a patient in this study,” said Dr Fraundorfer of Tauranga Urology Research. “The introduction of the device delivering bicalutamide selectively to the prostate of my patient with a sizable tumour was a very straightforward procedure.”

The Bay of Plenty District Health Board’s Head of Clinical Campus Professor Peter Gilling is Chairman of the Data and Safety Monitoring Committee for the global clinical study. He said the technique could prove a major advance.

“It’s a very promising technology and also a proof of concept for the technique of delivering these drugs straight into the tumour,” said Professor Gilling. “We use MRI scans to diagnose prostate cancers in our patients. Once identified, using this technology we can administer drugs straight to it, in the form of slow release pellets. It should open up a whole new way of treating prostate and potentially other cancers.”

The surgery took place on Thursday 8 October and all members of the Tauranga urology team, whose combined efforts helped make it possible, were thanked for their work.

The rate of prostate cancer in New Zealand is 103 cases per 100,000 men resulting in more than 3,700 annual cases. In Australia, the rate of prostate cancer is one of the highest among developed countries at 110 cases/100,000 men.

While some men with low-risk tumours choose to monitor their disease, most prostate cancer patients are treated with surgery to remove their prostate or with radiation therapy. Both surgery and radiation treatment can have complications including urinary incontinence and erectile dysfunction.

Alessa’s Biolen implant is designed to deliver an anti-androgen drug to the target tissue in the prostate, eliminating significant side effects and improving quality of life for men living with prostate cancer while avoiding surgery or radiation therapy.

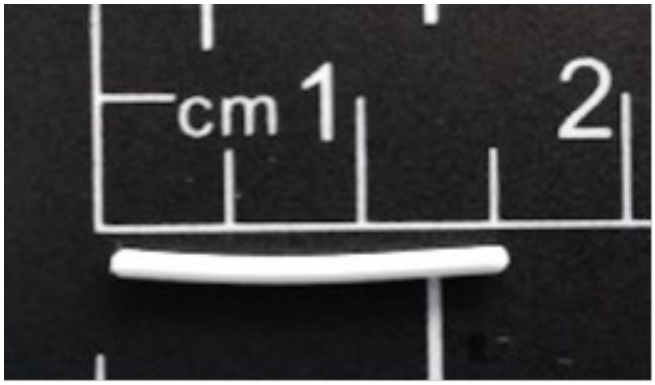
“We are excited to be conducting the first-in-man study of our revolutionary technology in patients with prostate cancer,” said Dr Pamela Munster, founder of Alessa Therapeutics. “I am grateful for the dedicated efforts of our University of California and Alessa teams together with the research group at Tauranga Urology for reaching this important milestone.

“The findings from the Biolen-PC study will be used to support our U.S. IND (Investigational New Drug) submission to the FDA (Food and Drug Administration) for our Phase 2 trial. We believe this novel implant therapy will increase the treatment options for men diagnosed with prostate cancer and provide a higher quality of life while under treatment.”

The company received approval in Australia and New Zealand for the study earlier this year. The Biolen-PC study will treat a total of up to 20 men scheduled for prostate surgery for treatment of non-metastatic prostate cancer.

In addition to Dr Fraundorfer at Tauranga Urology, Professor Henry Woo, Associate Professor Peter Chin, Associate Professor Daniel Moon and Associate Professor Jeremy Grummet are all participating in the Biolen-PC study at their respective centres in Australasia.

Above: The world first surgery at Tauranga Hospital could represent a major advance in cancer treatment.



Above: The Biolen implant which was used in the surgery.

For further information contact:

James Fuller
Communications Advisor - Bay of Plenty District Health Board
DDI: 07 579 8411
Mobile: 027 839 1791
Email: james.fuller@bopdhb.govt.nz
Website: http://www.bopdhb.govt.nz/

or

Peggy McLaughlin
Alessa Therapeutics
Email: PMcLaughlin@AlessaTherapeutics.com
Website: www.AlessaTherapeutics.com
Link for clinical trials information related to this study: NCT04284761

Media Release

FOR IMMEDIATE USE

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Wednesday 28 October, 2020

Internationally renowned trauma course held in Tauranga for first time

Hosting a high profile, internationally recognised trauma course at Tauranga Hospital for the first time is great news for both the Bay of Plenty District Health Board (BOPDHB) and the community it serves say medical experts.

Trauma physicians at the BOPDHB had been looking to hold the Emergency Management of Sudden Trauma (EMST) course locally for over 15 years and the stars finally aligned this year.

“Not only does the course improve trauma awareness and trauma care, but it also improves the standing of the BOPDHB as an entity in New Zealand,” said BOPDHB Medical Leader and Clinical Director for Tauranga ICU/HDU Troy Browne. “It’s a great day for the DHB, going from strength to strength in education and for the community.”

BOPDHB Emergency Medical Specialist Derek Sage echoed those thoughts saying the course would “improve the trauma health provision in our area”.

The three-day EMST course is mandatory for surgeons and rural GPs however it is also attended by Anaesthetists, Emergency Technicians, other GPs, and trainees from various medical specialities and backgrounds. 16 people attend each course and are split into groups of four for training. A nurse who has requested additional trauma training is also attached to each of these groups.

The course was developed in 1976 in the United States and has since been taken up by 78 countries globally. It has been running in Australia since 1988 and in New Zealand since 1989.

“It enables those in the trauma team to speak a common language and have a common set of skills,” explains Dr Sage. “There is no doubt that this course has improved trauma care around the world and continues to do so.”

BOPDHB Trauma Medical Director and Consultant General Surgeon Jacques Marnewick was an instructor on the course, along with Dr Sage and Dr Browne, and was thrilled it had finally come to the Bay.

“There is a need for the course here as we see a lot of trauma at Tauranga and Whakatāne hospitals. It also provides good training grounds for junior doctors as it is a vital component in their training. To be able to offer this here is gold,” he said.

“It is also important to recognise the work that went on behind the scenes because that was astounding; especially the work by the two nurses who ran the show – Christchurch Nurse Tracey Williams and Clinical Nurse Manager for Tauranga ED Stephanie Watson.”

National Trauma Network Clinical Director Ian Civil was also pleased to be among the faculty of instructors in Tauranga over the duration of the course, from Friday 16 October-Sunday 18 October.

“I have always loved doing the course,” he said. “It was really exciting for me to be back in the Bay of Plenty and have the opportunity to continue to teach this course which I know the team from the BOPDHB have been hanging out for for a long time. It was a great team and great instructors and I have no doubt they will lobby and it will be offered twice a year in Tauranga.”

Above: some of the course participants engaged in an exercise under the watchful eye of BOPDHB Medical Leader and Clinical Director for Tauranga ICU/HDU Troy Browne (right).

Above: BOPDHB Medical Leader and Clinical Director for Tauranga ICU/HDU Troy Browne (centre standing) addresses the EMST course participants.

Above: Hosting the internationally recognised EMST course at Tauranga Hospital for the first time was seen as great news for the BOPDHB and the community it serves.

James Fuller
Communications Advisor - Bay of Plenty District Health Board
DDI: 07 579 8411
Mobile: 027 839 1791
Email: james.fuller@bopdhb.govt.nz
Website: http://www.bopdhb.govt.nz/

Media Release

FOR IMMEDIATE USE

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Tuesday 3 November, 2020

Bay organisations meet to discuss COVID response - past, present, future

Organisations from across the Bay of Plenty have come together to appraise the local COVID response and to plan for future outbreaks.

39 organisations registered for the 'Past, Present, Future' event organised by the Bay of Plenty District Health Board (BOPDHB) and held at Te Puke's Orchard Church on Thursday (29 October).

The buy-in from all those present was clear and evident said BOPDHB Acting Medical Officer and COVID-19 Executive Lead Dr Joe Bourne.

"It was amazing to see how far the relationships have developed between all those present and that is great news for the Bay of Plenty in general," said Dr Bourne. "The level of enduring trust and commitment to the cause was plain for all to see and that stands us in great stead for, not only any future challenges with regard to COVID, but any other challenges which might present themselves to us as a health system."

BOPDHB Chief Executive Officer Pete Chandler said it "was a time for people to come together to share, reflect and celebrate the amazing collective effort as we navigated our way through the challenges that COVID has brought to us in 2020".

Over 100 people came together for the four-hour long event to acknowledge the COVID response work undertaken to date and the impact it has had on the health system and Bay of Plenty community in general. The current state-of-play was also discussed before a session on future scenario planning. This session was designed to plan coordinated responses should small, medium or even major outbreaks occur at some stage in the future.

BOPDHB Service Improvement Programme Manager Helen De Vere, who helped organise the event, said she had had a lot of positive feedback.

"It's the first time we've really run an event like this and it was really well received. It was a great way for people to connect, acknowledge the mahi that had been undertaken to this point, and to continue building relationships for the ongoing fight against COVID. We connected with a lot of organisations during the COVID lockdown and this was a great way to reinforce those connections.

"That connectedness ran through the future scenario planning and that exercise especially really helped sharpen the focus for organisations individually, and us collectively, around elements of our local resurgence planning."

The event participants covered 39 organisations large and small from across the Bay of Plenty including: Iwi, Māori health providers, local councils, the three regional primary health

organisations/alliances, Lakes DHB, community health providers and health charities, public health services, hospice providers and pharmacy representatives.

Above: Dr Joe Bourne said the commitment to the cause shown by the event's participants was plain to see.

James Fuller
Communications Advisor - Bay of Plenty District Health Board
DDI: 07 579 8411
Mobile: 027 839 1791
Email: james.fuller@bopdhb.govt.nz
Website: http://www.bopdhb.govt.nz/

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

BOARD WORK PLAN 2020

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