2021/22 Lakes DHB Annual Plan

Incorporating the Statement of Performance Expectations

Presented to the House of Representatives pursuant to sections 149 and 149(L) of the Crown Entities Act 2004

Contents

SECTION 1: Overview of Strategic Priorities

1.1 Strategic Intentions/Priorities

This annual plan articulates the commitment of Lakes District Health Board (DHB) to meeting the Aotearoa, New Zealand Minister of Health's expectations, and our continued commitment to achieving the Lakes DHB vision of *Healthy Communities – Mauri Ora!,* not just in the Lakes region, but across the whole Waiariki, Bay of Plenty. This narrative Annual Plan is supported by the Lakes DHB Financial Annual Plan. Clinical leadership teams have been involved in planning through the clinical Executive Directors at both DHBs, and will continue to support and monitor relevant sections of this Annual Plan.

The recent Health and Disability System Review[1] (2020), identifies "Strengthening Planning" as one of four key themes, and encourages DHBs to work collectively, to become more sustainable, effective and efficient. Therefore Lakes DHB and the Bay of Plenty District Health Board (BoP DHB) have agreed to use this annual planning opportunity to co-plan across Waiariki.

Achieving the objectives required by sections 22 and 38 of the New Zealand Public Health and Disability Act 2000, requires full commitment from the DHBs to Te Tiriti o Waitangi, the New Zealand Health Strategy, Whakamaua: Māori Health Action Plan 2020-2025[2], The UN Convention on the Rights of Persons with Disabilities, the Healthy Ageing Strategy and Ola Manuia 2020-2025: Pacific Health and Well-being Action Plan[3]. Lakes DHB is committed to implanting the outcomes of the Disability Strategy and are working with BoP DHB to develop a regional Disability Action Plan. Lakes DHB are working hard to roll out a successful COVID-19 vaccination programme.

Lakes and BoP DHBs have worked hard to develop savings plans to support system sustainability, and this will be reflected in the financial sections of this plan. Resources are directed to achieving Health Equity for Māori and vulnerable populations so that health service design and delivery aligns with the strategic vision and objectives of Pae Ora- Healthy Futures, as well as the New Zealand Health Strategy. Lakes DHB have undertaken a Commissioning Plan, which has an equity focus to ensure resources are directed to services and projects that will improve the health of Māori and vulnerable population groups. Lakes and BoP DHBs are jointly working on an equity focussed Disability Action Plan for the BoP and Southern Lakes Region.

The Waiariki Leadership Group

To fully optimise integration and equity aspirations and ensure health outcomes are realised, it is essential that the DHBs work in collaboration, not only with each other, but with the wider state sectors.

Changes to the State Sector Act 1988, prompted the Waiariki regional leaders of public agencies to join together to help deliver better outcomes and services for the population as a whole region. Since 2018, the region has been growing this approach to support regional and local government, and community leaders, to work together with central government agencies on agreed priorities for the wellbeing of local communities. The Regional Leadership group is comprised of CEOs, Governance and Iwi representatives from the following agencies:

- Health
- Ministry of Education
- Police
- Ministry of Social Development
- Oranga Tamariki
- Tuhoe
- Ngāti Rangitihi
- Te Arawa
- Ngāti Tūwharetoa Ki Kawerau (Putauaki)
- Bay of Plenty Regional Council

The regional vision closely aligns with both Lakes and BoP DHB priorities:

> *Bay of Plenty to be the best place in Aotearoa for whānau to raise a child – wellbeing is supported, brought up in a safe, loving, nurturing and healthy environment.*

[1] https://systemreview.health.govt.nz/
[2] https://www.health.govt.nz/our-work/populations/Māori -health/whakamaua-Māori -health-action-plan-2020-2025
[3] https://www.health.govt.nz/publication/ola-manuia-pacific-health-and-wellbeing-action-plan-2020-2025

There are five priorities:

1. **Building Capability to engage and partner with Māori** – address our unconscious bias and build our responsiveness, capability and capacity to better engage with our Iwi partners.
2. **Acting Early for Child Wellbeing** – identifying vulnerable whānau with focussed support especially in the first 2000 days.
3. **Engaging Rangatahi and Strengthening Pathways** – improve school attendance and engagement in education especially young people in care and strengthen the pathway to future employment and or training.
4. **Safe and Thriving Whānau** – keeping whānau safe from harm with a focus on addictions, as a way of improving the safety and social cohesion of our communities.
5. **Building Communities** – supporting whānau and communities most in need with appropriate and safe housing options so that whānau are warm, safe and healthy.

Lakes and BoP DHB have a number of commonalities, with health inequity and needs, demographic profiles and services provided across both Lakes and BoP DHB regions.

Shared services and forums include:

- Toi Te Ora Public Health Service
- Needs Assessment and Service Coordination - Disability
- Sports BoP
- BoP Regional Council
- BoP Collective Impact Group[4]
- Regional Skills Leadership Group
- Toi Ohomai Institute of Technology

Lakes and BoP DHBs' populations experience similar health inequity and have priority groups that are the same focus for improvement in 2021/22:

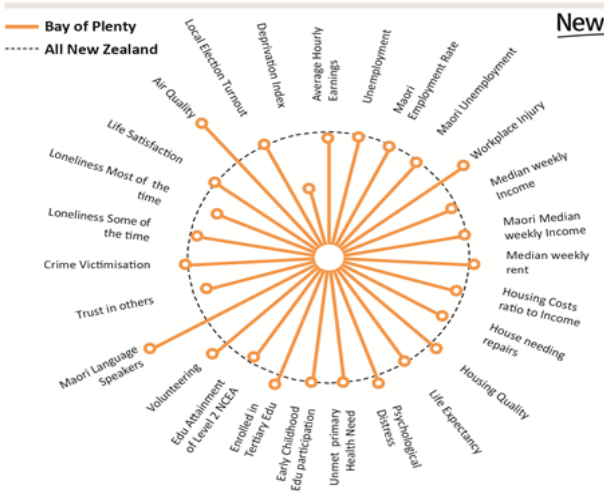
- Māori Health Equity
- Maternal, Child and Youth
- Immunisation
- Sustainability
- Mental Health
- Acute Demand
- Ageing populations
- COVID-19 response, impact and psychosocial wellbeing

Both Lakes and BoP DHBs are two of the five DHBs belonging to Te Manawa Taki region. Both DHBs belong to 10 Midland health networks to focus on regional health inequities and prioritising a collective effort to achieve the vision of Te Manawa Taki Health Equity Plan. Throughout this plan, reference will be made to Te Manawa Taki.

The following five pages show the whole Waiariki region profile and the commonalities we share, as well as health data comparisons.

[4] Bay of Plenty Collective Impact Governance Group - Lakes DHB is part of the inter-sectorial group Bay of Plenty Collective Impact Governance Group (BOPCIGG). BOPCIGG is a strategic leadership and governance group that feeds up into the Regional Leadership Group and is also made up of regional central government leaders in the Bay of Plenty including the Lakes DHB.

Bay of Plenty regional profile



New Zealand Government

Indicators compared to all New Zealand

Interpreting this graphic

This radial graphic compares indicators from Bay of Plenty with New Zealand over all.

If the orange line is outside the dotted line, Bay of Plenty is performing better than New Zealand overall.

This comparison is done using ratios between Bay of Plenty and New Zealand over all, allowing comparisons between indicators as well as between regions.

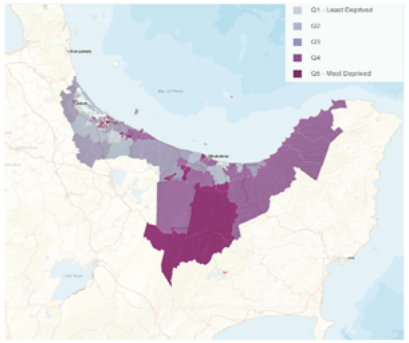
Indicators Snapshot over time

Draft v0.78.08.11.2019

New Zealand Deprivation Index

5,397 is median deprivation index number for Bay of Plenty DHB region.

(2,980 is the median for all New Zealand)



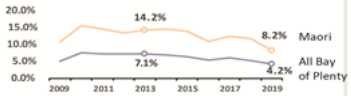
The 2013 New Zealand Deprivation Index is based off the 2013 New Zealand Census, and collates multiple indicators to provide comparisons between regionals and give a sense of deprivation.

The map used here is District Health Board for Bay of Plenty by area unit.

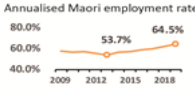
Bay of Plenty has some of the highest deprivation areas in all New Zealand.

Employment and Earnings

Annualised unemployment rate for Maori and All Bay of Plenty



Annualised Maori employment rate



64.5 percent of Maori in Bay of Plenty are employed, 2019.

(63.2 in all New Zealand)

3.8 percent of people in Bay of Plenty had a workplace injury in 2018.

(4.8 percent for All New Zealand)

Median hourly earnings

Income and Consumption

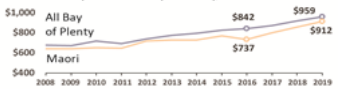
959 dollars is the median weekly in come in Bay of Plenty as at June 2019.

(1000 dollars is the median in all New Zealand)

912 dollars is the median weekly income for Maori in Bay of Plenty as at June 2019.

(912 dollars is the median in all New Zealand)

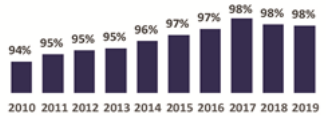
Median weekly income in Bay of Plenty, and for Maori



Poverty Indicator

Knowledge and Skills

Early Childhood Education participation in Bay of Plenty



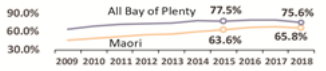
42.1 percent of school leavers in Bay of Plenty go on to study at the tertiary level

(38.8 percent for all New Zealand)

23.6 percent of school leavers in Bay of Plenty have a Bachelors within three years.

(32.1 percent for all New Zealand)

Percentage of school leavers with level 2 NCEA, Bay of Plenty



Health

Life Expectancy

6.4 percent prevalence rate of psychological distress in Bay of Plenty between 2014 and 2017.

(6.9 percent for all New Zealand)

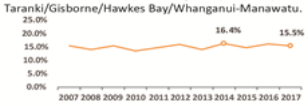
28.1 percent prevalence rate for people who have experienced one or more unmet primary healthcare needs in 2014-2017.

(28.0 percent for all New Zealand)

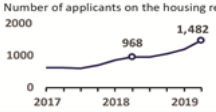
Housing

The median rent in Bay of Plenty, as at June each year

Ratio of income spend on housing in Bay of Plenty/Northland/ Taranki/Gisborne/Hawkes Bay/Whanganui-Manawatu.



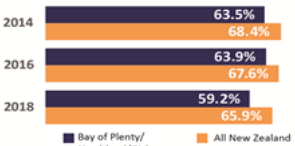
Number of applicants on the housing register in Bay of Plenty



6.3 percent of households the Bay of Plenty have major problems with mold or dampness, 2014

Safety

Percentage of people who have high trust in Others (broad region)



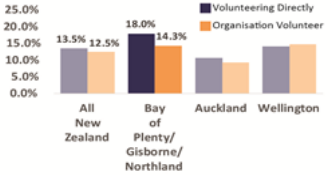
29.0 percent the prevalence of crime victimisation in Bay of Plenty.

(29.3 percent for all New Zealand)

Number of children in care

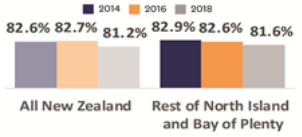
Time Use

Percentage of people who volunteer, by type and region 2018



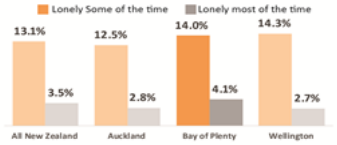
Subjective Wellbeing

The percentage of people who rated their life satisfaction as high or very high



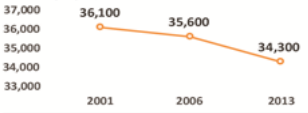
Social Connectedness

The percentage of people who felt lonely some or most of the time in 2018



Cultural Identity

Maori language speakers

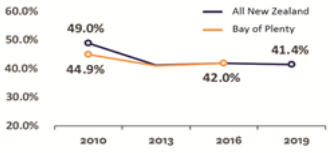


80.2 percent of people in Bay of Plenty find it easy to express themselves in 2018.

(83.8 percent for all New Zealand)

Civic Engagement

Percentage of registered voters who voted in local elections



Environment

Air quality in Bay of Plenty Urban centres

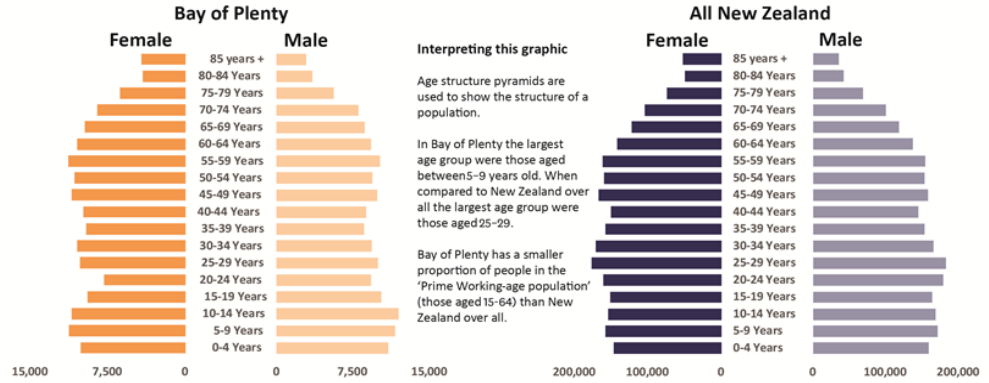
[5]

[5] Excludes Southern Lakes as this falls under Waikato Boundaries

Bay of Plenty in context

New Zealand Government Draft v0.78.08.11.2019

Age structure



Interpreting this graphic

Age structure pyramids are used to show the structure of a population.

In Bay of Plenty the largest age group were those aged between 5–9 years old. When compared to New Zealand over all the largest age group were those aged 25–29.

Bay of Plenty has a smaller proportion of people in the 'Prime Working-age population' (those aged 15-64) than New Zealand over all.

324,200 usually resident people live in Bay o Plenty as at June 2019.

(279,700 as at June 2013)

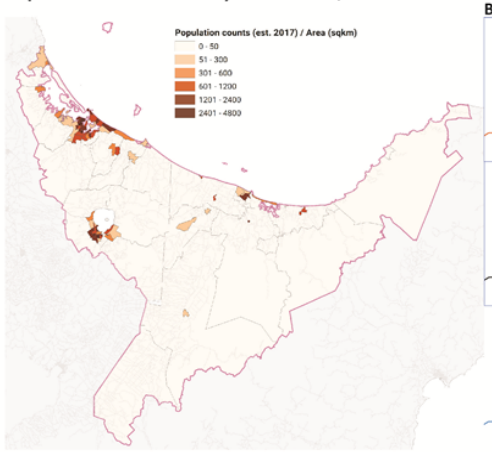
6.6 percent of people in New Zealand live in the Bay of Plenty as at June 2019.

(5.7 percent as at June 2013)

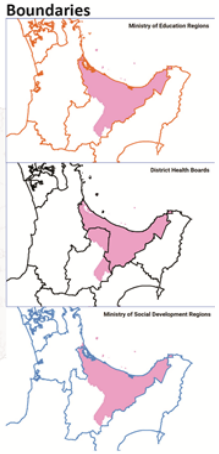
4,917,000 usually resident people live in New Zealand as at June 2019

(4,442,100 as at June 2013)

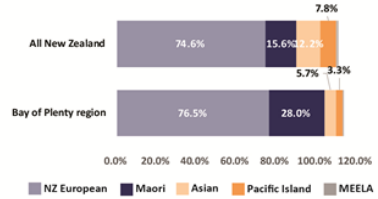
Population distribution by mesh-block, 2017



Comparing Organisation Boundaries

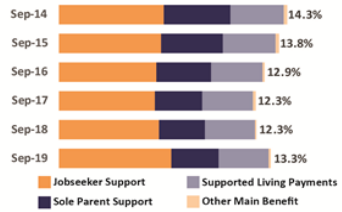


Self-identified total response ethnicity



Welfare assistance

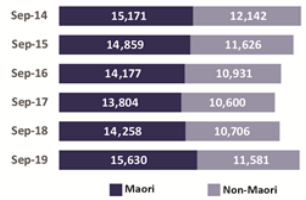
Percentage of the working-age population (18–64 years) receiving a main benefit in Bay of Plenty for each September quarter



13.3 percent of the working-age population receive a main benefit in Bay of Plenty as at September 2019.

(10.0 percent for all New Zealand)

Number of working-age Maori and Non-Maori receiving a main benefit in Bay of Plenty for each September quarter



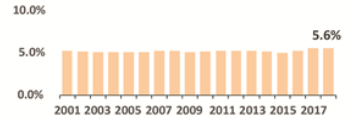
57.2 percent benefit recipients in Bay of Plenty are Maori.

(53.8 percent as at September 2019)

Economic snapshot

Regional nominal per capita gross domestic product (GDP)

Percentage of New Zealand GDP from Bay of Plenty



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[6] Excludes Southern Lakes as this falls under Waikato Boundaries

Regional Comparisons of Performance

Lakes District Health Board

Demographic drivers

Figure 1: % Māori population

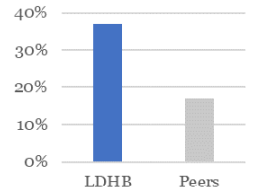


Figure 2: % >65 population

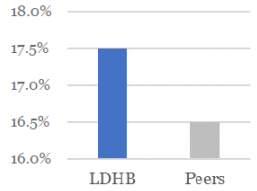


Figure 3: % quintile 4 and 5

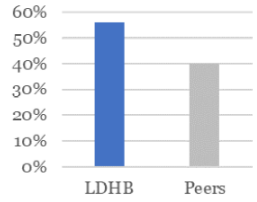
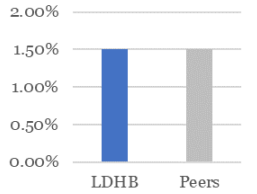


Figure 4: % population change compared to previous financial year



Lakes DHB's population is growing at a similar rate to the national average. This suggests that workload pressures from population growth is similar to the national average.

However, the DHB serves a greater proportion of older people, Māori and people living in areas considered to be of higher deprivation. This will increase workload pressure.

Bay of Plenty District Health Board

Demographic drivers

Figure 1: % Māori population

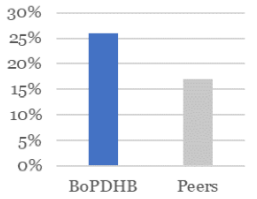
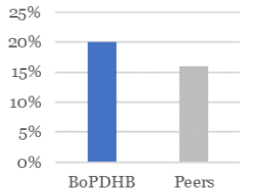


Figure 2: % >65 population



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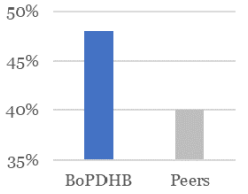
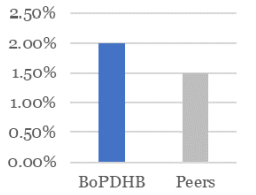


Figure 4: % population change compared to previous financial year



Bay of Plenty DHB's population is growing at a faster rate than the national average. The DHB has a larger proportion of those aged 65 years and over, of Māori and of people living in areas of higher deprivation compared to national averages.

This suggests that workload pressures from population growth and the demographic characteristics of the DHB are much more intense than national averages.

Secondary care activity trends

Metric	LDHB	Peers	Difference
Total ED attendances % change Q1 2019/20 – Q1 2020/21	-7.7%	-16.6%	8.9%
Planned hospital discharges % change Q1 2019/20 – Q1 2020/21	13.9%	6.5%	7.4%
Unplanned hospital discharges % change Q1 2019/20 – Q1 2020/21	-1.4%	-7.5%	6.1%
Standardised unplanned re-admissions (0-28 days)	12.3%	12.0%	0.3%
Expected and actual planned LOS variance (casemix-funded med/surg)	-0.1	0.0	-0.1
Expected and actual unplanned LOS variance (casemix-funded med/surg)	0.1	0.0	0.1

Between quarter 1 2019/20 and 2020/21, secondary care activity decreased, however, this decrease was less than peers. The decrease in unplanned secondary care activity despite increasing demographic pressure may indicate that primary and community care is meeting a portion of that workload pressure. While this is the case, there remains a need continue to improve length of stay while minimising risks for unplanned readmissions. Re-admission rates are higher than the national average.

Secondary care activity trends

Metric	BoPDHB	Peers	Difference
Total ED attendances % change Q1 2019/20 – Q1 2020/21	-8.3%	-16.6%	8.3%
Planned hospital discharges % change Q1 2019/20 – Q1 2020/21	7.0%	6.5%	0.5%
Unplanned hospital discharges % change Q1 2019/20 – Q1 2020/21	-2.8%	-7.5%	4.7%
Standardised unplanned re-admissions (0-28 days)	11.9%	12.0%	-0.1%
Expected and actual planned LOS variance (casemix-funded med/surg)	0.1	0.0	0.1
Expected and actual unplanned LOS variance (casemix-funded med/surg)	0.0	0.0	0.0

Between quarter 1 2019/20 and 2020/21, unplanned hospital activity decreased (although at a slower rate than peer DHBs), suggesting demand pressures moderated over the period. Planned hospital activity increased more than peers. Readmission rates and planned and unplanned length of stay were similar to peer rates. Inpatient quality and safety indicators compare favourably with peers.

Financial performance	Key indicators	20/21 September YTD	Peer average***	LDHB trend from June 2019/20 YTD	September report (June YTD 2019/20)*****
	EBITDA as a % of revenue	4.2%	2.8%		1.7%
	Net deficit as % of revenue	0.4%	-1.1%		-2.7%
	Net deficit variance to Plan	-0.8%	0.3%		0.2%
	Working capital ratio (excl. employee entitlement provisions)	0.9	0.6		0.9
Service performance	Key indicators	LDHB		Compared to peers****	Compared to Sep report*****
	DHB of Domicile - Lakes DHB*				
	Unplanned hospitalisation rate per 1,000 population	121	120	1	-2
	Planned hospitalisation rate per 1,000 population	65	64	1	1
	*DHB of Service** – Rotorua Hospital*				
	Standardised readmission rate (0-28 days)	12.3%	12.0%	0.3%	-0.1%
	Unplanned Average Length of Stay (ALOS)	2.42	2.28	0.14	0.02
	Planned ALOS	1.72	1.60	0.12	-0.06
	Case-weights (from discharges with a procedure) per operating theatre	1,715.0	1,749.6	-34.6	70.5

Financial performance	Key indicators	20/21 September YTD	Peer average***	BoPDHB trend from June 2019/20 YTD	September report (June YTD 2019/20)*****
	EBITDA as a % of revenue	2.5%	2.8%		1.4%
	Net deficit as % of revenue	-1.1%	-1.1%		-2.6%
	Net deficit variance to Plan	2.0%	0.3%		1.4%
	Working capital ratio (excl. employee entitlement provisions)	0.6	0.6		0.7
Service performance	Key indicators	BoPDHB		Compared to peers****	Compared to Sep report*****
	DHB of Domicile - Bay of Plenty DHB*				
	Unplanned hospitalisation rate per 1,000 population	117	120	-3	-2
	Planned hospitalisation rate per 1,000 population	64	64	0	0
	*DHB of Service** – Tauranga Hospital*				
	Standardised readmission rate (0-28 days)	11.9%	12.0%	-0.1%	-0.2%
	Unplanned Average Length of Stay (ALOS)	2.28	2.28	0.00	0.01
	Planned ALOS	1.74	1.60	0.14	-0.04
	Case-weights (from discharges with a procedure) per operating theatre	2,096.9	1,749.6	347.3	42.5

Lakes DHB Profile

The three key strategic areas of focus in Te Manawa Rahi for Lakes DHB for 2021-2022 remain:

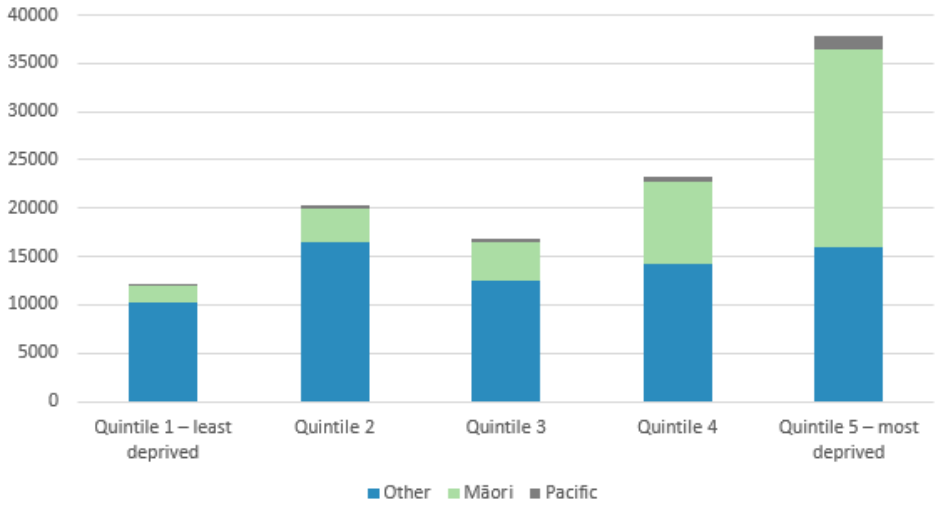
- Achieving equity in Māori health
- Building an integrated health system
- Strengthen people, whānau and community wellbeing

Lakes DHB has three organisational values. They are:

- **Manaakitanga** - Respect and acknowledgement of each other's intrinsic value and contribution
- **Integrity** - Truthfully and consistently acting collectively for the common good
- **Accountability** - Collective and individual ownership for clinical and financial outcomes and sustainability

Lakes DHB serves a population of just over 116,370 and covers 9,570 square kilometres. It stretches from Mourea in the north to Mangakino in the west down to Tūrangi in the south and across to Kaingaroa village in the east. The major centres of population are Rotorua and Taupō and the main smaller communities are Mangakino and Tūrangi. The DHB boundaries take in the two main Iwi groups of Te Arawa and Ngāti Tūwharetoa and Ngāti Kahungunu in the west (Mangakino).

As at the 2018 census, 37% of the Lakes population identify as having Māori ethnicity, a higher proportion of Māori than the national average of 17%. In the Lakes district, there are 36,750 under 25 (0-24) year olds, of whom 19,107 are Māori. The DHB area has a relatively high proportion of people in the most deprived section of the population[7].



[7] MOH NZ

Lakes DHB is responsible for the provision (or funding the provision) of the majority of health services in the Lakes district. These services in our district include:

- Māori health providers
- Mental health providers
- Doctors and primary health organisations
- Dentists
- Maternity services
- Rest homes
- Hospitals
- Other health services, such as pharmacies and physiotherapy.

Lakes DHB:

- works with key stakeholders to plan the strategic direction for health and disability services
- plans regional and national work in collaboration with the MoH and other DHBs
- funds the provision of the majority of the public health and disability services in the Lakes district, through the agreements with providers
- provides hospital and specialist services primarily for our population and also for people referred from other DHBs
- promotes, protects and improves our population's health and wellbeing through health promotion, health protection, health education and the provision of evidence-based public health initiatives

Health Challenges for Lakes

We know that health inequities exist in our population, particularly with Māori who:

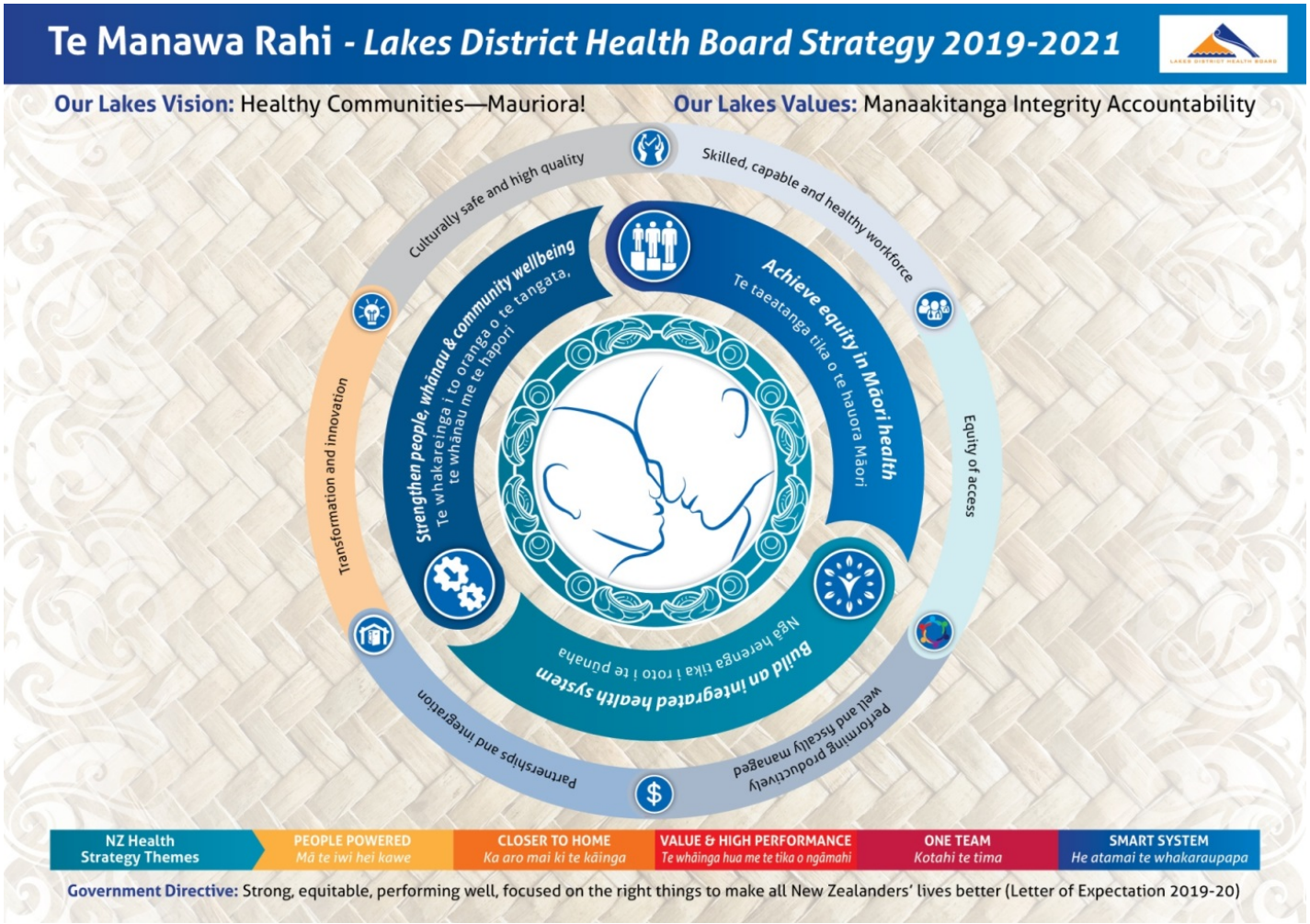
- are twice as likely to develop diabetes
- have higher rates of Cardiovascular Disease
- have higher rates of hospitalisation for chronic obstructive pulmonary disease (or 'smoker's lung')
- have higher cancer rates (especially for lung cancer)
- are more likely to need mental health and addiction services

There are also other big health issues in the Lakes district that need further plans including:

- the number of women who smoke in pregnancy
- homelessness and transient people
- the high number of obese, and morbidly obese adults and children
- poor oral health of our children
- declining Immunisation rates

Te Manawa Rahi Lakes DHB Strategy 2019 – 2021

This strategy sets out how we are going to do things differently to improve outcomes and enable our Whānau and community to Live Well, Stay Well and Get Well.



Governance

Iwi Governance Bodies

Lakes DHB has had formal relationships with Te Arawa and Ngāti Tūwharetoa since 2002. The basis for the relationships is:

- Provide leadership, direction, and advice to the Lakes DHB, Board committees, chief executive and management on all strategic matters affecting the health of Māori.
- To participate at a governance level (Board and Board committees) in agreeing the principles that underpin decision making processes that impact on the health and disability services for Māori within the Lakes DHB district.
- To be the vehicle for ensuring effective consultation, and participation of whānau, hapū and Iwi (Te Arawa and Ngāti Tūwharetoa).
- To participate in strategic development and planning to support the wellbeing of Te Arawa and Tūwharetoa and providing information and advice with the ability to influence and direct health service delivery.

Iwi governance representatives now participate in the Board and the Finance and Audit Committee (FAC) and continue to participate in the Hospital Advisory Committee (HAC), Community and Public Health Advisory Committee (CPHAC) and Disability Support Advisory Committee (DSAC).

Executive Governance – Te Kāhui Oranga

Te Kāhui Oranga is a combined leadership/executive group of Lakes DHB Board and Iwi governance representatives from Te Arawa and Ngāti Tūwharetoa. Te Kāhui Oranga aims to provide leadership, direction and advice to Lakes DHB, Board committees, the chief executive and management on all strategic matters affecting the health of Māori. Te Kāhui Oranga ensures participation at a governance level by agreeing the principles that underpin the decision making processes that impact on the health and disability services for Māori within the Lakes DHB district.

Te Tiriti o Waitangi

"Tihei Mauri Ora" – "The Breath of Life" signifies the direction for Māori health, Lakes DHB.

Lakes DHB is committed to Te Tiriti o Waitangi (The Treaty of Waitangi) and the principles and articles of partnership, participation and protection. Lakes DHB's implementation of the Treaty principles and articles is through a shared understanding that health is a 'taonga' (treasure). Giving proper and full effect to the Treaty goes beyond the traditional 'three Ps' principles of "Protection", "Partnership" and "Participation". The Waitangi Tribunal recommends adoption of the following principles:

- The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of primary health care.
- The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Māori.
- 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.
- The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori primary health services. Furthermore, the Crown is obliged to ensure that all primary health care services are provided in a culturally appropriate way that recognise and support the expression of hauora Māori models of care.
- The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of primary health services. Māori must be co-designers, with the Crown, of the primary health system for Māori.

Te Arawa and Ngāti Tūwharetoa are currently developing their Iwi Strategy – TRHOTA, and Action Plan Te Kapua Whakapipi, Ngāti Tūwharetoa. These key lead documents will provide the platform and direction for Lakes DHB ensuring that we work together to achieve the aspirations and visions of the Iwi.

Improving equity for Māori

The World Health Organization defines equity as "The absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. "Health equity" or "equity in health" implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential."

"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]."

Lakes DHB is continuing the process of redesigning the Māori health service model in partnership with Ngāti Tūwharetoa and Te Arawa Iwi. Part of this redesign centres on the acknowledgement that tikanga, kawa and Māori values are the key to improved Māori health outcomes. The model is a partnership model based on shared values that will see us working closely with Te Arawa Whānau Ora and Tūwharetoa Health Whanau Ora.

Lakes DHB, working in partnership with Te Arawa Whānau Ora and Tūwharetoa Health
– Healthy Communities – Mauri Ora!
He Tangata He Tangata

There is a strong focus in Te Manawa Taki, working with joint Iwi and chairs to increase impact and decrease inequity for Māori. Each DHB has a senior executive member in the equity leadership team with a focus on delivering the following aims:

- Prioritise a Te Ao Māori world view and whānau voice.
- Measure achievement (or not) of Māori Health equity using clear and evident data.
- Develop and apply a Hauora Commissioning Framework to commission health services using the optimal mix of cultural and clinical specificity.
- Agree, implement and monitor equitable funding strategies.
- Collaborate on the development and implementation of wellbeing plans for priority Māori health equity areas of mental health, child health, cancer and cardiology.
- Ensure the workforce reflects the needs and aspirations of Māori communities.
- Build Māori capacity to meet whānau Māori health needs and the regional Māori population.
- Build Māori provider capacity and capability to meet whānau Māori health needs.

Build an integrated health system

Lakes continues the ongoing development of strategic relationships, with an expectation of new innovations in integrated systems of health and social service delivery. Lakes DHB will show through System Level Measure reporting that we are achieving an integrated health system through seamless transfer of care between primary, secondary and community providers; care provided closer to home; easier access to services; sharing the right information between providers at the right time and people's health is improved as services share information and knowledge. Lakes DHB contribution will also be reflected in Regional Social Outcomes as we are an active contributing partner.

Strengthen people, whānau and community wellbeing

Keeping people healthy - We want our population to feel empowered to partner with our health system and achieve health outcomes for themselves, their whānau and community.

Making sure people, their whānau and communities are well informed and able to determine the health outcomes they choose.

A culture of excellence - A whole-of-system culture that demonstrates people-centred care where people and whānau will be able to easily connect with us and have control of their health and healthcare plans.

[8] Ministry of Health definition of equity

Primary and community based services - Emphasis in primary and community based services to increase wellness, planned care and reduce the need for medical interventions.

Workforce - Our workforce will be highly skilled, knowledgeable and confident in the principles of relationships and engagement, and able to respond to the things that matter the most to our people, whānau and communities. We will actively work towards increasing our Māori workforce at Lakes DHB, via the workforce recruitment project, to strengthen and up skill our current Māori staff members and to increase the number of Māori employees across the DHB.

Innovation - Our environment enhances innovation and works to provide responsive services, making it easier for those services to be people-centred.

Lakes DHB will demonstrate this through user experience. Through our feedback mechanisms developed for patients and whānau, and through our values and interactions, we ensure everyone is treated with dignity, cultural competence and respect. Our community is offered the highest level of health care, including access to preventative programmes and the provision of services our community have told us matter to them, through patient experience surveys.

Strategic themes underpinning the direction

Culturally safe & high quality	• designing programmes that optimise access for those most in need of health care • focussing and redirecting resources to communities and populations with the most need and re-designing services for best outcomes • using data to identify poor access, underserviced populations and variation
Skilled, capable & healthy workforce	• responding to our communities with newly thought through approaches • listening to staff, partners and communities • being bold and trying new things
Equity of access	• committing to our current and future workforce recognising the collective responsibility for delivering the practical and day to day actions in delivering our strategy and our collective vision • create a vibrant environment and workforce to deliver culturally appropriate and quality care unique to Lakes DHB population • investment and emphasis in high performing health services that focus on population wellbeing, early intervention and treatment) • redevelop systems to focus on wellness and earlier intervention
Performing productively, well & fiscally managed	• demonstrate responsible management of our resources through prioritising and targeting resources where there is the most need • investing early in the life span and preventative health care, reaping the benefits of 'allocative efficiency'
Partnerships & integration	• committing to the key concepts of quality care delivered in the most culturally appropriate and culturally acceptable settings unique to the Lakes population • co-design and collaboration • Advocate for healthy public health policies at a local and national level
Transformation & innovation	• Supporting people to live well, stay well and get well and improved equity is most likely to happen when our health services work as partners with people, whānau and communities. • What matters to our patients, whānau and communities should guide our health care delivery, and they way we think, act and invest. • Our partnership with iwi will provide the opportunity and environment to actively challenge ourselves on achieving our strategic goals and remaining focussed on delivering practical and successful actions to achieve for Māori. • When we have strong partnerships with our communities, other government and non-government agencies, there is the ability to harness the wealth of knowledge and experience in the population to have a collective vision and deliver shared outcomes.

6

Alliances and Leadership Groups

The Shared Leadership Groups have provided a consistent and planned approach to new service design in the region. The joint DHB and PHOs' development of the System Level Measures Improvement Plan has provided direction and focus to activity.

Lakes DHB is involved with the following Alliances:

Midland Health Alliance Team

An Alliance Agreement has been entered into between Pinnacle Midland Health Network Charitable Trust and Taranaki, Tairawhiti and Lakes DHBs. This alliance is governed by an Alliance Leadership Team (ALT). Reporting to the ALT is a clinically led expert team looking at specific rural health services areas referred to as the Rural Service Level Alliance Team (Rural SLAT). SLATS are established for fixed time periods with specified outcomes

and timeframes. The alliances and stakeholders guide and contribute to local service planning and delivery, which builds on the needs of population, as well as a shared provider scale of experience.

Te Manawa Taki[9] is the joined governance group of DHB Chairs and DHB Iwi Relationship Board Chairs.

Team Rotorua Alliance Leadership Team
The aim of the alliance is to provide increasingly integrated and co-ordinated health services through clinically-led service development and its implementation within a "best for patient, best for system" framework.

The Team Rotorua Alliance stakeholders guide and contribute to local service strategy and planning based on the needs of the population through a collaborative partnership. The alliance includes people from:

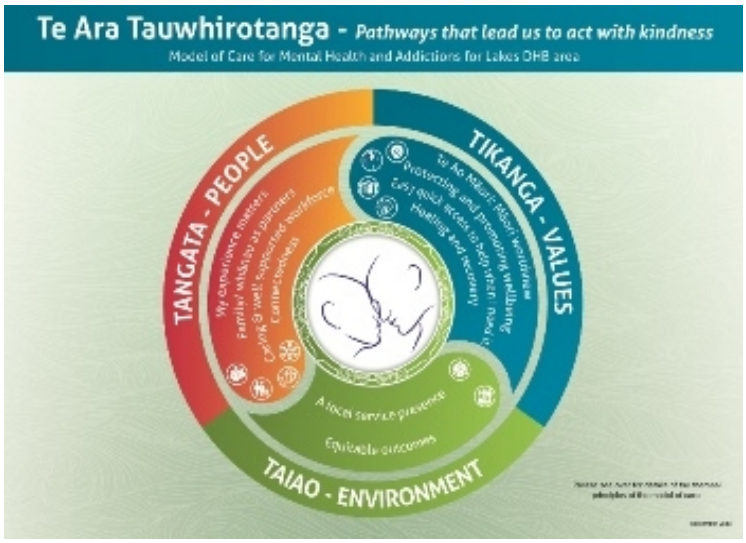
- Lakes DHB
- Rotorua Area Primary Health Services (RAPHS)
- Te Arawa Whānau Ora Collective

System Level Measures (SLM[10]*) leadership group:*
The purpose of the SLM leadership group is to develop, lead, deliver, and monitor an equity focussed SLM plan for Lakes DHB district. The leadership group includes people from Lakes DHB, RAPHS, Midlands Health Network (Pinnacle Health), Te Arawa Whānau Ora, Tūwharetoa Health Whānau Ora, and a representative of the local community pharmacy advisory group. The SLM plan is linked to this annual plan and referenced throughout activities. The entire SLM plan is in the appendices.

Joint Funders Forum
Ministry of Social Development, Oranga Tamariki, Corrections, Te Puni Kokiri, Education, MoH and Lakes DHB have formed this group to enhance commissioning for shared outcomes, and to ensure providers are sustainable and able to respond to holistic service provision.

Lakes Pharmacy Advisory Group
Lakes Pharmacy Advisory Group supports the vision of the Pharmacy Action Plan and the Integrated Community Pharmacy Services Agreement (ICPSA), by working with pharmacists, the public, primary care and the wider health care team, to commission integrated local services that prioritise local need and support equitable health outcomes.

Te Ara Tauwhirotanga[11] *Implementation Advisory Group*
The Te Ara Tauwhirotanga implementation advisory group has been convened to guide the next stage of the work with tangata whaiora and providers hard at work providing input into the implementation phase.



Te Ara Tauwhirotanga Advisory Group is made up of a broad range of individuals that bring a unique and valuable set of skills and perspectives to the redevelopment of mental health and addiction services in Lakes DHB. The Te Ara Tauwhirotanga Advisory Group is responsible for ensuring all projects, service changes and other initiatives adhere to and reflect the aspirations, principles and themes of the final model of care that was developed during the consultation process held throughout 2018.

[9] Te Manawa Taki is the name for the Midland Regional Group of DHBs
[10] Refer to Appendix B
[11] "Pathways that lead us to act with kindness"

1.2 Message from the Chair Dr Jim Mather

E rau rangatira mā, tēnā rā koutou katoa.

In late April I received the Minister of Health's Letter of Expectations which outlined the planning priorities for the 2021-22 year. This was a revised Letter of Expectations, to accommodate the Cabinet decisions to proceed with the health reforms, following the Heather Simpson health and disability services review.

At the heart of the new reforms is the goal of improving outcomes for those traditionally underserved by our health system – for Māori, for Pasifika people, for disabled people, for our rural communities and for people with lower incomes.

To achieve pae ora and a more sustainable and better health system, we must deliver on five key shifts:

1. The health system will reinforce Te Tiriti principles and obligations.
2. All people will be able to access a comprehensive range of support in their local communities to help them stay well.
3. Everyone will have access to high quality emergency or specialist care when they need it.
4. Digital services will provide more people the care they need in their homes and local communities.
5. Health and care workers will be valued and well-trained for the future health system.

The new system operating model agreed by Cabinet:

- Creates a new organisation, Health New Zealand, that will take responsibility for day-to-day running of our health system. All DHBs, shared services agencies and the Health Promotion Agency will move across into Health NZ on 1 July 2022.
- Creates a new Māori Health Authority to ensure our health system delivers improved outcomes for Maori, and to directly commission tailored health services for Māori.
- Establishes locality networks, to provide integrated care to communities via tightly connected primary and community providers working to a tailored locality plan.
- Refocuses the role of the Ministry of Health as the chief steward of the health system and the lead advisor to Government on health matters.
- Establishes a new Public Health Agency within the MoH and a strengthened, national public health service within Health NZ. This will ensure we are always ready to respond to threats to public health, like pandemics.

In the period between the announcement of the health reforms and when legislation enabling the new entities comes into effect on 1 July 2022 we must continue to provide high quality services to New Zealand.

Until Lakes DHB moves into Health NZ next year and the new legislation comes into effect, our Board retains the leadership role and accountability it has under the current Act. This means business as usual for Lakes DHB, along with ensuring access to services is maintained.

As a Board, we are also being tasked with providing oversight to strong fiscal management and to deliver on the financial and performance expectations of the Minister and the MoH, as outlined in this annual plan. The planning priority of strong fiscal management does represent considerable challenge however we are committed to working within allocated resources to improve, promote and protect the health of our population.

It is possible that some of the actions proposed in this annual plan may need to be rethought, and in some cases the DHB may not be able to deliver on all of the expectations. However, we are committed to working within allocated resources to improve, promote and protect the health of the Lakes population and to promote the independence of people who experience a disability.

This plan reflects the strong ongoing commitment of Lakes District Health Board to all of our stakeholders.

The decisions taken by Cabinet about the health reforms are the beginning of what will be a series of decisions to set the future system operating model. Our Board fully realises that preparing for and adjusting to the changes represents a great deal of work for many people, and we worry that we may lose key people in the next year.

Couple that with the enormous efforts in this DHB to rollout the COVID-19 immunisation plan, while at the same time providing the health response for three managed isolation facilities, and you get a sense of how much COVID-19 has impacted our health sector.

My thanks to all our staff as we move forward providing health services, while helping to prepare for the changed health environment.

Nāku it nei, nā

1.3 Message from the Chief Executive Nick Saville-Wood

The coming year will be very challenging for the DHB with not only the significant acute pressure and demand on the whole health system, the continued support provided by the DHB for the Managed Isolation Facilities, ongoing response to the COVID 19 pandemic and the roll out of the largest vaccination programme ever done in New Zealand. While we are facing these challenges we will also need to be managing the significant changes being signalled by the government for the health and disability sector.

The coming year will be quite different from many others, following the Government's announcement in March and April about a new operating model for the health and disability system, to be set up by July 2022.

And as we work towards July 2022 when Lakes DHB will move into the newly formed Health NZ, we are committed to continuing to deliver a high standard of clinical care and to transition the DHB successfully into the new organisation.

In order to achieve the guiding vision, the new system operating model is designed to achieve five main outcomes:

Equity for all New Zealanders – so that people can achieve the same outcomes, and have the same access to services and support, irrespective of why they are or where they live.

Sustainability – through refocusing the system to prevent and reduce health needs and not just treat people when they are unwell – 'wellness not illness' – and ensuring that we use resources to achieve the best value for money.

Person and whānau-centred care – by empowering people to manage their own health and wellbeing and putting them in control of the support they receive.

Partnership – through embedding the voice of Māori and other consumers into how the system plans and makes decisions, ensuring that Te Tiriti o Waitangi principles are meaningfully upheld.

Excellence – ensuring consistent, high quality care is available when people need it, and harnessing leadership, innovation and new technologies to the benefit of the whole population.

Our annual plan sets out the main initiatives we want to take on in terms of local, regional and national priorities during the 2021-22 year, and how those plans will improve the health of our population.

Lakes DHB and the Bay of Plenty DHB have agreed to use this annual planning opportunity to co-plan some initiatives across the rohe of the two DHBs.

To fully improve integration and equity aspirations and ensure health outcomes are realised, Lakes DHB is committed to working with BoP DHB as well as with the wider state sectors. This approach also ensures that we make the best use of resources across Lakes and BoP DHBs.

Since 2018, the region has been working towards developing a committed interagency arrangement to support regional and local government and community leaders. The objective is to work together with central

government agencies on agreed priorities for the wellbeing of communities within our respective rohe. A Regional Leadership group has been operating since 2018 and comprises the CEs from health, education, the Police, Ministry of Social Development, Oranga Tamariki and a number of Iwi organisation CEs who operate within the wider Lakes and BoP DHBs rohe.

The regional vision closely aligns with both Lakes and BoP DHB priorities and there are five priorities:

1. Building Capability to engage and partner with Māori
2. Acting Early for Child Wellbeing
3. Engaging Rangatahi and Strengthening Pathways
4. Safe and Thriving Whānau
5. Building Communities

Lakes DHB has worked very hard to address system sustainability. Despite continuing acute demand growth the DHB continues to strive to ensure that we meet all our elective services expectations and that we maintain an efficient productive workforce. The DHB is projecting to be breakeven in the 21/22 year and over the following three years. In order to achieve this the whole organisation had to be innovative and consider the most effective and efficient models for service delivery.

The 2018 census data reflects a steady reduction in our overall socioeconomic status and has seen us move from the third most deprived DHB population in the country to the second most deprived population in New Zealand. A significant number of our Māori whānau live in the most socially deprived communities.

In order to address this resources are being directed to achieving health equity for Māori and all the other vulnerable populations we have. Health service design and delivery is being aligned with our strategic vision and objectives of Pae Ora- Healthy Futures, as well as the New Zealand Health Strategy.

We continue to work together with iwi and the PHOs to progress our health strategy Te Manawa Rahi (2019-2021) which reflected three major priorities:

- *Achieve equity in Māori health* - Te taeatanga tika o te hauora Māori
- *Build an integrated health system* - Ngā herenga tika i roto i te pūnaha hauora
- *Strengthen people, whānau & community wellbeing* - Te whakareinga i te oranga o te tangata, te whānau me te hapori

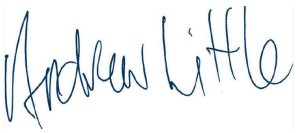
We have made significant progress with implementing a framework on which to progress Te Manawa Rahi, and the Government's direction as signalled in the health reforms announcement bears testimony to our chosen direction.

My thanks to all our staff and teams who are working extremely hard to ensure that the clinical services that we provide continue to meet both national and international best practice standards. Remaining focused on good clinical care and service delivery to our communities will be a priority in the 21/22 year despite the significant change programme we will also need to support over the same period.

1.4 Signature Page

Agreement for the Lakes DHB 2020/21 Annual Plan

between



Andrew Little
Minister of Health

Date: 27 September 2021

Hon Grant Robertson
Minister of Finance

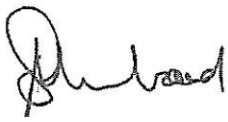
26 September 2021

Dr Jim Mather
Chair, Lakes DHB

Date: 10 August 2021

Dr Johan Morreau
Deputy Chair, Lakes DHB

Date: 10 August 2021



Nick Saville-Wood
Chief Executive, Lakes DHB

Date: 10 August 2021

SECTION TWO: Delivering on Minister Priorities

Minister of Health's Planning Priorities

The Minister's Letter of Expectations sets out the planning priorities for 2021/22. The Annual Plan has been structured to reflect these priorities, which are:

- Achieving health equity and wellbeing for Māori through Whakamaua Māori Health Action Plan 2020-2025
- Sustainability
- Improving child wellbeing
- Improving mental wellbeing
- Improving wellbeing through prevention
- Better population health outcomes supported by a strong and equitable public health and disability system
- Better population health outcomes supported by primary health care
- Strong fiscal management.

These priorities support the Government's overall priority of *Improving the well-being of New Zealanders and their families through:*

- *support healthier, safer and more connected communities*
- *make New Zealand the best place in the world to be a child*
- *ensure everyone who is able to, is earning, learning, caring or volunteering.*

2.1 Give practical effect to Whakamaua: Māori Health Action Plan 2020-2025

Whakamaua: the Māori Health Action Plan 2020-2025 has been developed to achieve the vision of pae ora- healthy futures set out in He Korowai Oranga, the Māori Health Strategy.

Importantly, the health and disability system is being challenged to do better and to go further. That includes continuing to meet our responsibilities under Te Tiriti o Waitangi (the Treaty of Waitangi), to address substantial health inequities, and to ensure all services for Māori are appropriate and safe.

These challenges are substantial and require a strong plan to implement actions and meet expectations. The first part of this section, engagement and obligations as a Treaty partner is based on your current legislative responsibilities. The other sections are based on the objectives from Whakamaua. Some action areas from Whakamaua are highlighted in each part. These are specific areas for DHB attention in 2021/22.

Engagement and obligations as a Treaty partner

The New Zealand Public Health and Disability Act 2000 (NZPHD Act) specifies the DHBs Te Tiriti o Waitangi obligations. The DHB will meet these obligations through information on:

- The DHBs obligations to maintain processes that enable Māori to participate in, and contribute to, strategies for Māori health improvement. Note: these processes may already be established but a description of how they operate, and any improvements planned, should be included.
- Specific plans and strategies for Māori health improvement, including how the DHB will be working in partnership with Māori to develop and implement these.
- The training of Board members (as per the NZPHD Act) in Te Tiriti o Waitangi and Māori health and disability outcomes.

Action(s)	Milestone(s)
Whakamaua Action 1.1: Lakes DHB maintains Iwi partnerships through a memorandum of understanding with Iwi, and also Board representation. Lakes DHB will attend the Te Manawa Taki equity leadership team meetings working with joint Iwi and chairs to increase impact and decrease inequity for Māori. Lakes DHB will complete the Lakes DHB Māori Equity Plan – Te Tuhi o Te Rangi.	 To be reported through Te Manawa Taki Equity Plan. Q2
Lakes DHB Iwi Governance will participate in the “Mauriora” Programme – build of a new Acute Mental Health Facility as part of Te Ara Tauwhirotanga to transform the Mental Health and Addictions services current model of care.	Q3
Whakamaua Action 2.3: Lakes DHB will support professional development and training opportunities for Iwi Governance members through the MoH Governance Training Programme.	Q2 & Q4 100% Iwi Governance will participate in the governance training programme.

Whakamaua: Māori Health Action Plan 2020-2025

Whakamaua: Māori Health Action Plan 2020-2025 is the implementation plan for He Korowai Oranga, New Zealand's Māori Health Strategy. Whakamaua will help us achieve better health outcomes for Māori by setting the government's direction for Māori health advancement over the next five years.

Whakamaua Objective: Accelerate and spread the delivery of kaupapa Māori and whānau-centred services
Accelerating the spread and delivery of kaupapa Māori and whānau centred services is an important element in enabling Māori to exercise their authority under Article Two. It enables Māori to have options when choosing care providers and pathways. DHBs will have plans to ensure that Māori capability and capacity is supported, enabling Māori to participate in the health and disability sector and provide for the needs of Māori.

Whakamaua Objective: Shift cultural and social norms
Shifting cultural norms within the health and disability system is critical to ensuring that Māori can live and thrive as Māori and that we address racism and discrimination in all its forms. DHBs will have plans to further these aims through actions like, building the knowledge of all DHB staff in Te Tiriti o Waitangi, addressing bias in decision making (e.g. build on https://www.hqsc.govt.nz/our-programmes/patient-safety-week/publications-and-resources/publication/3866/) and enabling staff to participate in cultural competence and cultural safety training and development (e.g. support the implementation of: https://www.mcnz.org.nz/assets/standards/8a24a64029/Statement-on-cultural-safety.pdf)

Whakamaua Objective: Reduce health inequities and health loss for Māori
Achieving equity in health and wellness for Māori is an overall goal of the health and disability system. It is mandated by article three of Te Tiriti o Waitangi and is an enduring principle of Te Tiriti. Achieving equity for Māori will be a key element of many of the DHB's plans throughout the rest of the document. DHBs should use this section to outline any equity focused initiatives that don't fit elsewhere and provide a summary and cross reference for those major initiatives elsewhere in their plan.

Whakamaua Objective: Strengthen system accountability settings
DHBs have a role to play in ensuring that the system settings across their parts of the health and disability system support the overall goal of pae ora (healthy futures). Included in this area are matters to do with how services are commissioned and provided and joint ventures with other local agencies.

Action(s)	Milestone(s)
Whakamaua Action 1.4: Lakes DHB engage with local Iwi when developing services and when services are commissioned and provided, as well as joint ventures with other local agencies through the Iwi representatives on committees and consultation processes. The Commissioning Plan has an equity focus to ensure resources are directed to services and projects that will improve the health of Māori and vulnerable population groups. Projects include: • Te Ara Tauwhirotanga (Mental Health) • Mental Health New Build (Mental Health) • Commissioning plan (Strategy Planning and Funding) • Māori Health Equity Plan (Māori Health services with SPF)	Various reporting in the 21-22 year.

Whakamaua Action 3.1: Lakes DHB will work with the Te Manawa Taki Māori Health Workforce Group and Kia Ora Hauora programme co-ordinator, to assist in the development of a regional Māori workforce plan (EOA)[12]	Q4
Whakamaua Action 3.3: The most significant actions Lakes DHB is undertaking to support DHBs and the Māori health sector to attract, retain, develop and utilise their Māori health workforce effectively, including in leadership and management: • Health Workforce actions to address racism, Reo lessons, Te Tiriti o Waitangi Training. • As above- Whakamaua Action 3.1 • Māori Leadership groups such as "Te Kuku o Te Manawa" that supports improved prevention and management of CVD. Lakes DHB will support the development and implementations of Māori led initiatives to achieve the group's goals (referenced below).	Various within this section and Health Workforce.
Whakamaua Action 4.4: As part of Te Ara Tauwhirotanga, Lakes DHB will establish Pūrākau – Māori world view of Talking Therapies.	Q3
Whakamaua Action 6.1: Lakes DHB will advance Telehealth programme and communication pathways through Pokapu o te Taiwhenua Network Lakes DHB will develop a Māori Immunisation Strategy to optimise immunisation rates. (links with the Immunisation Section)	Reported through Rural Health Q1
"Te Kuku o Te Manawa" is the Māori Leadership group that supports improved prevention and management of CVD. Lakes DHB will support the development and implementations of Māori led initiatives to achieve the groups goals.	Q2
Lakes DHB will lead development of Māori health outcomes/KPIs which will be applied to all Lakes DHB health system providers.	Q4
Lakes DHB Māori Health will work with a lead provider to support project management expertise among their services.	Q1
Lakes DHB will continue with the transformational model of care within the Mental Health and Addictions sector. Lakes DHB will: - Implement Te Ara Tauwhirotanga framework across all developments in Mental Health and Addictions.	Reported through Mental Health

[12] Note this is to be confirmed with Te Manawa Taki GMs Māori – Nga Toka Hauora Māori

Whakamaua Action 4.7: Lakes DHB Māori Health division, provides the link to Maori Communities and hapu/Iwi, leadership direction and on projects and programmes Lakes DHB are undertaking, to Invest in innovative tobacco control, immunisation and screening programmes to increase equitable access and outcomes for Māori: *Links to* Tobacco Control Immunisation Bowel Screening Program Breast Screening, Cervical Screening, and Maternity.	
Whakamaua Action 4.9: Māori Health KPIs are provided to Lakes DHB PHOs to ensure greater support to improving Māori Health outcomes and targeted approaches.	Q1
Whakamaua Action 5.6: Lakes DHB will scope an equity focussed Disability Action Plan with BoP DHB, and identify priority areas to be planned in Lakes DHB. Priority will be those impacted by COVID-19.	Q2
Lakes DHB will monitor health equity for Māori using Te Kaoreore, the Māori Health Equity Dashboard[13]. This is used to inform all priority areas of mahi. Lakes DHB utilise the IntelPlus system as its data warehouse and the FocusPro system for visualising KPIs that are calculated from data contained in the data warehouse. The vendor Costing and Business Solutions Ltd (CBS) upgraded the system in order to improve the visualisation of data and make the data more accessible to data analysts, management accountants, and managers. The upgrade has enabled the automation of the Te Kaoreore Māori Equity dashboard that is currently produced for Lakes DHB's Board. This particular dashboard will be used as part of the implementation upgrade and is considered as one of the key initial outcomes of the upgrade. This equity dashboard will them be integrated/rolled out to all levels of the DHB, to support addressing inequity at all levels of the organisation.	Q4

[13] Te Kaoreore goes to the monthly Board meetings where it is reviewed by board members and executive leads. This project is part of the Planned Care funded initiatives and programme.

Data upgrade will improve planned care in the following planned care principles: • *Equity and Experience* Understanding Māori equity and deep diving into data analytics around this issue will then enable the DHB to strengthen an evidence based focus to resolve inequity in Planned Care pathways. • *Quality* As CBS are specialist providers of clinical data warehousing, patient costing and analytics and the DHB has existing contracts in place, this upgrade falls within MBIE Procurement guidelines to not require an RFP to market. Back ups to the server are managed within the data centre (Kapua). Full recovery plans and virtual servers that can be moved to other physical hardware are in place.	
Whakamaua Action 8.2 - Te Kaoreore is one of the tools to measure DHBs performance against the targets and actions. - An Equity plan is under development for DHB, this will have an action plan that will implement what needs to be done.	Q1 and Q4
Whakamaua Action 8.5: Lakes DHB will use equity baselines from the Lakes DHB Equity plan to inform commissioning of services in the region.	Q3
Lakes DHB will attend the Lakes Joint Funders Forum to work in a cross agency approach to build capability and capacity of Māori providers across health and social sectors.	Q3

2.2 Improving sustainability (confirming the path to breakeven)

As New Zealand's population has continued to grow and age, with more complex health needs, the system has worked hard to keep up with demand, however the financial performance of DHBs is variable and has deteriorated in recent years. An enhanced focus on improving sustainability is required.

DHBs are expected to clearly demonstrate how strategic and service planning, both immediate and medium term, are supporting improvements in system sustainability, including work initiated from/supported by dedicated sustainability funding.

Consideration of sustainability objectives and actions should include how your DHB will work collectively with your sector partners to deliver the Government's priorities and outcomes for the health and disability system while also contributing to a reduction in cost growth paths and deficit levels.

All DHBs are expected to deliver a breakeven plan and to sustain a breakeven position over the three-year planning period.

Short term focus 2021/22

Improvements to support improved sustainability in 2021/22
It is expected DHBs will be undertaking a wide set of activities to improve sustainability, the action identified should be the action expected to have the most significant measurable sustainability impact in 2021/22.

Action(s)	Milestone(s)
Lakes DHB will move into phase 2 of the sustainability funded projects:	Q2 & Q4
Healthy Ageing Model of Care for Māori responding to Te Manawa Rahi The purpose of this project is, in partnership with Iwi, to design and develop a Healthy Ageing Model of Care for Māori that will lead to better prevention, identification of those at risk, and management of age related disease, and address the equity of outcomes for Māori[14]. (EOA) Savings have been calculated for approximately $427,500 per year, for implementing a physio into ED in Rotorua[15].	Reported in Healthy Ageing
Pokapū o te Taiwhenua Pokapū o te Taiwhenua is focused on digital health equity with its first test of change in modelling equity focused video telehealth facilitation.	Reported through Rural Health

[14] This includes a potential implementation of ACC Non-acute Rehabilitation Pathway Model of Care, and the implementation of the national framework for HCSS.
[15] In reality this financial gain is probably far greater as the majority of these clients needed Allied Health input due to mobility issues and escalated falls risk (many presenting having already had a fall). Intervention includes appropriate aides and activation of support packages to decrease falls risk – had they been discharged home from ED without appropriate intervention falls risk would have been high.

Te Kuku o Te Manawa The purpose of this project is to achieve a more integrated approach to the prevention and management of CVD and diabetes that works for whānau. Lakes DHB is adopting a Māori-led design process that will lead to a higher chance of success of working for the intended audience. Although this work falls under the banner of CVD and diabetes, Lakes DHB expect that the approach will be directly transferable to other areas. The vision for this approach is to develop the approach across the life-course that would engage with all whānau, and not just those with disease.	Reported through Whakamaua Objective: Strengthen system accountability settings
Action initiated from/supported by national analytics: Lakes DHB is implementing an Acute Flow Programme with a focus on internal flows from ED to inpatient wards to achieve reduced waiting time in ED, reduce service outliers, reduced ALOS, improved discharge planning. • Reduction in pre-surgery LOS for acutes • Increase in number of acute arrange admissions • Management of 'acute surgery time to theatre' within NZ standard • Reduction in total ALOS for acute surgical and medical patients • Increase in Average WIES per theatre session per specialty • Reduced theatre, Early finishes • Reduced theatre, Late starts • Reduced theatre Cancellations • Reduced Turnover/turnaround times Reduction in acutes average length of stay (ALOS) from 3.72 to 3.6 and 400 bed days = $250,000 savings across surgical/orthopaedics/medicine.	Reporting through Acute Demand section and SLM
Action initiated from/supported by strengthened production planning: **Lakes DHB reduce bed days for long stay patients through strengthened production planning:** Lakes DHB reduce bed days for long stay patients through improved patient clinical pathways, community actions, clinical focus in: Long Term inpatients: Introduction of new processes and options to manage discharges to Aged Residential Care, reduce length of stay for medical inpatients through early and concurrent investigations, and high and complex needs (Mental Health) to reduce the number of patients staying longer than 14 days. Reduction in average length of stay (LOS) and 800 bed day savings of $500,000 Number of attributable bed days to patients staying longer than 14 days reduces by 10% = $100,000	Q2 & Q4

Medium term focus (three years)	
Action(s)	**Milestone(s)**
Innovative approaches from COVID-19 learnings: Lakes DHB will implement new models of working for immunisation for the future COVID Immunisations from learnings regarding the flu immunisation programme during the COVID response in 2020.	Q2 & Q4
Sustainable system improvements over three years Lakes DHB will move into phase 3 of the sustainability funded projects.[16]	Q1 & Q4
Quantified actions from the DHB's path to breakeven (links to financial performance section): Lakes DHB will reduce the budget for the following infinitives:	
Reduction in travel through better coordination of travel particularly Tāupo, reducing avoidable trips, greater use of videoconferencing and teleconferencing: **22/23 250,000 23/24 250,000 24/25 250,000**	Q1 & Q4
Lakes DHB will move from 'specialling' top EPSE to reduce costs of specialling and enhance patient supervision and engagement: **22/23 250,000 23/24 250,000 24/25 250,000**	Q1 & Q4
Lakes DHB will produce a procurement savings plan to identify and realise procurement savings: **22/23 250,000 23/24 250,000 24/25 250,000**	Q1 & Q4

[16] Dependant on funding. Will aim to plan across Waiariki region to optimise funding opportunities.

2.3 Improving maternal, child and youth wellbeing

The Child and Youth Wellbeing Strategy (the Strategy) provides a framework to align the work of government and others to achieve the vision of 'Making New Zealand the best place in the world for children and young people'.

The nine principles promoting wellbeing and equity for all children and young people, operationalised for the Health and Disability system, are:

- Children and young people are taonga
- Māori are tangata whenua and the Māori-Crown relationship is foundational
- Children and young people's rights need to be respected and upheld
- All children and young people deserve to live a good life
- Wellbeing needs holistic and comprehensive approaches
- Children and young people's wellbeing are interwoven with family and whānau wellbeing
- Change requires action by all of us
- Actions must deliver better life outcomes
- Early support is needed - maintain contact across the early years and beyond and be alert and responsive to developing issues and opportunities.

There is an expectation that DHBs will actively work to improve the health and wellbeing of infants, children, young people and their whānau and carers with a particular focus on improving equity of outcomes.

DHB annual plans will consider the above principles in all their activities, as part of their contribution to delivering the Strategy, and preparing the health and disability sector for system transformation over time.

Focus on: Ambulatory sensitive hospitalisations for children age (0-4) (SLM)

- Please identify (or refer to specific actions from your SLM plan) two key improvement actions that are expected to have the most significant impact on performance improvement, with milestones for each quarter.

Maternity care

Equitable maternity care is a priority for the population. The overall way to achieve this in this planning cycle is through supporting a sustainable workforce, providing culturally safe services, ensuring integrated service models and supporting primary birthing.

Action(s)	Milestone(s)
Lakes DHB will review COVID preparedness interview findings undertaken in 2020 (COVID level four response) of LMCs in the community and develop a plan to address priority issues. Lakes DHB will supply LMCs PPE packs for community birthing to reduce the need for hospital referrals and continue services in the community.	Q1-Q4

Developing integrated service models. The most significant action the DHB is taking to ensure women and whānau have access to the following:	
Lakes DHB will implement the budget initiative for the Midwifery Clinical Coaches and Return to Practice Programme.	Q2

Social services
Lakes DHB will continue developing and implementing the Tipu Ora: Tiaki Whānau Model of Care for the provision of an Enhanced Well Child Tamariki Ora Service to hapū māmā aged less than 21yrs and their whānau.
• Increased access to whānau focused support for young parents and their whānau
• Intensive support for parents/whānau during the antenatal period
• Enhanced support for whānau mental wellbeing
• Whānau supported to achieve their own goals and aspirations regarding their parenting
• Insights and evaluation of the pilot to inform future redesign of the WCTO programme
• Improved child health outcomes for the enrolled population participating in the pilot, including:
  ○ Improved health, development and learning outcomes for children who are living in challenging circumstances
  ○ Increased parental and whānau understanding of childhood development and the role of parenting in child development, and increased confidence and skill in their own parenting.
	Provider reports directly to the MOH[17].

Lakes and BoP DHBs will work together to Co-design to develop and deliver Mana Ake – Stronger for Tomorrow. Including expanding Wellbeing in Schools.	See Mental Health Section
Ultrasound Lakes DHB will continue screening for growth restriction and small for gestational age babies, with the adoption of the Growth Assessment Protocol through using the education and software of the Perinatal Institute in the UK. Lakes DHB will undertake a health needs assessment for maternity services, including maternity scans, to identify where extra resource (such as covering co-payments) is required. There are no reported delays in accessing maternity scans.	Q1 & Q3 Timely access to ultrasound and laboratory testing for screening purposes are enabled through early enrolment with an LMC.
Parenting education SUDI Lakes DHB has established a new community service that contributes to the prevention of Sudden Unexplained Death in Infancy (SUDI). The risk factors for SUDI are well known and activity should focus on reducing smoking among women of childbearing age, promoting safe sleep environments and encouraging breastfeeding. Above all, Māori must be prioritised. There are a number of existing services that work with pregnant women, or focus on supporting young Māori women stop smoking. There is therefore an opportunity to take a more integrated approach to SUDI prevention and to give consideration to using this funding innovatively.	Q1 & Q3

[17] Manaki Ora report directly through the Ara Whanui database. Lakes DHB expect to have visibility of this in the 21-22 year.

Screening programme Smokefree screening: Smokefree Hapu Mama, incentive programme. Lakes DHB will support the Tipu Ora Stop Smoking Service Project which will incentivise an initial visit to the local stop smoking service on attendance and enrolment in the stop smoking service, and on short-term smoking cessation.	Q1 & Q3
Lakes DHB will continue to undertake Newborn hearing screening for all babies in Rotorua and Taupo by 1 month of age.	Q4
Lakes DHB will continue undertake Metabolic screening for all babies within 48 hours of being born. in Rotorua and Taupo as per the stipulations of the national programme. Lakes DHB are working to improve transit times to meet the 95% of samples reaching the laboratory in 4 days.	Q4
Lakes DHB will work with the Midwifery Accord to support three new graduate midwives through a local graduate support programme as well as the national Midwifery First Year of Practice programme[18].	Q2 & Q4
Lakes DHB are working to address workforce shortages through active recruitment of midwives nationally and overseas. Lakes is also actively recruiting Registered Nurses with sound maternity experience overseas to supplement the maternity workforce.	Q2 & Q4
The Perinatal and Maternity Mortality Review Committee recommendations are being implemented Activities for 2021-22 include[19]:	Q1 – Q4
• Monitor key maternity indicators by ethnicity to identify variations in outcomes and improve areas where there are differences in outcome	Q1 – Q4
• Cultural competency workshops for all Maternity Service staff, Courses are available via online e-learning modules. Planning to develop a programme of face to face sessions for staff in 2021.	Q1 – Q4
• Co-design models of care to meet the needs of women <20 years	Q1 – Q4
• Establish a clinical pathway for women with identified placental implantation abnormalities	Q1 – Q4
• Ongoing audit and review of MEWS and trigger tool, Full rollout in Rotorua Maternity began on 1st July 2020 and auditing is in progress. Further rollout to be commenced in Tāupo Maternity.	Q1 – Q4
• Equitable access to primary mental health services, maternal mental health referral and treatment pathway: Work on maternal mental health pathway is currently in progress. A pathway has been developed and is to be further refined.	Q1 – Q4

[18] Other aspects of the Midwifery Accord work are not yet released for implementation. Staff are supported through complaint investigations and serious events reviews. Any complaint is taken serious and attempted to resolve in a timely fashion. Regular team meetings are held and staff have an opportunity to be heard. Lakes DHB has taken on three New Graduates in order to grow our own. This is the highest number ever due to the small team. There is a robust graduate plan supporting them that sits within the national programme of support. The graduates have a dedicated preceptor in addition to the national programme requirements. The Midwifery Educator also work extensively with them on the floor.

[19] There are a number of activities underway addressing the PMMR and these are reported on through the MQSP quarterly report

Focus on: Ambulatory sensitive hospitalisations (ASH) for children age (0-4): Ambulatory Sensitive Hospitalisation (ASH) Rates Increase the number of Māori babies enrolled in primary care, immunisation, and oral health services. This will be achieved by creating a data extract of all live births to forward to the PHO that the baby's mother is enrolled. The PHO will then ensure that the child is registered on the NIR and pass on details to the oral health service. Our goals are to have: • ≥ 90% of all new-borns enrolled with a PHO by 6-weeks with an equity ratio of ≥0.95. • ≥ 90% of all new-borns registered with the NIR by 6-weeks with an equity ratio of ≥0.95.	SLM

Immunisation

Immunisation is an important priority for the Government as it is the best way to protect tamariki and whānau against a range of infectious and serious diseases

All DHBs are to contribute to healthier populations by establishing innovative solutions to improve and maintain high and equitable immunisation coverage at all scheduled immunisation events, from prenatal vaccinations through to adulthood vaccinations. Ensuring the Childhood Immunisation Schedule is maintained during New Zealand's COVID-19 response is essential.

It is essential that Māori General Managers (Tumu Whakarae) and Pacific General Managers have oversight of all Māori and Pacific focused work, respectively, in their DHBs. It is therefore the Ministry's expectation that DHB Immunisation Leads develop and maintain strong working relationships with their DHBs' Māori and Pacific General Managers to ensure they have a clear line of sight into immunisation work. This work includes:
- strategies on closing the equity gap
- prioritisation of Māori immunisation
- assisting to build networks through their contacts
- quarterly and annual reporting.

Focus on: Increased Immunisation at 2 years (CW05)

Action(s)	**Milestone(s)**
A key learning from COVID-19 was that Outreach Immunisation Services (OIS) demonstrated their ability to engage with hard to reach whānau. Lakes DHB will take a community based social marketing approach for increased community engagement in immunisation for the region: Childhood Immunisation Outreach Action Plan[20]	Q2

[20] Lakes DHB are taking a multi-component approach with a mix of immediate remedial action and in parallel a longer term analysis and implementation for a more sustainable delivery framework.

Maori Influenza and MMR Campaign This will be coordinated by a .5 Project Manager in Strategy, Planning and Funding who will liaise with BOPDHB to ensure alignment.	
The Ministry expects that DHBs develop and implement an Immunisation engagement and communications plan that is focused on delivering key, consistent and culturally appropriate messages to help promote immunisations and increase education around the importance of immunisation. This plan should be developed in collaboration with Māori, Pacific and other consumer voices in your communities. As part of the immunisation strategy, key stakeholders will be identified by December 2021.	Q2
A key learning from the Māori Influenza Immunisation Programme is that Māori-led, Māori-focused innovative approaches contribute to improving equitable immunisation coverage for Māori. Lakes DHB Māori Health will lead the development of an immunisation engagement strategy for Māori. (links with Whakamaua Action 6.1) EOA.	Q1 Also reported through Whakamaua Action 6.1.
Focus on: Increased Immunisation at 2 years (CW05) Lakes and BoP DHBs will reduce inequity in coverage for Māori immunisation through improved engagement (as noted above).	Q1-Q4
Increased coverage will be achieved through improved engagement across all populations of the Waiariki region.	Q1-Q4
Increase the number of Māori babies enrolled in primary care, immunisation, and oral health services. This will be achieved by creating a data extract of all live births to forward to the PHO that the baby's mother is enrolled. The PHO will then ensure that the child is registered on the NIR and pass on details to the oral health service. Our goals are to have: • ≥ 90% of all new-borns enrolled with a PHO by 6-weeks with an equity ratio of ≥0.95. • ≥ 90% of all new-borns registered with the NIR by 6-weeks with an equity ratio of ≥0.95.	SLM

The components include working with key communities (iwi, whānau, hapu mama and education sector); health providers within and across our own DHB to link together services to engage and deliver childhood immunisations such pharmacists, PHOs, public health and other projects already in flight.
We will also work with technology and process to ensure data is captured and flows through seamlessly (beneficial for both the patient and their electronic health record).
Linking and working with other DHBs to understand their success factors will also be investigated and their lessons built on and incorporated into the ongoing implementation plan.

To increase the proportion of children who have completed their MMR vaccinations by 18 months. Our goal is to have: • ≥ 83% of children completed their MMR vaccination at 18 months, with an equity ratio of ≥0.95.	SLM

Youth health and wellbeing

Youth health and wellbeing sits under the Government's Child and Youth Wellbeing Strategy and Current Programme of Action.

DHBs should take a youth health and wellbeing service planning and improvement approach in their Annual Plan. The approach could include a range of youth health service such as School Based Health Services (SBHS), mental health and wellbeing, sexual and reproductive health, alcohol and other drugs, and primary care.

Youth access to and utilisation of youth appropriate health services (youth are healthy, safe and supported) is a quality improvement focus for DHBs as one of the six System Level Measures.

Budget 2019's 'Taking Mental Health Seriously' package of initiatives included expanding access and choice of mental health and addiction supports in primary care settings with a particular focus on Māori, Pacific people and rangatahi. This is now an action in Whakamaua Māori Health Action Plan 2020-2025 (Priority Area 4, Objective 3).

The enhancement and expansion of SBHS was also a key initiative of Budget 2019's 'Taking Mental Health Seriously' package of initiatives. The Ministry has an SBHS Enhancement Programme underway. SBHS are aimed at increasing access to primary care for young people and provide clinical primary health care (both student-requested and nurse-initiated), referral onto required services, and support health promotion campaigns. Year nine students are also expected to receive a comprehensive bio-psycho-social assessment.

Action(s)	**Milestone(s)**
Wellbeing in Schools Partnership between DHB and MoE to leverage Werry Workforce Trauma Informed Approach training with exploration of 2nd workshop in the district with interagency inclusion of offering and standing up virtual support groups for Communities of Learning/Kahui Ako as well as interagency partners and setting up a grants application process for Communities of Learning/Kahui Ako to integrate TIA in school environment.	Q1 Werry Workforce Trauma Informed Approach training completed.
Immunisation programme key focus is MMR for rangatahi/youth (aged 15-29) in the Lakes DHB.	Q1 Increase in MMR immunisation rates.
Lakes DHB will work with all School Based Health Services and contracts will be revised for provider specifics, to enable connecting via telehealth through Pokapū o te Taiwhenua.	Reported through Rural Health

Lakes DHB will work on youth access to, and utilisation of youth appropriate health services for the priority populations[21] (SLM) as well as the following Mental Health Projects:	SLM
Five small community support initiatives grants with an addiction focus for improved awareness and education for Māori rangatahi will be fully delivered by 31 November 2021.	Q3 Key measurable outcomes are determined by each proposal as a range of activities will be identified, approved and reporting measures to be developed in collaboration
A youth one stop shop service will deliver a range of support services for health and wellbeing focused at Rainbow youth. The range of supports will include a local pride week, drop in service and diversity groups. This service will be contracted by 01 June 2021 with a 12 month period of delivery.	Q4 Measures will include the delivery of events and services to raise community cohesion and inclusivity, and increase service accessibility for rainbow youth.

[21] Māori rangatahi, Pacific rangatahi, rainbow rangatahi, rangatahi in care and disabled rangatahi.

Family violence and sexual violence

Reducing family violence and sexual violence is an important priority for the Government, and something we want all DHBs to be working on, in partnership with other agencies and contributions.

Action(s)	Milestone(s)
To support COVID-19 recovery plan, to achieve equity in Māori health, and to build an integrated health system and strengthen people, Lakes DHB will review VIP training delivery systems and development of online training resources[22]	Q1 & Q4 VIP training delivery systems will be reviewed and improved. Q1 & Q4 Online training resources developed.
Review placement and standardisation of IPV routine enquiry tool on admission documentation in designated services to assess effect on IPV enquiry.	Q4 Placement and standardisation of IPV routine enquiry tool review complete.
Alignment of Child Protection Checklist to national guidance to improve early identification of, and intervention to CAN, in addition to assessing biases within clinical practices and decisions, i.e. is the tool completed for Māori more often than other ethnicities? (EOA)	Q4 Child Protection Checklist is reviewed and refined with an equity focus.
Lakes DHB will deliver wananga through Whanau Manawaroa, to offer support to families and Whanau, to reduce incidents of family harm.	Q2

[22] Lakes DHB will review the Violence Intervention Programme delivery in view of the impact of COVID-19 and the potential for increasing risk of harm to children and adults experiencing family violence and sexual violence. The COVID-19 pandemic presented a unique set of circumstances that included increased social and personal risk to service users, as well as dynamic operational changes for the DHB that impeded VIP delivery (IPV and CAN). Key learnings: During the COVID-19 pandemic components of the VIP delivery systems were not sustained. To support COVID-19 recovery plan to achieve equity in Māori health, build an integrated health system and strengthen people, Whānau and community wellbeing Lakes

2.4 Improving mental wellbeing

Improving the mental wellbeing of people in New Zealand remains a priority for the Government. *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* and the Government's response have set the direction for transforming New Zealand's approach to mental health and addiction. This includes:

- ensuring our approach works for and meets the needs of Māori and addresses inequitable mental wellbeing outcomes experienced by other groups including Pacific peoples, rainbow communities and children and young people
- moving to a holistic approach grounded in wellbeing that recognises the social, cultural and economic foundations of mental wellbeing and looks across the life course
- ensure access to mental health services, alcohol and drug treatment and harm reduction services
- increasing access to and choice of mental wellbeing supports to ensure all people in New Zealand receive the support they need, when and where they need it
- putting people and their whānau at the centre of their care and designing supports collaboratively with whānau, communities and people with lived experience
- ensuring suicide prevention and postvention approaches demonstrably align with *Every Life Matters – He Tapu te Oranga o ia tangata Suicide Prevention Strategy 2019 – 2029 and Suicide Prevention Action Plan 2019 – 2024 for Aotearoa New Zealand*, and that each DHB has a current Suicide Prevention Action Plan.

This transformation has become more critical in the wake of COVID-19 and the expected ongoing impacts on people's mental wellbeing. Actions should further this transformation and align with the mental wellbeing framework that underpins *Kia Kaha, Kia Māia, Kia Ora Aotearoa: COVID 19 Psychosocial and Mental Wellbeing Plan.* DHBs will demonstrate leadership in transforming the system and will establish new services where appropriate. Collective action is needed to build a whole-of-system, integrated approach to mental health, addiction and wellbeing that provides holistic options for New Zealanders across the full continuum of need.

DHBs will work collaboratively with sector partners, communities and whānau to provide a range of services that are of high quality, safe, evidence informed, equitable and provided in the least restrictive environment.

Focus on: Follow-up within seven days post-discharge from an inpatient mental health unit (MH07)
Follow-up within seven days post-discharge is important for the prevention of suicide, self-harm, and other negative outcomes such as readmission.

Action(s)	Milestone(s)
Lakes DHB will co fund a newly developed community based response / crisis assessment and triage role with the homelessness provider collective.	Q3
Activities will consider how to embed approaches to virtual service delivery on an ongoing basis: Lakes DHB will implement phase one (training phase) of the Virtual Mental Health including using currently available free Apps, eg Clearhead, (E Mental Health Framework[23]) to deliver Mental Health Services for Lakes population.	Q2 & Q4

[23] Under Te Ara Tauwhirotanga- Develop and deliver a training programme for E-Mental Health collective and other trainers to be able to train the health, social and educational workforce to develop skills and capability to effectively utilise and deliver E-Mental Health solutions.

Homelessness- Dependent on recent Sustainability Funding: Lakes DHB will continue to develop and deliver an improved health response for homelessness with MSD: This project aims to improve our response to the health needs of our local homeless population by identifying and addressing barriers to healthcare delivery within the emergency housing setting. This will impact discharge planning and housing for Mental Health clients, people with complex chronic conditions and older people. The specific objectives are to: 1. To work with our partners[24] to develop a response that meets the health needs of our local homeless population, to support a change in delivery of mental health, addictions, and wellbeing services to the homeless; 2. To develop an approach that meets the health needs of women and children living in emergency housing; and 3. To develop an approach that meets the health needs of people with high need for 'home based' healthcare services. These objectives will directly address the current inequities in Māori health. (EOA) *Links with Cross Sector Collaboration.*	Q2 & Q4
DHBs will have COVID-19 resurgence plans in place that include a focus on supporting the psychosocial response. Lakes DHB will include a psychosocial component in the resurgence plan which is a collaborative plan across the Te Arawa COVID-19 Group[25]	Q1
Lakes DHB will participate in ongoing planning with key stake holders aimed at a community hub to better meet community needs: Working with sector Lead Partners to determine what communities of interest exist, where they might be located, and the benefits of co-location and different models of practice.	Q1 & Q4
Lakes DHB will implement the equity dashboard (*Te Kaoreore Dashboard project*[26]) with four mental health components: 1. A reduction in the rate of seclusions 2. A reduction in the rates of compulsion under the Mental Health Act 3. A reduction in the rate of alcohol related ED presentations for youth aged 10-24 years. 4. A reduction in the rate (age standardised) of self-harm hospitalisation rates in rangatahi (10-24 year olds)	Q3

[24] Includes Ministry of Social Development; Rotorua Lakes Council, Police, Ministry of Housing and Urban Development, local NGOs
[25] Resurgence plan in consult- including Te Arawa Covid group, welfare support with Iwi.
[26] Planned Care funded programme.

Admission processes have been directly aligned to Te Ara Tauwhirotanga principles (model of care) that speak to tangata, tikanga, taiao (specific engagement and attitude). (EOA) Lakes DHB will require that all Compulsory Treatment Orders have DAO and DAMHS reviews for both the need for mandated treatment and discharge from the MHA (92). (EOA)	Q1
Focus on: Follow-up within seven days post-discharge from an inpatient mental health unit (MH07) Follow-up within seven days post-discharge is important for the prevention of suicide, self-harm, and other negative outcomes such as readmission:	
Lakes DHB will improve discharge planning by requiring minimum of two weekly visits from the case manager of the person receiving inpatient services. Lakes DHB will improve discharge process by requiring that the case manager sets follow up appointments before person receiving treatment is discharged.	Q1-Q4 Q1-Q4
Lakes DHB will implement staff development around feedback informed treatment (FIT) with outcome measures additional to HONOS. (KPI MH03): • 28 day readmission data will be reviewed and analysed by Clinical Governance and case reviews actioned where multiple admission same NHI occur. Follow up and response through Operations team with recommendations for improved performance. • 7 day follow up data: Clinical Governance review and regular agenda item to ascertain any patterns in community team follow up and respond through Operations team with recommendations for improved performance.	Q2 Q2
Lakes DHB will implement a formal programme to embed Te Ara Tauwhirotanga: • Provider Arm Services will dedicate a Project Manager for Te Ara Tauwhirotanga • Broad sector discussion between community providers and NGO providers are commenced around knowledge and application of Te Ara Tauwhirotanga • Te Ara Tauwhirotanga dashboard will be rolled out across all sector providers.	Q2
Lakes and BoP DHBs will work together to Co-design to develop and deliver ***Mana Ake – Stronger for Tomorrow:*** Mana Ake provides a new approach to delivering additional mental health support for children aged 5–12 in schools. Mana Ake seeks to provide holistic support through: • direct support to children experiencing social, emotional or behavioural challenges • clarification of local support pathways, making it easier for schools, teachers and • whānau to access support when and where they need it	CFA reporting

• support for schools to make improvements to the school environment using whole • school and whole of classroom wellbeing programmes and wellbeing promotion • service sector improvements by providing greater collaboration across health • education and social sector partners in the provision of support. *Links to Cross Sector Collaboration and Child Wellbeing*	

2.5 Improving wellbeing through prevention

Public health services are distinct and different from publicly-funded personal healthcare services (eg, hospital services) in that they improve, promote and protect health at a community or population level, and may include services and programmes focused on identifiable community, population or sub-population groups.

Public health services address a broad range of disease risk factors and diseases at both the population level (eg, investigation of disease outbreaks, emergency planning and management) and the individual level (eg, immunisation, breast and cervical screening). The breadth of services delivered ranges from tackling emerging issues, such as environmental sustainability and climate change, and antimicrobial resistance, to encouraging DHBs to become Public Health competent and supporting communities to live well and achieve healthy lifestyle behaviours.

Preventing and reducing the risk of ill-health and promoting wellness are vital to improving the wellbeing of New Zealanders. As the population grows and ages, it is important to orient the health and disability system towards a public health and prevention focus. This focus includes working with other agencies to address key social determinants of health, creating supportive health-enhancing environments, identifying and treating health concerns early and ensuring all people have the opportunity and support to live active and healthy lives.

Accordingly, DHBs and their PHUs have an important role to play to address key determinants of health, improve Māori health and achieve wellbeing and equity by supporting greater integration of public health action and effort. They will continue to make a major contribution, not only in improving the health and wellbeing of all New Zealanders but also improving equity and the quality of health services and ensuring the health system is financially and clinically sustainable.

Communicable Diseases

Current context – COVID-19

Aotearoa New Zealand has a strategy for the elimination of COVID-19. The aims are to eliminate transmission chains and to prevent the emergence of new transmission chains originating from cases that arrive from outside the country.

COVID-19 is a public health emergency and global pandemic. It is fundamentally changing and challenging the way the New Zealand public health system responds, especially in terms of what and how public health services are delivered. The COVID-19 response and associated activities delivered by the DHB-based public health units (PHUs) are now integrated with the Ministry of Health (led by the COVID-19 directorate), for example, the National Investigation and Tracing Centre (NITC) and the use of a common IT platform in the National Contact Tracing Solution (NCTS).

Each outbreak is delivering significant learning opportunities for all parties, and the Ministry will ensure these learnings are shared across the sector and incorporated into future responses and activities.

In light of the above, the Ministry will be engaging with your DHB/PHU to design and implement a national public health response where we will more effectively share limited resources, avoid duplication and increase the agility with which we mount a surge response anywhere in the country and/or address future challenges.

Core functions – Health Promotion, Health Protection, Health Assessment & Surveillance and Public Health Capacity Development.

As the response to COVID-19 is the Ministry's top priority for all DHBs/PHUs please continue to support the response both in your own DHB/s areas and also, where applicable, in other DHB/s areas.

Action(s)	**Milestone(s)**
Implement MMR immunisation action plan (EOA)	Q1-4
Continue to develop and maintain COVID-19 preparedness and response capability including (EOA):	
• Delivering the ongoing training programme in emergency management as well as response protocols and systems	Q2 & Q4
• Providing public health intelligence to inform and support preparedness and response, as well as the local vaccination strategy and roll out	Q2 & Q4
• Undertaking community engagement and communication approaches to support the All-of-Government communications strategy for the COVID-19 vaccine programme	Q2 & Q4
• Developing and implementing a community engagement framework to inform communication strategies that support health equity initiatives across the health sector.	Q2 & Q4

Environmental sustainability

Climate change threatens the health of all New Zealanders. The Climate Change Response (Zero Carbon) Amendment Act provides an opportunity and an imperative for the health sector to respond. New Zealand's health sector is a large contributor of greenhouse gas (GHG) emissions: it is the largest emitter in the public sector, excluding emissions from transport. Fortunately, action on climate change has co-benefits for health and can reduce the burden of associated diseases on the health system.

DHBs and their PHUs will continue with actions that mitigate and adapt to the impacts of climate change, enhance the co-benefits to health from these actions, and support the health sector's response to the greenhouse gas emissions reduction targets under the Climate Change Response (Zero Carbon) Amendment Act. Actions should have a pro-equity focus. If not already actioned, this should include developing and implementing a sustainability action plan.

Action(s)	Milestone(s)
Lakes DHB will support working from home and Telehealth where possible, to contribute to the health sector goals around carbon reduction.	Q1
Lakes DHB will replace the transport fleet with hybrid vehicles at the expiration of the lease. Lakes DHB will scope an emissions reduction plan project, and the steps required to report emissions from 22-23[27]. Lakes DHB will consider the targets of Climate Change Response (Zero Carbon) Amendment Act, Carbon Neutral Government Plan (CNGP) and any further advice of the Climate Change Commission, Ministry for the Environment, or Ministry of Health[28]. There is significant work needed to gather and sort the information, invest and input that into the software that's required to do carbon conversions, then the additional tasks needed to start planning emissions reduction initiatives.	Q2 & Q4

[27] Lakes are doing some feasibility studies part funded by EECA that have the potential to reduce emissions but, again, we have not got the resource to dedicate to full emissions reporting as yet.
[28] Lakes DHB have plans to monitor emissions in the future. There is no plan to do this prior to 1 July 2022, which is the earliest new FTE can be applied for to dedicate to this task.

Antimicrobial resistance

Antimicrobial resistance (AMR) is an increasing global public health threat that requires immediate and sustained action to effectively prevent and mitigate its impact on individual and population health. DHBs have an important role in preventing and mitigating the impact of AMR. DHBs actions contribute to key areas of focus in the New Zealand Antimicrobial Resistance Action Plan (2017-2022) - raising awareness and understanding; surveillance and research; infection prevention and control; antimicrobial stewardship and governance; collaboration and investment.

Action(s)	Milestone(s)
Lakes DHB will continue the local priority actions in the Lakes AMR plan that was developed in 2020:	
Health equity for Māori and other groups: Achieve equity through surveillance by identifying[29] ethnic groups who are disproportionately affected by Methicillin-resistant Staphylococcus aureus (MRSA), Carbapenemase-producing Enterobacteriaceae (CPE), Vancomycin Resistance(VMR), C. difficile rates, TB (MDR), Drug resistant N. gonorrhoeae etc.	Q1 & Q4
Surveillance and Research: Surveillance of antibiotic usage and resistance rates and reporting to structured clinical governance and leadership team. e.g., implementation of point prevalence survey (PPS) etc.	Q1 & Q4
Infection prevention and control: Invest in Infection Prevention and Control programs to general practitioners under a Continuing Medical Education programme. Evidence to demonstrate there is prospective audit of antibiotic use systems in identified areas of focus (hospital-wide). Identify area of focus for auditing to assess antibiotic resistance rates in primary care, age residential care (ARC) or hospital wide. Identify hand hygiene compliance measure across hospitals.	Q1 & Q4
Antimicrobial stewardship: Lakes DHB will provide leadership and teach improved infection control processes to both internal and external providers to minimise the threat of AMR.	Q1 & Q4
Governance, collaboration and investment: Invest in Infection Prevention and Control programs as above. Invest in Infection Prevention and Control programs to general practitioners under a Continuing Medical Education programme. Evidence to demonstrate there is prospective audit of antibiotic use systems in identified areas of focus (hospital-wide, ARC facilities etc).	Q1 & Q4
Awareness and Understanding: Educational seminars for health professionals to promote optimal use of antibiotics supported by best practice.	Q1 & Q4

Drinking water

[29] Icnet Surveillance For Hospital And Community

DHB-based PHUs undertake routine investigations under public health legislation, including the drinking water provisions of the Health Act 1956.
Whilst recognising that legislation is only part of the suite of interventions and activities available to PHUs, compliance and enforcement activities are essential in an effective public health programme as part of the public health continuum and as one strategy in holistic programmes to improve public health. Compliance and enforcement activities are strategies within the Ottawa Charter for Health Promotion.

Drinking water activities should promote equity. In determining priorities, DHBs and their PHUs should use a public health risk assessment to identify and target vulnerable populations. While well-resourced communities may be vocal and exert influence over environmental health decision making processes, DHBs and their PHUs need to use evidence of environmental risks to identify and protect vulnerable populations to achieve equitable health outcomes.

DHBs and their PHUs are to undertake compliance and enforcement activities relating to the Health Act 1956, by delivering on the activities and reporting on the performance measures contained in the drinking water planning and reporting document 2021/22.

Action(s)	**Milestone(s)**
Drinking Water activities due to move to the new agency from 1 July. In event of delay: Undertake compliance and enforcement activities relating to the Health Act 1956, by delivering the activities and reporting on the performance measures contained in the Drinking water planning/reporting template 2021/22 Bay of Plenty DHB will highlight non-compliant supplies, or water supplies which predominantly serve Māori or Pacific, or those which potentially pose a public health risk, to Taumata Arowhai at handover (EOA).	Q2 & Q4
Lakes DHB will complete the annual review compliance reporting for 2020/21 during Quarter 1[30].	Q1 Annual review compliance reporting for 2020/21 is completed.

[30] The annual review compliance reporting is for the 2020/21 year, Lakes DHB will not be required to do this for the 2021/22 year.

Environmental and border health

DHB-based PHUs undertake routine investigations under public health legislation, including the Health Act 1956, Hazardous Substances and New Organisms Act 1996, Biosecurity Act 1993 and Burial and Cremation Act 1964. Whilst recognising that legislation is only part of the suite of interventions and activities available to PHUs, compliance and enforcement activities are essential in an effective public health programme as part of the public health continuum and as one strategy in holistic programmes to improve public health. Compliance and enforcement activities are strategies within the Ottawa Charter for Health Promotion.

DHBs and their PHUs are to undertake compliance and enforcement activities relating to the Health Act 1956 and other environmental and border health legislation, by delivering on the activities and reporting on the performance measures contained in the Environmental Health planning and reporting document.

Environmental health activities should promote equity. In determining priorities, DHBs should use a public health risk assessment to identify and target vulnerable populations. While well-resourced communities may be vocal and exert influence over environmental health decision making processes, DHBs and their PHUs need to use evidence of environmental risks to identify and protect vulnerable populations to achieve equitable outcomes.

Action(s)	Milestone(s)
Work with responsible agencies to ensure implementation of the new Bay of Plenty Regional Air Plan (EOA)	Q2 & Q4
Ensure smooth and safe operation of border health requirements relating to Maritime COVID-19 Border Orders	Q2 & Q4
Conduct Environment and Border Health activities as per Ministry of Health Reporting Template	Q2 & Q4

Healthy food and drink environments

Preventing and reducing risk of ill health and promoting wellness are vital to improving the wellbeing of New Zealanders. As the population grows and ages, it is important to orient the health and disability system towards a public health and prevention focus. DHBs and their PHU both have a role in contributing to improving the health and wellbeing of the population through prevention.

DHBs are expected to continue to include a clause in your contracts with health provider organisations stipulating an expectation that they develop a Healthy Food and Drink Policy covering all food and drinks sold on site/s and provided by their organisation to clients/service users/patients (excluding inpatient meals and meals on wheels), staff and visitors under their jurisdiction. Any policy must align with the Healthy Food and Drink Policy for Organisations (https://www.health.govt.nz/publication/healthy-food-and-drink-policy-organisations).

Action(s)	Milestone(s)
Implement Healthy Active Learning in priority settings (decile 1-4 Schools/ Kura, low equity index Kohanga Reo/ Early Learning Services and those with Māori/ Pasifika rolls > 35%) by (EOA)[31]:	Q2 & Q4
• Supporting them to have up to date healthy food and drink policies	
• Adequately supporting them to implement and maintain the policies in line with Ministry of Health Food and Drink guidance	
Mitigate the impact of food insecurity due to COVID-19 by (EOA):	
• Working with schools who are providing school lunches internally	Q4
• Contributing to evaluation of the government Lunch in Schools programme	Q4
• Supporting the operation of Ka Pai Kai school lunch service in Rotorua	Q4
• Supporting the development and implementation of local projects/initiatives that address food insecurity including Kai Rotorua, Everybody Eats Ōpōtiki, Western Bay Food Security Plan	Q4
Continue to implement the DHBs Healthy Food and Drink Policy including:	
• Actions recommended in the recent policy audit	Q2 & Q4
• Water and plain milk only	Q2 & Q4
• Increased staff awareness and support towards to the policy	Q2 & Q4
• Increased food literacy skills of staff and visitors	Q2 & Q4
• Support DHB service providers to adopt a healthy food and drink policy (based on Healthy Food and Drink Guidance for Organisations).	Q2 & Q4

[31] Reported through Lakes DHB

Smokefree 2025

New Zealand has a goal of reducing smoking prevalence and tobacco availability to minimal levels, making us essentially smokefree by 2025. To reach Smokefree 2025, there are opportunities to improve on what we are doing now, as well as to do more, with a sharper focus on reducing inequities in smoking prevalence. DHBs and their PHUs should focus their efforts on tobacco control coordination and leadership, including developing, delivering and implementing their district wide tobacco control plans. There is an expectation that DHBs are undertaking compliance and enforcement activities relating to the Smokefree Environments and Regulated Products Act 1990 by delivering the activities and reporting on the performance measures contained in the Smokefree 2025 planning and reporting document (attached above). There can also be other Health Protection actions.

Action(s)[32]	**Milestone(s)**
Lakes DHB will embed COVID-19 learning around offering quit smoking support to people in Managed Isolation Facilities.	Q4
Promote and support the implementation of smokefree outdoor spaces policies.	Q4
Conduct tobacco retailer visits for education and/ or compliance purposes to ensure retailers are aware of their responsibilities under the Smoke-free Environments Act 1990. Prioritise and conduct controlled purchase operations (CPOs) to support the Childhood Smokefree strategic goal and priority groups i.e. children, youth and Māori (EOA)	Q2 & Q4
Deliver retailer education to the vaping sector in line with the amended legislation	Q2 & Q4
Conduct Smokefree 2025 regulatory and enforcement activities as per Ministry of Health Reporting Template	Q2 & Q4
Lakes DHB will work with SLM partners to increase the proportion of babies living in smoke free homes by 10% by the end of June 2022.	SLM
Smokefree screening: Smokefree Hapu Mama, incentive programme. Lakes DHB will support the Tipu Ora Stop Smoking Service Project which will incentivise an initial visit to the local stop smoking service on attendance and enrolment in the stop smoking service, and on short-term smoking cessation. Links with Screening in the maternity section.	Reported in Maternity Section

[32] Reported through Lakes DHB

Breast Screening

Breast cancer is the most commonly diagnosed cancer for women in New Zealand. Wāhine Māori and Pacific women have higher breast cancer incidence and mortality than non-Māori/non-Pacific.

BreastScreen Aotearoa is New Zealand's free national breast screening programme for eligible women, aged between 45 and 69. Screening coverage for wāhine Māori is lower than non-Māori/non-Pacific women. The Ministry of Health, DHBs and Breast Screening Lead Providers all have an important role in ensuring that participation targets are achieved and in eliminating equity gaps between Māori and non-Māori, Pacific and non-Pacific/non-Māori.

Reporting will now include data for women 45 to 69 years.

Action(s)	**Milestone(s)**
Lakes DHB will continue work on this through the Lakes DHB equity plan to increase the proportion of eligible women participating in the breast cancer screening programme[33].	Q4
Actively work with BSM, Te Arawa and Ngāti Tūwharetoa Iwi on design of interventions where the impact will be significant for Māori health outcomes. (EOA) [34]: Facilitate and support network between BSM and Te-Roopu-a-Iwi with intention of achieving Iwi level promotion and support for breast screening services. Support BSM with distribution of communication and information across the rohe.	Q4 Equity in interventions are prioritised for Māori Increased % of wahine Māori screened in the most recent 24 months

[33] Percentage of eligible women (50-69) have had a breast screeen in the last 2 years. (PV01)
[34] An equity ratio of ≥0.95 is achieved- Screen at least 75% of eligible wāhine Māori.

Cervical Screening

Cervical cancer is the fifth most registered cancer in females in New Zealand.

Māori, Pacific and Asian women have lower screening coverage compared to Other women. Māori women have a much higher incidence of cervical cancer compared to Pacific, Asian and Other women, and Māori and Pacific women have significantly higher mortality compared to Asian and Other women (Ministry of Health, National Cervical Screening Programme Annual Report 2017).

Increasing coverage and improving equitable access to screening and colposcopy services, with a particular focus on Māori and Pacific women, will reduce the burden of cervical cancer in these priority groups.

Cervical screening is a preventative health activity, and while routine screening is paused at Government Alert Level 4 (COVID-19), it resumes at Alert Level 3. Women with an identified risk are prioritised at all alert levels. However, priority groups were slower to return to screening during Government Alert Levels 3 and 4.

Action(s)	Milestone(s)
Lakes DHB will work with PHO and Alliance Partners increase the proportion of Māori and Pacific women aged 25-69 years participating in the cervical cancer screening programme[35]: • Lakes DHB will work with our alliance partners and Whānau Ora to support their initiatives to improve cervical smears for Māori and Pacific women aged 25-69 years, including the "Smear your Mea" campaign. The aim of this is to improve uptake to the 80% target for eligible women. • Lakes DHB will use the NCSP funding to improve wait times for Māori and Pacific women.	Q4
Lakes DHB will scope a Whānau Ora role to improve equitable access to diagnostic and treatment colposcopies for priority groups referred with a high-grade result[36] (EOA).	Q4
Lakes DHB will improve equitable access to diagnostic and treatment colposcopies for priority groups referred with a high-grade result[37] (EOA): • Lakes DHB will work with Toi Ohomai Student Health Centre, and Te Arawa Whānau Ora to utilise Toi Ohomai for community smears specifically for wāhine who have been referred to the Support to Screening Service. • Lakes DHB is working with Te Arawa Whānau Ora and Ngāti Pikiao Hauora to support the establishment of offering smears to women in high-priority workplaces.	Q4

[35] Percentage of eligible women (50-69) have had a breast screen in the last 2 years. (PV01)
[36] An equity ratio of ≥0.90 is achieved-Screen at least 75% of eligible wāhine Māori.
[37] The baseline is measured using available data in late 2020 or early 2021 from DHB colposcopy units.

Reducing alcohol related harm

Alcohol contributes to a wide range of health and social harms, including injuries, road accidents, foetal alcohol spectrum disorder (FASD), long term addiction, cancer, violence and other crimes. Māori and people living in high deprivation areas face a disproportionate burden of disease due to alcohol availability and exposure, sale, supply and consumption. Preventing harm from alcohol is a priority, and cross-government collaborative strategies and actions are identified in the National Drug Policy 2015–2020 and 'Taking Action on Foetal Alcohol Spectrum Disorder 2016-2019'.

DHBs and their PHU have a role in contributing to the reduction of alcohol related harm and improving the equity and wellbeing of their population. Key actions include coordination and leadership, health needs assessment and data collection, primary prevention/health promotion and health protection. Under the Sale and Supply of Alcohol Act 2012, Medical Officers of Health employed by DHBs have a responsibility for regulatory functions and collaborating with Police and licensing inspectors to ensure ongoing monitoring and enforcement of the Act and the development and implementation of strategies to reduce alcohol-related harm.

Core functions – Health Promotion, Health Protection, Health Assessment & Surveillance and Public Health Capacity Development.
DHBs are to undertake compliance and enforcement activities relating to the Sale and Supply of Alcohol Act 2012. This includes delivering on the activities and reporting on the performance measures contained in the Reducing Alcohol Related Harm: Health Protection planning and reporting document (attached). The Ministry acknowledges that this work may be impacted by the national response to COVID-19.

Action(s)	**Milestone(s)**
Develop a Public Health alcohol strategy with focus on equity (EOA)	Q4
Develop a collaborative communications and health literacy support approach for the prevention of Foetal Alcohol Spectrum Disorder in the Bay of Plenty and Lakes districts (EOA).	Q4
Undertake compliance activities relating to the Sale and Supply of Alcohol Act 2012 as per the Ministry of Health Reporting template	Q2 & Q4

Sexual and reproductive health

Preventing and reducing risk of ill health and promoting wellness are vital to improving the wellbeing of New Zealanders. As the population grows and ages, it is important to orient the health and disability system towards a public health and prevention focus. DHBs and their PHUs have a role in contributing to improving the health and wellbeing of the population through prevention.

Sexually transmitted infections (STIs) are common in New Zealand. Associated complications include chronic pain, infertility, neonatal morbidity and genital tract cancer. Surveillance data regularly indicates that those aged less than 25 years and non-Europeans show a disproportionate burden of STIs, the highest numbers and rates for each STI are almost always seen in the 15 to 19 years and 20 to 24 years age groups.

Action(s)	**Milestone(s)**
Continued implementation of the syphilis (and other STI) epidemic response plan including (EOA):	Q2 & Q4
Providing supporting public health intelligence including on epidemiology, screening data and testing data - especially relating to local cases of syphilis and congenital syphilis	Q2 & Q4
Undertaking a health literacy and cultural responsiveness review of sexual health clinics in the Bay of Plenty and Lakes region to identify ways in which accessibility and appropriateness can be enhanced	Q2 & Q4
Providing data, both local and national, on other sexually transmitted infections and information on public health interventions, such as vaccination against HPV infection	Q2 & Q4
Reviewing the local HPV immunisation action plan for opportunities to improve HPV uptake in the Bay of Plenty and Lakes, especially among young Māori men	Q2 & Q4

Cross Sectoral Collaboration including Health in All Policies

The wider determinants of health[38] play a major role in the health and wellbeing of the community. Many of the opportunities to control or influence the determinants of health sit beyond individuals and outside the health system. Inequitable health outcomes are evident amongst populations with different levels of underlying social advantage/disadvantage. This may be on the basis of socioeconomic status, ethnicity, gender, stage of the life course (children/older people), locality, or due to discrimination or marginalisation (including on the basis of disability, religious affiliation, and sexual orientation or refugee status). These inequities result in cumulative effects throughout life and across generations.

All DHBs and their PHUs are expected to address wider determinants of health by working in partnership with other relevant agencies both within and outside the health system.

DHBs and their PHUs have an important role in supporting cross sectoral approaches to address the wider determinants of health and a critical role in ensuring health services themselves do not exacerbate inequities in health outcomes between population groups. Services must ensure they are accessible and relevant to all people and groups in their population.

Health in All Policies (HiAP) is an approach to working on public policies across sectors (both health and non-health) and with communities. It systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and achieve health equity. HiAP is an evolving and ongoing process that works at both strategic and operational levels to ensure health, wellbeing, sustainability and equity issues are explicitly addressed in all policy, planning and decision-making processes.

Action(s)	Milestone(s)
Lakes and BoP DHB CEOs on Regional Leadership Group will advocate for health in implementing the public sector reforms recommendations and “powering up the regions” in partnership with Iwi and local Government Lakes DHB will lead integration partnership relationship with: MSD - looking at priorities such as complex homelessness and building capacity with Māori providers that work across health and social sectors. MOE - truancy and trauma informed care approaches. Police - family harm and methamphetamine reduction. Department of Corrections - Waikeria Mental Health pathways of care back to the communities and forensic service engagement.	Q2 & Q4

[38] The causes of inequities in health outcomes are complex and largely arise from the inequitable distribution of and access to, the wider determinants of health such as income, education, employment, housing and quality health care amongst populations

Lakes and BoP DHBs will work together to Co-design to develop and deliver Mana Ake – Stronger for Tomorrow.	See Mental Health Section
Lakes and BoP DHB GMs will attend BOPCIGG to build relationships and be informed about other public sector agencies funding priorities to achieve common wellbeing goals.	Q2 & Q4
Toi Te Ora - Health in all policies programmes in local government, school, home and workplace settings.	Q2 & Q4
Implement Broadly Speaking training programme to improve understanding of the determinants of health and equity across multi-sector agencies to enable cross-sector collaboration (EOA)	Q2 & Q4

2.6 Better population health outcomes supported by strong and equitable public health and disability system

New Zealanders are living longer, but also spending more time in poor health and living with more disability. This means we can expect strong demand for health services in the community, our hospitals, and other care settings.

Responding to this challenge will require effective and co-ordinated care in the community supported by strategic capital investment, workforce development and joined-up service planning to maximise system resources; to improve system sustainability, to improve health and to reduce differences in health outcomes.

Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025

Pacific peoples are a growing, diverse and vibrant population. Improving health outcomes for Pacific families and communities is central to the wider wellbeing of Pacific populations in New Zealand. Pacific experience significant and long-standing health inequities across a range of health and socioeconomic indicators. These inequities are complex and multi-faceted, and impact directly on the comparatively poorer health outcomes of Pacific peoples (than non-Pacific people). On average Pacific people experience poorer health and higher rates of premature mortality, and a shorter life span, than non-Pacific people. Too many Pacific children and adults end up in hospital with preventable health conditions and with complications from health conditions that could be better managed at home and in the community.

Ola Manuia is the new Pacific health plan and provides the strategic framework to improve Pacific responsiveness. It gives clear direction to the health system about the fundamentals for Pacific health and it continues the momentum on what's working well, but also looks at where and how we can improve Pacific health outcomes. Ola Manuia identifies priority areas and where resources can be focused, as well as high-level actions that will contribute effectively to improving health and wellbeing for Pacific peoples. All parts of the health and disability sector are responsible and accountable for improving Pacific health outcomes and achieving health equity.

The outcomes are supported by: a focus on empowering Pacific people and their communities; changes at a systems level; and working with other agencies and sectors to target the socioeconomic determinants of health. The outcomes aim to allow innovation according to community needs and realities. The outcomes are:

1. We live independent and resilient lives - empowering Pacific people's knowledge and skills to take ownership of their health.
2. We live longer in good health - changing the healthcare system to be more responsive.
3. We have equitable health outcomes - strengthening actions with Government and across sectors to create environments that improve health equity for Pacific communities.

Ola Manuia includes a list of indicators and measures that will be used to monitor the progress of this action plan in improving outcomes for Pacific peoples (including indicators that are part of other frameworks for example the primary care and hospital patient satisfaction surveys could be used).

Action(s)	Milestone(s)
Lakes DHB will develop cultural responsiveness guidelines in alignment with Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025 indicators: • Health System Workforce • Health Information and quality of care • Cultural Safety • Responsiveness Capacity	Q1 & Q3

Delivery of Whānau Ora

DHBs are well placed to action system-level changes by delivering Whānau -centred services to contribute to Māori health advancement and to achieve health equity, including for Pacific communities.

Action(s)	Milestone(s)
A joined approach to the implementation of Purakau development (The use of Māori narratives) as part of the transformation of Mental Health and Addictions services project – Te Ara Tauwhirotanga. Lakes DHB Māori Health will work with Te Arawa Whānau Ora to support the establishment of Purakau with Te Arawa experts.	Reported through Whakamau Section
Develop a joined approach to Immunisation (MMR, Imms, and COVID-19 Vaccination) working with PHOs, Iwi, Te Arawa Whānau Ora, develop a communication plan and campaign targeting Māori.	Reported through Communicable Disease
Lakes DHB will support Te Arawa Whānau Ora who are an integral part of the Māori Provider network, and Te Arawa COVID-19 (network of Primary Industries, marae, hapu, Iwi.[39])	Reported through Communicable Disease

Health outcomes for disabled people

Statistics NZ surveys consistently show that disabled people experience poorer outcomes across multiple domains, including income, employment and health compared with non-disabled people. Disabled people are generally at higher risk of illness than non-disabled people. People with intellectual disabilities and Māori with disability have some of the poorest health outcomes of any group in the country and are at higher risk of illness, disease, disability and early death; this is an important ongoing challenge for the health and disability system.

Action(s)	Milestone(s)
Lakes DHB will review the disability provider interviews completed during level four COVID-19 response.	Q4
Lakes DHB will scope an equity focussed Disability Action Plan with BoP DHB, and identify priority areas to be planned in Lakes DHB[40]. Priority will be those impacted by COVID. Links with Whakamaua Action 5.6.	Q1-Q4

[39] Fortnightly zoom hui to ensure that the issues relating to COVID-19 are understood and addressed as they arise.

[40] An equity focussed Disability Action Plan with practical actions to guide the Lakes and BOP DHBs improvement of access to quality health services, and to improve the health outcomes of disabled people in the Waiariki Region, in alignment with already existing national disability strategies- Whāia Te Ao Mārama and Disability Action Plan 2019-2023.
The Disability Action Plan will be cognisant of wide range of disability need, equity requirements, workforce and a Human Rights based approach (UNCRPD) that is compliant with the principles of Te Tiriti as articulated by the courts and Waitangi Tribunal. It will also include the actions identified by the Ministry of Health as part of the 2020/2021 Annual Planning guidance. Aspire to achieve equity requirements and inclusive of Iwi's involvement at all levels of governance.

Planned care

Planned Care Vision: 'New Zealanders receive equitable and timely access to Planned Care Services in the most appropriate setting, which supports improved health outcomes'

Planned Care is patient centred and includes a range of treatments funded by DHBs, which can be delivered in inpatient, outpatient, primary or community settings. It includes selected early intervention programmes that can prevent or delay the need for more complex healthcare interventions. Planned Care includes, but is a wider concept than, the medical and surgical services traditionally known as Electives or Arranged services.
Planned Care is centred around five key principles, (Equity, Access, Quality, Timeliness and Experience) reflect the principles of clarity, timeliness and fairness. (Planned Care Engagement support pack and FAQs is available on QUICKR)

In 2021/22 DHBs will be in the second year of implementing their Three-Year Plans to improve Planned Care delivery. The Three-Year Plans will be addressing the five Planned Care Strategic Priorities of:

- Improve understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed.
- Balance national consistency and the local context
- Support consumers to navigate their health journeys
- Optimise sector capacity and capability and
- Ensure the Planned Care Systems and supports are sustainable and designed to be fit for the future.

Action(s)	**Milestone(s)**
Lakes DHB will continue with the COVID-19 Telehealth work across the Lakes DHB Planned Care programme. (Pokapū o te Taiwhenua Network project.)	Reported through Rural Health
Lakes DHB will implement phase 2 of the Planned Care three year plan (programme) with a focus on improving Planned Care services for Māori. (EOA)[41]:	CFA reporting
Improve understanding of local health needs: Equity Dash board- Te Kaoreore: Goals: • Achieving health equity in the Lakes region • One source of truth for equity data in the region • Preventing the disease process	Reported through Whakamaua Section

[41] Korowai Aroha- opening pathways for Māori, fit for surgery and waitlist reduction for major orthopaedic surgery. Oral health in community (rural dental, extending contract to do dental work for adults in the communities of interest)

• Improved access for Māori to experience planned care pathways earlier in their health journey, in a culturally appropriate and timely manner	
Balancing national consistency and local context: Ensuring consistently excellent care, regardless of where you are or where you are treated: Pokapū o te Taiwhenua Network , telehealth in rural communities.	Reported through Rural Health
Simplifying pathways for service users: Providing a seamless health journey, with a focus on providing person-centred care in the most appropriate setting: Lakes DHB will continue with Planned Care funded projects enabling partnerships with providers to address early identification and comorbidity for the population[i]: *Māori Fit For Surgery Project* • The first partnership is between Rotorua Surgical and Elective Surgery Services (Pre-Operative Assessment Clinic), and Korowai Aroha Health Centre supporting the planned care improvement initiative Māori Fit for Surgery.	CFA reporting Project outline agreed Meetings with Stakeholders Co-creation of programme Contract proposal drafted and agreed Data and reporting requirements established Patient selection process started Patient selection process completed Pilot commenced Monthly monitoring
Māori Oral Health Project *Milestone Description:* • The second partnership is between Rotorua Surgical and Elective Surgery Services (Dental Services) and Tipu Ora supporting the planned care improvement initiative Māori Oral Health.	CFA reporting Project outline agreed Meetings with Stakeholders Co-creation of programme Proposal drafted and agreed Patient selection process commenced Patient selection process completed Data and reporting requirements established Pilot commenced Monthly monitoring Pilot completed Evaluation and report

Optimising sector capacity and capability: Optimising capacity, reducing demand on hospital services and intervening at the most appropriate time- Planned Care projects: 1. Pokapū o Te Taiwhenua-rural hub: Virtual care to support health equity. 2. Fit for Surgery: a new model of care for Māori awaiting surgery 3. Te Kaoreore Māori Health Equity Dashboard - Planned Care Data Project – health pathways and Focus-Pro 4. Māori Oral Health: Reducing the clinical pathway to General Anaesthetic for dental care 5. Māori health community pathways 6. RN anaesthetic assistants Table 1[ii] describes the planned care innovation projects, the outputs and capacity expected to be delivered from the set of related projects in Table 1, the generation of expected outcomes that support benefit realisation across the set of related projects in Table 1, and the Links/dependencies each project has across a range of projects and Lakes DHB strategic priority activities.	CFA reporting
Fit for the future: Planning and implementing system support for long-term funding, performance and improvement: Dental – extending contract to improve wait list times for oral health in adults. (EOA): Lakes DHB will implement a clinical pathway from primary care to hospital dental services for Māori and vulnerable populations; increase community dental services capacity as part of the pathway for Māori and vulnerable populations; deliver community sedation at the community kaupapa Māori dental service; and decrease the number of Māori on the dental waiting list by referring them to community kaupapa Māori dental service, for early assessment and community treatment.[iii]	CFA reporting Project outline agreed Meetings with Stakeholders Co-creation of programme Proposal drafted and agreed Patient selection process commenced Patient selection process completed\Data and reporting requirements established Pilot commenced Monthly monitoring Pilot completed Evaluation and report
Focus on: Planned Care Interventions (SS07) Lakes DHB will hold extra surgical and outpatient clinics to reduce the wait list volume for Planned Care. Lakes will continue to maintain patient compliance and work to achieved compliance at the different urgency categories within each specialty.	Q1-Q4
Lakes DHB will maximise theatre utilisation rate to reduce wait list volume for Planned Care. Focus on start and finish times, theatre turnaround times, avoidance of cancellations due to patients not prepared for surgery, short notice wait lists	Q1-Q4

Lakes DHB will monitor the rates for surgical and outpatient DNAs: Lakes DHB is moving to a patient focused booking model for Māori in all specialities to reduce rates of DNA. A Manawa Pou is available for Māori patients for whom transport or hospital hesitancy is an issue. A successful patients focused booking in Medicine has proven the model and will be rolled out in early 21/22 for all specialties, initially for Māori where there are higher DNA rates.	Q1-Q4
Lakes DHB will measure the percentage of people who meet the four month wait time and monitor the split of Māori and non Māori. (EOA) All services are meeting wait times for ESPI 2 compliance. ESPI non-compliance is limited to Orthopaedics, General Surgery and Dental with the later two specialties expected to be compliant in early 21/22, and Orthopaedics by December 2021. Lakes DHB provider arm provides a bi-monthly report to HAC on equity measures. A programme is already in place to manage patients not suitable for surgery due to medical conditions requiring management, aimed at undertaking surgery when there is a healthy 'window' for the patient's medical conditions.	Q1-Q4
Other locally selected measures: • Casemix Adjusted Length of Stay management to avoid cancellations due to bed shortage • Volume of Arranged Acute Admissions (bed management) • Lengths of bed day stay greater than 14 days, or greater than 28 days (excludes neonates).	Q1-Q4

Care Capacity and Demand Management (CCDM)	
Action(s) (include one action and milestone per row)	**Milestone(s)**
Lakes DHB will transfer the core data set from manual upload in excel to automated electronic dashboard which will also include VRM data– this will increase visibility and ability to interrogate the data. Where applicable, the core dataset measures will be provided for Māori and non-Māori. (EOA)	Q1- Core data set available on electronic dashboard / Quarterly reporting on measures once in place (November 2021).
Lakes DHB will develop a new communications strategy to promote the progress of all components of CCDM to the wider staff groups.	Q1- Communication strategy submitted and approved at CCDM Council.
Local data councils will be supported and operational in all clinical areas where CCDM is in place.	Q1- Communications presented to CCDM Council from clinical areas demonstrate Local Data Council activities are taking place.
Lakes DHB will provide individual support plans for units whose patient acuity data remains outside validated benchmark.	Q1- Support plans are presented to Trendcare Operational Meeting / Outstanding units achieve appropriate data integrity to allow FTE calculation to be completed.
Lakes DHB will implement the outcomes of annual FTE calculations, using Safe Staffing Healthy Workplaces methodology. Engagement and recruitment of Māori candidates will be a focus to increase proportion of Māori in the workplace appropriate for the Lakes DHB population. (EOA)	Q1- Q4- Monthly financial reporting and communication to staff
Lakes DHB will support and monitor quality improvement opportunities within CCDM across all service	Q4- Annual plan submitted to SSHWU

Acute demand

Acute Data Capture: How SNOMED data will advise DHBs on improving health pathways for long term conditions e.g. Diabetes, respiratory conditions than could be managed in the community with a focus on equity.

Acute Demand: a plan on how the DHB will address the growth in acute inpatient admissions.

Acute Hospital Bed Days per Capita (refer to SLM plan)
The intent of the measure is to reflect integration between community, primary, and secondary care and it supports the strategic goal of maximising the use of health resources for planned care rather than acute care. The measure is supported by a suite of locally selected contributory measures to strengthen the ability to detect and understand factors that drive acute demand. This combination of measures avoids the risk of a single high-level measure which gives no indication of where improvements could be made. It also creates opportunities for inter-provider communication and promotes data transparency and knowledge sharing.

Action(s)	Milestone(s)
Lakes DHB will use SNOMED data improve health pathways for long term conditions (LTC) e.g. Diabetes, respiratory conditions than could be managed in the community with a focus on equity. Flow in both acute and outpatient care will be improved and more responsive through identifying (LTC) patients and referring to appropriate services faster.	Q1 & Q3
Lakes DHB will work with SLM partners to develop a whole of system acute demand dashboard, which shows demand on primary, secondary, and after hours care.[42]	SLM
Lakes DHB will implement the Lakes DHB Acute Demand Programme(see appendices[iv]) to slow down growth in acute demand (EOA): This includes detail on: • how patients will be better managed in the community, emergency department and hospital[43] • the organisations that Lakes DHB to plan with to achieve improvements[44] • percentage reduction in the standardised rate of acute bed days, while reducing the discrepancy between Māori and total population standardised bed days[45]	SLM

[42] This has stemmed from recent data analysis that shows that those who are admitted to hospital are also those patients that are more likely to have been seen multiple times in primary care. Our goal is to develop a mechanism that enables accurate and real-time demands on the local health system.
[43] Lakes DHB is working on pathways for a number of specific areas, in particular for patients presenting with acute exacerbations of COPD and for those requiring radiology after hours. Lakes DHB are also looking into after-hours provision generally, and the support and transition back into primary care after an ED or hospital attendance. This is being supported through transition teams and potentially additional supportive roles within ED. Patients will also be managed better by using the acute demand working group to identify and address bottlenecks as they arise.
[44] Lakes DHB, Whānau Ora, RAPHS PHO and Pinnacle PHO and their GP practices, ED leads in both hospitals as well as the DHB executive team.
[45] Bed occupancy focus through extended day-stay hours from 4pm-8pm to improve recovery time and reduce further admission to surgical and orthopaedic wards

Lakes DHB will undertake an environmental reconfiguration plan for where to treat COVID-19 patients.	Q1 & Q3
Lakes DHB will implement a Kaiawhina lead behavioural change project in the Emergency Department to improve services for Māori who present for acute care (EOA)	Q2
Acute Hospital Bed Days per Capita Lakes DHB will respond to the demand on our acute service through the following activities. These activities go into more detail in the SLM plan:	
Ambulatory Sensitive Hospitalisation (ASH) Rates Increase the number of Māori babies enrolled in primary care, immunisation, and oral health services. This will be achieved by creating a data extract of all live births to forward to the PHO that the baby's mother is enrolled. The PHO will then ensure that the child is registered on the NIR and pass on details to the oral health service. Our goals are to have: • ≥ 90% of all new-borns enrolled with a PHO by 6-weeks with an equity ratio of ≥0.95. • ≥ 90% of all new-borns registered with the NIR by 6-weeks with an equity ratio of ≥0.95.	SLM (links to Child and Youth wellbeing)
To increase the proportion of children who have completed their MMR vaccinations by 18 months. Our goal is to have: • ≥ 83% of children completed their MMR vaccination at 18 months, with an equity ratio of ≥0.95.	SLM
Increase the proportion of pre-school children (1-5 years of age) who have received an application of fluoride varnish in the last 12 months. We will do this by offering fluoride varnish application in preschools, especially those with a high Māori roll. Our goal is to have: • ≥ 85% of preschool children will have fluoride varnish applied with an equity ratio of ≥ 0.95. • Community-based smoking cessation initiative launched that will focus on Māori whānau living in areas of highest smoking prevalence. (EOA)	SLM
Lakes DHB will implement an electronic tool to transfer ED admission data to primary care in close to real time. The 2020/21 plan focussed on identifying frequent ED attendees, but this used retrospective data (i.e. more than 6 ED admissions in 6 months) and did not allow for proactive management. We will implement a mechanism by which ED presentations can be electronically notified to the PHO who will monitor and multiple admissions and act early. Our goal is to achieve: • A 10% reduction in frequent ED attendees • A 10% increase in the proportion of frequent attendees who have a care plan in place • A 5% reduction in the proportion of people attending ED with a triage category of 4 or 5 • ≥95% of people domiciled in Lakes DHB who attend ED have a named GP/GP practice (EOA)	SLM

To implement a campaign and process to increase flu vaccination in people aged 65 years and older and those with long-term conditions. Our goal is to achieve: • ≥ 90% of people 65 years of age or older or with long-term conditions receive their flu vaccination within the last year. *Links with Long Term Conditions.*	SLM

Rural health

Improving access for rural health is a priority for the Government and something we expect all DHBs to be working on, closely with their rural primary care partners and community.

Action(s)	Milestone(s)
COVID-19 learning was that Lakes DHB recognised the need for outreach / mobile vaccination clinics for rural communities, and will embed this in the Vaccination Strategy for the region.	Q1
Lakes DHB will implement the first phase of the Pokapū o te Taiwhenua Network project.[46] (EOA)	Q1
Lakes DHB will develop E-referral for primary care and specialty care to access the Pokapū o te Taiwhenua Network video telehealth facilitation support.	Q4
Lakes DHB will develop a Locality Plan for the Turangi community, using co-design methodology to ensure available service meet the health needs of the population.	Q3 Pilot developed

[46] Pokapū o te Taiwhenua Network is inclusive network of health and wellbeing community providers, community members, primary care, and specialist care actively closing the technology gap in virtual care to support health equity, whānau wellness, and integration of health and wellbeing services. Initiated in July 2020. First test of change is video telehealth facilitation leveraging a non-clinical workforce in rural Māori hubs (see Data and Digital Enablement Annual Plan Section for further detail).

Implementation of the Healthy Ageing Strategy 2016 and Priority Actions 2019-2022

New Zealand's population is ageing, increasingly diverse, and living longer and in better health than in the past. However, as a result of living longer there are more older people with more complex health and disability needs. Inequitable health outcomes are also evident in New Zealand amongst populations with different levels of underlying social advantage/disadvantage. The Healthy Ageing Strategy (the Strategy) was released in December 2016 and sets the strategic direction for the delivery of services to older people for the next 10 years to meet these increasingly complex needs and contribute to achieving equity and eliminating disparities in health outcomes between population groups. Cabinet agreed to Priority Actions for the next phase of the Strategy's implementation 2019 – 2022 in November 2019. Implementing these actions will contribute to delivering on the Strategy's vision that: Older people live well, age well and have a respectful end of life in age-friendly communities.

Action(s)	Milestone(s)
Lakes DHB has undertaken a programme to support community-based infection prevention control (ARRC and Hospice) that aligns to the new Health & Disability Services Safety Standard Part 5 criteria. We expect this to improve preparedness for a pandemic outbreak (and COVID-19 resurgence) on services in the community for older people including hospice through: 1. Developing a gaps analysis 2. Supporting education that addresses the criteria 3. Enabling community providers to have a better understanding of PPE and IPC requirements 4. Potentially to support an expert specialist IPC Nursing services for ARRC and Hospice if funding is available	Q1
Lakes DHB will scope possibilities for alternative models of respite delivery, including respite in the home, and kaupapa respite and daycare services.	Q1 & Q4
Lakes DHB will use the HCSS framework to inform the Healthy Ageing Model Of Care. Lakes DHB will progress towards integration and roll out of interRAI™ within all key provider services, to improve and support discharge planning and post discharge care.	Q1 & Q4

Health quality and safety (quality improvement)

- Spreading hand hygiene practice
- Improving equity
- Improving Consumer engagement
- Zero Seclusion

Action(s)	Milestone(s)
Lakes DHB will enhance more hand hygiene auditors – that not only undertake audits, but actively search out improvements.	Q1
Improving equity in diabetes work Lakes DHB will coordinate the local diabetes network in partnership with Diabetes NZ and develop a new Framework to approach Māori Health Equity, and will be implemented to enable equity to be improved throughout the system of care. (EOA)	Q1 & Q3 Framework is developed and implemented
Improving Consumer engagement Consumers are currently on all Board sub-committees and actively engaged through working with Iwi and hapu across Lakes DHB rohi. Lakes DHB will conduct a survey using and employing consumers to address the quality of engagement at a Service Level.	 Q1 & Q3
Lakes DHB will work with **SLM partners** to respond to the Patient Experience Survey in a joined-up approach within the whole system (including Māori and other community providers) to improve the patient experience of care.	SLM
Zero Seclusion a) Continue to focus on work towards zero seclusion. (EOA)Ensure the Safe Practice Effective Communication (SPEC) training has been completed by all current staff. b) Secondary Care Specialist Services maintain a focus on reduction of MH Act and evaluation of progress with Zero Seclusion.	100% of inpatient staff have completed training Trend demonstrates continued reduction in MH Act Reduced seclusion figure.

Te Aho o Te Kahu – Cancer Control Agency	
Action(s)	**Milestone(s)**
New Zealanders have a system that delivers consistent and modern cancer care – He pūnaha atawahi	
BoP and Lakes DHBs will support Te Aho o Te Kahu ACT-NOW project. Our DHB will implement ACT-NOW treatment regimens (national collection) for medical oncology and malignant haematology by: • Depending on the outcome of the 2020-21 Te Manawa Taki oncology e-prescribing feasibility project, we will implement information system that will enable implementation of the Te Aho o Te Kahu ACT-NOW treatment regimens. Te Manawa Taki oncology e-prescribing system will ensure data standards are compliant and that our local data can go into a national repository (EOA)	Q4
BoP and Lakes DHB will work with Te Aho o Te Kahu to plan and implement the adoption of the cancer-related Health Information Standards Organisation (HISO) standards, to be issued via Data and Digital • Our DHBs will continue to implement the Te Manawa Taki Clinical Pathway and MDM Management System that is HISO MDM compliant (EOA) • Our DHB will demonstrate evidence of implementation and compliance of other HISO standards	Q4
BoP and Lakes DHBs will work with other regional DHBs and Te Aho o Te Kahu Regional Hub to develop a 5-year regional radiation oncology service plan that ensures that the model of service is fit for purpose to meet the current and future needs of the region that they provide services to (EOA).	Q4
Lakes DHB will work in partnership with Waikato DHB and Te Aho o Te Kahu on the planning of the Waikato DHB 2nd LINAC replacement (timeframe yet to be determined) with the feasibility of a satellite LINAC outreach service sited in Rotorua (EOA). Lakes DHB and Waikato DHB Cancer Centre and will develop and implement a Business Case to facilitate the development of a new satellite LINAC radiation oncology service for Lakes population as part of the MoH LINAC replacement capital programme. The new radiation oncology service will provide responsive and timely radiation therapy services to patients in Lakes, avoiding the need for travel to another regional centre. The new service aims to improve access to and increase rates of radiation therapy, particularly for Māori who have a higher cancer mortality rate than non-Māori. Delivery against key process steps and timelines will be determined by the Business Case. The new Radiation Oncology service is due to be operational by 2022-23 (tbc).	Q4

New Zealanders experience equitable cancer outcomes – He taurite ngā huanga	
BoP and Lakes DHBs will participate in Te Aho o Te Kahu travel and accommodation project that aims to improve cancer patient equity of access and support to cancer services/treatment for local and for inter-district patient flow. Our DHB is committed to implementing the recommendations of this project, particularly those that ensure equity of access for Māori and rural communities who currently experience inequitable access to cancer services (EOA).	As required
BoP and Lakes DHBs will identify at least two actions specifically to address inequalities and access to diagnosis and care for Māori and Pacific patients. • Consider Te Aho o Te Kahu report and recommendations based on feedback from 15 Māori community hui and agree an action plan. The findings from these huis will also be used to develop the future model for cancer services in our district, with a focus on developing services that are culturally safe for Māori (EOA) • Lakes DHB will scope the development of a telehealth oncology initiative. (EOA) • BoP and Lakes DHBs will support locally driven community-based initiatives with cancer patients and their whānau to drive service improvement via a minimum of one Kia Ora E Te Iwi (KOETI) community-based programme for Māori by Māori lead by Cancer Society (EOA)	Q1 A minimum of one KOETI programme
New Zealanders have fewer cancers – He iti iho te mate pukupuku	
BoP and Lakes DHBs will undertake activities that address the modifiable risk factor for cancer as referenced in the following sections (links to Public Health activities) • Tobacco Control • Reducing Alcohol Related Harm • Healthy Food and Drink	
BoP and Lakes DHBs will also support an increase in activities and programmes aimed at improving Māori and Pacific participation in National Screening Programmes as referenced in the following sections (links to Public Health activities) • Breast Screening • Cervical Screening • Bowel Screening	

New Zealanders have better cancer survival, supportive care and end-of-life care- He hiki ake i te o ranga	
BoP and Lakes DHBs will continue to implement and report progress against our Bowel Cancer Service Improvement Plan (Bowel Cancer Quality Improvement Plan, 2020; Bowel Cancer Quality Improvement Report, March 2019). • Lakes and BoP DHBs will review and improve end of life care under the palliative care improvement programmes.[47] • BoP and Lakes DHBs will explore opportunities to increase the number of patients diagnosed with cancer in the elective pathway (and therefore reduce emergency department presentations) (EOA) • BoP and Lakes DHBs will undertake an audit to understand reasons for colorectal cancer emergency presentations and implement improvements alongside local bowel screening initiatives such as community / primary care awareness and engagement, and GP prompt (EOA)	Q1-Q4
Revise and update our DHB Bowel Cancer Quality Service Improvement Plan following publication of the second national bowel cancer QPI's results in quarter 3 2020-21.	Q1
Develop a DHB Lung Cancer Service Improvement Plan based on the results of the Lung Cancer Quality Improvement Monitoring Report (QPIs 2020) and the impending national Lung Cancer Quality Improvement Plan (2021). We will select the QPIs where our DHB is outside the national average (underperforming) to drive improvements. Lung cancer has been identified as a significant equity issue for BoP and Lakes with incidence rates for Māori being significantly higher than non-Māori and health outcomes for Māori being significantly poorer (due to a combination of factors including late presentation and access barriers to out of region diagnostic and interventional services). As a result of this the Lung Cancer Service Quality Improvement Plan will incorporate a strong equity focus, identifying how service access and delivery can be improved for Māori specifically. • BoP and Lakes DHBs will implement national lung cancer follow-up and supportive care guidance following curative treatment (EOA) • BoP and Lakes DHBs will explore feasibility to implement earlier detection of lung cancer initiatives within available resourcing (EOA) • Lakes DHB will develop a business case to improve access for the early detection of lung cancer.	Q1-Q4

[47] Dr Denise Aitken is leading Health Round Table End of Life Programme at Lakes DHB using deep analysis and benchmarking reports; also sharing innovations with other DHBs and Australia hospitals to plan for initiatives. Also there is a work around sharing patient information between Lakes DHB and hospice groups.

Develop a DHB Prostate Cancer Service Improvement Plan based on the results of the impending Prostate Cancer Quality Improvement Monitoring Report (QPIs 2021) and the impending national Prostate Cancer Quality Improvement Plan (2021). • BoP and Lakes DHBs will select the QPIs where our DHB is outside the national average (underperforming) to drive improvements. Prostate cancer rates are higher for Māori than non-Māori and health outcomes for Māori are typically poorer. As a result of this the Prostate Cancer Service Quality Improvement Plan will incorporate a strong equity focus, identifying how service access and delivery can be improved for Māori specifically. • BoP and Lakes DHBs will participate in regional development of prostate cancer community health pathway and e-referral (EOA) • Lakes DHB will implement a resident urology service that will provide care for prostate cancer patients/whānau (EOA) • BoP and Lakes DHBs will explore opportunities to increase the number of patients diagnosed with cancer in the elective pathway (and therefore reduce emergency department presentations). BoP and Lakes DHBs will undertake an audit to understand reasons for prostate cancer emergency presentations and implement improvements (EOA)	Q1-Q4
BoP and Lakes DHBs will ensure that the 31-day and 62-day cancer treatment wait time measures are met. Our DHB will implement service improvements to improve timely access and demonstrate effective engagement with Māori, Pacific, DHB Consumer Council and other key stakeholders that support local improvement initiatives • BoP and Lakes DHBs will continue to focus on achieving equity (via equity-based reporting), report and monitor Faster Cancer Treatment wait time measures, the identification of specific local issues and continuously implement service improvements • Work in partnership with Te Aho o Te Kahu, Ministry of Health and HealthShare to improve FCT data quality and business rule changes as required • Lakes DHB work in partnership with Waikato DHB and Te Aho o Te Kahu Regional Hub to develop a Lakes resident haematology service (on approval of business case)	Q1-Q4
BoP and Lakes DHBs will plan to implement the cancer COVID-19 guidance developed by Te Aho o Te Kahu should there be a COVID-19 resurgence to ensure minimal impact on cancer diagnostics and treatment services for patients/whānau.	As required

Bowel screening and colonoscopy wait times

New Zealand has one of the highest rates of bowel cancer in the world. Bowel cancer is the second most common cause of cancer death in New Zealand, after lung cancer, with the third highest bowel cancer death rate in the OECD for women and the sixth highest for men. The National Bowel Screening Programme aims to reduce the mortality rate from bowel cancer by diagnosing and treating cancers at an earlier more treatable stage. Early identification and removal of precancerous advanced bowel adenomas aims to reduce bowel cancer incidence over time.

Achieving equitable access is a key priority for the bowel screening programme because participation rates for Māori, Pacific and people living in our most deprived areas remain lower than other groups. The Ministry of Health, DHBs and the National Coordination Centre all have an important role in ensuring all participation targets are achieved with a dedicated focus on eliminating equity gaps between Māori and non-Māori, Pacific and non-Pacific/non-Māori.

The National Screening Unit has implemented an Equity and Performance Matrix in the annual planning reporting process. The Matrix measures both performance against a target and the equity gap between population groups notably, but not limited to, Māori and non-Māori.

To ensure all patients requiring diagnostic procedures are treated fairly, the Ministry uses a dedicated monitoring framework to measure symptomatic colonoscopy wait time performance alongside bowel screening colonoscopy performance. This process ensures both the recommended colonoscopy wait times and the number of people waiting longer than maximum wait times receive equal focus.

All DHBs preparing to implement bowel screening must be

- consistently meeting all diagnostic colonoscopy wait times and
- have no patients waiting longer than maximum in the months prior to the readiness assessment.
- If a DHB does not meet these two requirements, it will not meet the National Bowel Screening Programme readiness criteria, and its go-live date may be delayed.

All DHBs must ensure:

- There are no people waiting longer than the maximum wait times for any indicator.
- All recommended colonoscopy wait times are consistently met for urgent, non-urgent and surveillance procedures.

Action(s)	Milestone(s)
Lakes DHB have nominated a project lead to improve bowel screening rates in the Lakes region, and will work with Te Roopu Hauora o Te Arawa to ensure participation rates for bowel screening for Māori (EOA). Activities include: • Extra clinics will be held in Tāupo and Rotorua Hospitals to reduce wait times and increase participation rates for Māori and Pacific Peoples • Development of a Māori specific communication plan with Māori Health • Joined with Cancer Society and support with the Kia Ora I te Iwi Programme • Increased engagement with the Māori Womens Welfare League	Q1-Q4

• Supporting Te Aho o Te Kahu Māori Cancer Community • Presented to Te Roopu Hauora o Te Arawa • Attend Rapu Oranga Health shop at Western Heights weekly and engage with Community activities • Engaging with Te Arawa Ahurei	
Lakes DHB will complete the new endoscopy suite build to increase capacity and participation rates[48].	Q1
Endoscopy utilisation rate and additional sessions will be held in order to improve the colonoscopy wait time performance. This is an ongoing improvement and the measure will be shown via the waiting time report released by MoH.	Q1

Health workforce

Strengthening the workforce should be a high priority for DHBs. Workforce accounts for nearly 70 percent of total public health expenditure. It is important to ensure there is a sufficient and sustainable supply of skilled workers to deliver high-quality health services in a timely manner, driving equity and system improvement.

Please include the actions for the upcoming year that your DHB considers to be the most important for health workforce, including the reasons why the action(s) are important and the expected impact.

Action(s)	**Milestone(s)**
To better meet population need, Lakes DHB will utilise and grow the Kiawhina workforce to work in conjunction with the regulated workforce to increase covid swabbing, covid immunisation capacity and to support local managed isolation quarantine facilities (MIQF) with Welfare navigators. Kaiwhina Workforce to make up 20% of the combined workforce.	Q1 & Q4
To enhance the health and safety and wellbeing of the workforce during covid-19, Lakes DHB will: • improve working from home guidelines and IT remote working capabilities to sustain, support and enhance remote working of non patient facing staff during lockdown periods; • provide two Resilience training sessions specific to COVID 19 to increase staff awareness of strategies to retain resilience.	Q1 & Q4
Lakes DHB will dedicate a key person (ER manager) as an interface with all union partners to disseminate information and receive feedback.	Q1 & Q4

[48] Currently Lakes DHB is planning on Jul 2022 for the build commencement. This will have a significant positive impact on colonoscopy capacity.

Lakes DHB will offer targeted leadership development opportunities to underrepresented groups in the organisation as a pathway to increasing the future diversity representation in leadership and decision making roles. Target of 10% measured against actual applicants / attendance.	Q1 & Q4
As part of the work towards health equity, the DHB will provide cultural competency development to leadership and patient facing roles in the organisation by delivering two "Disrupting institutional racism training" sessions during the financial year. (EOA)	Q1 & Q4
Lakes DHB will follow recruitment processes and policy to ensure that all Māori applicants who meet the criteria of an advertised role are interviewed. (EOA)[49]	Q1 & Q4
Lakes DHB will provide Te Reo Māori language training with lunch time sessions available to the whole organisation. (EOA)	Q1 & Q4
To sustain the health, safety and wellbeing of our workforce, Lakes DHB will: • undertake an audit to measure the effectiveness and enhance health and safety controls identified through a series of workshops with workers from high risk clinical areas (ED, Mental Health and District Nursing services). • Monitor the severity, nature and incapacity duration from workplace injuries (physical and psychological harm) with a view to implement processes to minimise by 5%.	Q1 & Q4
Lakes DHB will initiate a workforce capacity and capability assessment for the Mental Health and Addictions sector to identify gaps in skill set. This will inform a workforce strategy for Mental Health and Addiction Services[50].	Reporting through Mental Health section

[49] As part of the work towards health equity and meeting the 2040 target of a workforce that by occupational grouping represents the diversity of the local population, recruitment policy and process will ensure all Māori applicants who meet the criteria of an advertised role, are interviewed. Every recruiting manager will receive this guidance pre-selection processes. Compliance monitoring will be via the recruitment function with deviations reported to the Executive member of the service for immediate corrective action.

[50] This aligns with Te Ara Tauwhirotanga- "caring and well supported workforce".

Data and digital enablement

A modern, digitally and data enabled health and disability system can realise the potential of information and digital services to support people to look after their own health and improve decision-making across the system to improve experience, care and outcomes. It is a priority for the Government, and something we want all DHBs to be working on, in partnership with other agencies, industry and consumers. It is expected that all DHBs follow the standard guidance detailed in Operational Policy Framework in relation to Data and Digital.

Please include the actions for the upcoming year that your DHB considers to be the most important for data and digital enablement, including the reasons why the action(s) are important and the expected impact.

We are asking DHBs to identify how digitally enabled changes to ways of working and the delivery of services as part of the COVID-19 response, will be adopted and normalised.

Initiatives should consider telehealth, changes to workforce practices including remote working, increased access to and sharing of data, increased use of data for reporting and analytics, acceleration of the use of cloud services and supporting the COVID-19 response such as electronic ordering of tests and results reporting and electronic tools for CBACs.

Action(s)	Milestone(s)
Lakes DHB will be able to better support the COVID-19 response, as well as respond to the learnings through the Pokapū o te taiwhenua Network[51] project. This project is also what lakes DHB considers to be the most important mahi for improving digital inclusion with regard to health services, including the reasons why the action(s) are important and the expected impact. This links to Rural Health, Equity actions and the Sustainability Section of this plan. (EOA)	Reported through Rural Health
Pokapū o te taiwhenua Network: Pokapū o te Taiwhenua is focused on digital health equity with its first test of change in modelling equity focused video telehealth facilitation.	Reported through Rural Health

[51] Pokapū o te Taiwhenua Network is inclusive network of health and wellbeing community providers, community members, primary care, and specialist care actively closing the technology gap in virtual care to support health equity, whānau wellness, and integration of health and wellbeing services. Initiated in July 2020. First test of change is video telehealth facilitation leveraging a non-clinical workforce in rural Māori hubs (see Data and Digital Enablement Annual Plan Section for further detail).

In alignment with the ICT plan, Lakes DHB will work with Te Manawa Taki partners on the following projects: Digital: • Medicines Management • Interoperability • Mental Health • InterRAI • Telehealth • Microsoft Compliance and technology updates • PACS/RIS • Identity/Access Management and Security Data: • Data exchange • Data Platform for Analytics and Insights	Q2 & Q4 Reported by HealthShare on behalf of Te Manawa Taki.

Implementing the New Zealand Health Research Strategy

Research and innovation, analytics and technology are all crucial for achieving an equitable, sustainable health system and better patient outcomes. In 2021/22, the Ministry expects that DHBs continue to build on the progress made in the previous year towards enabling a strong, supportive and collaborative environment for research.

Please include the actions for the upcoming year that your DHB considers to be the most important for implementing the New Zealand Health Research Strategy, including the reasons why the action(s) are important and the expected impact.

Action(s)	**Milestone(s)**
Lakes DHB will contribute to research related to follow up studies for people having the COVID-19 vaccine (through the vaccine alliance).	Q3
Lakes DHB will contribute expertise to the HRC funded project “Enhancing clinical trials in NZ” through the BoP DHB Research Manager being a Co-investigator.	Q4
Lakes DHB will undertake a review of current BoP DHB research policies to ensure they align with Lakes DHB Te Manawa Rahi priorities.	Q4

Lakes DHB will actively participate in local HRC funded research to better understand the needs of pregnant wahine Māori to inform future service delivery (EOA).	Q4
Lakes DHB will support clinical staff to undertake clinical research through better linkages with academic staff.	Q4
Lakes DHB supports staff to apply for HRC funding to provide opportunities for staff to undertake professional development to strengthen research capability.	Q4

2.7 Better population health outcomes supported by primary health care

Primary health care is a priority work programme for Government, the Ministry of Health and District Health Boards.

An affordable effective primary care system is essential to achieving the objectives of a strong public health system. Primary care is the means through which the health system can decrease use of expensive secondary health services, better manage and lower the incidence of long-term conditions, increase use of illness-preventing behaviours and treatments, and thereby increase people's ability to participate in work and education.

Primary health care is earlier, safer, cheaper, and with improved continuity of care better connected to people's daily routines However, the primary health care system does not serve all people equitably. Some people are delaying access to primary care services for several reasons including cost, travel, time off work or arranging childcare. There is also the potential for a different primary care model to better suit people's lives and better integrate across health disciplines and facilities, thereby improving health outcomes.

Primary care

Improving access to primary care services is a priority for the Government and something we expect all DHBs to be working on, closely with their primary care partners.

Action(s)	Milestone(s)
Lakes DHB will work on optimising digital and data networks across primary, and secondary Care to improve visibility around vaccinations given, and timing of vaccinations[52]. Lakes DHB communications team is using Medinz to communicate COVID-19 related information. This is shared across all of our providers, including the PHOs who are expected to share to GP practices in their own way[53].	Q2
Lakes DHB will support Te Arawa Iwi community hub to continue work in the community that commenced during the COVID-19 response, with plans to carry this forward to implement a community vaccination plan. (EOA)	Q2
Lakes DHB will use the Data and Digital Office funding for an online GP enrolment form as a test of change in the Lakes DHB region. This Pokapū Network will spotlight this enhancement at a future Pokapū virtual engagement with a view to use this in more interagency partnership pilots.	

[52] The Pokapū o te Taiwhenua Network will spotlight "Book my Vaccine" at the next Pokapū virtual engagement. Subsequent communications published via Medinz, an online communication portal to contracted community health providers. We will add "Book my Vaccine" to our Pokapū Healthpoint site, so our Pokapū facilitators can promote to whanau.
[53] This action will be done though the local Covid-19 Vaccination Alliance Group.

Pharmacy

Over recent years we have focused on developing pharmacist services, making better use of pharmacists' skills, within an integrated health and disability system that supports people to stay well throughout their lives. For 2021/22 we ask all DHBs to consolidate this work with an emphasis on immunisation and the expansion of one DHB nominated pharmacy service development.

Action(s)	Milestone(s)
Lakes DHB will support community pharmacies to develop, and implement Pandemic Plans.	Q1
Lakes DHB will offer community pharmacies and pharmacists to become vaccinators for MMR and in preparation for COVID-19 immunisation campaign[54].	Q1 & Q4 Pharmacy vaccinators will report directly to the National Immunisations Register
Lakes DHB will support our Alliance's SLM plan to develop local strategies that support pharmacy and other immunisation providers to work together to improve influenza vaccination rates in Māori, Pacific and Asian people over 65 years of age.[55] EOA	SLM
We will continue to support rural payments for rural communities (Turangi) EOA	Contract in place

[54] Increase from baseline of 6 Community Pharmacies ready to immunise MMR
[55] Milestones and quarterly reporting through the SLM plan

Reconfiguration of the National Air Ambulance Service Project – Phase Two

Air ambulance services are a critical part of how we respond to health emergencies in New Zealand. This service contributes to equity by enabling timely access to specialist clinical interventions regardless of where you live. Cabinet have endorsed a two-phased 10-year reconfiguration of the national air ambulance service. Phase one is complete, preparation for phase two has begun.

Phase Two seeks to achieve the following:

1. A nationally integrated aeromedical service that is coordinated and interoperable across ambulance services and supports the wider health service into the future.
2. A service which ensures that an aeromedical asset is dispatched with a crew capable to save a life, in the time needed to save that life.
3. A service that is optimised to improve clinical effectiveness and standards and achieve better patient outcomes.
4. A service that is financially sustainable with transparent funding flows.
5. A national network of bases, aircraft and crew that provide optimal coverage across New Zealand, which is fully compliant with Civil Aviation Rules and based on world-class aeromedical standards.
6. An appropriate infrastructure ownership model that achieves the best public value for money and supports better service delivery and patient outcomes

Project workstreams include:

1. Centralised tasking and clinical coordination
2. Service system performance
3. Infrastructure ownership and service configuration
4. Provider operational funding

Action(s)	Milestone(s)
Lakes and BoP DHBs are committed to supporting the reconfiguration of the national air ambulance service project. The successful delivery of this project will ensure that there is a nationally consistent framework that ensures regardless of location, people will have access to ambulance services. With our diverse and often rural population, this is essential in ensuring equitable access to services no matter where you live. Lakes and BoP DHBs will support through nominated attendees participating in required meetings and/or workshops, responding to information requests in a timely manner. Actions and Milestones will be developed as more information is made available by NASO.	Q1 & Q4

Long term conditions

Long term conditions comprise the major health burden for New Zealand now and into the foreseeable future. This group of conditions is the leading cause of morbidity in New Zealand, and disproportionately affects Māori and Pacific peoples and people who experience mental illness and addiction. As the population ages and lifestyles change these conditions are likely to increase significantly. The long-term conditions approach should focus on improving primary and community services to prevent, identify and manage behaviours to achieve wellbeing for people with, or at risk of, long term conditions. Gout and chronic kidney disease will be a focus for 21/22, as well as heart health, stroke, diabetes services and Hepatitis C[56]
System outcome to support the priority area: We live longer in good health.

Focus on: Ambulatory sensitive hospitalisations (ASH adult) (SS05)
A focus on improving ASH rates through improved system integration will contribute to a reduction in the total number of unplanned hospital admissions, a substantial proportion of which are ambulatory sensitive.

Action(s)	Milestone(s)
Lakes DHB will scope new relationships and service improvements for adults and Whānau, to improve physical activity and healthy lifestyle.	Q4
Lakes DHB will work with SLM partners to increase the routine monitoring of weight in patients with diabetes or cardiovascular disease and follow this with brief intervention to encourage healthy diet and physical activity.	SLM
Lakes DHB will implement a campaign and process to increase flu vaccination in people aged 65 years and older and on the long-term conditions register. Our goal is to achieve: • ≥ 90% of people 65 years of age or older on the long term conditions register receive their flu vaccination within the last year	SLM
Lakes DHB will work with the community, Primary Health and Te Manawa Taki to plan community focussed Hepatitis C mobile testing. The DHB will work with primary care and wider community providers to identify opportunities to improve the health of the DHB population through access to hepatitis C treatments. *This work will be ongoing and further refined following publication of the National Hepatitis C Action Plan.*	Q4

[56] New Zealand has the opportunity to eliminate hepatitis C in the next 10 years. Significant factors including access to publicly funded, highly effective, well-tolerated direct-acting antiviral (DAA) treatment, and activity from DHBs, primary care and affected communities means there is real prospect of curing hepatitis C for the 45,000 New Zealanders estimated to be living it. Priority groups, including Māori, are populations who have a high prevalence of hepatitis C and more of the long-term impact of infection. The priority settings are needle exchanges, prisons, primary and community care, and alcohol and other drug services (including opioid substitution therapy services).

Lakes DHB will work with SLM partners to decrease the proportion of current smokers, enrolled in a PHO, over the age of 15 years.	SLM
• Ensure that smoking status is checked and updated on a regular basis, so that at least 90% of all patients, recorded as current smokers, have their smoking status confirmed or updated in the last year to least 90%, with an equity ratio of ≥ 1.0. [to check if this can be measured] • Offer support to quit to at least 80% of all current smokers, with an equity ratio of ≥ 1.0. • Increase provision of stop smoking medications to people who smoke by 25%, from a baseline of 8%, with an equity ratio of ≥ 0.9. • Designing and implementing a community-based incentive programme to encourage and support whānau to stop smoking.	SLM
Increase the proportion of people who have been hospitalised with an acute cardiovascular event, and should be taking a combination of a lipid-lowering, blood pressure lowering and anti-platelet medication (triple therapy). • ≥ 70% of people who have had an acute CV event in the last 10 years are taking all three medications, with an equity ratio of ≥ 0.95.	SLM

2.9 Financial Performance Summary

PROSPECTIVE STATEMENT OF FINANCIAL PERFORMANCE (COMPREHENSIVE INCOME) FOR THE THREE YEARS ENDED 30 JUNE 2022, 2023 AND 2024

Statement of Comprehensive income	2019/20 Actual $000	2020/21 Forecast $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Revenue					
Ministry of health Revenue	407,840	444,315	487,130	500,408	522,882
Other Government Revenue	12,333	13,075	13,143	13,390	13,644
Other Revenue	5,160	15,025	7,633	7,444	7,586
Total Revenue	425,334	472,415	507,906	521,242	544,112
Expenditure					
Personel	(145,764)	(152,977)	(169,793)	(164,961)	(169,997)
Outsourced	(19,756)	(23,021)	(16,818)	(16,956)	(17,313)
Clinical supplies	(34,268)	(38,499)	(40,411)	(41,365)	(41,947)
Infrastructure and non clinical supplies	(18,122)	(20,850)	(23,332)	(21,841)	(22,283)
Payments and Non-DHB Providers	(201,420)	(219,446)	(236,496)	(248,323)	(259,802)
Interest	0	0	0	0	0
Depreciation and amortisation	(12,030)	(12,308)	(16,098)	(19,051)	(20,484)
Capital charge	(9,037)	(7,189)	(7,207)	(7,212)	(7,412)
Total Expenditure	(440,396)	(474,290)	(510,156)	(519,709)	(539,238)
Other Comprehensive income	(15,063)	(1,875)	(2,250)	1,533	4,874
Revaluation of land and buildings	0	62,417	0	0	0
Total Comprehensive Income/(Deficit)	**(15,063)**	**60,542**	**(2,250)**	**1,533**	**4,874**

PROSPECTIVE FINANCIAL PERFORMANCE BY OUTPUT CLASS FOR THE THREE YEARS ENDED 30 JUNE 2022, 2023 AND 2024

Prospective Summary of Revenues and Expenses by Output Class	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Prevention			
Total Revenue	15,899	16,316	17,032
Total Expenditure	(17,599)	(17,929)	(18,602)
Net Surplus / (Deficit)	**(1,700)**	**(1,612)**	**(1,570)**
Early Detection			
Total Revenue	104,801	107,553	112,272
Total Expenditure	(119,836)	(122,082)	(126,668)
Net Surplus / (Deficit)	**(15,035)**	**(14,529)**	**(14,396)**
Intensive Assessment & Treatment			
Total Revenue	326,734	335,313	350,025
Total Expenditure	(315,940)	(321,854)	(333,952)
Net Surplus / (Deficit)	**10,794**	**13,459**	**16,074**
Rehabilitation & Support			
Total Revenue	60,471	62,059	64,782
Total Expenditure	(56,780)	(57,844)	(60,017)
Net Surplus / (Deficit)	**3,691**	**4,215**	**4,766**
Consolidated Surplus / (Deficit)	**(2,250)**	**1,533**	**4,874**

SECTION THREE: Service Configuration

3.1 Service Coverage

All DHBs are required to deliver a minimum of services, as defined in The Service Coverage Schedule, which is incorporated as part of the Crown Funding Agreement under section 10 of the New Zealand Public Health and Disability Act 2000, and is updated annually.

Responsibility for service coverage is shared between DHBs and the Ministry. DHBs are responsible for taking appropriate action to ensure that service coverage is delivered for their population, including populations that may have high or different needs such as Māori, Pacific and high-needs groups. Lakes DHB may, pursuant to section 25 of the New Zealand Public Health and Disability Act 2000, negotiate and enter into, or amend any current agreement for the provision or procurement of services.

At this stage Lakes DHB is not seeking any formal exemptions to the Service Coverage Schedule in 2021-2022.

3.2 Service Change

The table below describes all service reviews and service changes that have been approved or proposed for implementation in 2021-2022.

Lakes DHB understands that some of the service changes identified below will need engagement with the Ministry of Health, prior to implementation, to ensure all service change protocols are observed. Lakes DHB understands that some of the service changes identified below will need engagement with the Ministry of Health, prior to implementation, to ensure all service change protocols are observed.

FTE changes are further documented in the financial performance section of this plan.

Summary of Service Changes

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons	FTE change
Service Change	Given the DHB's financial situation and forecast, any and all services have a potential for service change to allow the DHB to meet its funding envelope	Financial sustainability, service continuity and service sustainability	Local	Business Cases will determine impact
Community Oral Health Dental Services	Decommission of one fixed dental (Lynmore) and purchase three units of level one dental.	Increase in Mobile Dental Clinics to increase assess to community dental (more preventative dental care) for children in the Lakes region.	Local	Nil
Renal Dialysis	Expansion of services to include a pm shift for 9 patients three days per week – currently only a daytime shift is provided – six days per week. Service	Allows repatriation of Lakes DHB patients currently receiving treatment in Hamilton. The Waikato Renal Unit will continue to provide specialist renal (physician, training) for	Local/Waikato DHBs	2.75

	commenced in July 2021.	the Lakes services, but there will be greater access for patients locally. Waikato IDFs and NTA *costs will drop.*		
Older Peoples Rehabilitation Services	Opening of an extra 3 beds in the winter months (three months 21/22 year, then five months per year) due to acute demand in medicine	Reduce outliers of medicine patients in other services mainly surgical and reduce the pressure on the ED 6 hour target due to bed block.	Local	FTE increase in year 1 of 1.37 FTE of HCA's and year 2+ will be 2.24 FTE
CTCA (CT Coronary Angiography)	Increase in volumes for CTCA provided at Lakes DHB from 40 pa to 150 per annum Using current CT in Rotorua Hospital with additional capacity created by Tāupo CT to be commissioned in early 2022.	Approximately 70+ patients will no longer require Coronary Angiogram at Waikato Hospital (the majority of these 70+ patients) with net savings of $5k per patients. Patients are no longer being referred to the Waikato lists for CTCA or coronary angiogram. CTCA is better and lower risk for appropriate patients. More prompt treatment will reduce untoward events for patients while waiting for elective treatment. Reduction in IDFs from Lakes to Waikato.	Local. Waikato DHB are aware and promoting change	3.39 FTE Business case shows **cost neutral** as Waikato IDFs will reduce
Disability confident employer status	Reorient service provision at a sub-regional level in a co-design/consultative approach with the disability sector in order to improve access, responsiveness and experience as it affects those with disabilities either as employees of or users of the health system	Improved access, quality of experience.	Sub-Regional	Shared disability sector project support with Bay of Plenty DHB to develop plan – implementation to BAU teams
Turangi Wellbeing Network	The DHB, Ngāti Tūwharetoa Iwi, Pinnacle PHO and Tuwharetoa Health (with regional interagency funders) have agreed to the joint development of	Enhancing equity and turning traditional models of top-down service provision into an approach that best meets the aspirations and needs of local communities. In linking	Sub-Regional	Possibly some additional project specific support but will be within System Implementation Resource (SP&F)

	theTurangi Locality. This will progress during 21-22 in partnership with Iwi, state sector services linked through the Waiariki Leadership group and local council. The above stakeholders will progress the development of multi-agency placed based wellbeing partnerships. Two initial areas have been identified following work undertaken over the last year: (1) Opotiki and (2) Turangi. Opotiki sits under the Bay DHB area currently and therefore BOPDHB and Lakes DHB will work together with the Waiariki Leadership Group in these developments.	the collective resource and community wellbeing focus of Health, MSD, Education, Oranga Tamariki and Local Councils we have an opportunity to address historic challenges of inequity and disadvantage.		
Haematology repatriation	Discussions with Waikato DHB about Lakes DHB recruiting a haematologist to be resident in Rotorua and aligned with the Waikato DHB service.	Difficulty for Waikato DHB to recruit to positions and service outreach. Sufficient workload to justify role and provide on-site acute presence. Similar model to successful repatriation of oncology four years ago.	Lakes. Business case in collaboration with Waikato DHB.	As per developing Business Case – potentially: 1.0 FTE Haematology 1.0 registrar
Neurology Service provision	Business case currently under development to improve neurology service access for the people of Lakes – currently contracted to private providers and visiting Waikato DHB neurologist (14 days per year)	More frequent and responsive local service that is able to meet ESPI requirements.	Local Waikato DHB who are unable to meet service need in Lakes DHB	As per developing Business Case – potentially: 1.0 FTE SMO/Registrar
Introducing CT service in Tāupo	A CT service commencing in Tāupo Hospital from early 2022	Creates capacity in Rotorua to meet CT demand growth and to support CTCA volumes	Local	As per the Tāupo CT business case: 2.0 FTE Medical Imaging Technologist, 1.0 FTE RN, 1.0 FTE Administrator

Weekend shifts in MRI in Rotorua **Evening planned anaesthetic sessions – Rotorua Hospital**	Commencing Saturday sessions in MRI which are a combination of acute and planned Changes in Anaesthetic roster to have additional anaesthetist on evening session, rather than on call for both anaesthetics and ICU	Creates additional MRI capacity within the DHB to maintain waiting time targets and reduce inpatient acute LOS Improves safety for ICU patients Allows acute surgery, to be done until 2200 hours regardless of ICU acuity. Reduces acute LOS and bed blockage. More efficient, and better for health and safety, to operate as planned sessions rather than on call provisions.	Local	As per the MRI business case; 0.6 FTE MIT, 0.4 FTE Radiology Clinical Assistant 2.0 FTE - funded predominantly from on call sessions

SECTION FOUR: Stewardship

This section provides an outline of the arrangements and systems that Lakes DHB has in place to manage our core functions and to deliver planned services.

4.1 Managing our Business

This outlines Lakes DHB's stewardship of its assets, workforce, information technology and systems, and other infrastructure needed to manage core functions and deliver planned services.

Organisational performance management
To enable Lakes DHB to meet Te Manawa Rahi, Lakes DHB Strategic Plan, organisational performance must focus on:

- Improving the Lakes DHB population's health in terms of a percentage improvement in the health of those who would otherwise be in poor or fair health;
- Enhancing the experience of patients through health and wellbeing activities
- Lowering health care costs without compromising the quality and safety of care in terms of the impacts on total health care expenditure (inclusive of savings to patients/users, providers and government)
- Supporting the health and safety of people providing health care including paid and non-paid health care providers.

Each of the above is measureable in terms of qualitative or quantitative performance and involves regular reporting across the DHB Executive and to the Board and its sub-committees as part of the Performance and Assurance Framework reports.

Lakes DHB's performance is assessed on both financial and non-financial measures, which are measured and reported at Executive level(s) of the organisation. These are reported daily, weekly, fortnightly or monthly as appropriate.

Funding and financial management
Lakes DHB's key financial indicators are comprehensive income (surplus/deficit), financial position and cash flows. These are assessed against and reported through Lakes DHB's performance management process to the Board and the Ministry of Health on a monthly basis. Further information about Lakes DHB's planned financial position for 2020/21 and out years is contained within the financial Performance summary section of this document, and in Appendix A: Statement of Performance Expectations.

Investment and asset management
All DHBs are required to complete a stand-alone Long Term Investment Plan (LTIP) covering at least 10 years. LTIPs are part of the new Treasury system for monitoring investments across government, the Investment Management and Asset Management Performance (IMAP) system. The Lakes DHB LTIP was completed in March 2018 and has been used to inform the Annual Plan.

Shared service arrangements and ownership interests
Lakes DHB has a part ownership interest in HealthShare Limited New Zealand Health partnerships Limited. As one of the 20 DHBs nationally Lakes DHB also has interest in Central TAS and Partnership Health. The DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time.

Risk management
Lakes DHB Board is developing a comprehensive 'risk-based Board Assurance Framework (BAF)' which links to the DHB's goals and Minister's expectations. The BAF supports internal risk management using our Te Manawa Taki Regional DATIX Risk Management module for our risk register. The BAF covers all identified, controlled and mitigated priority risks as identified by each of the Executive Team and links to first and second lines of defence. Gaps in controls effectiveness are actively managed and mitigated.

Quality assurance and improvement
Lakes DHB actively addresses quality assurance and improvement initiatives under the Clinical Quality Governance Executive (CQGE) and the Quality Strategy and Roadmap. QA is actively linked to audit/review and to improvement initiatives both planned and emergent. QA also uses the PDSA and Rapid Cycle Improvement methods to ensure operational and clinical engagement and development. The CQGE acts as the key conduit for feedback, affirmation and endorsement and has key leadership in terms of clinical and management personnel that meet a minimum of 10 times per annum.

Work Health and Safety
Lakes DHB recognise that Health and Safety are integral to DHB operations, and commit to improving health and safety across the health workforce. (see Health Workforce section).

Health and Safety is an integral part of the DHB operations with monthly reporting to the Board. There are elected Health and Safety Representatives in all services in both Rotorua and Tāupo. The Health and Safety Representatives meet monthly with feedback to services by means of the Health and Safety team. These meetings are also open to all union partners to attend. The Lakes DHB Board receives a monthly report and this same report is on the agenda for discussion at all meetings with union partners.

As part of our commitment to improving health and safety across the health workforce, both the DHB Board and Executive Leadership group receive formal training opportunities to ensure full understanding and commitment to their health and safety responsibilities as leaders of the health board. In line with health and safety at work act regarding education and training of representatives, the DHB is committed to train health and safety representatives to NZQA level standard and most have achieved this qualification level.

4.2 Building Capability

Capital and infrastructure development
A business case was approved by joint Ministers in August and announced in September 2020 for the replacement of the Rotorua Mental Health Inpatient facility during the 2019/20, 2020/21 and 2021/2 financial years at an estimated cost of $35M. Extensions to the operating theatres are also planned for 2021 – 2023 at a cost of $4.0M. The expected completion date is the second half of 2023.

Data and Digital
A number of major IS projects underway in partnership with Te Manawa Taki (Te Manawa Taki Region) to implement strategies and initiatives for digital health. There are listed in the Data and Digital Section. A number of innovative Telehealth initiatives are referenced throughout the sections of this plan.

4.3 Workforce

Cross reference to the health workforce Section.

Below is a summary of Lakes DHB's organisational culture, leadership and workforce development initiatives. The Te Manawa Taki regional approach to workforce is contained in the draft Te Manawa Taki Regional Equity Plan.

The DHB's response to COVID-19, including the work at Managed Isolation Facilities and the risk of a second wave in New Zealand have introduced stronger links between the DHB and community networks with increased pressures on our workforces. It has seen the creation of new and/or changed roles and increases in staffing numbers. A strong focus remains on staff safety from infection and also caring for our staff from a welfare perspective.

Workforce development and organisational health are central to Lakes DHB to ensure the provision of high quality and effective services that meet the health needs of our community. We are committed to promoting a positive culture for our organisation and work towards ensuring our workforce reflects the cultural mix of our

service users. Through supporting flexibility and innovation; providing leadership and skill development opportunities and being a 'good employer' we continue to attract and retain a skilled workforce.

Our key mechanisms are the established clinical governance process and the well embedded workforce development systems and opportunities for staff. Leadership development for clinical and non-clinical staff is provided through the well-established and successful Te Manawa Taki Leadership Programmes and the implementation and extension of leadership initiatives that correlate with the national SSC leadership and talent management processes. Medical staff development is supported by a dedicated Medical Education Committee and the Medical Management Unit. The nursing and midwifery Professional Development Unit provides on-going training and development for these staffing groups whilst allied, technical and corporate support staff development is supported by the Learning and Development team.

We continue to build capacity with the strategic promotion of health careers through local / regional / national and international careers services and the national job portal, thereby increasing the numbers of key workforces as required i.e. medical; mental health; rehabilitation; cancer and emergency department.

Co-operative developments

Lakes DHB works and collaborates with a number of external organisations and entities, including Rotorua Lakes Council, a joint collaboration for the Rotorua children's centre; Collective Impact Group (all central agencies), Healthy Families Rotorua; Justice; Ministry of Education; Police; Housing; Ministry of Social Development; Children's Team and Accident Compensation Corporation.

A critical element for Lakes DHB is the relationship with the Māori Iwi Relationship Board (MIRB) and local Iwi governance bodies.

The MIRB relationship is supported through Nga Toka Hauora, the Te Manawa Taki DHB General Managers, and Directors Māori Health, Equity and Outcome.

An output of this relationship has been the articulation of the need for the region and its member DHBs to build a culture of equity across all activities and the outcomes that are sought. Four components form the focus: Health equity assessment; application of whānau centred health information management; removing differential targets for Māori and non-Māori and growing the Māori health and disability workforce across the Te Manawa Taki region and within HealthShare the regional shared service agency. Nga Toka Hauora will also support HealthShare in the application of the above commitments.

Public Health Unit

Lakes DHB is committed to working in partnership with our public health unit, Toi Te Ora, in its work on health promotion/improvement services, delivering services that enhance the effectiveness of prevention activities in other parts of the health system, and in understanding regulatory functions.

Toi Te Ora has a key role to play in supporting the DHB and continues to work with the DHB to ensure there is public health input into our planning, to assist with implementation plans and to advise on service delivery where appropriate. Further information is noted in section 2.3.1 Public Health Plans.

SECTION FIVE: 2021/22 Performance Measures

The health and disability system has been asked to focus on the following priorities:

- Improving child wellbeing
- Improving mental wellbeing
- Improving wellbeing through prevention.
- Better population health outcomes supported by strong and equitable public health and disability system
- Better population health outcomes supported by primary health care.

The DHB monitoring framework and accountability measures will be updated for 2021/22 to provide a line of sight between DHB activity and the health system priorities that will support delivery of the Government's priority goals for New Zealand and the health system vision and outcomes, within a system that has a foundation of financial, clinical and service sustainability and strong governance.

Performance measure		Expectation		
CW01	Children caries free at 5 years of age	Year 1	≥ 47%	
		Year 2	≥ 47%	
CW02	Oral health: Mean DMFT score at school year 8	Year 1	< 1.04	
		Year 2	< 1.04	
CW03	Improving the number of children enrolled and accessing the Community Oral health service	Children (0-4) enrolled	Year 1	≥ 95%
			Year 2	≥ 95%
		Children (0-12) not examined according to planned recall	Year 1	≤ 10%
			Year 2	≤ 10%
CW04	Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	Year 1	≥ 85%	
		Year 2	≥ 85%	
CW05	Immunisation coverage at eight months of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	95% of eight-month-olds olds fully immunised.		
		95% of five-year-olds have completed all age-appropriate immunisations due between birth and five year of age.		
		75% of girls and boys fully immunised – HPV vaccine.		
		75% of 65+ year olds immunised – flu vaccine.		
CW06	Child Health (Breastfeeding)	70% of infants are exclusively or fully breastfed at three months.		
CW07	Newborn enrolment with General Practice	The DHB has reached the "Total population" target for children enrolled with a general practice by 6 weeks of age (55%) and by 3 months of age (85%) and has delivered all the actions and milestones identified for the period in its annual plan and has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group, for both targets.		
CW08	Increased immunisation at two years	95% of two-year-olds have completed all age-appropriate immunisations due between birth and age two years.		

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.		
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.		
CW12	Youth mental health initiatives	Focus area 1 (Youth SLAT): Provide reports as required		
		Focus area 2 (School Based Health Services): Provide reports as required		
		Focus area 3: (Youth Primary Mental Health services) refer MH04		
MH01	Improving the health status of people with severe mental illness through improved access	Age (0-19)	Māori	5%
			Other	6.2%
			Total	5.5%
		Age (20-64)	Māori	9.8%
			Other	5%
			Total	6.5%
		Age (65+)	Māori	3.5%
			Other	3%
			Total	3%
MH02	Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan.		
		95% of audited files meet accepted good practice.		
MH03	Shorter waits t mental health services for under 25 year olds	Provide reports as specified		
MH04	Rising to the Challenge: The Mental Health and Addiction Service Development Plan	Provide reports as specified		
MH05	Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.		
MH06	Output delivery against plan	Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.		
MH07	Improving the health status of people with severe mental illness through improved acute inpatient post discharge community care	Provide reports as specified		

PV01	Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall.		
PV02	Improving cervical screening coverage	80% coverage for all ethnic groups and overall.		
SS01	Faster cancer treatment – 31 day indicator	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.		
SS03	Ensuring delivery of Service Coverage	Provide reports as specified		
SS04	Delivery of actions to improve Wrap Around Services for Older People	Provide reports as specified		
SS05	Ambulatory sensitive hospitalisations (ASH adult)	<4800 per 100,000		
SS06	Better help for smokers to quit in public hospitals (previous health target)	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.		Only applies to specified DHBs
SS07	Planned Care Measures	Planned Care Measure 1:		ESPI 1 ESPI 2
		Planned Care Interventions		
		Planned Care Measure 2: *Elective Service Patient Flow Indicators*	ESPI 3	100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less)
			ESPI 5	0% – no patients are waiting over four months for FSA
			ESPI 8	0% - zero patients in Active Review with a priority score above the actual Treatment Threshold (aTT)
			Coronary Angiography	0% - zero patients are waiting over 120 days for treatment
			Computed Tomography (CT)	100% - all patients were prioritised using an approved national or nationally recognised prioritisation tool
		Planned Care Measure 3: *Diagnostics waiting times*	Magnetic Resonance Imaging (MRI)	95% of patients with accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)
			No patient will wait more than or equal to 50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the	95% of patients with accepted referrals for CT scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).

			responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service.	
			Magnetic Resonance Imaging (MRI)	90% of patients with accepted referrals for MRI scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).
		Planned Care Measure 4: *Ophthalmology Follow-up Waiting Times*	All patients (both acute and elective) will receive their cardiac surgery within the urgency timeframe based on their clinical urgency.	
		Planned Care Measure 5: *Cardiac Urgency Waiting Times*	The proportion of patients who were acutely re-admitted post discharge improves from base levels.	
		Planned Care Measure 6: *Acute Readmissions*	Note: There will not be a Target Rate identified for this measure. It will be developmental for establishing baseline rates in the 2020/21 year.	10%
		Planned Care Measure 7: Did Not Attend Rates (DNA) for First Specialist Assessment (FSA) by Ethnicity (Developmental)	New NHI registration in error (causing duplication) Recording of non-specific ethnicity in new NHI registration	
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1: Improving the quality of data within the NHI	Update of specific ethnicity value in existing NHI record with a non-specific value	>1% and <=3%
			Validated addresses excluding overseas, unknown and dot (.) in line 1	>0.5% and < or equal to 2%
			Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% and < or equal to 2%

			Invalid NHI data updates NPF collection has accurate dates and links to NNPAC and NMDS for FSA and planned inpatient procedures.	>76% and < or equal to 85%
			National Collections completeness	Still to be confirmed
		Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC and NMDS for FSA and planned inpatient procedures.	Greater than or equal to 90% and less than 95%
			Assessment of data reported to the NMDS Provide reports as specified	Greater than or equal to 94.5% and less than 97.5%
			Assessment of data reported to the NMDS	Greater than or equal to 85% and less than 95%
		Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)		Provide reports as specified
SS10	Shorter stays in Emergency Departments	95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.		
SS11	Faster Cancer Treatment (62 days)	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.		
SS12	Engagement and obligations as a Treaty partner	Reports provided and obligations met as specified		
SS13	Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	Focus Area 1: Long term conditions	Report on the progress made in self-assessing diabetes services against the Quality Standards for Diabetes Care.	
			Ascertainment: target 95-105% and no inequity	
		Focus Area 2: Diabetes services	HbA1c<64mmols: target 60% and no inequity	
			No HbA1c result: target 7-8% and no inequity	
			Provide reports as specified	
			Indicator 1: Door to cath Door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram.	

		Focus Area 3: Cardiovascular health	**Indicator 2a:** Registry completion- >95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and
		Focus Area 4: Acute heart service	**Indicator 2b:** ≥ 99% within 3 months.
			Indicator 3: ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (i.e. have had an echocardiogram or LVgram).
			Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator in the absence of a documented contraindication/intolerance ≥85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge - Aspirin*, a 2nd anti-platelet agent*, and an statin (3 classes) - ACEI/ARB if any of the following – LVEF ,50%, DM, HT, in-hospital HF (Killip Class II to IV) (4 classes), - Beta-blocker if LVEF<40% (5-classes). * An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.
			Indicator 5: Device registry completion ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS-QI Device PPM forms completed within 2 months of the procedure.
			Indicator 6: Device registry completion- ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device PPM (Indicator 5A) and ICD (Indicator 5B) forms within 2 months of the procedure.
			Indicator 1 ASU: 80% of acute stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital **Indicator 6:** Device registry completion- ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device PPM (Indicator 5A) and ICD (Indicator 5B) forms within 2 months of the procedure.
		Focus Area 5: Stroke services	**Indicator 2** Reperfusion Thrombolysis /Stroke Clot Retrieval: 12% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile, (Service provision 24/7)

		Provide confirmation report according to the template provided	**Indicator 3:** In-patient rehabilitation: 80% patients admitted with acute stroke are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission
			Indicator 4: Community rehabilitation: 60% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.
			Indicator 3: In-patient rehabilitation: 80% patients admitted with acute stroke are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission
			Indicator 4: Community rehabilitation: 60% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.
SS15	Improving waiting times for Colonoscopy	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less 100% within 30 days or less.	
		70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less.	
		70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less.	
		95% of people who returned a positive FIT have a first offered diagnostic date that is within 45 working days or less of their FIT result being recorded in the NBSP IT system.	
SS17	Delivery of Whānau ora	Appropriate progress identified in all areas of the measure deliverable.	
PH01	Delivery of actions to improve SLMs	Provide reports as specified	
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers	All PHOs in the region have implemented, trained staff and audited the quality of ethnicity data using EDAT within the past three-year period and the current results from Stage 3 EDAT show a level of match in ethnicity data of greater than 90 percent.	
PH03	Access to Care (PHO Enrolments)	The DHB has an enrolled Māori population of 95 percent or above	
PH04	Primary health care: 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	
Annual plan actions – status update reports			

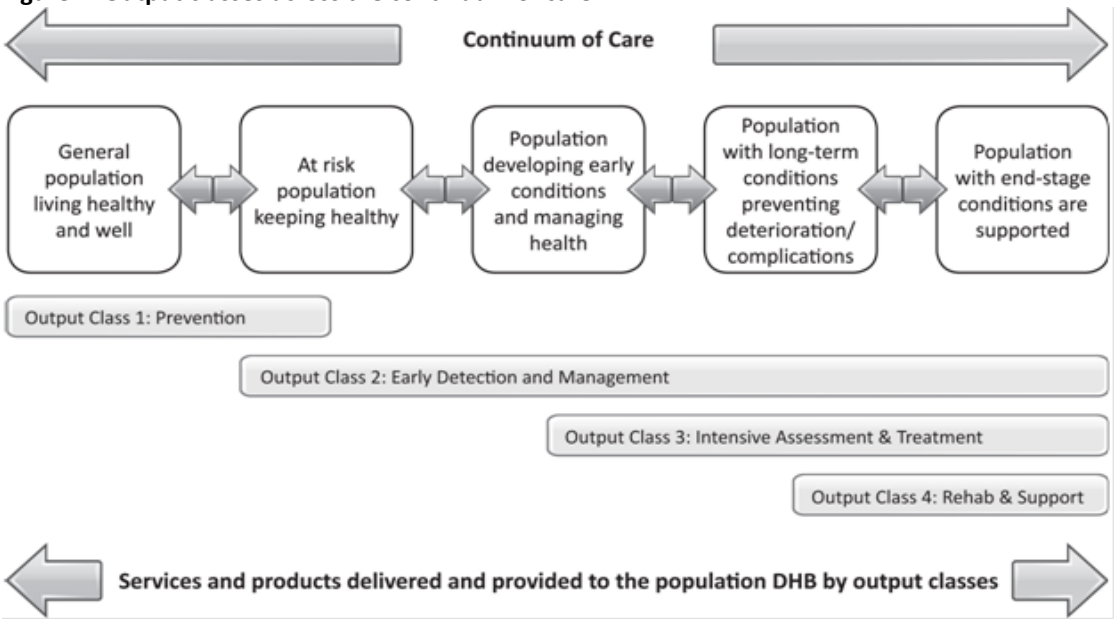
APPENDIX 1: 2021/22 Statement of Performance Expectations including Financial Performance

1 Statement of Performance Expectations

Lakes DHB has worked with other DHBs in Te Manawa Taki, our primary care partners as well as other key stakeholders to develop the Statement of Performance Expectations (SPE) in which we provide measures and forecast standards of our output delivery performance. The actual results against these measures and standards will be presented in our Annual Report 2021/22.

This SPE is organised by output class (see Figure 1 below) and describes the range of activities that Lakes District Health Board funds, plans, provides and promotes.

Figure 1: Output classes across the continuum of care



Performance measures

The performance measures chosen are not an exhaustive list of all of our activity, but they do reflect a good representation of the full range of outputs that we fund and / or provide. They also have been chosen to show the outputs which contribute to the achievement of national, regional and local outcomes.

The indicators of performance include volume (V), timeliness (T), quality (Q) and coverage (C).

Activity not mentioned in this document will continue to be planned, funded and/or provided to a high standard. We do report quarterly to the Ministry of Health and / or our Board on our performance related to this activity.

Unless otherwise stated the measures use data from Quarter 2 2019/20 (i.e. October – December 2019) as the COVID pandemic caused significant disruption during quarter 4 2019/20.

Some of the measures are reported via the Lakes District Health Board Systems Level Measure (SLM) Plan and in such cases a note is provided.

Output Class 1: Prevention Services

Prevention services are those aimed at protecting and promoting the health of the population. These can focus on individuals or may act on the social and physical environment. Prevention services include: health promotion to prevent illness and reduce unequal outcomes; statutorily mandated health protection services to protect the

public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services. Lakes DHB works closely with Toi Te Ora Public Health Service, as well as our Māori providers to help promote health and wellbeing and prevent disease.

Performance measure	Measure Type	Group	Baseline	Target 2021/22
Health Promotion				
Percentage of hospitalised smokers offered advice to quit (SS06)	C	Māori	76.3%[57]	95%
		Non-Māori	73.2%	
		Total	74.9%	
Percentage of PHO enrolled smokers offered advice to quit (PH04)	C	Māori	75.4%	90%
		Non-Māori	81.0%	
		Total	77.9%	
Percentage of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice to quit (CW09)	C	Māori	90.9%	90%
		Total	91.7%	
Percentage of babies living in smokefree homes at six weeks postnatal	C (SLM)	Māori	40%[58]	58%
		Non-Māori	65.7%	
		Total	53.4%	
Percentage of infants who are exclusively or fully breastfed at 3 months (CW06)	Q	Māori	42%	70%
		Non-Māori	60%	
		Total	52%	
Percentage of children identified as obese in the B4SC programme who are offered a referral to a registered health professional (CW10)	Q	Māori	100%[59]	95%
		Total	100%	
Immunisation				
Percentage of two years olds fully immunised (CW05)	C	Māori	82.0%	95%
		Non-Māori	86.7%	
		Total	84.4%	
Rate of HPV immunisation coverage (CW05)	C	Total	New measure	75%
Percentage of the population >65 years who have received the seasonal influenza immunisation (CW05)	C	Māori	49.7%	75%
		Non-Māori	52.7%	
		Total	52.3%	
Screening				
Percentage of women (25-69 years of age) who have had a cervical cancer screen completed in the last three years (PV02)	C	Māori	73.8%[60]	80%
		Non-Māori	77.8%	
		Total	76.5%	
Percentage of women (50-69 years of age)[61] who have had a breast screen in the last two years (PV01)	C	Māori	67.1%[62]	70%
		Non-Māori	72.7%	
		Total	71.2%	

[57] Baseline data are as at end of fiscal year 2019
[58] Baseline data covers 6 months period to December 2019
[59] Baseline data covers 6 months period to November 2019
[60] Baseline data covers 3 years period to December 2019
[61] Anyone with a cervix or vagina who has ever been sexually active should have regular cervical screening from the time they turn 25 until they turn 70 MOH NZ
[62] Baseline data covers 2 years period to December 2019

Performance measure	Measure Type	Group	Baseline	Target 2021/22
Percentage of eligible population who have had their B4 School Checks completed	C	Māori	90.5%[63]	90%
		Non-Māori	96.9%	
		Total	93.6x%	
A routine health assessment (including HEEADSSS assessment) coverage in DHB funded school health services	C	Māori	72.3%[64]	95%
		Non-Māori	20.0%	
		Total	34.6%	

[63] Baseline data covers financial year 2018/19 between 8 July 2018 and 7 July 2019. 2018/19 was used as the data provided by B4SC is accumulative every financial year rather than monthly basis.
[64] Baseline data covers 6 months period to December 2019

Output Class 2: Early Detection and Management

Early detection and management services are delivered by a range of health and allied health professionals in variety of settings including schools, Māori providers, pharmacy, oral health services and general practice. Access to these services helps to prevent and manage illness. Services typically focus on individuals and in some situations small groups of people.

Performance measure	Measure Type	Group	Baseline	Target 2021/22
Primary Health Care				
Percentage of population enrolled with a Primary Health Organisation (PHO)	C	Māori	86.9%[65]	90%
		Non-Māori	97.3%	
		Total	93.4%	
Proportion of people with diabetes (aged 15-74) and enrolled with Lakes DHB practices who have had an annual review	C	Total	TBC	85%
Proportion of people with diabetes (aged 15-74) and enrolled with Lakes DHB practices who have a HbA1C > 64 mmol/mol	Q (SLM)	Māori	TBC	65%
		Non-Māori	TBC	
		Total	TBC	
Proportion of people with CVD or diabetes and enrolled with Lakes DHB practices that have a weight recorded in the last year	Q (SLM)	Māori	74.0%[66]	85%
		Non-Māori	70.0%	
		Total	71.0%	
Proportion of people who have had an acute cardiovascular event in the last 10 years who are prescribed triple therapy[67]	Q (SLM)	Māori	44.8%[68]	55%
		Non-Māori	51.7%[69]	
		Total	49.5%	
Oral health				
Percentage of children (0-4) enrolled in DHB funded dental services (CW03)	C	Māori	88%	95%
		Non-Māori	100%	
		Total	95%	
Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years (CW04)	C	Māori	73.6%[70]	85%
		Non-Māori	96.2%	
		Total	84.6%	
Mean DMFT (Decayed Missing or Filled Teeth Score for Year 8 Children (12/13 years)	Q	Māori	1.2[71]	<1.65
		Non-Māori	0.6	
		Total	0.8	
Percentage of enrolled children caries free at age 5 years	Q	Māori	28%	>47%
		Non-Māori	77%	
		Total	51%	
Testing and diagnostics				
Non-urgent community laboratory tests are completed and communicated to practitioners within the relevant category timeframes	T	Category 1: Within 24 hours	96.0%[72]	100%
	T	Category 2: Within 96 hours	98.5%	100%

[65] Denominator for the baseline data (2019/20) was used from 2020 updated population projection provided by Statistics NZ
[66] This is a new measure and uses quarter 2 2020/21 as baseline
[67] Triple therapy consists of a lipid-lowering, blood pressure lowering, and anti-platelet medication
[68] Baseline data covers 12 months ending 31 December 2019
[69] These data are for 'Other' and do not include 'Pacific', 'Indian', and 'Asian'
[70] Baseline data covers 12 months ending 31 December 2019
[71] Baseline data covers the month of December 2019
[72] Baseline data covers the month of December 2019 and it is an average of two districts, Rotorua and Taupo

Performance measure	Measure Type	Group	Baseline	Target 2021/22
	T	Category 3: Within 72 hours	94.0%	100%
Pharmacy				
Number of community pharmacy prescriptions	V	Total	TBC	N/A

Output Class 3: Intensive Assessment and Treatment

Intensive assessment and treatment services are delivered by a range of specialist providers in secondary, tertiary and quaternary health care settings. They include ambulatory services (including outpatient, district nursing and day services), emergency department, inpatient services, as well as therapeutic, diagnostic, and rehabilitative services.

Performance measure	Measure Type	Group	Baseline	Target 2021/22
Acute services				
Percentage of all Emergency Department presentations who are triaged at levels 4 and 5	Q	Māori	New measure	Under develop ment
		Total		
Percentage of patients events admitted, discharged or transferred from ED within six hours	T	Māori	93.4%	95%
		Non-Māori	94.4%	
		Total	94.0%	
Average inpatient length of stay (acute)	Q	Māori	TBC	2.3 days
		Non-Māori		
		Total		
Average inpatient length of stay (elective)	Q	Māori	TBC	1.3 days
		Non-Māori		
		Total		
Acute re-admission rate[10]	V/Q	Māori	12.3%	<12%
		Non-Māori	12.4%	
		Total	12.4%	
Cancer services				
Faster Cancer Treatment –proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment within 62 days of diagnosis (SS01)	T	Total	95.8%	90%
Elective Services				
Proportion of patients waiting longer than 4 months for their first specialist assessment (FSA)	T	Total	3.54%[73]	0%
Proportion of patients who do not attend outpatient clinics (all patients)	V	Māori	New measure	<10%
		Non-Māori		
		Total		
Diagnostics				
Proportion of patients with accepted referrals for CT and MRI receive their scan within 6 weeks (SS07)	T	CT	71.9%	95%
		MRI	41.8%	90%
Proportion of patients receiving elective diagnostic colonoscopy within the prescribed waiting time (SS15)	T	Urgent colonoscopy (within 2 weeks)	89.5%	95%
		Non urgent colonoscopy (within 6 weeks)	91.2%	
		Surveillance colonoscopy (within 12 weeks)	79.3%	

[73] Baseline data covers the month of December 2019

Performance measure	Measure Type	Group	Baseline	Target 2021/22
Mental health				
Percentage of people referred for non-urgent mental health or addiction services are seen within 3 weeks (MH03)				
Mental health services	T	Age 0-19	47.9%[74]	80%
		Age 20-64	48.6%	
		Age 65+	74.1%	
Addiction services	T	Age 0-19	100.0%	80%
		Age 20-64	89.9%	
		Age 65+	100.0%	
Rates of 7 day follow-up in the community post discharge (MH07)	T	Total	56.1%	75%
Quality and safety				
Rate of in-hospital falls resulting in fractured neck of femur (FNOF) per 100,000 admissions	Q	Total	17.2	Under development
Surgical site infections per 100 hip and need operations	Q	Māori	0.0%[75]	Under development
		Non-Māori	0.4%[76]	
Percentage of respondents who reported the highest level of involvement in their own care	Q	Total	70.4%	Under development

[74] Baseline data covers 12 months period to December 2019
[75] Baseline data covers 12 months period to December 2019
[76] This data excludes Māori and Pacific.

Output Class 4: Rehabilitation and support services

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination input by Needs Assessment and Service Coordination (NASC) Services for a range of services including day care, home-based support services and residential care services. Rehabilitation services are provided by the DHB and a range of other providers (e.g. ARC providers, hospice and community groups.

Performance measure	Measure Type	Group	Baseline	Target 2021/22
Home-based support				
Percentage of the population over 65 years that access Home Based Support Services (HBSS)	Q	Total	TBC	Under development
Residential care				
Percentage of population over 65 years who have accessed aged residential care (ARC)	V	Total	3.3%[77]	
Palliative care				
Number of initial and follow-up primary care delivered palliative care visits	V	Māori		
		Non-Māori		
		Total		
Assessment, treatment and rehabilitation				
Number of people aged 65+ that have been seen by the Fracture Liaison Service (FLS)	V	Total	41	Under development

[77] Denominator for the baseline data (2019/20) was used from 2020 updated population projection provided by Statistics NZ

2 Financial Performance

Funding Policy and Overview

The Lakes DHB funding policy is to have a sound financial base to deliver and purchase health services outlined in the Annual Plan. Having a sound financial base involves the following:

- Funding and delivering health services within the funding received from Government. This implies that any cost growth must be limited to the cost growth allowed by the MoH in the Funding envelope.
- Eliminating any operating deficit by projecting a breakeven or better position for the four years. Lakes DHB is currently projecting a deficit in years one, going into breakeven and better in years 2, 3 and 4.
- Ensuring that there is appropriate funding available to invest in health technology.
- The Lakes DHB for purposes of transparency maintains three separate sets of financial information, namely:
  - The DHB Fund division
  - The DHB Governance and Administration division
  - The DHB Provider division.

Output Classes

This section depicts how the DHB has allocated its funding across specific output functions.
An output is a service supplied to someone outside of the entity for example a patient or aged residential care resident. An output class is a group of similar outputs or services.

Definitions for the four SOI Output Classes:

Intensive Assessment and Treatment comprise services that are delivered by hospitals to enable co-location of clinical expertise and specialised equipment. These services are generally complex and provided by health care professionals that work closely together. They include:

- Outpatient
- District Nursing
- Day services
- Diagnostic, therapeutic, and rehabilitative services
- Inpatient services
- Emergency Department services.

Early Detection and Management comprise services that are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. These include:

- General practice, community and Māori health services,
- Pharmacist services, Community Pharmaceuticals (the Schedule)
- Child and adolescent, oral health and dental services.

Prevention includes:

- Health promotion to ensure that illness is prevented and unequal outcomes are reduced
- Statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases
- Individual health protections services such as immunisation and screening services.

Support and Rehabilitation comprise services that are delivered following a 'needs assessment' process and coordination input by NASC Services for a range of services including palliative care services, home-based support services and residential care services.

Lakes District Health Board
Consolidated Schedule of Output Classes

	Forecast 2020/21 ($000s)	Budget 2021/22 ($000s)	Budget 2022/23 ($000s)	Budget 2023/24 ($000s)	Budget 2024/25 ($000s)
Revenue					
Prevention	14,788	15,899	16,316	17,032	17,739
Early Detection and management	97,478	104,801	107,553	112,272	116,928
Intensive Assessment and Treatment	303,903	326,734	335,313	350,025	364,545
Rehabiliation and Support	56,246	60,471	62,059	64,782	67,469
Total	**472,415**	**507,905**	**521,242**	**544,112**	**566,680**
Expenses					
Prevention	(16,362)	(17,599)	(17,929)	(18,602)	(19,311)
Early Detection and management	(111,411)	(119,836)	(122,082)	(126,668)	(131,495)
Intensive Assessment and Treatment	(293,729)	(315,940)	(321,854)	(333,952)	(346,678)
Rehabiliation and Support	(52,788)	(56,780)	(57,844)	(60,017)	(62,304)
Total	**(474,290)**	**(510,155)**	**(519,709)**	**(539,238)**	**(559,788)**
Surplus/(Deficit)					
Prevention	(1,574)	(1,700)	(1,612)	(1,570)	(1,572)
Early Detection and management	(13,933)	(15,035)	(14,529)	(14,396)	(14,567)
Intensive Assessment and Treatment	10,174	10,794	13,459	16,074	17,866
Rehabiliation and Support	3,458	3,691	4,215	4,766	5,165
Total	**(1,875)**	**(2,250)**	**1,533**	**4,874**	**6,892**

Financial Performance

The actuals for 2019/20 and the projections from July 2020 through to June 2024 have been prepared applying the International Public Section Accounting Standards (IPSAS). This is in line with what was presented last year.

Revenue contained in forecasts/projections is based on information supplied by the MoH, and assumptions pending the formal funding advice. Whilst the year ended June 2021 can be considered as a forecast, the following four years are considered projections. A forecast is based on assumptions which the governing body reasonably expects to occur whilst a projection is based on one or more hypothetical but realistic assumptions.

Major assumptions

In order to complete the projected financial statements a number of major assumptions had to be made. Revenue increases have been assumed as follows:

PBF Funding Growth (including demographic growth)

PBF Funding growth all years	**Actual** 19/20 ($000s)	**Forecast** 20/21 ($000s)	**Plan** 21/22 ($000s)	**Plan** 22/23 ($000s)	**Plan** 23/24 ($000s)	**Plan** 24/25 ($000s)
Base Start (including top slices)	13,288,100	14,271,622	15,330,538	16,187,149	16,937,149	17,687,149
Population share funding	579,000	958,185	752,740	750,000	750,000	750,000
Other in year funding updates	404,522	100,731	103,871			
Total increase	983,522	1,058,916	856,611	750,000	750,000	750,000
Annual % increase	7.40%	7.42%	5.59%	4.63%	4.43%	4.24%
Total Vote Health Funding	**14,271,622**	**15,330,538**	**16,187,149**	**16,937,149**	**17,687,149**	**18,437,149**
Lakes DHB share						
Base start	**326,948**	**349,610**	**382,702**	**411,801**	**434,291**	**454,699**
Population share funding increase	**11,641**	**30,946**	**26,363**	**22,490**	**20,408**	**20,121**
Other in year funding updates	**11,021**	**2,146**	**2,736**			
Total increase	22,662	33,092	29,099	22,490	20,408	20,121
Annual % increase	6.93%	9.47%	7.60%	5.46%	4.70%	4.43%
Total devolved Funding	**349,610**	**382,702**	**411,801**	**434,291**	**454,699**	**474,820**

Internal Funding allocation	**Actuals** 19/20 ($000s)	**Forecast** 20/21 ($000s)	**Plan** 21/22 ($000s)	**Plan** 22/23 ($000s)	**Plan** 23/24 ($000s)	**Plan** 24/25 ($000s)
Total						
PBF Revenue (per above)	349,610	382,702	411,801	434,291	454,699	474,820
MoH Sub Contract revenue	31,126	30,028	44,045	44,926	45,824	46,741
IDF revenue	22,789	24,366	26,949	28,296	29,711	31,197
Total Funding -Funder Arm	403,525	437,096	482,795	507,513	530,235	552,758
Increase %	*6.16%*	*8.32%*	*10.46%*	*5.12%*	*4.48%*	*4.25%*
Applied to Funder Arm	**205,251**	**216,745**	**236,497**	**259,918**	**271,719**	**283,897**
Applied to Funder Arm %	*50.86%*	*49.59%*	*48.98%*	*51.21%*	*51.24%*	*51.36%*
Increase %	*5.19%*	*5.60%*	*9.11%*	*9.90%*	*4.54%*	*4.48%*
Applied to Provider Arm	**188,909**	**208,070**	**234,958**	**236,006**	**246,927**	**257,071**
Applied to Provider Arm %	*46.81%*	*47.60%*	*48.67%*	*46.50%*	*46.57%*	*46.51%*
Increase %	*4.06%*	*10.14%*	*12.92%*	*0.45%*	*4.63%*	*4.11%*
Applied to G&A Arm	**9,365**	**12,281**	**11,340**	**11,589**	**11,589**	**11,790**
Applied to G&A Arm %	*2.32%*	*2.81%*	*2.35%*	*2.28%*	*2.19%*	*2.13%*
Increase %	*57.34%*	*31.14%*	*-7.66%*	*2.20%*	*0.00%*	*1.73%*

Cost year on year impact has been assumed as follows:

Staff

Staff Details	Auto Steps	Ctcp increase				Year on Year Impact			
		21/22	22/23	23/24	24/25	21/22	22/23	23/24	24/25
Medical Staff -SMO ***	2.00%	0.00%	0.00%	0.00%	2.00%	2.00%	2.00%	2.00%	4.00%
Medical Staff -RMO ***	2.00%	2.00%	0.00%	0.00%	2.00%	4.00%	2.00%	2.00%	4.00%
Nursing Staff ***	1.00%	1.50%	1.88%	1.88%	2.41%	2.50%	2.88%	2.88%	3.41%
Allied Health Staff **	1.00%	1.50%	1.88%	1.88%	2.41%	2.50%	2.88%	2.88%	3.41%
Support Staff **	1.00%	3.00%	3.00%	3.00%	3.00%	4.00%	4.00%	4.00%	4.00%
Administration **	0.40%	4.07%	1.62%	1.62%	2.54%	4.47%	2.02%	2.02%	2.94%
Management	0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

**prorated to accommodate 0% inc for $60k plus
***prorated to accommodate 0% inc for $100k plus

Other expenses

Details	21/22	22/23	23/24	24/25
Provider and G&A costs				
Clinical Supplies	2.10%	1.88%	1.90%	2.10%
Other Operating costs	2.10%	1.88%	1.90%	2.10%
Funder Arm costs (ctcp)				
Local DHB Non-Mental Health NGO Contracts	3.00%	3.00%	3.00%	3.00%
Local Mental Health NGO Contracts	3.00%	3.00%	3.00%	3.00%
Aged Residential Care, Respite and Home Support Contracts	3.00%	3.00%	3.00%	3.00%
Immunisation, GMS	3.00%	3.00%	3.00%	3.00%
Combined Dental Agreement	3.00%	3.00%	3.00%	3.00%
PHO First Contact Capitation Payments	3.51%	3.51%	3.51%	3.51%
PHO Management, Health Promotion etc	2.84%	2.84%	2.84%	2.84%

This draft annual plan includes planned care funding as per the 2020/21 year adjusted for assumed contribution to cost pressure growth. Pursuant to Clause 25 of the New Zealand Public Health and Disability Act 2000 the Lakes District Health Board may enter into service agreements for the provision of services outlined in this plan.

ESTIMATE - Overview of 2021-2025 Financial plan (GST excluded)

Consolidated Plan

The Consolidated Annual Plan financial forecast contained in this package can be summarised as follows:

CONSOLIDATED NET RESULT

	Actuals 2019/20 ($000s)	Forecast 2020/21 ($000s)	Budget 2021/22 ($000s)	Budget 2022/23 ($000s)	Budget 2023/24 ($000s)	Budget 2024/25 ($000s)
Revenue						
Funder	403,525	439,998	482,795	495,993	518,383	540,409
Governance & Administration	9,730	12,515	11,522	11,774	11,777	11,982
Provider	212,076	243,139	259,887	261,072	272,469	283,151
Consolidated Elimination	(199,997)	(223,238)	(246,299)	(247,597)	(258,517)	(268,862)
	425,334	472,415	507,905	521,242	544,112	566,680
Expenses						
Funder	(401,417)	(442,217)	(482,795)	(495,920)	(518,319)	(539,195)
Governance & Administration	(10,378)	(12,338)	(11,522)	(11,764)	(11,777)	(11,982)
Provider	(228,599)	(242,972)	(262,137)	(259,622)	(267,659)	(277,473)
Consolidated Elimination	199,997	223,238	246,299	247,597	258,517	268,862
	(440,397)	(474,290)	(510,155)	(519,709)	(539,238)	(559,788)
Net Result surplus/(deficit)						
Funder	2,108	(2,219)	0	73	64	1,214
Governance & Administration	(647)	177	0	10	0	0
Provider	(16,524)	167	(2,250)	1,450	4,810	5,678
Net Result	(15,063)	(1,875)	(2,250)	1,533	4,874	6,892

Operating Forecast

Overall results for Lakes DHB are reflected in the table below. After including some significant cost containment and productivity gains in this annual plan Lakes DHB has achieved a breakeven position in the Annual Plan over the four years.

The financial projections have been prepared on the basis of assumptions on future events that the Board reasonably expects to occur.

Net results	**2021/22 ($000's)**	**2022/23 ($000's)**	**2023/24 ($000's)**	**2024/25 ($000's)**
Funder arm	0	73	64	1,213
Governance and Administration arm	0	10	0	0
Provider arm	(2,250)	1,449	4,810	5,679
Net Result	**(2,250)**	**1,533**	**4,874**	**6,892**

Total FTE for Lakes DHB in the 2021/22 annual plan

Full Time Equivalents	19/20	20/21	21/22	22/23	23/24	24/25
	Actual	*Forecast*	*Budget*	*Budget*	*Budget*	*Budget*
	FTE	*FTE*	*FTE*	*FTE*	*FTE*	*FTE*
2052 Medical Personnel	202.7	202.9	220.7	222.3	223.7	225.1
2235 Nursing Personnel	595.0	645.1	710.5	715.6	720.1	724.5
2484 Allied Health	209.8	220.0	228.4	230.1	231.5	232.9
2651 Support Personnel	62.7	63.5	66.1	66.6	67.0	67.4
2825 Management/Administration	289.1	320.3	348.2	350.7	352.9	355.0
	1,359.3	**1,451.8**	**1,573.9**	**1,585.2**	**1,595.2**	**1,604.9**
% increase		*6.81%*	*8.41%*	*0.72%*	*0.63%*	*0.61%*

Total FTE variances to 2020/21 forecast are as follows:

Consolidated FTE Plan

	19/20	20/21	2021/22	
	Actual	*Forecast*	*Budget*	*variance*
	FTE	*FTE*	*FTE*	*FTE*
Personnel Costs -Employed				
2052 Medical Personnel	202.7	202.9	220.7	17.8
2235 Nursing Personnel	595.0	645.1	710.5	65.4
2484 Allied Health	209.8	220.0	228.4	8.4
2651 Support Personnel	62.7	63.5	66.1	2.6
2825 Management/Administration	289.1	320.3	348.2	27.9
	1,359.3	**1,451.8**	**1,573.9**	**122.1**
Outsourced Personnel	*Estimated FTE*			
3150 Outsourced - Medical Personnel	15	13	2	(11.3)
3250 Outsourced - Nursing Personnel				0.0
3350 Outsourced - Allied Health				0.0
3420 Outsourced - Support Personnel				0.0
3550 Outsourced - Management/Admin				0.0
	15	13	2	(11.3)
Total Personnel costs -Employed + contract	1,374.13	1,464.87	1,575.61	110.73

FTE variance explanations are as follows:

Budget 2021-22 -FTE

INDICATIVE STAFF MOVEMENT TO FORECAST Q3 - SUMMARY

	Medical Personnel	Nursing Personnel	Allied Health Personnel	Support Personnel	Management/Administration Personnel	Indicative Total Movement FTEs (Rounded)	NOTES AND COMMENTS
20/21 Forecast Q3	**202.90**	**645.10**	**220.03**	**63.52**	**320.27**	**1,451.82**	
FY Impact of 20/21changes	8.4	(22.0)	7.8	-	(0.1)	**(5.9)**	***Med** : 6.75 FTE Community RMO Full year budgeted; also 1.1 FTE Anaesthetics repatriate Eyes lists and existing ACC from private; also 0.23 FTE General Surgeons changes to JOBS // **RNs** (22) FTE Agency **Allied** : Clin Phys & MRTs;// **Admin:** mainly Holidays Act role*
CCDM Calculations	-	6.9	-	-	-	**6.9**	*Based on agreed CCDM calculation result*
CCDM applied Assumptions	-	8.6	-	-	-	**8.6**	*CCDM staff budget assumptions applied across organisaton for other RN categories*
Pandemic Response: CBAC & MIFs & IMMS	-	42.9	0.3	(0.0)	23.3	**66.4**	*Forecast did not include Immunisations rollout and budget assumption increased to 12/12 months*
Matariki Public Holiday Impact	0.1	1.2	0.0	0.1	0.1	**1.5**	*Penal effect of New Public Holiday effective June 2022*
Payfreeze						-	
New roles	5.5	7.3	8.9	-	4.7	**26.3**	***Med:** Increase Radiologist FTE based on Job-Size RU's; Anaesthetics change On-call & Right-sizing (risk mgmnt)// **RNs:** RNs v HCAs extra shift Renal; HCA's Extra beds in OPRS; NASC Dementia Co-Ord; OP HCAs for EEGs; Taupo CT // **Allied:** Dietician, Physio MSK,*
Other	(0.3)	5.5	5.0	2.6	2.2	**15.1**	*Mainly movements related to leave variances & non-productive & sickleave movements; also inter-service transfers*
Current vacancies net of action plan	4.2	15.0	(13.6)	(0.1)	(2.3)	**3.2**	*Budget assumes full recruitment net of action plan*
INDICATIVE MOVEMENT FTEs - 21/22 Draft Annual Plan	**220.7**	**710.5**	**228.4**	**66.1**	**348.2**	**1,573.91**	
Total Movement	**17.82**	**65.35**	**8.41**	**2.61**	**27.89**	**122.09**	

Efficiency/Productivity Gains

This annual plan includes projected operational savings and Performance Improvement Actions (PIAs) in numerous areas which are tabulated below:

Lakes DHB -Efficiency Action plan 2021-22

	Last year Budget	Budget			
Revenue Generation	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
Staff vacancy factor - Nursing Staff:	332,379	0	0	0	0
Staff vacancy factor - Allied Staff & Support Staff	693,757	1,475,098	1,519,351	1,564,932	1,611,880
Staff vacancy factor - Management & Admin Staff	583,530	1,271,282	1,296,708	1,322,642	1,349,095
Improve staff leave capture through introduction of electronic leave	30,000	20,000	50,000	50,000	50,000
Local procurement savings	250,000	250,000	250,000	250,000	250,000
National Procurement savings	261,000	261,000	261,000	261,000	261,000
Review ineligible patient fees and collection process	0	0	80,000	80,000	80,000
IS assume timing delays in Project (reduced IaaS costs)	250,000	200,000	0	0	0
Nursing hours savings - Bed days reduction plan	600,000	0	0	0	0
Moving 'specialling' to Enhanced Patient Supervision & Engagement	150,000	0	0	0	0
SMO Locums reduction - premium impact	680,000	420,000	420,000	580,000	580,000
Reduction in corporate overheads as a percentage of revenue	250,000	0	0	0	0
Review of transcription services	60,000	0	0	0	0
Reduction in Annual Leave accruals across the organisation	158,000	142,000	142,000	142,000	142,000
Enhanced management of revenue from ACC	200,000	0	0	100,000	100,000
Bed day reduction - Addressing cardiology bed blockage at Waikato	0	50,000	50,000	100,000	100,000
Bed day reduction - Reduction in Long Stay patients	0	50,000	50,000	50,000	50,000
Productivity in Outpatient Clinics	100,000	100,000	0	0	0
Review use of MAPU and CDU	10,000	0	0	0	0
Managing Nursing Graduate recruitment	60,000	80,000	80,000	80,000	80,000
Travel reduction	43,000	250,000	250,000	250,000	250,000
e-space delays	300,000	0	0	0	0
CME expenses	50,000	50,000	0	0	0
Reduce costs in Children's unit	130,000	0	0	0	0
Increase in domestic tourism, increased IDF Inflows	300,000	100,000	0	0	0
Timing of capex projects (IS HW/ IS SW/ Clinical Equip)	200,000	900,000	0	0	0
Respond to more data queries 'in-house' to contractor	10,000	0	0	0	0
Pay Freeze	0	1,996,200	2,056,086	0	0
Total	**5,701,666**	**7,615,580**	**6,505,145**	**4,830,574**	**4,903,975**

Capital Expenditure Forecast

The base line capital expenditure budget for the 2021/22 year was set following intensive scrutiny to ensure only essential purchases are planned. The budget for the annual plan period has been set using information gathered as part of the asset management process and Long term investment plan. This capital expenditure budget has been significantly impacted by the planned Metal Health inpatient facility replacement, a planned refurbishment of the perinatal, SCBU, Paediatric and Birthing units and Information System application changes.

Property Disposal

It is Lakes DHB's intention to divest of a portion of the Taupō excess land is on hold. No other disposals are being planned.

Procedure for Buying Shares

Lakes DHB will seek the Minister of Health's consent to its investment in any shares or interest in a body corporate or in a partnership, joint venture or other association of persons in accordance with S28 of the New Zealand Public Health and Disability Act.

Financial Strategies:

Plans for managing funding deficits

The DHB faces challenges achieving breakeven experiencing significant cost pressures to date. The Annual Plan contains cost containment strategies. In addition, a number of large action plans have been included in this annual plan which carry a level of risk around their achievement.

Risk Management Strategies

The DHB has well developed budgetary control systems to manage operating and capital expenditure. The major financial risks faced by the DHB are those relating to the staff cost increases and technology cost increases in the Provider arm. The DHB is working closely with the MoH to manage this risk. Other categories of risk are associated with National initiatives which may not achieve the indicated results. Lakes DHB will work closely with those national bodies to manage this risk.

Balance Sheet Forecast

Changes appearing in the Consolidated Statement of Financial Position (Balance Sheet) over the annual plan period are as follows:

- Short term fluctuations in cash will continue to be managed through the sweep arrangement with NZHPL where cash balances from all DHBs are swept daily into a central bank account and short term deposits are managed on the central pool. Overdraft facilities through the sweep pool are available to DHBs providing sufficient cash exists in the pool to support individual DHB overdrafts.
- The net book value of fixed assets will go up over the annual plan period as a result of planned capital expenditure, particularly the Mental Health inpatient facility replacement as well as assumed land and building revaluations.
- Equity injections totalling $25 mil in the years 2021/22, 2022/23 and 2023/24 are planned to fund the new mental health inpatient facility build. It is assumed this equity injections will trigger funding to offset the capital charge impact.
- Other capital equity injections have been assumed to fund the Children's and Maternity units at $6 mil, dental caravans at $0.8 mil and Endoscopy suite and theatres at $5.0 mil. These equity injections have also been assumed to trigger funding to offset the capital charge impacts.
- Equity injections of $15 mil in the form of deficit support have been assumed in 2021/22 and $12 mil in 2022-23 to cover the cash payout of the Holidays Act 2003 remediation.

Land and Building revaluations

A full revaluation of land and buildings took place on 30 June 2019 again in June 2021. The impact of the 2021 revaluation on capital charge is estimated to be $750k, which is also fiscally neutral and the impact on depreciation is assumed to be $610k per annum which is reflected in the plan starting in the 2021/22 financial year.

Risks

Funder Arm Risks

The Funder arm has a number of areas of significant risk which include:

- Acute demand remains a risk with very high presentations to GPs, After Hours and Emergency Departments. There are challenges with managing the cost of presentations in all parts of the system while also considering investment to both reduce and shift that demand to more appropriate places.
- The Funder has allocated all funding to services (all of which is in contract) and retains no risk pools to cover any unforeseen situations or spikes in demand (e.g. additional resources responding to pandemics).
- The pharmaceutical budget has been set to be in line with the Pharmac forecast.
- IDF outflows have been budgeted at agreed levels however there is risk that outflows could exceed plan.
- There is a risk that flow on cost pressures on the NGO sector from DHB MECA settlements may have yet been fully reflected in this annual plan.
- Pay Equity is an increasing challenge to understand and ensure processes are in place to allow us to manage the workforce fluctuations and flow on effects of the legislative requirements.

Governance & Administration Arm Risks

Governance and Administration have a number of risks:

- The budget assumes NZHPL costs remain in line with annual plan.
- Regional services provided out of HealthShare Ltd remains in line with annual plan.
- National services provided out of Central TAS remains at 2020/21 levels.

Provider Arm Risks

The proposed budget has a number of significant risk issues and these are as follows:

- As in previous years this annual plan assumes that permanent recruitment will occur for SMOs and RMOs rather than using locums. A premium is allowed for to cover the additional costs of a limited number of locums to cover known gaps.
- Acute demand growth has continued to increase in line with recent years. Budgeted volumes do not fully reflect increases experienced in recent years.
- Staff salary and wage increases remain in line with HR assumptions.
- Future MECA settlements are a risk to the annual plan.
- Significant action plan savings have been included in the annual plan and carry a risk of not being achieved.
- The tight financial situation of our main tertiary provider (Waikato) is resulting in changes to access and responsiveness for Lakes patients and is likely to lead to additional cost pressure through either growth of service in the provider arm or outsourcing further afield and the associated costs that brings.

CONSOLIDATED STATEMENT OF REVENUE AND EXPENSES

	Actuals 2019/20 ($000s)	Forecast 2020/21 ($000s)	Budget 2021/22 ($000s)	Budget 2022/23 ($000s)	Budget 2023/24 ($000s)	Budget 2024/25 ($000s)
REVENUE						
Government and Crown Asency sourced						
MOH						
PBF Vote Health - Mental Health Ring fe	34,931	36,995	38,215	40,303	42,197	44,066
PBF Vote Health - Funding Package	309,499	343,184	373,586	393,989	412,502	430,755
MoH - Funding Subcontracts	-	-	44,045	33,212	33,876	34,554
MoH – Personal Health	36,483	35,584	134	136	139	142
MoH – Mental Health	-	-	-	-	-	-
MoH – Public Health	-	-	-	-	-	-
MoH – Disability Support Services	1,768	1,768	1,768	1,801	1,835	1,874
MoH – Maori Health	-	-	-	-	-	-
Clinical Training Agency	2,082	2,096	2,085	2,124	2,164	2,210
IDF Revenue	22,789	24,366	26,949	28,490	29,809	31,035
Other DHBs	289	323	348	354	361	369
Training Fees and subsidies	71	97	105	107	109	111
Accident Insurance	4,852	5,464	5,378	5,479	5,583	5,701
Other Government						
Other Government	7,410	7,514	7,660	7,804	7,952	8,119
Government and Crown Agency sourced tota	**420,174**	**457,390**	**500,272**	**513,799**	**536,527**	**558,936**
Other Revenue						
Patient / Consumer sourced	2,135	2,625	2,800	2,852	2,907	2,967
Other Income	2,791	12,214	4,628	4,407	4,491	4,586
Interest income	236	186	205	185	188	192
Sale of Assets	-	-	-	-	-	-
Other Revenue total	**5,161**	**15,025**	**7,633**	**7,444**	**7,586**	**7,745**
REVENUE TOTAL	**425,335**	**472,415**	**507,905**	**521,243**	**544,113**	**566,681**
EXPENSES						
Personnel costs	(145,765)	(152,977)	(169,792)	(164,962)	(169,998)	(176,694)
Outsourced Services	(19,756)	(23,021)	(16,818)	(16,956)	(17,313)	(17,707)
Clinical Supplies	(34,268)	(38,499)	(40,411)	(41,365)	(41,947)	(42,979)
Infrastructure & Non-Clinical Supplies	(39,189)	(40,347)	(46,638)	(48,104)	(50,179)	(52,076)
Payments to Providers	-	-	-	-	-	-
Personal Health	(130,468)	(143,524)	(156,392)	(163,527)	(169,254)	(174,997)
Total Mental Health	(20,127)	(21,696)	(24,723)	(26,848)	(29,712)	(31,573)
Total Maori Health	(46,223)	(48,753)	(53,359)	(56,353)	(58,613)	(60,900)
Total Public Health	(3,598)	(4,484)	(712)	(413)	(482)	(549)
Total DSS	(1,005)	(988)	(1,309)	(1,182)	(1,741)	(2,314)
Total IDF	-	-	-	-	-	-
EXPENSES TOTAL	**(440,397)**	**(474,290)**	**(510,155)**	**(519,710)**	**(539,239)**	**(559,789)**
NET RESULTS	**(15,063)**	**(1,875)**	**(2,250)**	**1,533**	**4,874**	**6,892**

CONSOLIDATED STATEMENT OF FINANCIAL POSITION

	Actuals 2019/20 ($000s)	Forecast 2020/21 ($000s)	Budget 2021/22 ($000s)	Budget 2022/23 ($000s)	Budget 2023/24 ($000s)	Budget 2024/25 ($000s)
Current Assets						
Cash and cash equivalents	7,877	(12,087)	(15,247)	(7,910)	290	12,189
Term Investments	500	500	500	500	500	500
Debtors and other receivables	13,768	16,929	16,929	16,929	16,929	16,929
Inventories	2,673	2,444	2,444	2,444	2,444	2,444
Non - current assets held for sale	-	-	-	-	-	-
Total current assets	**24,818**	**7,786**	**4,626**	**11,963**	**20,163**	**32,062**
Non Current Assets						
Property, plant and equipment	176,898	249,105	259,636	268,462	271,865	265,569
Intangible assets	4,859	8,118	12,994	14,406	15,307	15,927
Investment property	0	0	0	0	0	0
Investment in subsidiaries	-	-	-	-	-	-
Investment in associates	429	429	429	429	429	429
Donation - RECT	-	-	-	-	-	-
Prepayments - Non Current	346	2,190	2,190	2,190	2,190	2,190
Total non current assets	**182,531**	**259,842**	**275,249**	**285,486**	**289,790**	**284,115**
Current Liabilities						
Creditors and other payables	(24,639)	(27,134)	(27,555)	(27,444)	(27,561)	(27,623)
Employee Entitlements	(32,688)	(30,817)	(30,937)	(20,414)	(21,194)	(20,617)
Borrowings	(631)	(528)	(341)	(250)	(153)	(162)
Provisions						
Other Financial Instruments	-	-	-	-	-	-
Total current liabilities	**(57,958)**	**(58,480)**	**(58,833)**	**(48,109)**	**(48,909)**	**(48,403)**
WORKING CAPITAL	**(33,141)**	**(50,694)**	**(54,207)**	**(36,145)**	**(28,745)**	**(16,340)**
NET FUNDS EMPLOYED	**149,390**	**209,148**	**221,042**	**249,341**	**261,045**	**267,775**
Non - Current Liabilities						
Employee Entitlements	(3,557)	(3,557)	(3,557)	(3,557)	(3,557)	(3,557)
Borrowings	(1,524)	(996)	(651)	(400)	(247)	(85)
Other Financial Instruments	-	-	-	-	-	-
Total non - current liabilities	**(5,081)**	**(4,553)**	**(4,208)**	**(3,957)**	**(3,804)**	**(3,642)**
Equity						
Crown Equity	(71,992)	(71,723)	(86,230)	(113,230)	(120,230)	(120,230)
Revaluation Reserve	(102,110)	(164,527)	(164,527)	(164,527)	(164,527)	(164,527)
Cashflow hedge reserve	-	-	-	-	-	-
Retained (Earnings)/Losses	30,620	32,495	34,745	33,212	28,338	21,446
Trust funds	(828)	(840)	(823)	(840)	(823)	(823)
Total equity	**(144,309)**	**(204,594)**	**(216,834)**	**(245,384)**	**(257,241)**	**(264,133)**
NET FUNDS EMPLOYED	**(149,390)**	**(209,147)**	**(221,043)**	**(249,341)**	**(261,046)**	**(267,775)**

CONSOLIDATED STATEMENT OF CHANGES IN EQUITY

	Actuals 2019/20 ($000s)	Forecast 2020/21 ($000s)	Budget 2021/22 ($000s)	Budget 2022/23 ($000s)	Budget 2023/24 ($000s)	Budget 2024/25 ($000s)
Total equity at besinning of the period	(159,668)	(144,309)	(204,594)	(216,834)	(245,384)	(257,241)
Net Results for the period - DHB Governa	647	(177)	(0)	(10)	0	0
Net Results for the period - DHB Provide	16,523	(167)	2,250	(1,450)	(4,810)	(5,678)
Net Results for the period - DHB Funds	(2,109)	2,219	(0)	(73)	(64)	(1,214)
Revaluation of Fixed Assets	-	(62,417)	-	-	-	-
Equity Injections	-	(32)	(14,808)	(15,000)	(7,000)	-
Equity Injections - Deficit Support	-	-	-	(12,000)	-	-
Equity Repayments	301	301	301	-	-	-
Other -asset revaluation reserve on asse	-	-	-	-	-	-
Cash flow hedges	-	-	-	-	-	-
Movement in Trust and Special Funds	(8)	(12)	17	(17)	17	-
Trust funds transferred to Provider Divisi	-	-	-	-	-	-
Total Equity at end of the period	(144,313)	(204,594)	(216,834)	(245,384)	(257,241)	(264,133)

CONSOLIDATED STATEMENT OF CASH FLOWS

	Actuals 2019/20 ($000s)	Forecast 2020/21 ($000s)	Budget 2021/22 ($000s)	Budget 2022/23 ($000s)	Budget 2023/24 ($000s)	Budget 2024/25 ($000s)
CASH FLOWS FROM OPERATING ACTIVITIES						
Cash was provided from:						
Receipts from MOH and patients	428,722	470,389	507,700	521,057	543,924	566,488
Cash was applied to:						
Payments to suppliers	67,983	95,724	79,631	79,351	80,668	82,676
Payments to employees	140,572	154,848	169,672	175,484	169,217	177,270
Payments to Providers	201,420	219,446	236,495	248,322	259,801	270,332
Payments to other DHBs	0	0	0	0	0	0
Distribution to owners: capital charge	8,825	7,401	7,207	7,212	7,412	7,612
GST (net)	(138)	229	(389)	79	(85)	(94)
	418,662	477,648	492,616	510,448	517,013	537,796
Net cash flows from operating activities	10,060	(7,259)	15,084	10,609	26,911	28,692
CASH FLOWS FROM INVESTING ACTIVITIES						
Cash was provided from:						
Interest received	236	186	205	185	188	192
Proceeds from sale of fixed assets	0	0	0	0	0	0
	236	186	205	185	188	192
Cash was applied to:						
Purchase of property, plant and equipment	5,748	8,007	26,152	26,300	21,800	13,000
Purchase of intangible assets	1,412	2,207	5,356	3,000	3,000	3,000
Increase/decrease in investments	(269)	1,832	17	(17)	17	0
	6,891	12,046	31,524	29,283	24,817	16,000
Net cash flows from investing activities	(6,655)	(11,860)	(31,319)	(29,098)	(24,629)	(15,808)
CASH FLOWS FROM FINANCING ACTIVITIES						
Cash was provided from:						
Proceeds from finance leases	0	0	0	0	0	0
Proceeds from MOH loans	0	0	0	0	0	0
Proceeds from shareholder capital injection	0	32	14,808	27,000	7,000	0
	0	32	14,808	27,000	7,000	0
Cash was applied to:						
Repayments of shareholder capital	(301)	(301)	(301)	0	0	0
Repayments of MOH borrowings	0	0	0	0	0	0
Repayments of finance lease liabilities	(731)	(631)	(532)	(342)	(250)	(153)
Interest paid	(384)	0	(486)	(420)	(420)	(420)
Repayments - other	(118)	0	0	0	0	0
	(1,534)	(932)	(1,319)	(762)	(670)	(573)
Net cash flows from financing activities	(1,534)	(900)	13,489	26,238	6,330	(573)
Net increase/(decrease) in cash, and cash ec	1,871	(20,019)	(2,747)	7,749	8,612	12,311
Cash and cash equivalents at beginning of year	6,006	7,932	(12,500)	(15,659)	(8,322)	(122)
Cash and cash equivalents at end of year	7,877	(12,087)	(15,247)	(7,910)	290	12,189

CAPITAL EXPENDITURE

	Actuals 2019/20 ($000s)	Forecast 2020/21 ($000s)	Budget 2021/22 ($000s)	Budget 2022/23 ($000s)	Budget 2023/24 ($000s)	Budget 2024/25 ($000s)
Capital expenditure by equipment type						
Prior Year carry-over	0	0	7,258	0	0	0
Land	0	0	0	0	0	0
Buildings & Plant (inc Lifts etc)	596	1,099	15,089	18,500	14,000	5,200
Clinical Equipment	1,884	3,825	3,935	3,500	3,500	3,500
Other Equipment	187	237	263	300	300	300
Information Technology - Hardware	2,989	2,620	1,690	3,400	3,400	3,400
Information Technology - Software	1,412	2,207	3,055	3,000	3,000	3,000
Motor Vehicles	93	226	217	600	600	600
	7,160	10,214	31,507	29,300	24,800	16,000
Capital expenditure by major project						
Baseline capital expenditure	**7,160**	**8,077**	**14,257**	**12,595**	**13,057**	**16,000**
Major strategic capital projects						
MH Building		568	4,541	14,205	11,743	
WCF Unit upgrade			6,000			
Endoscopy Theatre			2,500	2,500		
Midland Clincal Platform		1,356	321			
Midland Med management			1,500			
Dental Caravan -twin chair x 3			800			
NZHP system catalogue -national project		213	888			
Taupo CT			700			
Total Strategic	**0**	**2,137**	**17,250**	**16,705**	**11,743**	**0**
	7,160	10,214	31,507	29,300	24,800	16,000

EQUITY INJECTIONS

	Actuals 2019/20 ($000s)	Forecast 2020/21 ($000s)	Budget 2021/22 ($000s)	Budget 2022/23 ($000s)	Budget 2023/24 ($000s)	Budget 2024/25 ($000s)
Equity Injections -capital:	0	0	0	0	0	0
Equity injection -Mental Health Build		0	8,000	10,000	7,000	0
Equity injection -Mobile Dental		0	800	0	0	0
Equity injection -WCF upgrade		0	6,000	0	0	0
Equity injection -Endoscpy suite & Theatre expansion		0	0	5,000	0	0
Equity injection -Maori dashboard		32	8	0	0	0
Equity Injections -repayments	(301)	(301)	(301)	0	0	0
Equity Injections -Holidays Act remediation	0	0	0	12,000	0	0
Total Equity injections	(301)	(269)	14,507	27,000	7,000	0

FUNDER ARM STATEMENT OF PROSPECTIVE FINANCIAL PERFORMANCE

The Consolidated budget for the Fund Division is as follows:

Statement of comprehensive Revenue and Expenditure

Funder Division	Full Year	Full Year		Full Year			
	19/20	20/21	20/21	21/22	22/23	23/24	24/25
Description	*Actual*	*Budget*	*Actual*	*Budget*	*Budget*	*Budget*	*Budget*
	$000	$000	$000	$000	$000	$000	$000
REVENUE							
MOH - Vote Health	34,930	37,400	36,996	38,215	40,302	42,196	44,065
MOH - Vote Health	309,499	343,600	343,184	373,586	393,989	412,502	430,755
MoH Funding - Sub Contracts	36,307	27,939	35,454	44,045	33,212	33,875	34,554
MOH Devolved Funding	**380,736**	**408,939**	**415,633**	**455,846**	**467,503**	**488,573**	**509,374**
IDF'S - Mental Health	781	635	1,167	439	464	486	506
IDF'S - Personal Health	22,008	22,842	23,199	26,510	28,026	29,324	30,529
Inter DHB Revenue	**22,789**	**23,477**	**24,366**	**26,949**	**28,490**	**29,809**	**31,035**
REVENUE TOTAL	**403,525**	**432,416**	**439,999**	**482,795**	**495,993**	**518,383**	**540,409**
EXPENDITURE							
Personnel Health	(301,151)	(327,317)	(329,090)	(354,211)	(374,347)	(390,993)	(406,881)
Mental Health	(37,215)	(40,005)	(40,481)	(43,685)	(45,700)	(48,564)	(50,425)
Disability Support Services	(50,459)	(53,198)	(53,165)	(58,358)	(60,661)	(62,921)	(65,208)
Public Health	(5,038)	(1,869)	(5,759)	(13,515)	(1,877)	(1,946)	(2,013)
Maori Health	(1,564)	(1,466)	(1,460)	(1,685)	(1,746)	(2,305)	(2,878)
DHB Governance and Administration	(5,991)	(11,441)	(12,260)	(11,340)	(11,589)	(11,589)	(11,790)
EXPENDITURE TOTAL	**(401,417)**	**(435,297)**	**(442,217)**	**(482,795)**	**(495,920)**	**(518,319)**	**(539,195)**
NET RESULT	**2,108**	**(2,880)**	**(2,218)**	**0**	**73**	**64**	**1,213**

GOVERNANCE AND ADMINISTRATION ARM STATEMENT OF PROSPECTIVE FINANCIAL PERFORMANCE

The Consolidated budget for the Governance and Administration Division is as follows:

Statement of comprehensive Revenue and Expenditure

G&A Division	Full Year	Full Year		Full Year			
	19/20	20/21	20/21	21/22	22/23	23/24	24/25
Description	*Actual*	*Budget*	*Actual*	*Budget*	*Budget*	*Budget*	*Budget*
	$000	$000	$000	$000	$000	$000	$000
REVENUE							
Patient and Other	356	186	228	181	186	188	192
Internal Revenue	9,375	11,508	12,288	11,340	11,589	11,589	11,790
REVENUE TOTAL	**9,730**	**11,694**	**12,515**	**11,522**	**11,774**	**11,777**	**11,982**
EXPENDITURE							
Personnel Costs	(3,477)	(3,820)	(3,424)	(4,076)	(4,160)	(4,265)	(4,362)
Outsourced Services	(2,908)	(3,118)	(4,141)	(3,288)	(3,350)	(3,413)	(3,485)
Infrastructure & Non Clinical Supplies							
Hotel Services, Laundry & Cleaning	(18)	(21)	(28)	(24)	(24)	(25)	(25)
Facilities	(73)	(93)	(92)	(104)	(106)	(108)	(110)
Transport	(97)	(106)	(81)	(58)	(60)	(61)	(62)
IT Systems & Telecommunications	(74)	(83)	(44)	(87)	(89)	(90)	(92)
Interest & Financing Charges	(2,715)	(2,600)	(2,236)	(2,357)	(2,223)	(2,233)	(2,233)
Professional Fees & Expenses	(1,302)	(1,021)	(1,490)	(737)	(751)	(765)	(781)
Other Operating Expenses	(206)	(289)	(279)	(190)	(190)	(190)	(190)
Democracy	(606)	(544)	(521)	(600)	(811)	(626)	(640)
Total Infrastructure & Non Clinical Supplies	**(5,090)**	**(4,757)**	**(4,772)**	**(4,157)**	**(4,253)**	**(4,098)**	**(4,134)**
Internal Allocations	**1,154**	**(1)**	**(1)**	**(1)**	**(1)**	**(1)**	**(1)**
EXPENDITURE TOTAL	**(10,321)**	**(11,696)**	**(12,338)**	**(11,522)**	**(11,764)**	**(11,777)**	**(11,982)**
NET RESULT	**(590)**	**(2)**	**177**	**(0)**	**10**	**0**	**0**

PROVIDER ARM STATEMENT OF PROSPECTIVE FINANCIAL PERFORMANCE

The Consolidated budget for the Provider division is as follows:

Statement of Comprehensive Revenue and Expenditure

Provider Division -Hospital and secondary support services

$000	Full Year	Full Year		Full year Budget			
	19/20	20/21	20/21	20/21	21/22	22/23	23/24
Description	*Actual*	*Budget*	*Forecast*	*Budget*	*Budget*	*Budget*	*Budget*
REVENUE							
MOH Non Devolved Contracts	**4,026**	**4,033**	**3,995**	**3,986**	**4,061**	**4,139**	**4,225**
Other Government	**12,333**	**11,651**	**13,075**	**13,143**	**13,390**	**13,644**	**13,931**
Patient and Other	**6,519**	**6,548**	**14,775**	**7,452**	**7,261**	**7,399**	**7,556**
InterDHB and Internal	**189,198**	**208,964**	**211,294**	**235,306**	**236,360**	**247,288**	**257,439**
REVENUE TOTAL	**212,076**	**231,196**	**243,139**	**259,887**	**261,072**	**272,470**	**283,151**
EXPENDITURE							
Personnel Costs							
Medical Personnel	(44,852)	(48,491)	(46,288)	(50,517)	(51,894)	(53,258)	(55,711)
Nursing Personnel	(58,138)	(55,474)	(60,011)	(66,969)	(62,622)	(64,820)	(67,426)
Allied Health	(14,199)	(15,244)	(15,273)	(16,454)	(16,953)	(17,548)	(18,254)
Other Allied Health	(3,116)	(3,710)	(3,476)	(3,929)	(4,115)	(4,305)	(4,504)
Support Personnel	(3,847)	(3,849)	(4,033)	(4,479)	(4,602)	(4,724)	(4,891)
Management/Administration	(18,137)	(18,564)	(20,472)	(23,367)	(20,617)	(21,077)	(21,542)
	(142,288)	**(145,332)**	**(149,552)**	**(165,716)**	**(160,803)**	**(165,732)**	**(172,329)**
Outsourced Services							
Outsourced - Medical Personnel	(4,955)	(1,100)	(4,489)	(653)	(665)	(678)	(692)
Outsourced - Nursing Personnel	(35)	0	2	(2)	(2)	(2)	(3)
Oursourced - Allied Health	(401)	(117)	(484)	(120)	(123)	(125)	(128)
Outsourced - Support Personnel	0	0	0	0	0	0	0
Outsourced - Management/Admin	(204)	(127)	(411)	(428)	(365)	(372)	(379)
Total Outsourced Personnel	**(5,594)**	**(1,343)**	**(5,383)**	**(1,204)**	**(1,155)**	**(1,177)**	**(1,202)**
Outsourced Services	(11,254)	(10,681)	(14,012)	(12,327)	(12,451)	(12,723)	(13,020)
Total Outsourced Services	**(16,849)**	**(12,024)**	**(19,395)**	**(13,531)**	**(13,606)**	**(13,900)**	**(14,222)**
Clinical supplies							
Treatment Disposables	(13,528)	(14,038)	(15,135)	(15,689)	(16,012)	(16,334)	(16,777)
Diagnostic Supplies & Other Clinical	(259)	(304)	(252)	(271)	(276)	(282)	(287)
Instruments & Equipment	(4,756)	(5,289)	(5,142)	(5,666)	(5,914)	(5,689)	(5,746)
Patient Appliances	(710)	(764)	(764)	(789)	(804)	(819)	(836)
Implants and Prostheses	(3,441)	(4,213)	(4,402)	(4,470)	(4,586)	(4,702)	(4,829)
Pharmaceuticals	(9,250)	(9,088)	(9,622)	(9,843)	(10,024)	(10,277)	(10,556)
Other Clinical & Client Costs	(2,266)	(2,724)	(3,133)	(3,683)	(3,749)	(3,844)	(3,948)
Total Clinical supplies	**(34,210)**	**(36,420)**	**(38,451)**	**(40,410)**	**(41,364)**	**(41,946)**	**(42,979)**
Infrastructure & Non Clinical Supplies							
Hotel Services, Laundry & Cleaning	(4,892)	(5,006)	(5,122)	(5,555)	(5,506)	(5,611)	(5,728)
Facilities	(9,733)	(10,826)	(10,356)	(13,955)	(13,638)	(14,058)	(14,574)
Transport	(873)	(1,048)	(1,336)	(1,962)	(1,535)	(1,655)	(1,718)
IT Systems & Telecommunications	(7,195)	(9,154)	(9,347)	(10,735)	(13,067)	(14,374)	(15,239)
Interest & Financing Charges	(6,718)	(6,097)	(4,704)	(5,336)	(5,409)	(5,599)	(5,799)
Professional Fees & Expenses	(2,034)	(1,921)	(1,751)	(2,007)	(1,734)	(1,767)	(1,804)
Other Operating Expenses	(2,640)	(2,367)	(2,959)	(2,930)	(2,962)	(3,018)	(3,082)
Democracy	(0)	0	0	0	0	0	0
Subsidiaries, Joint Ventures & Minority Interests	(14)	0	0	0	0	0	0
	(34,099)	**(36,419)**	**(35,575)**	**(42,480)**	**(43,851)**	**(46,082)**	**(47,945)**
Internal Allocations	**(1,154)**	**1**	**1**	**1**	**1**	**1**	**1**
EXPENDITURE TOTAL	**(228,599)**	**(230,195)**	**(242,972)**	**(262,137)**	**(259,623)**	**(267,660)**	**(277,473)**
NET RESULT	**(16,524)**	**1,001**	**167**	**(2,250)**	**1,449**	**4,810**	**5,679**

STATEMENT OF ACCOUNTING POLICIES

Reporting Entity

The Lakes District Health Board (Lakes DHB or the DHB) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled in New Zealand. The DHB's ultimate parent is the New Zealand Crown.

The consolidated financial statements of the Lakes DHB Group comprise of Lakes DHB and its subsidiaries (together referred to as 'The Group') and Lakes DHB Group's interest in associates and jointly controlled entities.

The group consists of Lakes DHB, its subsidiary, Spectrum Health Limited (100% owned), in substance subsidiary, The Lakes District Health Board Charitable Trust, and jointly controlled entities HealthShare Limited (20% owned), and NZ Health Partnerships Limited (2.15% owned).

The DHB's primary objective is to deliver health, disability and mental health services to the community within its district. Accordingly, the DHB has designated itself and the group as a public benefit entity (PBE) for accounting purposes applying the International Public Sector Accounting Standards (IPSAS).

Statement of compliance

These financial statement are prepared in accordance with the Public Health and Disability Act 2000 and the Crown Entities Act 2004, which include the requirement to comply with New Zealand generally accepted accounting practice (NZ GAAP).

These financial statements, including comparatives, have been prepared in accordance with Public Sector PBE Accounting Standards (PBE Standards) -Tier 1. The standards are based on International Public Sector Accounting Standards (IPSAS).

For the purposes of these financial statements, the Lakes District Health Board reporting entity has been designated as a public benefit entity. PBEs are reporting entities whose primary objective is to provide goods and services for community or social benefit and where any equity has been provided with a view to supporting the primary objective rather than for as financial return to equity holders.

Basis of Preparation

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the year. The financial statements have also been prepared on the basis of historic cost modified by the revaluation of certain assets and liabilities, and prepared on an accrual basis, unless otherwise specified (for example in the statement of cash flows).

The financial statements are presented in New Zealand dollars rounded to the nearest thousand, ($000) unless separately identified.

Judgements and estimations

The preparation of these financial statements requires judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, revenue and expenses. For example, the present value of cash flows that are predicted to occur a long time into the future, as with the settlement of some staff provision, depends on judgements regarding future cash flows, including inflation assumptions and the risk free discount rate used to calculate present values.

The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an on-going basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised, if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Where judgements or estimations could significantly affect the amounts recognised in the financial statements the details of this are highlighted in red in the notes they relate to.

Standard early adoption

In line with the Financial Statements of the Government, the DHB has elected to early adopt PBE IFRS 9 Financial Instruments. PBE IFRS 9 replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. Information about the adoption is provided in Note 32.

Standards issued and not yet effective and not early adopted

Standards and amendments, issued but not yet effective that have not been early adopted, and which are relevant to the DHB are:

Impairment of Revalued Assets

In April 2017, the XRB issued Impairment of Revalued Assets, which now clearly scopes in revalued property, plant, and equipment into the impairment accounting standards. Previously, only property, plant, and equipment measured at cost were scoped into the impairment accounting standards. Under the amendment, a revalued asset can be impaired without having to revalue the entire class of-asset to which the asset belongs. This amendment is effective for the 30 June 2020 financial statements, with early adoption permitted. The timing of the DHB adopting this amendment will be guided by the Treasury's decision on when the Financial Statements of Government will adopt the amendment.

Interests in other entities

In January 2017, the XRB issued new standards for interests in other entities (PBE IPSAS 34 - 38). These new standards replace the existing standards for interests in other entities (PBE IPSAS 6 - 8). The new standards are effective for annual periods beginning on or after 1 January 2019, with early application permitted. The DHB plans to apply the new standards in preparing the 30 June 2020 financial statements. The DHB has not yet assessed the effects of these new standards.

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for reporting periods beginning on or after 1 January 2021. The DHB has not yet determined how application of PBE FRS 48 will affect its statement of performance.

Amendment to PBE IPSAS 2 Statement of Cash Flows

An amendment to PBE IPSAS 2 Statement of Cash Flows requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash exchanges. This amendment is effective for annual periods beginning on or after 1 January 2021, with early adoption permitted. The DHB does not intend to early adopt.

Reporting period

The reporting period for these financial statements is the financial year ended 30 June 2021.

Changes in accounting policies

There have been no accounting policy changes in the 2021 financial statements when compared to 2020.

Significant Accounting Policies

Basis of consolidation

Subsidiaries

Lakes DHB is required under the Crown Entities Act 2004 to prepare consolidated financial statements in relation to the group for each financial year. Subsidiaries are entities controlled by Lakes DHB. Control exists when Lakes DHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable or convertible are taken into account. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

Joint ventures
Joint ventures are those entities over whose activities Lakes DHB Group has joint control, established by contractual agreement. The consolidated financial statements include Lakes DHB's interest in joint ventures using the equity method from the date that joint control commences until the date that joint control ceases.

Transactions eliminated on consolidation
Intragroup balances and any unrealised gains and losses or Revenue and expenses arising from intragroup transactions, are eliminated in preparing the consolidated financial statements. Unrealised gains arising from transactions with associates and jointly controlled entities are eliminated to the extent of Lakes DHB Group's interest in the entity. Unrealised losses are eliminated in the same way as unrealised gains, but only to the extent that there is no evidence of impairment.

Foreign currency
Foreign currency transactions
Transactions in foreign currencies are translated at the foreign exchange rate at the date of the transaction.

Monetary assets and liabilities denominated in foreign currencies at the balance date sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the statement of comprehensive revenue and expenses.

Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-Monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at foreign exchange rates ruling at the dates the fair value was determined.

Budget figures
The budget figures are those approved by the board in its Annual Plan, included within the Statement of Intent, tabled in parliament. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the board in preparing these financial statements.

Investments in equity securities
Investments in equity securities held by Lakes DHB Group are classified as available-for-sale, except for investments in equity securities of subsidiaries, associates and joint ventures which are measured at cost.

The fair value of equity investments as available-for-sale is their quoted bid price at the balance sheet date.

Impairment
"When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that has been recognised directly in equity is recognised in the statement of comprehensive revenue and expenses even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the statement of comprehensive revenue and expenses is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in the statement of comprehensive revenue and expenses.

Impairment losses on an individual basis are determined by an evaluation of the exposures on an instrument by instrument basis. All individual trade receivables that are considered significant are subject to this approach. For trade receivables which are not significant on an individual basis, collective impairment is assessed on a portfolio basis based on numbers of days overdue, and taking into account the historical loss experience in portfolios with a similar amount of days overdue.

Calculation of recoverable amount
The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration are not discounted.

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. Value in use is calculated differently depending on whether an asset generates cash or not. For an asset that does not generate largely independent cash inflows, the recoverable amount is determined for the cash-generating unit to which the asset belongs.

For non-cash generating assets that are not part of a cash generating unit value in use is based on depreciated replacement cost (DRC). For cash generating assets value in use is determined by estimating future cash flows from the use and ultimate disposal of the asset and discounting these to their present value using a pre-tax discount rate that reflects current market rates and the risks specific to the asset.

Impairment gains or losses, for items of property, plant and equipment that are revalued on a class of assets basis, are also recognised on a class basis.

Reversals of impairment
Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss on an equity instrument investment classified as available-for-sale or on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through the statement of comprehensive revenue and expenses. An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

Provisions
A provision is recognised when Lakes DHB Group has a present legal or constructive obligation as a result of a past event, and it is probable that an outflow of economic benefits will be required to settle the obligation. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability.

Restructuring
A provision for restructuring is recognised when Lakes DHB Group has approved a detailed and formal restructuring plan, and the restructuring has either commenced or has been announced publicly. Future operating costs are not provided for.

Onerous contracts
A provision for onerous contracts is recognised when the expected benefits to be derived by Lakes DHB Group from a contract are lower than the unavoidable cost of meeting its obligations under the contract.

Income Tax
Lakes DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 1994.

Goods and services tax
All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Statement of cash flows
Cash means cash balances on hand, held in bank accounts, demand deposits and other highly liquid investments in which the health board invests as part of its day-to-day cash management.

Operating activities include cash received from all revenue sources of the health board and records the cash payments made for the supply of goods and services.

Investing activities are those activities relating to the acquisition and disposal of non-current assets. Financing activities comprise the change in equity and debt capital structure of the health board.

Cost of service (Statement of Service Performance)

The cost of service statements, as reported in the statement of service performance (note 28), report the net cost of services for the outputs of Lakes DHB and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.

Cost allocation

Lakes DHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.

Cost allocation policy

Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity/usage information.

Criteria for direct and indirect costs

Direct costs" are those costs directly attributable to an output class.

"Indirect costs" are those costs which cannot be identified in an economically feasible manner with a specific output class.

Cost drivers for allocation of indirect costs

The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area.

Critical accounting estimates and assumptions

In preparing these financial statements, the Board has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

APPENDIX 2: System Level Measures Improvement Plan

Lakes District Health Board and Alliances

Systems Level Measures Plan 2021/22

Background

Systems Level Measures (SLMs) provide a way of looking at how components of the health care system work together to improve health care for all people. This can include care provided in the community, for example by GPs, midwives, and well child providers, through to outpatient and inpatient services.

This planning supports a way for everyone in Lakes District Health Board (Lakes DHB) to work together to make health care better for all, but with a focus on reducing the inequities in health for Māori. There are six SLMs that ensure an equity focus on a wide range of improvement activities.

Ambulatory Sensitive Hospitalisation (ASH) rates 100,000 for 0-4 year olds
Improving preventive and community care for young tamariki so they can avoid the types of illnesses that need treatment in hospital.

Acute hospital bed days per capita
Improving preventive and community care for adults so they can avoid the types of illnesses that need treatment in hospital.

Patient experience of care
This concerns improving people's experience of health care in the community and in hospital.

Amenable Mortality
Focusing on preventing and better treating illnesses that can result in people dying too young.

Babies who live in a smoke-free household at six weeks postnatal
Giving tamariki the best start to life through reducing exposure to tobacco smoke in pregnancy and infancy.

Youth access to and utilisation of youth appropriate health services
Creating services that meet the needs of teenagers and young adults.

Development of this plan

The Lakes DHB SLM plan has continued to evolve over the last two years as we focus on the issues associated with the greatest inequity. Our goals are informed by data and collective opinion on where we can make the largest gains.

We have identified some areas of urgent action (e.g. acute demand, MMR and COVID immunisation) and turn our focus to system level changes that will help us address these. We will work collaboratively to improve the health systems ability to respond to challenges, and overall addressing inequity and health outcomes for our population. The SLMs will be used as a focus for collaboration and allow us to see what the contribution of our individual components are to the overall improvement we are aiming to achieve.

Health equity for Māori is a key driver of this plan and we deliberately focus on improving outcomes for Māori. All measures, unless otherwise stated, will report data for Māori versus non-Māori. We use an equity ratio to indicate how well we are doing for Māori. Where the indicator is positive (e.g. proportion of children who are vaccinated, or babies living in smokefree homes) the ratio is calculated by [rate for Māori] / [rate for non-Māori]. If the measure is negative (e.g. proportion of people of an unhealthy weight) then it would be the [rate for non-Māori] / [rate for Māori]. A ratio of ≥1.0 indicates better outcomes for Māori.

Baseline data, unless otherwise stated, are from 2019.

The following pages provide detail of our approach to each of the SLMs.

Ambulatory Sensitive Hospitalisation (ASH) Rates for 0-4 year olds

Rationale for our approach: The top five causes of ASH for 0-4 year olds in Lakes DHB are asthma, upper and ENT respiratory infections, dental conditions, gastroenteritis, and cellulitis. Childhood immunisations are also a priority for Lakes DHB and are related to a number of causes of ASH.

Improvement milestone	Actions / Activities	Contributory Measures
The equity in total ASH rates, as measured by an equity ratio, will increase by 5% from a baseline of 0.77[78] to 0.81.	Increase the number of Māori babies enrolled in primary care, immunisation, and oral health services.[79] This will be achieved by creating a data extract of all live births to forward to the PHO that the baby's mother is enrolled. Those without a GP would also be included so that we can support the new-born and whānau enrol in a general practice. The PHO will then ensure that the child is registered on the NIR and pass on details to the oral health service. Our goals are to have: • ≥ 90% of all new-borns enrolled with a PHO by 6-weeks with an equity ratio of ≥0.95. • ≥ 90% of all new-borns registered with the NIR by 6-weeks with an equity ratio of ≥0.95.	New-born enrolments at 6-week Children fully immunised at 12M
	To increase the rate of children who have completed their MMR vaccinations by 18 months, by ethnicity. Our goal is to have: • ≥ 83% of children completed their MMR vaccination at 18 months, with an equity ratio of ≥0.95.	Children fully immunised against MMR at the 18 month milestone.
	Increase the rate of pre-school children (1-5 years of age) who have received an application of fluoride varnish in the last 12 months, by ethnicity.[80] We will do this by offering fluoride varnish application in preschools, especially those with a high Māori roll. Our goal is to have: • ≥ 85% of preschool children will have fluoride varnish applied with an equity ratio of ≥ 0.95.	Children who have had fluoride treatment in the last 12 months.
	Take initial steps to explore the implementation of the National Hauora Coalition Clinical Decision Support Best Start Pregnancy Tool Gen2040. This tool enables consistent comprehensive best practice assessment of health and wellbeing needs of a hapū māmā and her pēpi throughout the pregnancy utilising appropriate	

[78] The non-standardised ASH 0-4 (12-months to December 2019) were 7,470 for Māori and 5,761 for non-Māori

[79] These were goals were included in our 2020/21 SLM plan but we found that mechanisms that replied on training and completion of enrolment forms had little impact.

[80] This activity was included in our 2020/21 SLM plan but within an age range of 1-13 years. We demonstrated some success that we think should continue, but want to focus now on preschool children. We have increased the goal from 80% to 85% and have included an equity goal as well. We have been unable to measure ethnicity in our current data extract and this will be a priority for 2021/22.

	enquiry, investigations, management and referral to support services. We will adopt a stepwise approach to implementation of this tool to ensure that if it is implemented in Lakes DHB then this is done with the support and commitment of all key stakeholders. Specifically we will: (a) Have the National Hauora Coalition present the tool the SLM leadership group. If there is support at this level, we will (b) Meet with key stakeholders in Lakes DHB to present the tool and seek feedback. If there is support for local implementation then we will (c) Develop a business case for implementation; and assuming progression through each step (d) Implementation of the tool.	(a) Meeting undertaken in Q1 2021/22 (b) Meet with key stakeholders (c) Business case completed / not completed (d) Tool implemented / partially implemented / not implemented

Acute Hospital Bed Days

Rationale for our approach: Through earlier intervention and prevention we will reduce the impact of acute hospital stays and system pressure resulting from this. The standardised acute bed days (per 1,000 population) for Lakes DHB was 425 for the 12 months to December 2019, with an equity ratio of 0.66[81]. In the 12 months to December 2020, the rate was 384 per 1,000 population, but with a slight worsening of the equity ratio (0.63), indicating that whilst Lakes DHB has had a decline in acute bed days between 2019 and 2020, the fall is greater in among 'Other' ethnic groups. However caution is needed when interpreting these results as the COVID-19 pandemic is likely to have had a significant impact on these rates. We will build on our 2020/21 plan which relied heavily on manualised systems. Although these have provided a good starting point we need to look for more sustainable approaches.

Improvement milestone	Actions / Activities	Contributory Measures
The standardised rate of acute bed days will reduce by 10% (i.e. from 384 to 346 per 1,000 population) and the equity ratio will increase to ≥ 0.69	The 2020/21 plan focussed on identifying frequent ED attendees, but this used retrospective data (i.e. more than 6 ED admissions in 6 months) and did not allow for proactive management. In addition defining frequent ED attenders as those who attend ED > 6 times in 6 months (as used in our 2020/21 SLM) may not be the most meaningful. We will develop a whole of system acute demand dashboard that shows demand on primary, secondary, and after hours care (including frequent ED attendees). This has stemmed from recent data analysis that shows that those who are admitted to hospital are also those patients that are more likely to have been seen multiple times in primary care. Our goal is to develop a mechanism that enables accurate and real-time analysis of the demands on the local health system that can guide changes in practice.	Dashboard implemented/partly implemented / not implemented with context provided in the end of year reflection.
	To implement a campaign and process to increase influenza vaccination in people aged 65 years and older and those with long-term conditions. Our goal is to achieve: • A 10% increase (from a baseline of 52.3% to 57.5%), in the rate of people 65 years of age or older, or others eligible[82] for free seasonal influenza vaccination, receive their influenza vaccination within the last year	Number and rate of people ≥ 65 years of age who have received the influenza vaccination in the last year Number and rate of others eligible for free seasonal influenza vaccination who have received the influenza vaccination in the last year
	Implement an electronic tool to transfer ED presentation and admission data to primary care in close to real time.	Tool to transfer ED presentation and admission data to primary care implemented/partly implemented/not implemented with context provided in the end of year reflection

[81] Rates for Māori and 'Other' were 555 and 365 (per 1,000 population), respectively

[82] https://www.influenza.org.nz/eligibility-criteria

	Our 2020/21 data also show that we have around 1 in 10 Māori ED users without a named GP/practice, which still needs addressing. We will implement a mechanism by which ED presentations can be electronically notified to the PHO who will monitor and multiple admissions and act early. Our goal is to achieve: • ≥ 95% of people domiciled in Lakes DHB who attend ED have a named GP/GP practice	Number (%) of ED users not enrolled with a GP/practice.

Patient experience of care

Rationale for our approach: We propose to implement activities that aim to improve, or maintain, the response to two specific questions in the primary care survey, and the response to an inpatient survey. Additionally, we have added activities that will focus around COVID-19 vaccinations, which will be a priority activity for us in the first six months of 2021/22. Good patient experience in this process will be critical in achieving our goal and will require a joined-up approach within the whole system (including Māori and other community providers).

Improvement milestone	Actions / Activities	Contributory Measures
Improve the responses to the following two questions in the primary care patient experience survey (1) In the last 12 months, was there ever a time when you wanted healthcare from a GP or nurse, but you could not get it? In 2019 13.6 % answered yes to this question. Our goal is to reduce this by 5% to 12.9%	We will • Develop and implement a strategy to boost the primary care workforce. This is a long-term (5-10 year) plan, but is critical if we are to continue to provide timely and good clinical care to our community; • Adopt different models of care, such as telehealth options, nurse practitioners and pharmacist prescribers; • Develop a common measure (e.g. time to the 3rd next available appointment) that can be used as an indicator of GP waiting time across all practices	Number of FTEs, by profession and ethnicity, in our primary care workforce N (%) of all consultations that were conducted via (a) Telephone (b) Video (c) Different primary care workforce
(2) Did the GP or nurse involve you as much as you wanted to be in making decisions about your treatment or care? In 2019 80.4 % answered yes to this question. Our goal is to maintain this at ≥ 80%	We will • Undertake regular review of the comments that are provided in the patient surveys to gain a better understanding of the issues in decisions about patient care and treatment • Feedback provided to primary care teams about key issues identified	Thematic analysis of patient comments provided in the survey. Feedback to primary care completed / not completed
Improve the result for 'Patient was definitely told the possible side effects of the medicine (or prescription for medicine) they left hospital with, in a way they could understand'. In Q4 2019 49.9% of patients answered yes to this question. We aim to increase this by 5% from 49.9% to 52.4%.	We will facilitate a workshop with the hospital pharmacy team to • Understand some of the barriers and facilitators to providing clear and simple information to patients • Identify resources that could be used to assist patients understand medications and their side effects We will facilitate a workshop with Te Aka Matua service to • Gain and understanding of barriers and facilitators for Māori in understanding their medications • Develop resources and/or training materials to support clinicians in discussing medications with Māori	Workshops completed Resources identified and made available on wards

Achieve equity for Māori in COVID-19 and influenza vaccination	We will implement a campaign and process to ensure high uptake of the COVID-19 vaccine. Our goal is to achieve: • At least the same rate of full immunisation within Lakes DHB as the national rate of the eligible population who are fully immunised • ≥ 1.0 equity ratio is achieved We have included this activity in patient experience of care because patient experience will be an important factor, especially among our Māori communities, in vaccine uptake. Many of the specific actions will be delivered as part of the national campaign, but locally we will (1) engage with iwi; (2) involve iwi communications teams in the local campaign; (3) utilise local radio to communicate key messages and dispel myths; (4) work collaboratively to ensure vaccine related information is shared quickly between primary care and other services responsible for COVID and flu vaccination; (5) provide options for Māori to receive their vaccinations (e.g. marae-based clinics. The last action will be a critical piece of work, especially given the time needed between different vaccines. To link with the activity being undertaken in primary care with influenza vaccination we also report on the uptake of COVID vaccination in the over 65 year olds and vulnerable populations. It is likely that most of that group will receive their influenza vaccine prior to COVID and so this provides an opportunity to provide a good experience of care, as well as information on the COVID vaccine. Our goal is to achieve: • ≥ 95% of those aged 65+, or others who are eligible for free influenza vaccination, who received the influenza vaccine also received the COVID vaccine[83] • ≥ 1.0 equity ratio is achieved	Proportion of people, by ethnicity, who have received the full dose of COVID-19 vaccine Proportion of people, by ethnicity, who have received the influenza vaccine Number of marae-based clinics held Number of people attending marae-based clinics

[83] Note that some exploratory work will be required to assess how these data can be collected from the various practice management systems and so a measure may not be available for Q1.

Amenable mortality

Rationale for our approach: Lakes DHB Amenable Mortality Rate is the number of deaths of those aged 0-74 years per 100,000 in this age cohort domiciled in Lakes DHB region who have died from a condition for which there is a known successful intervention.

Amenable mortality rates have decreased over the 8-year period (2009-2016) by 29% and 28% in Māori and non-Māori, respectively. However the 2016 rate for Māori (246.5) remains considerable higher than the rate for non-Māori (76.2), giving an equity ratio of 0.31. Avoidable hospitalisations in 45-64 year olds provide an indication of how we are tracking with amenable mortality. The standardised ASH rates (per 100,000 population) for Lakes DHB was 4,964 for the 12 months to December 2019, with an equity ratio of 0.44. Cardiovascular disease features heavily in causes of ASH. For example ASH rates for myocardial infarction were 900 for Māori and 560 for non-Māori in the 12 months to December 2019 (equity ratio of 0.62). Smoking is a major risk factor for multiple diseases and premature death with rates significantly greater among Māori, compared with non-Māori, and so is a priority area. Unhealthy weight and diabetes are related and both associated with cardiovascular disease.

Improvement milestone	Actions / Activities	Contributory Measures
The standardised ASH rate will reduce by 10%, from 4,964 to 4,468 per 100,000 population by June 2022, with an and the equity ratio equity ratio of ≥ 0.65.	Increase the routine monitoring of weight in patients with diabetes or cardiovascular disease and follow this with brief intervention to encourage healthy diet and physical activity. We will do this via (1) educational sessions for healthcare professionals; (2) development of a local health promotion campaign using Hauora Hemi[84]; and (3) collaboration with Green Prescription. Our goal is to • Increase the proportion of patients with CVD or diabetes who have a BMI recorded in their clinical record in the last year to at least 73.5% from a baseline of 70% (i.e. a 5% increase), and to have an equity ratio of ≥ 1.0.	Number (%) of patients with CVD or diabetes that have a weight recorded in the last year Number (%) of patients with CVD or diabetes that have a BMI ≥ 25 kg/m^2 Number (%)of patients with CVD or diabetes that have a BMI ≥ 30 kg/m^2 Number of referrals to the green prescription programme (note these data are only available every six months).
	We will develop a local approach to advocate for the use of the new SLGT2 inhibitors for the management of diabetes among Māori and Pacific people with Type2 Diabetes Mellitus (T2DM). A SLGT2 inhibitor has recently become available, subject to special authority, and has the potential to support better diabetes management as well as supporting moderate weight loss. Our goal is to achieve: • ≥ 50% of eligible Māori and Pacific patients with T2DM and an HbA1c > 90 mmol/mol are prescribed a SLGT2 inhibitor by the end of June 2022.	Number (%) of eligible patients with T2DM that have received a prescription for SLGT2 inhibitor in the last year. Number (%) of people with T2DM with a HbA1C > 90 mmol/mol

[84] Hauora Hemi is a health promotion superhero that was developed in 2020/21 to promote a range of healthy lifestyles via social media. We will use existing collateral to develop a local campaign for primary care to encourage healthy eating and physical activity for whānau.

	• A 5% reduction in the proportion of people with T2DM with an HbA1c > 90 mmol/mol, with an equity ratio of ≥ 0.90, from a baseline of 18.6%% to 17.7%. We will achieve these goals via (1) educational sessions with GPs and practice nurses; (2) a local promotional campaign that encourages people to attend their Diabetes Annual Review to discuss the use of this medication with their healthcare team; and (3) work with our Local Diabetes Team to ensure clear and consistent messages and ready access to treatment for people with T2DM.	
	Increase the proportion of people who should be taking a combination of a lipid-lowering, blood pressure lowering and anti-platelet medication (triple therapy) following an acute cardiovascular event. Our goal is to achieve: • A 10% increase (from 49.5% to 54.5%) in the proportion of people who have had an acute CV event in the last 10 years who were prescribed and dispensed all three medications. We will achieve this goal via (1) RMO/Nursing training to ensure that patients who have had a CV event are provided with accurate information based on their level of health literacy; (2) implementing a mechanism by which the PHO extended care teams are notified of all patients, enrolled in one of their practices, who have been discharged from hospital with an acute CV so that these patients can be followed up and support to be using their medications; and (3) support our community workforce (e.g. health coaches; health improvement practitioners) to reinforce the message of the importance of continued use of these medications, even though people may be feeling better. We will also introduce a new measure that will establish what proportion of the eligible population are using these medications regularly.	Number (%) of eligible patients who are prescribed triple therapy in the last year Number (%) of eligible patients[85] who are dispensed triple therapy in the last year (reported annually by the National Cardiac Network) Number (%) of eligible patients who have had at least three prescriptions for triple therapy in the last year
	Decrease the proportion of current smokers, enrolled in a PHO, over the age of 15 years. Our goals are to: • Offer support to quit to at least 80% of all current smokers, with an equity ratio of ≥ 1.0. • Increase provision of stop smoking medications to people who smoke by 25%, from a baseline of 8%, with an equity ratio of ≥ 0.9.	Current smokers, enrolled in a PHO, who are offered support to quit by their primary care team. Current smokers, enrolled in a PHO, who are prescribed a stop smoking medication.

[85] Eligble patients will be those people admitted to hospital with a defined CV diagnosis or procedure in the last 10 years

	• Designing and implementing a community-based incentive programme to encourage and support whānau to stop smoking. We will achieve these goals by (a) holding CME/CNE sessions; (b) implementing a local social media campaign that reminds people who smoke that they can get medications to support a quit attempt from their GP; (c) establishing simple guidance to help in the recording of accurate smoking and vaping status; and (d) Developing and implementing an electronic referral system for smoking cessation Regarding the last goal, we will work with local Māori providers to co-design a novel approach to encourage mass quitting in the community. This will be based on current evidence of effectiveness of financial incentives for smoking cessation, but the design will be led by Māori to ensure that it is relevant for the Māori who smoke. Within this work we will also capture data to gain an understanding of people's preferred methods of quitting smoking.	Number of CME/CNE sessions completed Local social media campaign implemented Guidance document created and distributed E-Referral system implemented / not implemented Number of referrals received by the stop smoking service

Babies living in smokefree homes

Rationale for our approach: A reduction in the prevalence of smoking in women who are intending pregnancy or who are pregnant is a priority. Maternal smoking is associated with a range of poor neonatal and child health outcomes, as is exposure to second-hand cigarette smoke in the environment in which an infant lives. This measure will focus attention beyond just maternal smoking to the home and family/whānau environment and will encourage an integrated approach between maternity, community and primary care.

Improvement milestone	Actions / Activities	Contributory Measures
Increase the proportion of babies living in smoke free homes by 10%, from 53.4% to 58.7%	Increase the proportion of young Māori, aged < 40 years of age, who are smokefree. Our goals are to: • Increase the offer of support to quit to at least 80% of all current smokers, with an equity ratio of ≥ 1.0. • Increase the proportion of the enrolled population aged ≥ 15 and < 40 years of age who are smokefree (never smokers or ex-smokers) by 1% point from 20.1% to 21.1%. We will achieve these goals by (a) holding CME/CNE sessions; (b) implementing a local campaign that reminds people who smoke that they can get medications to support a quit attempt from their GP; (c) establishing simple guidance to help in the recording of accurate smoking status; (d) work with local Māori providers to co-design a novel approach to encourage mass quitting in the community; (e) work with the Local Stop Smoking Service to increase promotion of their service, including via primary and secondary care services as well as directly with the community; and (f) design, implement and evaluate novel approaches to quitting that appeal to young smokers.	Number (%) of the enrolled population aged ≥ 15 and < 40 years of age who are smokefree (never smokers or ex-smokers), by ethnicity and gender. Number (%) of the enrolled population aged ≥ 15 and < 40 years of age who are current smokers and who are provided with an offer of support to quit in the last year, by ethnicity and gender.
	Increase the proportion of hapū māmā who are smokefree. Our specific goal is to: • Increase the proportion of hapū māmā who report being smokefree at their booking appointment by 5%, from a baseline of 88% to 92%, with an equity ratio of ≥ 0.9. We will achieve this goal via all of the actions relating to smoking cessation interventions above.	Number (%) of pregnant women who are smokefree at booking

Youth access to and utilisation of youth appropriate health services

Rationale for our approach: We want youth in the Lakes DHB region to have access to the right health services that are easily accessible and youth friendly. In the past we have focussed on youth self-harm. Whilst this is still a priority area, we also want to address other priorities such as MMR and oral health.

Improvement milestone	Actions / Activities	Contributory Measures
To increase youth engagement with health services specifically by Increasing the utilisation of DHB funded dental services by adolescents from School year 9 up to an including 17 years by 5%, from a baseline of 84.6% to 88.8%.	We propose to do this by • Promoting engagement with youth health services, which will lead to better engagement with health services generally, including oral health • Undertaking work to provide a continuation of care, via follow-up, for young people who are not accessing oral health services. For children in Year 8 and below follow-up is undertaken by the DHB oral health service. On reaching the end of year 8 parents/guardians are given the option of continuing with the DHB service or using the services of a local dentist. For those who chose not to continue with DHB run a service there is no way of capturing who is overdue for oral health care. Whilst the overall results are over 80%, we have inequity in utilisation where only 73.6% of Māori are utilising services, compared with 96.2% of non-Maori. We therefore need to develop a strategy that focusses on increasing utilisation for Māori.	N (%) of adolescents from School year 9 up to an including 17 years utilising DHB funded dental services.
	This is priority focus and in addition to receiving the vaccination it provides an opportunity for engagement with health services. We will achieve this goal via (1) implementing the national MMR campaign; (2) working with local secondary and tertiary educations settings; (3) working with Māori providers to look for opportunities to extend reach to Māori; and (4) investigating how we could tie in MMR vaccination to the smoking cessation incentives programme noted above. Our goal is to increase the proportion of 15-30 year olds that are fully immunised against MMR by 5% from baseline (Q4 2020/21)	Number (%) of young people, aged 15-30 and domiciled in Lakes DHB, who have completed MMR vaccination.

[i] Each partnership has custody of an agreed process that delivers capacity to build a model of care that is fit for purpose in addressing the immediate clinical need, but also address social and cultural needs of each patient and their whānau.

A shared output of both projects is data sharing practices and mechanisms agreed to and shared across the project stakeholders as appropriate. This capacity to access patient information across hospital level and community level healthcare systems realises timely and accurate access to patient health information where and when needed. Data sharing practices and mechanism are fundamental to integrated care systems and place based delivery of care for service users to experience a seamless health journey, with a focus on providing person-centred care in the most appropriate setting.

Mapping alternative referral and treatment pathways requires stakeholders working in partnership for the purpose of achieving a measurable improvement in delivery of planned care services. Supporting such improvement is dependent on appropriately skilled and capable workforce capacity supported by timely and accurate access to patient health information.

Supporting continued improvement and Māori workforce capacity, both planned care improvement projects involve Rotorua Hospital Services providing orientation and familiarisation training to Kaupapa Māori Health Care Service providers to support a safe and quality standard of clinical service delivery across the range of planned care improvement innovation projects.

[ii] ***Table 1:*** **Planned Care Innovation Projects and Expected Outputs / Capacity / Outcomes / Benefits / Links.**

Table 1 is a mix of Compliance and Emergent projects designed to transform the delivery of service outcomes for Lakes District Health Board population, with a focus on improving health equity for Māori and vulnerable population groups. The projects individually and collectively support key stakeholders such as:

- Ministry of Health and other partnering crown agencies with delivering on a health system that is fair, sustainable and capable of delivering equitable health outcomes for Māori and vulnerable population groups within the Lakes DHB rohe.
- Iwi, hapū, whānau and communities to exercise their authority to improve their health and wellbeing within a health system that is inclusive and respectful of aspirations to deliver health outcomes based on Māori matauranga and indigenous health principles.

Project	Outputs and Capacity Delivery	Outcome Generation and Benefit realisation	Links with priority/current Projects (based on Project Manager KPI)
1. Pokapū o Te Taiwhenua-rural hub: Virtual care to support health equity.	➢ Increased capacity for accessing patients ➢ Creates capacity for consultation with vulnerable patient groups ➢ Creates capacity to inform, educate and improve health literacy ➢ Create capacity to build Māori workforce		➢ Māori fit for surgery ➢ Māori oral health ➢ Healthy Housing Initiative Taupō - Tūrangi and Rotorua ➢ Māori Health Community Pathways ➢ Healthy Ageing Model of Care
2. Fit for Surgery: a new model	➢ Creates capacity to increase Māori engagement earlier in their health		➢ Pokapū o te Taiwhenua – Virtual Health

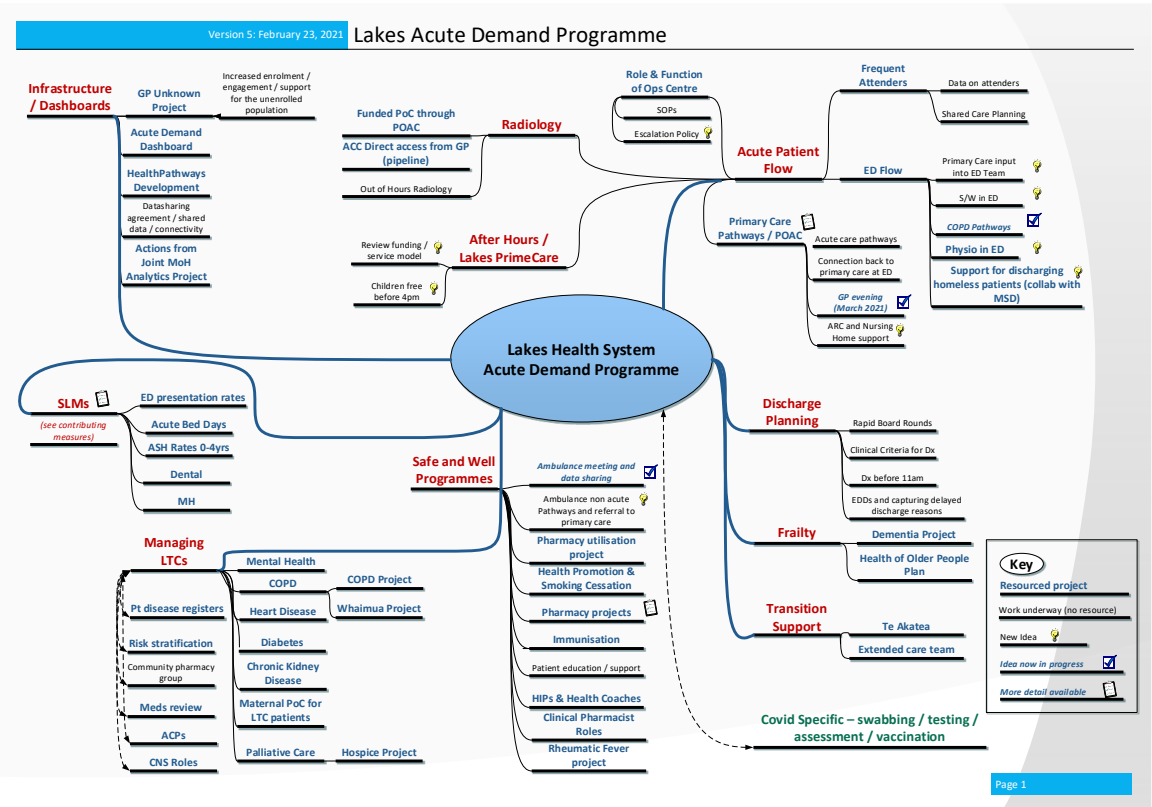
	of care for Māori awaiting surgery	journey in a culturally appropriate and timely manner ➢ Creates capacity to reduce patient numbers waiting pre surgical assessments ➢ Creates capacity to reduce patient numbers on surgical wait list ➢ Creates capacity to support patients with health and lifestyle change aspirations ➢ Capacity to support patients to prepare to be fit for surgery ➢ Create capacity to build Māori workforce	➢ Māori oral health ➢ Healthy Housing Initiative Taupō-Tūrangi and Rotorua ➢ Māori Health Community Pathways ➢ Healthy Ageing Model of Care ➢ Te Kaoreore Māori Health Equity Dashboard
3.	Te Kaoreore Māori Health Equity Dashboard - Planned Care Data Project – health pathways and Focus-Pro	➢ Capacity to capture effectiveness of planned care interventions based on reports of positive outcomes not just research that identifies the scientific basis of its effectiveness ➢ Capacity to inform a multitude of health care improvements projects and initiatives on Māori health equity outcomes and needs ➢ Capacity to inform decision making and funding	➢ Pokapū o te Taiwhenua – Virtual Health ➢ Māori oral health ➢ Healthy Housing Initiative Taupō-Tūrangi and Rotorua ➢ Māori Health Community Pathways ➢ Healthy Ageing Model of Care ➢ Māori Fit for Surgery
4.	Māori Oral Health: Reducing the clinical pathway to General Anaesthetic for dental care	➢ Creates capacity to reduce patient numbers waiting pre dental surgical assessments ➢ Crates capacity to decrease hospital admissions for children and adults ➢ Creates capacity to support Māori fit for surgery project interventions ➢ Creates capacity to increase engagement with Māori to experience planned care pathways earlier in their health journey in a culturally appropriate and timely manner ➢ Learning's from a specific Māori designed and delivered clinical service	➢ Pokapū o te Taiwhenua – Virtual Health ➢ Māori Fit for Surgery ➢ Healthy Housing Initiative Taupō-Tūrangi and Rotorua ➢ Māori Health Community Pathways ➢ Healthy Ageing Model of Care ➢ Te Kaoreore Māori Health Equity Dashbaord
5.	Māori health community pathways	➢ Creates capacity for clinicians and whānau, to become involved in improving the health outcomes of hapū, Iwi and community ➢ Creates capacity for whānau, hapū, Iwi and communities to define their own priorities for health and plot a course to realise their collective aspirations for Māori health development. ➢ Create capacity to build Māori workforce	➢ Pokapū o te Taiwhenua – Virtual Health ➢ Māori oral health ➢ Healthy Housing Initiative Taupō-Tūrangi and Rotorua ➢ Māori Fit for Surgery ➢ Healthy Ageing Model of Care ➢ Te Kaoreore Māori Health Equity Dashbaord
6.	RN anaesthetic assistants	➢ Increased capacity to support surgical services	➢ Pokapū o te Taiwhenua – Virtual Health

	➢ Reduction of patients on waitlist ➢ Creates capacity for benefit realisation in Māori Fit for Surgery and Māori Oral Health projects	➢ Māori oral health ➢ Healthy Housing Initiative Taupō-Tūrangi and Rotorua ➢ Māori Health Community Pathways ➢ Healthy Ageing Model of Care ➢ Te Kaoreore Māori Health Equity Dashbaord

Table 1 Planned care innovation projects and expected outputs/capacity/outcomes/benefits/links

[iii] The eligibility criterion for this project is patients on the inpatient waiting list aged between 5 and 18 years inclusive. The Pilot commenced 23 February 2021 with 13 additional community based clinics scheduled through until 30 June 2021. The number of clinics remaining to 30 June 2021 is eight (8). The total number of patients awaiting inpatient treatment at the commencement of the pilot was 188.

To date almost all 188 patients have been assessed. Of the patients assessed to date, 25% of patients were able to be treated in the community setting. Of the remaining 75% of patients assessed to date, a large number of patients require hospital level dental care. Currently Lakes DHB has exhausted all know pathways to improve healthcare outcomes for Lakes DHB healthcare users requiring hospital level dental care, where the only right thing to do is engage a service provider to support a continuum of service delivery in this healthcare area. Even though the cost of such service will not be cost effective for Lakes DHB, it will provide an equitable, safe and quality solution for the manaaki and healthcare of our patient /consumer. Lakes DHB is not in a position to extend the contract to improve wait list times for oral health in adults with EOA until such time that a solution can be found to address the shortage in supply of hospital level dental care to the Lakes DHB population. Discussions are currently underway with Southern Cross Hospital to investigate options of support for hospital level dental care surgery.



[iv]