BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Board Meeting
Agenda

Wednesday, 23 September 2020
10.00 am

Please note Board Only Time 9.00 am

Venue: Kahakaharoa Room, The Whare Whakamana
17th Ave (Opp Historic Village main entry)

Minister's Expectations

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

Minister's COVID-19 Expectations

- Financials
- Health and Safety
- Clinical Quality
- Planning and Reporting

Minister's Expectations

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

The Quality Safety Markers

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

Strategic Health Services Plan Objectives

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

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 Sustainability Strategy Vicktoria Blake, Sustainability Manager 2.1.1 Sustainability at BOPDHB 2.1.2 A Framework for Sustainability at BOPDHB 2.1.3 BOPDHB Environmental Sustainability Action Plan	 **5** **22** **33**
3	**Apologies**	
4	**Interests Register**	**39**
5	**Minutes** 5.1 Board Meeting – 19.8.20 Matters Arising 5.2 BOPHAC Meeting - 2.9.20	 **44** **50** **52**

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	6.1 Position Statement on Te Tiriti o Waitangi, Health Equity and Racism	**60**
7	**Items for Discussion**	
	7.1 Inquiry into Health Inequities for Maori	**73**
	7.2 Indicators of District Health Board Performance (IDP) Quarter Four Summary	**116**
	7.3 Chief Executive's Report	**134**
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8	**Items for Noting**	
	8.1 Te Toi Ahorangi Action Plan and Investment/Annual Plan Alignment Update	**183**
	8.2 Board Work Plan 2020	**191**
9	**General Business**	
10	**Resolution to Exclude the Public** Pursuant to clause 33(3) of the NZ Public Health & Disability Act 2000 Mr Pouroto Ngaropo who is the Chair of the Maori Health Runanga is permitted to remain after the public have been excluded because of his knowledge of the aspirations of Maori in the Bay of Plenty that is relevant to all matters taken with the public excluded. Pursuant to clause 33(5) of the NZ Public Health & Disability Act 2000 Mr Pouroto Ngaropo must not disclose to anyone not present at the meeting while the public is excluded, any information he becomes aware of only at the meeting while the public is excluded and he is present.	
11	**Next Meeting** – Wednesday 21 October 2020.	

Sustainability at BOPDHB

Board Presentation

Wednesday 23 September 2020

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CARE
Manaakitanga

What does environmental sustainability mean to BOPDHB?

Toitū te marae ā Tāne
Toitū te marae ā Tangaroa
Toitū te iwi

Uphold the wellbeing of the land, uphold the wellbeing of the ocean, and we uphold the wellbeing of the people.

93%
of staff
think it is important for BOPDHB to become more sustainable

Sustainability leadership
should be demonstrated both internally and externally according to our staff

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Why is sustainability important?

Ministers expectations – 50% carbon reduction by 2030

Specific legislation will have an impact including:

- Climate Change Response (Zero Carbon) Amendment Act
- Waste Minimisation Act

Other compliance requirements:

- Public Health and Disabilities Act 2000 Section 22 (1)(j) to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations.
- Treaty of Waitangi Article I, demonstrate a commitment to the best interests of its citizens, including tāngata whenua; and Article II, actively support tāngata whenua in their aspirations, which are clearly connected to a healthy and sustainable environment.

Climate change and environmental degradation impact human health!

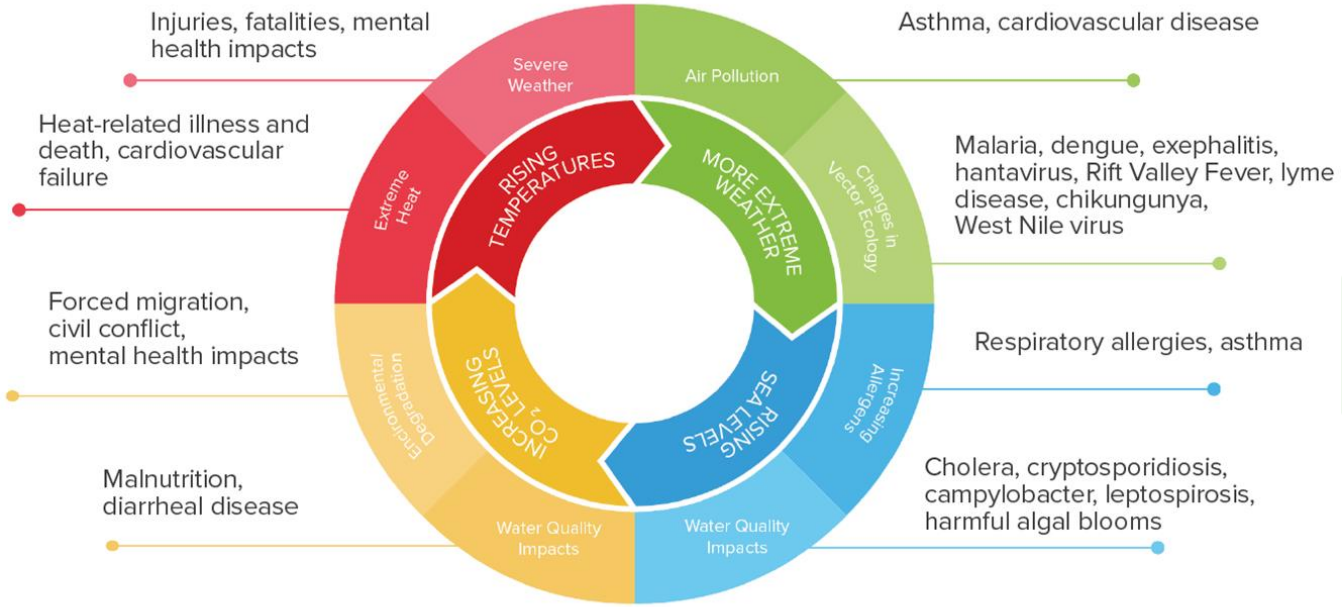

Figure 1: Impact of climate change on human health (Source: U.S. Centers for Disease Control and Prevention)

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Resource: [Human Health Impacts of Climate Change for New Zealand – Evidence Summary]

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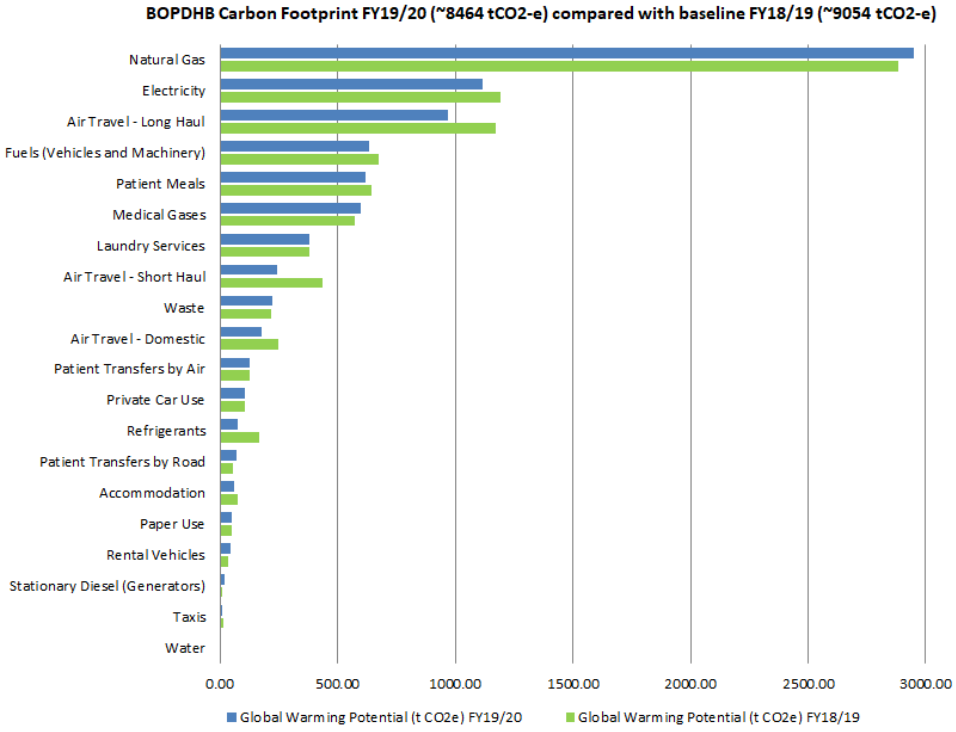
Environmental Risk

- Recent Health and Disability System Review acknowledged that climate change is a significant risk to health
- Recent MfE Climate Change Risk Assessment
- Ministry of Health is beginning some work into climate change adaptation planning
- Climate change mitigation work is currently underway guided by the outcomes of our carbon footprint

What is BOPDHB's environmental impact?



48% of footprint relates to energy use

29% of footprint relates to travel and transport

16% of footprint relates to air travel

7% of footprint relates to medical gases

65% reduction in desflurane use in FY19/20

510 Pohutukawa Houses from basement to roof filled with greenhouse gases based on our FY19/20 carbon footprint

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Environmental Sustainability Framework

We understand that while our work has positive outcomes for our people, it consumes resources and impacts the environment, and therefore goals must be set to reduce these impacts as much as possible, and to regenerate the environment where we can.

In February 2020 BOPDHB Executive Committee endorsed the Kaitiakitanga Farmework for Environmental Sustainability.

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Bay of Plenty District Health Board
Hauora a Toi

Sustainability and Equity

Indigenous peoples and low socio-economic groups are disproportionately impacted by climate change and environmental degredation.

Further, equity is not just relevant to all people alive today. Inter-generational equity is concerned with fairness between current and future generations. This means striking a reasonable balance between satisfying our needs now and setting aside enough to provide for needs of our children and grandchildren in the future.

The relationship between equity and environmental sustainability is clear. Without a well environment, we cannot enable the equitable needs of our communities to ensure their wellness.

Kaitiakitanga – caring for people and planet

Kaitiakitanga principles:

- Collective decision making
- Sustainable
- Intergenerational
- Adaptive
- Regenerative
- Knowledge-based
- Tailored
- Revitalising mauri

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Commitment to Sustainability – Kaitiakitanga Framework

BOPDHB will:

- show internal and external leadership in environmentally sustainable practice
- be accountable for our environmental/carbon footprint
- be committed to finding and embedding sustainable solutions for all our business practices (including those related to waste, energy, water, transportation, food, built environment, and procurement)
- use its resources responsibly
- consider co-benefits (economic, health, social and environmental resilience/regeneration) during all decision making processes
- be future focused, while reflecting on the past

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Environmental Sustainability Action Plan (ESAP)

Our Environmental Sustainability Action Plans stem from the Kaitiakitanga framework and our carbon footprint audits.

We have 10 priorities: Leadership, Accountability, Waste, Energy, Transport/Travel, Procurement, Built Environment, Water, Food, Climate Change Adaptation and Mitigation.

Our main areas of focus currently are Waste, Transport/Travel and Procurement, however Leadership and Accountability are always embedded.

Built Environment is a priority of the Ministry of Health and we have adopted a Sustainable Building Design framework for current projects as a first step.

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Sustainability Leadership

Full-time Sustainability Manager reporting to GM Facilities & Business Operations, guided and supported by:

Sustainability Steering Group *(high level decision making and guidance)*
Members: Executive and Senior Leadership representatives

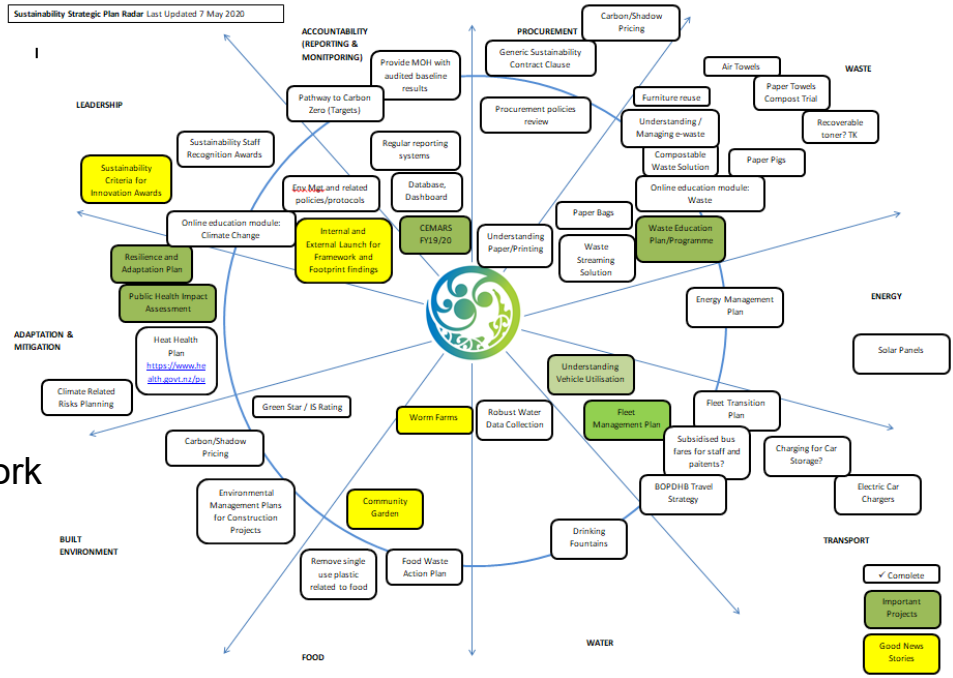
Clinical Green Team *(greening clinical practice)*
Current Membership: 50+ Clinical Staff Members

Non-Clinical Green Team *(greening the non-clinical environment)*
Current Membership: 40+ Clinical and Non-Clinical Staff Members

VB30

Acheivements to Date

- ✓ Board endorsement of BOPDHB Travel Plan
- ✓ Removal of polystyrene cups from use
- ✓ Introduction of scissor/tweezer/forcep recycling across the whole DHB
- ✓ Meat Free Mondays (Tauranga Hospital Level 1 Cafe)
- ✓ Increase in battery recycling
- ✓ Installation of worm farms (six month trial)
- ✓ Executive endorsement of Kaitiakitanga Framework
- ✓ Waste Minimisation and Management Plan v1
- ✓ Environmental Sustainability Action Plan v1
- ✓ And more...



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VB31

Current Major Projects

SUSTAINABLE APPROACH TO HEALTHCARE BUILDING DESIGN

THE FOLLOWING PRINCIPLES LAY THE FOUNDATIONS FOR SUSTAINABLE DESIGN IN NEW AND EXISTING HEALTHCARE BUILDINGS

Energy & Emissions

Sustainable Principles:

1. High performance building fabric
2. Energy efficient HVAC systems
3. Demand control HVAC
4. Automatic lighting control
5. Efficient water use
6. Consider renewable and/or low carbon energy
7. Simplify operation
8. Effectively monitor, measure and manage energy consumption

Aims to:

- Reduce impact on the environment
- Lower running costs
- Alignment with Ministry of Health Zero Carbon by 2050 target
- Minimize stormwater impact on infrastructure

Materials and Waste

Sustainable Principles:

1. Use environmentally preferable materials
2. Lean design approach for reduced waste
3. Reduce environmental impacts during the construction stage
4. Promote recycling and avoidance of waste
5. Include materials that can be easily renewed

Aims to:

- Reduce embodied carbon
- Reduce waste to landfill
- Increase waste diversion
- Improved air quality and construction safety

Sustainable Transport

Sustainable Principles:

1. Promote the adoption of low carbon and zero carbon models of transport for staff and visitors
2. Promote public transport links

Aims to:

- Reduce embodied carbon
- Reduce waste to landfill
- Increase waste diversion
- Improved air quality and construction safety

Resilience

Sustainable Principles:

1. Design to increase resilience from the predicted effects of climate change
2. Protect against seismic and natural disaster events

Aims to:

- Improve health and safety
- Reduce risk

Benchmarking

Sustainable Principles:

1. Benchmark and verify design strategy with environmental certification schemes

Aims to:

- Benchmarks the design against best practice
- Improved quality outcomes from formal certification, i.e. Greenstar
- Third-party recognition
- Assist stakeholder buy-in and BOPDHB staff attraction

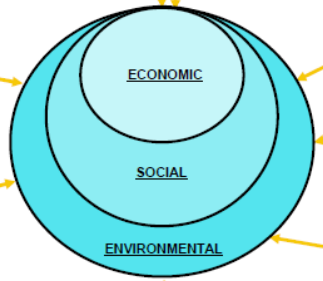
Health & Wellbeing

Sustainable Principles:

1. Enhanced indoor air quality (IAQ)
2. Maximise natural daylight
3. Access and unobstructed views to outdoor spaces
4. Flexibility
5. Comfortable acoustic conditions

Aims to:

- Enhance patient experience and BOPDHB reputation
- Faster patient recovery rates
- Increase staff attraction and retention
- Reduced sick days



Management and Operations

Sustainable Principles:

1. Empower management to monitor and target ESD objectives during building operation
2. Soft Landings approach

Aims to:

- Improved performance outcomes
- Align with performance focused approach
- Ensures users understand the design philosophy

Landscaping, Plants and Site Ecology

Sustainable Principles:	Aims to:
1. Enhance site ecological value	Enhance patient experience and staff comfort
2. Provide accessible connection with nature	Reduce environmental impact
	Reduce stormwater run-off

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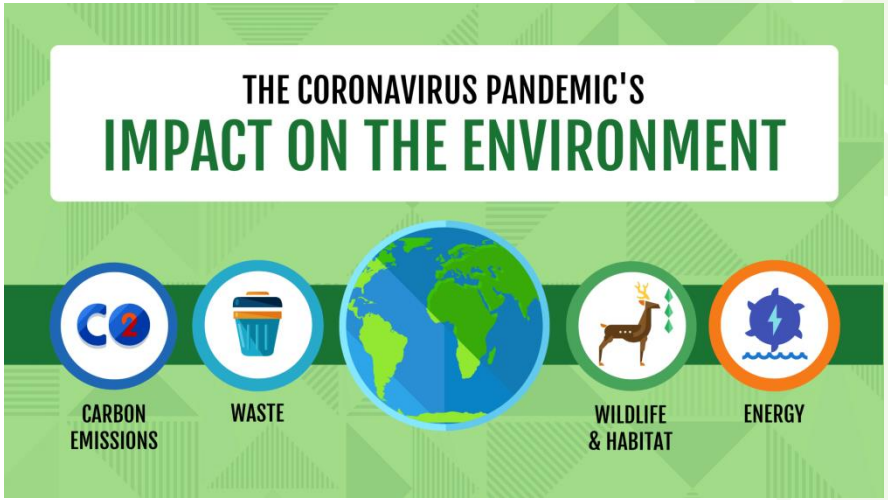
Beca

Post-COVID Recovery – Opportunities

- Telehealth
- Flexible working
- Active transport engagement
- Buy local / travel local
- Food preparation – zero waste
- Whānau connection – reflecting on whats important



Discussion

- What are your thoughts on the model/framework we have endorsed? Will you endorse the framework?
- Is there any specific peices of work you would like undertaken in this space?
- Is there any specific reporting you would like to see? How would you like to be updated on our Environmental Sustainability Action Plan etc.?
- Questions?

He waka eke noa!

We're all in this together**!**

Vicktoria Blake – Sustainability Manager
vicktoria.blake@bopdhb.govt.nz
07 557 5394
027 268 5905

sustainability@bopdhb.govt.nz

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Kaitiakitanga

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A Framework for Environmental Sustainability at Bay of Plenty District Health Board

Version 1 **February 2020**

Prepared by: Vicktoria Blake, Sustainability Manager, BOPDHB
Endorsed by: BOPDHB Executive Committee

What is Sustainability?

Toitū te marae ā Tāne
Toitū te marae ā Tangaroa
Toitū te iwi

"Uphold the wellbeing of the land, uphold the wellbeing of the ocean, and we uphold the wellbeing of the people."

There are many definitions of sustainability; however, all discuss meeting the needs of today while ensuring that future needs are able to be met.

There have been various models for organisational/business sustainability argued over the years, including the Triple Bottom Line (TPL) model which incorporates the three pillars (3Ps) of sustainability (people – society, planet – environment, and profit – economy). This model inferred that the 3Ps need to be balanced in order to achieve sustainability. However, since the introduction of TPL, a more appropriate model, known as the Strong Sustainability model, was introduced.

The Strong Sustainability model suggests that the environment is of more importance, as without the natural environment there is no space for society, and without society there is no economy. This model argues that the environment requires more focus to reach true sustainable principles, followed by society, and finally the economy.

More recently, understanding the role of indigenous knowledge in sustainability solutions is having significant impact globally. In Aotearoa New Zealand, a healthy environment is integral to tāngata whenua[1]. It is a tāonga[2] under Article II of Te Tiriti o Waitangi (TTOW), and needs to be protected as part of Treaty obligations. Any degradation of the natural environment or relationships with the environment can have consequences for Toi Ora[3].

The sustainability models discussed, and a respect for and understanding of the tāngata whenua (indigenous) perspective, guide the sustainability model adopted by the Bay of Plenty District Health Board (BOPDHB), and the design of this framework.

[1] Tangata whenua literally means people of the land. The term reflects the Māori world view that people and land are inextricably linked.
[2] Treasure
[3] Toi Ora – flourishing descendants of Toi

BOPDHB Model for Sustainability

The model for organisational sustainability adopted by BOPDHB is presented below, with each of the dimensions defined for clarity:

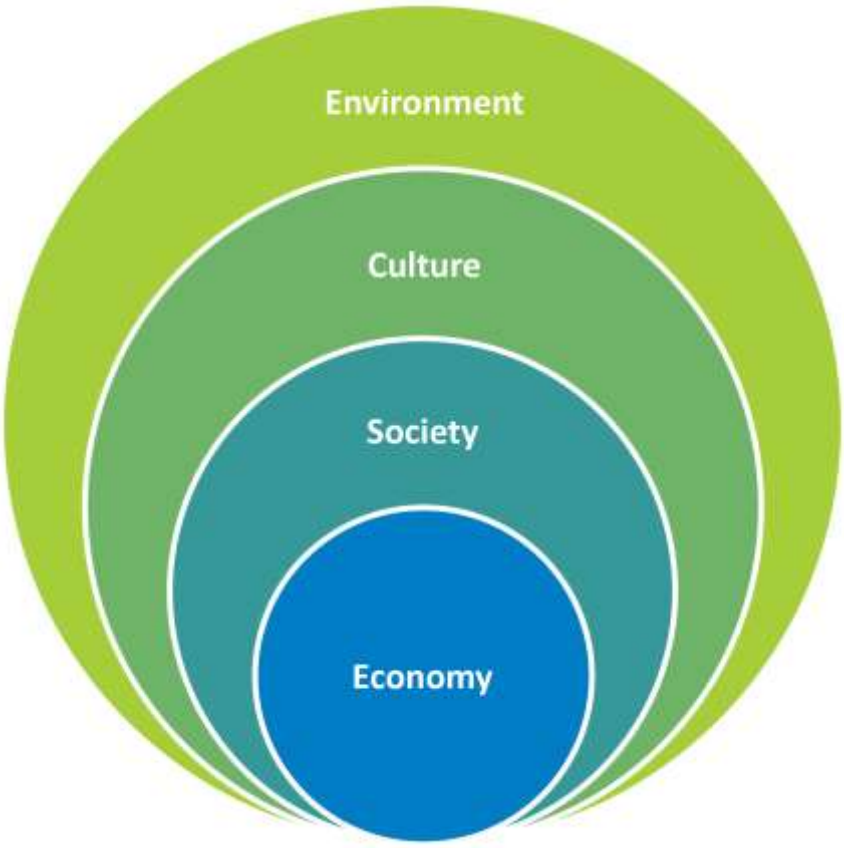


Figure 1. BOPDHB Model for Sustainability

Environment

Environmental sustainability can be defined in many ways, but for BOPDHB environmental sustainability relates to treading as lightly as possible on the earth.

We understand that while our work has positive outcomes for our people, it consumes resources and impacts the environment, and therefore goals must be set to reduce these impacts as much as possible, and to regenerate the environment where we can.

Society

Society exists within the environment. We cannot have a healthy society without a healthy environment.

Social sustainability is the ability of a community to develop processes and structures which not only meet the needs of its current members but also support the ability of future generations to maintain a healthy community.

The community of BOPDHB includes our paid workforce, our volunteers, our patients and their whānau, as well as iwi and other stakeholders such as our providers. We are responsible not only for the sustainability of our own community, but also have a responsibility to the wider communities in our rohe, due to our responsibilities as health promotion providers.

Culture

Culture and indigenous knowledge are the link between the environment and society, therefore cultural sustainability refers to the necessity for a commitment to the maintenance and nurturing of indigenous cultures.

In Aotearoa New Zealand, tāngata whenua are an integral part of the ecosystem which they whakapapa[4] to and holders of the mātauranga[5] that is critical to ensuring sustainability. Iwi, hapū and whānau provide guidance to act as kaitiaki[6] to preserve the mauri[7] of Papatūānuku[8]. BOPDHB supports and respects the guardianship role of our Treaty partners, our iwi and hapū, as mana whenua.

Economy

We cannot have a healthy economy if society and the environment are not healthy. However, it too is important as this how we can fund initiatives and resources that support our society and the environment.

Practically, economic sustainability requires that we are meeting the financial needs of the organisation in order to continue to provide for the health needs of our rohe.

What does Sustainability mean to BOPDHB?

BOPDHB's vision is healthy, thriving communities. And as discussed above, in order for our communities to thrive, we must have a healthy and flourishing environment.

BOPDHB accepts the environmentalist view that humans (society) are a 'part' of nature (the environment) and not 'apart' from it[9]. This resonates with Te Ao Māori[10], evident in the perspective that tāngata whenua whakapapa has direct lineage with the environment.

BOPDHB's Te Toi Ahorangi strategy is grounded in upholding the self-determination of tāngata whenua, which must also be the foundation for the work in the environmental sustainability space. Worldwide, indigenous knowledge is having a substantial impact on global sustainability solutions, and BOPDHB is committed to seeking and considering the mātauranga of tāngata whenua on our

[4] Genealogy; Māori are direct descendants of the Earth (Tāne-mahuta [God of the Forest]; Papa-tū-ā-nuku [Earth Mother]; Rangi-nui [Sky Father])
[5] Knowledge
[6] Guardians
[7] Simply defined, mauri is the life supporting essence of air, water and soil. It is a spiritual understanding of the importance of the health of these three things.
[8] Earth Mother; the Earth
[9] Cairns, J. (1999). Exemptionalism vs environmentalism: the crucial debate on the value of ecosystem health. Aquatic Ecosystem Health and Management, 2(3), 331–338, p. 333.
[10] Māori world view

journey to becoming a sustainable organisation. Ngā Pou Mana is representative of that mātauranga in the Bay of Plenty. These pou are the fullest expression of wellbeing and sustainability for our Māori communities: Mana Atua; Mana Whenua; Mana Moana; Mana Tupuna; Mana Tangata.

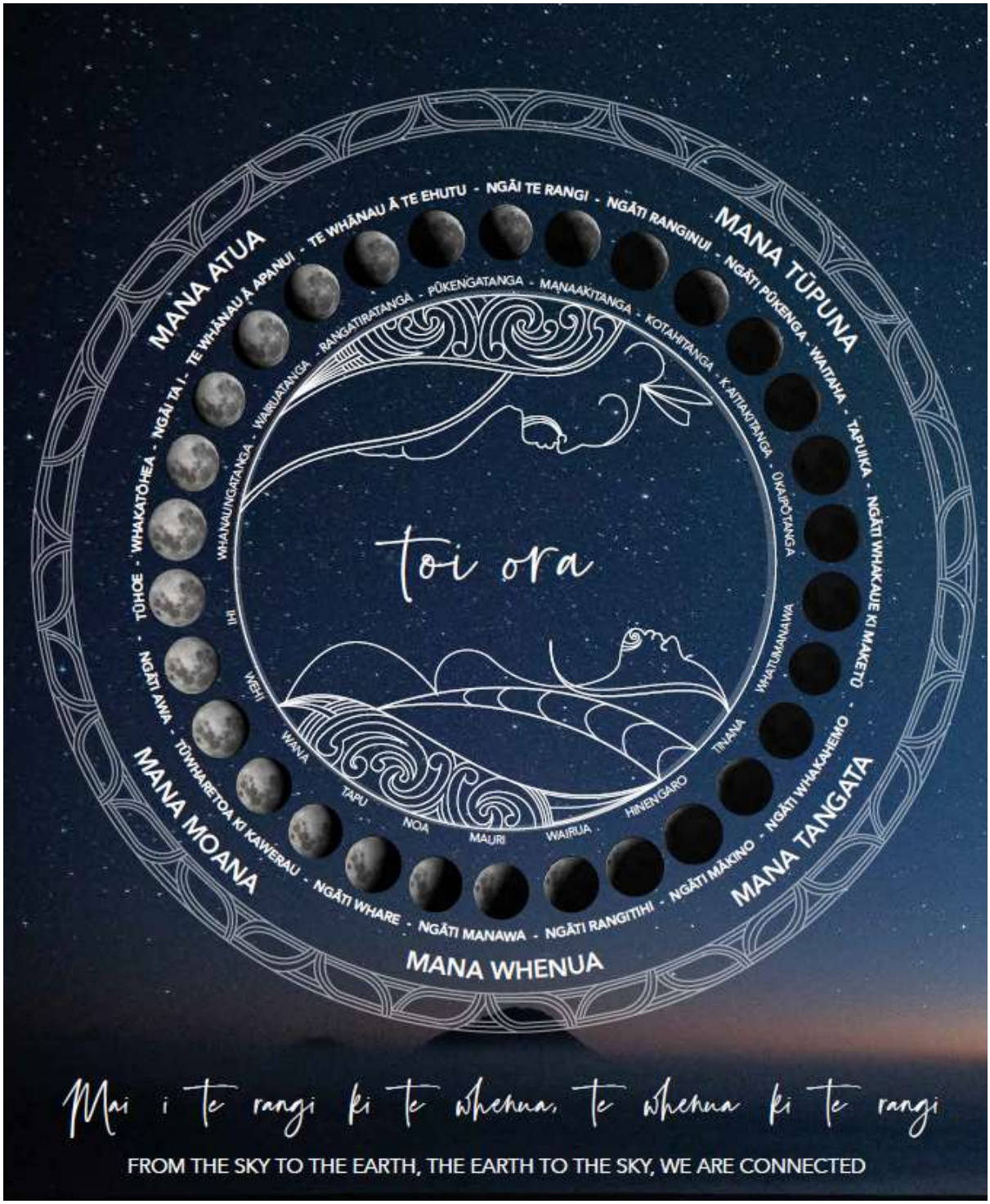


Figure 2. He Pou Oranga, Tangata Whenua Determinants of Toi Ora (Source: p 7, Te Toi Ahorangi)

Further to Te Toi Ahorangi, the Bay of Plenty Strategic Health Services Plan 2017 – 2027 sets out the following three strategic objectives:

Live Well	Stay well	Get well
1 Empower our populations to live healthy lives	2 Develop a smart, fully integrated system to provide care close to where people live, learn, work and play	3 Evolve models of excellence across all our hospital services

Figure 3. The SHSP's three strategic objectives (Source: p7 Bay of Plenty Strategic Health Services Plan)

It can be argued that adopting the BOPDHB Model for Sustainability will help BOPDHB to achieve each of these three aims. To give an example, providing care close to where people live, learn, work and play, reduces the need for patients (and staff) to travel long distances to access care (attend work); having service close to users would enable participation in active transport modes[11], therefore empowering healthy living; and, BOPDHB could work with council to ensure public transport is fit for purpose therefore evolving the current model to ensure excellence. This one example, relating only to transport implications, sees improvements across social, environmental, and economic sustainability.

BOPDHB views its sustainability principles and organisational purpose and vision holistically. By understanding and applying the concepts of this framework, BOPDHB aims to work with stakeholders to protect our environment, culture, society, and economic stability, to enable our communities to get well, live well, and stay well.

What is the role of BOPDHB in relation to Environmental Sustainability?

The role of the BOPDHB is to embed the principles of Kaitiakitanga as set down in this document, in its day-to-day decision making practices, and to lead others, including individuals, communities, and businesses in the wider rohe, to work towards considering these principles too.

BOPDHB is a Crown Agent, so has responsibilities to environmental sustainability as a TTOW partner under Article I and II. In Article I, BOPDHB must develop strategy, policy and procedures that demonstrate a commitment to the best interests of its citizens, including tāngata whenua, and a healthy and sustainable environment is a part of that commitment. In Article II, BOPDHB must work to actively support tāngata whenua in their aspirations, which are clearly connected to a healthy and sustainable environment.

Further to TTOW, the Public Health and Disabilities Act 2000 Section 22 outlines the objectives of DHBs, specifically (1)(j) to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations.

[11] Active transport includes walking, biking, and using public transport systems.

The Kaitiakitanga Framework focuses on environmental sustainability, however it is understood that all four dimensions of sustainability work together and rely on each other, and that BOPDHB will not achieve environmental sustainability in isolation (see: BOPDHB Sustainability Model).

The Principles of Kaitiakitanga

Kaitiakitanga is the concept of intergenerational sustainability in a Te Ao Māori framing, basically an intergenerational approach to resource management. It is primarily about "managing humans and what we do"[12].

At BOPDHB, Kaitiakitanga is one of the eight Pou Oranga in He Pou Oranga Tāngata Whenua. This pou is acknowledgement that we are all custodians of knowledge and practices that enhance our relationships with each other and our environment.

The following principles are adopted under this Kaitiakitanga framework[12]:

- Collective decision making
- Sustainable
- Intergenerational
- Adaptive
- Regenerative
- Knowledge-based
- Tailored
- Revitalising mauri

In adopting these principles, Bay of Plenty District Health Board will:

- show internal and external leadership in environmentally sustainable practice
- be accountable for its environmental/carbon footprint
- be committed to finding and embedding sustainable solutions for all business practices (including those related to waste, energy, water, transportation, food, built environment, and procurement)
- use its resources responsibly
- consider co-benefits (economic, health, social and environmental resilience/regeneration) during all decision making processes
- be future focused, while reflecting on the past

These aspirations of the Bay of Plenty District Health Board align to ten of the 17 United Nations Sustainable Development Goals:

Figure 4. Kaitiakitanga framework alignment to UNSDGs
(UNSDG source: https://www.un.org/sustainabledevelopment/sustainable-development-goals/)

[12] Dr Dan Hikuroa, Ngāti Maniapoto, Waikato-Tainui, Senior Lecturer, Te Wananga o Waipapa, University of Auckland: Toitū te whenua Whatungarongaro he tangata: A Kaitiaki approach for Aotearoa New Zealand, WasteMINZ Conference 2019, Opening Plenary

How will environmental sustainability be governed?

Environmental sustainability at BOPDHB is led by the Sustainability Manager guided and supported by the Sustainability Steering Group, a Clinical Green Team and a Non-Clinical Green Team.

The Sustainability Manager is a full time role reporting to the General Manager Facilities and Business Operations, who acts as the Executive Sponsor.

The Sustainability Steering Group has five members, made up of BOPDHB Executive and Toi Te Ora management representation, chaired by the Sustainability Manager. This group is responsible for high level decisions in relation to environmental sustainability at BOPDHB and will determine decisions that require full executive or board level approval.

The Clinical Green Team is a group of volunteers from across the DHB who meet regularly to discuss and debate initiatives and actions related to making clinical practice more sustainable. Membership includes clinical staff from across the DHB such as House Officers, Infection Control Nurses, and Clinical Nurse Managers. The Non-Clinical Green Team is a group of volunteers from across the DHB who meet regularly to discuss environmentally sustainable initiatives and actions in a non-clinical environment. Membership includes both clinical and non-clinical staff from across the organisation. Members of both Green Teams also act as champions for any sustainability actions being launched throughout the DHB.

What will guide our environmental sustainability action planning and objective setting?

BOPDHB conducted a Toitū Carbon Reduce[13] carbon footprint audit for the financial year 2018/2019 to establish a carbon footprint baseline. Moving forward, the findings of this annual audit exercise will guide the actions required by BOPDHB to work towards reducing this footprint.

Further, the voices of BOPDHB's stakeholders are crucial in guiding these sustainable organisational actions. The list below outlines a number of resources and guidelines utilised by BOPDHB to assist these discussions and decisions. This ensures informed and reasonable actions and objectives can be set to enable BOPDHB to meet the principles outlined in this framework.

- BOP Strategic Health Services Plan
- Te Toi Ahorangi
- Expectations of relevant Minister's (e.g. Minister of Health, Associate Ministers of Health, Minister for the Environment, Associate Ministers for the Environment, Minister for Climate Change)
- Ministry of Health Policy Priority PP40: Climate Change (and all other relevant government priorities)
- United Nations Sustainable Development Goals
- OECD Framework for Measuring Wellbeing and Progress
- New Zealand Treasury Living Standards Framework
- Toitū Envirocare

[13] Was CEMARS

Further, BOPDHB has signed up to the Climate Leaders Coalition, and the Global Green and Healthy Hospital's initiative, and is a member of a number of Bay of Plenty based professional and community groups with an interest in carbon reduction and sustainable solutions, which will further guide these actions.

Action Plans will be set on an annual basis and presented with the annual carbon footprint information. BOPDHB aim to have a pathway to Carbon Zero 2050 in place by FY20/21.

How will we report on our achievements?

BOPDHB will report on its annual sustainability achievements by way of the organisation's Annual Report. It is envisaged that sustainability will have its own section in the annual report, likely 1 – 2 pages, where it will specifically report on carbon footprint and traction towards sustainability goals as set by the organisation.

BOPDHB will also engage in internal and external communications by way of a One Place Community (intranet resources), local media engagement, sustainability events, and other marketing, PR, and education activities as and when appropriate.

A journey to becoming an environmentally sustainable organisation

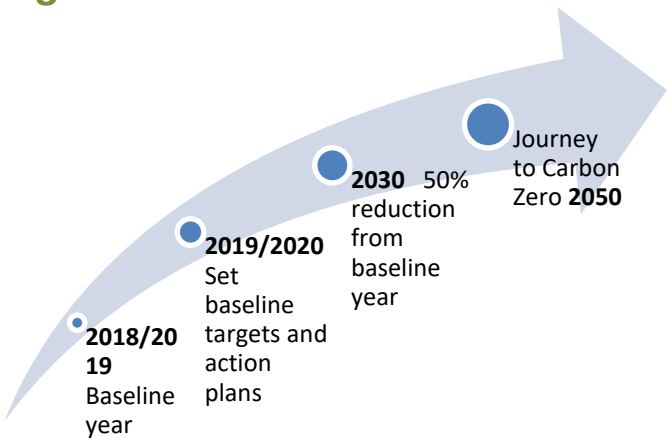


Figure 5. Journey to Carbon Zero 2050

2018/2019 **Baseline Year** Understanding our carbon footprint.
2019/2020 **Set incremental baseline targets and action plans** Initial targets and action plans are set and reviewed on an annual basis with a focus on continual improvement.
2030 **50% Reduction from baseline year (based on a Science-based Target (SBT) to a 1.5°C scenario)** The initiatives and steps have been put in place to achieve this target.
2050 **Carbon Zero** Journey to 2050 includes ongoing target alignment and action planning.

Kaitiakitanga branding

Figure 6. Kaitiakitanga framework/initiatives logo

The image above, and the words *Kaitiakitanga – caring for people and planet*, have been approved for use by the Sustainability Steering Group and BOPDHB's Pou Tikanga.

The image itself has great meaning with the growing fern representing regeneration, the four fronds representing the four realms of sustainability (environment, culture, society, and economy) and the four pou of Ngā Pou Mana o Io (Mana Atua, Mana Whenua/Moana, Mana Tūpuna, Mana Tangata). New Zealand is represented as our land, air and sea, where we need to revitalise and replenish the mauri, and the BOPDHB kōwhaiwhai is embedded within this to show that this initiative is BOPDHB wide.

This (co-)branding will appear on all communication materials relating to any environmental sustainability initiatives across the BOPDHB.

Summary

BOPDHB recognises its responsibility to environmental sustainability by adopting the Kaitiakitanga Environmental Sustainability Framework. BOPDHB acknowledges that all four dimensions of sustainability work together and rely on each other, and that we will not achieve environmental sustainability in isolation. Wrapped with BOPDHB's organisational values and strategies, and the principles of Kaitiakitanga as set out in this framework, BOPDHB can become a sustainable organisation.

BOPDHB's role and responsibilities as a public health provider and health promoter implies that the organisation should become an exemplar of sustainable business practices.

It is important to note that while the actions required to meet any action plans linked to this framework may be led by specific departments and teams within the organisation, the responsibility for sustainable practice in all four of the dimensions rests on the shoulders of all members of the BOPDHB whānau.

He waka eke noa! We're all in this together.

Associated Documents

Bay of Plenty District Health Board Environmental Sustainability Action Plan

Kaitiakitanga
Caring for people and planet

Bay of Plenty District Health Board
Environmental Sustainability Action Plan
FY19/20 – FY20/21

Version 2: March 2020

Prepared by: Vicktoria Blake, Sustainability Manager, BOPDHB
Endorsed by: Sustainability Steering Group

What is Environmental Sustainability?

Environmental Sustainability and what it means to Bay of Plenty District Health Board (BOPDHB) is outlined in the Kaitiakitanga Framework for Environmental Sustainability.

Put simply, BOPDHB has committed to:

- show internal and external leadership in environmentally sustainable practice
- be accountable for its environmental/carbon footprint
- be committed to finding and embedding sustainable solutions for all business practices (including those related to waste, energy, water, transportation, food, built environment, and procurement)
- use its resources responsibly
- consider co-benefits (economic, health, social and environmental resilience/regeneration) during all decision making processes
- be future focused, while reflecting on the past

What are our Priorities?

BOPDHB has set 10 environmental sustainability priorities. These are briefly described below:

1. Leadership

Prioritising environmental health as a strategic imperative[1]. This includes staff engagement alongside broader communications endeavours which demonstrate leadership and commitment to environmental sustainability and carbon footprint reduction.

2. Accountability

Accountability and commitment to change. This includes a specific focus on reporting and monitoring to inform our engagement with the Toitū Carbon Reduce (previously CEMARS) programme, and setting annual goals, biennial action plans, and longer term carbon reduction targets.

3. Waste

Reducing, treating, and safely disposing of healthcare waste. This includes understanding our waste footprint and setting targets and instigating solutions to reduce this footprint.

4. Energy

Implementing energy efficiency and promoting and adopting clean, renewable energy generation. This is closely linked to the Built Environment priority and includes understanding our behaviours relating to energy use within the DHB.

5. Transport/Travel

Improving transportation strategies for patients and staff. This includes implementing the recommendations from the BOPDHB Travel Plan.

[1] The italicised descriptions for priorities 1 and 3 – 9 are taken and/or adapted from the Global Green and Healthy Hospital Sustainability Goals http://www.greenhospitals.net/sustainability-goals/

6. Procurement

Buying safer and more sustainable products and materials. This includes working with our current providers to ensure they are working towards more sustainable solutions.

7. Built Environment

Supporting green and healthy hospital design and construction. This includes considering Green Star and NABERS initiatives, and biophilic design principles.

8. Water

Reducing hospital water consumption and promoting water as the drink of choice. This includes investigating solutions to ensure water is freely available on site for staff, patients, visitors and whānau.

9. Food

Purchasing and serving healthy, sustainably grown food, reducing the carbon footprint created by food consumption where possible. This includes investigating the feasibility of hospital-based community gardens.

10. Climate Change Adaptation and Mitigation

Understanding the impacts that climate change will have on our hospitals, our people and our communities. This includes adaptation planning and climate related risk mitigation.

Action Plan Purpose

As BOPDHB has a significant list of priorities, tasks within these priorities must themselves be prioritised. The purpose of this action plan is to identify actions within these priorities that will be achieved over the coming two years. It may also indicate longer term objectives for these priorities, both internal and external (e.g. Ministry of Health or New Zealand Government Procurement).

Carbon Footprint FY18/19 (Baseline Year)

The graphs found on the following page illustrate the FY18/19 carbon footprint information.

The findings indicate the top six emissions sources as:

#1 **Natural Gas** – used for the generation of steam and hot water. This source is significantly larger than all other sources making up 39% of the total carbon footprint.

#2 **Electricity** – used for all other onsite energy requirements. Electricity makes up 15% of the total carbon footprint.

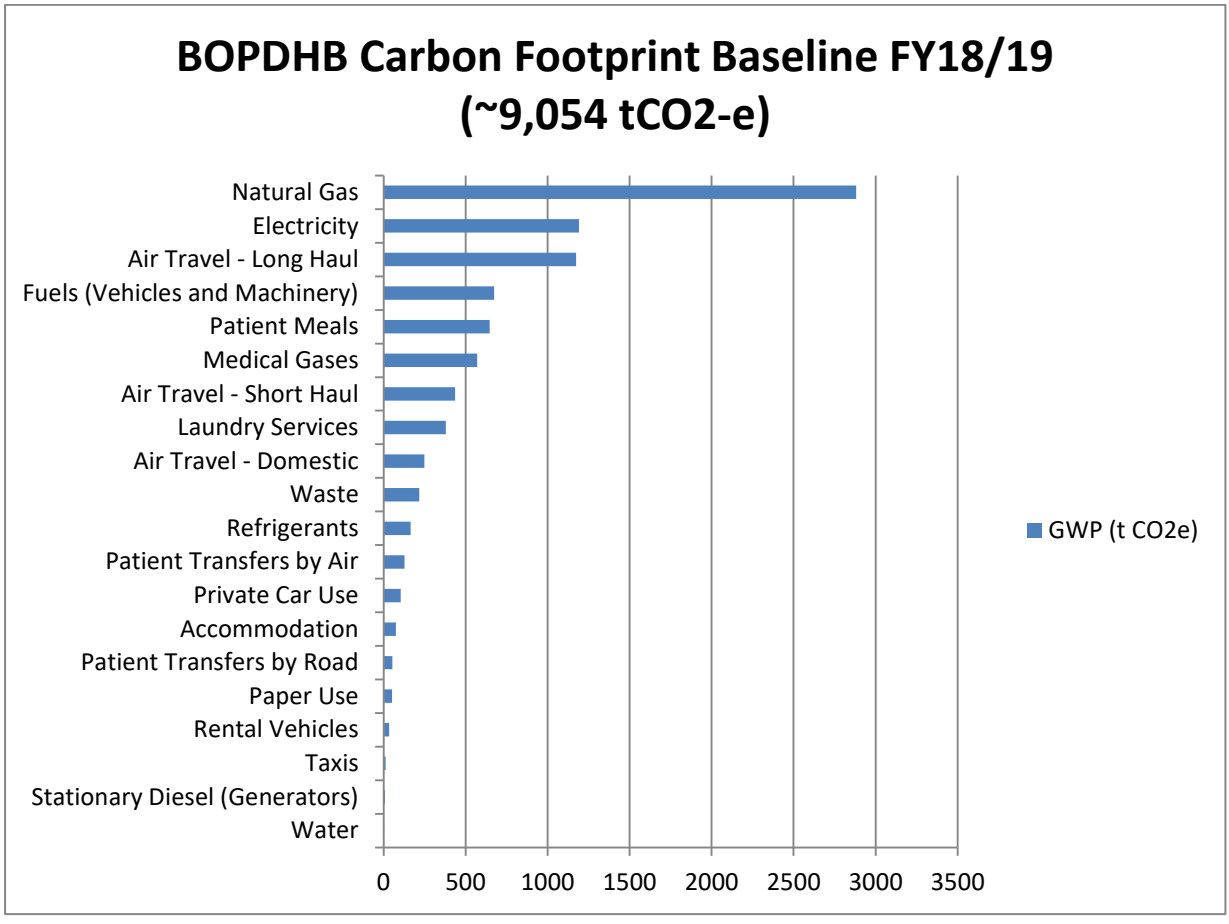
#3 **Long Haul Air Travel** – Air travel is known to have a significant carbon footprint. Due to the current processes relating to reimbursement for overseas travel a large proportion of this figure has had to be estimated from expense claims. It is recommended that processes related to air travel are investigated to ensure we have a reasonably accurate record of this footprint in future.

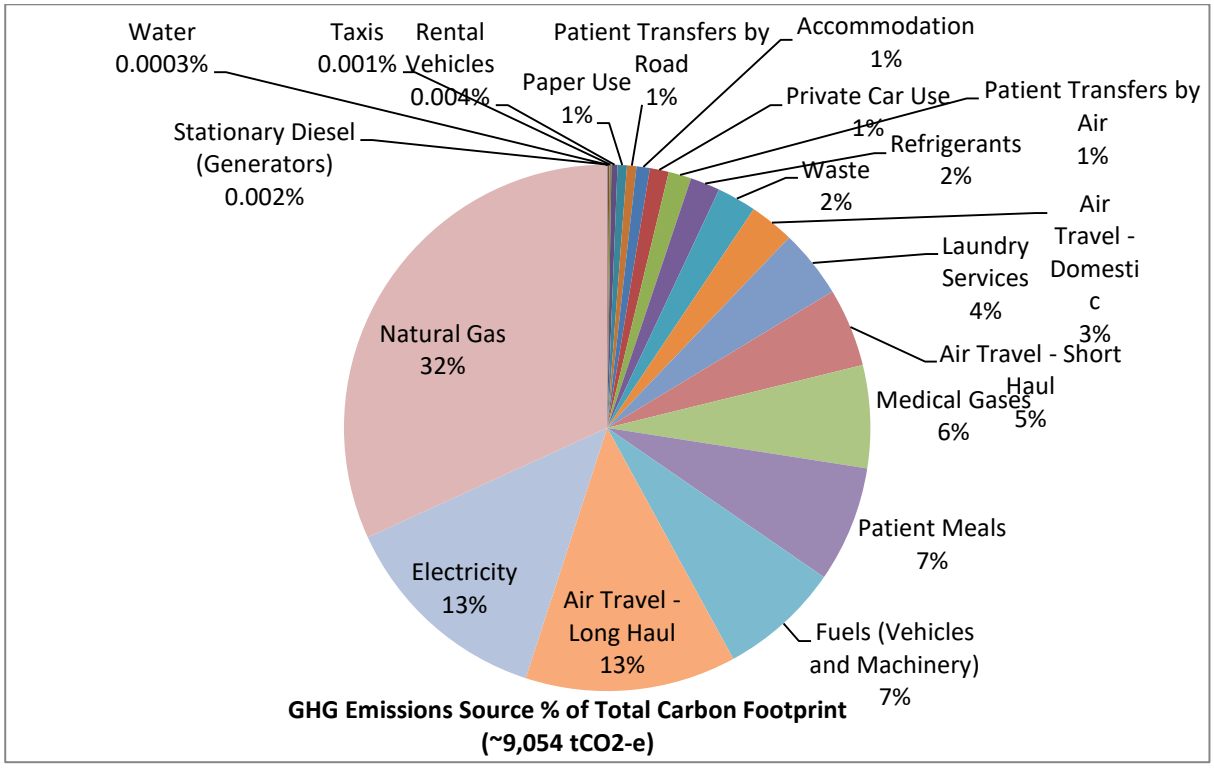
#4 **Fuels (Vehicles and Machinery)** – used in fleet vehicles and machinery (excluding generators).

#5 **Patient Meals** – the carbon footprint of each meat-based meal is equivalent to 1.88 $kgCO_2$-e compared with 1.27 $kgCO_2$-e for vegetarian meals and 0.96 $kgCO_2$-e for vegan meals. Meat based meals make up almost 70% of all patient meals.

#6 **Medical Gases** – including CO_2, NO_2, Desflurane and Sevoflurane.

After the top six, the emission sources drop significantly with short haul air travel, domestic air travel, waste, the transportation of laundry, refrigerants, and private car use for business purposes being the next most significant in descending order. It should be noted that while waste is not in the top six of carbon emitters, it is of significant environmental concern for other reasons, including microplastic pollution, and is therefore a significant priority for BOPDHB.





FY19/20 – FY20/21 Sustainability Goals

Sustainability Goals for Annual Reporting FY19/20

1. To form and establish Sustainability Team – *COMPLETE*
2. Carry out and complete the audit and baseline creation of the BOPDHB Carbon Footprint utilising CEMARS accreditation for FY18/19 – *Almost Complete*
3. Create a Sustainability Strategy to guide DHB Culture and Practice – *In Progress*
4. Utilise Carbon Footprint information and Sustainability Strategy to create Emissions Reductions/Environmental Sustainability Action Plans – *In Progress*
5. Scope project for database, dashboards, business intelligence and reporting. Implement and roll out for first evaluation at FY end 2020 – *In Progress*

Sustainability Goals for Annual Reporting FY20/21

1. Paper use and printing activities are reduced by 25% from baseline year (FY18/19)
2. 10% reduction in waste to landfill footprint from baseline year (FY18/19)
3. A Fleet Operations study has been undertaken, including data collection, analysis and reporting, to inform future goals.
4. Fleet Management Planning, identifying activities to reduce the carbon footprint of the BOPDHB fleet, including transitioning to low emission vehicles, has commenced.
5. Reduce energy consumption by 2% from baseline year (FY18/19)

FY19/20 – FY20/21 Action Plan

This section links to the Action Plan tasks for FY 19/20 and FY20/21 and what is currently on the radar to enable BOPDHB to work towards becoming a sustainable organisation.

- **Environmental Sustainability Action Plan (ESAP)**
  Note: The ESAP is a living document and is updated regularly via partnership within various departments of the BODPHB.

- **Sustainability Strategic Plan Radar**
  Note: The Sustainability Strategic Plan Radar is a living document and is updated regularly as new concepts and ideas come to light.

Action Plan Review

The Sustainability Action Plan will be reviewed and updated annually for the two year period ahead. Future action plans will also reflect on the achievements of the previous plan.

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

Bay of Plenty District Health Board
Board Members Interests Register

(Last updated September 2020)

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

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

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

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

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

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Minutes

Bay of Plenty District Health Board

Via Zoom

Date: Wednesday 19 August 2020, 10.00 am

Board: Sharon Shea (Interim Chair), Ron Scott, Hori Ahomiro, Mark Arundel, Bev Edlin, Geoff Esterman, Marion Guy, Ian Finch, Arihia Tuoro, Annabel Davies, Pouroto Ngaropo, Lindsey Webber (PHO Rep)

Attendees: Simon Everitt (Interim CEO), Bronwyn Anstis (Acting Chief Operating Officer), Owen Wallace (GM Corporate Services), Mike Agnew (Acting GM Planning & Funding and Population Health), Hugh Lees (Chief Medical Advisor), 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** Nil	
3	**Apologies** An apology was received from Leonie Simpson **Resolved** that the apology from L Simpson be received Moved: M Arundel Seconded: A Tuoro	
4	**Interests Register** Board Members were asked if there were any changes to the Register or conflicts with the agenda. No conflicts were advised. Interim Deputy Chair no longer undertakes his Volunteering Tauranga role Interim Board Chair advised of new interests which she has emailed to the Board Secretariat for interests register amendment.	
5	**Minutes** 5.1 Minutes of Board meeting **Resolved** that with the Board receive the minutes of the meeting held on 15 July 2020 and confirm as a true and correct record. Moved: I Finch Seconded: R Scott 5.2 Matters Arising 5.4 *Maori Health Dashboard report* – There is a presentation scheduled for next meeting on Dashboards in general - Remove 7.1 *Te Manawa Taki Equity Plan* has a noting paper in agenda today - Remove 7.1 *A Seat at the Table* - 4 candidates attending Open Board today. Selection of two will be progressed – Remove	

Item No.	Item	Action
	8.1 *Hand Hygiene* - There has been an improvement plan developed. CMA has met with all HODs to complete training. Work has been undertaken with Comms for a hand hygiene awareness plan going out for whole organisation. Next Audit period is to be completed as at 31 August - Completed 5.3 CPHAC/DSAC Meeting 5.8.20 The Board received the Minutes of the meeting held on 5 August 2020.	
6	**Items for Decision** Nil	
7	**Items for Discussion** 7.1 Chief Executive's Report The Chief Executive highlighted: *COVID* - Things have changed since the report was compiled with COVID resurface. There has been a focus in the Bay regarding the Port. There has been surge planning work undertaken with Toi Te Ora (TTO), planning for a second COVID wave which has turned into actual with Auckland at Level 3. *HQSC Certification Audit* - went well. There were 15 Auditors on site for 4 days. A report will come to the Board in September. Auditors presence was at the same time as the start of COVID actions with hospitals working at capacity. *Allied Health* - Lifecurve is in testing phase with partners, Body in Motion, Aged Concern, Nga Kakano and others. There was a workshop two weeks ago with a view to having testing for another month and then rollout. A Project Manager has been appointed. *Hospitals* - have been very busy. There were particular pressures on ICU which did impact electives at the time. Hospital alert level is Yellow but operating in Green. BOPDHB is supporting Lakes DHB with their COVID response. Interim Chair advised of thanks from Taranaki DHB for collaboration among regional DHBs. A good working and collegial environment. There has been some commentary from the MOH for DHBs to work regionally. DHB COOs, EOC and HealthShare have met to understand region's ICU capacity and to support Public Health Unit and Laboratories across the region. Waikato DHB offered support for the Port testing. Query was raised re ICU busyness and whether it could cope with COVID cases. Acting COO advised of circumstances of ICU status over the last while. ICU is quite often at capacity, particularly over the last 12 months. As part of planning for COVID, positive cases in the Bay would mean looking at additional ICU capacity. Query was raised as to whether Port testing will be ongoing. It will be ongoing. As with other border controls, there will be surveillance testing put in place, likely to be fortnightly, particularly for those in contact with crew.	SAGQ

Item No.	Item	Action
	Comment was made by BOPDHB Board representative to Lakes Committee, of Lakes DHB modification to Ventilators. CMA advised of BOPDHB has also made modification to ventilators. *CCDM* - there has been a lot of focus on compliance with the programme. An important factor is what the measure of success looks like. There are 23 measures and collection of the data across these is . ongoing work. Overtime hours are included, overtime being reflective of pressure on the system and its use allows response to increased pressure but this is not ideal in the long term. The use of casual staff is another indicator. Casual staff should be used to respond to variance. As more FTE goes into the base staffing, casual use should decline. The additional 5 FTE put into SCBU had seen a decline in casual staff in this regard. Query was raised re SCBU in Whakatane. The challenge is around the size of the Unit and the impacts of staff departure. They are currently fully staffed. The Nursing Resource team is allocated for leave and has staff trained to work in SCBU. CCDM and its measures will transfer into lead and lag and help plan going forward. Forecasting data is used. The importance of CCDM investment for return is a valuable consideration. *Opotiki Medical Centre* has ENT Services commencing. There has been a meeting recently with positive change and GPs coming together in a much more co-ordinated approach with Whakatohea being in the building. Query was raised on ENT referals and followup. Reference was made to the Planned Care 3 year strategy which is an impressive document and indicates a different way of working, with electives in the primary and community space. The Community Orthopaedic Triaging Service (COTS) is a good example. There is rapid expansion with COTS with 16 practices engaged. There has been a 50% increase in referral rates. Of those, only 30% are needing to be referred onwards for a specialist assessment. People are being put onto appropriate pathways for their individual needs. DNA rates are low. *PHO /PHA Clinical leads* - great to see collaboration with Primary Care. Acknowledgement was made to PHO/PHA Clinical Cleads in the COVID space. Strong professional links have been developed. There are a number of workstreams under way in the Quality & Patient Safety area , trying to tie Health Quality and Patient Safety into the Business intelligence space with more interactive data. The two new Public Health Physicians have data which has shown lower mortality rates in the community over the COVID period , in contrast to other national and international data. With economic effects there may be a long term increase in mortality because of COVID effects. There has been a portal set up to continue to update on a monthly basis. It is not completely accurate but is extremely indicative. P&C - a preferred candidate with glowing qualifications and references has been offered appointment to the Executive Director. There were 3 strong candidates.	

Item No.	Item	Action
	From a people strategy view there is a wellbeing programme with resilience as a target area. There have been impacts on staff from Whakaari and COVID. The programme has specialist intensive interventions. There are also inhouse workshops which have had significant uptake. *The Australian High Commission visit* to thank staff for care of the Australian patients following the Whakaari disaster, has unfortunately been postponed. *Financials* - the year end position is a deficit of $23.7m. It is important to understand that the Operating deficit was $15.9m (67%) and the remainder of the deficit $7.8m (33%) was directly linked to the **unanticipated impact** of COVID and Whakaari. The $7.8m contribution to our overall deficit is **not part** of the annual plan or budget. It is also important to note that the forecast operational deficit was originally $16.5m. Therefore, all things considered, we were very close to aligning with our forecast operational deficit. The Holidays Act liability is not in the figures and is being worked thorough with the national audit (as per audit guidance). The Board and the management team are totally committed to ensuring the DHB adheres to its agreed budgets and will continue to work hard to achieve the same. *Longest Serving Staff Member departure* - Rona Stanley's farewell went very well. The Board noted her service and iterated their sincere thanks. **Resolved** that the Board receive the report Moved: M Arundel Seconded: B Edlin	
	7.2 <u>Primary Care Overview</u> CEO WBOP PHO acknowledged GP teams for response over the last week. There have been 2,900 tests including NMO and EBPHA testing. Response has been amazing and efforts of GPs, Nurses and Admin teams has been fantastic. Challenge is being at level 2 and carrying out BAU. Flu vaccinations and immunisations still need to be prioritised. Primary Care is preparing for ongoing requirements or if alert levels change and CBACS need to be reinstated. Primary Mental Health support is in high demand following initial COVID period. PHOs are working together on a paper to introduce a new model for Primary Mental Health, delivered in General practice. Query was raised with regard to EBPHA and Health Care homes. There is confidence that practices will come into the programme as soon as possible. Query was raised on timelines. Healthcare Home leads are in discussion at the moment and nationally a new model of care is being looked at which could help practices who do not meet the full criteria. Good progress was being made however COVID has again stepped in. Progress in the next month should be made.	Acting GMPF

Item No.	Item	Action
	7.3 Dashboard Report Query was raised on childhood obesity figures for July. Community Public Health Nurses have been taken off BAU for COVID which could be a contributor. Interim CEO will review and report back. Exec Committee had a session on the new look Dashboard yesterday. The Dashboard has been developed using a Business Intelligence (BI) tool which is interactive and allows deep dive. The hard copies in today's agenda are static views. At next Board an interactive session will be had with the Board. It is very impressive. It picks up strategic drivers from the Annual Plan and breaks down into measures with ethnicity measures. The Board thanked management for the efforts being made in this area. 7.4 Te Tumu Whakarae Handover Report The Board noted the handover report.	
8	**Items for Noting** 8.1 Te Manawa Taki Regional Equity Plan 2020 – 2023 - Final 8.2 Board Member Attendance - Jan - June 2020 8.3 Chief Executive Expenses - 1.7.19 - 30.6.20 8.4 Choosing Wisely 8.5 Advice from State Services Commission re Public Service Commission 8.6 Correspondence for Noting 8.3 Board Work Plan 2020 The Board noted the reports and correspondence	
9	**General Business** There was no General Business	
10	**Resolution to Exclude the Public** **Resolved** that Pursuant to S9 of the Official Information Act 1982 and Schedule 3, Clause 33 of the New Zealand Health and Disability Act 2000 the public be excluded from the following portions of the meeting because public release of the contents of the reports is likely to affect the privacy of a natural person or unreasonably prejudice the commercial position of the organisation: Confidential Minutes of last meeting: Board Minutes FARM Meeting - 5.8.20 CPHAC/DSAC Meeting - 5.8.20 NZ Health Partnership Statement of Performance expectations 2020/21 National Catalogue COVID-19 Update Board Strategic Planning Workshop Report CEO's Report CCDM Quarter 4 Implementation	

Item No.	Item	Action
	That the following persons be permitted to remain at this meeting, after the public have been excluded, because of their knowledge as to organisational matters or for the purpose of legal records. This knowledge will be of assistance in relation to the matter to be discussed: Simon Everitt Owen Wallace Mike Agnew Debbie Brown Hugh Lees Julie Robinson Jeff Hodson Marama Tauranga Sarah Mitchell **Resolved** that the Board move into confidential. Moved: P Ngaropo Seconded: S Shea	
11	**Next Meeting –** Wednesday 23 September 2020	

The open section of the meeting closed at 11.00 am

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

RUNNING LIST OF ACTIONS

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

	Task	Who	By When	Status	Response
15.1.20 Item 5.2	**Chief Executive's Report – Clinical School** CEO advised that it would be good for the Head of Clinical School, Prof Peter Gilling to meet with the Board at a future meeting. One of the Clinical School's priorities was to give students an experience that made them want to work for BOPDHB. – Board Secretariat	HOCS	Nov		Scheduled for Nov Face to Face Board.
15.7.20 Item 7.4	**Primary Care Overview – Funding for Tuapapa** BOPDHB has committed to Tuapapa and it has been planned and budgeted for. Acting GMPF will follow up and report back. – Acting GMPF	Acting GMPF	Sept		See below – Completed
A meeting is scheduled with Māori Health Gains and Development and Planning and Funding in September 2020 to progress specific reporting measures aligned to Tūāpapa.					
15.7.20 Item 9.2	**General Business – CARE Badges** To explore provision of care logo badges to catering and cleaning contractors.	GMFBO	Sept		Discussions are underway with both the food and cleaning contractors - Completed
19.8.20 Item 7.1	**Chief Executive's Report – HQSC Certification Audit** A report will come to the Board in September.	SAGQ	Sept		In progress – report due from HQSC October
19.8.20 Item 7.3	**Dashboard Report – Childhood Obesity** Query was raised on childhood obesity figures for July. Community Public Health Nurses have been taken off BAU for COVID which could be a contributor. Interim CEO will review and report back	Acting GMPF	Sept		See below – Completed

Community Health 4 Kids (CH4K) have completed recruitment to Before School (B4SC) Co-ordinator position critical for achieving and maintaining the health target; a period without this role caused a decline in performance to the target below the 95% set

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 2 September 2020 at 10:30am

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

Attendees: Pete Chandler (Chief Executive), Bronwyn Anstis (Acting Chief Operating Officer), Hugh Lees (Chief Medical Advisor), Julie Robinson (Director of Nursing), Debbie Brown (Senior Advisor, Governance & Quality), Sarah Mitchell (Executive Director, Allied Health Scientific & Technical), Marama Tauranga (Manukura, MHGD)

Item No.	Item	Action
1	**Karakia** The meeting opened with a karakia.	
2	**Presentation** 2.1 Hospital Presentations and COVID Impacts Dr Hugh Lees, Chief Medical Advisor Trevor Richardson, Service Improvement Manager Trevor presented on pre and post COVID scenarios within the hospitals. Both hospitals had low numbers / presentations immediately post COVID. Some Triage categories have built back up since (Triage 3 in particular), some have not (Triage 4). It is considered that the environment was still fairly turbulent with people perhaps still fearful of presenting to hospital and that the unworried, unwell population, which would weigh towards Maori communities, are the people not presenting. Comment was made that the consistent messaging and communication that has been put out regarding staying away unless an emergency, may have had an impact. Numbers of Maori patients at both hospitals have not returned to historical figures. Cellulitis and respiratory are the two main conditions for Maori, Arrhythmia / heart failure and Respiratory for Non Maori. Orthopaedic acutes and arranged admissions have spiked heavily post COVID. ICU which is now busy most of the time, was heavily burdened with long stay cases and some operative procedures where the patients would have required ICU, have needed to be postponed. CEO advised the Committee that steps will need to be taken to relieve the ICU issue over the next few months.	

Item No.	Item	Action
	Concern was expressed on the statistics for Maori still being high. Maori often do not access hospitals until it is late in their presenting condition. A different model is required to cope with this which may be in the community. It was considered that TTA may assist. PHOs have been socialising TTA through forums and networks. It is a work in progress. TTA is a six year strategy which is in its first year, setting up solidly, creating a structure. There is a lot of business hygiene taking place and providing support to IOC. It was considered that some of the drops in presentation may be due to COVID situations of social distancing etc, accounting for COVID and Winter illness contamination. Query was raised on shifting the dial on new behaviours and how we know how we are moving the needle. It is recognised that this may take some 18 months. Tangible milestones need to be considered. The Committee thanked Trevor for a very interesting presentation and asked what could be taken from the information. It is considered that one of the biggest learnings is that public health is important and if we use public health on all levels, it results in great things. Communication is important. CMA considered Cellulitis was a big issue. It is being treated in the community so the query is why there is such a high instance in Maori hospital presentations. More clarity was provided around ICU. ICU is registered as a long term investment plan need. It was advised that the information presented today is incorporated into the IOC and the aim is to have an entire range of information available to SMOs in live time. 2.2 <u>Evolving Model of Excellence in Orthopaedics – Community Orthopaedic Triage Service (COTS)</u> Sarah Mitchell, Executive Director, Allied Health Scientific and Technical Sarah Nash, Project Manager, COTS Sarah advised of the possibilities the programme has when driven to its potential. It is a wellbeing message and is about how musculoskeletal conditions are managed. The current models will not achieve wellbeing. There is a radical shift required from a secondary care medical model. Over the last few months, the pace has been accelerated through the COTS Project Management team. There are a number of DHBs keeping watch on the programme. There is potential to have the cost savings required. FSAs can be undertaken in the Community by Physiotherapists. There are 6 workstreams within the programme: • Community Orthopaedic Triage Service – getting patients on the right path	

Item No.	Item	Action
	• Emergency Department Musculoskeletal (MKS) – supporting the 22% of people who present at ED with MSK problems • Hip Fracture Care pathway – optimising care of frail older people • Enhanced Recovery – optimising patient recovery after joint replacement – link to Non Acute Rehabilitation Services (NARS)/ Keeping Me Well (KMW) • Fracture Pathway Redesign – Patients only attend fracture clinic if there is a clinical need and opportunity for virtual clinics • Demand and Capacity Planning Management – supporting strategic and operational decisions Pre and post care can be undertaken in the Community. People do not need to revisit secondary care 3 or 4 times pre or following care. Under the COTS pathway the people who get to surgery are those who require it. The discussions taking place in the community are creating a culture shift. The aim is for people across the BOP to manage their health and wellbeing (specifically musculoskeletal conditions) through a proactive recovery based pathway. From an equity perspective Maori have a 25% higher prevalence of arthritis. If compared to current BOP Orthopaedic referral rates, there is a suggestion that there is a significant inequity of access to Orthopaedic services for Maori. There is a pilot of community led physiotherapy services that is culturally embedded. For those who do require surgery, the surgical journey can be fast-tracked and patients are fully worked up prior, as well as having solid recovery pathways in the community. A high level slide of what is happening currently with orthopaedic services and demand was shown. There are usually around 3 visits to a GP in the referral journey / process which can include not meeting thresholds and referral back to the GP. The patient illustrated's (Ron) condition slipped outside primary care but was not severe enough to access secondary care. What the process could look like for Ron under the programme was shown which indicates a pathway of primary intervention and wellness pathways. The Lifecurve will be a future measure. Costs associated with current pathways are huge and so significant efficiency opportunities exist in this area. Comment was made on ACC care. ACC care is currently out of the scope of proposed pathway. The current journey of a 69 year old female's MSK Orthopaedic journey was also shown. COTS identified the lady and she was transferred to the COTS programme. She was seen in the community. It was found that her condition had deteriorated and the radiology within her file was outdated. She was confirmed with significant joint destruction and was sent for fresh radiology.	

Item No.	Item	Action
	She was regraded to be seen urgently and was seen within two weeks. She is currently waiting for surgery. The COTS programme is using BI data which reflects positively. COTS is a locality model and is being piloted in the Te Puke / Papamoa region with 10 GP on board. It was opened to 6 practices in Whakatane / Opotiki. There has been strong positive engagement. There are two community clinics, one in the BOPDHB Community Centre in Te Puke, the other is in Te Koru at Whakatane Hospital, however a community site will be sourced. Currently orthopaedic surgeons are only spending 22% of their time in theatre. Query was raised on whether discussion had taken place with insurance companies. This has not occurred as yet but was taken as a good option. There are other pathways in parallel to COTS with educational classes and wellbeing options. Lifecurve is linked to COTS. Query was raised on the opportunity for TTA to be considered in the programme. Within COTS there are multiple workstreams. Equity for Maori and cultural responsiveness is a standalone workstream. There has been continual engagement with MHGD. COTS is committed to threading TTA throughout the work. As a pilot there is opportunity to analyse and adapt. Engagement with Kaupapa providers is envisaged. There may also be an opportunity for self-referral. Evidence based data will indicate the need. Kawerau (and Murupara) and Opotiki are the next focusses of expansion. It is envisaged that Te Pou Kokiri services will be included in COTS. Comment was made on the lessons from COVID being considered in taking the services to Maori. Comment was made on the positiveness in including Te Pou Kokiri as they know the people in their area. The second part of the COTS programme is with regard to presentations to ED. 22% of presentations to ED are musculoskeletal in nature at Triage Levels 4 and 5. 65% of presentations breached the ED waiting time and 70% were referred on to Radiology. 25% were admitted to hospital. A Business Case was put forward which has resulted in funding for a physiotherapy service providing services in ED, with 7 day cover 8am to 8pm. The potential in this service is seen as huge. These people work with the ED team, not in isolation. It is considered that though the programme was musculoskeletal there was an opportunity for inclusion of wider wellbeing going forward. The Committee thanked the presenters for presentation of their very successful COTS programme.	

Item No.	Item	Action
3	**Apologies** An apology was received from Sharon Shea **Resolved** that the apology from S Shea be received. Moved: G Esterman Seconded: M Guy	
4	**Interests Register** The Committee was asked if there were any changes to the Register or conflicts with the agenda. No changes or conflicts were advised.	
5	**Minutes** BOPHAC Meeting – 1.7.20 **Resolved** that the minutes of the meeting held on 1 July 2020 be confirmed as a true and correct record. Moved: H Ahomiro Seconded: M Guy	
6	**Matters Arising** 7.2 - *Oral Health* - has been delayed due to COVID. Will be scheduled for November. 7.2 – *Reporting Linkages to BOPHAC – Discussion, BOPHAC TOR.* Board Committee Chairs had had a conversation, with a further discussion scheduled for Friday 4 Sept.	
7	**Matters for Discussion / Decision** 7.1 Chief Operating Officer's Report Chief Operating Officer highlighted the following: *Pharmacy Strike* is tomorrow. There was mediation yesterday without resolution. There is a further meeting next week. *CCDM*. A meeting was held with the MOH last week who were happy with the approach and FTE. There is a follow up meeting next Tuesday. BOPDHB has received an 'outstanding' rating for CCDM through last reporting. Query was raised on medical staff trending upwards. Locum numbers affect the number. Numbers went back down in July. *Hand Hygiene*. CMA has delivered hand hygiene education to Clinical areas. *Surgery* - BOPDHB is in a process of applying for MOH funding. The Service Improvement Unit (SIU) have lead collation of ideas for a bid towards Service Improvement and capital. There are 10 items put forward. Top priority is a stream within He Pou Oranga. It is a holistic model and sets up other proposals which require a holistic approach. The Enterprise Scheduling Platform for planned care is another priority proposal. Query was raised re Planned Care Recovery "taking into consideration the whole of health system approach" and what this means.	

Item No.	Item	Action
	PHO and GPs Liaisons have been involved and consulted in the Planned Care Strategy. The Planned Care Strategy will be shared with the Committee. *COVID resurgence* is an ongoing consideration. Query was raised as to whether COVID has changed the way in which the hospitals are cleaned. There are standards for cleaning for different scenarios. COO will review whether a higher level was required. Query was raised on wearing of masks. If staff are within 1 metre of patients, they are required to wear masks. There is regular communication / education on wearing of masks. *Termination of Pregnancy (TOP)* - Legislation has changed and there are implications on requirements which has necessitated work with the funder. The Committee requested more detail. **Resolved** that the Committee receive the Chief Operating Officer's report. Moved: G Esterman Seconded: R Scott	
8	**Matters for Noting** 8.1 BOPHAC Work Plan 2020 The Committee noted the plan.	
9	**Correspondence for Noting** Nil.	
10	**General Business** There was no General Business	
8	**Resolution to Exclude the Public** **Resolved** that Pursuant to S9 of the Official Information Act 1982 and Schedule 3, Clause 33 of the New Zealand Health and Disability Act 2000 the public be excluded from the following portions of the meeting because public release of the contents of the reports is likely to affect the privacy of a natural person or unreasonably prejudice the commercial position of the organisation: Confidential Minutes of last meeting Chief Operating Officer's Report 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 Bronwyn Anstis Julie Robinson Hugh Lees Sarah Mitchell	

Item No.	Item	Action
	Debbie Brown Marama Tauranga **Resolved** that the Board move into confidential. Moved: G Esterman Seconded: R Scott	
9	**Next Meeting -** Wednesday 4 November 2020	

The open section of the meeting closed at 12.10 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

Board Meeting
Agenda

Items for Decision

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Position Statement on
Te Tiriti o Waitangi, Health Equity and Racism

SUBMITTED TO:

Board 23 September 2020

Prepared by: Dillon Te Kani, Health Improvement Advisor, Toi Te Ora
Roimata Timutimu, Toi Oranga Tikanga, Māori Health Gains and Development

Endorsed by: Graham Bidois-Cameron, Pou Tikanga, Māori Health Gains and Development
Marama Tauranga, Manukura, Māori Health Gains and Development

Submitted by: Pete Chandler, Chief Executive

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

RECOMMENDATION:
That the Board endorse the position statements for Te Tiriti o Waitangi, Equity and Racism.

ASSURANCE:
The Executive Committee reviewed and endorsed the paper at its meeting on 15 August 2020.

ATTACHMENTS:
Draft position statement for Te Tiriti o Waitangi, Health Equity and Racism

DEFINITIONS USED:

Term	***Definition***
"the Board"	Bay of Plenty District Health Board, the Board
"the organisation"	Bay of Plenty District health Board, the organisation
"the DHB"	Both the Board and the organisation of Bay of Plenty District Health Board

BACKGROUND:

The Board requested position statements from the Manukura on the following topics:

- Te Tiriti o Waitangi
- Health Equity
- Racism

Toi Te Ora have a planned programme of work to lead, develop and review position statements for the DHB. Due to capacity and time constraints, Māori Health Gains and Development have led the development of a combined position statement on the three topics.

The DHB has a position statement on Health Inequalities on the its website which will be replaced/superseded by this or parts of this new combined position statement, if endorsed.

Purpose of a position statement

Position statements examine an issue or topic and describe the organisation's stance and approach to the issue. Internally, they help bring clarity to the topic, and ensure common understanding and direction. This enables staff to confidently fulfil their roles and represent the organisation. Externally, they can be used as a persuasive document to inform stakeholders and public on public health issues, provide advice and respond to queries (e.g. through submissions) on how to respond to public health issues.

Line of sight

Taking a position on Te Tiriti o Waitangi, Health Equity and Racism is extremely important for the DHB to achieve its strategic outcomes articulated in Te Toi Ahorangi, Te Rautaki a Toi Ora 2030 and the Bay of Plenty Strategic Health Services Plan 2017-2027.

This position statement will communicate clearly with stakeholders and communities the DHB's view of these important public health issues and how the DHB is enacting its health leadership role across sectors, both regionally and nationally. It will also reiterate and reconfirm for staff the DHB's intent to deliver on its strategies, providing staff with a trigger for change in organisational policy, process and practice.

Toi Ora – Flourishing descendants of Toi

The DHB can and does influence the social fabric of the Bay of Plenty, i.e. the social norms and practices that create the society we live in. By taking a strong position on these issues, particularly on racism, the lives of all whānau and communities, whether they are interacting with the health system or not, will be positively impacted.

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

Position Statement on Te Tiriti o Waitangi, Health Equity and Racism

Ē hoki koe ki ō Maunga, ki ō Awa.
Kia pūrea koe ē ngā Hauora ō Tāwhirimatea.

Return to your sacred mountains and rivers.
So that you can be purified by the sacred winds of Tāwhirimatea.

The Bay of Plenty District Health Board supports and advocates the spirit of partnership on which Te Tiriti o Waitangi was conceived, the intent located within its Articles and the Principles derived to apply Te Tiriti in the present-day context. The Ministry of Health's Te Tiriti o Waitangi Framework[1] has been adopted to give meaning to Te Tiriti; anchoring our obligation to partner with iwi Māori in the reorienting of our local health system, to respond to Māori health aspirations and achieve Māori health equity.

The Bay of Plenty District Health Board is committed to a 'zero tolerance' position on all forms of racism; and addressing unequal power relationships that create differential access to the determinants of health and health care; and differences in quality of care; that result in difference in health outcome between Māori and non-Māori.

On Te Tiriti o Waitangi, the Bay of Plenty District Health Board will:

- Partner with Te Rūnanga Hauora o Te Moana a Toi to rebalance control of the local health and disability system through genuine co-governance: Crown kāwanatanga authority and iwi and hapū tino rangatiratanga.
- Uphold the tino rangatiratanga of Tangata Whenua through direct engagement with whānau, hapū, iwi and hapori (communities).
- Advocate and support He Pou Oranga Tangata Whenua Determinants of Health. Tangata whenua self-determination, aspirations and worldview will be valued and invested in across Te Moana a Toi.
- Partner on and support implementation of Te Toi Ahorangi: Te Rautaki a Toi Ora 2030 to drive towards a whole of system transformation to Toi Ora, that will improve the wellbeing of whānau, hapū, iwi and hapori resident in Te Moana a Toi.
- Ensure Ngā Pou Mana o Io cultural standards of practice are embedded within the design, delivery and monitoring of health and disability services to Māori.
- Recognise the relationships, knowledge and commitment of Tangata Whenua to lead and partner on systems change; to improve health outcomes for Māori; and close the gap on health inequities between Māori and non-Māori.

The Bay of Plenty District Health Board notes:

He Whakaputanga o te Rangatiratanga o Nu Tireni (translated as the Declaration of the Independence of New Zealand) signed in 1835 is an important foundation document of Te Tiriti o

[1] Further detail can be found in the Cabinet Office circular CO (19) 5: Te Tiriti o Waitangi/Treaty of Waitangi Guidance 22 October 2019.

Waitangi. He Whakaputanga constituted Aotearoa New Zealand as a sovereign state under the authority of the United Tribes of New Zealand, and inaugurated the King of England as its parent, who will protect the state from any attempts on its independence. He Whakaputanga o te Rangatiratanga o Nu Tireni and its guarantee of rangatiratanga (sovereignty) of the tribes of New Zealand, was recognised by the Crown, confirming the expectations of the parties leading into the development and signing of Te Tiriti o Waitangi in 1840.

On the basis of contra proferentem, the Bay of Plenty District Health Board privileges the reo Māori version of Te Tiriti o Waitangi and its Articles[2]:

Ko te Tuatahi – Article 1 – Kawanatanga: Article 1 supports meaningful Māori representation, kaitiakitanga and participation at all levels of our health system, including within governance structures and mechanisms, decision-making, prioritisation, purchasing, planning, policy development, implementation and evaluation (Bergen et al, 2017).

Ko te Tuarua – Article 2 – Tino Rangatiratanga: Tino Rangatiratanga is about self-determination. Implementing article 2 involves: addressing institutional racism within the Aotearoa New Zealand health system (Bergen et al, 2017); actively supporting Māori providers and organisations; applying Māori-centred models of health; using strength-based approaches that engage and involve Māori communities; and recognising that Māori control and authority are critical to successful interventions.

Ko te Tuatoru – Article 3 – Ōritetanga: This article is about equity and guarantees equity between Māori and other citizens of Aotearoa New Zealand (Health Promotion Forum of New Zealand, 2010). It requires action to intentionally and systematically work towards a steady improvement in Māori health (Bergen et al, 2017). This involves considering the wider determinants of health, access to health care, and the quality and appropriateness of services.

Ko te Tuawha – Article 4: This article confirms the protection of Māori custom and the position of wairuatanga and of te reo and tikanga Māori. All of these are central to understanding and connecting with Māori cultural and worldviews (Te Puni Kōkiri, n.d.) *.

The intent within the articles of Te Tiriti to inform our goals, each expressed in terms of mana[3]:

- **Mana whakahaere:** effective and appropriate stewardship or kaitiakitanga over the health and disability system. This goes beyond the management of assets or resources.
- **Mana motuhake:** enabling the right for Māori to be Māori (Māori self-determination), to exercise their authority over their lives, and to live on Māori terms and according to Māori philosophies, values and practices, including tikanga Māori.
- **Mana tangata:** achieving equity in health and disability outcomes for Māori across the life course and contributing to Māori wellness.
- **Mana Māori:** enabling ritenga Māori (Māori customary rituals), which are framed by te ao Māori (the Māori world), enacted through tikanga Māori (Māori philosophy and customary practices) and encapsulated within mātauranga Māori (Māori knowledge).

The principles of Te Tiriti o Waitangi, as articulated by the Courts and the Waitangi Tribunal, provide the emphasis for how we will meet our obligations:

[2] Health Quality & Safety Commission. (2019). *He matapihi ki te kounga o ngā manaakitanga ā-hauora O Aotearoa 2019: A window on the quality of Aotearoa New Zealand's health care 2019.* Wellington.

[3] 'Mana' is a uniquely Māori concept that is complex and covers multiple dimensions (Mead, 2003).

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

The New Zealand Public Health and Disability Act 2000 Part 1 makes explicit that "Treaty of Waitangi provisions require District Health Boards to establish mechanisms to enable Māori to contribute to decision making and participate in the delivery of health and disability services".

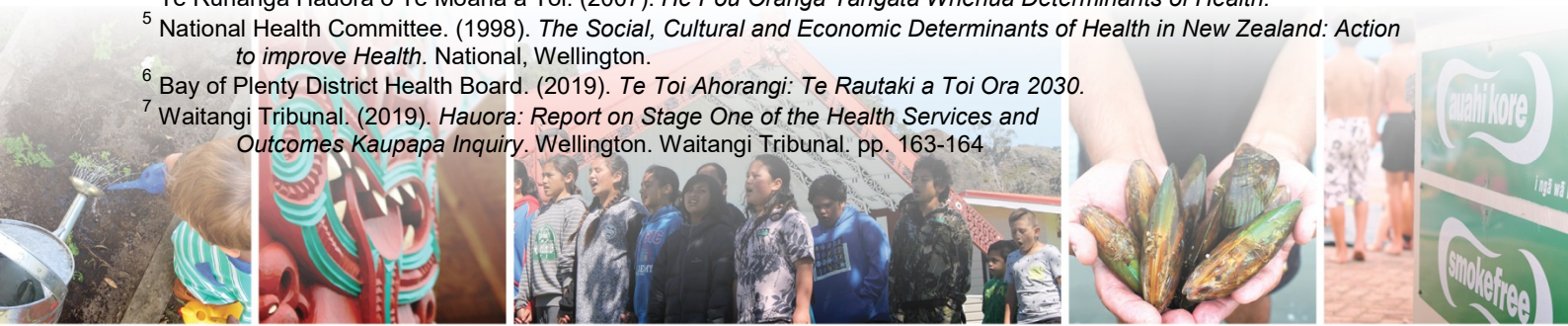
This requirement is partly fulfilled by Te Rūnanga Hauora o Te Moana a Toi as the mandated partner to the Bay of Plenty District Health Board. Made up of 17 of the 18-constituent iwi within the Bay of Plenty District Health Board area, the Rūnanga are a key mechanism for iwi engagement and have an important role in ensuring the Board meets its Te Tiriti obligations. Noting the findings of the Waitangi Tribunal Health Services and Outcomes Inquiry (Wai 2575) on the failure of the Crown to recognise tino rangatiratanga and mana motuhake, the Bay of Plenty District Health Board will also ensure direct relationships with iwi and kaupapa Māori partners, to fulfil its objectives under the Act, and the rights of Tangata Whenua under Article 2 of Te Tiriti.

Te Rūnanga Hauora o Te Moana a Toi has produced He Pou Oranga Tangata Whenua Determinants of Health[4] to ensure traditional tangata whenua values, knowledge and institutions are recognised as key indicators of Toi Ora (optimum health and well-being). He Pou Oranga Tangata Whenua compliments the social, cultural and economic determinants of health[5], the nexus of which endorses te taiao (environment) and wairuatanga (spirituality) as fundamental to the state of Toi Ora; consolidating matauranga Māori (Māori wisdom) alongside of Pākehā knowledge.

Giving effect to He Pou Oranga Tangata Whenua Determinants of Health is Te Toi Ahorangi: Te Rautaki a Toi Ora 2030[6]. Te Toi Ahorangi affirms the unified vision, voice and intention to drive towards a whole of system transformation to Toi Ora, that will improve the wellbeing of whānau, hapū and iwi resident in Te Moana a Toi. Along with the best practice model Ngā Pou Mana o Io, Bay of Plenty District Health Board will ensure tangata whenua aspirations are embedded within the design, delivery and monitoring of its health and disability services to Māori.

A transformation of the health and disability system is required to fulfil our Te Tiriti obligations and achieve health equity for Māori[7]. Bay of Plenty District Health Board recognises the relationships, knowledge and commitment of Tangata Whenua to lead and partner on systems change; to

[4] Te Rūnanga Hauora o Te Moana a Toi. (2007). *He Pou Oranga Tangata Whenua Determinants of Health.*
[5] National Health Committee. (1998). *The Social, Cultural and Economic Determinants of Health in New Zealand: Action to improve Health.* National, Wellington.
[6] Bay of Plenty District Health Board. (2019). *Te Toi Ahorangi: Te Rautaki a Toi Ora 2030.*
[7] Waitangi Tribunal. (2019). *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry*. Wellington. Waitangi Tribunal. pp. 163-164



improve health outcomes for Māori; and close the gap on health inequities between Māori and non-Māori. This will result in valuable lessons that will support equity for all populations and benefit the whole of society.

On Health Equity, the Bay of Plenty District Health Board will:

- Develop a pro-equity agenda that puts Te Tiriti o Waitangi at the centre of our local health system.
- Work alongside other sectors of government to prevent or reduce economic and social inequities that lead to health inequities.
- Seek to prevent and reduce health inequities through equitable health service and programme design, within the allocation of health inputs and resources made available to it by Parliament.
- Involve population groups experiencing health inequities in decision-making on the allocation of health resources, and the design and delivery of health services.
- Be responsive to changes over time in the social and economic circumstances experienced by the BOP population and seek to increase people's control and capacity to manage their own health.
- Prioritise resources and targeted and tailored approaches to meet Māori aspirations for wellbeing and unmet need.
- Implement proportionate universalism as an approach to balance targeted and universal population health perspectives through action proportionate to needs and levels of disadvantage.

The Bay of Plenty District Health Board notes:

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes[8].

Health equity is a basic human right and responding to Māori health aspirations which includes achieving equity, is an indigenous right[9] and Te Tiriti o Waitangi obligation under Article 3.

Equity is about social justice and fairness; and inequity relates to 'unfairness', where there is differential access to the determinants of health or exposures leading to differences in disease incidence; differential access to health care; and differences in the quality of care received. These contributors to inequities in health manifest as difference in health outcomes between and within ethnic groups.

Health inequities in Aotearoa New Zealand stem from colonisation, neglect of Te Tiriti and the appropriation of power and resources that has established and maintained advantage for non-Māori and disadvantage for Māori within the determinants of health, and within the health system itself[10]. Following Willams and Mohammed's model of societal level determinants of health inequity, the relationship between these basic causes (including racism), social status, proximal pathways that

[8] Ministry of Health. (2019). Definition of equity. Retrieved from https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity

[9] UN General Assembly. (2007). United Nations Declaration on the Rights of Indigenous Peoples: resolution / adopted by the General Assembly, 2 October 2007, A/RES/61/295.

[10] Health Quality & Safety Commission. (2019). *He matapihi ki te kounga o ngā manaakitanga ā-hauora O Aotearoa 2019: A window on the quality of Aotearoa New Zealand's health care 2019.* Wellington.

contribute to unwellness, and individual and collective responses that lead to adverse health outcomes, is evident.

Restoring the balance, power, equity and unity inherent to Te Tiriti and human rights can provide for co-existing systems of governance: Crown kāwanatanga authority and iwi and hapū tino rangatiratanga[11]. As pre-requisites for achieving Māori health equity and aspirations, these changes alone will go some way to improving health outcomes for Māori. Notwithstanding, the drivers of health inequity in Aotearoa New Zealand are complex, requiring sustainable system wide solutions supported by collective intersectoral action, as no one entity will eliminate health inequities on their own.

The societal costs of health inequities are profound. Clair Mills et al (2012) found that addressing inequity in childhood illnesses for Māori would bring about a cost saving to the health sector of $24,737,408 per annum in avoidable hospitalisations. This figure does not account for inequitable rates of General Practice consultations, prescription claiming and laboratory utilisation that can further reduce hospital admissions. Māori avoidable mortality rates were also shown to be significantly higher than non-Māori in all age groups except for the first month of life, equating to 5,210 life years lost per year due to premature mortality. That represents $224 million in years of life lost.

Concerningly, the research showed health sector expenditure appeared skewed towards non-Māori children. Findings revealed the cost to admit acutely sick Māori children is less than the cost of preventing severe illness through equitable primary care access or effective population-based interventions. This suggests perverse incentives to admit Māori children into hospital care, rather than meet their health needs through equitable primary care access.

Bay of Plenty District Health Board will develop a pro-equity agenda that puts Te Tiriti o Waitangi at the centre of our local health system. Te Tiriti o Waitangi will provide our operational mandate and improvement tool for monitoring and addressing equity through sustained systemic and multi-levelled approaches.

On Racism, the Bay of Plenty District Health Board will:

- Commit to addressing racism as a determinant of health and driver of health inequities.
- Address racism, privilege and unequal power distribution within the local health system which are known barriers to achieving Māori health aspirations and equity.
- Demonstrate leadership in addressing health inequities through disrupting racism and upholding our obligations as a Te Tiriti o Waitangi partner.
- Commit to leading the local health sector towards a society that is free from prejudice and discrimination.
- Pro-actively seek out and dismantle racist policies and practices within the organisation that systematically advantage outcomes for one population group over another.
- Create and promote an environment that celebrates diversity and inclusiveness across all BOPDHB spaces.
- Call-out and address inter-personal acts of racism that occur between staff, between staff and patients, and between patients.

[11] Human Rights Commission. (2020). Human Rights and Te Tiriti o Waitangi: COVID-19 and Alert Level 4 in Aotearoa New Zealand.

- Provide staff and patients with safe processes to speak-out about discrimination they experience and/or witness.
- Promote and deliver anti-racism training for all BOPDHB staff.

The Bay of Plenty District Health Board notes:

"Racism is a complex system rooted in unequal power relations by race or ethnicity that involves shared social recognition (prejudice), as well as social practices of exclusion, inferiorisation or marginalisation (discrimination) at both the macro level of social structures and the micro level of specific interaction and communicative events" [12].

Racism manifests as privilege for some, and disadvantage for others. Racism is the organisation of a system in to ranked categories of social groups. The system is premised on the unequal and unfair distribution of resources and access to opportunities where those groups or races perceived as inferior receive less.

The International Convention on the Elimination of All forms of Racial Discrimination defines racial discrimination as "…any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life"[19].

The United Nations Declaration on the Rights of Indigenous Peoples affirms that "all doctrines, policies and practices based on or advocating superiority of peoples or individuals on the basis of national origin or racial, religious, ethnic or cultural differences are racist, scientifically false, legally invalid, morally condemnable and socially unjust" [20]. The declaration reaffirms for indigenous peoples the human right to be free from discrimination of any kind.

Racism is a global public health issue and a breach of human rights that contravenes the United Nations Declaration of the Rights of Indigenous Peoples.

There are many faces to racism[13].

- **Internalised racism** – is the acceptance by members of the stigmatised race or ethnicity of negative messages about their own abilities and intrinsic worth[14].
- **Interpersonal or personally-mediated racism** – is prejudice and discrimination, where prejudice means differential assumptions about the abilities, motives and intentions of others according to their race or ethnicity; and discrimination means differential actions towards others according to their race or ethnicity. This can include both explicit, racially motivated violence, crime and harassment and implicit, subtle, ambiguous, actions.
- **Institutional or structural racism** – where there is "differential access to the goods, services and opportunities of society by race or ethnicity, expressed in material conditions and in access

[12] Van Dijk, T. (1993). *Elite discourse and racism*. Newbury Park, CA: Sage Publications.
[13] Ministerial Advisory Committee. (1986). *Puao-te-Atatu: The report of the Ministerial Advisory Committee on a Maori perspective for the Department of Social Welfare*. Wellington: Department of Social Welfare.
[14] Jones CP. (2000). Levels of racism: a theoretical framework and a gardener's tale. *American Journal of Public Health* 90(8): 1212–1215.

to power"[15] and/or "…when an entire network of rules and practices disadvantages less empowered groups while serving at the same time to advantage the dominant groups"[16] .

- **Cultural racism** – is a driver of institutional and interpersonal racism and is entrenched in the philosophy and belief in the superiority of Europeans. In the New Zealand context, it is the assumption that Pākehā culture, that is, Pākehā values, beliefs and systems are superior to those of other New Zealand cultures. This is pervaded through benchmarking Pākehā culture as the 'norm' to which Māori culture, the culture of the 'exotic' other, is compared. Cultural racism is a direct inheritance of colonialism and imperialism [17]. Internalised racism is driven through cultural racism.

At a societal level, racism and privilege are predicated on the belief of one ethnic group having superiority over others and their appropriation of power and control to maintain that position. Conversely, other ethnic groups are considered (prejudice) and treated (discrimination) as different, resulting in disadvantage and inevitably inequities in health outcomes.

While benefits and privileges accrue to the predominant population, Māori have differential entitlement that restricts their choices and opportunities to flourish. On a personal level, there is clear evidence linking the experience of racial discrimination to poorer health outcomes[17].

Racism impacts the distribution of the socioeconomic determinants of health between ethnicities. In Aotearoa this can be observed when comparing differences in the distribution of Māori and non-Māori across deprivation deciles, income brackets and occupational classes[16]. Institutional and cultural racism impact access to quality healthcare and can be seen in the lower cervical screening (within the recommended timeframe) rates for Māori compared to non-Māori and the increased likelihood of reporting a negative patient experience[18]. Racially motivated violence has obvious negative impacts on health and there is clear evidence showing that chronic exposure to racial discrimination has significant impacts across multiple health domains (mental health, physical health, smoking and hazardous alcohol consumption, sleep problems, maternal and child health, maternal stress and depression[19][20][21]).

Organisations and individuals who have more power, control and influence, have a broader range of opportunities to contribute to or oppose the reproduction of racism[18]. Bay of Plenty District Health Board has a critical view of itself and the important leadership role it has in the local health system and nationally, as it aspires to be the first Te Tiriti o Waitangi led District Health Board.

[15] Jones C. (2001). Invited commentary: "race," racism, and the practice of epidemiology. *American Journal of Epidemiology*. 154(4): 299-304.

[16] Human Rights Commission. (2012). *A fair go for all*. Wellington: Human Rights Commission.

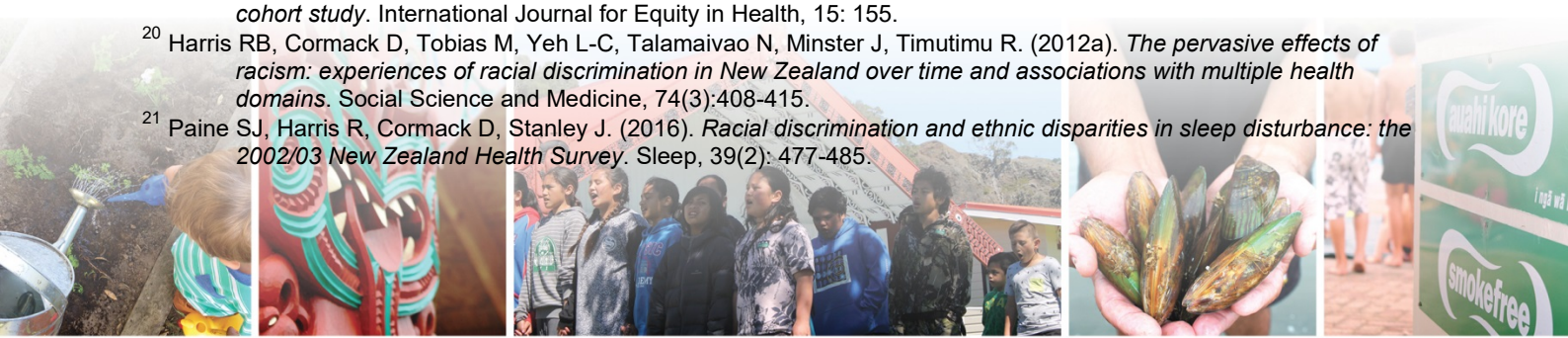
[17] Ministerial Advisory Committee. (1986). *Puao-te-Atatu: The report of the Ministerial Advisory Committee on a Maori perspective for the Department of Social Welfare*. Wellington: Department of Social Welfare.

[18] Harris RB, Cormack D, Tobias M, YehL-C, Talamaivao N, Minster J, Timutimu R. (2012b). Self-reported experience of racial discrimination and health care use in New Zealand: results from the 2006/07 New Zealand Health Survey. *American Journal of Public Health*, 102(5): 1012–1019.

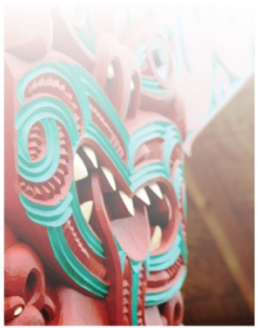
[19] Bécares L, Atatoa-Carr P. (2016). *The association between maternal and partner experienced racial discrimination and prenatal perceived stress, prenatal and postnatal depression: findings from the Growing Up in New Zealand cohort study*. International Journal for Equity in Health, 15: 155.

[20] Harris RB, Cormack D, Tobias M, Yeh L-C, Talamaivao N, Minster J, Timutimu R. (2012a). *The pervasive effects of racism: experiences of racial discrimination in New Zealand over time and associations with multiple health domains*. Social Science and Medicine, 74(3):408-415.

[21] Paine SJ, Harris R, Cormack D, Stanley J. (2016). *Racial discrimination and ethnic disparities in sleep disturbance: the 2002/03 New Zealand Health Survey*. Sleep, 39(2): 477-485.



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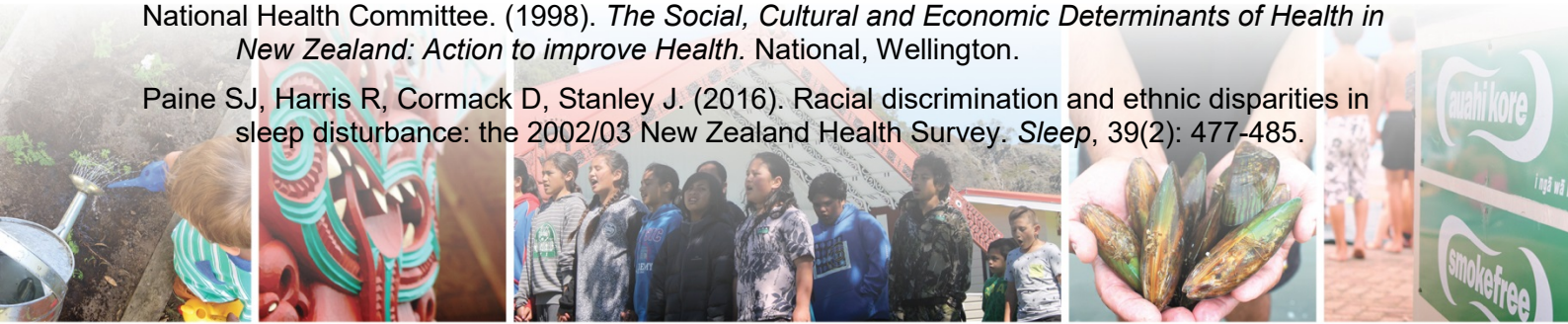

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BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Board Meeting
Agenda

Items for Discussion

"Inquiry into health inequities for Maori" – Summary of Key Findings

Submitted to:	Board Meeting	23 September 2020
Prepared by:	Dr George Gray, Pou Matai Rongoa, Maori Health Gains & Development	
Endorsed by	Marama Tauranga, Manukura, Maori Health Gains & Development	
Submitted by:	Pete Chandler, Chief Executive Officer	

RECOMMENDED RESOLUTION:

1) That the Board note:

- **a)** The key findings from the recently published "Inquiry into health inequities for Maori" facilitated by the Maori Affairs Committee.
- **b)** Analysis of 19 recommendations within the report and the ability of Bay of Plenty District Health Board (BOPDHB) to implement those recommendations.

ATTACHMENTS:

Inquiry into health inequities for Maori (pdf)

The original report can be viewed at the New Zealand Parliament website.

BACKGROUND:

Key Findings

1. On 10 August 2020 The Māori Affairs Committee published a report summarising the findings and recommendations from an 'Inquiry into health inequities for Māori".
2. Rather than review data and experiences across the entire health system, the Inquiry focused on equities in cancer care.
3. The Inquiry report briefly summarised the patterns and likely causes of inequities in cancer care.
4. 19 recommendations were produced by the Inquiry. The recommendations at a local DHB level will be best enabled by central government and the Ministry of Health taking leadership.

Key points related to the report have been presented below in a question and answer format, along with excerpts (in italics) and page references supporting each answer.

1. When was this inquiry performed?

1.1. This inquiry was initiated in March 2019 by The Māori Affairs Committee. The final report was published in August 2020.

1.2. The Māori Affairs Committee opened this inquiry as we are deeply concerned about Māori experiencing inequitable treatment in the health and disability system. - p43

1.b.1. Inquiry Initiated - 6 March 2019

1.b.2. Submissions closed - 20 Sep 2019

1.b.3. Reported - 10 Aug 2020 (NZ Parliament link - accessed 31 August 2020)

Why was this inquiry initiated?

This inquiry was initiated based on concerns about Pharmac and the way cancer treatment drugs are funded.

1.1. *We opened this inquiry in 2019 after hearing concerns about the operation of Pharmac. These concerns were about how it decides which drugs to fund, how much funding it receives from the Government, why certain cancer treatment drugs are funded in other countries but not in New Zealand, and whether it attempts to ensure equitable outcomes for Māori. - page 46*

1.2. *In 2018 we received a comprehensive letter from Matthew Mulholland calling for our committee and the Health Select Committee to open an inquiry into Pharmac. This was after Mr Mulholland went public about his wife's fight against breast cancer in the hope that he could raise awareness and urge Pharmac to fund the cancer drugs Ibrance and Kadcyla. We also received correspondence from the National Māori Authority requesting that such an inquiry be undertaken. - page 46*

3. What was the scope of the inquiry?

The inquiry focused on cancer because of the size and complexity of the health system. Rather than attempt to assess inequities in the entire New Zealand health system the inquiry used cancer as a proxy for experiences of Maori in the wider health system.

3.1. We acknowledge that unpacking the reasons for this disparity across the entire health sector is an enormous task. The reasons are complex and require a deep understanding of history, and socioeconomic issues. Because of this, we decided to narrow the focus of our inquiry to look at cancer care and use it to gauge the experiences of Māori within the wider healthcare system. - page 43

What were the Terms of Reference of the Inquiry?

The Terms of Reference are listed in Appendix A.

5. What were the findings?

Submissions were received from multiple entities:

5.1. *We received 103 submissions from various health entities, DHBs, advocacy groups, and individuals who have been affected by (or have an opinion on) cancer care. - page 46*

The typical epidemiological pattern for Maori was one of moderately higher cancer incidence than non-Maori, and significantly higher mortality. There is of course significant variation in incidence and mortality when categorised by cancer type.

On average:

5.2. *Cancer incidence is 20% higher among Maori (compared with non-Maori) - page 44*

5.3. *Mortality is twice as high (compared with non-Maori) - page 44*

Examples of differences within specific cancers from Waikato DHB include:

5.4. *Māori women are approximately twice as likely to die from breast cancer compared with non-Māori. Explanations include presenting symptoms at a later stage at diagnosis and less breast screening. - page 44*

5.5. *Māori women have a cervical cancer registration rate twice that of non-Māori but the mortality rate for Māori females is disproportionately higher at four times that of non- Māori females. - page 44*

5.6. *Prostate cancer registration was lower for Māori males than for non-Māori males, but Māori males had a prostate cancer mortality rate twice that of non-Māori males. - page 44*

Do the findings differ from what we currently know about the origins of inequalities in health in Bay of Plenty District Health Board and health outcomes?

Both the origins of inequalities in health and the measurable differences in access and outcomes are consistent with what has been reported in the past at both a national level, and within Bay of Plenty District Health Board.

Was there any similar work underway at the time of the Inquiry that helps generate insight and solutions for inequalities in health outcomes between Maori and non-Maori?

There were two other relevant areas of work underway at the time of the Inquiry that also seek to understand and improve health outcomes for the Maori population. These include the Waitangi Tribunal's Wai 2575 Health Services and Outcomes Kaupapa Inquiry, and The New Zealand Health and Disability System Review.

8. What are the origins of inequalities in health such as those for cancer care and outcomes that the Inquiry summarised?

The report noted that inequalities in health care and outcomes are due to a range of factors. Over the long-term, these include the post-colonisation effects on the distribution of the social determinants of health, along with medium and short-term intermediaries such as various forms of racism.

8.1. We recognise that the systemic issues affecting Māori result from New Zealand's colonial history and that many of the health complications Māori suffer today did not exist in pre-colonial Aotearoa. We acknowledge that the resulting problems for Māori are intricate and vast. They relate to many wider determinants of health, including social, political, environmental, and economic factors. These can create a level of health advantage or disadvantage for people in New Zealand before they even engage with the health and disability system. We heard that the presence of structural disadvantage is not necessarily limited to any one step in the cancer journey but can be small, incremental, and cumulative. - page 45

8.2. Many submitters including individuals and health organisations said that inequities for Māori in the health and disability system are caused by systemic racism and unconscious bias. Submitters pointed to a large body of national and international research outlining the effects of racism and bias on health. We agree with this and believe the statistics above make it clear that there are ingrained inequities for Māori across the whole health and disability system. - page 45

What recommendations did the Inquiry make?

19 recommendations were provided by the Inquiry (pages 41-42); these are listed below:

Summary of recommendations

The Māori Affairs Committee has conducted an inquiry into health inequities for Māori. We make the following recommendations to the Government:

Delivering equitable Māori health outcomes

1. We recommend to the Government that a Government-funded entity be made responsible for eliminating health inequities for Māori, and be given the authority and resources to do so, and that strategic decision-making be reported and monitored annually (page 49).

New Zealand Cancer Action Plan

2. We recommend to the Government that it review the New Zealand Cancer Action Plan 2019–2029 every five years (page 50).

Bowel cancer screening age

3. We recommend to the Government that it provide a more flexible bowel cancer screening programme that responds more effectively to the specific needs of those affected (page 53).
4. We recommend to the Government that the Ministry of Health build up its number of colonoscopists to meet demand (page 53).

HPV self-testing

5. We recommend to the Government that it implement primary HPV screening, and that self-testing for HPV be made available (page 55).

Introducing a lung cancer screening programme

6. We recommend to the Government that it introduce and resource an equity-positive lung cancer screening programme and that it take note of the outcome of Auckland and Waitematā DHBs' lung cancer screening pilot (page 55).

Smoking habits among Māori

7. We recommend to the Government that it review the Māori Affairs Committee's 2010 report, "Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori", to identify further strategies to drive progress to achieving its Smokefree 2025 goal, and that it report back to this committee (page 56).

Breast cancer screening for wāhine Māori

8. We recommend to the Government that it ensure all Māori women can access screening programmes, with a particular focus on Māori women residing in rural areas (page 57).

The relationship between alcohol and cancer

9. We recommend to the Government that it require the Health Promotion Agency to develop a programme to increase awareness about the link between alcohol and cancer (page 58).

Increasing health literacy for whānau

10. We recommend to the Government that it develop and fund health literacy programmes for whānau (page 59).

Establishing a te ao Māori Health Promotion Agency

11. We recommend to the Government that it establish a te ao Māori Health Promotion Agency run by Māori for all Māori, regardless of their geographic location (page 60).

Pharmac

12. We recommend to the Government that Pharmac conduct a five-yearly review of its "variation in medicines use by ethnicity" analysis (page 62).

Kaupapa Māori cancer navigation roles

13. We recommend to the Government that it establish new kaupapa Māori cancer navigation roles and fund existing ones (page 65).

Increasing and upskilling the health workforce

14. We recommend to the Government that it take measures to increase the number of Māori working in the health and disability system (page 66).
15. We recommend to the Government that any tertiary programmes or qualifications on hauora Māori are evaluated to ensure that they are up to standard, well designed, and comprehensive (page 67).
16. We recommend to the Government that healthcare workers (and supporting staff) are required to undergo comprehensive training to ensure they are culturally capable to treat Māori (page 67).
17. We recommend to the Government that healthcare workers undergo accredited cultural safety training as part of their professional development, and that workers be re-assessed annually to retain a medical practising licence (page 67).

Palliative care

18. We recommend to the Government that it support and fund the implementation and evaluation of Mauri Mate and draw on the framework for service development in the wider palliative care sector (page 69).
19. We recommend to the Government that it fund a public health campaign targeted at Māori (with engagement at a national and local level) to increase their understanding of the palliative care sector. This campaign would aim to raise awareness and improve access to hospice services for Māori (page 69).

10. To what extent is the Bay of Plenty District Health Board currently implementing these recommendations?

The recommendations in the Inquiry can be led at a national or local-DHB level. Overall, leadership on these recommendations is most cost-effective if centrally led. The recommendations require a wide array of skills and resources to be implemented successfully.

Recommendation:	Is this recommendation best led by central Government or can it be led by a DHB?	Current activities underway at BOPDHB (where recommendation can be DHB-led)
1. A government-funded entity is resourced and made responsible for eliminating health inequities for Maori.	Central Government	n/a
2. Government to review the New Zealand Cancer Action Plan every five years.	Central Government	n/a
3. Provide a more flexible bowel cancer screening programme that responds more effectively to the specific needs of those affected. (e.g. eligible age expansion)	Central Government	n/a
4. Ministry of Health to increase the number of colonoscopists to meet demand.	Central Government	n/a
5. Implement primary HPV screening, self-testing is made available.	Central Government	BOPDHB has submitted a proposal to MOH and National Cervical Screening program to work with women who were under screened or never screen (major Equity issue identified). We did not receive endorsement or support for BOPDHB involvement or for the pilot in general. Recommend board consider following up with the MOH on this matter.
6. Introduce and resource an equity-positive lung cancer screening programme.	Central Government	n/a
7. Identify further strategies to drive progress to achieving its Smokefree 2025 goal, and	Central Government	n/a

report back.		
8. Ensure all Māori women can access screening programmes, with a particular focus on Māori women residing in rural areas.	Central Government	n/a BOPDHB has limited access to geographic screening data. We are working with the NSU to improve breast screening database access. Cervical screening data is held by primary care.
9. Require the Health Promotion Agency to develop a programme to increase awareness about the link between alcohol and cancer	Central Government	n/a
10. Government to develop and fund health literacy programmes for whānau.	Central Government	n/a
11. Establish a te ao Māori Health Promotion Agency run by Māori for all Māori, regardless of their geographic location.	Central Government	n/a
12. Pharmac conduct a five-yearly review of its "variation in medicines use by ethnicity" analysis.	Central Government	n/a
13. Establish new kaupapa Māori cancer navigation roles and fund existing ones.	Central Government	n/a There is some potential for BOPDHB to fund cancer navigator roles, independent of new funding. This is performed by individual services at present e.g. the Anaesthesia and Surgical Service, Cancer Coordination services.
14. Increase the number of Māori working in the health and disability system.	Central Government	n/a
15. Tertiary programmes or qualifications on hauora Māori are evaluated to ensure that they are up to standard, well designed, and comprehensive.	Central Government	n/a
16. Healthcare workers (and supporting staff) are required to undergo comprehensive	Central Government (and BOPDHB)	n/a There is scope for BOPDHB to implement

training to ensure they are culturally capable to treat Māori.		evidence-based training that may improve health outcomes for Maori. This requires further research.
17. Healthcare workers undergo accredited cultural safety training as part of their professional development, and that workers be re-assessed annually to retain a medical practising licence.	Central Government	n/a The Inquiry recommends training and accreditation beyond that required by the Health Practitioners Competence Assurance Act 2003.
18. Government to support and fund the implementation and evaluation of Mauri Mate and draw on the framework for service development in the wider palliative care sector.	Central Government	n/a
19. Government to fund a public health campaign targeted at Māori (with engagement at a national and local level) to increase understanding of the palliative care sector.	Central Government (and BOPDHB)	n/a There is scope for BOPDHB to implement a local public health campaign on this issue.

Appendix A - Inquiry Terms of Reference (page 43-44)

- collating existing statistics and evidence regarding Māori cancer health and identifying significant inequalities
- studying the higher incidence rate Māori experience with specific cancers compared to non-Māori
- identifying specific sets of issues experienced by Māori health service users
- investigating and critiquing the lower engagement rate for Māori with prevention, early
- detection, screening programmes, treatment, and medication
- looking at the role primary and health professionals play in improving cancer survival rates for Māori
- researching how to best design, develop, and roll out an early detection and/or wellbeing programme
- identifying where whānau “touch” the system to find “moments of impact” where bias (unconscious or deliberate) consistently occurs
- exploring a conceptual best-practice whānau-centric model of cancer care.

Inquiry into health inequities for Māori

Report of the Māori Affairs Committee

Fifty-second Parliament
(Rino Tirikatene, Chairperson)
August 2020

Presented to the House of Representatives

Rino Tirikatene
Chairperson

Contents

Inquiry into health inequities for Māori

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4. We recommend to the Government that the Ministry of Health build up its number of colonoscopists to meet demand (page 53).

HPV self-testing

5. We recommend to the Government that it implement primary HPV screening, and that self-testing for HPV be made available (page 55).

Introducing a lung cancer screening programme

6. We recommend to the Government that it introduce and resource an equity-positive lung cancer screening programme and that it take note of the outcome of Auckland and Waitematā DHBs' lung cancer screening pilot (page 55).

Smoking habits among Māori

7. We recommend to the Government that it review the Māori Affairs Committee's 2010 report, "Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori", to identify further strategies to drive progress to achieving its Smokefree 2025 goal, and that it report back to this committee (page 56).

Breast cancer screening for wāhine Māori

8. We recommend to the Government that it ensure all Māori women can access screening programmes, with a particular focus on Māori women residing in rural areas (page 57).

The relationship between alcohol and cancer

9. We recommend to the Government that it require the Health Promotion Agency to develop a programme to increase awareness about the link between alcohol and cancer (page 58).

Increasing health literacy for whānau

10. We recommend to the Government that it develop and fund health literacy programmes for whānau (page 59).

Establishing a te ao Māori Health Promotion Agency

11. We recommend to the Government that it establish a te ao Māori Health Promotion Agency run by Māori for all Māori, regardless of their geographic location (page 60).

Pharmac

12. We recommend to the Government that Pharmac conduct a five-yearly review of its "variation in medicines use by ethnicity" analysis (page 62).

Kaupapa Māori cancer navigation roles

13. We recommend to the Government that it establish new kaupapa Māori cancer navigation roles and fund existing ones (page 65).

Increasing and upskilling the health workforce

14. We recommend to the Government that it take measures to increase the number of Māori working in the health and disability system (page 66).
15. We recommend to the Government that any tertiary programmes or qualifications on hauora Māori are evaluated to ensure that they are up to standard, well designed, and comprehensive (page 67).
16. We recommend to the Government that healthcare workers (and supporting staff) are required to undergo comprehensive training to ensure they are culturally capable to treat Māori (page 67).
17. We recommend to the Government that healthcare workers undergo accredited cultural safety training as part of their professional development, and that workers be re-assessed annually to retain a medical practising licence (page 67).

Palliative care

18. We recommend to the Government that it support and fund the implementation and evaluation of Mauri Mate and draw on the framework for service development in the wider palliative care sector (page 69).
19. We recommend to the Government that it fund a public health campaign targeted at Māori (with engagement at a national and local level) to increase their understanding of the palliative care sector. This campaign would aim to raise awareness and improve access to hospice services for Māori (page 69).

1 Introduction

The Māori Affairs Committee opened this inquiry as we are deeply concerned about Māori experiencing inequitable treatment in the health and disability system. Throughout our consideration we have heard both anecdotal and statistical evidence that make it very clear that Māori do not receive the same level of care as non-Māori. We know that Māori have less access to healthcare services, experience a poorer quality of care, and are offered services developed from Western science that are not always in accordance with tikanga Māori.

We acknowledge that unpacking the reasons for this disparity across the entire health sector is an enormous task. The reasons are complex and require a deep understanding of history, and socioeconomic issues. Because of this, we decided to narrow the focus of our inquiry to look at cancer care, and use it to gauge the experiences of Māori within the wider healthcare system.

Many valuable ideas were raised in submissions, and many of them have been incorporated into this report. While we have been unable to address some of the issues raised that are outside of our terms of reference, submissions are publicly available to anyone who wishes to view them. We also acknowledge that this report is not all-encompassing, so we would like to see these submissions form a basis for constructive thinking about how New Zealand's health and disability system can better serve Māori. We strongly encourage leaders in the health and disability system to read them.

Since we opened this inquiry, other reports and initiatives have been released which also push for reducing health inequities for Māori. They include te Mahere mō te Mate Pukupuku o Aotearoa (the Ministry of Health's New Zealand Cancer Action Plan) as well as the New Zealand Health and Disability System Review.

Terms of reference

The terms of reference we adopted for this inquiry are as follows:

- collating existing statistics and evidence regarding Māori cancer health and identifying significant inequalities
- studying the higher incidence rate Māori experience with specific cancers compared to non-Māori
- identifying specific sets of issues experienced by Māori health service users
- investigating and critiquing the lower engagement rate for Māori with prevention, early detection, screening programmes, treatment, and medication
- looking at the role primary and health professionals play in improving cancer survival rates for Māori
- researching how to best design, develop, and roll out an early detection and/or wellbeing programme

- identifying where whānau "touch" the system to find "moments of impact" where bias (unconscious or deliberate) consistently occurs
- exploring a conceptual best-practice whānau-centric model of cancer care.

Cancer rates among Māori

The Ministry of Health states that Māori are 20 percent more likely to develop cancer than non-Māori, and nearly twice as likely to die from cancer as non-Māori.

We heard that the stage a cancer has reached when diagnosed is a strong predictor of survival for many people experiencing cancer. However, Māori are three times more likely to be diagnosed at a later stage than non-Māori, and are also more likely to present with symptoms later than non-Māori.

Waikato District Health Board told us several alarming facts about inequalities that it has observed for Māori experiencing cancer:

- Māori rates of mortality from all types of cancers are twice that of non-Māori.
- Māori women are approximately twice as likely to die from breast cancer compared with non-Māori. Explanations include presenting symptoms at a later stage at diagnosis and less breast screening.
- Māori women have a cervical cancer registration rate twice that of non-Māori but the mortality rate for Māori females is disproportionately higher at four times that of non-Māori females.
- Māori females have a lung cancer registration rate four-and-a-half times that of non-Māori females and a mortality rate five times that of non-Māori females.
- Māori male lung cancer registration and mortality rates are three times those of non-Māori males.
- For Māori males, the liver cancer registration rate is five-and-a-half times that of non-Māori males.
- Rates of stomach cancer registration and mortality are almost three times higher for Māori males than for non-Māori males.
- Prostate cancer registration was lower for Māori males than for non-Māori males, but Māori males had a prostate cancer mortality rate twice that of non-Māori males.
- Māori are more likely than non-Māori to access services later and to experience serious disorders and/or co-existing conditions.

We encourage more action from the Government to address inequities for Māori in regard to all cancers, and throughout the health and disability system in general. We heard that survival rates for Māori could triple with an early diagnosis of the most common cancers. This shows that achieving more equitable outcomes is possible.

Many Māori lives could be saved if screening programmes for lung, prostate, bowel, stomach, and other cancers were offered to Māori earlier, or catered to their needs. Prevention, early detection, and screening are critical for the survival of Māori. These topics make up a large part of our report.

Systemic racism in the health and disability system

Many submitters including individuals and health organisations said that inequities for Māori in the health and disability system are caused by systemic racism and unconscious bias. Submitters pointed to a large body of national and international research outlining the effects of racism and bias on health. We agree with this and believe the statistics above make it clear that there are ingrained inequities for Māori across the whole health and disability system.

We heard that the health and disability system in Aotearoa has been set up by Pākehā for Pākehā and does not align with kaupapa Māori. We recognise that the systemic issues affecting Māori result from New Zealand's colonial history and that many of the health complications Māori suffer today did not exist in pre-colonial Aotearoa. We acknowledge that the resulting problems for Māori are intricate and vast. They relate to many wider determinants of health, including social, political, environmental, and economic factors. These can create a level of health advantage or disadvantage for people in New Zealand before they even engage with the health and disability system. We heard that the presence of structural disadvantage is not necessarily limited to any one step in the cancer journey but can be small, incremental, and cumulative.

Several Māori submitters (some of whom are cancer survivors or currently suffering from cancer) discussed their own experiences of the health and disability system failing them. We heard from one submitter that a whānau member was not referred for an ultrasound because the doctor assumed she could not afford one. After enquiring how much the ultrasound would be, the whānau member was surprised to find that it was perfectly affordable for her and booked in the appointment herself. Tragically, a tumour was found and she was diagnosed with terminal cervical cancer which could have been detected much earlier. We were saddened to hear this. We think this is unacceptable and have made a recommendation about HPV screening and self-testing below.

We heard that, to reduce systemic racism in the health and diability system, the system needs to follow the principles of te Tiriti o Waitangi (the Treaty of Waitangi), and Māori should be able to practice tino rangatiratanga (self-determination). We discuss this further below.

2 Approach to this inquiry

We opened this inquiry in 2019 after hearing concerns about the operation of Pharmac. These concerns were about how it decides which drugs to fund, how much funding it receives from the Government, why certain cancer treatment drugs are funded in other countries but not in New Zealand, and whether it attempts to ensure equitable outcomes for Māori.

In 2018 we received a comprehensive letter from Matthew Mulholland calling for our committee and the Health Select Committee to open an inquiry into Pharmac. This was after Mr Mulholland went public about his wife's fight against breast cancer in the hope that he could raise awareness and urge Pharmac to fund the cancer drugs Ibrance and Kadcyla. We also received correspondence from the National Māori Authority requesting that such an inquiry be undertaken.

We sympathise with Mr Mulholland and his whānau and decided to take a closer look at the experience of Māori throughout the health and disability system, with a particular focus on cancer care. Our inquiry does not focus specifically on Pharmac as we identified that barriers for Māori exist all the way through the health and disability system and, in many cases, before Māori even come into contact with the system.

Early on in our inquiry we were briefed by the Ministry of Health on its soon-to-be released New Zealand Cancer Action Plan. We also heard from a small panel of health experts who informed us of the vast health inequities between Māori and non-Māori and helped us steer our inquiry. We then sought the help of an independent adviser to analyse submissions and guide us through the process.

We received 103 submissions from various health entities, DHBs, advocacy groups, and individuals who have been affected by (or have an opinion on) cancer care. We are impressed by the breadth and quality of the submissions and thank all individuals and organisations who took the time to submit to us. Your expertise and passion for improving outcomes for Māori is invaluable. We would also like to thank our expert adviser for his effort towards our inquiry.

3 Initiatives in the wider public sector

Waitangi Tribunal findings

Several submitters referred to the Waitangi Tribunal's Wai 2575 Health Services and Outcomes Kaupapa Inquiry.[21] That ongoing inquiry was initiated in November 2016 for the Tribunal to hear all claims concerning grievances relating to health services and health outcomes of national significance for Māori.

The Tribunal's inquiry progresses in stages. Stage one concluded in March 2019 and focused on claims concerning the way the primary health and disability system in New Zealand has been legislated, administered, funded, and monitored by the Crown since the passing of the New Zealand Public Health and Disability Act 2000. Stage two (currently under way) covers three priority areas related to mental health (including suicide and self-harm), Māori with disabilities, and issues with alcohol, tobacco, and substance abuse. Stage three will cover the remaining significant issues and eligible historical issues.

The Tribunal found that the Crown had breached te Tiriti by failing to design and administer the primary health and disability system to actively address persistent Māori health inequities and by failing to give effect to tino rangatiratanga. The Tribunal recommended that the Act and its associated policies and strategies be amended to "give effect to the Treaty principles and ensure that those principles are part of what guides the primary health sector; and include an objective for the health sector to achieve equitable health outcomes for Māori". We discuss primary health further into this report.

The Tribunal also made an interim recommendation that the Crown and stage one claimants work together to further assess the extent of the problems in primary health, and co-design a set of solutions. We understand that the claimant groups broadly suggested creating a national, Māori-controlled agency, organisation, or collective that would have oversight and control of Māori health-related spending and policy.

Submitters maintained that te Tiriti was New Zealand's first health policy, and that under the Treaty the Crown made a commitment to a partnership to improve the participation and health status of Māori.

Recommendations from the New Zealand Health and Disability System Review

The New Zealand Health and Disability System Review is a comprehensive review of Aotearoa's health and disability system commissioned by the Minister of Health.[22] The review was completed in 2020 and makes a number of recommendations. The review's report includes a section relating solely to hauora Māori (Māori health). Like the submitters

[21] https://waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/.

[22] Colloquially known as the "Simpson Review".

we heard from, and the Tribunal, the review recommends that the principles of te Tiriti should be integrated throughout the entire health and disability system.

The review makes a number of recommendations in regard to hauora Māori. The review's main recommendations are:

- incorporating te Tiriti o Waitangi principles across the system and updating legislation accordingly
- establishing a Māori health authority
- reflecting te Tiriti partnership in governance structures
- investing in kaupapa Māori services
- embedding Māori knowledge and worldview perspectives across the system.

The review states:

> The Review recommends an increased emphasis on health equity and quality improvement performance for hauora Māori. This requires updating the equity clauses in legislation; addressing racism and discrimination, inclusive of improving cultural safety and competence; growing and investing in the future Māori health workforce and providers and increasing Māori-specific funding.
>
> The Review believes that Māori equity will be enhanced through accountability of the entire health and disability system to address equity issues at all levels. The Review recognises that systemic inequity cannot be addressed through piecemeal initiatives alone.

Many of the review's recommendations align with themes that have come through in submissions for our inquiry. We will naturally address some of these later in our report.

Establishing a Māori health authority

A number of submitters said that, to achieve tino rangatiratanga, a Māori health authority should be established. This is also one of the recommendations of the New Zealand Health and Disability System Review and the Tribunal. The review states that the authority should be an independent departmental agency with direct accountability to the Minister of Health. The review recommends that the agency sit alongside the Ministry of Health and have a similar range of functions relating to Māori health as the ministry does for the overall system. The review goes into a lot of detail about what the agency might look like, how it would function, and how it would fit into the current health and disability system. Some submitters on our inquiry said that if a separate authority is created they would like this entity to be run by Hei Āhuru Mōwai, the Māori Cancer Leadership Group.

The review states an authority's main functions could be:

- advising the minister on all aspects of Māori health policy
- partnering with all other parts of the health and disability system
- monitoring and reporting on Māori health outcomes and equity

- investing in kaupapa Māori health services and providers
- developing and leading the implementation of the Māori health workforce strategy.

We heard about similar models that have been successful, such as the Southcentral Foundation Nuka System of Care model, which operates in Alaska. We heard that it has a relationship-based, customer-owned approach to transforming healthcare, and has significantly improved health outcomes for the indigenous peoples of Alaska. We heard that the Independent Māori Statutory Board to the Auckland Council holds a similar mandate and accountability, and could be an adaptable model.[23]

We agree with submitters that we want to see better health outcomes for Māori with greater independence and resourcing of Māori health strategies. However, our views differ on how this should be done. Government members want to see an independent Māori health authority established. Opposition members want to see Māori health directorates within the Ministry of Health and district health boards strengthened and are concerned a new entity would create another layer of administration for Māori to navigate. We are in agreement that any entity that has the power to eliminate inequities for Māori should have the authority and resourcing to do so.

We also consider that the Māori workforce needs to be resourced from the ground up, and make a recommendation about this in regard to kaupapa Māori cancer navigators later in this report.

Recommendation 1

We recommend to the Government that a Government-funded entity be made responsible for eliminating health inequities for Māori, and be given the authority and resources to do so, and that strategic decision-making be reported and monitored annually.

Te Mahere mō te Mate Pukupuku o Aotearoa

In 2019 the Ministry of Health briefed us on te Mahere mō te Mate Pukupuku o Aotearoa (New Zealand Cancer Action Plan). The details for this plan were released in a report in December 2019.[24]

We heard that the plan has four main goals, which are:

- New Zealanders have a system that delivers consistent and modern cancer care
- New Zealanders experience equitable cancer outcomes
- New Zealanders have fewer cancers
- New Zealanders have better cancer survival, supportive care, and end-of-life care.

We heard that the plan will undertake specific actions to ensure equitable outcomes for tangata whenua and will ensure that tangata whenua world views, values, and wairuatanga (spirituality) inform its work.

[23] https://scfnuka.com/our-story/.

[24] https://www.health.govt.nz/system/files/documents/publications/new-zealand-cancer-action-plan-revised-january-2020.pdf.

We were told that the ministry's definition of equity underpins this plan. Its definition is:

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

The ministry said that this definition will drive the coordinated and collaborative effort required to achieve equitable cancer outcomes for all New Zealanders across the entire cancer continuum. We heard that the Ministry of Health and the Cancer Control Agency aim to align their work with their Tiriti obligations and go beyond just remedying disadvantage and reducing inequities. Their aim is to enable Māori to flourish, and to develop and lead their own goals for health and wellbeing.

According to the plan, the ministry aims to achieve cancer survival equity by 2030 in a variety of ways. They include:

- developing a robust equity-first prioritisation methodology to be used in cancer investment decision-making
- developing a monitoring framework for the cancer plan that includes explicit focus on equity
- developing and implementing people- and whānau-centred care guidelines.

We are pleased that the ministry has released a national cancer plan with equity as one of its foundations. However, we note that while submitters are also happy about the plan, some said that although Māori are mentioned in various sections throughout the plan, it lacks specific information about how inequities will be addressed. We hope this will become clear over time as the plan is put into action.

We think the plan should be reviewed regularly to ensure it is progressing as it should. We particularly want to make sure that it is meeting the needs of Māori.

Recommendation 2

We recommend to the Government that it review the New Zealand Cancer Action Plan 2019–2029 every five years.

4 Prevention, screening, and raising awareness

Māori are more likely to suffer from other chronic conditions that can lead to cancer. We heard that the introduction of alcohol, drugs, food, and Western models of health and economy into Aotearoa have disrupted the traditional way of life for Māori. This has resulted in a variety of health issues not previously experienced

We were told that, although many risk factors for developing cancer are beyond people's control (such as age and family history), a substantial proportion of inequalities in cancer are preventable. Some submitters said that the Government could reduce inequities for Māori in a number of ways. They said the Government could strengthen and reaffirm its Smokefree 2025 goal. They also said it needs to reduce alcohol advertising, increase the price of alcohol, and regulate the marketing of unhealthy, sugary food for children. We heard that Māori are more likely to be exposed to the major risk factors associated with the development of certain cancers.

Submitters also stressed that the prevention of cancer does not just involve better access to healthcare or early screening. Several mentioned the social determinants that need to be addressed to eliminate inequities. They include: improving housing conditions, ensuring adequate work and income, ensuring access to high quality education, and creating healthy physical environments.

The table below shows risk factors that can lead to cancer. It provides a comparison between Māori and non-Māori in regard to tobacco, alcohol dependency, obesity, and nutrition, all of which contribute to cancer outcomes. The higher the ratio, the larger the exposure to risk for Māori than for non-Māori.

Risk factor exposure, Māori and non-Māori 2017/18[25]

Risk Factor	Māori (% of total population)	Non-Māori (% of total population)	Ratio
Current tobacco smoker	33.5	14.9	2.58
Hazardous use of alcohol	31.7	21.2	1.42
Body size – obesity (BMI over 30)	47.5	30.7	1.65
Physical activity	54.0	55.2	0.99
Nutrition – fruit and vegetable intake	35.5	42.2	0.94

[25] https://www.health.govt.nz/publication/annual-update-key-results-2017-18-new-zealand-health-survey.

The benefits of equitable screening

Many submitters discussed the potential benefits of early screening. The cancers that submitters mentioned the most are the types we have focused on and made recommendations on below. However, we acknowledge that earlier screening and diagnosis for all cancers would result in significant health benefits for Māori. The Cancer Society told us that cancer survival rates (among Māori and non-Māori) could be tripled with an early diagnosis of the most common cancers. We maintain that any detection strategies should be aligned with mātauranga Māori, be equity-positive, and be co-designed with Māori.[26]

Lowering the screening age for bowel cancer

We heard that the Ministry of Health funded Waitematā District Health Board to run a bowel cancer screening pilot from 2012 to 2015. The pilot transitioned to become the National Bowel Screening Programme (NBSP) which is being rolled out to people aged 60 to 74 across 10 district health boards, with the aim of reaching all district health boards by June 2021.[27]

We understand that the NBSP has sent out more than 430,000 FIT kits (faecal immunochemical test kits) since it began nearly three years ago, and has detected more than 600 cancers and removed thousands of potentially cancerous polyps (abnormal tissue growths).

We are pleased that the NBSP is being extended across the country and that it has detected a number of cancers. However, we heard that at least half of bowel cancers among Māori (60 percent female and 50 percent male) are diagnosed before 60 years of age, compared to 30 percent of bowel cancers among non-Māori. Because of this, most Māori will not be diagnosed by the screening programme.

We heard that during the pilot stage of the NBSP (2012 to 2015), people aged between 50 and 74 were screened. However, when the NBSP was rolled out in 2017, the age range for screening was changed to age 60 to 74. We heard that expanding the age range for testing to between 50 and 74 resulted in a larger backlog of patients (who tested positive) waiting to be seen by a specialist. We understand that this is because of a shortage of colonoscopists, which means that patients who test positive cannot be seen quickly enough.

While we acknowledge that this is an issue, it does not change the fact that Māori are vulnerable to bowel cancer at an earlier age. As our report shows, a “one-size-fits-all” approach to healthcare is inefficient, and in this case the benefits are in favour of non-Māori.

Many submitters recommended that the screening age for bowel cancer should be lowered to 50. While Bowel Cancer New Zealand did not make a submission on this inquiry, in February it reported that it wants screening to be offered immediately to Māori aged 50 to 59.[28] We also heard from Hei Āhuru Mōwai (the National Māori Cancer Advisory Board) that

[26] Definition of mātauranga Māori: the body of traditional knowledge.

[27] https://www.health.govt.nz/our-work/preventative-health-wellness/screening/bowel-screening-pilot.

[28] https://bowelcancernz.org.nz/wp-content/uploads/2020/03/Bowel-Cancer-NZ-Media-Release-26Feb2020.pdf.

expanding the age range for bowel cancer would double the number of cancers detected among Māori.

Statistics from Bowel Cancer New Zealand show that every year around 3,000 New Zealanders are diagnosed with colorectal (bowel) cancer and 1,200 die. Twelve percent of bowel cancers are detected annually in New Zealanders aged 50 to 59. For Māori, one in five (22 percent) are diagnosed in this age range, which equates to 60 Māori patients. Thirty-nine percent of New Zealanders are diagnosed aged 60 to 74 (the current screening age). We understand that in 2014 alone there were 120 deaths from bowel cancer in New Zealand in the 50 to 59 age range. We are deeply concerned about these figures and would like to see the bowel cancer screening programme respond more effectively to Māori and those at risk.

Recommendations 3 and 4

We recommend to the Government that it provide a more flexible bowel cancer screening programme that responds more effectively to the specific needs of those affected.

We recommend to the Government that the Ministry of Health build up its number of colonoscopists to meet demand.

Preventative measures for cervical cancer

We are aware of inequities among wāhine Māori being screened for cervical cancer. We heard from Family Planning New Zealand that, according to a 2017 monitoring report, 81 percent of New Zealand European women had been screened for cervical cancer, compared to 64 percent of wāhine Māori.[29] We were also told that cervical cancer is almost completely preventable through a combination of vaccination against high-risk types of human papillomavirus (HPV) and cervical screening.

HPV is a common virus transmitted by skin-to-skin contact and most of the time the body resolves the infection on its own. However, HPV leads to almost all cervical cancers which could be prevented if HPV was detected early and monitored regularly. We also understand that Māori women are almost twice as likely to get cervical cancer and almost three times as likely to die from it compared to non-Māori women. We think it is unacceptable that wāhine Māori do not have the same survival rates for a cancer that could be prevented through simple measures.

We are impressed by the overall success of the National Cervical Screening Programme (NCSP) which is available to all women in New Zealand between 20 and 70 years old. The test checks for abnormal cell changes to the cervix before any abnormalities develop into cervical cancer. We understand that, since the introduction of the programme in 1990, cervical cancer in New Zealand has decreased by approximately 50 percent, and the mortality rate has decreased by 60 percent. However, Māori are still underserved through this programme and we are disappointed to note that wāhine Māori have a lower participation rate in the screening programme compared with non-Māori.[30] From 2016 to

[29] https://www.nsu.govt.nz/system/files/page/national-cervical-screening-programme-monitoring-report-47-1-january-30-june-2017-jun2018.pdf.

[30] https://www.nsu.govt.nz/health-professionals/national-cervical-screening-programme.

2018, participation in the programme for women aged 20 to 69 was 63.8 percent for Māori and 71.5 percent for non-Māori. The target coverage is 80 percent.

Studies on cervical cancer screening for Māori

We heard about two equity-focused studies investigating the potential for women to self-test for HPV. They were undertaken by Waitematā DHB, Auckland DHB, and the research team at the Massey University Centre for Public Health Research. One of the studies (now complete) focused on wāhine Māori in west Auckland. The second project (ongoing) is a larger community trial. It tests different implementation methods and targets Māori, Pacific, and Asian women with tailored approaches. We heard that the projects explore the potential for the implementation of self-testing for women who are underserved by the current national screening programme. They look at whether self-testing is acceptable, what invitation methods might increase the uptake of tests taken, and what needs to be done to ensure women with positive tests have the required follow-up appointments or procedures.

We heard that the first study shows that the primary barrier for wāhine Māori getting screened is the invasiveness of the test itself, with many Māori women saying they had a bad experience in the past or would not feel comfortable asking for a test from their nurse or doctor. We also heard that time constraints or difficulty travelling are common reasons Māori women are not screened. For the study, Māori women were able to try self-testing. This involved an easy-to-use cotton swab instead of the usual speculum smear test. We heard that wāhine Māori universally reported a positive experience with HPV self-testing. We heard that the women found the test easy, more convenient, less embarrassing, and more comfortable. We heard that 84 women took part in the study and that 6 percent of the women were HPV positive.

The second study focused on three methods of invitation to self-test: being invited to self-test at the clinic, being mailed a kit for a self-test at home, or being sent a reminder letter to have a smear test (a control group, following the usual approach). We heard that results of the study are expected later in 2020. However, early results suggest that Māori women find self-testing more acceptable than a standard smear test.

We heard that the above studies show that different approaches to HPV testing best address inequities, and that the National Cervical Screening Programme should offer the option of self-testing through a variety of invitation methods, including mail.

We heard that these findings have been shared with the NCSP and the Ministry of Health and have been positively received. We heard that the NCSP plans to change to primary HPV screening, which allows for self-testing, and that this change is scheduled for 2021. However, we share the concern of several submitters that in the recently released National Cancer Action Plan it only states that it will “consider” the implementation of primary HPV screening.

We heard that following up positive HPV screening tests is critical for preventing cervical cancer. Many submitters expressed that a “wrap-around” approach is needed for Māori women who test positive. This might include follow-up phone calls and tailored support to ensure they progress through the health system to further tests or treatment. We see the

importance of this. If our recommendations are implemented, we strongly encourage a robust follow-up system that is tailored to meet the needs of Māori women.

Recommendation 5

We recommend to the Government that it implement primary HPV screening, and that self-testing for HPV be made available.

Introducing a lung cancer screening programme

We heard that lung cancer has the highest mortality rate for Māori out of all cancers. We also note that New Zealand has a worse five-year survival rate than comparable countries even though most lung cancer is avoidable. Cancer survival for the total population of New Zealand is poor, with a five-year relative survival of 11 percent. Comparatively, the five-year survival figure for Māori is 7 percent.

Submitters pointed out that Māori have the highest lung cancer rates of indigenous people worldwide. We are very concerned to hear this.

Lung cancer screening trials have been undertaken in other countries and have yielded promising results. We heard that international lung cancer screening trials for early detection have demonstrated a 20–26 percent reduction in lung cancer mortality. However, there is currently no lung cancer screening programme in New Zealand despite the fact that lung cancer kills more New Zealanders than melanoma, breast cancer, and prostate cancer combined.

We were told about a lung cancer screening trial based out of Auckland DHB and Waitematā DHB. It is run by the Lung Cancer Screening Project Steering Group, which targets at-risk Māori. We heard that the goal of an initial study (under way at the time of the submission) was to first find out how Māori would engage with a lung cancer screening programme. It used different methods to understand Māori beliefs, attitudes, and perspectives of lung cancer screening and associated tests. The findings of the study would then be used to inform a screening demonstration trial suited to the needs of whānau. We heard that the screening would be undertaken through a low-dose CT scan. The team behind the project would then explore how a programme could be both cost-effective and equity-positive.

It is clear to us that Aotearoa needs a lung cancer screening programme and we recognise that many lives, Māori and non-Māori, could be saved if lung cancer is detected early. We want any lung cancer screening programme to have a strong focus on providing equitable results for Māori. This might mean screening Māori earlier or ensuring that Māori in rural communities have access to screening.

Recommendation 6

We recommend to the Government that it introduce and resource an equity-positive lung cancer screening programme and that it take note of the outcome of Auckland and Waitematā DHBs' lung cancer screening pilot.

Smoking habits among Māori

We are concerned that, without systemic changes, inequities for Māori in regard to lung cancer will persist because the number of Māori smokers in New Zealand remains high. The

smoking rate for Māori adults is 34 percent (31.5 percent for Māori men and 36 percent for Māori women) and Māori are 2.7 times more likely to be smokers than non-Māori.[31] Māori are also the youngest demographic to start smoking, beginning the habit at just over 14 years old on average.

We are concerned that the Government's momentum has slowed for its Smokefree 2025 goal. In 2010 the Māori Affairs Committee of the 49th Parliament undertook an inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori.[32] It made several recommendations with the aim of reducing tobacco consumption among Māori, which resulted in the Government's Smokefree 2025 initiative.

In 2018 we opened a joint briefing with the Health Committee on achieving the Smokefree 2025 goal for New Zealand. As a result of this briefing the Smoke-free Environments (Prohibiting Smoking in Motor Vehicles Carrying Children) Amendment Bill was introduced and received Royal assent in 2020. The Smokefree Environments and Regulated Products (Vaping) Amendment Bill was introduced in 2020 and has progressed through the select committee stage to its second reading. We are pleased these bills were introduced but believe more needs to be done for Aotearoa to be smoke free by 2025.

We urge the Government to revisit this inquiry and consider further what it can do to reduce smoking in New Zealand, particularly among Māori.

Recommendation 7

We recommend to the Government that it review the Māori Affairs Committee's 2010 report, "Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori", to identify further strategies to drive progress to achieving its Smokefree 2025 goal, and that it report back to this committee.

Breast cancer screening for wāhine Māori

Submitters discussed the high incidence of breast cancer among Māori women. We also heard that Māori women who are diagnosed with breast cancer are 76 percent more likely to die from their cancer compared with non-Māori women. Waikato DHB told us that the most important contributor to the mortality rate is the stage of the disease at diagnosis (Māori are diagnosed later than non-Māori, so the disease is often at an advanced stage). It said this can be compounded by the additional inequities along the cancer care pathway. We heard that these include differences in neighbourhood deprivation, mode of diagnosis, and treatment facility type.

We heard from Waikato DHB that Māori women who have screen-detected breast cancers experience five-year survival rates of over 90 percent. It also said that in Waikato, Māori and Pacific women diagnosed through the breast cancer screening programme have outcomes comparable to non-Māori and non-Pacific women. We heard the mortality benefits for

[31] https://www.smokefree.org.nz/smoking-its-effects/facts-figures#:~:text=The%20smoking%20rate%20for%20M%C4%81ori%20adults%20is%2034%25.&text=M%C4%81ori%20men%20%E2%80%93%2031.5%25%2C%20M%C4%81ori,be%20smokers%20than%20non%2DM%C4%81ori.

[32] Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori.

screening Māori women are likely much greater than for the average population given that, outside the screening programme, Māori women do much worse.

It is clear that the breast cancer screening service is not reaching Māori women at the same rate that it is reaching non-Māori women. We are highly concerned by this and the huge disparity of diagnosis and death between Māori and non-Māori women. It is clear that the rates of survival of Māori women could drastically increase if more Māori women are screened.

Submitters overall addressed breast cancer less than other cancers. However, those that did address breast cancer often mentioned that alcohol consumption can increase the risk of developing breast cancer. We heard concerning statistics about drinking among Māori women. We heard that in 2017/18 one in every four (25.3 percent) of Māori women were classified as hazardous drinkers compared to 13.3 percent among European/other women and 12 percent among Pacific women. We heard that this equates to Māori women being 2.05 times more likely than non-Māori women to be classified as hazardous drinkers. We discuss the links between alcohol and cancer further below.

Recommendation 8

We recommend to the Government that it ensure all Māori women can access screening programmes, with a particular focus on Māori women residing in rural areas.

The relationship between alcohol and cancer

Several submitters, including Counties Manukau DHB, the Cancer Society, and Alcohol Healthwatch, noted the link between alcohol consumption and cancer. The Cancer Society told us that Māori women have one of the highest incidences of breast cancer in the world and that this is in part due to higher rates of alcohol consumption.

Alcohol Healthwatch told us that alcohol is a class one carcinogen and is related to the causation of seven types of cancer. It said that, despite alcohol's ill effects, the link between tobacco and cancer has far more public awareness. It said that in the past decade, alcohol consumption among Māori women has increased and yet alcohol is more affordable than ever. We also heard that Māori children are much more likely to be exposed to alcohol marketing compared with other ethnicities. We heard that the failure to enact evidence-based legislation that reduces alcohol across the population continues to play a role in alcohol-attributable cancer inequities.

The Cancer Society emphasised that measures need to be taken to stop the saturation of alcohol outlets and marketing in Māori communities that lead to increased alcohol consumption. We heard that, while the link between alcohol and cancer is not widely known, it can cause cancers of the throat, voice box, oesophagus, colorectum, liver, and breast. We heard that it may also contribute to pancreatic cancer.

The Cancer Society recommends:

- regulating and restricting marketing, including in social media (particularly to children)
- banning alcohol sponsorship of events open to the public
- increasing alcohol taxes to reduce affordability

- removing the right of appeal to allow local authorities to establish local alcohol policies following consultation in their community
- ensuring licensing fees cover all costs of licensing administration.

Alcohol Healthwatch recommends similar strategies but also suggested mandatory warning labels on alcohol products and marketing campaigns that increase the awareness of the link between alcohol and cancer.

The Health Promotion Agency (HPA) similarly noted the correlation between alcohol and cancer. It told us that it attended a hui with a range of Māori stakeholders, including Māori health promoters and providers who did not realise the link between alcohol and cancer risk.

We heard that the Sale and Supply of Alcohol Act 2012 sought to enable local communities to have more control of alcohol in their local areas.[33] We heard that this has not happened because of policy processes (locally driven and developed local alcohol policies) as well as individual alcohol licensing decisions. We heard that changes to this Act would help address the imbalance for Māori communities.

We agree that the link between alcohol and cancer is not well known by the general population. We hope this link can be made clear and encourage the HPA to initiate a nation-wide campaign that will raise awareness about the concerning connection between alcohol and cancer.

Recommendation 9

We recommend to the Government that it require the Health Promotion Agency to develop a programme to increase awareness about the link between alcohol and cancer.

Health literacy and education for whānau

Health literacy can be a big barrier for whānau receiving timely and effective cancer treatment. Waikato DHB told us that health literacy is the degree to which individuals have the capacity to obtain, process, and understand health information and services to make health decisions. Health literacy also includes the capacity of professionals to communicate effectively to patients so they can make informed decisions about their health. We understand that poor health literacy is common and that more than 50 percent of the adult New Zealand population is likely to have some difficulties with health literacy. In 2010 Kōrero Mārama reported that:

- “four out of five Māori males and three out of four Māori females have poor health literacy skills
- Māori who live in a rural location have on average the poorest health literacy skills, closely followed by Māori who live in an urban location.
- Māori in the 50–65, 16–18, and 19–24 age groups have the poorest health literacy compared to the rest of the population. This is particularly concerning because over half of the Māori population (53 percent) was less than 25 years of age at the 2006 census.

[33] http://www.legislation.govt.nz/act/public/2012/0120/latest/DLM3339333.html.

Also, older age groups have high levels of health need and are generally high users of health services.

- Māori and non-Māori with a tertiary education are more likely to have good health literacy skills compared to those with lower levels of education. This is consistent with international evidence.
- Māori across all labour force status types have poorer health literacy skills compared to non-Māori, but Māori who are unemployed or looking for work have the poorest health literacy skills of all groups.
- Māori have poorer health literacy statistics across gender, age, and location than non-Māori".[34]

Submitters said that health information needs to be available in an appropriate format, be easily understood, and preferably be delivered face-to-face (kanohi ki te kanohi) for whānau. Submitters said that health literacy can be increased through further training for healthcare workers. We heard that health workers should reduce medical jargon and use plain English and easy to understand written and visual materials.

We heard that providing whānau information this way would help build rapport, informed consent, and enhanced understanding. This in turn could contribute to improved medication adherence and better outcomes.

Recommendation 10

We recommend to the Government that it develop and fund health literacy programmes for whānau.

Establishing a te ao Māori Health Promotion Agency

Some submitters said that campaigns spreading awareness about cancer care need to be more targeted to reach Māori. The body responsible for raising awareness about health issues in New Zealand is the HPA. The HPA uses marketing approaches to create behavioural changes and is required to give effect to government policy when directed by the responsible Minister. The HPA is also required to have a strong focus on equitable outcomes. Its campaigns have focused on alcohol, tobacco, cervical cancer, healthy eating, and physical activity, and it uses TV, radio, online, social media, and outdoor media to get its messages across. It also produces 58 Māori language resources (pamphlets and posters) freely available on request, 13 of which relate to common cancers among Māori.

While the HPA has a track record of marketing success and has won a number of accolades, including some for reaching a priority audience, we are aware of concern that the HPA is not effectively getting its messaging across to vulnerable Māori. Those concerned said that while the HPA receives a number of "likes" and page visits for its campaigns, those metrics do not necessarily translate to real-life behavioural change.

We heard from the HPA as part of this inquiry. It made a number of suggestions and recommendations for improving health outcomes for Māori. One of them includes expanding existing HPA-funded training for Māori wardens in alcohol-harm reduction, screening, and

[34] https://www.health.govt.nz/system/files/documents/publications/korero-marama.pdf.

intervention. The HPA told us that there are examples across Aotearoa of whānau, hapū, and iwi developing their own solutions for health and wellbeing that can be supported and used as models for new initiatives. It also advocated for the expansion of existing Māori-focused and Māori-led prevention projects.

We were advised that campaigns could be more effective if they were designed by Māori for Māori. It was suggested that a te ao Māori HPA (that operates under a Māori world view) could be established.[35] We were told that this agency could form trusted relationships and partner with iwi, hapū, and existing Māori advocacy entities like Whānau Ora. It could then co-design promotion campaigns and health literacy initiatives for Māori.

We agree that messaging about preventative measures to reduce cancer could more effectively reach and resonate with Māori if that messaging is designed by Māori. We consider that a te ao Māori HPA could assist in raising awareness about the screening programmes we mention earlier in this report. It could also contribute to our recommendation above, about increasing health literacy among Māori. Health campaigns can be very effective when targeted correctly and we consider that an HPA run by Māori for Māori could make a big difference to health outcomes for Māori. We think it is important that a te ao Māori HPA ensures it is reaching all Māori, including Māori in more remote areas who can be overlooked by the health and disability system. A te ao Māori HPA would also be able to team with kaupapa Māori cancer navigators who could assist in getting important health messages across to Māori as well as supporting Māori on their health journey. We consider that the success of a te ao Māori HPA could positively link into and interact with several of the recommendations made throughout this report.

Recommendation 11

We recommend to the Government that it establish a te ao Māori Health Promotion Agency run by Māori for all Māori, regardless of their geographic location.

[35] Definition of te ao Māori: the Māori world view that acknowledges the interconnectedness of all living and non-living things.

5 Pharmac's role in equitable treatment

Some submitters made recommendations either regarding the operation of the Pharmaceutical Management Agency (Pharmac) or about increasing the number of cancer medications funded by Pharmac as a way to address health inequities for Māori.

Hei Āhuru Mōwai noted that if the screening age for Māori is lowered for a number of cancers, the cost to Pharmac would drastically increase and the agency would require more funding. We were also told that New Zealanders often travel to other countries to receive treatments that are not available in New Zealand. We heard from Lung Foundation New Zealand that if you live in Australia you have a better chance of surviving lung cancer, and that deaths in New Zealand could be avoided if more treatments were funded.

We heard that, despite lung cancer having the highest mortality rate of all cancers in New Zealand, Pharmac spends a much smaller amount on drugs for lung cancer compared to other cancers. We heard that the top three lung cancer drugs funded by Pharmac (in 2017/18) equate to just 2.3 percent of spending on the top five cancer drugs ($122 million).

Submitters also called for an investigation into the funding allocation models that Pharmac uses as the brokering agency for medicine in Aotearoa. Many submitters maintain that drugs should be funded that are effective in treating cancers that are known to disproportionately affect Māori, particularly where the same cancers do not burden non-Māori. Submitters also pointed out the expense of certain cancer treatments and the unfair access and affordability of these treatments for Māori who are more likely to suffer from socio-economic deprivation.

Steps Pharmac is taking

We understand that in 2018 Pharmac commissioned an update of a 2006/07 analysis of variations in the use of medicines by ethnicity, using 2012/13 data from the Ministry of Health.[36]

The updated report showed that, while there has been improvement in some areas, inequities continue in the number of Māori using and accessing medicines.

The report said that:

- compared with 2006/07, Māori remain less likely to access dispensed medicine than non-Māori
- Māori access to medicines remains lower despite the health need of Māori being higher
- disparities in medicine access and use are linked to chronic conditions that are responsible for an estimated 88 percent of the burden of disease in New Zealand
- in 2012/13 gaps in medicine dispensing meant there were about 608,800 lost opportunities for Māori to access medicines, with 1,126,280 pharmaceutical treatments that Māori did not receive.

[36] https://www.pharmac.govt.nz/assets/2018-01-19-Variation-in-medicines-use-by-ethnicity-Final-Report.pdf.

Pharmac said that gaps in access to medicines are evident in long-term conditions like diabetes, heart disease, and respiratory conditions like asthma.

In response to these findings, Pharmac said it is committed to eliminating inequities in access to medicines by 2025 as one of its priorities.[37] It plans to work with partners in the health sector to identify barriers and underlying causes of the inequities. It said it would ensure its own processes are not contributing to inequities.

Pharmac acknowledged that equity cannot be achieved solely by its own action, and said that the whole health system needs to collaborate to fight inequities. We also recognise this fact, which is reflected throughout our recommendations. We believe that Pharmac needs to make sure it is regularly reviewing how many Māori are accessing medicines and continues to monitor its role in contributing to equitable outcomes for Māori.

Recommendation 12

We recommend to the Government that Pharmac conduct a five-yearly review of its "variation in medicines use by ethnicity" analysis.

Pharmac and the New Zealand Cancer Action Plan

We note that Pharmac is mentioned throughout the New Zealand Cancer Action Plan. Several of the plan's intentions would affect certain ways Pharmac operates. The plan states that it will improve cancer diagnosis and treatment outcomes by:

- developing fast-tracked diagnostic pathways for priority cancers
- implementing quality improvement indicators and initiatives to support access to quality cancer treatment
- nationally agreeing on the scope and distribution of specialist cancer services and cancer surgical services
- investing in workforce, technology, and treatment capacity for oncology
- collecting detailed data to identify and address inequities and inefficiencies in drug-based cancer treatments
- undertaking earlier assessment of new medicine applications
- developing options for early access to new medicines
- ensuring more transparent funding decisions by Pharmac
- supporting the use of traditional therapies as part of care planning
- acknowledging the use of complementary therapies as part of care planning
- proactively assessing, treating, and managing patients with long-term conditions.

The plan states that it will assess funding applications for new cancer medicines in parallel with Medsafe's safety assessment process (rather than waiting for Medsafe approval). We understand that this is to reduce the overall time for new cancer medicines to be assessed.

[37] https://www.pharmac.govt.nz/assets/achieving-medicine-access-equity-in-aotearoa-new-zealand-towards-a-theory-of-change.pdf.

This will shorten the time it takes for a cancer medicine to reach Pharmac's list of options for potential funding. However, the plan states that while this change will speed up the assessment process it will not necessarily result in more cancer medicines being funded.

Pharmac's 2018/19 annual review

At its 2018/19 annual review, Pharmac discussed its release of Pharmconnect in August 2019. This is an online tool that can be used by suppliers, clinicians, and consumers to make medicine funding applications.[38] It also allows the public to track the progress of funding applications. We are pleased that Pharmac is improving its processes in regard to funding.

Submitters expressed concern about the time it takes for Pharmac to assess funding applications. Between 2011 and 2017 it took two to three times longer than other OECD countries to make assessments—an average of 512 days compared with 233 days.

Pharmac noted that other countries operate different models for decision-making and funding medicines than New Zealand. For example, the equivalent agency in the United Kingdom is not responsible for funding a medicine that is approved; that is the hospital's role. This means that medicines move through the system more quickly, because the agency does not consider funding. Pharmac believes that the different systems partly explain why there is a perceived "delay" of funding medicines in New Zealand. While it accepts that reducing the application times for medicines is important, Pharmac said there is a limit. Assessments by Pharmac and its subcommittees need a high level of accuracy and DHBs need time to prepare for any changes that Pharmac makes.

Pharmac's decision-making process

We understand that Pharmac uses a framework called "Factors for Consideration" in deciding whether to fund medications or devices. One factor is called "the impact on the health outcomes of population groups experiencing health disparities". In relation to this framework, Pharmac said it considers health disparities to be "avoidable, unnecessary, and unjust differences in the health groups of people". We note that Pharmac also considers the Government's health priorities when deciding on medications to fund. One of the Government's priorities is to have "better population health outcomes supported by a strong and equitable public health and disability system".

We are pleased that Pharmac has recognised health inequities for Māori and the role it can play in improving outcomes. However, despite its stated intention to reduce inequities, we are concerned that it will not achieve this target soon enough. We acknowledge that, as Pharmac contends, its success will be determined by action taken across the entire health and disability system.

[38] https://www.parliament.nz/resource/en-NZ/SCR_96364/0574fffec41ae385e54b3ddc7848fe9b8f47fa12.

6 Improving cultural capability

Mātauranga Māori and primary healthcare

As we briefly discussed above, many submitters said that the health and disability system has been set up by Pākehā for Pākehā and that this is why it does not work for Māori. We heard and agree that Māori should be able to have treatment for cancer that is consistent with their tikanga.

We note that the New Zealand Health and Disability System Review supports mātauranga Māori (the body of traditional knowledge) being embedded in the health system. It states that the health system should recognise the holistic approach to mātauranga Māori as more than just a cultural option. The review maintains that it should be an integral part of the health and disability system.

Several submitters discussed the importance of Māori having continued care with a trusted general practitioner. A general practitioner's medical room is one of the first places that whānau encounter the health and disability system. Therefore, it is crucial that general practitioners are sensitive and responsive to the needs of whānau.

We heard that it is necessary that health practitioners understand the difference in the concept of health between Māori and non-Māori. Māori tend to have a more holistic view of health where different elements contribute to overall health and wellbeing. The Ministry of Health uses te Whare Tapa Whā (the four sided house) as a model to explain Māori health.[39] The four equal sides are symbolic of a wharenui. The sides include: taha tinana (physical health), taha wairua (spiritual health), taha whānau (whānau health), and taha hinengaro (mental health).

During our consideration of this inquiry we were interested to learn of a Pākehā, Horowhenua-based general practitioner who uses a kaupapa Māori approach to healthcare. We heard that the practitioner has a "Māori-friendly clinic" as part of their larger clinic. They said that they try to remove as many barriers as possible for Māori attending appointments and that many of these barriers are due to systemic and socioeconomic issues. We heard that the practitioner sees Māori patients through a "no appointment" system and that patients are able to bring whānau along with them. We heard that the practitioner also ensures staff at the front desk greet patients in te reo Māori. We believe that small changes like this can make a big difference for Māori in how comfortable they feel attending appointments and addressing their health.

[39] https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha.

Other ways primary care workers can improve outcomes

We consider that by recognising and better managing a patient's comorbidities, primary care professionals could improve outcomes. We heard that comorbidities are more common among cancer patients and they affect the outcomes for people with cancer. We were told that Māori have a higher prevalence of comorbidities compared to non-Māori.

Māori are also more likely to live outside main urban centres and more likely to need to travel for cancer care. We heard that simple changes to systems, such as arranging mutually convenient appointment times and aiding access to support services, have increased Māori engagement with healthcare providers, particularly in rural areas.

Kaupapa Māori services

We are aware of kaupapa Māori entities helping Māori through their cancer journey. Some of these were referred to and commended in submissions. We heard about:

- **Te Mauri**: A support group established under Mana Wāhine (a group of Māori health providers from the Wellington region) for whānau experiencing cancer. The group mainly includes wāhine Māori who meet every fortnight for two-hour sessions to discuss their experience of living with cancer.
- **Kia ora E te Iwi**: A cancer education and support programme run by two trained co-facilitators for two hours a week over six weeks, or over two full days. The programme is a kaupapa Māori adaptation of the Cancer Society's Living Well programme. The aim is to help those with cancer and their whānau to:
    - have the confidence to discuss common concerns in a safe setting
    - increase their knowledge of cancer and its treatment
    - increase their knowledge of oncology services
    - develop the confidence to ask questions
    - build on coping skills—practical, emotional, and spiritual
    - learn about support options available and plan for the future.

We also heard about Whānau Ora navigators who support whānau by linking them to appropriate services they need (not just in the health and disability system). In the health and disability system this might include attending appointments with whānau and helping them work their way through a system that is not designed for their needs.

We also heard that Te Putahitanga o Te Waipounamu, the South Island Whānau Ora commissioning agency, also provides support to general practice staff so they receive appropriate cultural training to communicate effectively with Māori.

Throughout our hearings we heard several positive stories about these services and the support they provide for whānau.

Recommendation 13

We recommend to the Government that it establish new kaupapa Māori cancer navigation roles and fund existing ones.

Māori in the health workforce

We heard concern that there is a lack of Māori in the health workforce. Submitters said that Māori are likely to feel more comfortable being treated by other Māori who understand the nuances around tikanga.

Growing the Māori and Pacific health workforce is a focus in the Ministry of Health's Cancer Action Plan (mentioned in more detail below). According to the plan, evidence shows that Māori treating Māori patients results in a better health outcome for those patients. The plan also states that although Māori constitute 15 percent of the population, Māori account for less than 4 percent of the active medical workforce, and less than 7 percent of nursing and allied health workforces. We heard that the ministry is focusing on growing the Māori and Pacific health and disability workforce and creating environments in which they can thrive.

We understand that the University of Otago established the Māori Health Workforce Development Unit in 2010, designed to inspire Māori into health professional courses. It was also designed to guide students through their study and into the workforce.

The development of the unit was hugely successful and Māori now represent 20 percent of the new intake into a Bachelor of Medicine at the University of Otago. We hope that this increase will positively affect health outcomes for Māori in the future.

Recommendation 14

We recommend to the Government that it take measures to increase the number of Māori working in the health and disability system.

Cultural training and awareness

Several submissions discussed the importance of a culturally capable health workforce. Many Māori who made submissions told us stories of unfavourable experiences with health care workers who appeared to have little knowledge of tikanga and how to appropriately respond to their needs. We understand that the standards of cultural competence are regulated by the Health Practitioners Competence Assurance Act 2003 and that an amendment came into effect in April 2019 that requires health practitioners to have cultural competencies allowing them to have an "effective and respectful interaction with Māori".[40] Throughout hearings we heard some positive stories of health staff working effectively with Māori who had made a world of difference to the experience of the patient, and their whānau. Sadly, the majority of submitters told us stories of health staff lacking competency, making whānau more hesitant to engage with the health and disability system.

Some submitters described feeling judged, misunderstood by health practitioners, or talked down to if they did not have a good understanding of the health issues affecting them. We heard that these experiences are not just with health professionals but also health support staff, such as receptionists at the offices of general practitioners.

[40] Health Practitioners Competence Assurance Act 2003.

We are aware of courses, university papers, qualifications, and certificates across health tertiary education that address hauora Māori and cultural competency. We are also aware that some DHBs have best practice tikanga guidelines. However, the fact that we are hearing of the unfavourable experiences of Māori by healthcare staff and that health disparities between Māori and non-Māori are still so vast show there is much more work to be done in this space. We heard that there are variances in what kaupapa Māori best practice information is taught throughout health education. We are concerned that any learnings on appropriately responding and caring for Māori may not be reinforced, revisited, or refreshed once students begin working in the health and disability system. We hope that our recommendations will remedy this concern. We want the next generations of the healthcare workforce to have an extensive understanding of issues that affect Māori compared to non-Māori and believe this is an important stepping stone towards more equitable outcomes.

Recommendations 15, 16, and 17

We recommend to the Government that any tertiary programmes or qualifications on hauora Māori are evaluated to ensure that they are up to standard, well designed, and comprehensive.

We recommend to the Government that healthcare workers (and supporting staff) are required to undergo comprehensive training to ensure they are culturally capable to treat Māori.

We recommend to the Government that healthcare workers undergo accredited cultural safety training as part of their professional development, and that workers be re-assessed annually to retain a medical practising licence.

7 Palliative care

We heard that there are significant issues for Māori with palliative care needs. They include: access to palliative care, communication of diagnosis and prognosis, and understanding of the treatment and support options available.

We heard that the palliative care sector has been derived from Pākehā healthcare models developed in the United Kingdom. We consider that the palliative care sector should be committed to responding to the end-of-life preferences of Māori under principles set by te Tiriti and that Māori need end-of-life services that are suited to tikanga Māori.

Submitters told us that it is often the preference of Māori patients and whānau to undertake end-of-life care at home. However, social and living circumstances can take a heavy toll on whānau supporting someone in need of palliative care. As submitters maintain, whānau is at the centre of te ao Māori and palliative care models need to work for whānau. While caring for whānau at home incurs no cost to the health and disability system, it can incur great cost for whānau. We heard that financial caregiver support does not reflect the work carried out in the home. We also heard that whānau often give up work to care for parents or whānau. This can lead to a period of mounting debt and difficulty returning to the workforce, which can take a serious emotional and financial toll. We also understand that there can be issues for whānau receiving end-of-life care due to systemic barriers mentioned earlier in this report, such as having a lower income, patterns of chronic illness, or unsuitable housing. We consider that a service (or services) like the cancer navigation roles discussed earlier in our report could better meet the needs for Māori in palliative care.

We heard from the Mary Potter Hospice that in the next 20 years the number of deaths in New Zealand is projected to increase by almost 50 percent from the current rate of around 30,000 per year, to 45,000 in 2038. As a result, the need for palliative care is projected to increase between 2016 and 2038 by 37.5 percent in public hospitals, 84.2 percent in aged residential care, and 51.8 percent under hospice care. We were told that this means that Māori deaths are projected to increase from 3,000 to 5,000 a year (a 45 percent increase). We think it is crucial that the health and disability system prepare for the needs of Māori.

The Mary Potter Hospice told us it is the only organisation delivering specialist palliative care to Māori in the Capital and Coast District Health Board (CCDHB) region. We heard that in the year ended 30 June 2019 it received referrals for 56 new Māori patients and that 66 percent had a diagnosis of cancer. The hospice told us that often Māori arrive at the hospice with comorbidities and their cancer in an advanced state. It also said that often Māori arrive deeply affected by their experience elsewhere in the health and disability system.

We think it is important that Māori are provided with end-of-life care that suits their needs and tikanga. The end-of-life journey is a sacred one and Māori should be able to undertake it in a way that makes them feel comfortable, supported, and respected. We note and commend the release of Mauri Mate, a national Māori palliative care framework for hospices.

The framework is the result of a collaborative effort between Te Ohu Rata o Aotearoa (the Māori Medical Practitioners Association), Totara Hospice based in South Auckland, and Mary Potter Hospice in Wellington. It includes guidelines for hospices so that Māori can receive access to good palliative care. We want to see this framework funded and offered throughout the country.

We are aware of research that highlights that many Māori do not know what palliative care services are and how these services can be provided. We consider that a public health campaign would help raise awareness for Māori about the kind of care they can access and increase understanding of the palliative care sector.

Recommendations 18 and 19

We recommend to the Government that it support and fund the implementation and evaluation of Mauri Mate and draw on the framework for service development in the wider palliative care sector.

We recommend to the Government that it fund a public health campaign targeted at Māori (with engagement at a national and local level) to increase their understanding of the palliative care sector. This campaign would aim to raise awareness and improve access to hospice services for Māori.

Appendix

Committee procedure

We met between 6 March 2019 and 5 August 2020 to consider the inquiry. We called for public submissions with a closing date of 20 September 2019. We received 103 submissions from organisations and individuals. We heard evidence in Auckland and Wellington.

Committee members

Rino Tirikatene (Chairperson)
Dan Bidois (until 27 May 2020)
Marama Davidson
Joanne Hayes
Harete Hipango (from 27 May 2020)
Matt King
Adrian Rurawhe
Hon Nicky Wagner
Hon Meka Whaitiri

Advice and evidence received

The documents we received as advice and evidence for this inquiry are available on the Parliament website, www.parliament.nz.

We received advice from independent committee adviser Joseph Stafford.

We received either written or oral submissions from the following individuals and organisations:

Alcohol Healthwatch
Aroha Bray on behalf of Natalie Richards, Meleissa Selwyn and Lydia Rickard
AYA Cancer Network Aotearoa
Cancer Society of New Zealand
Canterbury District Health Board
Chester Penaflor
Chrissy Paul
Christine Hawea
Corina Alipate
Dirt Myster
Ellyn Dean
Faculty of Pain Medicine
Family Planning
Gary Howat
Georgia Smith
Gevana Dean

Graham Howell
Hapai Te Hauora Tapui Limited
Head and Neck Cancer Support Network
Health Coalition Aotearoa
Health Promotion Agency
Hei Ahuru Mowai
Ian Clay
James Parlane
Jean Masters
Julie Nevin
Karen Judith Petley
Lisa Te Paiho
Lung Cancer Screening Project Steering Group (Auckland District Health Board and Waitemata District Health Board)
Lung Foundation New Zealand Inc.
Maori Women's Welfare League Inc
Marewa Glover
Marion Grant
Mary Potter Hospice
Michael Jameson
Miriama Barton
Monique Heke
Nadia Keogh
National Hauora Coalition
Navigate Your Way Trust
New Zealand Federation of Business and Professional Women
New Zealand Māori Council
New Zealand Medical Association
No Nga Hau e Wha (branch of Maori Womens Welfare League)
Pacific Women's Watch New Zealand
Palliative Care Nurses New Zealand; Hospital Palliative Care New Zealand; Hospice New Zealand; Australian and New Zealand Society of Palliative Medicine
Paul Christiansen
Paul Strongman
Phillipa Cunningham
Public Health Association of New Zealand
Public Service Association
Ray Craig
Rebecca Lee
Regional Public Health
Royal Australasian College of Physicians
Royal Australasian College of Surgeons
Smear Your Mea Charitable Trust
STIR Stop Institutional Racism
Stu Sanders
Susan Young

Takiri Mai Te Ata Whanau Ora Collective (TMTA)
Tangihaere Macfarlane
Te Hau Ora O Ngapuhi
Te Mauri
Te Miringa Huriwai
Te Pora Thompson-Evans
Te Puna Ora o Mataatua
Te Putahitanga o Te Waipounamu
Te Runanga o Aotearoa NZNO
Te Tatai Hauora o Hine (Centre for Women's Health Research, Victoria University of Wellington)
Te Whanau O Waipareira
Teresa Goza
The Population Health Directorate of Counties Manukau Health
The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
The Salvation Army New Zealand Fiji Tonga and Samoa Territory
The Whānau Ora Commissioning Agency
Viv Roberts
Waikato District Health Board
Waitemata DHB and Auckland DHB
Wellington Howard League
Whanau Ora Commissioning Agency
Zoe Hayes

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Indicators of District Health Board Performance (IDP) Quarter Four (April – June 2020) Summary

Submitted to

Board Meeting: 23 September2020

Prepared by: Roselle Entwistle – Planning Manager, Planning and Funding

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

Submitted by: Pete Chandler, Chief Executive

RECOMMENDED RESOLUTION:
That the Board receives the following report outlining quarter four (April - June 2020) Indicators of DHB Performance (IDPs) for 2019/2020. This is based on initial ratings provided by the MOH in August 2020.

ATTACHMENTS:
Achievements, Partial Achievements and Not Achieving

MOH initial rating and criteria

Crown Funding Agreement ratings and critera

BACKGROUND:
District Health Boards (DHBs) are required to provide quarterly reports to the Ministry of Health (MOH) under the Crown Funding Agreement (CFA). The reporting includes a number of non-financial measures and qualitative measures agreed with DHBs in their Annual Plans (APs).

Section 13.6 of the Ministry's Operational Policy Framework 2019/20[1] sets out the requirement to provide these reports and the process by which reports are submitted and assessed.

[1] Operational Policy Framework 2019/20

The MOH provides a consolidated assessment of the measures referred to as the Indicators of DHB Performance Report to the Minister of Health. Initial ratings and feedback were received from the Ministry of Health at the end of August 2020.

ANALYSIS:

This section sets out a brief outline of the results, showing highlights and areas for improvement, a summary of the health target results and the Crown Funding Agreement results. The MOH Performance Measures Ratings Report, the CFA (Crown Funding Agreement) Variation Reporting, the Performance Measures Ratings Descriptors and the CFA Variation Ratings Descriptors are set out in Appendices 1, 2 and 3.

This year our analyst has developed an extensive dashboard, in a move to automate reporting and display data in one place. The purpose of this development is that we will be able to monitor change over time, and health equity easily, as well as remove the manual processes in reporting which are hugely time consuming. Where IDP data is available we have been able to get a visual over the results for this quarter. Below is a screenshot of the IDP dashboard where data is available, some is based on Q3 data as Q4 data is not yet available:

IDP	Description	Last period	Target	Last Value	YTD	Equity
CW01	Caries free aged 5	2020-08-01	53.00	42.70	41.62	
CW04	Adolescent dental utilisation	2020-08-01	85.00	60.91	60.93	
CW05	Children are fully immunised at five years of age	2020-08-01	95.00	85.59	85.60	
CW05	Child Immunisation 8M milestone 12M stats	2020-08-01	95.00	85.94	86.00	
CW05	Influenza 65+	2020-07-01	75.00	74.09	74.09	
CW06	Breastfeeding at 6 months	2020-07-01	70.00	72.12	72.12	
CW08	Children are fully immunised at two years of age	2020-08-01	95.00	86.14	86.15	
CW09	Maternal smoking	2019-12-01	90.00	85.71	80.95	
CW10	Percentage of obese children (B4SC) oferred a referral	2020-08-01	95.00	95.00	95.37	
MH05	Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	2020-03-01	100.00	96.11	96.11	
PH03	PHO enrolment	2020-06-01	90.00	96.20	96.20	
PH04	Primary care smoking	2020-06-01	90.00	89.10	89.10	
PV01	Improving breast screening coverage and rescreening	2020-03-01	70.00	73.89	74.44	
PV02	Improving cervical screening coverage	2020-03-01	80.00	78.85	79.12	
SS01	Patients receive their first cancer treatment within 31 days from date of decision-to-treat	2020-06-01	85.00	92.92	90.54	
SS05	Ambulatory sensitive (avoidable) hospital admission 45_64	2020-06-01	3,691.00	3,718.00	3,718.00	
SS10	ED wait times less than 6 hours SS10	2020-06-01	95.00	92.62	91.23	
SS11	Patients with a confirmed diagnosis of cancer who receive their first cancer	2020-06-01	90.00	95.12	95.05	

Where data was not available, the measures have been manually checked with extra information provided on the following pages. This report will be a work in progress as we look to improve and progress reporting systems and processes.

Achieved

Positive results have been achieved in this quarter across the following performance measures. The results are listed below, with some visual displays taken directly from the Quarterly Report:

CW07 – Improving newborn enrolment in GP
Both indicators are over their targets:

New Borns Enrolled by 6 weeks of Age					
DHB of Domicile	Enrolment Rate				
	Annual			Quarterly	
	June 2019	June 2020	Change	June 2020	Qtrly : Annual
Bay of Plenty	76.8%	74.5%	-2.3%	68.1%	0.91

New Borns Enrolled by 3 months of Age					
DHB of Domicile	Enrolment Rate				
	Annual			Quarterly	
	June 2019	June 2020	Change	June 2020	Qtrly : Annual
Bay of Plenty	92.2%	91.9%	-0.4%	88.3%	0.96

CW09 – Better help smokers to quit - Maternity –100% of pregnant women who are smokers were given brief advice and/or support to stop smoking. The total % pregnant smokers in the BOP was 11% (n= 311) which was a decrease from 18/19 by 1% (n=367).

CW12 – Youth mental health initiatives (initiative 3 & 5 only) reported through the SLM plan.

MH01 – Improving health status of people with severe mental illness through improved access

BOPDHB overall access rates remain higher than the national average. This has been an on-going trend. The system wide transformational process that began in 2020 has been inhibited by COVID but is now beginning to gain momentum again with collaboration between stakeholders to develop a Programme leadership and governance structure to support transformation of the system.

MH04 – Mental Health and Addiction Service Development:

FA2 District suicide prevention and postvention: On track

FA3 Improving Crisis Response

The SMO has continued to work in the Acute Care Team in March. Over COVID, changes in procedures to meet infection control needs were implemented to maintain response times.

Business cases for crisis workers in Whakatane (2 FTE) and Tauranga (4 FTE) were approved in December and are now predominantly recruited to. 3 additional FTE that will eventually be recruited to within NGOs to make a collaborative crisis model in the East between NGO and Provider Arm, are being appointed to in Whakatane (making 5 FTE in total) so that a dedicated Crisis Team can be set up for the Eastern Bay.

Mental Health Line has been in place and operational across Eastern and Western Bay of Plenty after hours since 10 December 2019. This continues to be positive.

FA4 Improve outcomes for children:

Expectations have been built into NGO contracts for implementation of essential and best practice SPHC guidelines by June 2020 and these are now incorporated into future audits.

Family Link and Pou Whakaaro are our SPHC providers in WBOP and EBOP respectively, and both have worked with secondary specialist services to implement closer working with our inpatient units to ensure weekly presence in these facilities so that whanau have ready access to these supports. Furthermore, secondary services have worked hard at the development of data capture to both address accurate reflection of whanau involvement in care as well as accurate tracking of this data to guide service improvements.

MH05: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders

	Quarter	For the time period
2020	Quarter 1 (reported 20 October)	197
	Quarter 2 (reported 20 January)	214
	Quarter 3 (reported 20 April)	222
	Quarter 4 (reported 20 July)	218

The focus in BOPDHB is on culturally appropriate practice. Mental Health and Addiction Services are collaborating closely with Māori Health Gains and Development partners to work together on the implementation of the key cornerstones of Te Toi Ahorangi the strategic document focused on a flourishing future for BOP communities. We await the outcome of business cases for additional Te Pou Kōkiri to work in collaboration with the community teams. BOPDHB's Strategic Health Services Plan is driving transformational change of Mental Health and Addictions Services as a priority – the structure of this work is currently in development through collaboration with community partners (NGOs, Primary Care, Lived Experience, Family/Whānau etc).

Initial discussions held with Māori Health Gains and Development in relation to a Cultural Lead role becoming permanent in the MH&AS Cluster Leadership. This role has been in place as a transition role over the last 2 years and we are not looking at creating this to be permanent.

Business Cases for additional Te Pou Kōkiri roles have not been accepted. Collaborating with MHGD on other funding which might be able to be utilised to increase this resource to support our workforce and Tangata Whaiora.

MH06: Improving mental wellbeing -Mental health output Delivery against Plan
BOPDHB continues to utilise accrued FTE to report in order to represent the true cost of services.

PH03 – Access to Care (PHO enrolments) Target 90% Achieved 96.20%
During the 2019/2020 financial year Bay of Plenty District Health Board (BOPDHB) had been using the denominator projected from the 2013 Census. The denominator and numerator (population enrolled in a PHO) had been posted on the Ministry of Health's website each quarter. (https://www.health.govt.nz/our-work/primary-health-care/about-primary-health-organisations/enrolment-primary-health-organisation)

These data indicated that BOPDHB had surpassed the Ministry's PHO enrolment target for its Māori and non-Māori populations over the 2019/2020 DHB financial year.

SS01 – Faster cancer treatment (31 days)
BOPDHB tracking above average to a 89.6% achievement for the 31 Day Indicator.

SS05 – Ambulatory sensitive hospitalisations (ASH adult):
Rates for Maori remain high generally though. It is good to see flu vax having an impact on reducing pneumonia presentations. Outcomes of the COPD programme may be able to be applied to other diseases.

SS07 – Planned Care Measures
The DHB has completed and submitted a number of Planned Care initiatives during the reporting period. These include the Three Year Planned Care Plan, the Planned Care Catch Up Plan (to recover from Covid back log) and a number of Funding Proposals to the MOH for Capital Expenditure and Improvement of Planned Care Pathways.

SS09 – improving quality data:
FA1 NHI: Bay of Plenty are to be congratulated for maintaining NHI data quality in these unprecedented times.
FA3 PRIMHD

SS12 – Engagement & obligations as a Treaty partner:
On track but issues with the way this is reported: This narrative-style of reporting is not an effective monitoring tool. Therefore BOPDHB recommends that the MOH co-develop a reporting template with DHBs before the next reporting period end, to facilitate effective monitoring and accountability of the DHB and the Crown to its legislative obligations and Te Tiriti o Waitangi.

SS13 – Improved mgmt. for long term conditions:
Achieved all groups:
FA1 Long Term Conditions
FA2 Diabetes Services
FA4 Acute heart service

CFA – B4 School Check Funding:

The Ministry recognises that BOPDHB has performed well in B4SC delivery despite the challenges presented by Covid19 and congratulate us on that. Result for Quarter 4 was 79%. Unfortunately the service has been without its co-ordinator role, which is critical to following up on acknowledgements for the target. Replacement in progress; start due in August.

Partially Achieved

SS10 – Shorter stays in Emergency Departments:

The result of 92.6% is >1.5% on Q3 and <0.3% down on last year given the challenges you have had it is good to see you heading in the right direction of meeting the 95% target.

SS11 – Faster Cancer Treatment (62 days)

BOPDHB tracking to a 95.3% achievement for the 62 Day Indicator.

SS15 – Improving waiting times for colonoscopies

Urgents – 113/114 = 100%

Non Urgents – 635/2902 = 21.8%

Surveillance – 384/1575 = 24.4%

Urgents continue to meet the indicator

The period of COVID 19 lockdown and reduced elective procedures clearly has impacted on the result. However even before this the results were only in the high 30 to low 40%. The key factor is volume of demand (referrals) against current capacity. The service is running extra procedure lists when an operator is willing and using locums to cover leave where available. In addition a outsourcing contract for the Eastern Bay has been signed facilitating up to 20 additional scopes per month.

A further large number of colonoscopies is being negotiated with another private provider over a year period. The monthly figure outsourced to them will significant reduce the current waiting list volumes and improve the waiting list indicators.

PH01 – Improving system integration and SLMs

Not achieved: Work within this area progressed well during Q1 and Q2 (as per the quarterly updates) but was suspended from an SLM perspective during the emergence of Covid-19. All goals are ongoing and were updated in the new 20/21 plan.

PH02 – Improving quality of ethnicity data collection in PHO & NHI registers

All PHOs in BOPHDHB received training for the EDAT tool in 17/18 and are in maintenance phase.
BOPDHB recommends the Ministry monitors ethnicity data quality centrally to allow for consistent measurement and benchmarking against high performers. BOPDHB is increasing its focus on ethnicity data quality within hospital datasets and requests that the Hospital Ethnicity Data Audit Tool, which is still sitting in draft with the Ministry, be finalised and released to support this work.

PV01 – Improving breast screening coverage and rescreening

MH – Improving mental wellbeing
It is pleasing to see further improvement in the standard of documentation, other measures are remaining the same. The MOH plan to enhance communication of this and include in our monthly DHB reporting to increase visibility of the information

CFA – Primary Health Care Services
Of the 127 under 6s this quarter, 68 were seen in the Whakatāne GP After Hours clinic, 43 patients were seen in the Opotiki After Hours Medical Hub(between 8pm and 10pm weekdays, and all day weekend,) the remaining 16 patients were seen in early morning clinics (6:45am to 8:00am), run by the practices.

Areas Not Meeting Target or data not available

CW04 –Utilisation of DHB funded dental services by adolescents from school year 9 to 17yrs:
Although utilisation is lower than last year it is good to see that the NHI level data that the Ministry shared with DHBs is helping BOPDHB to identify and contact adolescents who are not accessing dental care. Keep up the good work. *Achieved 68% -target is 85%*

CW05 –Immunisation coverage:

FA1 8-mth old imms coverage-
Total immunisation coverage at eight months has decreased by 0.1 percent this quarter and coverage for Māori children has decreased by 1.5 percent. At age five years the total coverage has decreased by 0.4 percent and coverage for Māori children has decreased 1.2 percent. Your DHB has total coverage of 88.2 percent and Māori coverage of 82.5 percent at age 8 months and total coverage of 88.2 percent and Māori coverage of 84.1 percent at 5 years.

The 3 months to June 2020 has continued to see the benefits of process and system improvement for the 8 month immunisation target coverage; at the Total level and for Māori.
There remains an equity gap in coverage for Maori which is actively monitored; the gap in up for this quarter at 9%, Māori at 83% and Non-Māori at 92%, although there is an improving trend with increasing rates for Maori
Our individual PHO rates are; WBOPPHO 3 months coverage is Total 91%/Maori 86%; EBPHA 87%/Maori 84% and NMO 73%/Maori 71%; showing positive improvement

As part of our improvement we have a strong focus on Missed babies – of which there were a higher number in June – 16 in total; in detail all but one of these missed babies was due to either parental choice to delay, immunisations given at GP practice but after the milestone age, transfers in to BOPDHB already overdue and missed target, children were on catch-up programme so unable to complete by milestone age. Only one missed baby was due to late referral and unable to be contacted prior to milestone.

CW05: FA2 5yr old imms coverage

5 years immunisation coverage shows consistent improvement for the 4 quarters, at the Total level and for Māori
The equity gap for Maori at 8% for 5 yrs cohort; NME 92% and Maori 84% and a key focus for individual practices and B4SC checks process improvement

CW05: FA3 HPV coverage

The HPV Strategic Action Plan was updated and focus areas identified. One objective, for example, was the focus on increasing HPV uptake among Maori youth. To this end we invited a speaker from Auckland University (Dr Natalie Gauld) to share her research on gathering information from young people for the implementation of interventions in different settings ie pharmacies; we also met with the student health nurse at Toi Ohomai on supporting HPV vaccination among tertiary students in the western bay with mobile clinics for satellite campuses in the eastern bay (eg communication resources, vaccinator training, cold chain advice).

Toi Te Ora Public health provided information to Family Planning Services in support of a grant proposal to enable HPV immunisation at local family planning services, and also answered an OIA on HPV vaccination outside the school- based programme.

Despite the COVID-19 lockdown, the school-based vaccination programme completed the delivery of the first dose of HPV for Year 8 students and is planning to complete the second dose before the school year ends.

CW08 – Increased Imms at 2 years

Total immunisation coverage at two years has decreased by 0.4 percent this quarter and coverage for Māori children has decreased by 0.7 percent. National immunisation coverage at age 2 years is still below the 95 percent target and coverage for Māori is 6.8 percent lower than for non-Māori. Your DHB has total coverage of 85.1 percent, Māori coverage of 80.6 percent and Pacific coverage of 92.6 percent at 2 years.

MH03 – Shorter waits for non-urgent mental health and addiction services

Mental Health Provider Arm

	<= 3 weeks		<8 weeks	
Age	target (%)	Achieved (%)	Agreed target (%)	Achieved (%)
0-19	80%	68.1%	95%	91.7%

Addictions (Provider Arm and NGO)

	<= 3 weeks		<8 weeks	
Age	Target (%)	Achieved (%)	Target (%)	Achieved (%)
0-19	80%	73.8%	95%	85.9%

SS17 – Delivery of Whanau Ora
PH04 – Better help for smokers to quit - primary care (Maternity is separate in CW09)
PH – Better population health outcomes supported by primary health care
SS – Better population health outcomes supported by strong and equitable public health services
CW – Improving child wellbeing

Ministry Initial Ratings Q4

Criteria:

Rating	Abbrev	*Criterion*
Outstanding performer/sector leader	**O**	1. Applied in the fourth quarter only—this rating indicates that the DHB achieved a level of performance considerably better than the agreed DHB and/or sector expectations.
Achieved	**A**	1. Deliverable demonstrates targets / expectations have been met in full. 2. In the case of deliverables with multiple requirements, all requirements are met. 3. Data, or a report confirming expectations have been met, has been provided through a mechanism outside the Quarterly Reporting process, and the assessor can confirm.
Partial achievement	**P**	1. Target/expectation not fully met, but the resolution plan satisfies the assessor that the DHB is on track to compliance. 2. A deliverable has been received, but some clarification is required. 3. In the case of deliverables with multi-requirements, where all requirements have not been met at least 50% of the requirements have been achieved.
Not achieved – escalation required	**N**	1. The deliverable is not met. 2. There is no resolution plan if deliverable indicates non-compliance. 3. A resolution plan is included, but it is significantly deficient. 4. A report is provided, but it does not answer the criteria of the performance indicator. 5. There are significant gaps in delivery. 6. It cannot be confirmed that data or a report has been provided through channels other than the quarterly process.

Indicators	MoH Initial Rating
CW04 – Utilisation of DHB funded dental services by adolescents from school year 9 to 17yrs	**N**
CW05 – Immunisation coverage: **FA1** 8-mth old imms coverage	**N**
CW05: **FA2** 5yr old imms coverage	**N**
CW05: **FA3** HPV coverage	**N**
CW07 – Improving newborn enrolment in GP	**P**
CW08 – Increased Imms at 2 years	**N**
CW09 – Better help smokers to quit - Maternity	**A**
CW10 – Raising Healthy Kids	**P**
CW12 – Youth mental health initiatives (initiative 3 & 5 only)	**A**

MH01 – Improving health status of people with severe mental illness through improved access	A
MH02 – Improving mental health services using wellness & transition (discharge) planning	**P**
MH03 – Shorter waits for non-urgent mental health and addiction services	**NR**
MH04 – **Mental Health and Addiction Service Development** **FA1** Primary mental health	**A**
FA2 District suicide prevention and postvention	**A**

FA3 Improving crisis response services	**P**
FA4 Improve outcomes for children	**A**
FA5 Improving employment and physical health needs of people with low prevalence conditions	**A**
MH05 – Reduce the rate of Maori under the Mental Health Act section 29 community treatment orders	**P**
MH06 – Mental health output delivery against plan	**P**

SS01 – Faster cancer treatment (31 days)	**A**
SS02 – Delivery of Regional Service Plans	
SS03 – Ensuring delivery of Service	**NR**
SS04 – Implementing the Healthy Aging Strategy	**P**
SS05 – Ambulatory sensitive hospitalisations (ASH adult)	**A**
SS07 – Planned Care Measures	**NR**
SS08 – Planned Care Three Year Plan	**P**
SS09 – improving quality data: **FA1 NHI**	**A**
FA2 National Collections	**O**
FA3 PRIMHD	**A**
SS10 – Shorter stays in Emergency Departments	**P**

SS11 – Faster Cancer Treatment (62 days)	**N**
SS12 – Engagement & obligations as a Treaty partner	**A**
SS13 – Improved mgmt. for long term conditions **FA1 LTC**	**A**
SS13 – Improved mgmt. for long term conditions **FA2 Diabetes Services**	**A**
SS13 – Improved mgmt. for long term conditions: **FA3 CVD**	**P**
SS13 – Improved mgmt. for long term conditions: **FA4 Acute heart service**	**A**
SS13 – Improved mgmt. for long term conditions: **FA5 Stroke Service**	**P**
SS15 – Improving waiting times for colonoscopies	**P**
SS17 – Delivery of Whanau Ora	**NR**

PH01 – Improving system integration and SLMs	**P**
PH02 – Improving quality of ethnicity data collection in PHO & NHI registers	**P**
PH03 – Access to Care (PHO enrolments)	**O**
PH04 – Better help for smokers to quit - primary care (Maternity is separate in CW09)	**N**

PV01 – Improving breast screening coverage and rescreening	**P**

Part H – Care Capacity Demand Management Calculation (CCDM)	**O**
Indicators	**MoH Initial Rating**
PH – Better population health outcomes supported by primary health care	**N**
SS – Better population health outcomes supported by strong and equitable public health services	**NR**
CW – Improving child wellbeing	**NR**
MH – Improving mental wellbeing	**P**
PV – Improving wellbeing through prevention	**P**

Crown Funding Agreement – Ratings Q4 2019-20:

Category	Abbrev	*Criterion*
Satisfactory	**S**	1. The report is assessed as up to expectations 2. Information as requested has been submitted in full
Further work required	**B**	1. Although the report has been received, clarification is required 2. Some expectations are not fully met
Not Acceptable	**N**	1. There is no report 2. The explanation for no report is not considered valid.

Indicators	MoH Initial Rating
CFA – B4 School Check Funding	**S**
CFA – Disability Support Services (DSS) Funding increase	**S**
CFA – Primary Health Care Services	**B**
CFA – Well Child / Tamariki Ora Services	**B**
CFA - DHB level service component of the National SUDI Prevention Programme	**B**
CFA – Appoint Cancer psychological & social workers	**S**

Chief Executive's Report

This report covers the period 12th August 2020 to 16th September 2020.

1. Chief Executive's Overview

Pete Chandler commenced in post as Chief Executive on 31st August, with the first half of September being focused on the transfer of responsibilities from Simon Everitt, Interim CEO.

During the process of handover, consideration was given to the significant amount of the Interim CEO's time that had been occupied with COVID matters and with new port testing requirements imminent this was set to increase further. Hence Simon is continuing to lead this area of focus at the present time to work with our sector partners in developing a more sustainable and efficient BAU model for testing and management of COVID in the year ahead; the intention is that this will reduce the volatile impact of COVID on senior management and allow progression of our strategic transformation intentions, which have been limited due to capacity constraints over recent months.

With the Board and Executive Team's strong desire to be a transformational organisation, there are a number of step changes that need to be made to reduce the amount of time spent by senior managers on BAU matters, and increase the amount of time spent on progressional and transformational activity. The CEO is currently discussing this with our key healthcare partners with a view to the development of a **transformation hub** which provides a central point for prioritising, sequencing and most importantly executing change not only for the DHB, but to serve and support the wider Bay of Plenty Health System.

As we confirm key transformational activities and timelines these will be reported on in a much clearer way in future Board papers, and a workshop with our Innovation and Improvement team later in September will begin to change how we visualise and share key work which is underway. We acknowledge the critical steer from the **Board workshop** in June and whilst progress to embed the Board priorities has been somewhat hampered by the July-August COVID demands, this work is now proceeding at pace.

Board papers

The process for improving the content and robustness of Board papers is in progress, alongside work on performance dashboards which commenced earlier this year. The production of Board papers is part of a complex interconnected reporting system of many parts, from individual service teams, subject matter experts, through senior management to the Executive. This means that a wide range of people are key to this workstream and over coming months our objective is to provide content which:

- Avoids duplication with single source, rather than multiple authors and entries, on specific topics
- Is clearer, more concise, visually appealing and current
- More appropriately balances future thinking with past reporting
- Reduces unnecessary content but provides access to further information as appropriate
- Is more robust in recommendations and assurances to the Board

Historically, some content for Board papers is arriving very close to the finalisation deadline.

Whilst this means that such information is fresh, it also reduces the ability of the Executive to be able to be clear about what our intentions and plans are in relation to key pieces of information and this is a key issue which will require more advance planning and working through before some submissions are made;

in short this means that as well as re-designing the content, our management planning cycle needs to run 4-6 weeks ahead in some areas to provide the content and quality we are aspiring to. We look forward to ongoing feedback and guidance from the Board in this development phase.

Risk Management

The monthly Executive Committee is now taking a systematic, in-depth look at our top rated risks. This month Risk 75 (Violence against staff) was explored with the input of our new Health and Safety manager and our Risk Co-ordinator. A brief report has been compiled on next steps.

Website

The DHB's website is extremely outdated and due for a major re-design. We have approved this work to progress and intend to use as much internal resource as we can to reduce the cost and the Communications team are preparing time vs cost options for the Executive to review. We would anticipate this to be a 9 month project.

2. News and key events

Privacy Commissioner visit

An informal visit from the Privacy Commissioner this month has formed a helpful relationship connection and enabled discussion about our organisational approach and preparadness for changes to the Privacy Act later this year. We were able to explore potential for the Commission's privacy training to be integrated into our own online training programmes and ensure we are well connected with the forthcoming Privacy Week awareness campaign.

Ngai te Rangi Visit

On 15 September the Executive Committee was visted by a group from Whareroa Marae who presented passionately on the challenges faced by the surrounding industrialisation. They outlined details of the resident community on the Marae and the concerns that the community have about their health and wellbeing. Ngai te Rangi have appealed to us as the DHB, along with appeals to other State Sector agencies to support the improvement of the local environment for both themselves and other nearby residents. As a DHB we need to form an agreed position on this and it is proposed to therefore explore Ngai te Rangi's strategic proposals in the next CPHAC/DSAC Committee to establish our own position statement.

Annual Planning

The 2020-21 Annual Plan has been signed by the Board and submitted to the MOH for ministerial sign off. A copy of the final plan has been made available in Stellar for Board members reference and we have been advised that we should be in the next tranch for Ministerial approval.

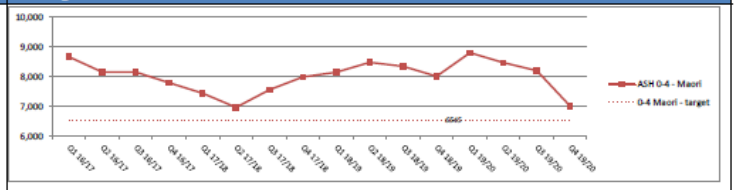
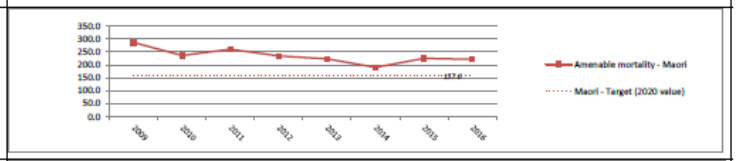
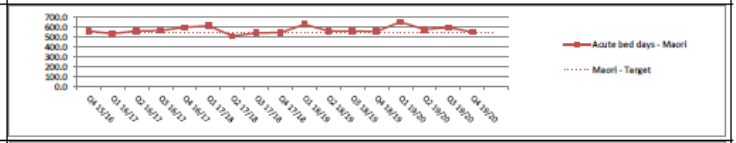
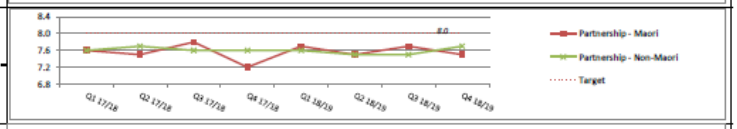
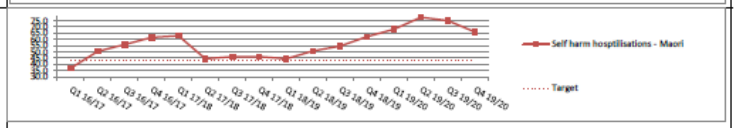
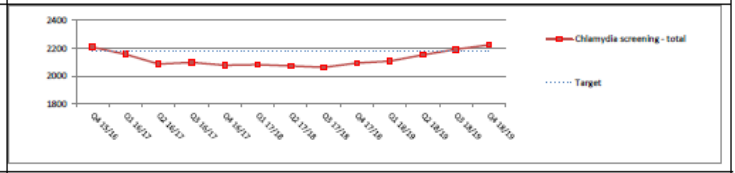
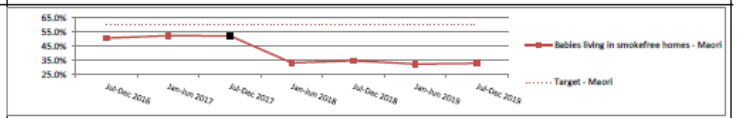
Other planning activities include the upcoming submission of the Planned Care Improvement Plan including funding proposals that all DHBs are making bids for to develop new planned care pathways.

The Bay of Plenty Health System Level Measures for 2020/2021 have now been formalised by the BOP Alliance Leadership Team and approved by the Ministry of Health. System Level measures provide a way of measuring how effectively the various parts of the health system are working together to improve health outcomes and therefore these are important indicators for us.

For the Board's reference, the specific measures are included below along with historic tracking of our collective performance.

The Executive team will now be working through the operational relationship of the Annual Plan, System level Measures and other key indicators of performance for the year ahead and aim to consolidate these into our dashboard. This activity, linking to the re-cutting of our Strategic Priorities and the Board Strategy Day outcomes are part of a mutli-faceted piece of work which will itself trigger a new approach to execution which will be more robust and connected than in previous years.

Headline System Level Measures for 2020-21

System Level Measure	Baseline	Target	Current	Status	Trending
0-4 ASH Milestone: Reduce rates of Maori 0-4 ASH to 6,545 (current national average for the total population at time of print) by 30 June 2019 *Clinical lead: TBA* *Operational lead: TBA*	Māori: 7,183	6,545	*8,812*	R	
Amenable Mortality Milestone: 30% reduction in standardised amenable mortality rates for Maori by 30 June 2023 *Clinical lead: TBA* *Operational lead: TBA*	Māori: 225.2	157.6	*221.3*	R	
Acute Bed Days Milestone: 5% reduction in standardised acute bed days for Maori by 30 June 2019 *Clinical lead: TBA* *Operational lead: TBA*	Maori: 577.3	548.4	*560*	A	
Patient Experience Milestone: We will achieve 8 or more for participation in the primary care PES for Maori and non-Maori by 30 June 2019 *Clinical lead: TBA* *Operational lead: TBA*	Maori: 7.6	8.0	*7.7*	A	
	Non-Maori: 7.6	8.0	*7.5*	A	
Youth Health - *Youth (10-24) age-standardised self-harm hospitalisation rates per 10,000 population* Milestone: A 5% reduction in age-standardised self-harm hospitalisation rates for Maori	Maori: 45.9	43.6	*68.0*	R	
Youth Health - *Chlamydia testing coverage (per 100,000 pop.)* Milestone: A 5% increase in chlamydia testing coverage for youth by 30 June 2019 *Clinical lead: TBA* *Operational lead: TBA*	2074.25	2178	*2225*	G	
Babies living in Smokefree Households Milestone: 60% of Maori babies will live in smokefree households by 30 June 2018 *Clinical lead: TBA* *Operational lead:TBA*	52.3%	60.0%	*32.5%*	R	

R: The current result is 10% or more from target; A: The current result is within 10% of target; G: The result is equal to or exceeds the target set

Maternal and Infant Health

Toi Te Ora supported the two successful virtual Latch On events which were held on World Breastfeeding Day (31 July) and received positive media coverage. Both community celebrations are the result of collaboration between multiple providers.

- The Eastern Bay latch on included 11 participating māmā and 12 local service providers were represented, with an opportunity to hear about local services and many sponsored prizes.

  The event was supported by Plunket Whakatāne, Hapainga Stop Smoking Service, Te Pou Oranga o Whakatōhea Social & Health Services, Te Puna Ora o Mātaatua, Eastbay REAP, Eastern Bay Primary Health Alliance, BOPDHB Oral Health, Te Tohu o te Ora o Ngati Awa (Whakamanahia te Waiū -Breastfeeding Support), Tuhoe Hauora and The Lactation Station.
- In the Western Bay WBOP 26 māmā participated and 6 local service providers were represented including Nga Kakano (Māmā Maia Breastfeeding Service), Plunket, Pēpi Ora (Te Manu Toroa), Western Bay PHO and La Leche League.

The Healthy Pregnancies' Education Day for midwives and tamariki ora providers has been rescheduled for Friday 16 October. Planning is underway with four keynote speakers confirmed to attend.

Healthy Active Learning Service (schools and early learning service)

Toi Te Ora, alongside Ohana Kindergarten, delivered an interactive presentation for staff and whānau on healthy eating as part of their Matariki Celebration programme. The presentation covered a range of relevant topics including the current food environment and how it has affected children's health status, the four food groups, an interactive label reading session, the Ministry of Health's Healthy Food and Drink Guidelines and examples of healthy lunchboxes. All present completed an evaluation form and positive feedback was received.

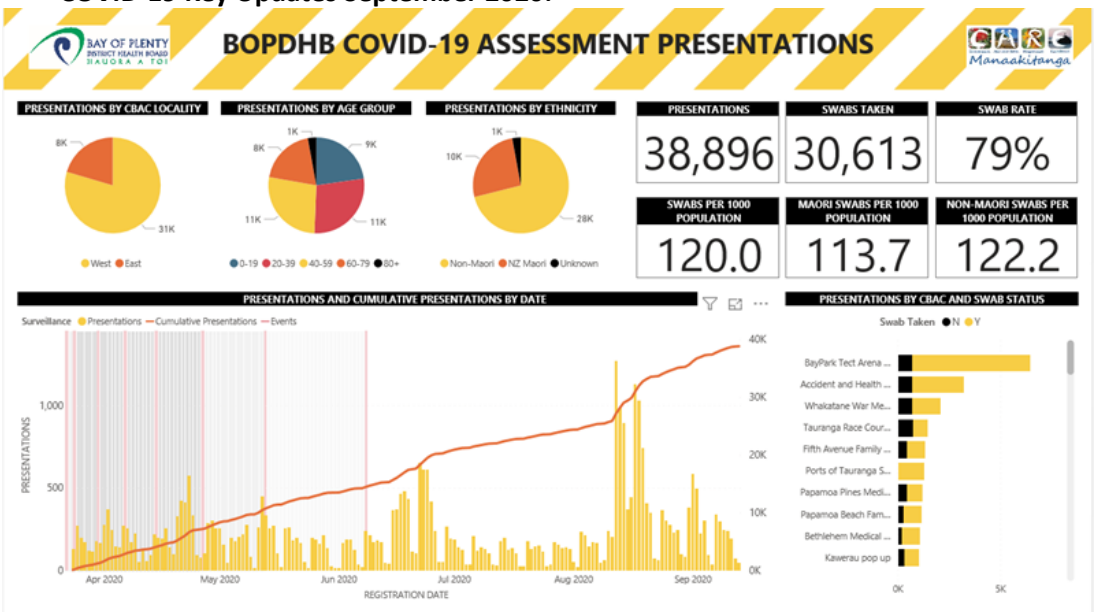
The Toi Te Ora Healthy Active Learning advisors have made contact with 17 schools across the region (Taupō, Eastern and Western Bay of Plenty) to introduce the service and arrange a time to discuss further with the schools' leadership.

Building Blocks for Under 5s

The Building Blocks online tool development is progressing well with all website content completed and with the Communications Advisor and Medical Officer of Health for approval. Over the next month the branding will be finalised, a photo shoot completed at two local Early Learning Services, and the development of the home page. The two new blocks: Engaging with Nature and Mental Wellbeing have been drafted and will be shared with some Early Learning Services for feedback over the coming months before being included in the online tool.

2.1 COVID

COVID-19 Key Updates September 2020:



Key Developments for the month

- The Bay of Plenty remains in alert level 2 and has no active cases in its region.
- Implementation of a new sustainable Port testing service which is a Joint Ventrure between Western Bay of Plenty PHO and Ngati Ranganui. This service commenced 14th September 2020 and will ensure ongoing compliance with all Port Order and Maritime Order requirements.
- The DHB is completing approximately 200 symptomatic tests for COVID-19 across the BOPDHB region daily through its general practice and kauapapa Maori provider network. Pahi Tahi mobile services also continue across the BOP.

For example in the Eastern Bay in the last week mobile services were provided to KFL forestry, at the Kawerau recreation hall and to Kawerau Kaumatua.

- PPE revisded guidelines have been issued which will see more community providers paying for their own PPE. The DHB is working through the new guidlines and impacts on providers with a view to implementation of the new guidelines from 1 October. To give a sense of the PPE continuing to be issued by the DHB in the past week, please refer to the following table (previous week figure in black in brackets):

Aprons x 1350 (1750)	Gloves x 238 boxes (207)	Goggles/ Shield x 82 (42)	Gowns x 110 (pack 10) (106)
Handwash x 108 (60)	Swabs x 693 (1140)	Masks x 293 (pack 50) (186)	Surface wipes x 90 (54)

- We are currently looking at the letter of agreement for community testing with Primary Care which will include a new asymptomatic testing category. The current letter of agreement expires at the end of September.
- Community health staff from BOPDHB are still supporting Lakes DHB, primarily with swabbing in CBACs. We are currently discussing whether they can now be released back to their normal roles given the current alert levels and lack of cases across our regions.
- Despite good progress, the Microsoft Modern Workplace Project is having to adjust to the impact of COVID-19 with some of the planned changes being paused to ensure service needs are not adversely impacted by technology upgrades during this time.

Emergency Management – COVID Response and Recovery

The Emergency Management team are embedded into the COVID response planning and delivery activities including:

- Changes to DHB Pandemic Plan – the issues encountered with COVID are being used to update the DHB's existing pandemic plan as COVID and/or influenza are not the only threats faced.
- Te Manawa Taki Regional COVID-19 Surge planning is underway with DHBs working together to plan for response to further outbreak within the region.
- Second wave response – Emergency Management team members are embedded into the reactivated Emergency Operations Centre. Team members are covering roles of EOC Manager, psychosocial support co-ordination, and Civil Defence liaison

Communications

COVID-19 remains the key focus for the Communications team. The collaborative activities implemented with Lakes DHB during the first response have been re-instituted including common COVID website and publishing a panui for stakeholders.

With the shift to COVID-19 Alert Level 2 there has been a focus on improving communications for patients, families and staff with new signage developed and the widespread distribution of the QR code resource to support the national tracing application.

Provider Arm

COVID re-emergence of community transmission in New Zealand has required a ramping up of our EOC; community, Toi Te Ora and hospitals response teams. The joint BOP, Lakes and Toi Te Ora response team, our primary care providers, PHO's, Pathlab and the Integrated Operations Centre has been key in the co-ordination of the current response.

Testing and surveillance has been the main focus of this activity with port staff and healthcare workers being a priority. This increased testing and contact tracing required has involved a reasonable number of staff from both primary and secondary services and has impacted on the ability to fully deliver some of the public health school based programmes this month. In addition some BOPDHB staff are supporting Auckland DHB with contact tracing and tracking.

Hospital planned care operations have continued to be scheduled and completed as clinical need indicates and ambulatory services continue to be scheduled and provided with the change being that non-contact assessments are encouraged rather than face to face where possible.

Planned care activity has not been interrupted by the current Covid level 2 situation. However the relentless series of external factors interrupting the DHB's ability to provide planned care , commencing July 2018 with the nursing strike, together with a growing population, has resulted in an expectation that it will take at least 18 months for the DHB to meet the 4 month waiting times target for all services.

2.2 Communications

Top social media postings for each month will be included in future Board papers to help inform our approach to sharing information and engaging more successfully with our communities. The below table shows our most viewed five postings:

Post Message	Type	Posted	Lifetime Post Total Reach	Lifetime Engaged Users
Tauranga and Whakatāne Hospitals will be extremely busy over the next 24 hours with high numbers of patients arriving for treatment. Senior Manager on call Dr Sarah Mitchell asks that people who are unwell phone their GP first. After hours those calls are redirected to a registered nurse for health advice. Alternatively people can phone the HealthLine 0800 358 5453 or go to www.healthline.govt.nz, for free health advice. Also after hours (accident and healthcare) the 2nd Avenue Medical Centre, Tauranga; is open 8am-9pm every day of the year, no appointment is necessary. For life threatening conditions, severe or rapidly worsening symptoms, or major injuries, please call 111 or go to your nearest Emergency Department. #BOPDHB #TaurangaHospital #WhakataneHospital	Photo	8/9/20 11:36 pm	62452	17041
Yesterday the BOPDHB posted on Facebook that it was receiving unprecedented numbers of people coming to the Emergency Departments at both Tauranga and Whakatāne Hospitals, and asked people to go to their GP or use the Healthline 0800 358 5453 before coming to hospital. The statement was released as both hospitals were full to capacity. Winter Sundays and Mondays are normally busy in both hospitals. However last Sunday and Monday we received higher than normal numbers of presentations.	Photo	8/10/20 6:51 pm	6667	786

The reasons for this unprecedented demand was the cumulative effect of patients presenting with a wide range of winter illnesses (not COVID nor the flu); many of the people coming into our Emergency Departments were older people with complex health issues, and this resulted in the admission rates from the Emergency Departments into hospital wards, higher than normal. The situation was the result of increased demand on already particularly busy hospitals. The BOPDHB has a backlog of elective surgery and while we are continuing to maximise our own theatre capacity and work with private providers to reduce the waiting times for our patients, we have had to defer some elective surgeries to take pressure off the hospitals this week. We continue to be in contact with those patients who are experiencing delays and apologise for any inconvenience this creates for our patients. We thank people for understanding the situation and helping us work through an unprecedented situation while ensuring that our patients and staff remain safe. Dr Hugh Lees BOPDHB Medical Director #BOPDHB #TaurangaHospital #WhakataneHospital				
Level 2 Reminders - Help keep your whānau and community safe! Make sure you do your bit by keeping up to date on Level 2 guidelines. For up-to-date BOP and Lakes COVID-19 information visit: https://covid19.bopdhb.govt.nz/ #BOPCOVID19 #BOPDHB #LakesDHB #ToiTeOra	Photo	8/14/20 11:35 pm	5256	257
There has been a lot of misinformation circulating on Facebook about whether there is a charge for COVID-19 tests. Testing is FREE for those presenting with symptoms or those who require testing because they have been identified as a close contact or have received a directive from the Ministry of Health to get tested. This is the case with the Port of Tauranga testing taking place from tomorrow. If you are a worker at the port of Tauranga, an onsite testing centre is being set up. Your employer will contact you directly to advise your time slot. #GovtFunded #Free #BOPCOVID19 #BOPDHB #LakesDHB #ToiTeOra	Photo	8/15/20 11:19 pm	4083	209
The head of the country's National Burn Centre has passed on a message of gratitude to Whakatāne Hospital staff from Whakaari/White Island survivors who 'you moved heaven and earth' to keep alive. National Burn Centre Clinical Leader and Plastics Surgeon Dr Richard Wong She yesterday visited the hospital along with National Burn Service Coordinator Tracey Perrett, Burn Governance Group Chair Dr Mark Moores and a group of burns specialists who treated patients from the December 9 2019 eruption. Read our full story here http://ow.ly/hP3G50AT8lb #BOPDHB #WhakataneHospital	Photo	8/6/20 11:00 pm	3852	344

Marama Tauranga (Ngāti Maniapoto, Tainui, Taranaki) has been appointed as the new Manukura - Executive Director Toi Ora at Bay of Plenty District Health Board. A powhiri was organised last month by Te Rūnanga Hauora Māori o Te Moana a Toi along with tāngata whenua of Tauranga Moana to officially recognise her appointment. Marama brings of wealth of experience with her, having previously held roles as the Bay of Plenty District Health Board's Health Equity Manager and Tauranga Hospital ED Clinical Nurse Manager. Read our full story here http://ow.ly/uHBU50AT9tg #BOPDHB #TeToiAhorangi	Photo	8/6/20 10:30 pm	3777	445

3. Our People

3.1 Senior management changes

Executive Director P&C Recruitment Update

The preferred candidate for the role of Executive Director P&C has accepted the DHBs offer and will be taking up the role towards the end of November after working out a 3 month notice period with his current employer.

It is intended to revisit the People & Culture review outcomes and recommendations of last year with particular focus on the recommendation to phase in the new role to being a direct report of the Chief Executive.

Head of Department (HOD) / Leadership Review

The current round of HOD appointments is complete. Positive feedback was received re process and selection, an included a comment that it was "pleasing to see women are well represented and at least two HODs identify as Māori".

These are our current HODs:

Dr Heidi Omundsen	HOD Anaesthesia & Pain Management
Dr Jonathan Tisch	HOD Cardiology
Dr Rudi Johnson	HOD Dental/Maxillo-Facial
Dr Dinaz Irani	HOD ENT
Dr Alex Lampen-Smith	HOD Gastroenterology
Dr Pierre de Villiers	HOD General Medicine
Dr Barnaby Smith	HOD General Surgery
Dr Mohana Maddula	HOD Health in Aging
Dr Vicki Higson	HOD ICU
Dr Penelope Makepeace	HOD O&G
Dr Richard North	HOD Oncology/Haematology
Dr Vaughan Poutewera	HOD Orthopaedics
Dr Vivienne Hobbs	HOD Paediatrics
Dr Suzanne Poole	HOD Respiratory Medicine

The HOD changes include a fixed term of three years and will enable us to grow in distributive clinical leadership. Workshops to support and equip the new HODs are being prepared and we are thrilled to have such an energetic group of doctors wanting to be part of shaping the future of care delivery in the Bay.

Hugh Lees retirement

Dr Lees will be retiring in October after a highly regarded career serving the Bay of Plenty. Careful consideration is being given to the next iteration of this role, with feedback being sought from ASMS, PHOs and our medical and leadership workforce on changes that would be beneficial. We have had excellent feedback and this is currently being reviewed as part of the revised job design.

Advertising will commence in October, with an interim position being planned whilst the recruitment phase is underway.

Business leader resignation

Our Business leader for the Medical Cluster will be leaving the DHB before Christmas as his family is relocating. With other interim positions as a result of the CEO appointment, this provides an opportunity to consider the future structure of the Provider Arm with a view on the recommendations of the Health and Disability review and our aspirations for a more connected Bay of Plenty Health System. Consideration is at an early stage of exploration.

3.2 Education and Training

The Education, Library and Online Learning teams have started the pilot of a workflow coaching programme that has come recommended from Taranaki DHB. This is part of our work towards business redesign and a way of ensuring the team is working the most efficiently and effectively as possible with increased workloads. It's a programme over nine weeks with a mix of group sessions and one-on-one. We are trialling this being all through video conference with no need for the presenter to travel to Tauranga. If this is successful, the Education Manager will prepare a proposal for it to be rolled out in other teams across the hospital, particularly for teams with a heavy administrative workload.

The Education Manger is working on a proposal with HealthShare for a shared Instructional Designer resource for the midland region. This would contribute to collaboration and consistency across the region for the development of online modules on Te Whāriki a Toi. This is a significant step to return to Midland regional collaboration which changed when the other Midlands DHBs opted for Ko Awatea instead of the shared Midland platform.

Linda Hutchings Leadership Programmes are starting to get up and running again after being on hiatus over Covid-19 lockdown and winter. While there have been a number of people who have since withdrawn, we are filling the spaces.

The Aged Residential Care Education project manager is currently information gathering and meeting with a range of staff from different facilities, from Health Care Assistants, Registered Nurses and Facility Managers. By the end of October, a proposal will be provided on the best ways for the DHB and PHOs to provide education to this sector. This involves conversations with the Waikato DHB team who have produced http://www.inspiringpeople.co.nz/

The Digital Capability Trainers continue to be heavily involved with the roll out of Microsoft Modern Workplace Programme, with the majority of their days being taken up by floorwalking and one-on-one support when there are deployments happening.

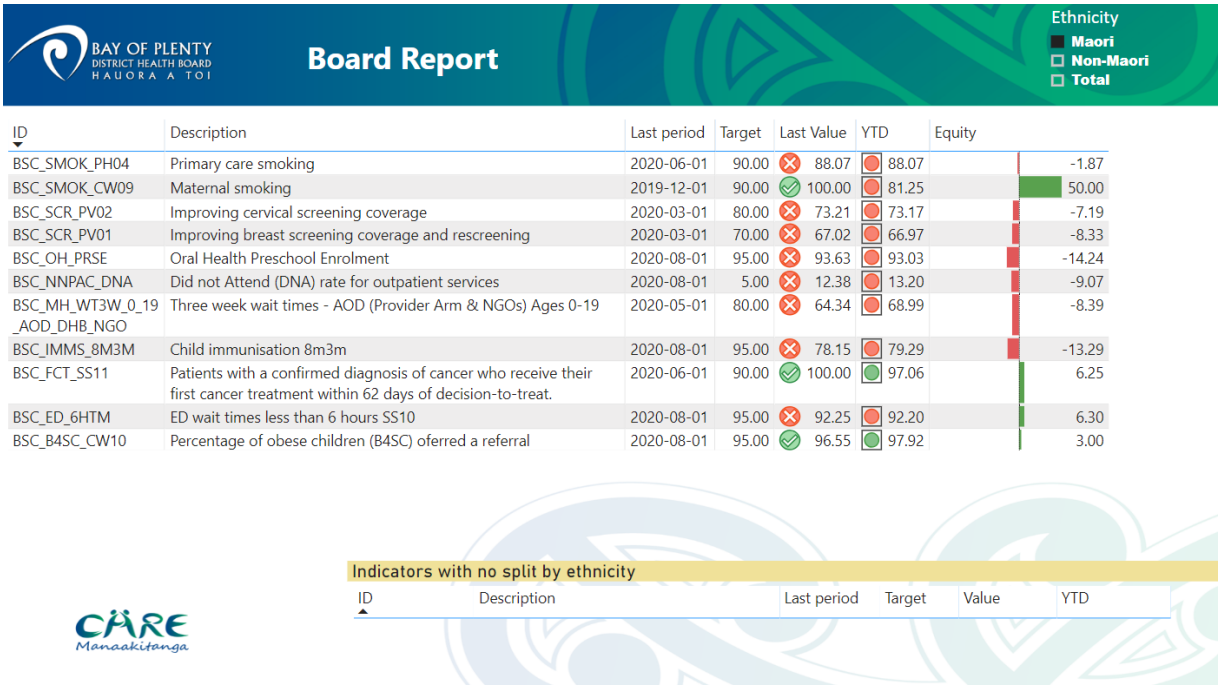
They follow up the next week to pick up on more queries. Planning is underway for the best way to connect with people after the deployment.

The implementation of the new library system has been going well with a positive response from library users who can now manage their use of the library much more comprehensively. We have had 207 DHB staff sign up so far plus a few students on placement (17) and community practitioners (8).

We are working to offer a series of in-depth sessions on effective engagement via video conference, after the success of the Grand Round with Miriam Chancellor.

4. Bay of Plenty Health System Performance

Our new dashboards, which have been part of our development work over recent months, are beginning to be released and an opportunity to walk through these in detail is provided in a session at the end of the Board meeting. The below is an extract from the session and future Board reports will include performance highlights as agreed with the Board.



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	2019-12-01	90.00	100.00	81.25	50.00
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	2020-08-01	95.00	93.63	93.03	-14.24
BSC_NNPAC_DNA	Did not Attend (DNA) rate for outpatient services	2020-08-01	5.00	12.38	13.20	-9.07
BSC_MH_WT3W_0_19_AOD_DHB_NGO	Three week wait times - AOD (Provider Arm & NGOs) Ages 0-19	2020-05-01	80.00	64.34	68.99	-8.39
BSC_IMMS_8M3M	Child immunisation 8m3m	2020-08-01	95.00	78.15	79.29	-13.29
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	2020-08-01	95.00	92.25	92.20	6.30
BSC_B4SC_CW10	Percentage of obese children (B4SC) oferred a referral	2020-08-01	95.00	96.55	97.92	3.00

5. Financial Performance

DHBs are required to report showing impact of COVID and Holidays Act separate from the "business as usual" results. As per MoH instruction, the DHB's Annual Plan excludes any budgeted financial impact for COVID so reporting has to recognise the actual impact as a variance for explanation.

The "business as usual" year to date position of $516k adverse is a sharp turnaround from the $146k positive variance at end of July – a $662 deterioration.

6. Bay of Plenty Health System Transformation

Innovation + Improvement Programme Office overview

A number of the Innovation and Improvement team have been involved in supporting the DHB's covid-19 response and these efforts have been broad ranging – from leading efforts in the EOC; working with hospital teams to mobilise their plans; providing clinical leadership; helping the PHOs and Iwi providers to manage community testing and the port response, supporting Portfolio Managers with their provider networks like ARC, HBSS, Palliative Care; managing communications with primary care and pharmacy; keeping people in the loop; responding to increases in demand for services like BOP Community Care Co-ordination; setting up the tech for the port testing teams; and supporting the upsurge in telehealth.

It has been impressive how everyone has mobilised again, quickly identified the needs and established the workstreams, with collaboration working well across the sector.

A strategic session with the CEO is being held late in September to determine how we balance the input to COVID activity and best support other pressing transformational activity.

6.1 DHB Operating System

Integrated Operations Centre (IOC)

The ongoing development of the IOC to become the central hub for optimising patient flow is progressing. Recruitment for the IOC manager is underway; long length of stay reviews; and completing the red and green bed day process at Tauranga Hospital occurred this month.(Red days are those days where there is no value for patients to be in hospital).

Whakatane Hospital patient flow Standard Operating Procedures have been revised and published and the perioperative team and Medical Daystay at Tauranga are working with the IOC around providing information that will support improving efficiency.

6.2 Digital Transformation

Midland Clinical Portal
This major regional programme is reaching the next major delivery point – go live of the core scope at BOPDHB on 28/29 September. This is the culmination of months of planning, development, testing and training and the regional and BOPDHB teams are heavily involved in resolving the final issues to ensure that BOPDHB can go live with as much confidence as possible. BOP will be the first DHB in Midland to go live and this project provides a launch pad for future digital health records advancements and a mechanism for enabling greater visibility across health providers of patient care records.

To provide context over 2.1 million patient records have been loaded by the BOP team encompassing every inpatient encounter and Emergency Dept attendance dating back to the beginning of 1999. The upload of a further 4.6 million outpatient records should be completed by mid-September.

Information Management - Microsoft Modern Workplace
After Midland Clinical Portal, the Microsoft Modern Workplace is the largest programme of work currently underway within the Information Management service. The programme transitions the DHB onto the latest Microsoft enterprise level cloud based operating systems and Office applications and will be the foundation for enhanced workplace automation and mobile enablement whilst also enabling future adoption of modern technologies. By the end of August, approx. 1450 of the 3000 desktop, laptop and tablet devices had been upgraded (approx. 48%), compared to 400 devices at the end of July.
Despite this good progress, the project is having to adjust to the impact of COVID with some of the planned changes being paused to ensure service needs are not adversely impacted by technology upgrades during this time

Confidence levels around this project are currently assessed as "***Medium***" due to the technical complexity and the COVID environment being catered for.

6.3 Mental Health and Addictions Services

MICAMHS Redevelopment
The move of the Adolescent, SORTED and Duty teams to 290 Cameron Road occurred this month. This is part of the re-invetion of our MICAMHS service which we aspire to move into a whole of system model and further information will come to the Board on this approach in due course.

The Nurse Leader has taken on the Acting Service Manager Role for MICAMHS to ensure senior clinical support to the team and to continue relationship building for the service development.

Health Quality Safety Commission (HQSC) Visit
HQSC visited BOPDHB to discuss opportunities and to offer support to improve equity for Māori.

A new contract has been signed with the MOH to support improving capability of Crisis Support. Initial meetings with stakeholders – ED, MH&AS, and Consumers across both sites have been held to scope ideas about this project.

Suicide Prevention + Postvention
On 21 August the annual provisional suicide statistics were released by the Chief Coroner. In the year to 30 June 2020, 654 people died by suicide, compared to 685 the year before – a decrease of 31 deaths, and a drop in the suicide rate from 13.93 deaths per 100,000 to 13.01.

There was a decrease in the number of young people dying by suspected suicide, particularly in the 15-19 age range (down from 73 to 59) and the 20-24 age range (down from 91 to 60). Both rates decreased from 23.14 to 18.69 and from 26.87 to 17.77 respectively. However, there was an increase in suspected suicides in the 80-84 age range, with 12 more people dying by suicide in the past year (18) than the year before (6). The rate increased from 6.49 to 19.48.

The Māori and Pacific Island suspected suicide rates both decreased over the past year, from 21.78 to 20.24 and from 8.91 to 7.07 respectively. The European rate also dropped from 13.02 to 12.08. However, the Asian rate went up from 5.09 to 7.91 – an increase of 20 deaths.

At a glance, in the year to 30 June 2020 the BOPDHB region recorded 36 provisional suicide deaths, same as in the previous year. As reflected in the national figures we also saw a reduction in the number of youth suicides, particularly in the 20-24 age cohort. Number of provisional suicide deaths for Māori and Pacific Island have also reduced.

The SPC is currently working with the I&I analyst to produce an updated statistical report on BOPDHB suicide data.

6.4 Integrated Healthcare

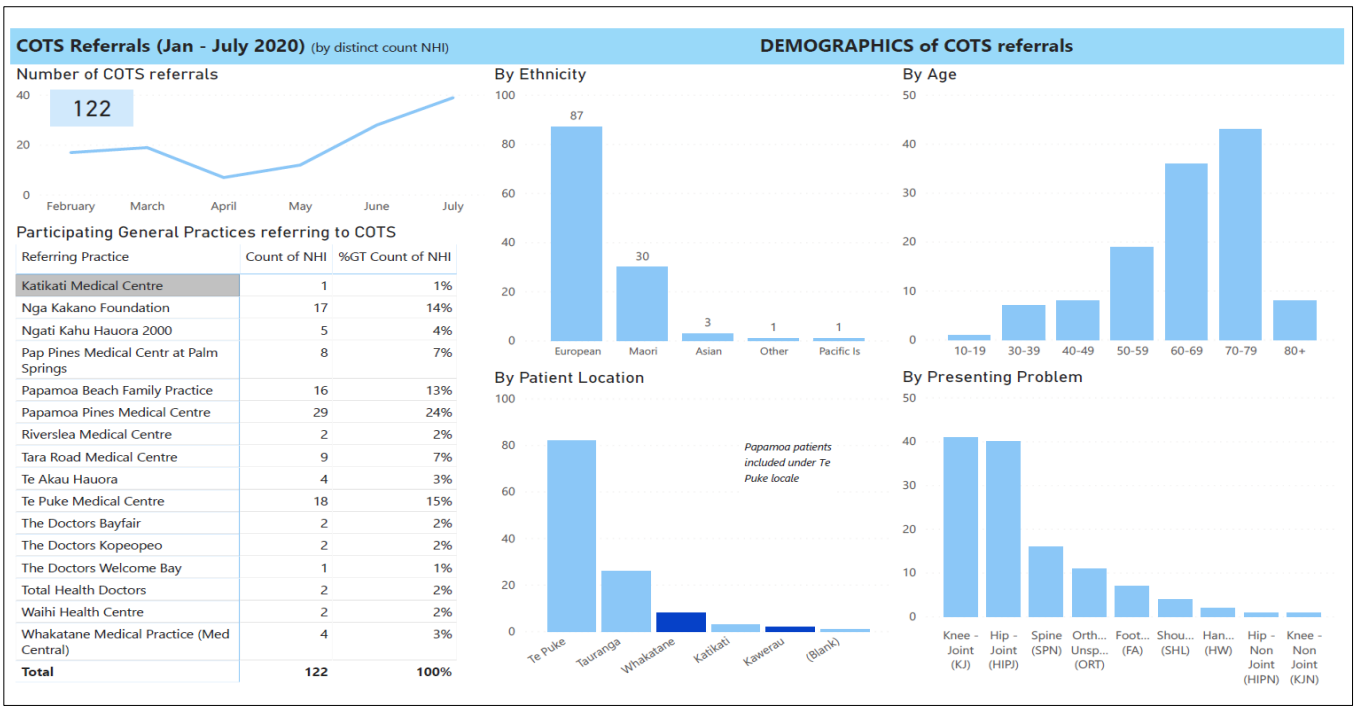
Orthopaedic Transformation Programme

This is one of our Gold Star programmes of clinical transformation which is a sector leading initiative. There are three strands of work within this programme:

1) <u>Community Orthopaedic Triaging Servicing (COTS)</u>

   This pilot has expanded to six Eastern Bay based General Practices. There are now 16 participating GP practices covering Te Puke, Papamoa, Whakatane, Ohope and Taneatua.

   The following newly developed COTS activity reports captures real time activity of the project, enables the project team to closely monitor the service and projects measures with confidence that the data is accurate.
   There has been a 44% increase in COTS referral volumes from June to July.



Participating General Practices referring to COTS

Referring Practice	Count of NHI	%GT Count of NHI
Katikati Medical Centre	1	1%
Nga Kakano Foundation	17	14%
Ngati Kahu Hauora 2000	5	4%
Pap Pines Medical Centr at Palm Springs	8	7%
Papamoa Beach Family Practice	16	13%
Papamoa Pines Medical Centre	29	24%
Riverslea Medical Centre	2	2%
Tara Road Medical Centre	9	7%
Te Akau Hauora	4	3%
Te Puke Medical Centre	18	15%
The Doctors Bayfair	2	2%
The Doctors Kopeopeo	2	2%
The Doctors Welcome Bay	1	1%
Total Health Doctors	2	2%
Waihi Health Centre	2	2%
Whakatane Medical Practice (Med Central)	4	3%
Total	**122**	**100%**

2) Musculoskeletal Emergency Department (ED) Project

Providing physiotherapists in ED managing triage 4 and 5 patients presenting with frailty and musculoskeletal (MSK) conditions is now a seven days week service across both hospital sites. Physiotherapists now see approximately 50% of the total presentations of triage 4/5 MSK presentations with the intent to increase this to 90%.

Health Round Table (HRT) data consistently placed the BOPDHB as an outlier for spinal and back pain admissions from ED. Tauranga is no longer in the top five DHB outliers on this HRT measure. This change coincides with the new physiotherapy triage roles in ED. The following tables summarise current activity.

Total triage 4 and 5 MSK patients seen by MSK physio in ED (Feb-July 2020)	349
Total patients admitted after seen by MSK physio in ED	16 (4.5%)
Number of patients imaged (after MSK Physio Assessment)	172 (49%)
Number of +ve imaging results	62 (36%)
Number of cases escalated to medical team	25

Admitted % triage 4&5 MSK presentations:

2018	25%
2019	12.4%
Triaged by Physio in ED (Feb-July 2020)	4.5%

3) Orthopaedic Inpatient Ankle/Foot Pathway Project

This project focuses on decreasing the length of stay by reducing barriers for discharge for elective foot and ankle surgery.

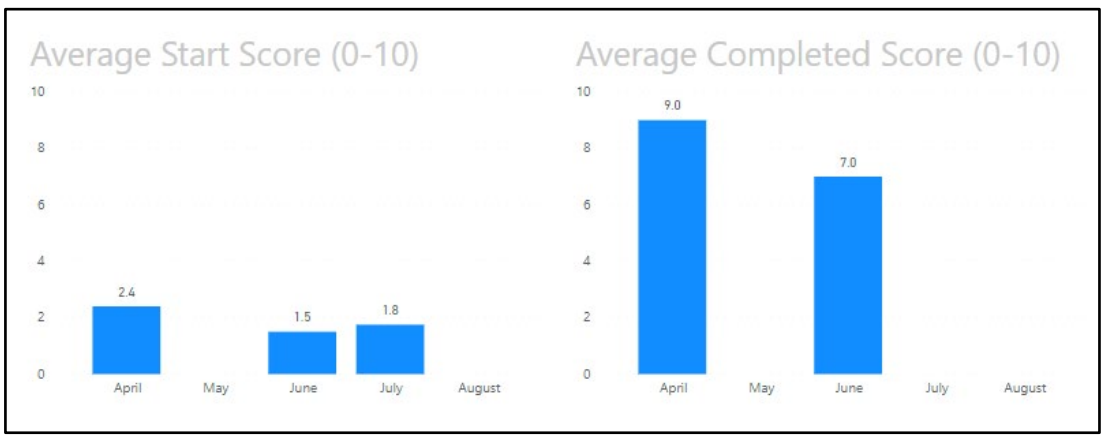
Early indications are that this project is contributing to a reduction in length of stay

- Average LOS before pilot 4.6 days
- Average LOS since project in place 3.5 days
- Mean LOS since project in place 3 days

Keeping Me Well - Western Bay Ngā Kākāno Practice Test Team.

Our second Gold Star tranformation programme – Keeping Me Well – has been extensively shared with the Board but due to it's significance we will continue to provide short updates as the programme develops.

A key measurement of wellbeing progress within the pilot is how fufilled a client is with their overall wellbeing both before and after the programme finishes. The following graph shows the average starting point on a scale of 0-10 of where a client rates how fufilled they are, the completed score shows their level of fufillment following completion of the programme with the PPH service. Overall clients are reporting at least a 5-6 point step change.



The LifeCurve™ Implemetation

A Workshop with key stakeholders was held this month, this included four community based partners who are testing the app. The Project lead for this implementation commences in September.

Key messages around benefits of using the LifeCurve™ across the Bay include:

- Service users receive tailored outcomes to improve/maintain their ability
- Commissioning Organisations and Partners can assess the impact of their services on healthy ageing using the LifeCurve™ as a measurement tool and 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

7. Health and Safety

The key focus for the new Health & Safety manager and her team is the upcoming ACC Accredited Employer Program (AEP) audit scheduled for 5/6th October. The focus of the audit is injury management and the DHB is working through its self-assessment (a prerequisite of the audit) and ensuring that unions and Health & Safety representatives are engaged in the self-assessment process.

The timeframe for completion of the pre-audit work including stakeholder engagement is tight – the team has weekly work plans to ensure completion of the necessary activities. The plan is to have the self-assessment documentation completed by 11th September.

The Health and Safety manager is working with the CEO, Executive and Health and Safety leads to provide a regular dashboard report to the Board and management teams, something which has been absent whilst this vanacy was recruited to. A first version will be included in this section next month.

8. Maori Health Gains and Development

Due to the importance of Te Toi Ahorangi, a separate section has been included in this month's Board papers which provides an update and Strategic Plan for the next 12 months. Further discussion needs to take place with Board and Runanga Members who are committed to playing an active part in the execution of Te Toi Ahorangi and we hope that the presentation of the plan for the year ahead will provide stimulus to this in the relevant section.

9. Governance and Quality

Health Consumer Council – Chairs Report

The HCC is in the final stages of revising the Terms of Reference. The "Purpose" statement of the Council has been reworded to reflect a clearer reference to promoting excellence and equity of health services across the Bay of Plenty, underpinned by the revised Council "Functions". A small number of additions and alterations remain to be clarified at the September meeting.

Arising from this process of review is the current lack of clarity around HCC connectedness and communication with DHB committees. The HCC will progress the establishment of regular representation at committee level to contribute a consumer perspective.

HCC has communicated with the DHB to seek an update on plans for tenant relocation from the Clarke Street flats where the future Mental Health facility is to be built. The HCC will continue to monitor the situation of tenant relocation and has requested to be notified of future DHB plans regarding this situation.

A second area of interest that the HCC is currently considering is the communication procedures for the referral of patients from Papamoa and Te Puke to Whakatane Hospital for surgery. This aspect of patient care will be discussed in greater detail at the September meeting.

Hospital certification

Verbal feedback from the recent Hospital certification process was engouraging, with no major issues flagged for immediate attention. The final report is now expected in October and will then be shared with the Board.

10. Clinical Campus

Students

The University of Auckland (UoA) will go to a 10-week elective for year 6 students in 2021 and the two-week cohort option discarded. This will put extra pressure on the DHB as previously these students mostly went overseas.

UoA Year 4 and Year 5 students that were in lock down in Auckland will be allowed to travel down to BoP on Monday 31 August and start their placements one day late on Tuesday 1 September.

House Officers and Registrars are organising a Mock year 4 exam in October for the UoA Year 4 students and also Ward Call teaching for Year 6 students to get them ready to start as House Officers (HO) in either November or January. The start date for HO has been changed to 18 January 2021 and in some cases, HO will be allowed to start in November as has been traditionally been the case.

With the Level 3 Lockdown we have seen Allied student placements cancelled eg in Pharmacy.

National Clinical Trials Network workshop

The Research Manager attended a virtual National Clinical Trials Network Workshop which was hosted by the MoH and led by Dr Ian town, Chief Science advisor to MOH.

The objective of the meeting was to bring together researchers, consumers, private providers, the public sector and other stakeholders to generate insights about national structures and functions that would enable increased coordination and capacity across all stakeholders involved in the New Zealand clinical trials research sector.

The specific objectives of the workshop were:

1. To enhance the visibility of different people and groups involved in clinical trials and gain a shared understanding of the scope of activities, drivers and overlapping interests.
2. To understand what consumers, researchers, private providers and the public sector see as limiting national-level collaboration and coordination across the clinical trials research sector, and to consider: what could be built, what could be enhanced, and what could be shared?
3. To explore ways of working together to better connect and coordinate activities to achieve shared goals, including understanding the potential barriers to doing so.

The workshop relates to other initiatives, such as the public sector-focused Clinical Trials RFP, and the wider ranging National Health Research strategy. Outcomes and next steps from the workshop are pending, but the workshop itself was well attended, and provided a forum for valuable and constructive discussion around a potential National Clinical Trials Network.

11. Te Teo Herenga Waka and Toi Te Ora

Toi Te Ora COVID-19 Management

The Ministry of Health has asked all public health units to cease much of its business as usual work to enable resources to be focussed on the pandemic response. With a national approach now being taken to manage the second wave of the pandemic, in August all public health units were asked to stand up their resources needed to manage phase one of their respective resurgence plans. This was primarily to be in a position to assist the Auckland Regional Public Health Unit with their work. Toi Te Ora is involved in following up a number of contacts of cases who are linked to the Auckland cluster. Despite this region having no positive cases of our own, this contact tracing was a lot of work for a number of staff in the service. Toi Te Ora is prepared to move to a seven day a week service if required.

Toi Te Ora is working with the Bay of Plenty and Lakes DHBs' GMs Maori Health to respond to a request from Te Tumu Whakarae to nominate a single point of contact for each DHB that the Ministry of Health contact tracing team staff can provide to Māori and Pacific close contacts if they need to access local health and/or welfare support.

Strengthening Community Resilience

- Toi Te Ora connected with Katikati Taiao following their enquiry to discuss local food security project developments.
- Pirirākau Hauora contacted Toi Te Ora to seek support for their vision to establish community gardens in Te Puna. Toi Te Ora met with their Rangatahi Projects Coordinator to discuss their vision and project and what support we can provide.
- Toi Te Ora participated in the bi-monthly Bay of Plenty DHB's Green Team meeting to progress the sustainability plan. Toi Te Ora will combine the upcoming Bay of Plenty DHB Healthy Food and Drink Policy audit with looking at the type of packaging used within our cafes and vending machines and see how this complies with the sustainability plan goals of moving to recyclable or compostable packaging.

Preventing Childhood Obesity

Toi Te Ora is providing a lot of support to a number of agencies and schools to support the roll out of the Lunch in Schools programme across this region. Highlights include:

- Working with Tamaki Maori Village, who have the capacity to be a Lunch in Schools provider, to work through a variety of processes that may see them partnering with Ka Pai Kai in Rotorua to provide local employment for the COVID-affected tourism industry as part of the Lunch in Schools regional roll out.
- Supporting the Garden to Table group with their application to be part of the programme. Garden to Table proposes to complement other food providers by working with a portion of the school population each day, to grow, harvest, cook and eat kai, bringing an important element of education to the Lunch in Schools programme.
- Supporting the Search Party Charitable Trust with their plans to tender for the Lunch in Schools contract in Te Puke. The Search Party operates the Daily Cafe in Te Puke, where all profits go back into the local community. Their focus is on breaking the poverty cycle and improving community wellbeing.
- Communicating with the Ministry of Education and Tauranga City Council to find a waste solution for the Lunch in Schools packaging to ensure a suitable waste management component of the programme is part of the roll out.
- Meeting with several schools and organisations to discuss the Lunch in Schools programme including partnering with the Ministry of Education to provide support for Te Kura Kaupapa Māori o Te Kura Kokiri, Welcome Bay Primary School, Gate Pa Primary School, Brookfield School, Rotorua Girls High School, Reporoa College and Reporoa Primary School.

The discussions covered the schools' plans for the roll out of healthy lunches in schools, guidance for implementation and exploring what success looks like for them.

- Providing nutrition training to schools on food provision and the new healthy food and drink guidance, alongside the Ministry of Education and the Heart Foundation.

Toi Te Ora – WorkWell Programme

The team's activities over this period have included:

- Holding a national WorkWell Advisor mentoring session alongside the Mental Health Foundation who shared observations about the impacts of the previous lockdown on people and workplaces across New Zealand. The Mental Health Foundation also shared the work they are doing to support mental wellbeing in the workplace setting, and the resources and workshops that are in development post the first lockdown.
- The team are in discussions with the Mental Health Foundation to partner on upcoming workshops including how they can be delivered in the regions where WorkWell is currently available. Depending on the current alert levels, these will either be face to face workshops or delivered as online webinars.
- Re-engaging with most of workplaces and stakeholders to determine their current needs post lockdown.
- The Workplaces team has entered into discussions with the Northland DHB and their public health unit regarding the delivery of WorkWell in the Far North region. Both have expressed an interest to get involved in workplace wellbeing and have heard good things about WorkWell. The public health unit will take their recommendation to their Executive for approval.

Health In All Policies

Toi Te Ora prepared a submission on behalf of the Bay of Plenty DHB to the Tauranga City Council draft Totara Street Safety Upgrade proposal.

Toi Te Ora attended the National Healthy Public Policy Network via Zoom with policy representatives from seven of the twelve public health units. A highlight was a presentation delivered by the Society of Local Government Managers on their Community Well-being Service. The Service includes a data warehouse which contains a range of indicators which can be used to measure the current well-being of communities and is available to Councils as a living web-based dashboard. Most councils in the Toi Te Ora region use the service and SOLGM is in discussion with the remaining three to bring them on board.

Toi Te Ora provided some initial comments on the Taupō District Council's current Gambling Machine policy, which is due for review later this year. This gave an opportunity for early engagement into their review process and we are strongly recommending a sinking lid policy and a reduction of gambling machines in the region.

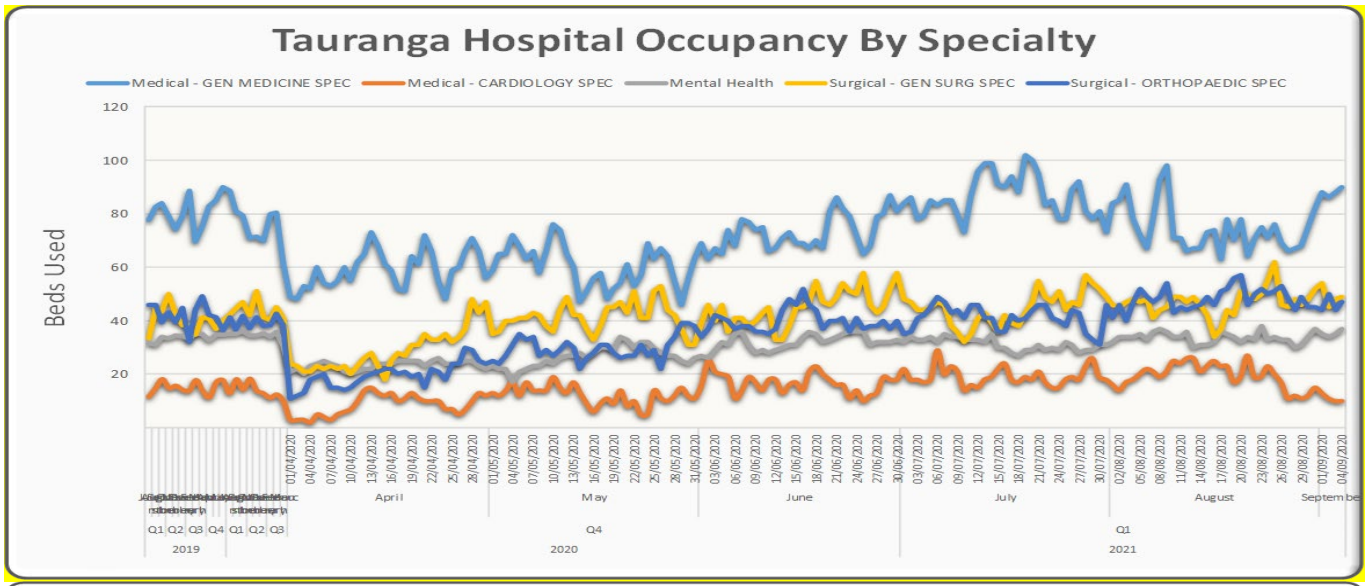
12. DHB Provider Services

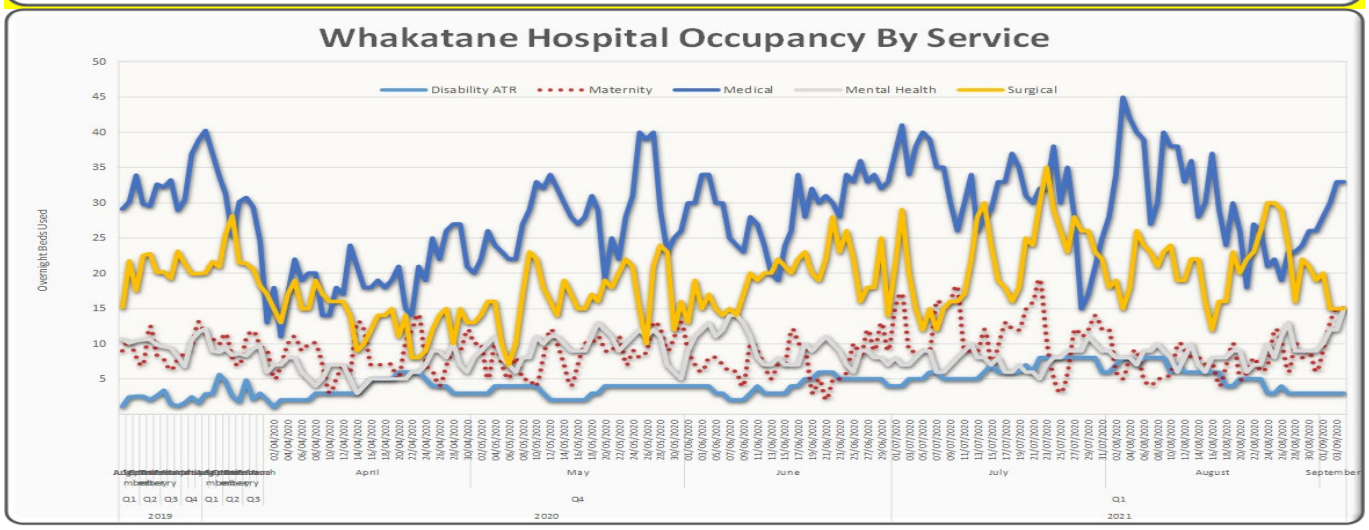
Acting Chief Operating Officer Overview

August has experienced periods of unprecedented demand at BOP hospitals with patient presenting with a wide range of illnesses which resulted in the deferment of some elective surgeries over a three week period.

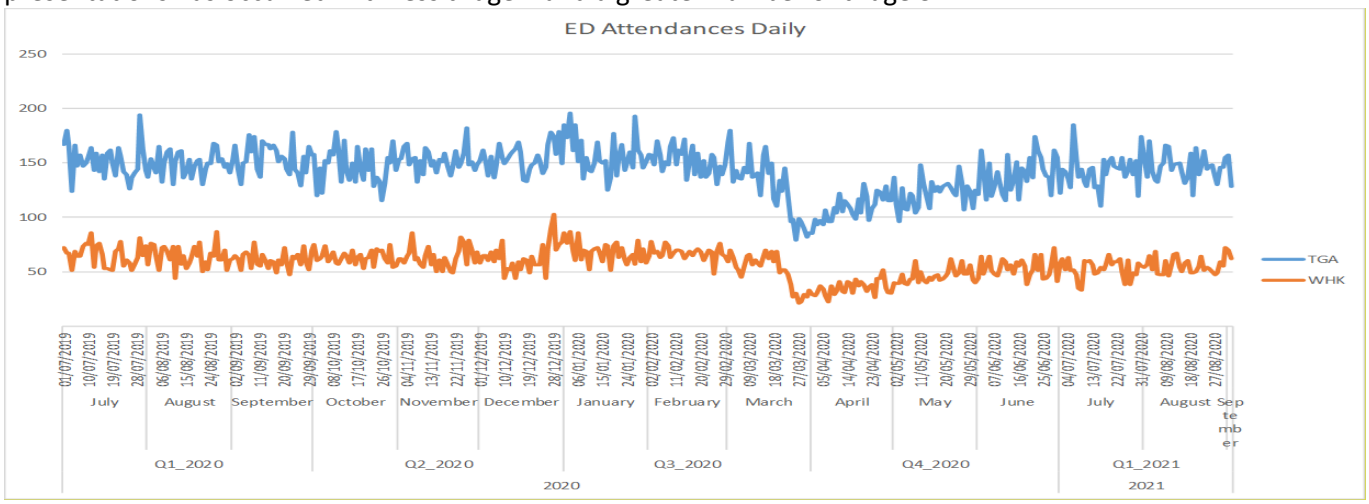
During this month the Hospital certification audit team completed a recertification audit and overall there were no concerns of significance based on the verbal feedback at the audit closure session.

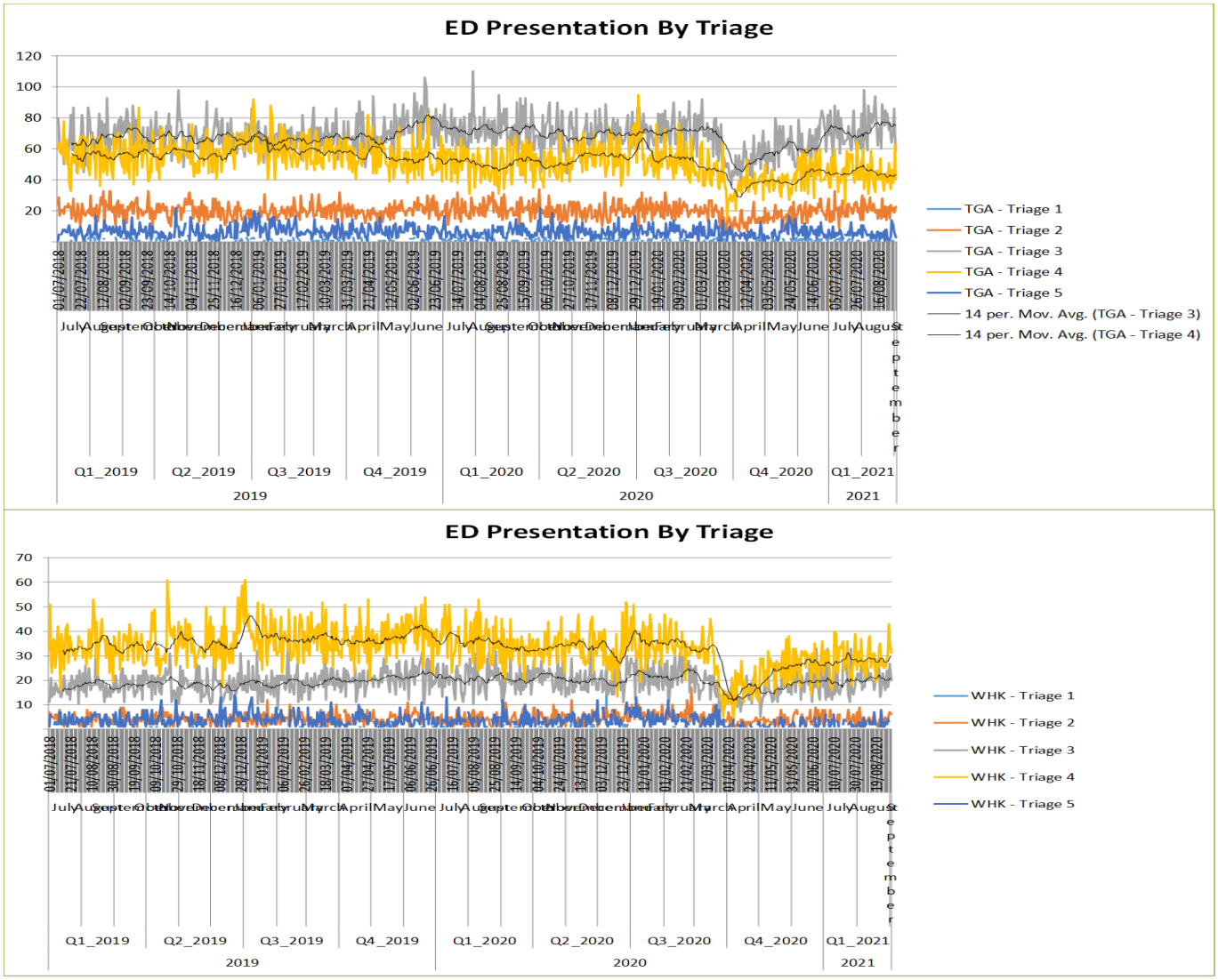
There has been a small improvement from last month despite Hospital Capacity under pressure; ICU / HDU constraints and the resulting deferred elective operations this month. The following graphs show that for Tauranga and Whakatane Hospitals there has been some reduction in acute workload since the second wave of COVID 19 12th August 2020.





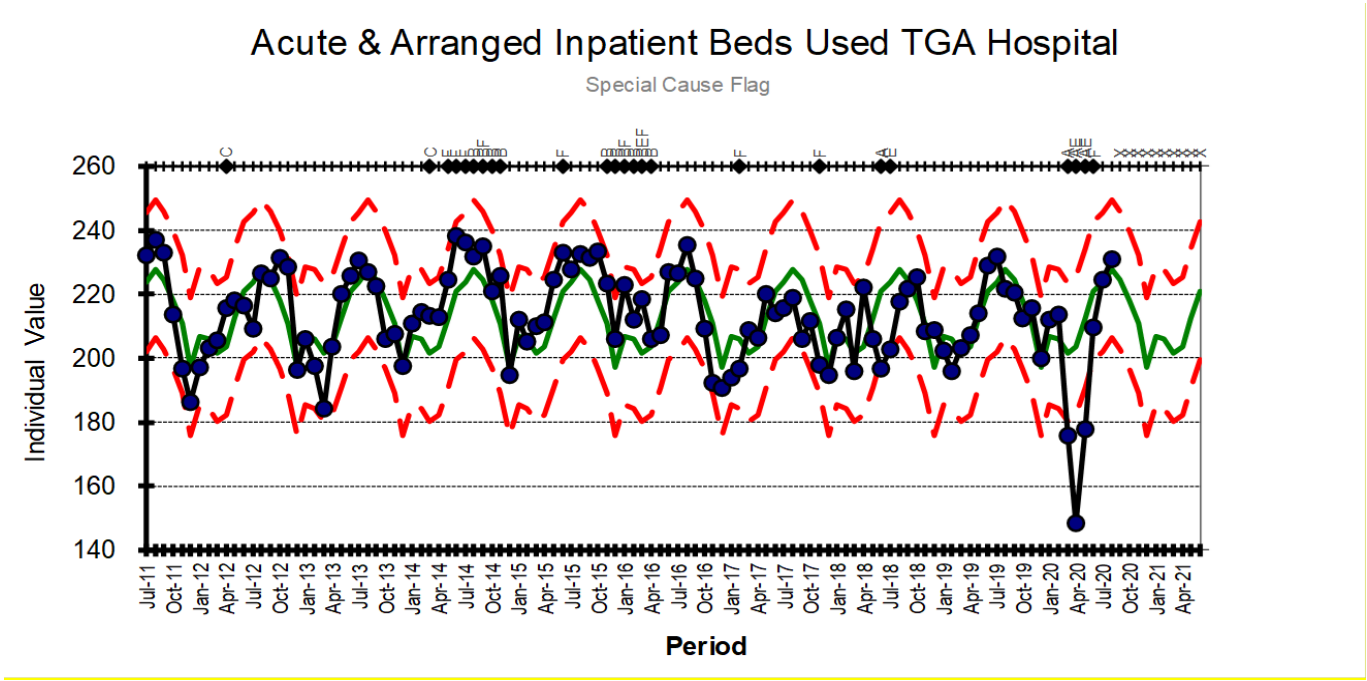
The next graphs show ED activity returning to pre-Covid volumes although changes in the acuity of presentations has occurred with less triage 4 and a greater number of triage 3.

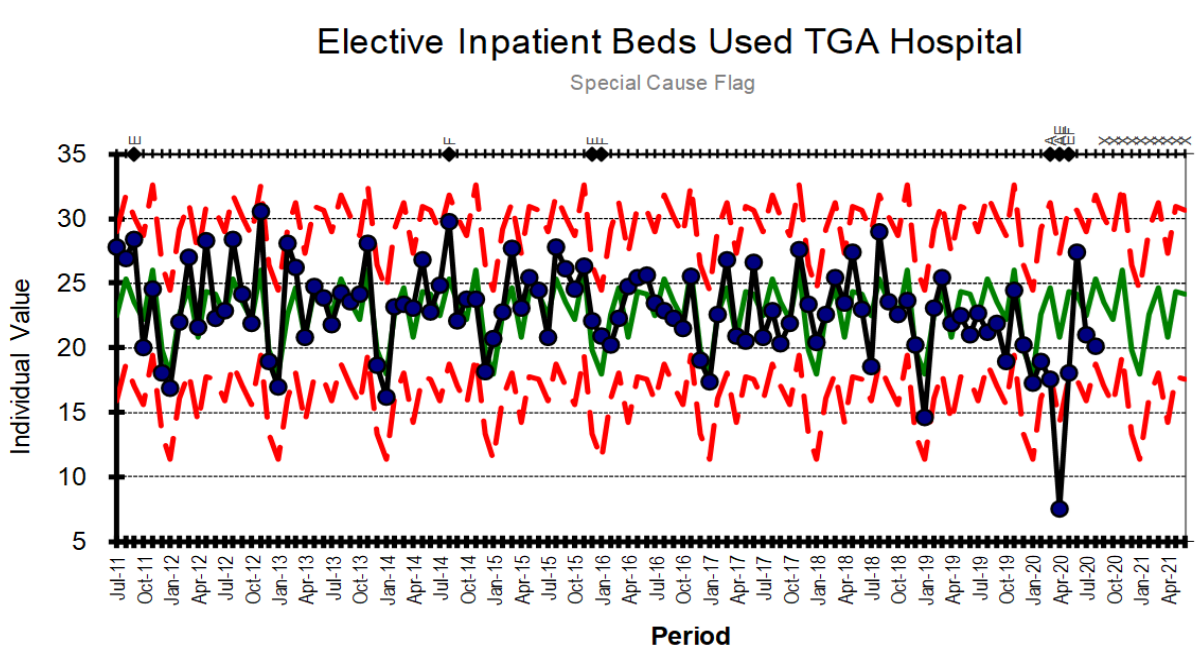




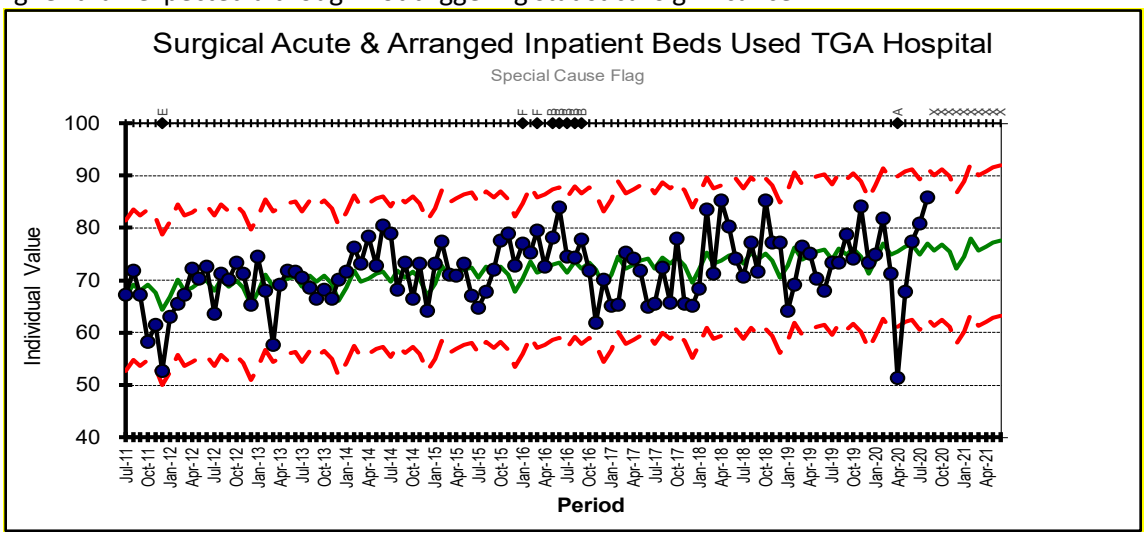
Tauranga Hospital Acute and Arranged Inpatient High Occupancy

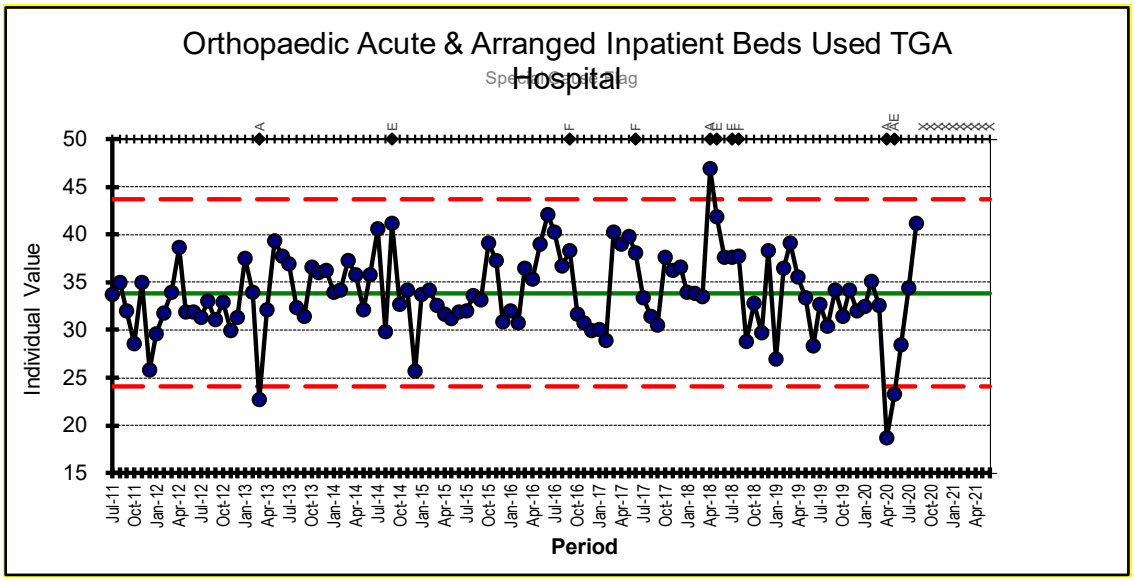
As shown in the following graphs Tauranga Hospital experienced a very busy July and early August 2020 with occupancy higher than expected.

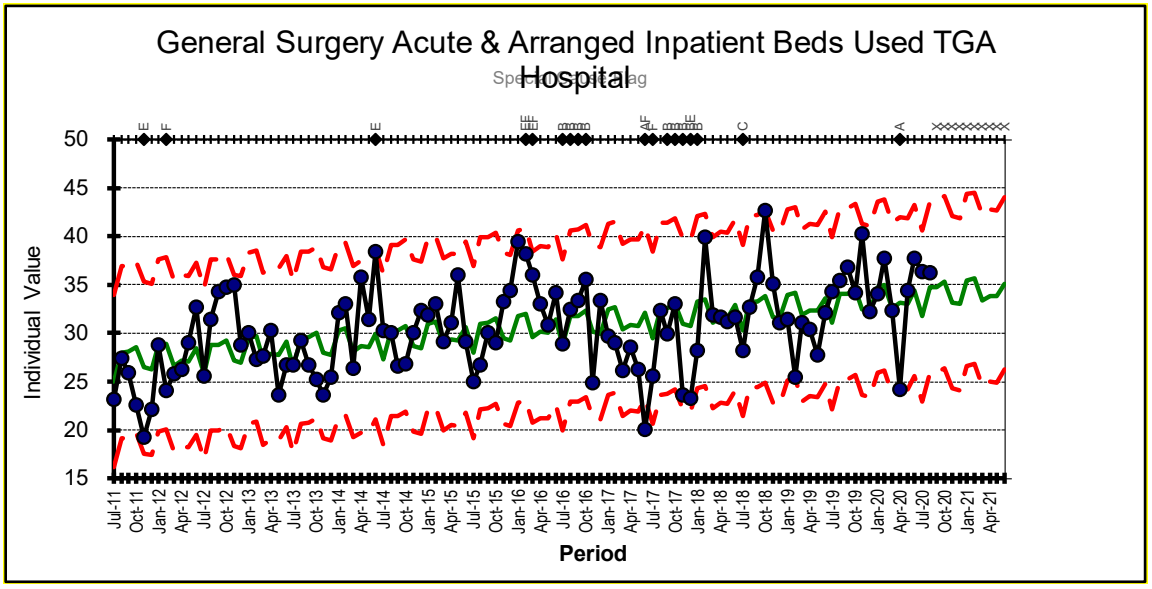




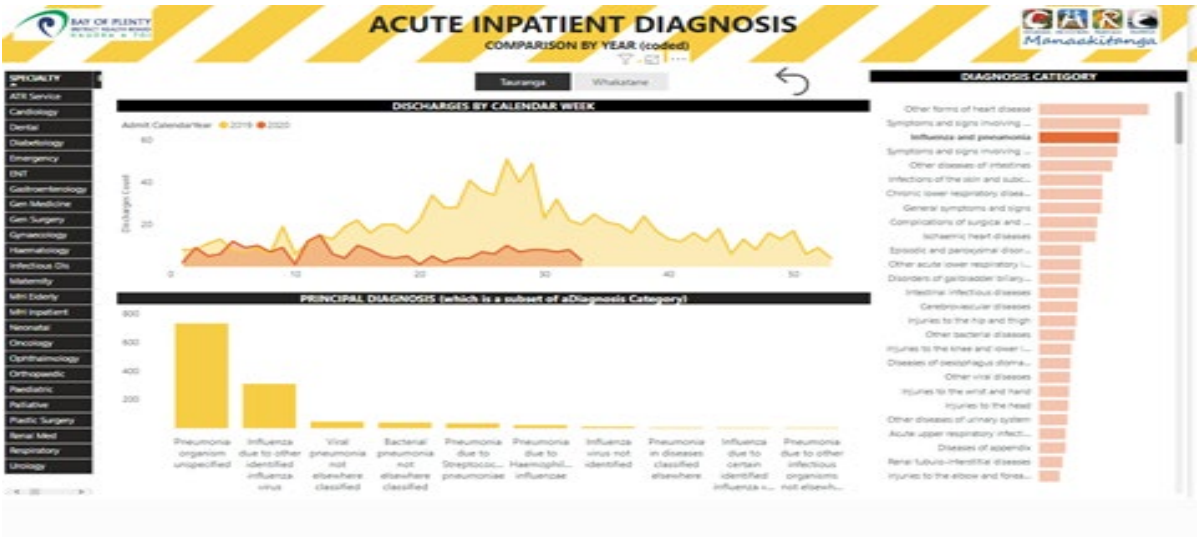
Surgical specialities Orthopaedics and General Surgery make up the bulk of acute and arranged and are higher than expected although not triggering statistical significance.

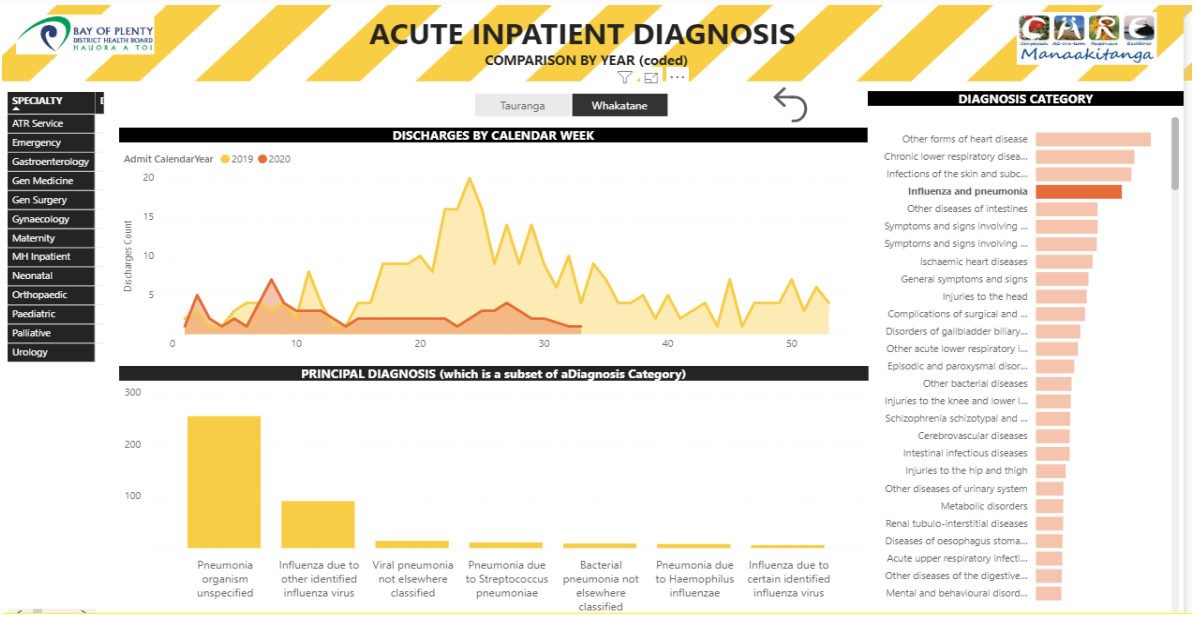




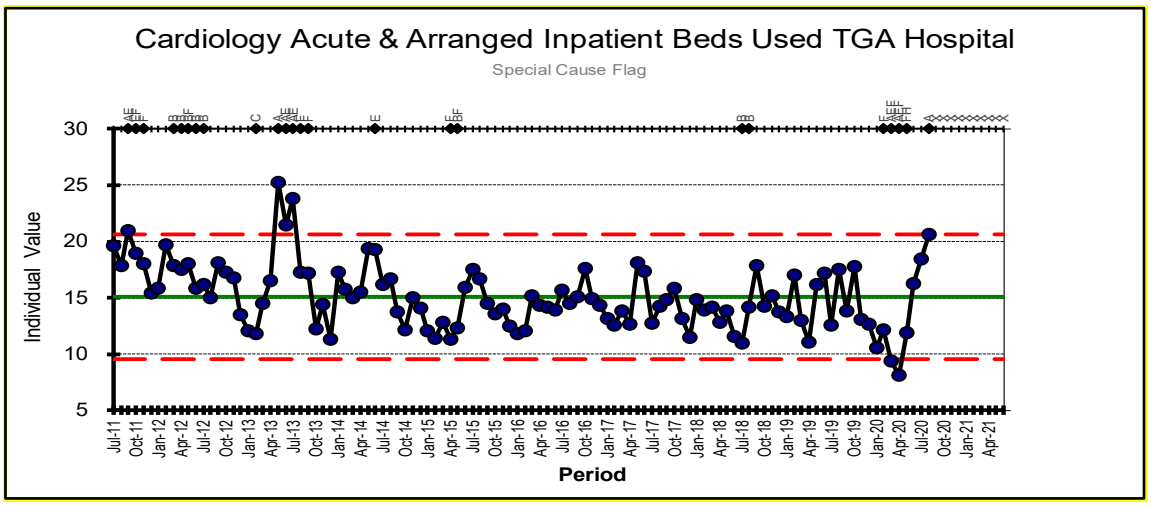


Most Medicine Health Specialties have had below seasonally expected bed utilisation. The following graphs show the low admissions from influenza for both Tauranga and Whakatane hospitals.





The following graph shows a change for Cardiology Health representing higher than expected admissions for chest pain; heart failure, arrhythmias and other cardiac and circulatory conditions.



Staffing Levels: Midwifery and Nursing

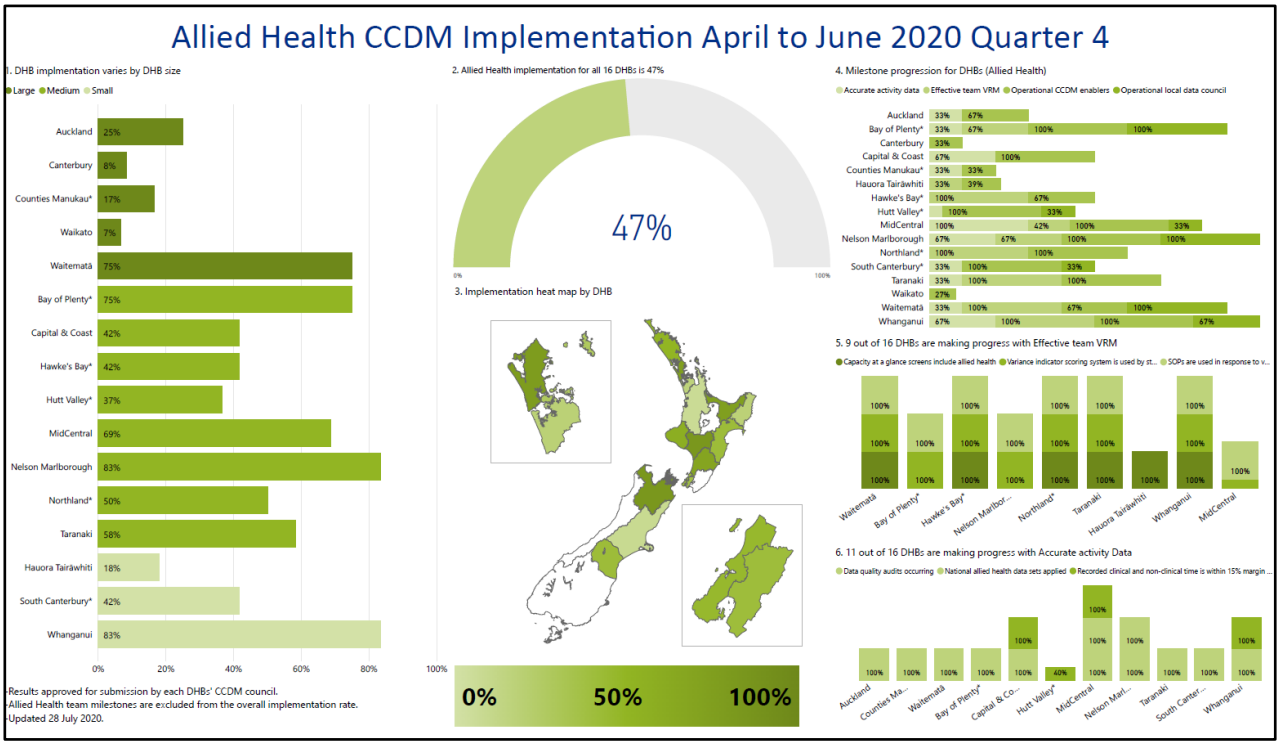
The commencement of Clinical Midwifery Coordinators (CMCs) at Tauranga Maternity Unit is proving successful, providing improved patient flow and Variance Response Management processes. CMCs are also providing clinical support to midwifery / nursing staff and to LMCs.

Midwifery/ Nursing Professional Development

A focus on improving maternity education management systems is nearing completion with more effective oversight and individual midwife education planning support. BOPDHB midwifery education supports both DHB employed and self-employed LMC midwives. Significant attention has also been given to building a responsive maternity education curriculum. With the increased use of RNs in the maternity setting, development of a curriculum to support the RN scope of practice in maternity has been undertaken and is now being delivered to the RN workforce. This will extend in coming months to upskilling the SCB staff in postnatal care increase Variance Response Capability.

Allied Health CCDM

The following image shows the implementation of Allied Health CCDM across NZ DHBS highlighting that BOPDHB is doing well in comparison to many other DHBs.



Pre-school Oral Health Enrolment

Total population enrolments are 99.9%, with Maori at 92.4% (95% target). Reconciliation of births and pre-schoolers who have moved into the region is in progress. Ministry of Health have also provided NHI level data that showed 1,400 pre-schoolers not enrolled with Community Dental (CDA) and preschool enrolment co-ordinators are working through the list contacting parents/caregivers to enrol.

Child Development Services (CDS)

Te Whanau Kotahi transition to BOPDHB has been completed this month.

Service implementation includes increased BOPDHB staffing with many of the new staff now in place. Already there has been a significant impact on psychology waitlist – reduced 25% even though referrals have increased. Plans are underway to streamline referral intake, caseload management and systems and process. The DHB clinical activity tool, ABC; highlights significant community engagement by all staff with increased current caseloads.

The Incredible Years Autism Parenting Programme has made a successful transition to the DHB with three programmes currently run and another three planned for after Christmas.

Support Net

There continues to be a significant increase in demand across all client groups for Support Net assessment and coordination services. This requires triaging and prioritising clients, resulting in a waiting time for those clients deemed at lower risk living at home.

Funded Family Care

Changes have been made to Funded Family Care provisions and these:

- Give disabled people who want a family member to provide their support a choice of employment arrangements.
- Make pay rates for family carers consistent with rates for other care and support workers
- Allow partners and spouses to provide paid care to their disabled family member
- Allowing eligible people under 18 years of age to receive paid family care
- Lower the minimum age of family carers from 18 to 16 years

As a result of these changes Support Net is receiving an increase in enquiries from people wanting to use Funded Family Care.

Community Care Coordination (BOPCCC)
BOPCCC have extended capacity to receive referrals from external providers and community organisations and this continues to have a positive effect.

Community Dental Services
A co-design project with Maori Health Gain and Development and CDS has had an initial hui to design a position description for a dental kaiawhina role. Two further Patient Liaison positions are being recruited for, one Tauranga Intermediate and the other Whakatane Intermediate.

The third year of the joint partnership with Absolute Dental, Murupara Area School and CDS is set to roll this month to provide services for high school aged students in Murupara region. Work and Income NZ and Ngati Manawa Runanga support this project. Planning is underway for Absolute Dental to deliver a mobile dental service at the high school from October 2020.

Family Violence Intervention Programme (FVIP) and Vulnerable Unborn (VU)
The workload continues to increase in these disciplines. The Family Safety System designed by NZ Police is a great process for intersectoral working however places additional workload on the team.
A back-up Vulnerable Unborn co-ordinator is now available to cover planned leave.

Care Capacity Demand Management (CCDM) Update
The CCDM programme has 23 measures which reflect quality of patient care, quality of work environment and best use of health resources. Below are examples of the measures monitored from the Core Data Set (CDS). Noting the report is always a month behind. Timeliness of information will improve when the electronic CDS is implemented Hours worked over contract are under the quality of the work environment suite of measures. This is all staff hours worked that are additional to normal contracted hours of work. This applies to part time staff only.

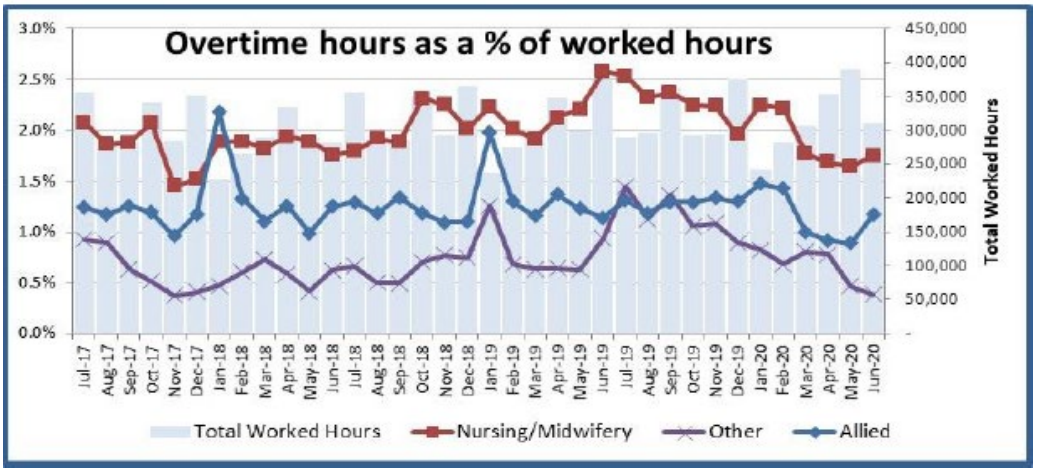
Working additional shifts is an important and valuable variance response however when this is prolonged it indicates a shortage in the base nursing care hours on the roster. Consistently working additional shifts can lead to tiredness and reduced resilience.
There is a downward trend for nursing however Medical staff are trending upwards:

HOURS WORKED OVER CONTRACT

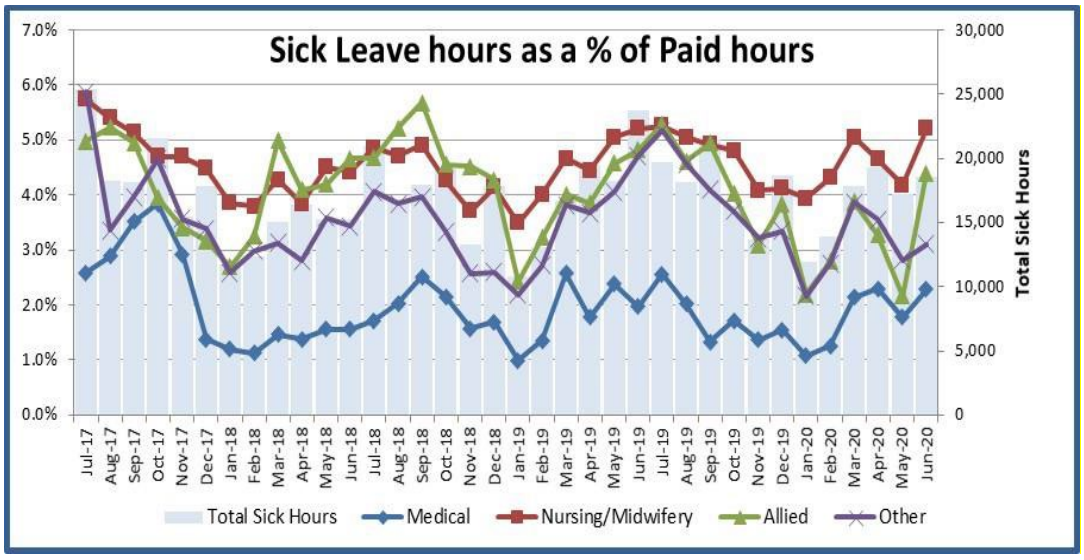
Note - upward trend denotes an increase in hours being worked above contract

	This Month	Forecasted Monthly Result	Trend [from Jan-18]
Medical	-0.91%		
Nursing	4.51%		
Allied	1.89%		
Non Clinical	10.22%		
Admin/Mgmt	7.25%		

Overtime also comes under the quality of the work environment measures. Overtime should be used in exceptional circumstances only. Nursing overtime shows a slight increase although remains low compared to the same month 2019.



Sick leave is one indicator of the health of the workplace. Burnout and job stress increase staff absenteeism due to sickness. As expected, there is a seasonal pattern to sick leave. There is normally a sustained peak May through to September. Currently there is an impact from the requirement for staff to remain off work if they have a cold, rather than the usual winter influenza type illnesses.



Health Quality and Safety Service
Activity this month includes:

- Covid related activity : Supporting the August COVID re-emergence including port testing and EOC intelligence COVID effects on mortality paper presented to Exec & Board
  COVID Research and Predictive modelling in collaboration with Auckland University and Health Quality & Safety Council (HQSC).
- Culturally safe restorative practice embedment into quality management systems Reinvigoration of quality management systems with a more customer-centric focus (e.g. incident/ adverse event investigation and learning) that includes developing specifications for an improved Consumer and Whānau Feedback system.
- Support development of clinical governance systems across services and committees (e.g. service excellence metrics). Initial focus Paediatric, Gynaecology and Maternity services.

  Maternity Clinical Governance is leading the establishment of a Severe and Acute Maternal Morbidity Review. This is a Health Quality and Safety Commission programme which will review cases of severe illness and near miss maternal morbidity events.
- Health Intelligence Systems action plan approved and being implemented
- Hospital certification coordination, self-assessment & preparation
- Auditing of quality of ethnicity data now included as part of internal audit schedule
- Choosing Wisely: involvement with community of practice, and scoping potential foci
- Consumer Council: terms of reference refresh and recruitment of new members
- New Adult Hospital Patient Experience Survey (AHPES) implemented.
- Development of co-design approaches and systems needed post review of existing resources (eg, website, print resources, signage, social media, with a focus on the needs of consumers and whānau)
- Integrated Operations Centre (IOC) development and support

Hand Hygiene Improvement Plan
As BOPDHB did not meet the national compliance rate of 80% for hand hygiene for two quarters a more comprehensive improvement plan has been developed.

There is an overarching Hand Hygiene Awareness campaign developed in conjunction with communications to communicate the importance of the “5 moments” of hand hygiene to all BOPDHB staff. The campaign uses the tagline “Clean care is in your hands” from the World Health Organisation (WHO). The professional groups have been provided with completion rate information for the on-line training module. There is a focus on increasing the number of staff who have completed the online training module.

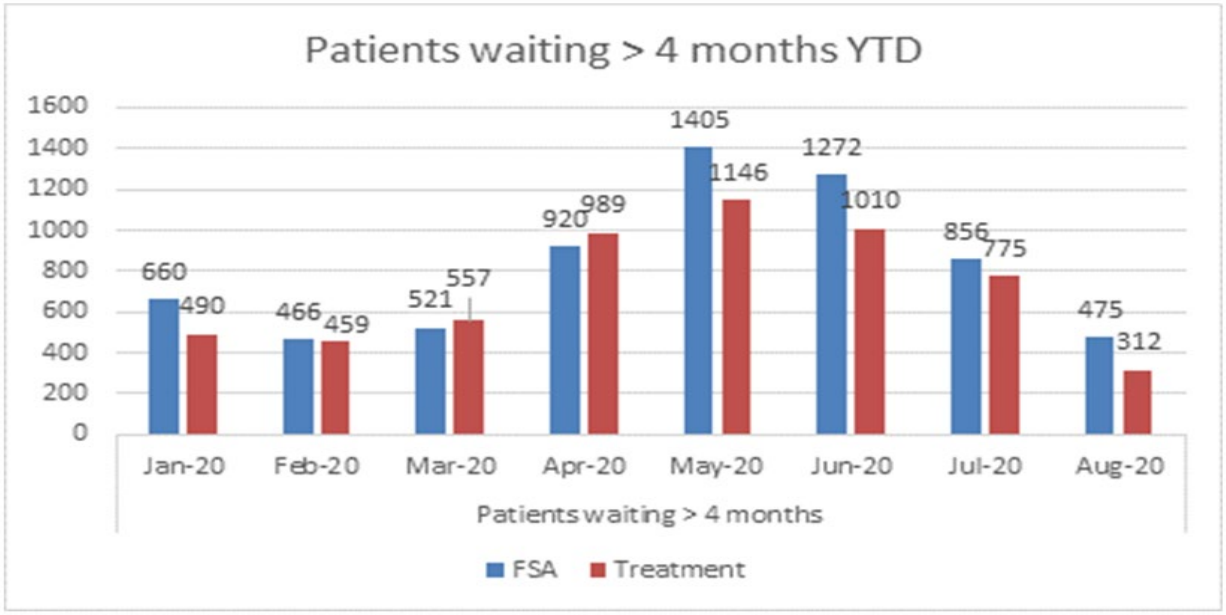
Both Allied Health and Medical professions have improvement plans to improve results. The Chief Medical Advisor has met with all Heads of Departments to discuss the importance of hand hygiene and support completion of the online training. Allied Health has identified a new champion and they are running scenario training to embed good practice.

Planned Care Recovery
Capacity constraints (Theatre and ICU) and funding are the two significant barriers to addressing our Planned Care Backlog. Operating theatres are at capacity and the growth of orthopaedic acute surgery continues to increase further impacting on our ability to reduce the number of patients waiting for planned care.

To manage clinical risk and patient experience all patients waiting over clinically intended waiting times are reviewed by clinical teams on a regular basis and these patients have been updated with changes to anticipated waiting times and advised to communicate any concerns or changes in their condition to their GP or referrer.

The following table provides a summary as at August end the volume of patients who have been waiting more than 4 months for ESPI 2 (First Specialist Appointment) and ESPI 5 (Treatment). This position has significantly improved, however the volume of referral by specialty being received for all specialities for July and August is high and will have an impact on our ability to recover ESPI compliance in 3 months' time.

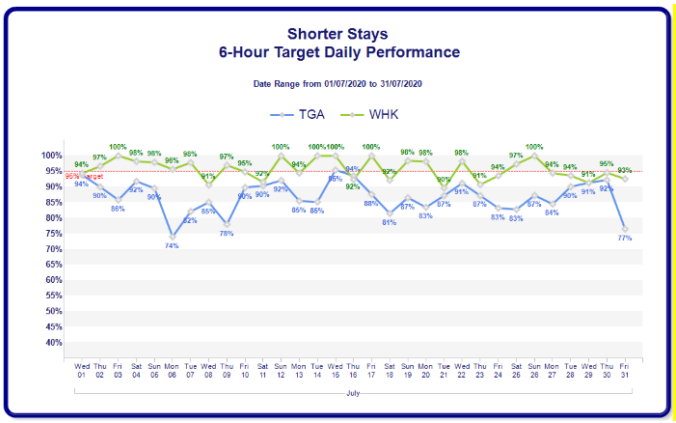
Year to date overview as at August 31:

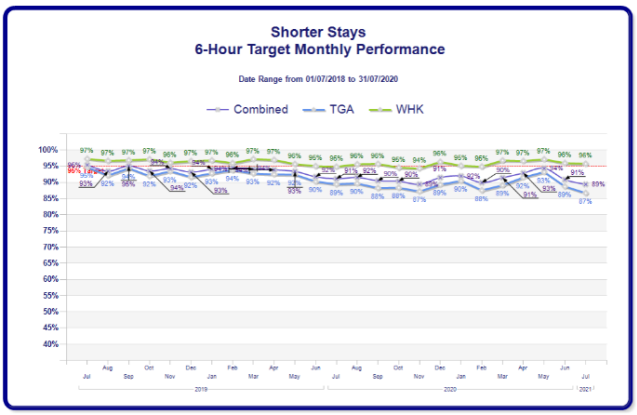


Shorter Stays in ED

Result for July 2020 – 89%

The results across the month of July are very indicative of the considerable pressures that have been seen across both sites with increasing attendances and increasing admission rates – many days now sitting above 40%. This high admission rate combined with significant bed blockage in the ICU has contributed considerably to the decline in performance against the indicator.

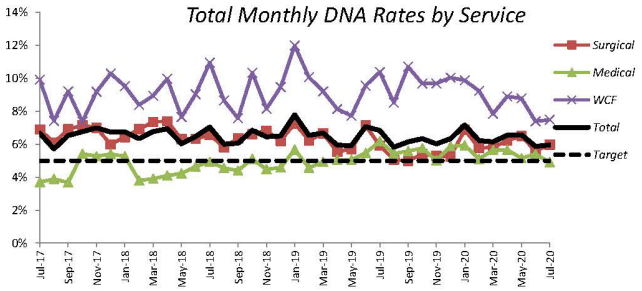




Failed Appointments (DNAs) Dashboard

Jul-20

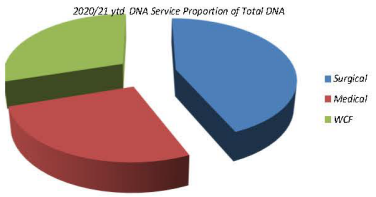
	Jul-20	Maori	Target
Provider Arm	✗ 6.1%	13.9%	5.0%
Surgical	! 5.1%	11.1%	5.0%
Medical	✗ 5.7%	12.0%	5.0%
WCF	✗ 9.2%	20.0%	5.0%

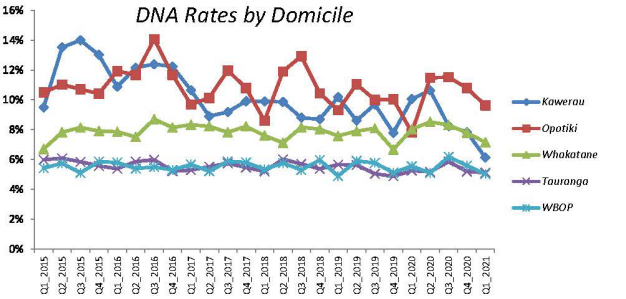


DNA Rate:	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21 ytd
Provider Arm (Maori)	15.84%	15.42%	15.53%	14.85%	14.55%	13.85%	14.76%	13.88%
Provider Arm (Total)	6.55%	6.57%	6.56%	6.32%	6.32%	6.07%	6.30%	6.07%
Surgical	6.84%	6.75%	6.41%	5.70%	5.84%	5.42%	5.88%	5.10%
Medical	4.12%	4.41%	4.90%	5.55%	5.84%	5.63%	5.37%	5.69%
WCF	8.77%	8.91%	9.29%	9.21%	8.93%	8.56%	9.05%	9.18%

Provider Arm DNA #								
Surgical	3360	3328	3109	2803	3001	2815	2758	229
Medical	952	1071	1255	1493	1482	1542	1276	141
WCF	1644	1639	1690	1615	1665	1570	1376	157

DNA Propn of Total DNA:								
Surgical	56.4%	55.1%	51.4%	47.4%	48.8%	47.5%	51.0%	43.5%
Medical	16.0%	17.7%	20.7%	25.3%	24.1%	26.0%	23.6%	26.8%
WCF	27.6%	27.1%	27.9%	27.3%	27.1%	26.5%	25.4%	29.8%

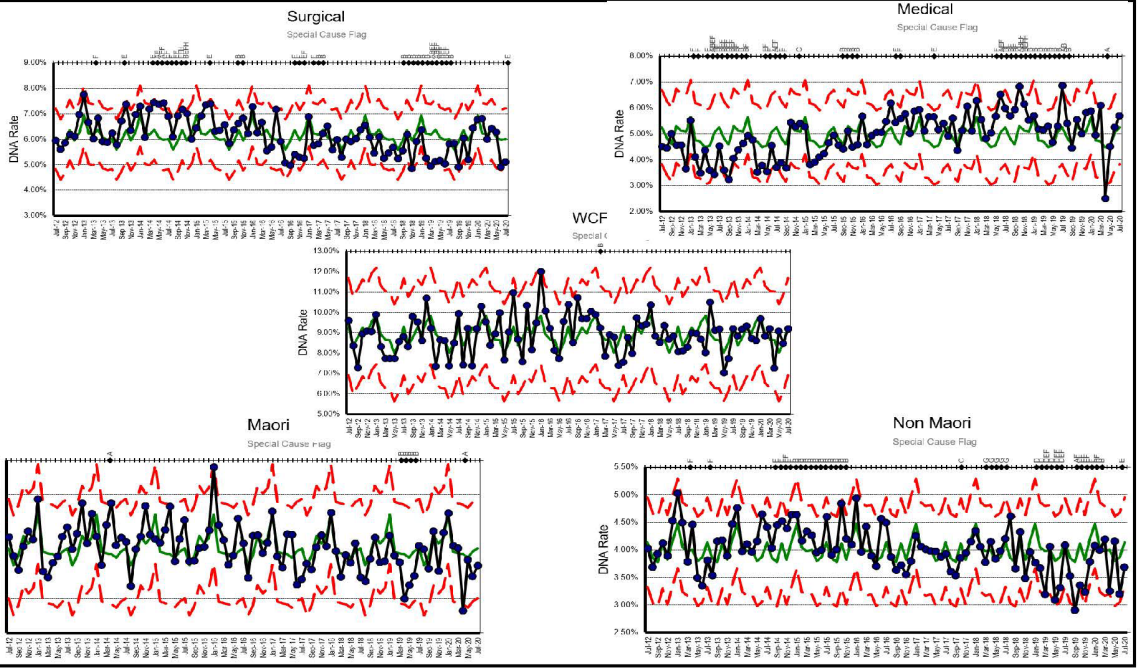




2020/21 YTD Result:

	Total FSA DNA Rate		Raw FSA DNA		Total FU DNA Rate		Raw FU DNA	
Total	5.5%	Total	220	Total	5.9%	Total	492	
MATERNITY	9.2%	ORTHOPAEDIC	58	PAEDIATRIC	11.7%	PAEDIATRIC	104	
RENAL MED	8.3%	GENERAL SURGERY	43	MATERNITY	10.6%	ORTHOPAEDIC	99	
CARDIOLOGY	6.6%	GENERAL MEDICAL	28	GENERAL MEDICAL	7.0%	GENERAL MEDICAL	86	
PAEDIATRIC	6.4%	CARDIOLOGY	20	GYNAECOLOGY	6.8%	GENERAL SURGERY	77	
ORTHOPAEDIC	6.1%	PAEDIATRIC	19	CARDIOLOGY	6.0%	OPHTHALMOLOGY	48	
GENERAL MEDICAL	5.9%	MATERNITY	19	ORTHOPAEDIC	5.8%	GYNAECOLOGY	25	
GENERAL SURGERY	5.7%	GYNAECOLOGY	18	GENERAL SURGERY	5.8%	MATERNITY	21	
GYNAECOLOGY	4.8%	OPHTHALMOLOGY	9	NEUROLOGY	4.5%	CARDIOLOGY	17	
NEUROLOGY	3.1%	NEUROLOGY	4	RENAL MED	4.3%	ANAESTHETICS	5	
OPHTHALMOLOGY	2.3%	DENTAL HEALTH	1	OPHTHALMOLOGY	3.5%	NEUROLOGY	4	
DENTAL HEALTH	1.4%	RENAL MED	1	ANAESTHETICS	2.7%	ONCOLOGY	3	
ANAESTHETICS	0.0%	ANAESTHETICS	0	ONCOLOGY	0.5%	RENAL MED	3	
ONCOLOGY	0.0%	ONCOLOGY	0	DENTAL HEALTH	0.0%	DENTAL HEALTH	0	

	Maori FSA DNA Rate		Raw Maori FSA DNA		Maori FU DNA Rate		Raw Maori FU DNA	
Total	11.4%		111	Total	13.6%		263	
RENAL MED	20.0%	GENERAL SURGERY	21	PAEDIATRIC	21.3%	PAEDIATRIC	79	
GENERAL MEDICAL	16.7%	ORTHOPAEDIC	20	GYNAECOLOGY	19.5%	ORTHOPAEDIC	50	
CARDIOLOGY	14.9%	PAEDIATRIC	16	MATERNITY	19.2%	GENERAL MEDICAL	32	
PAEDIATRIC	14.0%	GENERAL MEDICAL	16	GENERAL MEDICAL	14.6%	GENERAL SURGERY	31	
GYNAECOLOGY	13.9%	GYNAECOLOGY	14	ORTHOPAEDIC	13.2%	OPHTHALMOLOGY	24	
MATERNITY	13.5%	MATERNITY	10	CARDIOLOGY	12.5%	GYNAECOLOGY	17	
GENERAL SURGERY	11.9%	CARDIOLOGY	10	OPHTHALMOLOGY	11.5%	MATERNITY	15	
ORTHOPAEDIC	9.9%	NEUROLOGY	2	GENERAL SURGERY	11.1%	CARDIOLOGY	9	
NEUROLOGY	6.9%	OPHTHALMOLOGY	1	RENAL MED	5.0%	ONCOLOGY	3	
OPHTHALMOLOGY	1.4%	RENAL MED	1	ONCOLOGY	2.6%	RENAL MED	2	
DENTAL HEALTH	0.0%	DENTAL HEALTH	0	ANAESTHETICS	1.7%	ANAESTHETICS	1	
ANAESTHETICS	0.0%	ONCOLOGY	0	DENTAL HEALTH	0.0%	DENTAL HEALTH	0	
ONCOLOGY	0.0%	ANAESTHETICS	0	NEUROLOGY	0.0%	NEUROLOGY	0	



Primary Care Overview

Eastern Bay Primary Health Alliance

1-3 highlights for the month:

- Rescinding of the BOPDHB two PHO policy and merger requirement.
- Eastern Bay Covid-19 testing station resurgence plan operational within one day.
- 275 Covid-19 swabs completed by our EBPHA practices during July 2020.
- Positive discussions between Eastern Bay Secondary Services Mental Health Providers and EBPHA.

Challenges:

- Development of a locality-based model of Health Care that spans Primary, Secondary, Iwi and Community in the Eastern Bay.
- Support the transition of the Eastern Bay's free Specialist Review Clinic into a self-sustaining model hosted by General Practice.
- Decline in support by the MOH for an HPV testing pilot targeted at @2000 women (mainly Maori) that are un-screened or under screened.

Western Bay of Plenty Primary Health Organisation

1-3 highlights for the month:

- For the surveillance testing operation at the port a dedicated surveillance testing site was established in partnership with the DHB, Pathlab and the Port and became operational in record time. Both Ngāi Te Rangi and Ngāti Ranginui iwi are providing support for this operation through the deployment of kaimahi to assist whānau who will be required to undergo testing.
- We have also been working closely with Māori Health Gains and Development and providers on the plans to recommence the Pahi Tahi mobile assessment service.
- My sincere thanks to everyone for their hard work during this period. It has been an amazing collective effort all round.

Challenges:

- Maintaining our usual programmes and services and progressing some key major projects whilst responding to level 2 impacts and requirements has been challenging. We are relying more than ever on the good relationships we have with our network, the DHB and other stakeholders to see us through and keep our communities safe.
- We are also monitoring staff resilience and well-being carefully to ensure we can sustain the current level of busyness. We have EAP services in place for all PHO staff and practice teams.

Monthly Indicators report

From Board Dashboard and Balanced Scorecard

September 2020

CARE Manaakitanga

From Balanced Scorecard on PowerBI Indicators on Annual Report

CUSTOMER/WHANAU FACTORS

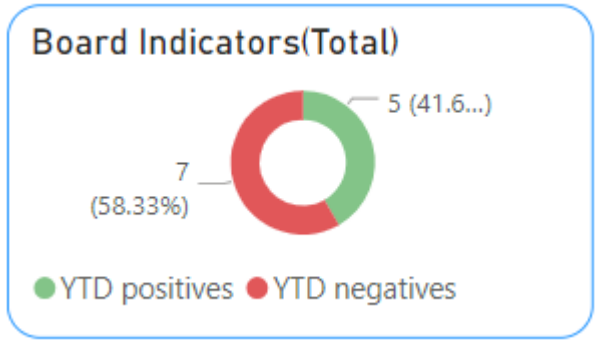
Area	YTD positive total	YTD negative total	YTD positive maori	YTD negative maori	Indicators No Ethnicity
Wai Ora	21	18	6	11	24
Whanau Ora	7	10	4	9	4
Mauri Ora	5	11	2	13	1

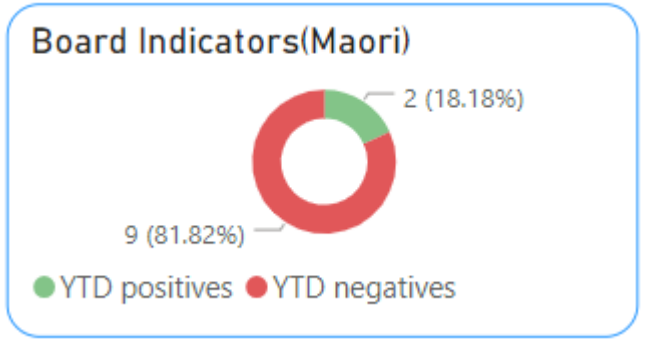
These are the indicators from the Annual Report(Statement of Performance)
From a total of 72 indicators, we can see that 33 indicators are in green, which represents 46%.
From a total of 45 indicators with split by ethnicity Maori, only 12 are in green which represents 27%
From the 72 indicators, 29 do not have split by ethnicity, which represents 40%.

OBS: This is an overview to look how we are in the Annual Report. These indicators will not be disaggregated further in this presentation.

CARE Manaakitanga

From Board dashboard on PowerBI





From a total of 12 indicators, 5 indicators are in green, which represents 42%.
From a total of 11 indicators with split by ethnicity Maori, 2 are in green which represents 18%
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	2019-12-01	90.00	85.71	80.95	50.00
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	2020-08-01	95.00	101.89	100.92	-14.24
BSC_NNPAC_DNA	Did not Attend (DNA) rate for outpatient services	2020-08-01	5.00	5.40	5.79	-9.07
BSC_MH_WT3W_0_19_AOD_DHB_NGO	Three week wait times - AOD (Provider Arm & NGOs) Ages 0-19	2020-05-01	80.00	67.18	74.43	-8.39
BSC_IMMS_8M3M	Child immunisation 8m3m	2020-08-01	95.00	86.52	87.13	-13.29
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	2020-08-01	95.00	87.99	88.67	6.30
BSC_B4SC_CW10	Percentage of obese children (B4SC) oferred a referral	2020-08-01	95.00	95.00	95.37	3.00

Indicators with no split by ethnicity

ID	Description	Last period	Target	Value	YTD
BSC_PCI_T	Planned care interventions	2020-07-01	1,462.00	1,621.00	1,621.00

CARE Manaakitanga

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	2019-12-01	90.00	100.00	81.25	50.00
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	2020-08-01	95.00	93.63	93.03	-14.24
BSC_NNPAC_DNA	Did not Attend (DNA) rate for outpatient services	2020-08-01	5.00	12.38	13.20	-9.07
BSC_MH_WT3W_0_19_AOD_DHB_NGO	Three week wait times - AOD (Provider Arm & NGOs) Ages 0-19	2020-05-01	80.00	64.34	68.99	-8.39
BSC_IMMS_8M3M	Child immunisation 8m3m	2020-08-01	95.00	78.15	79.29	-13.29
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	2020-08-01	95.00	92.25	92.20	6.30
BSC_B4SC_CW10	Percentage of obese children (B4SC) oferred a referral	2020-08-01	95.00	96.55	97.92	3.00

Indicators with no split by ethnicity

ID	Description	Last period	Target	Value	YTD

CARE Manaakitanga

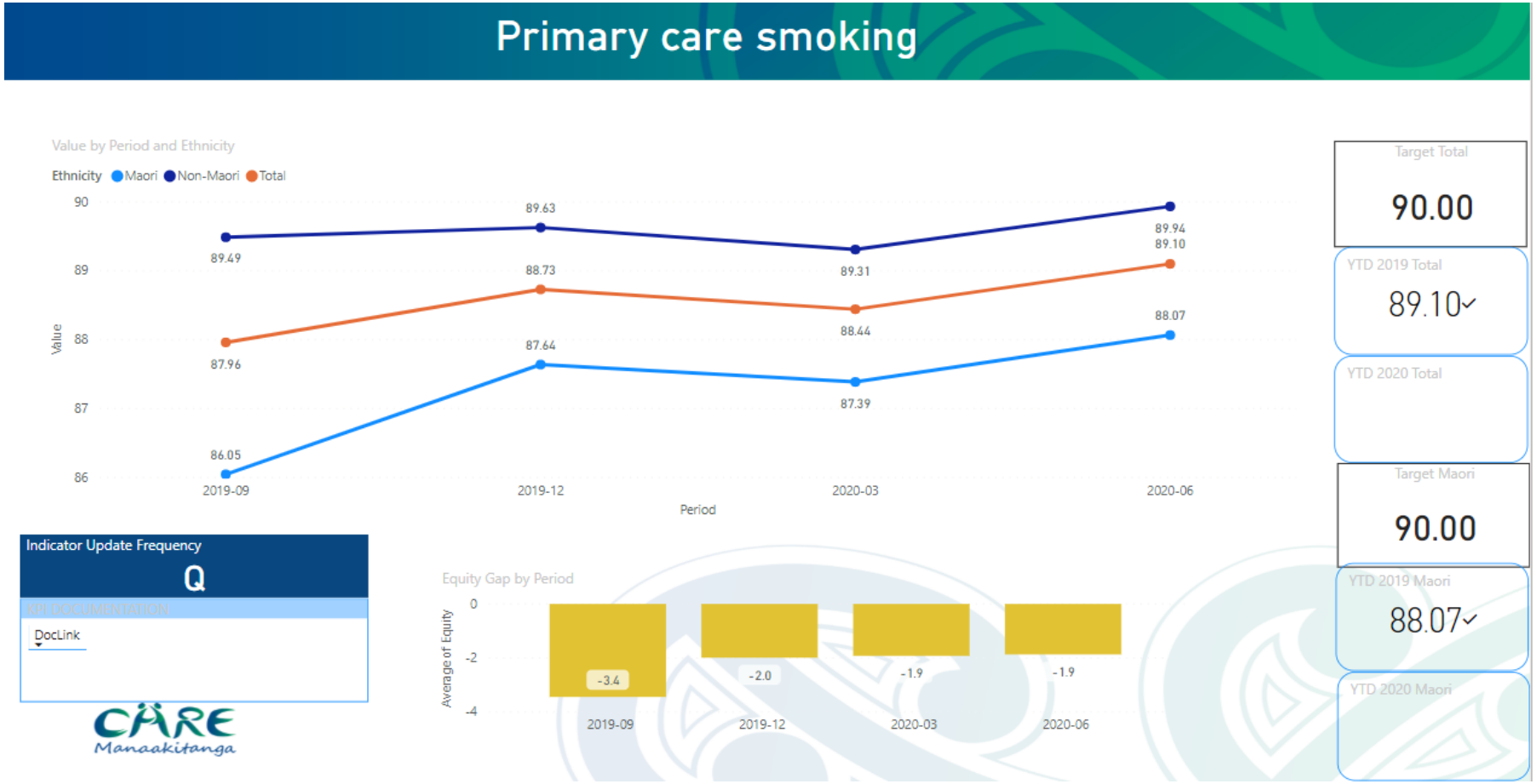
Individual Indicators

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.

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.

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:

Due the MoH reduced reporting requirement for Q3, the Q3 maternity smoking advice results are not yet available.

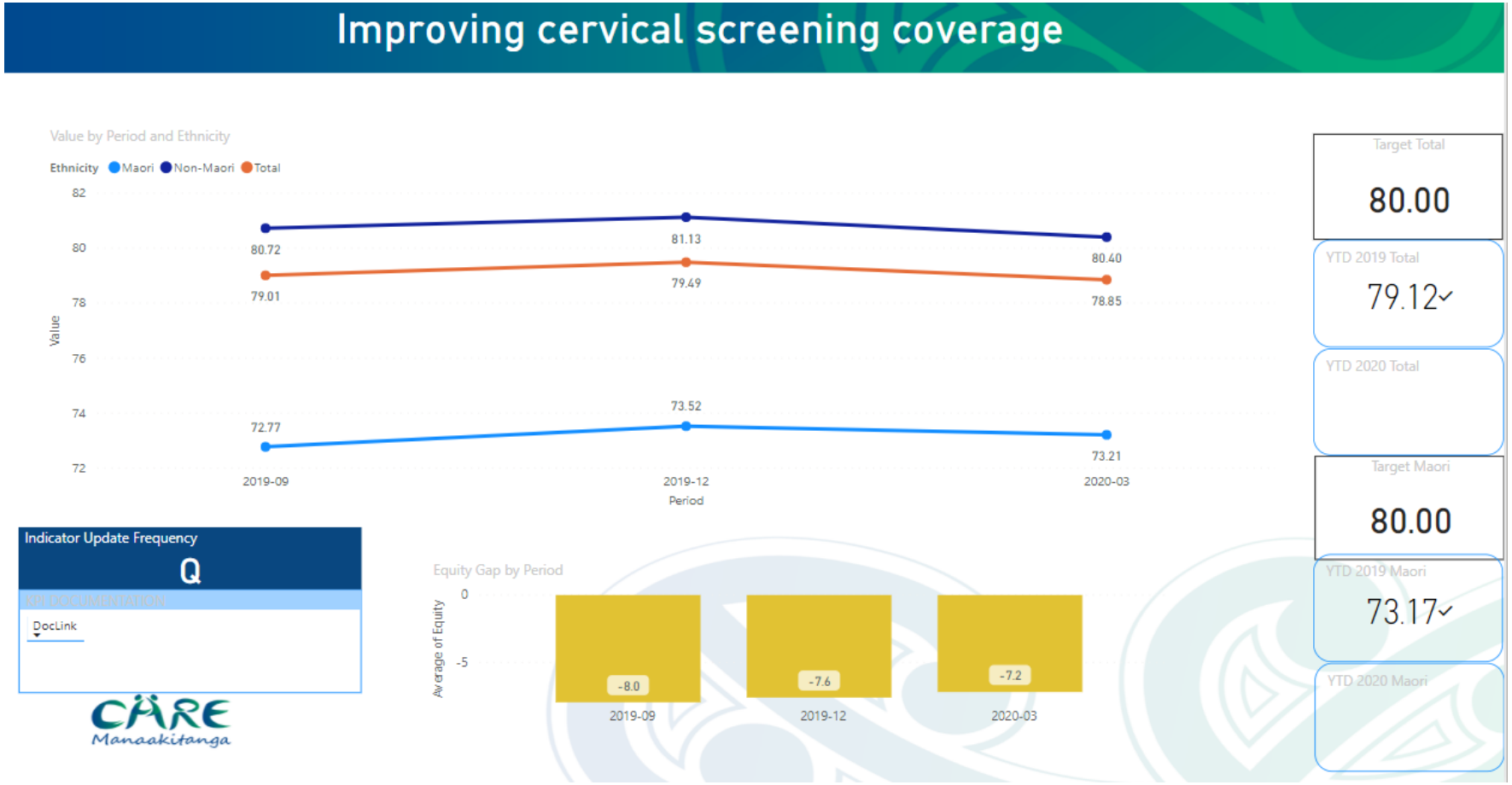
Due to small numbers data does not look very clear, therefore we cannot see a trend.

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.



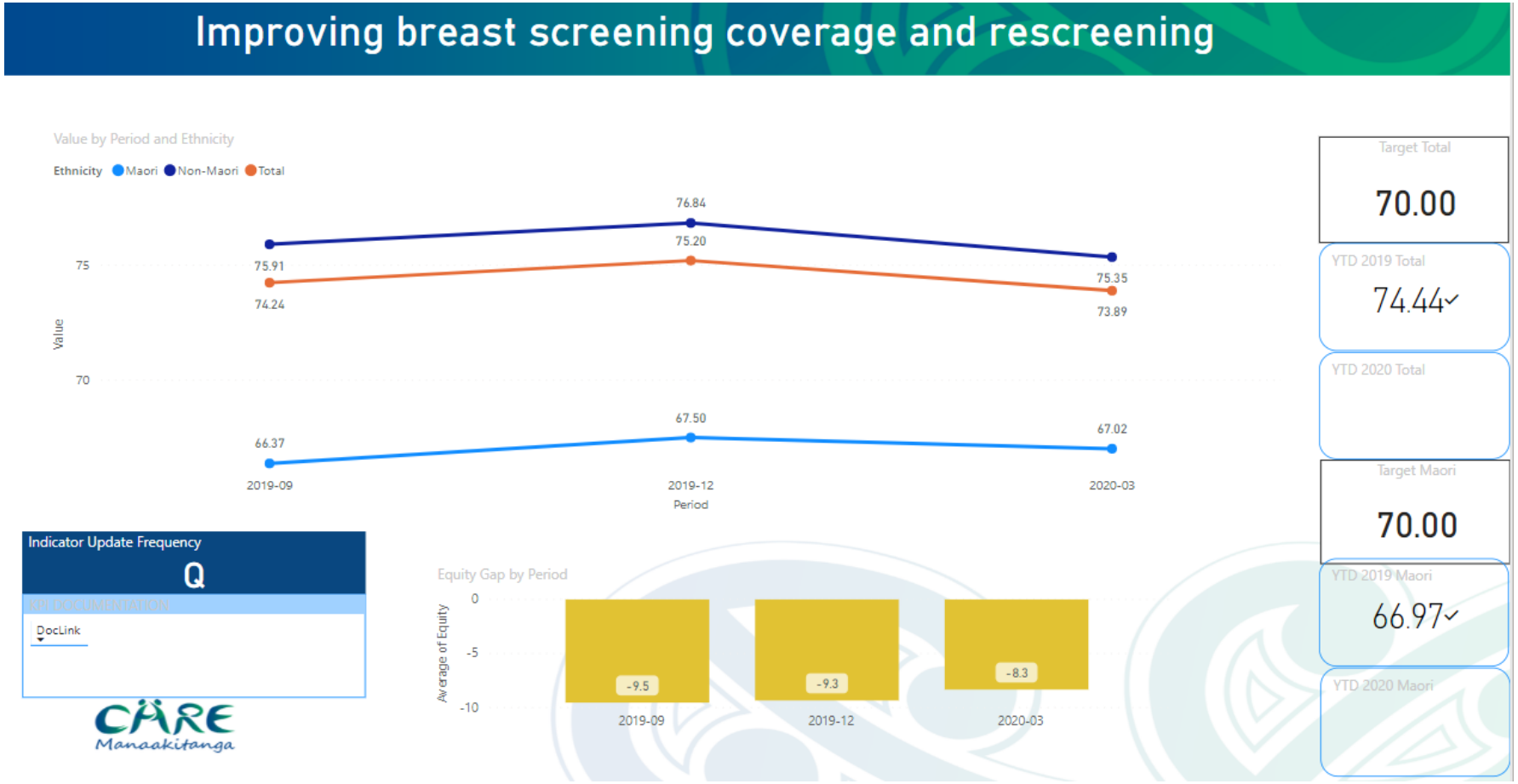
Comments

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.



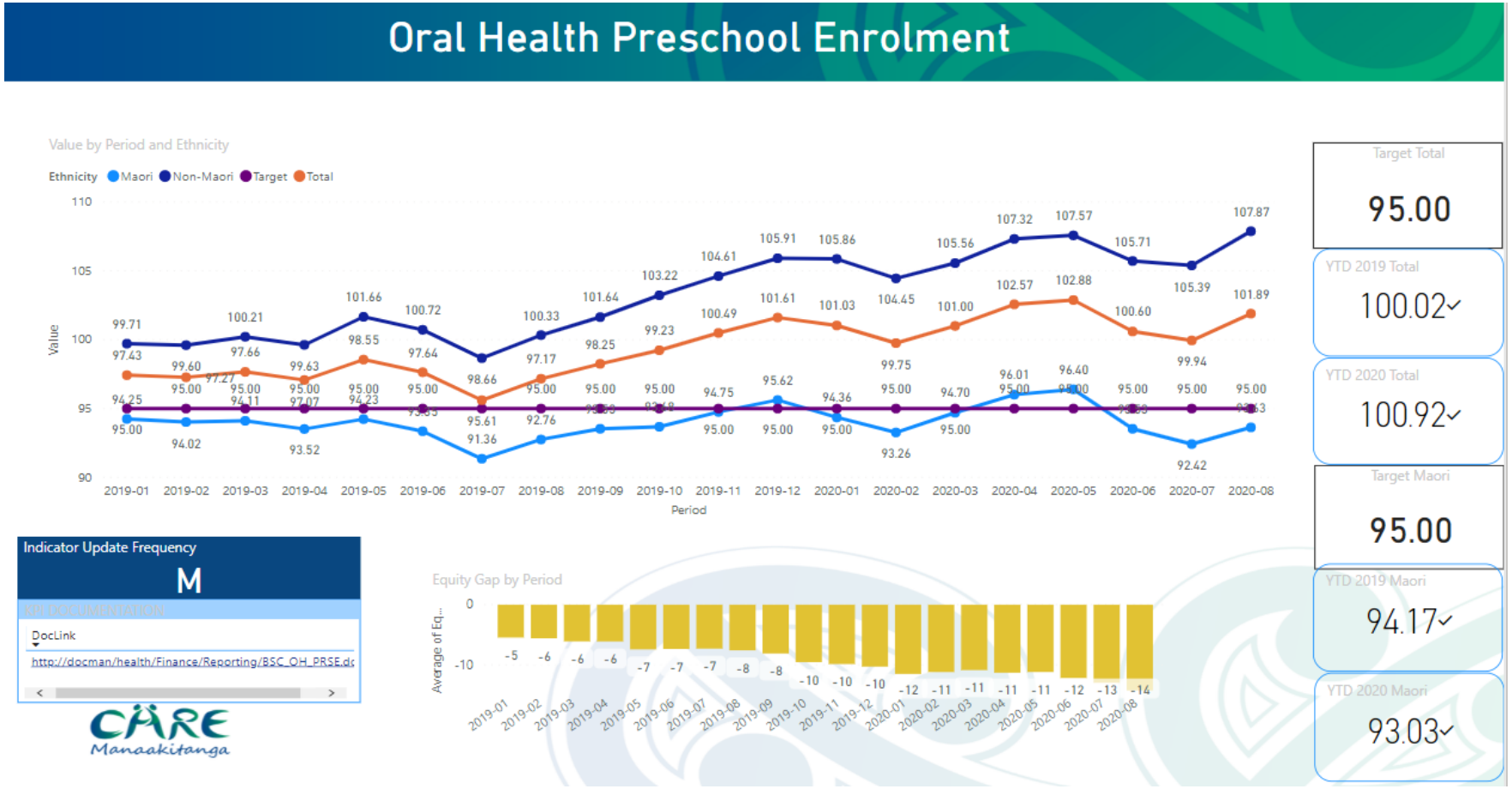
Comments

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%



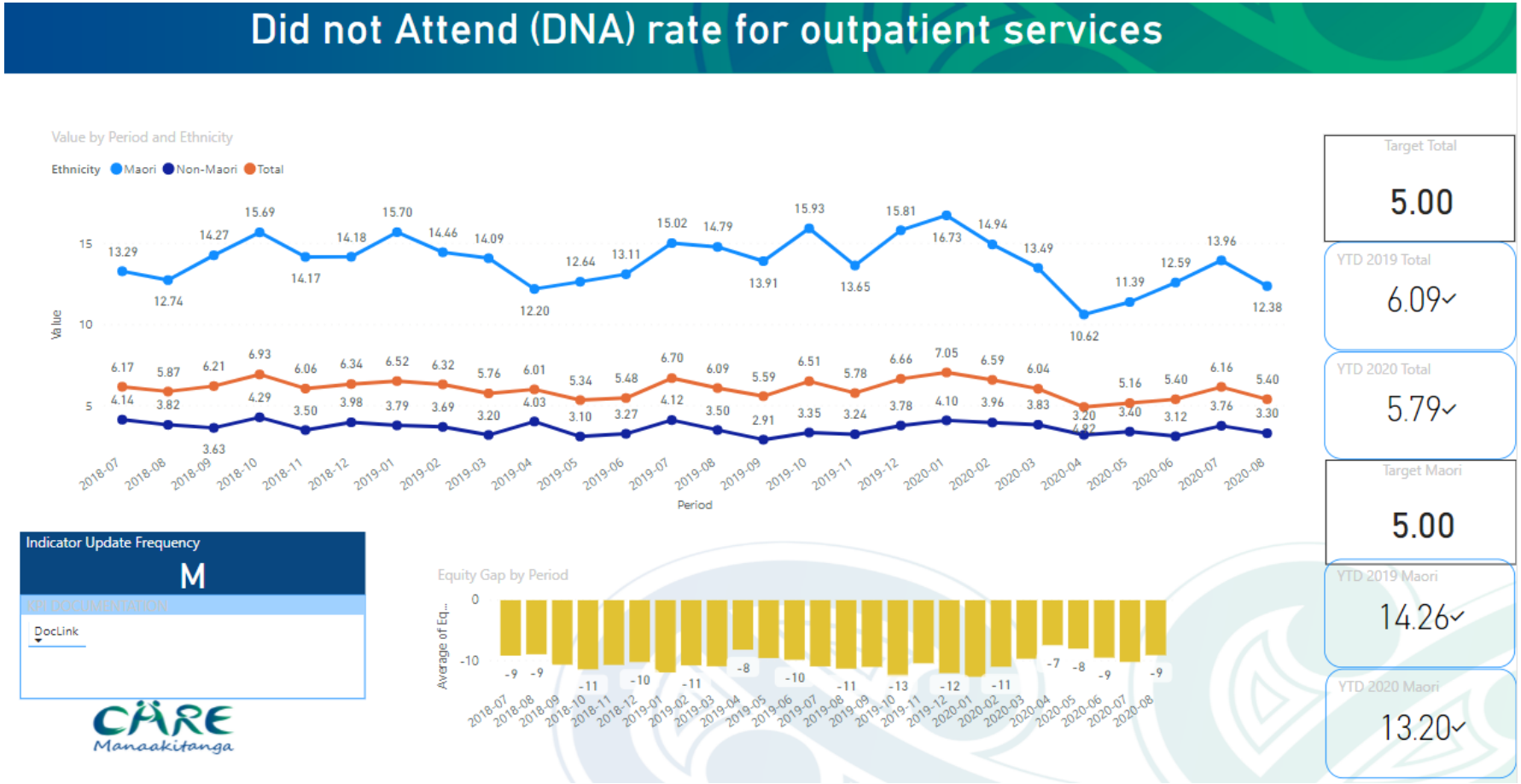
Comments

The denominator for this measure was revised in January 2020 to reflect the latest Population Projections (2019 Update).

Māori preschool enrolment has dropped 3 months below the target.

The equity gap for this indicator is increasing monthly.

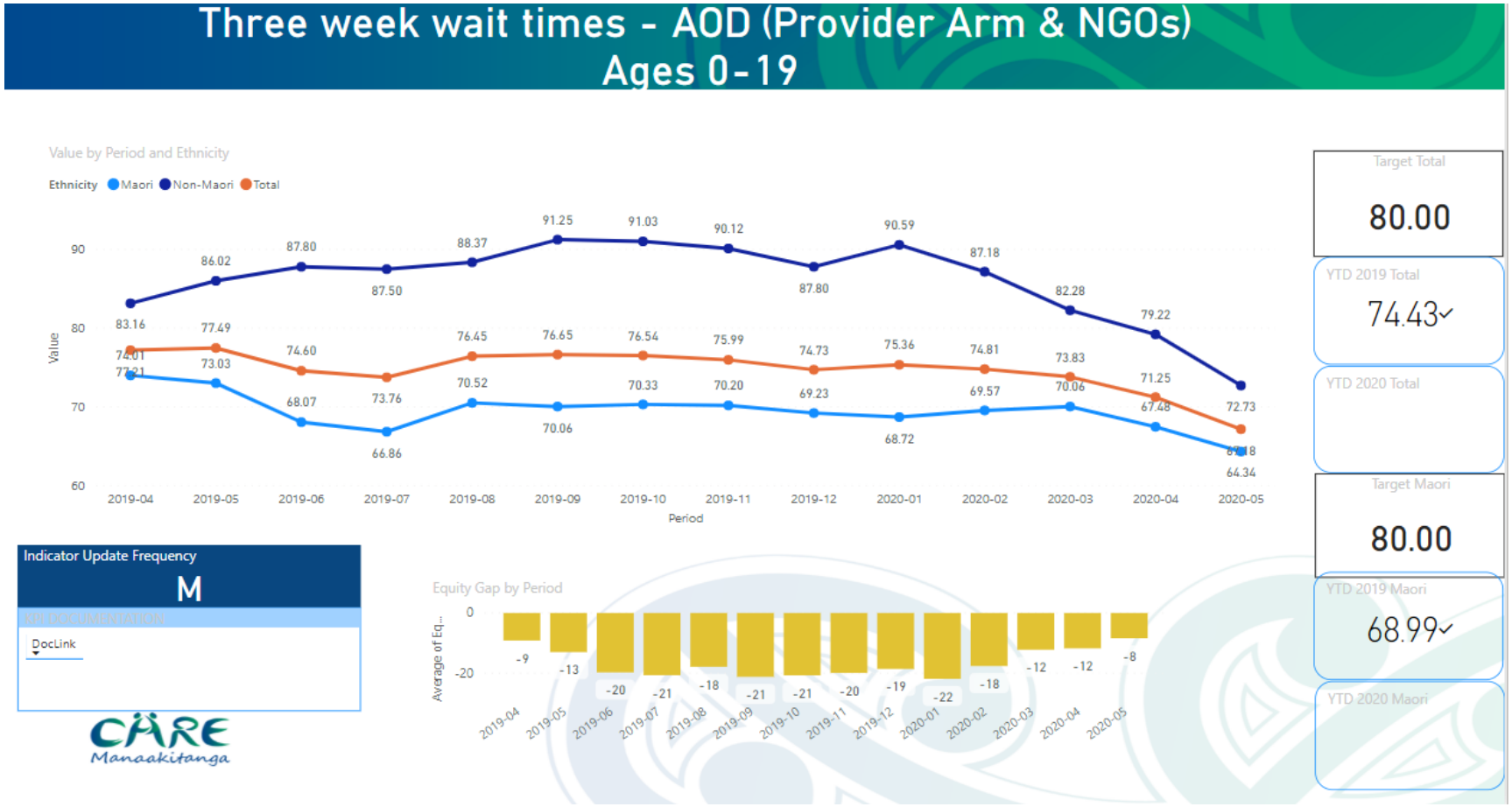
Definition
Internal Indicator:
Did not attend rate for outpatient services, Target 5%.



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.
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.

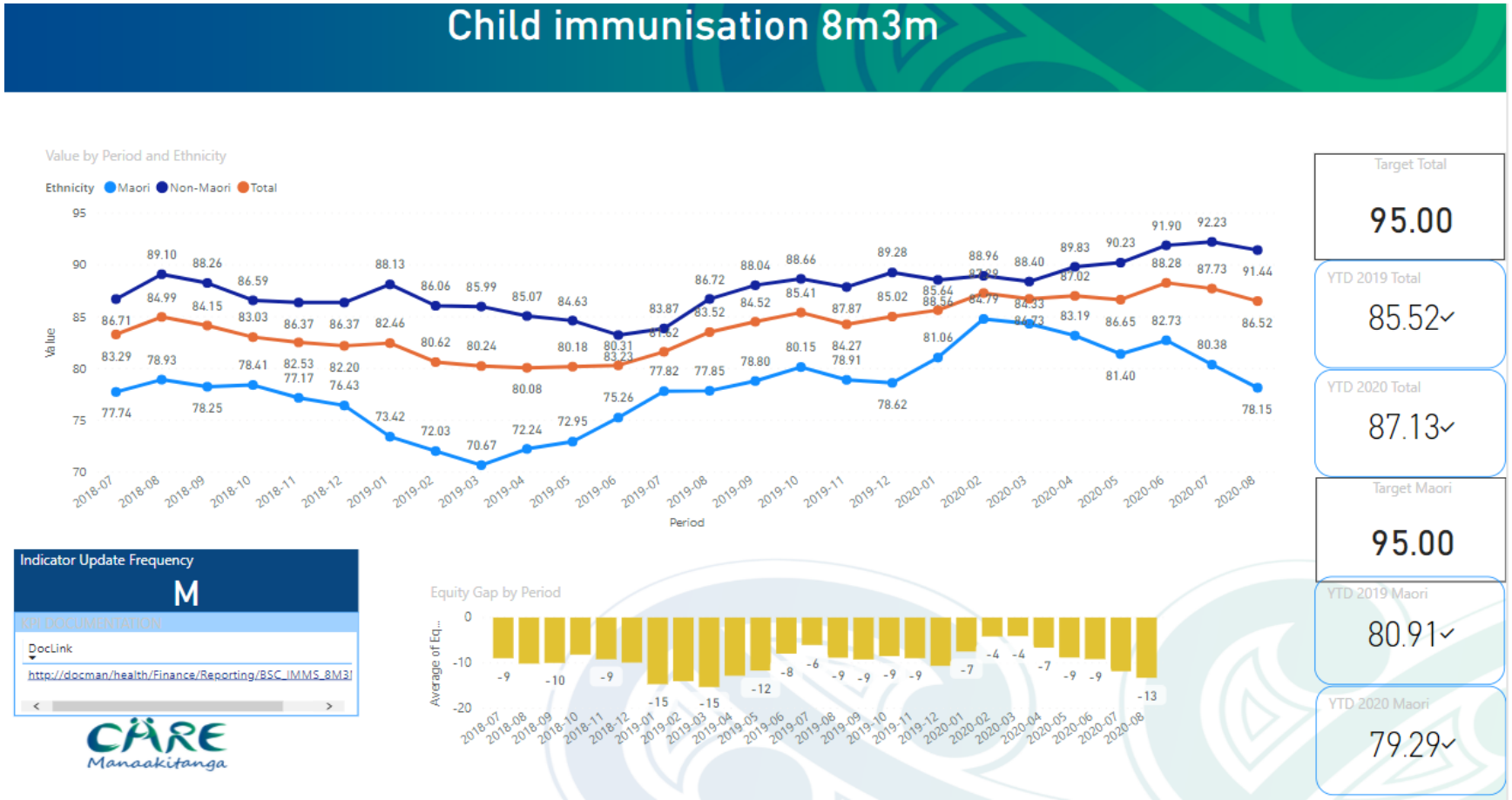
The latest figures cover the Covid-19 lockdown period.

The equity gap for this measure has been decreasing in the last two months but again this was Covid period, therefore we cannot say that is actually improving.

Definition

MOH Indicator CW05 Immunisation coverage at eight months of age:

≥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%.



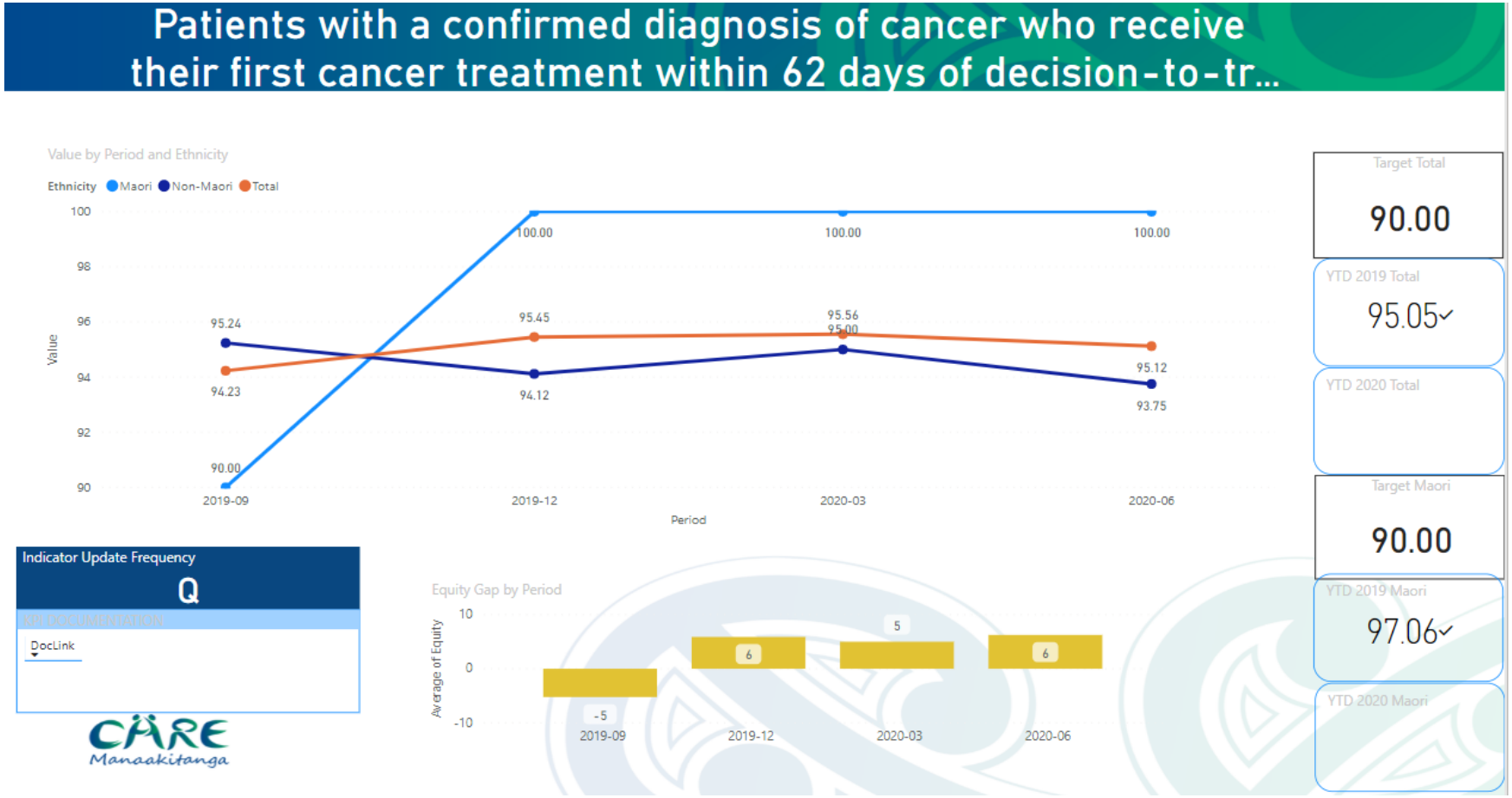
Comments

The 8-month immunisation coverage has improved since June 2019, although in the last 2 months equity gap between Māori and Non-Māori has been increasing to 13% points in August.

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.

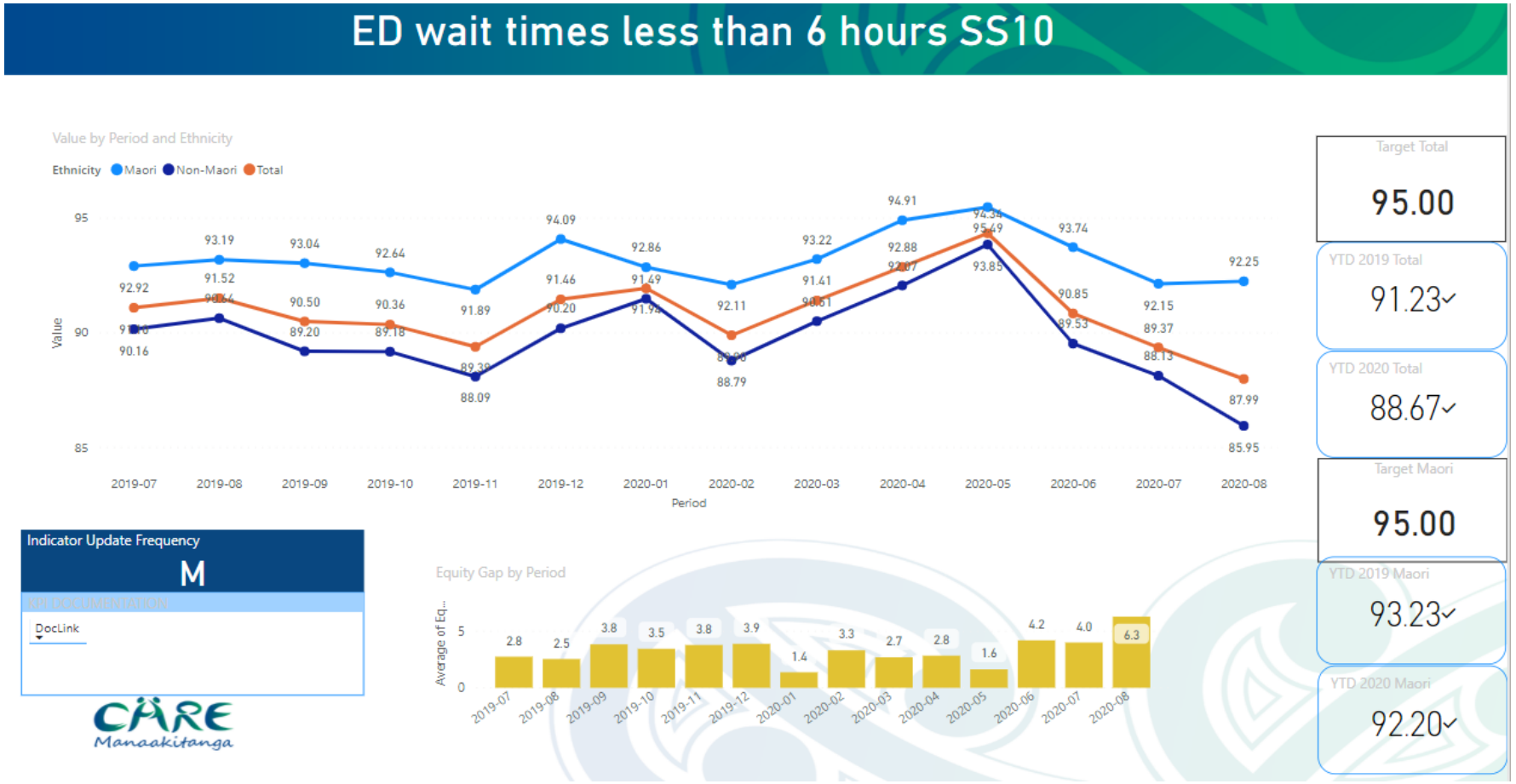


Comments:

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.



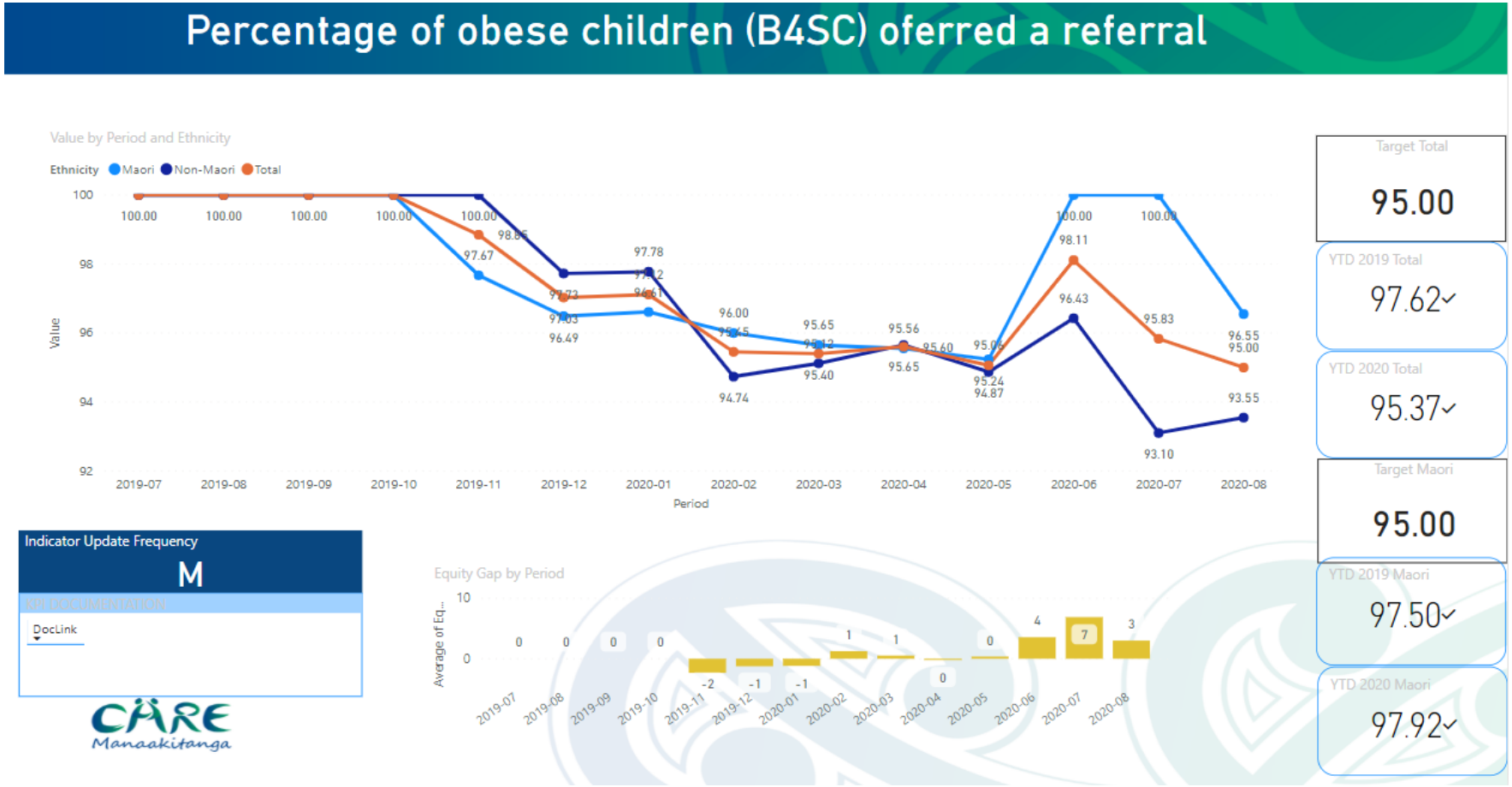
Comments:

Performance against the shorter stays in ED target improved in March, April and May as the volumes of ED Presentations dropped due to the COVID-19 response, however since June as the volumes of presentation have been increasing monthly.

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.

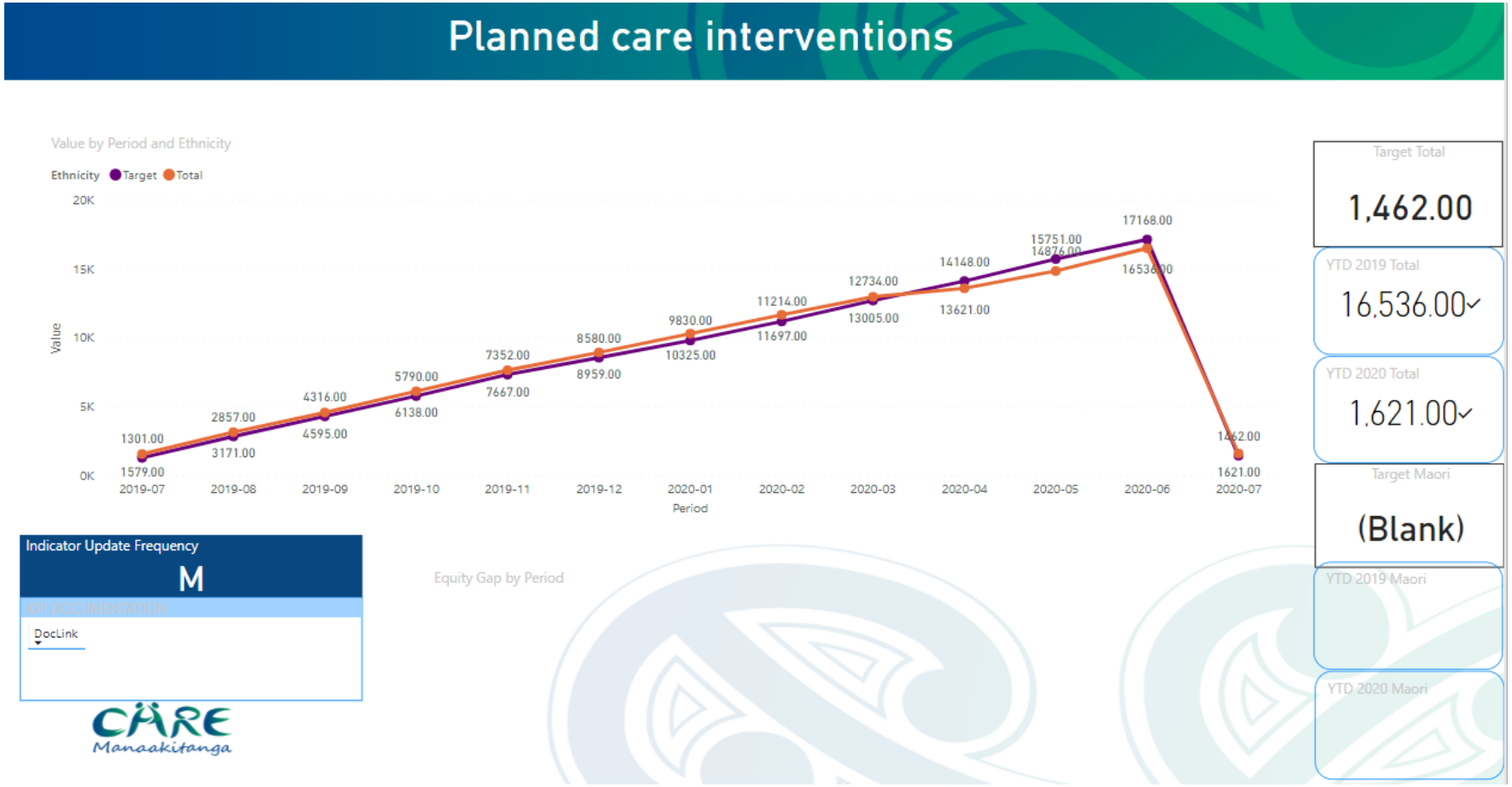
This measure met the target for total population in the last 3 months along with a positive equity gap.

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.



Comments:

Planned care interventions for 2019/20 was 17168, we were on target until march 2020. Actual interventions were 16536 (96%). For July 2020 the monthly target was 1462 and we achieved 1621(111%).

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Board Meeting
Agenda

Items for Noting

Māori Health Gains & Development

TTA 12 month Action Plan & Investment / Annual Plan alignment

TE TOI AHORANGI

TUKUNA ATU KI A / SUBMITTED TO:

Board (23 September 2020)	
Chief Executive Officer	27/08/2020
Board & Runanga Chairs	31/08/2020
Runanga Meeting (9th September, 2020)	31/08/92020

KAIWHAKARITE / PREPARED BY: Marama Tauranga, MANUKURA/ Executive Director Toi Ora,

KAIWHAKAMANA / ENDORSED AND SUBMITTED BY: Pete Chandler, CHIEF EXECUTIVE, BOPDHB

NGĀ TAUNAKI / RECOMMENDEDATION(S):

1. That this information is noted by Chief Executive and the Chairs of BOPDHB Board and Runanga.
2. That the information meets the matter/s arising from the Joint Board meeting on 19th August, 2020 which were:

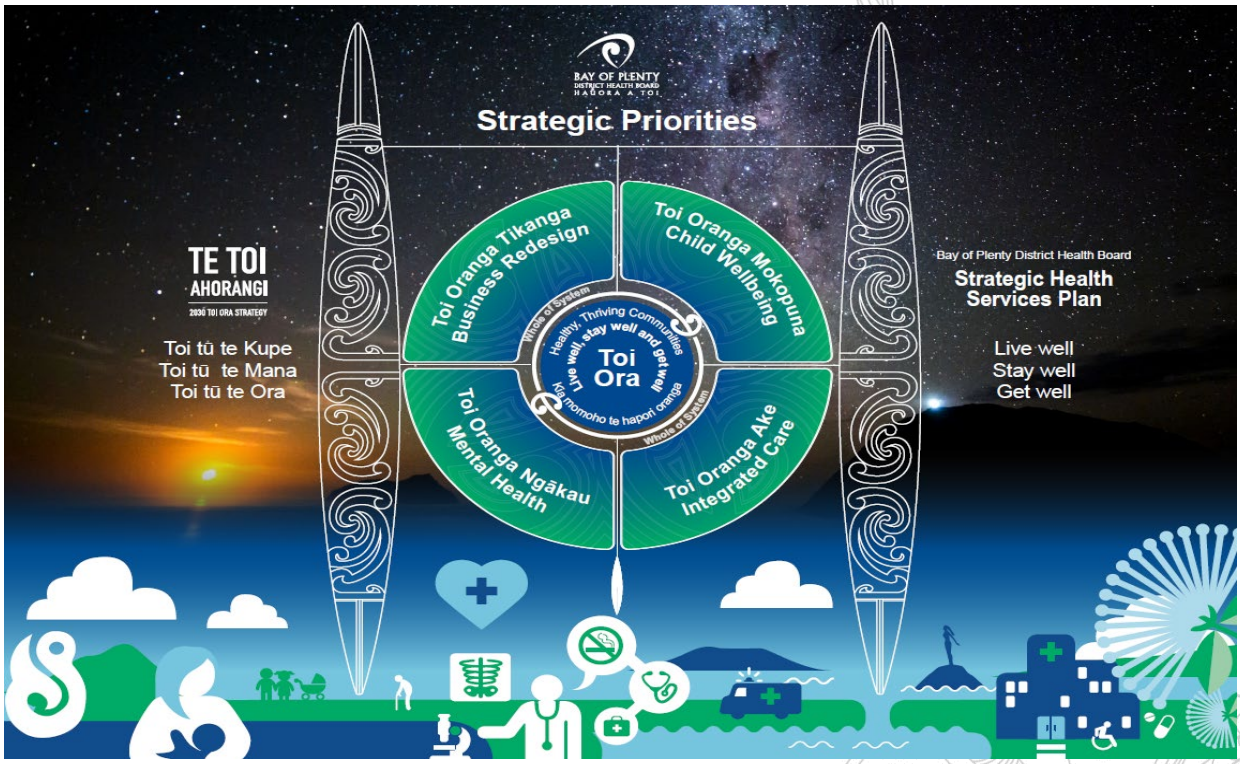
- TTA 12-month action plan needed to be submitted to Board and re-submitted to Runanga
- Clarify budget allocated TTA implementation
- Identify connection points of Annual Plan to TTA Au Rangi.

NGĀ TĀPIRITANGA / ATTACHMENTS

- Te Toi Ahorangi (TTA) 12- month action plan
- Roadmap TTA & Annual Plan
- FMC Paper - Whare Waka

HE KŌRERO WHAKATAKI / BACKGROUND:

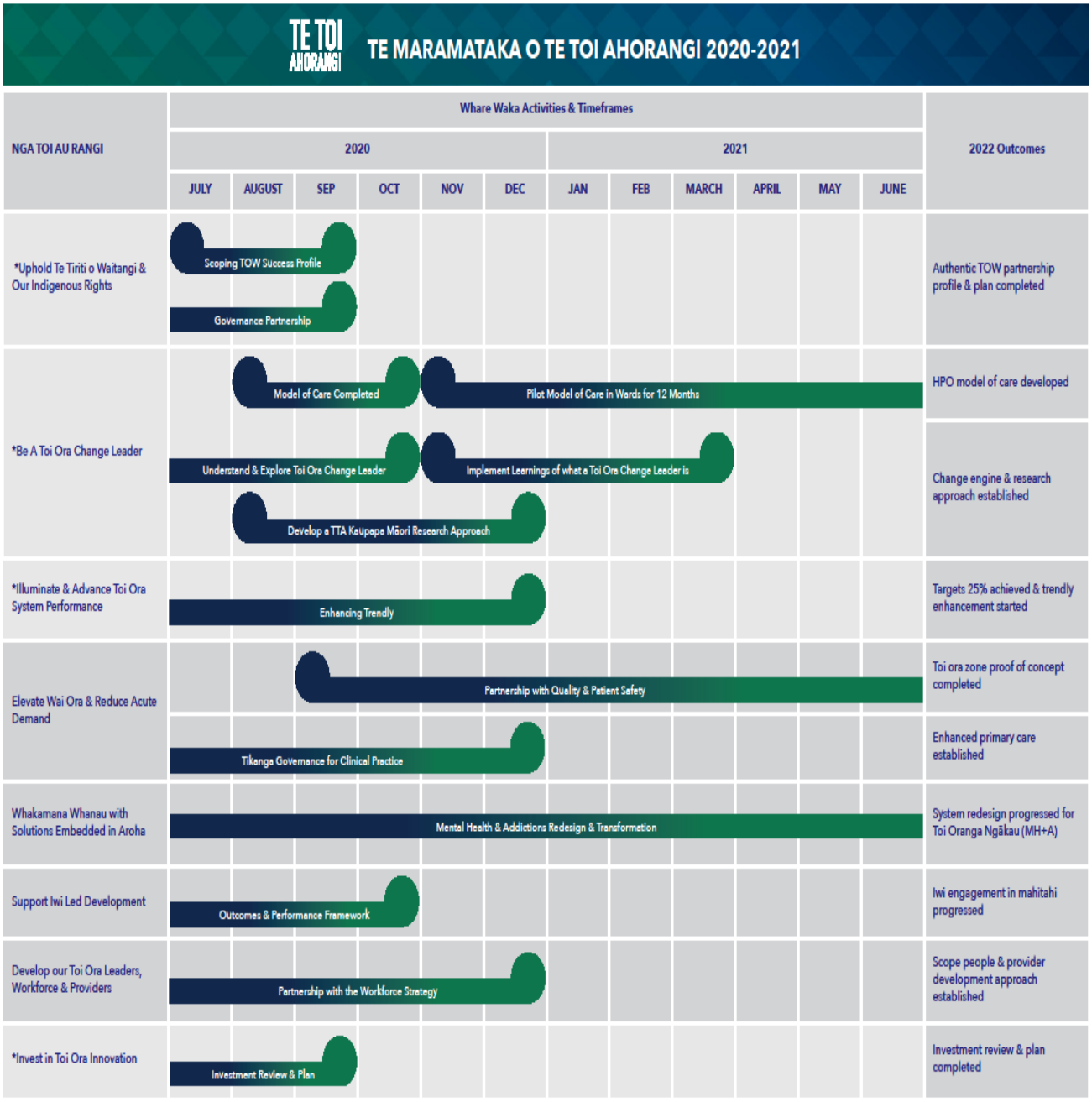
The 12-month action plan was submitted for Runanga endorsement in July as part of an overall update on TTA implementation. The Runanga endorsed the 12-month action plan at this meeting. Through Ngā Toi Au Rangi, Te Toi Ahorangi maps the high level, high impact goals that will enable whānau to progress to Toi Ora (flourishing) over the next 10 years.



The four combined strategic priorities: Toi Oranga Mokopuna, Toi Oranga Ngakau, Toi Oranga Ake and Toi Oranga Tikanga have clear linkages mapped within and between Te Toi Ahorangi and the Strategic Health Services Plan therefore the milestones achieved through the Whare Waka will positively impact the DHB's strategic priorities.

The Te Toi Ahorangi action plan for the next 12-months is presented on the next page (pg.3); it identifies the timelines for the nominated projects 20/21 and shows the remaining au rangi where preparatory work and business hygiene is being undertaken.

Note: The timelines for this 12-month period include the national pandemic environment – work continued during all alert phases with the goal of meeting expected milestones overall in 2021 and 2022.



The specific projects being activated in the next 12 months for Te Toi Ahorangi are:

- **Uphold Tiriti o Waitangi & Indigenous Rights**
  - Develop authentic ToW partnership profile and plan
  - Implement ToW partnership plan (25% completed)

- **Be Toi Ora Change Leaders**
    - HPO model of care developed and tested
    - HPO model of care (15% implemented in DHB)
    - Change engine and research approach established
    - Centre of Toi ora excellence and innovation established
    - Explore shift to Iwi Governance

- **Invest in Toi Ora Innovation**
    - Investment review & plan completed

Note: Maori Health Gains and Development continues to support the enhancement and creation of a health intelligence system for the DHB providing equity expertise in the design of power BI performance monitoring boards.

Note: Improvement work continues for Māori Health targets lead by the Pou Mātai Rongoa, key areas of focus are breast screening, oral health, flu immunization for all at risks groups, support of speciality areas with regards DNA rates in orthopaedics and paediatrics.

Note: The mental health transformation has been underway since 2018 when the He Ara Oranga (HAO) recommendations where released and the Ministry of Health activated processes for DHB's to commence improvement and system redesign work. Progress against objectives and recommendations in HAO have been compromised for a myriad of reasons.

In March 2019, Maori Health Gains appointed our first Toi Oranga Change Leader which was focused on the Mental Health space, the role design was distinctly different to a portfolio manager because MHGD review of itself recognised the need for roles to be driven by te reo me ona tikanga to affect change. The first priority was whanaungatanga with Maori providers and groups to reconnect the organisation with these key partners.

Since March 2019, Kaupapa Maori providers in the east and the west have worked with the Toi Oranga Ngakau to realign contracts, to look for collaboration opportunities, this includes working with entities like Nga Matapuna Oranga's Tuapapa Model of Care and Service delivery, working with EBOP providers on test of change for respite options, supporting the organisation work in authentic partnership with our Iwi partnership with regards the AOD residential options.

In March 2020, Project Management resource to support this project was introduced by Improvement and Innovation Service, the intention of this role was to drive the transformation, a reset of this role which is now vacant is underway in recognition that leadership for transformation must come from the leadership group compromising of lived experience representatives, providers incl. Kaupapa Maori, frontline representatives from DHB not necessarily leadership. The Mental Health transformation program has consulted with key groups incl. lived experience and is ready for next step to form a leadership group, the Pou Tikanga has been asked to support the formation of this group.

Note: Executive Sponsor's are allocated to each strategic priority, the Manukura is allocated Mental Health, a sponsor is not delegated authority for decision making over project manager and the program of work has no allocated budget.

An FMC proposal (see appendix 1) was submitted to purchase strategic expertise and capacity within the Whare Waka (PMO) that will activate and operationalise projects and initiatives to achieve the milestone goals in Ngā Toi Au Rangi. Following the successful submission of the Whare Waka business case the $500k budget was allocated by project:

	Allocated
Budget: *Breakdown by Project*	$500k
Develop authentic ToW partnership profile, plan, implement *Associated Aurangi: Uphold Te Tiriti o Waitangi & Our Indigenous Rights*	120k
HPO model of care development, tested and implemented *Associated Aurangi: Be A Toi Ora Change Leader*	155k
Change engine & research approach established *Associated Aurangi: Be A Toi Ora Change Leader*	30k
Centre of Toi Ora excellence and innovation established *Associated Au rangi: Be A Toi Ora Change Leader*	50k
Explore shift to iwi governance *Associated Au rangi: Be A Toi Ora Change Leader*	80k

HE TA TĀTARITANGA / ANALYSIS:

As stated, the four strategic priorities are linked to the both strategic plans for the DHB and this connection was enhanced during the annual planning preparation period because the Maori Health Gains and Development team identified that a large number of items in the annual plan had potential to contribute to Te Toi Ahorangi.

Note: The Te Toi Ahorangi items in the annual plan are not operating under the same scrutiny, or involvement with MHGD and or the Whare Waka program of work therefore it is difficult to ascertain if the Te Toi Ahorangi outcomes will be achieved.

Note: The Whare Waka has been designed with a number of quality assurance mechanisms incl. matauranga maori expertise across the au rangi programmes of work to ensure it meets the TTA vision and stays grounded in Te Ao Maori. In-addition the robust program structure which includes the recent invitation to the chairs of the Runanga and Board to nominate a representative to join the program executive (Manukura role) is aimed to enable, support and champion the work at a governance level.

Conclusion

MHGD will work alongside our peers and the organisation to support progression of actions in the Annual Plan noting we do not have unlimited capacity to be in all projects the BOPDHB is undertaking and our priority remains the implementation of the Te Toi Ahorangi strategy to ensure we are moving towards Flourishing.

NGĀ KUPU WHAKAMĀRAMA / DEFINITIONS USED:

Ngaā kupu / Term	***Ngā Māramatanga / Definition***
	[Tab to add rows]

TE TOI AHORANGI — TE MARAMATAKA O TE TOI AHORANGI 2020-2021

NGA TOI AU RANGI	Whare Waka Activities & Timeframes												2022 Outcomes
	2020						2021						
	JULY	AUGUST	SEP	OCT	NOV	DEC	JAN	FEB	MARCH	APRIL	MAY	JUNE	
*Uphold Te Tiriti o Waitangi & Our Indigenous Rights	Scoping TOW Success Profile												Authentic TOW partnership profile & plan completed
	Governance Partnership												
*Be A Toi Ora Change Leader		Model of Care Completed			Pilot Model of Care in Wards for 12 Months								HPO model of care developed
	Understand & Explore Toi Ora Change Leader				Implement Learnings of what a Toi Ora Change Leader is								Change engine & research approach established
		Develop a TTA Kaupapa Māori Research Approach											
*Illuminate & Advance Toi Ora System Performance	Enhancing Trendly												Targets 25% achieved & trendly enhancement started
Elevate Wai Ora & Reduce Acute Demand			Partnership with Quality & Patient Safety										Toi ora zone proof of concept completed
	Tikanga Governance for Clinical Practice												Enhanced primary care established
Whakamana Whanau with Solutions Embedded in Aroha	Mental Health & Addictions Redesign & Transformation												System redesign progressed for Toi Oranga Ngākau (MH+A)
Support Iwi Led Development	Outcomes & Performance Framework												Iwi engagement in mahitahi progressed
Develop our Toi Ora Leaders, Workforce & Providers	Partnership with the Workforce Strategy												Scope people & provider development approach established
*Invest in Toi Ora Innovation	Investment Review & Plan												Investment review & plan completed

TE TOI AHORANGI

COMBINED TE TOI AHORANGI & DHB ANNUAL PLAN PROJECTS

Nga Toi Au Rangi		Combined Te Toi Ahorangi & DHB Annual Plan Projects												Te Toi Ahorangi Outcomes 2022
		2020						2021						
		JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	
***Uphold Te Tiriti o Waitangi & Our Indigenous Rights**	Te Toi Ahorangi	Scoping TOW success profile			Developing an Authentic Partnership Profile Plan				Implementation of the Authentic Partnership Profile Plan					Authentic TOW partnership profile & plan completed
						Authentic Governance Partnership								
	DHB Annual Plan	Engagement and obligations as a Treaty Partner												
***Be a Toi Ora Change Leader**	Te Toi Ahorangi	Kaupapa Māori Model of Care review												HPO model of care developed
						Pilot Kaupapa Māori Model of Care in ward for 12-mths								
			He Pou Oranga Tangata Whenua review - Model of Practice review (Nga Pou Mana o Io)					Implementation of He Pou Oranga Tangata Whenua						
	DHB Annual Plan	Engagement and obligations as a Treaty Partner												
***Illuminate & Advance Toi Ora System Performance**	Te Toi Ahorangi	Understand & explore Toi Ora Change Leader				Implement learnings of what a Toi Ora Change Leader is								Change engine & research approach established
			Develop aTTA Kaupapa Māori Research Approach											
		Enhancing Trendly												Targets 25% achieved & trendly enhancement started
	DHB Annual Plan	Accelerate the Spread and Delivery of Kaupapa Māori Services												
		Planned Care												
		Savings plans - out year gains												
Elevate Wai Ora & Reduce Actue Demand	Te Toi Ahorangi			Partnership with Quality & Patient Safety										Toi ora zone proof of concept completed
		Tikanga Govenance for Clinical Practice												Enhanced primary care established
	DHB Annual Plan	Primary healthcare integration / integrate car deiveray of regional service plans (RSP) priorities and relevant national service plans												
		Acute Demand												
		Family violence and sexual violence												
		Saving plans - out year games												
		Engagement and obligations as a Treaty Partner												
Whakamana Whanau with Solutions Embedded in Aroha	Te Toi Ahorangi	Mental Health & Addictions Redesign & Transformation (only involvement is that Manukura is Programme Executive)												System redesign progressed for Toi Oranga Ngākau (MH+A)
	DHB Annual Plan	NZ Cancer Action Plan 2019 -2029												
		Planned Care												
		Mental Health & Addictions Systems Transformation												
		Delivery of Whānau Ora (Model of Care Development - He Pou Oranga Tangata Whenua)												
		Maternity and early years												
		Improving Quality - Mental Health and Addicitons												
Support Iwi Led Development	Te Toi Ahorangi	Outcomes & Performance Framework												Iwi engagement in mahitahi progressed
	DHB Annual Plan	Healthy Ageing												
		Acute Demand												
		Accelerate the Spread and Delivery of Kaupapa Māori Services												
		Engagement and obligations as a Treaty Partner - Mahitahi												
		Māori Health Action Plan - Strengthening System Settings												
Develop our Toi Ora Leaders, Workforce & Providers	Te Toi Ahorangi	Partnership with the Workforce Strategy												Scope people & provider development approach established
	DHB Annual Plan	Workforce, Māori Health Action Plan - Shifting Cultural and Social Norms - Accelerate the spread and delivery of Kaupapa Māori Services												
		Māori Health Action Plan - Shifting Cultural and Social Norms												
		Accelerate the spread and delivery of Kaupapa Māori Services												
***Invest in Toi Ora Innovation**	Te Toi Ahorangi	Investment Review & Plan												Investment review & plan completed
	DHB Annual Plan	Working with sector partners to support sustainable system improvements												
		Saving plans out year games												
		Māori Health Action Plan - Accelerate the spread and delivery of kaupapa maori services Review of investment												

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											√		