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2021/22 Bay of Plenty District Health Board 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.

Bay of Plenty District Health Board's
Annual Plan dated August 2021
(Issued under Section 38 of the New Zealand Public Health and Disability Act 2000)
Bay of Plenty District Health Board
P O Box 12024, Tauranga, 3143
ISSN: 2230-4371 (Print)
ISSN: 2230-438X (Online)
This document is available on the Bay of Plenty District Health Board website:
www.bopdhb.govt.nz

Hon Andrew Little

Minister of Health
Minister Responsible for the GCSB
Minister Responsible for the NZSIS
Minister for Treaty of Waitangi Negotiations
Minister Responsible for Pike River Re-entry

Sharon Shea
Chair
Bay of Plenty District Health Board
sharon@sheapita.co.nz

Tēnā koe Sharon

Bay of Plenty District Health Board 2021/22 Annual Plan

This letter is to advise you that we have jointly approved and signed Bay of Plenty District Health Board's (DHB's) 2021/22 annual plan (Plan) for one year.

When setting expectations for 2021/22 it was acknowledged that your Plan would be developed in a period where our COVID-19 response, recovery and immunisation programmes remained a key focus and therefore planning requirements were streamlined towards your DHB's work to improve equity and to embed lessons and innovations from COVID-19. Thank you for providing a strong plan for these areas.

Your Plan for 2021/22 will be delivered in an environment where this work continues to be of critical importance and where our system transition process is underway. We acknowledge that providing clarity on the critical areas for improvement through transition is helpful and, on that basis, we are confirming the top challenges that will be of focus for us through 2021/22:

- Supporting readiness and management of COVID-19.
- Supporting the mental wellbeing of people, particularly of youth and young people.
- Ensuring child wellbeing, particularly through increased immunisation.
- Managing acute demand.
- Managing planned care.

More broadly, we also confirm the importance of your Board delivering on the Plan in a fiscally prudent way. We expect that the financial position as presented is an absolute outer limit budget expectation and the Board must look to improve over this further where possible. We have asked the Ministry of Health (the Ministry) to closely monitor and report to us on the progress made.

In addition to the DHB's financial position we are aware of a range of clinical and operational concerns, including colonoscopy management (and the subsequent impact on the Bowel Screening programme), workforce vulnerability, and service continuity. We understand the Ministry will be following up with you on regarding intensive support processes to better enable the DHB to be supported around its financial, clinical, workforce, and service performance.

We invite you to work closely with your regional Chair colleagues to share your skills, expertise, and problem-solving efforts to ensure progress is achieved in these top challenges. As performance progress is discussed through the year, we will look forward to hearing about your joint efforts and progress.

Please note that approval of your Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health

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(the Ministry), including changes in FTE. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases or requests for equity support that have not been approved through the normal process.

Your 2021/22 Plan provides an important foundation to ensure our health system delivers for New Zealanders during the period of system transition and we expect all DHBs will be disciplined in delivery of their plans.

Please ensure that a copy of this letter is attached to any copies of your signed plan made available to the public.

Nāku noa, nā

Hon Andrew Little
Minister of Health

Hon Grant Robertson
Minister of Finance

Cc Pete Chandler
Chief Executive of Bay of Plenty DHB

Table of Contents

SECTION 1: Overview of Strategic Priorities

1.1 Strategic Intentions/Priorities

This annual plan articulates the commitment of Bay of Plenty District Health Board (BOPDHB) to meeting the Aotearoa, New Zealand Minister of Health's expectations, and our continued commitment to achieving the BOPDHB vision of *Healthy, Thriving Communities - Kia momoho te hapori oranga!,* not just in the BOPDHB region, but across the whole Waiariki, Bay of Plenty. This narrative Annual Plan is supported by BOPDHB Financial Annual Plan. Clinical leadership teams have been involved in planning through the clinical Executive Directors at both DHBs, who 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 (BOPDHB) 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 New Zealand Disability Strategy, the Healthy Ageing Strategy and Ola Manuia 2020-2025: Pacific Health and Well-being Action Plan[3]. BOPDHB are working hard to support the national roll out and success of the COVID-19 vaccination programme.

BOPDHB and Lakes DHB 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 and BOP DHB's are jointly working on an equity focussed Disability Action Plan for the BOP and Southern Lakes Region in alignment with the New Zealand Disability Strategy.

The Waiariki Leadership Group

To fully optimize 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

[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

The Regional Vision closely aligns with both BOPDHB and Lakes 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.

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 1000 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.

BOPDHB and Lakes DHB have a number of commonalities, with health inequity and needs, demographic profiles and services provided across the region.

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[1]
- Regional Skills Leadership Group
- Toi Ohomai Institute of Technology

Lakes and BOPDHBs populations experience similar health inequity and have priority groups that are the same focus for improvement in 2021-22:

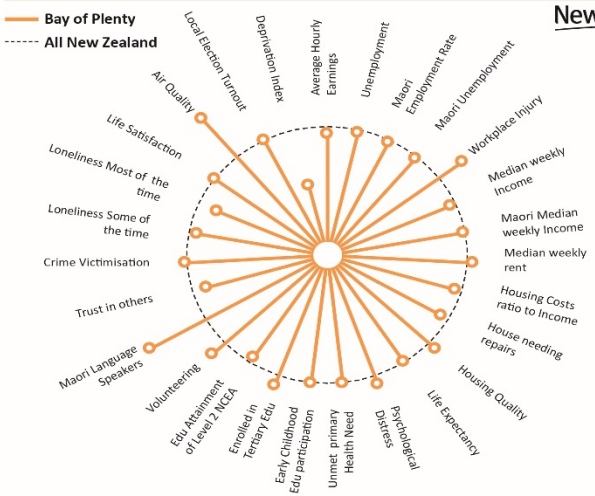
- Māori Health Equity
- Maternal, Child and Youth
- Immunisation
- Sustainability
- Mental Health
- Acute Demand
- Ageing populations
- COVID-19 response, impact and psychosocial wellbeing

[1] Bay of Plenty Collective Impact Governance Group - BOPDHB 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 both DHBs.

Both Lakes and BOPDHB are two of the five DHBs belonging to Te Manawa Taki region. Both DHBs belong to ten 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.

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

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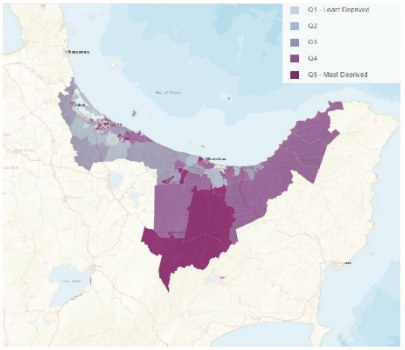
New Zealand Deprivation Index

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

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



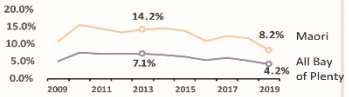
The 2013 New Zealand Deprivation Index is based off the 2013 New Zealand Census, and collates multiple indicators to provide comparisons between regionals and give a sense of deprivation.

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

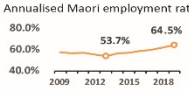
Bay of Plenty has some of the highest deprivation areas in all New Zealand.

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

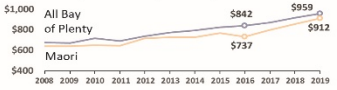
959 dollars is the median weekly in come in Bay of Plenty as at June 2019.

(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)

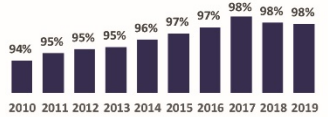
Median weekly income in Bay of Plenty, and for Maori



Poverty Indicator

Knowledge and Skills

Early Childhood Education participation in Bay of Plenty



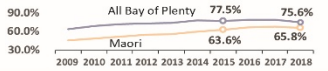
42.1 percent of school leavers in Bay of Plenty go on to study at the tertiary level

(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 be tween 2014 and 2017.

(6.9 percent for all New Zealand)

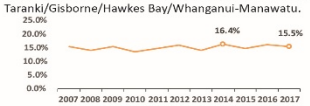
28.1 percent prevalence rate for people who have experienced one or more unmet primary healthcare needs in 2014-2017.

(28.0 percent for all New Zealand)

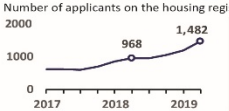
Housing

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.



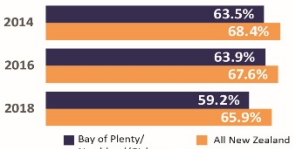
Number of applicants on the housing register in Bay of Plenty



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

Safety

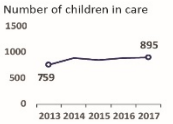
Percentage of people who have high trust in Others (broad region)



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

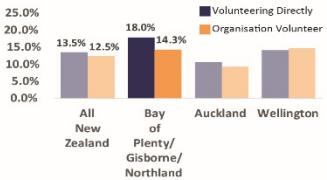
(29.3 percent for all New Zealand)

Number of children in care



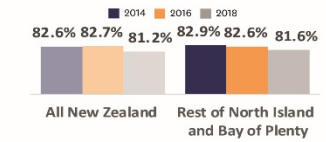
Time Use

Percentage of people who volunteer, by type and region 2018



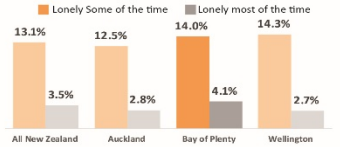
Subjective Wellbeing

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



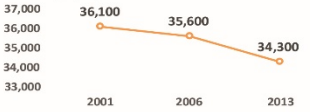
Social Connectedness

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



Cultural Identity

Maori language speakers

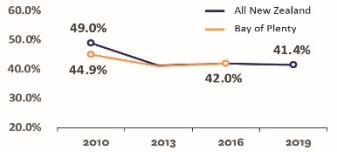


80.2 percent of people in Bay of Plenty find it easy to express themselves in 2018.

(83.8 percent for all New Zealand)

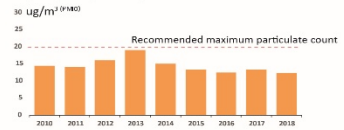
Civic Engagement

Percentage of registered voters who voted in local elections



Environment

Air quality in Bay of Plenty Urban centres

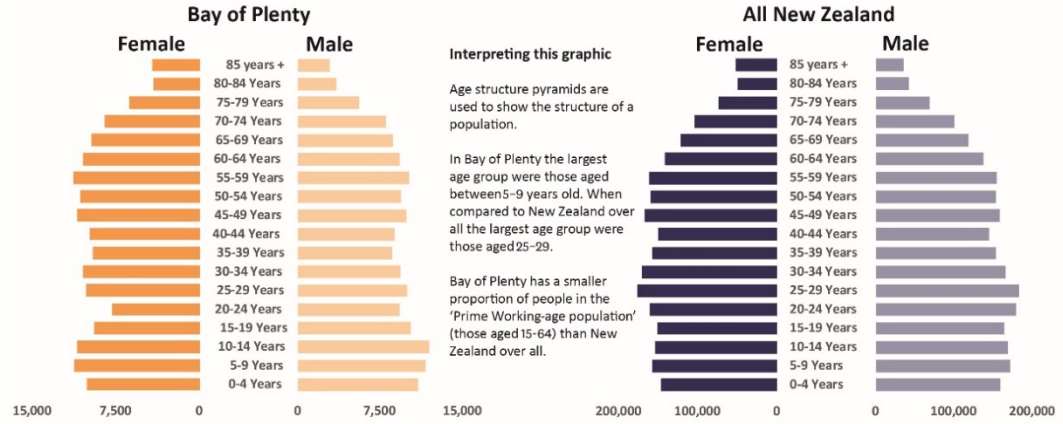


Bay of Plenty in context

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)

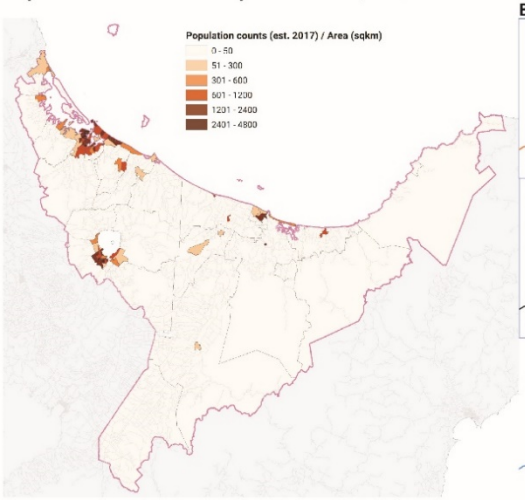
6.6 percent of people in New Zealand live in the Bay of Plenty as at June 2019.

(5.7 percent as at June 2013)

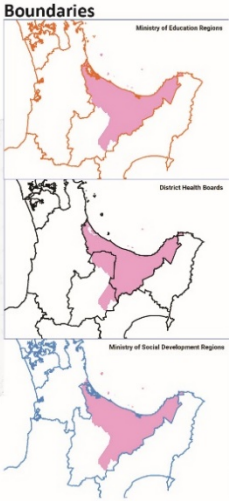
4,917,000 usually resident people live in New Zealand as at June 2019

(4,442,100 as at June 2013)

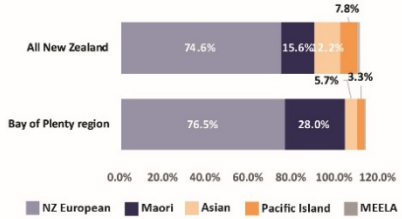
Population distribution by mesh-block, 2017



Comparing Organisation Boundaries

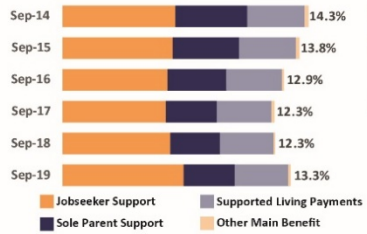


Self-identified total response ethnicity



Welfare assistance

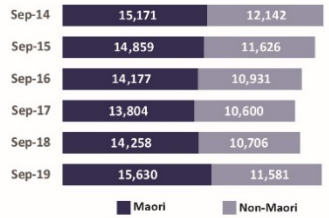
Percentage of the working-age population (18-64 years) receiving a main benefit in Bay of Plenty for each September quarter



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



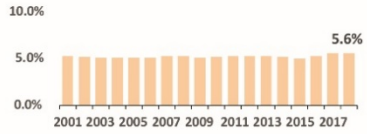
57.2 percent benefit recipients in Bay of Plenty are Maori.

(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



[2]

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

Regional Comparisons of Performance

Lakes District Health Board

Demographic drivers

Figure 1: % Māori population

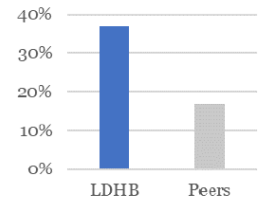


Figure 2: % >65 population

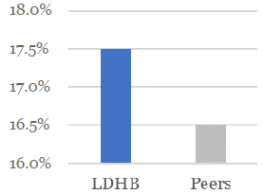


Figure 3: % quintile 4 and 5

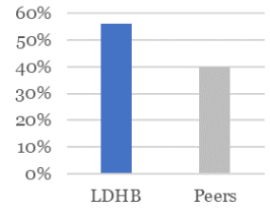
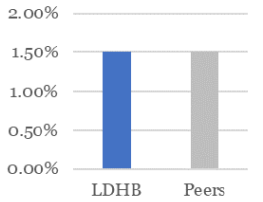


Figure 4: % population change compared to previous financial year



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

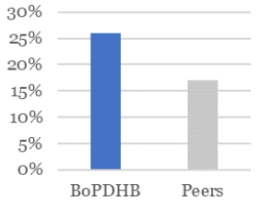


Figure 2: % >65 population

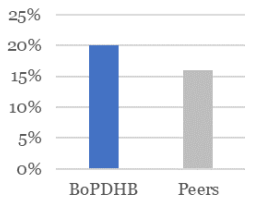


Figure 3: % quintile 4 and 5

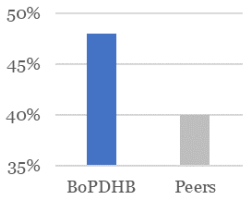
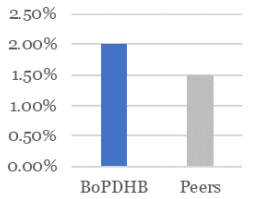


Figure 4: % population change compared to previous financial year



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 Se 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

BOPDHB Profile

BOPDHB continue to focus on two local strategies for 2021-2022. The Bay of Plenty Strategic Health Services Plan and Te Toi Ahorangi set the scene for what we need to focus on to support our communities to be healthy and thriving. It guides us to provide health services which better support people to stay well and manage their own health.

Over the next ten years, the BOPDHB and the Māori Health Rūnanga (collectively known as Te Kohao o Te Waka o Toi) commit to working together, partnering for outcomes across sectors and ensuring that tangata whenua determinants of wellbeing are addressed and invested here in Te Moana ā Toi.

Te Toi Ahorangi 2030 provides a strategic framework that describes a unified vision, voice and intention to successfully influence health and wellbeing outcomes for tangata whenua and all people living in Te Moana ā Toi, from preconception throughout the life course. This vision directly aligns with He Korowai Oranga, the Government's national Māori Health Strategy and vision of Pae Ora - healthy, Māori futures.

Toi Oranga Mokopuna (Enhancing Child Health and Wellbeing) is one of our four strategic development areas. Several planned developments for this year are components of this priority however there is additionally an overarching strategic intention to begin to link our DHB owned and operated services to form an integrated service model during 2020-2021. As this develops, BOPDHB intends to explore wider service user and whole of system aspirations and opportunities for improvement to guide future activity. This strategic approach will grow at three levels over time:

(a) Connecting child health services within the DHB
(b) Working in partnership with child health services across the wider care system
(c) Growing partnership with other agencies

Toi Oranga Ake (Integrated Healthcare) represents our growing range of Integrated Healthcare developments. Initiatives are referenced in this plan relating to integrated care, however we are seeking to ensure these are linked and mutually enhancing, rather than separate initiatives which might add new silos and boundaries and thereby impede our intention of seamless care. Community Care Co-ordination and Keeping me Well initiatives link closely with the established Healthcare Home model and all focused on supporting wellness at home and providing care and support in communities through the care of GPs and community-based services wherever possible. A key new phase of Toi Oranga Ake involves growing the number of traditionally hospital-based specialist clinics that can be provided in rural communities. Tests of change undertaken over the last year have been extremely successful where developed in partnership with local communities, GP practices and Iwi and are becoming a key component of both improving access to care locally and reducing demand on central hospital facilities.

Toi Oranga Ngakau (Mental Wellbeing and Addiction) is a representation of our commitment to He Ara Oranga in building a connected whole of system approach to care and support across our Mental Health and Addictions Services. Our future state needs to take account of the differences in need and access across localities within the Bay of Plenty and focus on easily accessible early support as part of a graduated and connected model of care. In 2020-2021 the establishment of a whole of system governance group will ensure that lived experience, local knowledge and specialist skills are working together to help define, develop, and progress our aspirations for a model of excellence across the Bay of Plenty.

Toi Oranga Tikanga (Workforce Development) is the seeding of refreshing how we work as a DHB in a changing world with a focus on empowering and supporting our workforce to flourish. This strategic priority links our developing People Strategy, digital transformation, workforce wellbeing initiatives, policy, and internal processes with the aim of supporting people to be able to give their best and enjoy their work in an agile, positive and supportive culture. This strategic development area will increasingly support our whole of system integration initiatives, where workforce teams are moving across Tier 1 and Tier 2 services requiring us to support the training, education, development and career progression needs of the wider Bay of Plenty healthcare workforce.

Evolving our Culture

The BOPDHB's Creating our Culture programme continues to support these themes as it moves into the next phase, Evolving our Culture. Quarterly progress updates on the delivery of confirmed planning intentions outlined above will be provided by the BOPDHB as part of routine quarterly reporting processes to our Board and the Ministry of Health. To deliver on our priorities, BOPDHB planning and budgeting is done in partnership with a number of key stakeholders. These partnerships endeavor to create a more sustainable, integrated, and equitable health system, in an environment that is becoming increasingly challenging with population growth and increased demand.

Effective health planning in the BOPDHB relies on extensive consultation with providers, including the executive and senior leadership teams of the Tauranga and Whakatane hospitals, our primary and community partners, the wider DHB, Public Health and our kaupapa Māori providers. Outlined below are some of the key points of connection.


TE TOI AHORANGI
2030 TOI ORA STRATEGY
Uphold Te Tiriti O Waitangi & Our Indigenous Rights
Be A Toi Ora Change Leader
Illuminate & Advance Toi Ora System Performance
Elevate Wai Ora & Reduce Acute Demand
Whakamana Whanau With Solutions Embedded In Aroha
Support Iwi Led Development
Develop Our Toi Ora Leaders, Workforce & Providers
Invest In Toi Ora Innovation
BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI
Strategic Priorities
Toi Oranga Tikanga Business Redesign
Toi Oranga Mokopuna Child Wellbeing
Toi Oranga Ngākau Mental Health
Toi Oranga Ake Integrated Care
Whole of System
Healthy, Thriving Communities
Live well, stay well and get well
Kia momoho te hapori oranga
Toi Ora
Whole of System
Bay of Plenty District Health Board
Strategic Health Services Plan
Community Based Acute Care
Avoidable Hospital Admissions
Care In The Community
Ambulatory Child Health
Mental Health & Addictions Redesign
Evolving Our Culture
Agile Business Culture & Processes
Workforce Wellbeing Support Team
Coordinated Transformation
Leadership Evolution
Financial Sustainability
Quality & Safety Improvement

Achieving Health Equity

Achieving equity in health and wellness is a focus for BOPDHB. Given our population make up and our obligations under the Treaty of Waitangi, the DHB has further focused on this to ensure that reducing Māori health inequities are prioritised.

Equity in health for the BOPDHB and the wider Manawa Taki region is aligned with all Articles and Principles in Te Tiriti o Waitangi, in particular Article III (which has an Equity focus) and the Principle of Equity. It is also aligned with the United Nations Declaration on the Rights of Indigenous Peoples, which affirms the rights of Māori to determine, develop, maintain access and administer programmes, medicines and practices that support optimal health and wellbeing. Finally, it incorporates and enhances the Ministry of Health's definition.

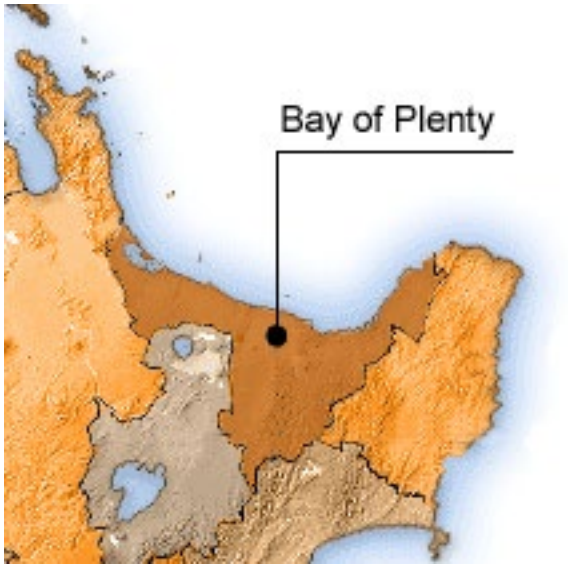
In the Bay of Plenty, this means prioritising service delivery to achieve equity of access, equity of quality, and equity of outcomes for Māori that reflects aspirations and needs in the context of advancing overall health outcomes.

"Equity is purposeful investment of resources that transforms pathways of disadvantage to advantage:

1. Supports rectifying differences that are avoidable, unfair and unjust:
   It recognises that avoidable, unfair, and unjust differences in health are unacceptable.
2. Proportionate investment of resources based on rights and needs:
   It requires that people with different levels of advantage, receive proportionate investment of resources and approaches based on rights and need.
3. Implements Te Tiriti o Waitangi in contemporary ways at system and service levels:
   It demands a health and disability system that is committed to implementing Te Tiriti o Waitangi in contemporary ways as a catalyst for success; that our system is culturally safe, competent and enabling of wellbeing.
4. Success is measured by equity of access, quality and/or outcomes:
   We will know we have achieved Equity when we see equity of access, quality and outcomes in the region; particularly for Māori and then for all others who are affected unnecessarily by disadvantage."

Equity actions are clearly identified within this annual plan by including the code "EOA" for "equitable outcomes action" immediately following any action that is specifically designed to help reduce health outcome equity gaps.

Making measurable progress to achieve equity in health and wellness requires innovation and different approaches to how services are delivered, as evident in both Te Toi Ahorangi and the Strategic Health Services Plan.

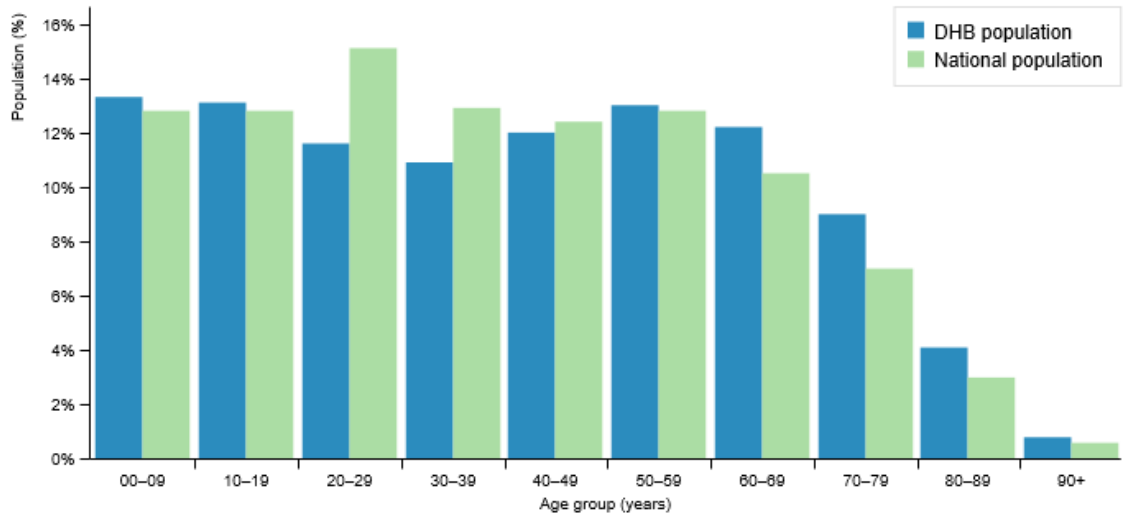


Bay of Plenty DHB is based in Tauranga and Whakatane covers an area from Waihi Beach in the north-west, to Whangaparaoa on the East Cape, and inland to the Urewera, Kaimai and Mamaku ranges. It has a population of 238,380 people (2018/19 projection).

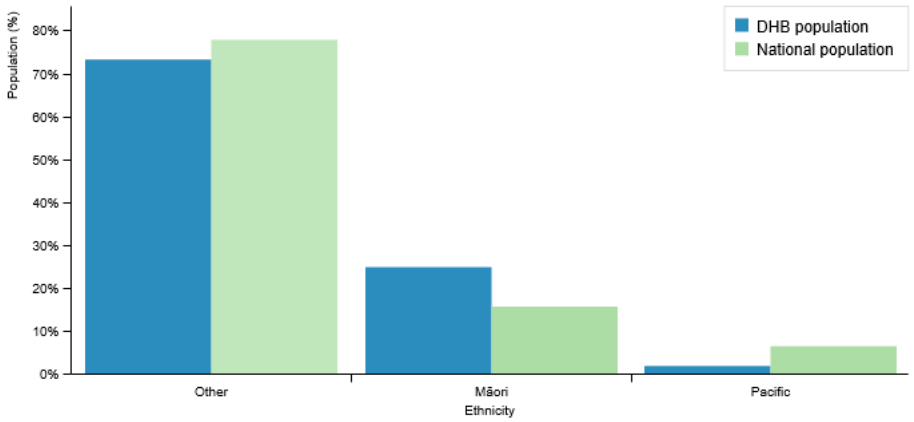
- Bay of Plenty's population tends to be older than the national average.
- Bay of Plenty has a higher proportion of Māori in comparison to the national average, and a lower proportion of Pacific people.

- Bay of Plenty has a relatively low proportion of people in the least deprived section of the population while the most deprived sections are over-represented.

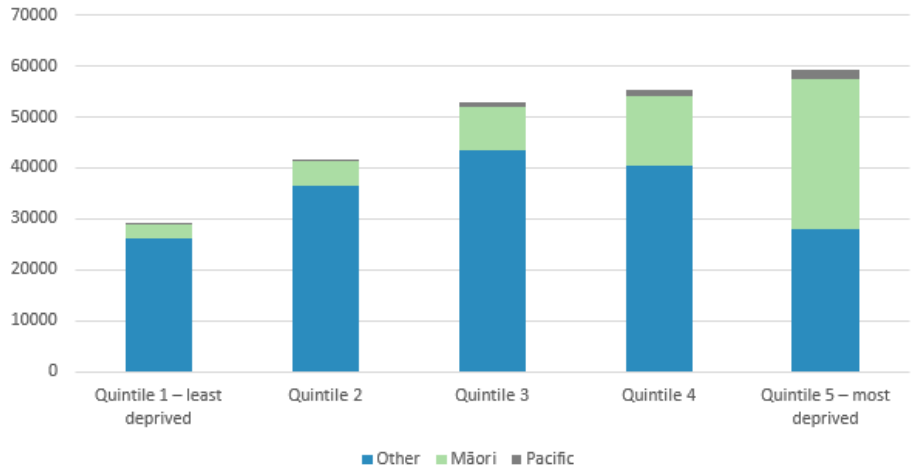
Bay of Plenty's population tends to be older than the national average.



As at the 2018 census, Bay of Plenty has a higher proportion of Māori in comparison to the national average, and a lower proportion of Pacific people.



Bay of Plenty has a relatively low proportion of people in the least deprived section of the population while the most deprived sections are over-represented.


70000
60000
50000
40000
30000
20000
10000
0
Quintile 1 – least deprived
Quintile 2
Quintile 3
Quintile 4
Quintile 5 – most deprived
Other
Māori
Pacific

BOPDHB is responsible for the provision (or funding the provision) of most health services in the BOP 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.

BOPDHB:

- 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 most of the public health and disability services in the BOP district, through the agreements with providers
- provides hospital and specialist services primarily for our population and 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 BOP

We know that a health equity gap exists between some of our population, particularly Māori who:

- are twice as likely to develop diabetes
- 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 BOP 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

Alliances and Leadership Groups

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.

Midland Health Alliance Team

An Alliance Agreement has been entered into between Te Manawa Taki Regional 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[3] is the joined governance group of DHB Chairs and DHB Iwi Relationship Board Chairs.

[3] Te Manawa Taki is the name for the Midland Regional Group of DHBs

Primary Health Organisations

The BOPDHB region has three PHOs with a direct head agreement, being Western Bay of Plenty PHOs (190,000 enrolled service users), Eastern Bay PHA (20,000 enrolled service users) and a kaupapa Māori PHO, Nga Mataapuna Oranga (11,000 enrolled service users). Nga Mataapuna Oranga has embarked on the develop and implementation of an indigenous system of care (Tūāpapa) in the primary care setting .The DHB also has smaller service agreement with Te Manwa Taki Health for a GP practice in Waihi Beach and Rotorua Area Primary Health Services (RAPHS) for the GP practice in Murupara. The PHOs are represented by one representative PHO CEO on the DHB Executive leadership Team to ensure a strong primary and community presence.

Toi Te Ora Public Health

BOPDHB acknowledges the pivotal role Toi Te Ora Public Health (Toi Te Ora), plays in supporting the DHB in planning and implementation of the Strategic Health Services Plan and Te Toi Ahorangi. Toi te Ora has also played a critical role in our Public Health response to COVID-19. The Toi Te Ora Public Health plan is integrated for the first time with the 2020/2021 BOPDHB Annual Plan, and relevant Ministry of Health priorities.

Toi Te Ora established Te Waka Eke Noa, an internal advisory group, which reflects the partnership between Toi Te Ora's management and its Māori staff. Te Waka Eke Noa with the support of BOPDHB Māori Health Gains and Development, will guide Toi Te Ora on the development and implementation of this work to ensure a focus on achieving equity for Māori.

System Level Measures

System Level Measures (SLM's) framework aims to improve health outcomes for people by supporting DHBs to collaborate with health system partners such as primary, community and hospital services. Equity gaps for Māori and Pacific populations are evident in all SLMs and in nearly all districts. The SLM plan is placed in the appendices with SLM actions highlighted throughout this Annual Plan. Quality improvement is an integral part of the BOPDHB Annual Plan, and we recognise that quality in healthcare will deliver on the government commitments of the New Zealand Health Strategy.

BOP Pharmacy Advisory Group

BOP 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.

1.2 Message from the Chair and Deputy Chair of the Bay of Plenty District Health Board

He rangi tā matawhāiti, he rangi tā matawhānui

This whakatauki means that a person with a narrow vision has a restricted horizon, whereas a person with a wide vision has plenty of opportunities. The whakatauki is apt as it underpins how the Bay of Plenty has risen to successive challenges in 2020-2021 and will continue do so in 2021-2022. In short, the people of the Bay, and our health system, has always had a wide vision and we envisage multiple opportunities for us all in the following year.

Before describing these opportunities, first, we must acknowledge the many families and whānau who lost loved ones and/or are dealing with the impact of Whakaari. We see you and support you. We also acknowledge the tremendous resilience of the whole health system, the workforce and the community linked to dealing with COVID-19. We are immensely proud of the innovation and collaboration that occurred to ensure the people in the Bay were kept safe and well. Ka mau te wehi.

Looking forward, our collective future opportunities, the Board is keen to continue a journey of resilience, agility and to stride into the new health sector reforms with confidence and assuredness. There have been several highlights from 2020-2021, that will showcase to Aotearoa, how the Bay's health system is innovative and delivers outcomes. For example, the continued development of Te Toi Ahorangi model of care to address Health Equity and the BOP Community Care Co-ordination service.

As a Board, we take very seriously our role as local stewards or kaitiaki of the health system. In this regard, and on your behalf, we will embrace change, bid 'ka kite' to the DHB and help drive a new system that is even more inclusive, outcome-achieving, financially responsible, and one that continues to deliver the highest standards of care (as we have always aspired to do).

There will be aspects of the new health system that must be led nationally. However, there are many services and solutions that will need to be designed and determined locally. Our mantra is locally led, regionally and nationally aligned. The retention and elevation of local community voices and expertise will be very important, and we will champion this moving forward. Paramount to this is design around whole of system changes, upholding and strengthening key partnerships and developing the talent required for the future.

For the next year, I invite you and our team of '5,000' (who work across our whole health system) to join with us on a journey of rangatiratanga, and joined up leadership that position the Bay to thrive now and in the future. As one of our key strategy states, we are all flourishing descendants of Toi Ora, an eponymous ancestor of Toi.

Mauri ora,

Sharon Shea
Chair
Bay of Plenty District Health Board
Date: August 2021

Dr Geoff Esterman
Deputy Chair
Bay of Plenty District Health Board
Date: August 2021

1.3 Message from the Chief Executive

I am pleased to present Bay of Plenty District Health Board's Annual Plan 2021/22 which sets out the activities planned to meet national, regional, and local priorities for the coming year. It describes to the Minister of Health, the Hon Andrew Little, and to our communities, our intentions to improve equitable health outcomes for the Bay of Plenty population in way that is sustainable and meets our obligations under the Treaty of Waitangi.

With bold and far-reaching health reforms pending, our planning effort this year has been mindful of our custodian responsibilities, as the Health system transitions away from the DHB structure. Towards this end, we as an organisation of caring and committed professionals have endeavoured to craft an accountability document that strikes a balance between the twilight of the current era and the dawn of a new one. Our assumption, borne out by the Ministers letter of expectations, is that some priorities remain constant. These include delivering equitable health outcomes for our community, in a manner that is clinically and financially sustainable and honours our Te Tiriti obligations.

While these key imperatives remain unwavering, we have in this document sought to create space for change, and to provide a supporting platform from which new successes and advances can flourish. This has impacted on year to year planning continuity, but in the pursuit of substantive change, such discontinuity is necessary. What you as the community we serve can be assured of though, is absolute continuity of care.

This is a particularly important and fundamental commitment, especially considering the volatility and uncertainty associated with the COVID-19 pandemic. While structures may change, your right to quality health services remains immutable and will be honoured throughout the current round of reforms, as it has been by the many thousands of healthcare professionals, past and present, who have done their best for their community under the DHB structure.

I wish you all well for the future and thank you for the privilege of being able to serve as the Chief Executive Officer of the Bay of Plenty District Health Board.

Pete Chandler
Chief Executive Officer
Bay of Plenty District Health Board
Date: August 2021

1.3 Message from the Chair of Te Rūnanga Hauora Māori ō Te Moana ā Toi

Mai e te tipua
mai e te tawhito
mai e te kāhui o ngā ariki
mai e tawhiwhi atu ki ngā atua
Oi ka takina te mauri
ko te mauri i ahua noa mai ki runga ki ēnei taura, ki runga ki ēnei tauira
kia tau te mauri ki runga ki ēnei tama, he tukuna no te whaiorooro a Tāne te waiora
tēnei te matatau kia eke whakatū tārewa ki te rangi
uhi, wero, tau mai te mauri ki te arā ko te mana atua,
mana whenua, mana moana, mana tupuna, mana tangata
ka puta rā ki te whei ao, ki te ao mārama
tūturu whakamaua kia tīna
tīna, hui ē, Toi ora ē!

Te Toi Ahorangi as the way finder on the essential change in direction and approach for both kaupapa Māori and kaupapa Pākehā is reflected strongly in the recent release of the combined BOPDHB Board and Rūnanga Position Statement on Te Tiriti, Equity and Racism which was developed over a nine-month period and launched in May 2021. Te Rūnanga and the Board are active in the progression of our relationship as authentic Te Tiriti partners. It is envisaged the relationship is one of mutual benefit between those who were here (tangata whenua) and all those who have come (tangata Tiriti). The focus for both boards is ensuring tangata whenua rights to equitable access, quality and experience of care within the environs of the Bay of Plenty health system.

It will be challenging to uphold our word "Toitū te Kupu", uphold the power "Toitū te Mana" and uphold our vision "Toitū te Ora" as we navigate our waka through the stormy waters that lay just over the horizon. However, the Runanga is confident that in partnership with the BOPDHB there are the mechanisms and leadership in place for us all to flourish as descendants of Toi.

"Te arā tawhāiti o tāwhaki"
(In the now is the pathway of all time)

Linda Steel
Rūnanga Chair

1.5 Signature Page

Agreement for the BOPDHB Annual Plan 2021-2022
between

The Honourable Andrew Little
Minister of Health
Date: 12/12/21

The Honourable Grant Robertson
Minister of Finance
Date:

Sharon Shea
Chair
Bay of Plenty District Health Board
Date: August 2021

Pete Chandler
Chief Executive
Bay of Plenty District Health Board
Date: August 2021

A number of sections of this annual plan have been jointly developed between our organisations and the BOPDHB. We are committed to working in partnership with the BOPDHB to ensure achievement of the outcomes described in this plan.

Janice Kuka
Chief Executive Officer
Ngā Mataapuna Oranga

Date: August 2021

Lindsey Webber
Chief Executive Officer
Western Bay of Plenty Primary Health Organisation

Date: August 2021

Greig Dean
Chief Executive Officer
Eastern Bay Primary Health Alliance

Date: 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.*

Bay of Plenty District Health Board wish to acknowledge the current Health and Disability System Review, and the effect this may have on some of the following activities and programmes.

Some programmes of work may be re-prioritised, paused or disestablished if they do not align with the national direction of the Health System reforms, are unlikely to be delivered during this financial year, or are unlikely to have ongoing benefit once the new structural arrangement come into place.

2.5.1 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.	
<u>Te Toi Ahorangi</u> **Te Toi Ahorangi is the Toi Ora Strategy determined by Te Rūnanga Hauora o Te Moana a Toi, the mandated Te Tiriti o Waitangi partner of the Bay of Plenty District Health Board (BOPDHB).** Te Toi Ahorangi 2030 provides a strategic framework that describes a unified vision, voice and intention to successfully influence health and wellbeing outcomes for tangata whenua and all people living in Te Moana ā Toi, from preconception throughout the life course. This vision directly aligns with He Korowai Oranga, the Government's national Māori Health Strategy and vision of Pae Ora - healthy, Māori futures.	
Whakamaua Action 1.1 BOPDHB have developed iwi partnerships that support local-level Māori development and kaupapa Māori service solutions. BOPDHB maintain Iwi partnerships through a memorandum of understanding with Iwi, and also Board representation.[4]	Q2 & Q4
BOPDHB will attend the Te Manawa Taki equity leadership team meetings working with joint iwi and chairs to increase impact and decrease inequity for Māori.	To be reported through Te Manawa Taki Equity Plan.

[4] Runanga and representation on board.

Whakamaua Action 2.3 BOPDHB Design and deliver professional development and training opportunities for Māori DHB board members, and members of DHB/iwi/Māori partnership boards: BOPDHB will support professional development and training opportunities for Iwi Governance members through the MOH Governance Training Programme[5].	Q2 & Q4

[5] Examples of training offered to Māori Health Rūnanga members:

- Ministry of Health – DHB Financial Governance Series Workshops – facets of DHB financial model/insights into finance and performance
- Ministry of Health - Whakamaua Training – Te Tiriti and Māori Health equity governance and leadership workshops
- BOPDHB/Canterbury DHB – "Broadly Speaking about Health and Its Determinants"

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 (the following areas in Whakamaua specifically relate to this objective).

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) (the following areas in Whakamaua specifically relate to this objective).

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 (the following areas in Whakamaua specifically relate to this objective).

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.

Whakamaua Action 3.1 BOPDHB 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)[6] The DHB specifically supports the transition to work workstream through our range of placement programmes e.g. graduate nurses (links to Health Workforce)	Q4
Whakamaua Action 4.4 BOPDHB will increase access to primary mental health services for Māori through funding a Ngaiterangi Iwi Court Assessor.	Q4
Whakamaua Action 6.1 Telehealth projects in Rural and Remote Communities, including Motu, are being undertaken at BOPDHB to adopt innovative technologies and increase access to telehealth services to streamline patient pathways and provide continuity of care for Māori and their whānau, while building on recent experience of operating differently during COVID-19 alert levels 3 and 4: • Telehealth Sustainability – Video Consults workflow integration • Telehealth Sustainability – Action Plan • Telehealth Sustainability – Rural Connectivity • Telehealth (WebPas/Patient Management Systems)	Reported through DHB Planned Care Section
Whakamaua Action 3.3 The most significant actions BOPDHB 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 and engagement with the BOPDHB Runanga to support improved prevention and management of poor health.	Q3

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

BOPDHB engage in the regional work of the Kia ora Hauora programme, with the identified work streams: • Promote health careers • Support science achievement • Support tertiary achievement • Transition to work	
Whakamaua Action 4.7 BOPDHB Māori Health Service Te Pare o Toi lead and advise on projects and programmes the BOPDHB 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: Te Pare o Toi is overseeing and joining up efforts to increase the provider capability in order to respond to immunization need. Screening Programmes / Ultrasound in Planned Care section, Breast Screening, Cervical Screening, Bowel Screening, and Maternity	
Whakamaua Action 8.2 The most significant actions the DHB is undertaking to publish plans and progress in achieving equitable health outcomes for Māori: BOPDHB will continue to develop the Toi Ora Optimum for Health and wellbeing Outcomes Framework with indicators and measures (EOA). This is communicated through: • Reports to the Runanga and Board every month • Pare o toi e-panui to DHB, Iwi and Community providers (e newsletter)	Q4

Whakamaua Action 1.4 BOPDHB engage with local Iwi, using an engagement framework and guidelines, to develop major capital business cases. BOPDHB are undertaking and will complete an investment review in 21-22, to develop an equity-based investment model (Pare O Toi Investment for Māori) with MSD, TPK, MOE and PHOs with Iwi are involvement through the BOPDHB Runanga.	Q4
Whakamaua Action 4.9 BOPDHB will invest in growing the capacity of iwi and the Māori health sector as a connected network of providers to deliver whānau-centred and kaupapa Māori services to provide holistic, locally led, integrated care and disability support: BOPDHB will develop a mental health Senior Leadership Group with Māori health providers to lead and transform the mental health sector across the BOP and create a joined-up system of care.	Q3
Whakamaua Action 5.6 BOPDHB support the delivery of Whāia te Ao Mārama 2018-2022: The Māori Disability Action Plan BOPDHB and Lakes DHB will engage with MOH to scope the delivery of and Equity Based Disability Action plan in response to Whāia te Ao Mārama 2018-2022: The Māori Disability Action Plan under the Toi Ora Optimum for Health and wellbeing Outcomes Framework.	Q4
Whakamaua Action 8.5 BOPDHB will ensure that major system funding frameworks consider and adjust for unmet need, and the equitable distribution of resources to Māori. These will likely be joint actions with other DHBs and the Ministry.	Q1 & Q4

Phase one: BOPDHB is developing a Toi Ora investment tool, that will identify the current spend in the organisation to Māori, which will set a baseline to inform where further investment is needed to improve Equity for Māori. This is aligned with the aspirations of Te Toi Ahorangi[7]. Phase Two: Understanding Data across the public sectors and where to focus investment to boost the wellbeing and will help inform approaches of co-commissioning and codesign.	

[7] The Toi Ora Investment Review will analyse the investment across government (DHB, MSD, TPK, MoE, as well as three PHOs) within the Bay of Plenty, as part of developing an equitable funding framework with a completion date of September.

2.5.2 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) (include one action and milestone per row)	**Milestone(s)**
BOPDHB will move into phase 2 of the sustainability funded projects with benefits being not only financial hard savings, but health equity focussed, cost avoidance, and capacity creation.	Q2 & Q4
BOPDHB will implement the Acute Demand Flow Programme to reduce acute bed days for both planned and unplanned care. This will reduce spend on acute bed days by approximately 1.9M per year. Other measurables include: To increase the number of days between Red and Orange Days occurring and increase staff satisfaction by May 2022. Reduce the total bed days by 10% by May 2022. Bed days per month are running at between 4000 and 7OOO per month at Tauranga.	

(See table in appendices for some more financial benefits of Acute Demand Programme)	
One action initiated from/supported by national analytics: BOPDHB will implement Rural Hospital programme to reduce the need for higher cost locum – outsourced medical personal. Two registrars doing rural generalist runs. Estimated financial impact: $500, 000 (cost avoidance and capacity creation)	
Action initiated from/supported by strengthened production planning: BOPDHB will avoid spend on excessive acute demand levels through the development of the Acute Demand Programme[i] with a focus on reduction of Māori ASH rates (EOA). Estimated Financial Impact: $500, 000 (cost avoidance and capacity creation)	Reported through Acute Demand

Medium term focus (three years)

Innovative approaches from COVID-19 learnings
From the set of actions that the DHB is embedding as a result of COVID-19 learning/innovation (included throughout this plan) please identify **one** action expected to have the most significant impact on medium term sustainability.

Sustainable system improvements over three years
Please identify **one** action that will contribute the most to a reduction in cost growth over the next three years:
(for example, in the areas of equity-based commissioning, integration of community and hospital services, using workforces in different ways)
Quantified actions from the DHB's path to breakeven
Please include a subset of **three** actions/initiatives from the DHB's path to get to and/or sustain its path to breakeven over the next three years. Identify key milestones for each of the 3 years and quantify the impacts of each action to be realised in each year.

Please include at least a **Q2** and a **Q4** milestone for each action.

Action(s) (include one action and milestone per row)	**Milestone(s)**
Innovative approaches from COVID-19 learnings From the set of actions that the DHB is embedding as a result of COVID-19 learning/innovation (included throughout this plan) please identify **one** action expected to have the most significant impact on medium term sustainability.	
One action that will contribute the most to a reduction in cost growth over the next three years: **Telehealth Programmes**	Reported through Planned Care.
1. BOPDHB will continue to invest in strategic procurement to realise and make savings.[3] KPIs: Procurement Investment: 0.6% of spend covered (FY22 target $1.15m). Return on Investment of 3x (FY22 target $3.46m). Milestones: Additional resource brought on in Q1 Additional resource brought on in Q2 KPIs are continuous and measured monthly.	Q2 & Q4

[3] BOPDHB target a return on investment of 3:1 on procurement spent.

2. Anaesthesia recovery sessions BOPDHB has invested in Anaesthetist FTE to reduce reliance ad-hoc locum sessions (at $1,000 per session) which is currently costing $832k p.a. This should result in both locum savings and reduced cancellation of theatre sessions. KPIs: Anaesthetist Locum Sessions (expected based on trend). Milestones: Additional resource brought in by end of Q2 Reduction in locum sessions trend to be reviewed at Q3 and Q4.	Q2 & Q4

2.5.3 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.

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) (include one action and milestone per row)	**Milestone(s)**
COVID19 learning BOPDHB will provide ongoing active PPE supply chain for L2-4 for rapidly available PPE to LMCs and Primary care unit (BBC)	Q1-Q4
L3-4 DHB support to primary assessment and HIS case care in DHB facilities Integrated models:	Q1 & Q3
Social services BOPDHB will establish a LMC Liaison role to integrate between DHB maternity and LMCs BOPDHB will review and recruit DHB maternity smoking cessation positions to integrate with Stop smoking services and hapu mama smokefree and wahakura wananga.	Q1 & Q3

Maternity based social workers and maternity staff to increase referrals to Healthy Housing Initiative.	
Ultrasound BOPDHB will implement and communicate the removal of co-payments Eastern Bay of Plenty pregnancy USS	Q1 & Q3
Parenting education BOPDHB will develop the 'women's portal' resources for Badgernet and provide in house education resources (mobile devices on wards)	Q1 & Q3
Wellchild Tamariki Ora (WCTO) BOPDHB **WCTO** Improvement Project launched; Two national quality improvement indicators are identified with WCTO providers that will prioritise equity improvement in coverage for Māori Pepe and children with high needs. It is proposed; that all core contacts in the first year have a key focus on improving rates of childhood Immunisation for children at 8 months; and promote and encourage the continuing of vaccination for, 2 yrs and 5 yrs. (EOA)	Q1 & Q3
BOPDHB will continue the First 2000 Days Programme:[8] Supporting pregnant women, pēpi and whānau living socially complex lives; undertake investigation, implementation and commissioning for new support services, that embed `Pae Ora' Māori models of care. (EOA) Utilise co-design/ mahi-tahi with new mothers or who have had experience of mild-moderate post-natal depression, anxiety 'not-coping' and parenting struggles to facilitate solutions and service recommendations. Apply an equity lens throughout this process to enable better access and service designed with Māori. (EOA)	Q1 & Q4 Q1 & Q4

[8] Bay of Plenty District Health Board's (BOPDHB) First 2000 Days programme is a system wide response to the evidence around this critical window of opportunity in the life course. This programme is an ongoing body of work that seeks opportunities for service improvement covering the life stages from conception until five years of age.
The by-line of this programme is '*unbroken chain of care',* derived from the original First 1000 Days Advisory Group as an aspirational desire for the continuity of care for women, children and whānau as they navigate through the pregnancy and life course journey. Hapū māmā and tamariki are a source of whakapapa. Early investment in whānau is essential to ensure the future of pēpi are nurtured where they are valued and raised to realise their ultimate potential.

Screening programme - GAP programme (antenatal growth screening) progression - FSEP programme (foetal monitoring education for all providers offered) 3rd year	Q1 & Q3
Initiatives to support a sustainable workforce through a positive culture. - Continuation of Midwifery Journey to Excellence series (x3 full day forums) - Further development of Maternity Clinical Governance and Ward Quality Portfolios - Programme for PTSD in the maternity workforce	Q1 & Q3
BOPDHB will identify and report on recommendations from the Perinatal and Maternity Mortality Review Committee:[9] BOPDHB will complete a Maternity Strategic Plan which will include PMMR recommendation actions to inform service plans. 100% staff will attend Te Tiriti Waitangi and equity training, and Unconscious Bias & Institutional Racism course.	Q1-Q4
<u>Focus on: Ambulatory sensitive hospitalisations for children age (0-4) (SLM)</u> 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**. **Respiratory/Asthma/Oral Health** 1. Enhance risk identification and enable intensive support/education programmes to reduce prevalence of Emergency Department presentations, resulting in avoidable admissions. 2. Identify contributing factors at home for asthma suffers to reduce admissions. 3. Promote and strengthen service availability to increase asthma referrals to healthy homes from primary care.	Reported through SLM

[9] TBC (following PMMRC presentation and MCG consideration)

4. Continue to work in a COVID-19 environment with a commitment to achieving equity in oral health outcomes and equity in access to oral health services for our BOP children. **Contributory Measures** • Treatment interventions for Māori children aged 0-4 enrolled with the Community Oral Health service who have received treatment. • Failed to Attend rate for Oral Health appointments for Māori Children aged 0-4. • Percentage of children who present to ED 0-4 or are frequent attenders with respiratory issues who are contacted by their General Practice team post discharge for ongoing management. • Primary and secondary referrals rates to the Healthy Housing Initiative, re, for children with respiratory conditions admitted to hospital. **Overall SLM Milestone change** We will reduce the childhood ASH rates for Māori by 5% by 30 June 2022.	

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) (include one action and milestone per row)	**Milestone(s)**
A key learning from COVID-19 was that Outreach Immunisation Services (OIS) demonstrated their ability to engage with hard to reach whānau: BOPDHB will take a community based social marketing approach for increased community engagement in immunisation for the Waiariki region.	Q1
BOPDHB will maintain childhood immunisation coverage while COVID-19 vaccinations are rolling out through a number of activities below: Bed in the new leadership group, draft communication plan and start co-design. Confirm new stakeholder leadership structure, including partnership and accountability agreement, and schedule of meetings to operationalise Action Plan – implementation Understand barriers and place Whanau at centre for new Communications Plan draft, including education information requested from surveys with Maori and Pacific	

Identify local Iwi and Maori role models as influencers, to ensure a Whanau centred approach and scope alternative immunisation system engagement through `Co-design` with Kaupapa providers.	
BOPDHB will work to increase immunisation for 0-5 year olds: BOPDHB will develop and implement an Immunisation Action Plan with five priority areas, including a focus on delivering key, consistent and culturally appropriate messages to help promote immunisations and increase education around the importance of immunisation. This plan has been developed in collaboration with Māori, Pacific and other consumer voices in the BOP Region[10]. Five Priority Areas: • Systemic Improvement to Access • Analysis • Education Interventions • Workforce • Innovative System Interventions BOPDHB will establish leadership and stakeholder groups, which will have direct responsibility to the DHB CE ensuring key areas of influence can be achieved through the *Immunisation Stakeholder Team/Forum* (to operationalise the Action Plan).	Q1
Understand barriers and place Whanau at centre for new Communications Plan, including education information requested from surveys with Maori and Pacific (EOA). Identify local Iwi and Maori role models as influencers, to ensure a Whanau centred approach and scope alternative immunisation system engagement through `Co-design` with Kaupapa providers (EOA).	Q1
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. Te Pare Ō Toi will support and lead engagement with Māori in developing an Immunisation strategy.	Q1

[10] BOPDHB have a Childhood Immunisation Action Plan 2021-2022 currently with the MOH for review.

<u>Focus on: Increased Immunisation at 2 years (CW05)</u> Lakes and BOP DHBs will reduce inequity in coverage for Māori immunisation through improved engagement (as noted above). Children are fully immunised at two years of age **– CW08** Increased coverage will be achieved through improved engagement across all populations of the Waiariki region.	Q1-Q4 Target Māori 95% Target total 95% Q1-Q4
Locally selected measures: BOPDHB will monitor the immunisation rates through quarterly IDP reporting: Eight month olds will have their primary course of immunisation (six week, three months and five months immunisation events) on time **– CW05** Children are fully immunised at five years of age – **CW05**.	Reported through IDP quarterly reporting Target Māori 95% Target total 95% Target Māori 95% Target total 95%

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.

BOPDHB will complete the STI (chlamydia and gonorrhoea) self-testing pilot targeting Māori rangatahi, Pacific rangatahi, rainbow rangatahi and produce report of recommendations for future implementation for wider scale use across the BOP.	Measured through Sexual and reproductive Health section.
BOPDHB will design new primary community mental health and addiction support services for transgender and rainbow youth and adults.	Contract to be established with NGO Reported through Mental Health.
BOPDHB will improve nurse/student ratio for 1/650 in decile 1-4 schools across the region and 1/750 for Māori in decile 5-10 schools in the western bay and improved coverage for Kaupapa/Kura schools aligned with the concept of proportionate universalism (EOA).	Q2 & Q4
BOPDHB will make the immunisation programme a key focus for MMR for rangatahi/youth (aged 15-29) in the BOP.	Q1

Child & Adolescent Oral health: BOPDHB will continue to work in a COVID-19 environment with a commitment to achieving equity in oral health outcomes and equity in access to oral health services for our BOP children and adolescents is a priority: Oral health data and feedback from local oral health services, education providers, other health service providers and community-based organisations will provide opportunities to collectively support whānau and communities to eliminate disparities in oral health. (EOA)	Q4
Community Dental BOPDHB will reconfigure the BOPDHB Community Dental Service in a COVID-19 environment, with an equity first approach will ensure priority scheduling for Māori and Pasifika children and adolescents, and then those with clinical urgency[11]. Additionally, the design and delivery of the oral health service will be actively monitored by ethnicity.	Q4
BOPDHB will investigate with Eastern Bay PHO a trial telehealth service working with rural Māori in the Eastern BOP region: Phase One: A trial funded by the PHO will contract a private provider to deliver a GP-led Virtual GP model to students in Kura Kaupapa facilities starting with Te Kura Kaupapa Motuhake o Tawhiuau Murupara (see appendices for further information) [i]. The trial will co-ordinate with primary care services and facilitate operational understanding of the clinical and system integration issues for Telehealth required for a quality and safe service.	Q1 & Q3

[11] Emergency or urgent dental needs, those currently receiving treatment, those most overdue and those in their final year at intermediate school.

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) (include one action and milestone per row)	**Milestone(s)**
Work with suppliers (pharmacy) of the Emergency Contraception pill to provide navigation for family and sexual violence assistance through Tautokomai and provision of information on consent. (EOA)	Q2 – information included in ECP packs
Support the STI self-test kit service delivery (pilot at places young Māori and rainbow community gather) with links to information on consent and sexual violence support services. (EOA)	Q2 – Implementation team trained in consent and information for navigation given at STI self-test kits outreach opportunities
To support COVID-19 recovery plan, to achieve equity in Māori health and to build an integrated health system and strengthen people, BOPDHB DHB will review VIP training delivery systems and development of online training resources.[12] (EOA)	Q2- number of Iwi groups engaged with
BOPDHB will provide ethnicity breakdown of attendees in the Police/community led FSS (Family Safety System) of which BOPDHB participate. (EOA)	Q4-Ethnicity breakdown reported

[12] BOPDHB 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 in BOP.

2.5.4 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.

Please note that contributory measures must have written documentation about the measures, including technical documents and quality assurance processes as these documents may be subject to external audits. The online measures library is a resource for the selection of contributory measures.
https://nsfl.health.govt.nz/dhb-planning-package/system-level-measures-framework/health-quality-measures-nz

Action(s) (include one action and milestone per row)	**Milestone(s)**

Continue to progress a programme of work regarding the review and redesign of BOP's MH&A system in alignment to He Ara Oranga, Te Tumu Whakarae submission to the Mental Health Inquiry and the governments Wellbeing focus and budget with a clear focus on integration across the system (EOA).	Q1-Q4 To establish a leadership/advisory group representative of an integrated approach across primary, secondary and NGO as well as Lived Experience and Family/Whānau to prioritise the workstreams needed for transforming the sector.
BOPDHB will seek to demonstrate a focus on wellbeing and equity at all points of the system including working with our partners on, for example, a community resiliency work stream for Toi Te Ora, BOPDHB's public health unit at population health level through to more specific work in partnership with our Māori Health Gains and Development team (Te Pare ō Toi) as part of our inpatient unit rebuilds.	Q1-Q4 Inpatient rebuild processes to be completed in partnership with Te Pare O Toi. Toi Te Ora will develop a Community Resiliency work plan in partnership with input from Mental Health and Addiction.
BOPDHB commits to strengthening the capacity across NGOs and Primary MHA through engagement in supporting RFP processes and utilisation of cost pressure and ring fence funding to support investment in expansion of existing and/or development of new services, as well as addressing sustainability pressures with a particular focus on vulnerable communities such as Māori, youth, and rainbow communities. A key focus in development of these primary mental health and addiction services will be integration across the system.	Q1-Q4 Passing on of full cost pressure uplift to NGO providers. Invest in increasing peer, non-clinical and clinical capacity across NGO providers with a particular focus on vulnerable communities such as Māori, youth, and rainbow communities. Focus on advisory groups for development of new services to include an integrated approach across primary, secondary and NGO. E.g. for the governance and advisory groups to support establishment and implementation of the Primary MH&A integrated GP services.
Continue to expand the Tihore Mai I Uta Tihore Mai I Tai, education-based early intervention MICAMHS service, investing in preventative child mental health roles in partnership with education and the kahui ako	Q1-Q4 To expand and embed this approach in a further kahui ako in the 21/22 financial year.

based learning support processes. The rollout of this approach will be developed in consultation with MOE and in consideration of any funding as indicated by the government regarding future investment in school-based mental health approaches.	
To support the Principles of Kia Kaha, Kia Māia, Kia Ora Aotearoa: COVID-19 Psychosocial and Mental Wellbeing Plan BOPDHB will recruit to two .5FTE Kairuruku Kaupapa Papori- psychosocial coordinator roles across EBOP and WBOP to work in partnership with local iwi/hapu/whānau and other stakeholders to support the needs of their communities in response to COVID-19. These roles are embedded within Te Pare ō Toi (Māori Health Gains & Development) within BOPDHB and will be guided by an advisory group consisting of staff from Toi Te Ora (Public Health Unit), Te Pare ō Toi, Emergency Planning, Planning & Funding and others as required. [EOA] These roles fit into a broader framework of emergency response under the mandate for DHBs to provide psychosocial coordination following adverse events under the Civil Defence Act. Within this wider framework the Lead psychosocial coordinator or delegate will maintain working relationships with the BOP Regional Welfare Coordination Group, local welfare committees and other government agencies to maintain situational awareness of emerging needs in the community to be agile in response.	Q1-Q4 Recruitment of two .5FTE Kairuruku Kaupapa Papori for psychosocial coordination across EBOP/WBOP. These are fixed term roles for 18months. A key milestone for the Kairuruku Kaupapa Papori- psychosocial coordination roles will be to implement a localised engagement strategy for identification of COVID-19 related psychosocial needs in order inform local response and pathways to support.
Continue to embed and grow the capacity of the Navigate collaborative across Community Support and Peer support NGOs as well as Mental Health & Addiction NASC. Navigate is a branded pathway built on the concepts of 'all one team' and 'any door is the right door' in order to provide increased access and choice for the community to support for non-acute mental health and addiction difficulties. This includes continued close working with secondary specialist services as well as continued NGO workforce development including the continued rollout of training in the Recovery Outcomes Star and future training in Just a Thought. It will also include capacity as part of BOPDHB's psychosocial response plan to be able to integrate with BOP Community Care Coordination team as part of a psychosocial referrals coordination and triaging hub should BOP return to Level 3 or 4.	Q1-Q4 Completion of Outcomes Star and Just a Thought training for Navigate services as well as relevant Housing & Recovery providers. Continued growth in referral numbers for Navigate as well as implementation of a Navigate NGO workforce development plan.
Secondary Specialist services will review MDT processes to ensure comprehensive and collaborative approaches to patient care are documented, communicated and undertaken in a consistent manner (1). An integral part of this review will be the development of relationships with community providers and exploration of consistent collaborative processes to support tangata whaiora being discharged from inpatient units to ensure appropriate follow up and supports are in place (2). Contributory measures for the above actions will include:	(1) Q1 –documented summary of tests of change with decision on consistent process in the EBOP Q2 – Audit of processes completed with gap analysis and improvement plan in EBOP and WBOP Q4 – Re- Audit of processes

• Transition planning • Family / Whānau involvement in care Both measures are regularly audited within BOPDHB and make up part of the national KPI programme.	(2) Q1 – Tests of change of collaborative discharge processes with a community provider undertaken Q 2 – Tests of change rolled out to multiple providers Q4 – Consistent collaborative processes with all providers in place.
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 across Canterbury and Kaikōura. 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 • 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.	Q2 & Q4 Mana Ake BOP and Lakes Steering group established Terms of Reference agreed to Project Managers appointed Upon completion of the co-design process, Lakes DHB will submit a report to the Ministry summarising the outcomes of the co-design process
BOPDHB will design new primary community mental health and addiction support services for transgender and rainbow youth and adults.	Q2 & Q4 NGO contract established

2.5.5 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.

Action(s) (include one action and milestone per row)	**Milestone(s)**
Implement MMR immunisation action plan (EOA)	Q2 & Q4
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) BOPDHB will:	**Milestone(s)**
Revisit 2019 BOPDHB Travel Plan and embed other forms of transport (particularly air travel) into a Travel Strategy aimed at including the learnings from the COVID-19 response in relation to mode-shift, flexible working, online conferencing, telehealth, and the inability to travel by air, with an aim to significantly reduce global warming potential (GWP) from activities relating to travelling to, from or for work at our two main hospitals.	Updated strategy approved Q2 Short term actions completed Q4
Realign Kaitiakitanga Framework, Environmental Sustainability Action Plan, and Emissions Management and Reduction Plan to embed learnings from COVID-19 response, and align to 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.	Updated strategy/action plans drafted Q1 Updated strategy/action plans approved Q3
Ensure that all work conducted in the space of Environmental Sustainability continues to be completed through a Te Ao Māori lens, ensuring an equitable focus and that responsibilities within Te Tiriti O Waitangi are upheld.	Māori Health Rūnanga Delegate is attending Steering Group Meetings regularly Q1 All strategies/action plan changes are endorsed by the Māori Health Rūnanga alongside the District Health Board where required Q3
An infrastructure focused climate related risk assessment is conducted ensuring that equitable health provision is part of any climate change adaptation planning.	Climate Related Risk Assessment completed Q2

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.	
BOPDHB will continue the local priority actions in the BOPDHB AMR plan that was developed in 2020:	
Health equity for Māori and other groups: Achieve equity through surveillance by identifying[13] 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. BOPDHB will use ICNET surveillance data to help inform improvement activities related to infection prevention and control. BOPDHB will carry out an AMR review[14], and project resource will be agreed for 6-9 months with Decision Support Analyst capability to co-ordinate and progress the work in partnership with stakeholders.	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). Business Case for Infection Prevention and Control specialist nurses (priority business case for DON/Nursing Services) submitted	Q1 & Q4
Antimicrobial stewardship: BOPDHB 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.	Q1 & Q4

[13] Icnet Surveillance For Hospital And Community.

[14] Review of the whole infection service including response to COVID-19, and ability to respond to COVID-19.

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). Business Cases for an Antimicrobial Pharmacist (priority business case for Medical Cluster) submitted	
Awareness and Understanding: Educational seminars for health professionals to promote optimal use of antibiotics supported by best practice.	Q1 & Q4

Drinking water

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) (include one action and milestone per row)	**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
BOPDHB will complete the annual review compliance reporting for 2020/21 during Quarter 1.	Annual review compliance reporting for 2020/21 is completed

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) (include one action and milestone per row)	**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).

Create support environments for healthy eating

Action(s) (include one action and milestone per row)	**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):	Q2 & Q4
Supporting them to have up to date healthy food and drink policies	Q2 & Q4
Adequately supporting them to implement and maintain the policies in line with Ministry of Health Food and Drink guidance	Q2 & Q4
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

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) (include one action and milestone per row)	**Milestone(s)**
BOPDHB and Lakes DHB will embed COVID-19 learning around offering quit smoking support to people in Managed Isolation Facilities (in Rotorua).	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
BOPDHB to provide leadership, training and funding support for initiatives that reduce harm from tobacco smoke for Māori. This includes the following initiatives: hapu mama programmes, ABC training support for General Practices, local coalitions, Mental Health services ENDs project, Lead Maternity Carers training and maternity in reach.	Q3
BOPDHB will review their smokefree policy to align with the Smokefree regulation changes.	Q2

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) (include one action and milestone per row)	**Milestone(s)**
Support to Screening Services will work with Breast Screen Midland to send Māori and Pacific referrals as early as possible and offer appointments that best suit their needs when recovering from any COVID-19 lockdown of screening services.	Q3
BOPDHB will support PHOs and BSM to increase Māori BSA enrolment to 90% in all General Practices[15].	Q3
BOPDHB will support BSM with a mobile site visit in Opotiki to increase participation by Māori women.	Q3

[15] Data is sourced from BSA DHB quarterly reports published on the NSU website https://www.nsu.govt.nz/health-professionals/breastscreen-aotearoa/breast-screening-coverage

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) (include one action and milestone per row)	**Milestone(s)**
BOPDHB will support iwi Hauora coordinated 'women's health wananga', and the Pacific Island Community trust to screen women in the mobile nursing service to improve cervical screening coverage for Māori and Pacific women aged 25-69 years.	Q4
BOPDHB will lead a cross-sectoral working group with the PHO's and Eastern Bay iwi Hauora to collaboratively plan to catch up on the cervical screening COVID-19 related backlog in screening in Māori and Pacific women .	Q4
BOPDHB will support additional clinical capacity in the Whakatane site to ensure better access for Māori women to have colposcopies closer to home.	Q4

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) (include one action and milestone per row)	**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) (include one action and milestone per row)	**Milestone(s)**
Continued implementation of the syphilis (and other STI) epidemic response plan including (EOA):	
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
Complete the STI (chlamydia and gonorrhoea) self-testing pilot targeting under 25's, Māori rangatahi, Pacific rangatahi, rainbow rangatahi and men who have sex with men and produce report of recommendations for future implementation for wider scale use across the BOP.	Q2 & Q4
Provide access to Long Acting Reversible Contraception (LARC) in new settings that meet the target groups of the Protected & Proud service.	Q2 & Q4
Develop and implement actions in a communications plan to build awareness of syphilis and routine 2nd testing antenatally.	Q2 & Q4

Cross Sectoral Collaboration including Health in All Policies

The wider determinants of health[16] 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) (include one action and milestone per row)	**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" BOPDHB will partner with Lakes DHB to 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.	Q2 & Q4

[16] 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 attend BOPCIGG to build relationships and be informed about other public sector agencies funding priorities to achieve common wellbeing goals.	
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
BOPDHB will work in partnership on the cross-sectoral Western Bay of Plenty housing and homeless strategic programme – Kainga Tupu and key action groups.	Q3
BOPDHB will support the establishment of a strategic housing and homelessness partnership approach in the Eastern Bay of Plenty.[17]	Q3

[17] BOPDHB are current partners in the Kainga Tupu (Western Bay Homeless strategy)- a multi-agency collective strategy.

2.5.6 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) (include one action and milestone per row)	**Milestone(s)**
BOPDHB 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) (include one action and milestone per row)	**Milestone(s)**
Develop a joined approach to Immunisation (MMR and COVID-19 Vaccination) working with PHOs, Iwi, NMO Whānau Ora, develop a communication plan and campaign for Māori.	Reported through Communicable Disease Section
BOPDHB will develop an equity plan for COVID-19 immunisation roll out through engagement with Whānau Ora providers and Iwi (EOA).	Q1

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.	
BOPDHB will engage with MOH and Lakes DHB to scope the delivery of an equity focussed Disability Action Plan across the Waiariki Region (EOA)[18].	Q1 & Q3

Care Capacity and Demand Management (CCDM) Detail key results for the DHB from the SSHW evaluation of fully implementing Care Capacity Demand Management (CCDM) for nursing and midwifery in all units/wards by June 2021.	
Action(s) (include one action and milestone per row)	**Milestone(s)**
BOPDHB will submit request to Safe Staffing Healthy Workplaces Unit for assessment of "Fully Implemented" for the five standards of CCDM. BOPDHB will maintain all standards once assessment has been complete.	Q1- Q4 Q1 A formal request for assessment of "fully implemented" has been made to SSHWU. Due to industrial action and COVID alert levels the process is being amended by SSHWU and a date for assessment to be set. Q1 Actions to maintain/improve the CCDM performance against standards is reflected in BOPDHB CCDM annual workplan endorsed at governance level.
The BOPDHB will use the recently implemented electronic core data set dashboard, which enables all 23 of the electronic CCDM measures to be reported against. Where applicable, the core dataset measures will be provided for Māori and non-Māori. (EOA)	Q1-Q4 Q1 CDS measures are raised at service level via monthly reporting. Specific measures reviewed at governance level include bed

[18] This will include consultation and development with Runanga and Iwi to ensure an equity approach is prioritised. There will be specific outcomes relating to Māori.

	utilisation, shifts below target and patient incidents.
BOPDHB will implement the outcomes of annual FTE calculations, using Safe Staffing Healthy Workplaces methodology. BOPDHB will report quarterly on: • How many FTE calculations have been completed since reporting to the Ministry in Q4 2021 • Have the FTE calculations been agreed at an executive level and is it within budget • What additional FTE have been recruited	Q1- Q4

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.

DHBs are expected to engage with DHB Consumer Councils and other key stakeholders in the ongoing implementation of their plan.

DHB plans need to be explicit about HOW their planned actions will address the Strategic Priorities for Planned Care and the five underling principles, and will:

- enable delivery of the agreed level of Planned Care interventions
- prioritise patients using nationally recognised prioritisation tools
- ensure patients wait no longer than the clinically appropriate time for a specialist assessment or treatment
- identify and address inequities in access to Planned Care services.

Delivery and improvements will be measured against the agreed Planned Care Measures, and quarterly qualitative reports.

DHBs are expected to engage with DHB Consumer Councils and other key stakeholders in the ongoing implementation of their plan.

Focus on: Planned Care Interventions (SS07)

Contributory measures must have written documentation about the measures, including technical documents and quality assurance processes as these documents may be subject to external audits. The online measures library is one resource available for the selection of contributory measures.

https://nsfl.health.govt.nz/dhb-planning-package/system-level-measures-framework/health-quality-measures-nz

Action(s) (include one action and milestone per row)	**Milestone(s)**
BOPDHB will implement phase two of the Planned Care Three Year Plan (Planned Care Programme):	
Improve understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed: Toi Ora Optimum for Health and wellbeing Outcomes Framework and He Pou Oranga Tangata Whenua Model of Care. BOPDHB will complete the community Based Ultrasound Services[19] at Kawerau and Opotiki project in 21-22: • A reduction in failed appointment rates • Improved clinician and imaging service communication and pathway delivery • Valuing people and whānau time • Reducing the time to access diagnostics with patient appointments delivered in appropriate timeframes • Timely diagnosis and appropriate advice and treatment in the most effective and convenient location o Patient centred approach with choice as to how, where and what services are accessed o Locality Based access to Toi Ora Care o Care closer to home, outreach clinics provided in community settings whenever possible • Empowering or populations to live healthy lives o Having clarity of priorities; a good understanding of the profile of Māori Health Status; where there is underrepresentation and inequity in access; and what actions need to be taken to mitigate inequity	Q1-Q4

[19] Community Ultra Sound and Scanning are essential services for hapū Māmā, Pāpā and Pēpī achieves health equity outcomes.

Balance national consistency and the local context[20]: BOPDHB will increase radiology services for Māori -community Based Ultrasound Services at Kawerau and Opotiki Toi Ora System of Care - He Pou Oranga Tangata Whenua Model of Care (EOA) (national baseline).	Q1-Q4
Support consumers to navigate their health journeys: Telehealth: Programme of Sustainability: BOPDHB are developing a Telehealth Sustainability Team to coordinate, lead and normalise Telehealth in the BOPDHB region. Enterprise scheduling module including electronic communications- that will enable streamlined and agile management of our Planned Care appointments, contributing to equity based and patient centred models of care, enabling self-management and being digitally responsive to the needs of our patients and operational requirements. (EOA)	Q1-Q4 Telehealth sustainability team recruited Project plans completed
Optimise sector capacity and capability: Telehealth Video Consultations Workflow Integration: Integrating Microsoft Teams into BOPDHB patient management systems. Enterprise scheduling module including electronic communications. Orthopaedic Transformation: Community Orthopaedic Triage Service/Physio-led paediatric orthopaedic pilot Telehealth: Programme of Sustainability as above	Q1-Q4
Ensure the Planned Care Systems and supports are sustainable and designed to be fit for the future: BOPDHB will pilot a Paediatric Orthopaedic Triage Service project as part of the Orthopaedic Transformation Programme.	Q1-Q4

[20] BOPDHB monitor equity and are investigating an equity dashboard for guiding local service development.

Orthopaedic Transformation: Community Orthopaedic Triage Service/Physio-led paediatric orthopaedic pilot Enterprise scheduling module including electronic communications Telehealth: Programme of Sustainability Telehealth: Integration of Telehealth into PAS	
BOPDHB Integrated Operations Centre will focus on improving patient flow. Whole of system Acute Demand programme[21] development - Project manager appointed - Key projects identified BOPDHB will investigate options around additional theatre and clinics as capacity allows.	SS07 Q1-Q4
Locally selected contributory measures that will support measurement of progress. These measures may include other existing planned care measures (SS07) or other additional measures that support delivery. BOPDHB will monitor the reduction in secondary service referrals for MSK conditions, relating to the following services: Orthopaedic Transformation: Community Orthopaedic Triage Service/Physio-led paediatric orthopaedic pilot. Orthopaedic Transformation: Paediatric Orthopaedic Triage Service/Physio-led orthopaedic pilot.	SS07
BOPDHB will monitor locally selected contributory measures through quarterly IDP and CFA reporting[22]: Number of inpatient surgical discharges under elective initiative **SS07 Measure1** Improved wait times for diagnostic services – accepted referrals receive their scan for - **SS07 Measure 3** • Coronary Angiography (within 90 days)	Reported through IDP quarterly reporting

[21] See Appendices
[22] See the Statement of Performance

• Computing Tomography (CT) (within six weeks) • Magnetic Resonance Imaging (MRI) (within six weeks)- For Elective Services Patient Flow Indicators, only ESPI2 Did-not Attend (DNA) rate for outpatient services **SS07-Measure 7**. • Māori • Non Māori • Total Population	

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.

- Improving wait times for patients requiring mental health and addiction services who present to ED
- Identifying and address inequities when accessing emergency departments
- Better population health outcomes in partnership with primary health care
  Excessive delays to admission for acute patients are associated with poor patient outcomes: adverse events incl. errors, delayed time-critical care, increased morbidity and death. Associated with better patient experience. Indicative of hospital capacity – and use of community and step-down processes.

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.

BOPDHB will work towards using SNOMED data to 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[23].	Q1 & Q3
BOPDHB will develop an Acute Demand Programme[ii] with a focus on reduction of Māori ASH rates (EOA): This will include detail on:	Q2 & Q4

[23] BOPDHB awaits the MoH provision of a national SNOMED terminology server, in order to enable the DHB's investment into SNOMED so far, to be able to begin supporting projects such as identifying LTC patients.

• how patients will be better managed in the community, emergency department and hospital[24] • the organisations that BOP DHB to plan with to achieve improvements[25] • percentage reduction in the standardised rate of acute bed days, while reducing the discrepancy between Māori and total population standardised bed days[26] Sustainability and spread- links to Sustainability Section The Programme is focused on equity, sustainability and spread from the outset by incorporating evidence-based success factors; progressing organisational culture changes with a focus on staff wellbeing and enhancing clinical leadership and establishing the information and monitoring systems required for on-going sustainable change over time. Community based acute demand interventions, including Community Care Coordination, Advanced Care Planning, Palliative Care Service Review and Primary Options will be assessed for equity of access, care delivery and outcomes. In partnership with Māori or Iwi providers, Kaupapa Māori options or models will be advanced.	
BOPDHB will implement Tele-Medicine to improve the health pathways from primary health to ED- links to the Sustainability Section.	Q1 & Q3
Acute Hospital Bed Days per Capita (refer to SLM plan) BOPDHB will respond to the demand on our acute service through the following. These activities go into more detail in the SLM plan. 1. ASH 0-4 ASH rates for 0-4 year olds have deteriorated, for Māori, over the last two years. Whilst there are many social and environmental reasons for this BOPDHB will be prioritising this for a refreshed focus during 20/21. (EOA) Links with Improving maternal and child wellbeing (ASH 0-4)	Reported through the SLM

[24] 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.

[25] Lakes DHB, Whānau Ora, RAPHS PHO and Pinnacle PHO

[26] Bed occupancy focus through extended day-stay hours from 4pm-8pm to improve recovery time and reduce further admission to surgical and orthopaedic wards

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.	
BOPDHB will continue to provide outreach services in rural communities, such as supporting Mobile Vaccination Stations alongside Kaupapa Māori Hauora. BOPDHB will commit to fund ongoing testing in rural communities and extending to immunisation for COVID-19.	Q1 & Q4
BOPDHB will continue to develop the Toi Ora Optimum for Health and wellbeing Outcomes Framework and Model of Care (Te Toi Ahorangi-centred model of care) with Toi Ora zones (communities of interest).	Q1 & Q4
Tele Health activities funded through Planned Care initiatives will have a positive impact on the health of Rural Communities, as this will increase access for Māori and vulnerable populations living in remote and rural areas: • Telehealth Sustainability – Video Consults workflow integration • Telehealth Sustainability – Action Plan • Telehealth Sustainability – Rural Connectivity including Motu • Telehealth (WebPas/Patient Management)	Reported through Planned Care

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) (include one action and milestone per row)	**Milestone(s)**
BOPDHB will finish reviewing independent owner operators of ARC facilities for their C19 preparedness in order to identify those needing further support to improve services by July 21.	Q1
BOPDHB will implement the final phase of the integrated home and community short term services, with long term services as part of the Keeping Me Well[27] (KMW) initiative. This initiative continues to identify frail and vulnerable older people, with a focus on Māori[28]. Keeping Me Well[29] has two specific objectives: • To prevent admissions to hospital • To enable timely, supported transfer of care from hospital or transitional care. We will be implementing prototype projects to test home and community support services under the Keeping Me Well enablement model – There are three stages that we will be completing over this year: 1. Complete prototype testing in 2021 2. Develop and refine service specifications	Q2

[27] Keeping Me Well is an Integrated Community Enablement approach that aims to assist with early supported discharge and preventing hospital admissions and re-admissions.

[28] Māori representation on the KMW governance group

[29] Keeping Me Well project aims: Introduce a community enablement approach to:

- Enable, engage, empower and enhance a person to remain well or get well within their own home;
- Provide a more joined-up, seamless approach which is easy to navigate for people and their family/whānau to access;
- Improve current state of the system by removing barriers that exist to reduce inequalities and improve health and wellbeing outcomes;
- Provide a more effective, agile way of working with our highly skilled community-based allied health, medical, nursing, allied health workforce with increased support by the non-registered workforce.
- Proactively respond to the short-term needs of our population within a home or community setting.

3. Finalise contract service specifications	
BOPDHB will work with Te Manawa Taki to review current respite services in order to improve access and responsiveness to of dementia services, that better reflects family/whānau needs.	Q4
BOPDHB will establish a programme of work to operationalise the national long-term services specs and HCSS. (KMW and contracts).	Q3

Health quality & safety (quality improvement) Actions for the upcoming year that BOPDHB considers to be the most important for improving quality, including the reasons why the action(s) are important and the expected impact. **Spreading hand hygiene practice** **Improving equity** **Improving Consumer engagement** **Zero Seclusion, National Mental Health & Addiction Quality Improvement Programme (for Bay of Plenty, Canterbury, Nelson Marlborough, Northland and Waikato DHBs only).**	
Action(s) (include one action and milestone per row)	**Milestone(s)**
BOPDHB will follow the Hand Hygiene NZ programme to improve hand hygiene practice. Strategies and improvement methodologies for 21-22 include: • Update and refresh the Hand Hygiene communication plan • Continued audits • Contribute to national patient safety initiative • Regular promotion through the CE newsletter • Professional leads working with staff around education • Online hand hygiene course at BOPDHB • Using the auditing outcomes to inform which specialties need ongoing support around	Q1-Q4
Improving Consumer engagement BOPDHB will progress the implementation of the quality and safety marker (QSM) for consumer engagement by: Continuing to support the governance group (or oversight group) of staff and consumers guiding implementation of the marker. Report against this QSM twice-yearly via the online form on the Commission's website using the SURE framework as a guide[30].	Q1 & Q3
Improving equity	

[30] A report against the maturity matrix in the QSM has been drafted for consideration by the governance group.

BOPDHB will review the diabetes health pathway for Māori, along with the Kaupapa Māori Hauora.	Q3
The BOPDHB is committed to the HQSC work and has convened a project team to drive the reduction of seclusion. The project team includes members from Te Pou Kokiri, a Consumer advocate, Nursing, Health Care Assistant and Allied Health with a focus on Māori. (EOA)	Reporting through mental health section

Te Aho o Te Kahu – Cancer Control Agency

Te Aho o Te Kahu is a stand-alone departmental agency hosted by the Ministry of Health reporting directly to the Minister of Health. These new arrangements provide the foundations for strong central leadership and oversight of cancer control, and better recognise the impact that cancer has on the lives of New Zealanders.

Te Aho o Te Kahu is equity-led, knowledge driven, person and whānau-centred and outcomes focused, taking a whole-of-system focus on preventing and managing cancer. Our commitment to the goal of achieving equity is central in all Te Aho o Te Kahu processes and work programmes.

Cancer is the leading cause of death in New Zealand and presents unique challenges to the health system. The number of people diagnosed with cancer is projected to double in the next two decades, the costs and complexity of care and the pace of change present major challenges for our system and services. Cancer survival is improving in New Zealand, but our rate of improvement is slower than other comparable countries, so we are at risk of falling behind.

When diagnosed with cancer, survival is poorer for Māori than for non-Māori. Te Aho o Te Kahu is committed to an equity first approach to our work. This will ensure improved health outcomes for those disadvantaged.

DHBs are required to monitor the impact of COVID-19 on cancer diagnostic and treatment services and use this information to plan and manage service volumes. In the event of a resurgence of COVID-19, DHBs are required to implement the guidance developed by Te Aho o Te Kahu on service delivery expectations at each of the hospital alert levels to ensure minimal impact on cancer patients.

It is expected that all actions and quality improvement resulting from the annual planning process will be inclusive of actions that improve outcomes for Māori, Pacific and those who are disadvantaged.

New Zealand Cancer Action Plan 2019 – 2029

The New Zealand Cancer Action Plan has four main goals

1. New Zealanders have a system that delivers consistent and modern cancer care – He pūnaha atawahi
2. New Zealanders experience equitable cancer outcomes – He taurite ngā huanga
3. New Zealanders have fewer cancers – He iti iho te mate pukupuku
4. New Zealanders have better cancer survival, supportive care and end-of-life care – He hiki ake i te o ranga.

Te Aho o Te Kahu are responsible for setting the direction for change that delivers improved outcomes for New Zealanders. District Health Boards will have key responsibility for the successful achievement of these outcomes locally and regionally. Te Aho o Te Kahu also works closely with the Ministry of Health to ensure were there are synergies in our expectations of DHBs that these are aligned i.e. prevention strategies, tobacco control, screening services and palliative care.

New Zealanders have a system that delivers consistent and modern cancer care – He pūnaha atawahi

- To better understand the national provision of chemotherapy, Te Aho o Te Kahu is developing nationally agreed treatment regimens and associated data standards – the ACT-NOW project. This initiative will inform our knowledge of treatment delivery, identify issues relating to equity, and support resource planning and cost savings
    - To realise these gains, it is necessary that DHBs implement ACT-NOW data standards in their oncology e-prescribing systems and the ability to message data to a national repository.
- DHBs will implement cancer specific Health Information Standards Organisation (HISO) standards issued by the Ministry of Health, including but not limited to:
    - HISO:10038.4:2021 Cancer Multidisciplinary Meeting Data Standards
    - HISO: 10080:2021 Systemic Anti-Cancer Therapy Regimen Standard
    - And associated FHIR messaging standards (to be released 2020/2021) of service.

DHB Cancer Centres providing Radiation Oncology Services will work with Te Aho o Te Kahu Regional Hubs to contribute to, and implement the recommendations of, the national Radiation Oncology Service Plan.

New Zealanders experience equitable cancer outcomes – He taurite ngā huanga

Te Aho o Te Kahu has an equity first approach to improving health outcomes. It is expected that all deliverables against the annual planning process will be demonstrate inclusive actions to improve outcomes for Māori, Pacific and those who are disadvantaged.

New Zealanders have fewer cancers – He iti iho te mate pukupuku

Preventing cancer is the best strategy for controlling cancer and reducing inequities. It is estimated that around 40 percent of health loss from cancers is potentially preventable. The modifiable risk factors can be influenced by socioeconomic and physical environments.

(Te Aho o Te Kahu will work in partnership with the related MOH – Population Health, Public Health and National Screening Unit - to support the delivery and evaluation of these programmes – separate actions and reporting is not required in this section)

New Zealanders have better cancer survival, supportive care and end-of-life care - He hiki ake i te o ranga

Te Aho o Te Kahu is committed to work in partnership with DHBs to undertake quality improvement (QI) activities to address unwarranted variation in cancer care. Quality Performance Indicators (QPIs), both existing and yet to be developed, that measure performance against best practice, will be the foundation for improvement activity.

Te Aho o Te Kahu will develop tumour specific Quality Improvement Action Plans. DHBs are expected to use these plans as guides for their quality improvement activity and, where appropriate, Te Aho o Te Kahu will support them to do this. For example, where DHBs perform poorly against the national average, remedial action to address unwarranted variation is expected. Te Aho o Te Kahu expects DHBs to develop or evolve existing clinical practice to ensure continuous improvement in their QPI results. It is also expected that DHBs will maintain their performance against any indicators where they perform well or highly. Opportunities for improvement are to be developed utilising the national cancer QPI monitoring reports, the national QPI action plans and internal DHB quality systems. Where relevant, DHBs will align their improvements with actions undertaken to improve performance in screening services i.e. bowel, breast, cervical. Additionally, DHBs will ensure their improvement activity demonstrates effective engagement with Māori, Pacific, DHB Consumer Councils and other key stakeholders. As part of the development of the national QPI programme, Te Aho o Te Kahu expects that DHBs will support clinician participation in the appropriate tumour-specific quality forums.	
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

BOPDHB will work with Kathleen Kilgour Centre and Te Aho o Te Kahu Regional Hub to contribute to and implement the recommendations of the national Radiation Oncology Service Plan, and ensure that the model of service is fit for purpose to meet the current and future needs of the region that they provide services to.	Q4 Joint planning initiated and TOR agreed
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 hui 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) • BOPDHB will scope a Telehealth Oncology initiative if prioritised, once the Telehealth Sustainability Team has been recruited (Planned Care Section) (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[31] (KOETI) community-based programme for Māori by Māori lead by Cancer Society. (EOA)	Q4 (or as soon as Te Aho o Te Kahu have reported to DHBs) 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: • Tobacco Control • Reducing Alcohol Related Harm • Healthy Food & 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: • 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	

[31] Delivered by the Cancer Society

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). • BOPDHB will review and improve end of life care alongside the palliative care improvement programmes and within the Acute flow project[32]. • 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) • BOP DHB will review stoma closure and implement improvements as required	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)	Q1-Q4

[32] Optimal End of Life Care – this workstream will enhance work underway in two key areas: advanced care planning and palliative care in the community with a specific focus on reducing admissions and re-admissions for people at the end of life.

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.

Note: DHBs should report quantitative data under the SS15 Improving waiting times for colonoscopies framework. DHBs should provide qualitative narrative to support SS15 performance reporting here.

Note: DHBs preparing to implement the bowel screening programme should report onboarding progress via the readiness process.

Action(s) (include one action and milestone per row)	**Milestone(s)**
BOPDHB will continue to optimise colonoscopy delivery, to meet the MOH targets for access by Q3.	Q3

Participation rates for bowel screening priority population groups are at least 60% (EOA) AND An overall participation rate of at least 60% in the most recent 24-month period (EOA) Bowel screening indicator 306 is consistently met.	Q1-Q4
BOPDHB will complete an Equity Engagement plan for the National Bowel Screening Programme. (EOA)[33] BOPDHB are currently finalising the Equity Plan (how we will engage priority populations - Maori, Pacific, and Dep 9 & 10 communities in the NBSP), and the Outreach Plan (how we will follow up priority populations who have not engaged in the NBSP), for Governance Group sign off prior to our readiness assessment by the MoH on 31/8 and 1/9. (EOA)	Q2 Sign off by governance group November 2021
Lakes and BOP DHBs will continue to implement and report progress against Bowel Cancer Service Improvement Plan (Bowel Cancer Quality Improvement Plan, 2020; Bowel Cancer Quality Improvement Report, March 2019).	Q2
Lakes and BOP DHBs will revise and update the Bowel Cancer Quality Service Improvement Plan following publication of the second national bowel cancer QPI.	Q4
BOPDHB are implementing activities to ensure people waiting over maximum will have received their colonoscopy and meet regularly with MoH to: • Outsourcing of additional colonoscopy capacity to address wait times for colonoscopy (goal 215 colonoscopies delivered at private facilities per month) • Management of waiting list to reduce numbers of patients waiting beyond maximum time for surveillance and non-urgent colonoscopy / quarter • Submission of twice monthly recovery plans to MOH NBSP team with updated performance indicators	Reported through MOH NBSP providing a twice a month (recovery plan) report to MOH outlining performance and initiatives being used to achieve MOH CWTI.

[33] Te Pare ō Toi are leading this work for the BOPDHB

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.	
Action(s) (include one action and milestone per row)	**Milestone(s)**
BOPDHB have established forums such as Bipartite, Joint Clinical Council and joint project steering committees (for example Holidays Act Project, Pay Equity Project), and will engage with union organisers, and delegates to drive or develop new initiatives to increase workforce flexibility and mobility in order to respond to COVID-19. **COVID-19 and BOPDHB workforce:** BOPDHB will use established forums for Union engagement during times when there are community outbreaks and/or level changes weekly Union forums are offered until all parties agree these weekly forums are no longer needed. BOPDHB will appoint a lead to manage the workforce component for COVID 19 response. This position will also establish a community forum with Union partners to ensure these conversations are collaborative and supportive.	Q1 & Q4
As a Te Tiriti organisation the BOPDHB ensures recruitment into leadership roles, assessing equity and cultural competence are integral to our recruitment practices.	Q1 & Q4 Establishing metrics will be undertaken to track demographic representation in leadership roles
Diversity: BOPDHB will Increase diversity of representation in leadership/decision-making roles through: The appointment of a Talent Acquisition Lead to increase diversity, equity and innovation across the organisation, including that off leadership recruitment.[34]	Q2
BOPDHB offer the cultural and Te Tiriti o Waitangi training for all staff, and all primary and community providers contracted by BOPDHB. BOPDHB will review feedback from attendees of the Tiriti o Waitangi and Unconscious Bias/Institutional Racisms courses, to ensure training is meeting the needs of the workforce.	Q4 16 Sessions per year held with approximately 500 attendees.

[34]The health reforms have created some uncertainly in how this space will be supported and managed in the new world of health NZ.

BOPDHB have engaged a Workforce Wellbeing Co-ordinator and completed a needs assessment/survey in the Eastern BOP region, with plans to conduct a similar process in the western BOP. This work will derive an action plan to be delivered and monitored following implementation.	Q1 & Q4 Action plan developed
BOPDHB are ensuring work health and safety by adhering to policy and Setting annual strategic health and safety objectives and targets, which form part of the business plan, to measure and monitor health and safety performance.	Q4
BOPDHB are working with Iwi groups as part of the BOPDHB Equity vaccination plan to sustainably build and support swabbing and vaccinator workforces. BOPDHB are running vaccinator clinics with Iwi staff supporting at the front line. BOPDHB have a COVID Immunisation Programme team running the full vaccination programme response for both the Eastern and Western BOP.	Q4
BOPDHB are addressing concerns related to workforces under pressure due to pandemic response/planning through onsite counselling, Resilience Training, EAP and personalised check-ins with the COVID team, and all DHB staff, from the wellbeing lead and dedicated communications encouraging the staff to access support. Workforce sustainability: The organisation is aware that there is a need to formalise both structure and strategy for the wellness, wellbeing and welfare of our people. BOPDHB will develop a formal business case to our Executive, identifying was it is to be developed, implement, and agreed for this space including a proposed structure and the required resourcing to ensure sustainability and delivery of wellness, wellbeing and welfare of our people.	Q4
Due to the sustained numbers of patients with high acuity and complexities arriving at our hospitals resulting in high occupancy levels, three areas of support for staff have been highlighted: • The newly created roles of Patient Flow Navigator Nurses to support frontline staff • A test of change where Transit Lounge hours have been extended • Supporting staff health and wellbeing in our hospitals.	Reported through Acute Demand
BOPDHB have significantly increased the ability of staff to 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, or where space is required for emergency or COVID planning.	Reported through Data and Digital

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.	
Action(s) (include one action and milestone per row)	**Milestone(s)**
Key actions that will digitally enable health services to support COVID-19 recovery, sustain changes to service delivery models and/or embed key learnings from your COVID-19 response: Telehealth projects are underway at the BOPDHB and referenced in various sections (Rural Health, Acute Demand, planned Care, Sustainability, Cancer Control) throughout this plan. Key projects to improve patient health pathways include: • Telehealth Sustainability – Video Consults workflow integration • Telehealth Sustainability – Action Plan • Telehealth Sustainability – Rural Connectivity • Implementation of an Enterprise Scheduling solution[35] • Implementation of an Electronic Shared Care planning solution[36]	Q2 & Q4 Workflow integration completed by 31 December 2021 Sustainability team and telehealth implementation plan completed by 31 March 2022
BOPDHB will recruit to a digital health equity lead, to work with Māori communities to enable training for awareness building from an equity perspective including digital security, data security, and utilisation of tools	Q4 Digital Health equity framework in place by 31 March 2022
BOPDHB will continue to focus on improving equity of access to health services through digitally enabled means by the implantation of the Rural Connectivity Project: • Establish infrastructure on Matakana and the surrounding motu(islands) to enable rural communities to have high quality internet and data connectivity, to support distance medicine (eg video consults). (EOA) (BOPDHB consider this to be the action with the most significant impact on improved outcomes).	Q4 Assessment of rural digital connectivity capability completed by 31 March 2021 Test of change in one Rural location completed between July 21- June 22. Q4
In alignment with the ICT plan, BOP and Lakes DHBs will work with Te Manawa Taki partners on the following projects:	Q2 & Q4

[35] Cross sector resource optimization to improve patient experience
[36] A significant local improvement towards continuity of care

Digital: • Medicines Management • Interoperability • Mental Health • InterRAI • Telehealth • Microsoft Compliance & technology updates • PACS/RIS • Identity/Access Management and Security Data: • Data exchange • Data Platform for Analytics and Insights	Reported by HealthShare on behalf of Te Manawa Taki.
BOPDHB have significantly increased the ability of staff to 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, or where space is required for emergency or COVID planning.	Q4

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.	
Action(s) (include one action and milestone per row)	**Milestone(s)**
BOBDHB will contribute expertise to the HRC funded project "Enhancing clinical trials in NZ" through the BOPDHB Research Manager being a Co-investigator.	Initial engagement with protocol design – Q2
Engage with PHOs in BOP region to discuss and develop a framework to support health research activities across primary care from 2021/22	Engage with CEO of PHOs – Q2

BOPDHB will undertake a review of current BOPDHB research policies to ensure they align with BOPDHB priorities, around Te Tiriti o Waitangi (EOA).	Complete review and report - Q4
BOPDHB will engage with external organisations and internal stakeholders to identify opportunities for participation in the delivery of health and disability research, including commercially sponsored clinical trials and collaborative research projects.	Undertake feasibilities for commercial trials throughout 2021 and report on status in Q4.

2.5.7 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) (include one action and milestone per row)	**Milestone(s)**
BOPDHB will undertake an evaluation (either internal or external) of the first two years of Health Care Home implementation by Western Bay of Plenty PHO, with a focus on the equity approach for Māori.	Q2 Evaluation complete and shared among key stakeholders. Any potential additional investment decisions made based on the evaluation outcomes.
Equity: 50% of General Practices engaged in the Health Care Home model of care will undertake at least two equity engagement and co-design projects. We know if patients are educated about their conditions (health literacy), and involved in treatment options, they are more likely to succeed in managing their chronic conditions.	Q4 50% of general Practices in the Health Care Home model of care have undertaken the equity and co-design projects.
Equity: 50% of General Practices engage in the Health Care Home model of care will participate in training to the standards within the Cornerstone equity module. This equity model is new and it builds on the RNZGPC work completed in the Foundation Standard to provide next steps towards delivering sustainable health equity outcomes being more targeted to individual and cultural needs that can make significant differences to patient and whānau care.	Q4 50% of general Practices complete in the Cornerstone equity module.
COVID-19 learning: The Community Care Coordination (CCC)[37] activity accelerated during COVID-19 lockdown, supporting GPs to respond to unmet need, avoid unnecessary admissions to hospital and to use our existing resources more efficiently. Work has intensified to establish a single point of entry for timely and coordinated care in the community for primary care. The CCC coordinates appropriate response to client care needs from GP referral, especially for clients with complex needs, where previously there was a need for several referrals for one client. This has previously led to duplication and fragmentation of service delivery.	Q4 the CCC will have developed a coordinated community service response for acute and complex needs and meet patients' needs closer to home. There will be a reduction in ASH rates and an increased and sustained uptake of referrals from Primary care into CCC[iii]. See Statement of Performance measure SS05.

[37] Community Care Coordination
CCC provide a single point of access for Primary Care to identify need and request coordination of community services. This means no declines, falling through gaps, duplication of service or long waits for triage from our community services. BOPDHB measure the number of non-complex wound care requests that are redirected to Primary care with the use of the non-complex wound care package.
During Covid-19 lockdown BOPDHB offered Primary Care the new option of requesting Short-term home help services, with wrap around assessment to reduce risk of an unnecessary admission to hospital. This is reflected in the uptake of this service. Whilst the intent was to prevent unnecessary admissions, there is no measure in place to monitor the overall impact on ASH rates at this stage.

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) (include one action and milestone per row)	**Milestone(s)**
BOPDHB and community pharmacy identified that there was a need for individual, clear, concise, and agreed pandemic planning to maintain staff and patient health as key to preparedness for ongoing changes in alert levels. BOPDHB will continue to work with BOP Community Pharmacy Group to maintain sector preparedness and ensure all community pharmacies have COVID-19 deep cleaning kits provided by the DHB.	Q2 & Q4 Pandemic plans are updated All community pharmacies have deep cleaning kits in preparedness for community outbreak.
BOP Community Pharmacy Group will maintain, with BOPDHB support, Communications to Community Pharmacies.	Q4 Maintained and updated every quarter and as necessary.
BOPDHB will work with BOP Community Pharmacy Group to maintain high numbers of pharmacist vaccinators which has increased for influenza and MMR vaccinating. Both parties agree that community pharmacy provides easy access for the public especially for Māori who utilise community pharmacy for additional services, especially rurally, well. BOPDHB will work with BOP Community Pharmacy Group to facilitate more timely pharmacist vaccinator training. This will assist in readiness for COVID-19 vaccinating. DHB will work with BOP Community Pharmacy Group to support pharmacies with resources to support local vaccination initiatives.	Q1-Q4 Each quarter maintain at least 40% community pharmacies providing influenzas and MMR vaccinations.
BOPDHB will maintain additional annual rural funding (part 3c) to rural community pharmacies in Opotiki and Edgecumbe and to those pharmacies servicing Murupara (increased investment 2020) and Tekaha to ensure the timely provision of medicines to rural areas via deliveries, depots and general practice stocks.	Q1-Q4 Each quarter rural funding (part c) remains in Eastern Bay of Plenty and for the population of Murupara.
BOPDHB will continue to support, both financially and clinically, the new Pharmacy Kiri Ora Pilot Project introduced in community pharmacies located in Eastern Bay of Plenty and TePuke, throughout 2021-22.	Q1-Q4 Each quarter the skin lesion initiative remains supported financially and clinically.

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

DHBs are expected to actively support and participate in the above project, led by the National Ambulance Sector Office (NASO).
More information is available here.

Action(s) (include one action and milestone per row)	**Milestone(s)**
Lakes and BOPDHBs 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 BOPDHBs 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.	Operational reports from central tasking team.

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[38] System outcome to support the priority area: We live longer in good health.	
Action(s) (include one action and milestone per row)	**Milestone(s)**

[38] 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).

BOPDHB will continue to fund Green Prescription for adults, active families for children and Te Hihiko (a kaupapa Māori healthy lifestyle service for children 0-18 years and their whānau). The main referral pathway will be via General Practice and will include referees with long term conditions.	Q4 Green Prescription referrals will be a minimum of 2977 by quarter 4.
COVID-19 learning (see primary care section CCC).	(see primary care section CCC).
Keeping Me Well is a new model of care concept focussing on integration, wellbeing using allied health and nursing resource to support general practice. There are two proof of concept tests underway. The first focusses on locations with high Māori populations and rural populations with limited access to secondary services. This concept uses allied health staff, placed with a kaupapa Māori community health team, trained in hui and wayfinding to work collaboratively existing teams in the local community. The service provides enablement programmes within client's homes. The second concept, in TePuke, is providing services within the community for clients with long term conditions, in their homes, e.g. respiratory physiotherapy, heart failure Nurse Practitioner clinics in general practice and vestibular rehabilitation. These services prevent the 40-minute drive to Tauranga Hospital and reduces DNAs. The use of wayfinding links accesses those hard to reach in the population. [39]	Q1-Q4 Concept test 1: Quarter 2-train wider local community health staff in hui process and enablement approach. Complete an evaluation in quarter 3. Submit a business case in quarter 4 to operationalise the enablement model. Quarter 3: Expand services to include geriatric care within the local community. Quarter 4: complete "in reach" testing to facilitate successful hospital discharges. Quarter 2: Introduce Keeping Me Well into Eastern Bay. Quarter 4: Evaluate test sites to inform recommendations to expand and implement the model.
A primary care community hepatitis C update education session will be delivered annually.	Q4 A hepatitis C education session will be delivered by quarter 4.
BOPDHB will facilitate the formation of a local diabetes network in partnership with Diabetes NZ.	Q2 A diabetes network will be established and functioning by quarter 2.

[39] Concept test 1: Quarter 2-train wider local community health staff in hui process and enablement approach.
Complete an evaluation in quarter 3.
Submit a business case in quarter 4 to operationalise the enablement model.
Quarter 3: Expand services to include geriatric care within the local community.
Quarter 4: complete "in reach" testing to facilitate successful hospital discharges.
Quarter 2: Introduce Keeping Me Well into Eastern Bay.
Quarter 4: Evaluate test sites to inform recommendations to expand and implement the model.

2.6 Financial performance summary

BOPDHB has experienced a deteriorating financial position over recent years (the last breakeven position achieved was in 2016/17) linked to a range of challenges:

- revenue allocations not reflecting the impact of population change
- increasing cost of employment settlements (eg MECA's)
- the advent of new clinical treatments and/or pharmaceuticals to treat chronic conditions
- the increasing age, associated complexity and acuity of patients presenting for treatment
- increased capital investment costs (depreciation),
- increased compliance costs.

While the majority of these challenges are being felt by all DHBs, the gap between revenue allocation and fast-growing population has been a major contributor to the deterioration experienced by BOPDHB.

BOPDHB's Population Based Funding Formula (PBFF) revenue allocations for the three years 2017/18 to 2019/20 were static – despite the continually changing population demands. This movement has been recognised in the last two years 20/21 and 21/22 where significant adjustments to revenue were allocated.

PBFF Share of Total NZ	15/16	16/17	17/18	18/19	19/20	20/21	21/22
BOPDHB	5.55%	5.61%	5.61%	5.62%	5.61%	5.99%	6.02%

However, due to limitations within the PBFF model, the adjustments of the last two years have been subject to revenue caps of $37m and $26m respectively – reflecting the model's limitation when addressing fast growing populations.

BOPDHB understands the financial pressure on the health system and is working to ensure it is as efficient as it can be for the services it funds and delivers. However, the imposition of the revenue caps across the last two years totals approximately $63m and contributes markedly to the ongoing deterioration in the BOPDHB's financial position.

In addition to the ongoing issue of acute service demands, the burden of chronic disease arising from a growing and ageing population is being felt in significant cost growth. For example, cancer service costs and cardiology service costs in particular, as new technologies and medications enable people to live with chronic disease for longer.

Annual Plan Budget Financials

It is in this environment that the BOPDHB puts forward its operating budget for 2021/2022 that reflects a deficit and a continued erosion of the DHB's financial position. The BOPDHB submits a budget deficit of $30.7m for 2021/2022 which reflects a continuation of widening deficits over the last four years. While every effort has been made to reduce costs to align with funding, the budget must be a realistic reflection of the cost required to safely deliver the health services required by the population, meet our Te Tiriti commitments and transition the DHB to Health NZ in sustainable state.

In arriving at this deficit forecast a number of key assumptions have been made, along with consequent associated risk:

- Revenue growth has been based on the Funding Envelope (FE) provided in May 2021 with outyears based on FE indications. Historic issues with population estimates have impacted the revenue allocation and therefore the resources available to meet the growing levels of acute and planned care demand.

- Health service pricing adjustments agreed at national level have been included – despite the fact that the revenue caps mean the 21/22 pricing uplifts for BOP have been eroded. This decision reflects the fact that financial pressures are not restricted to crown owned services. Primary and community providers are struggling to deliver required services within the publicly funded revenue streams, hence nationally agreed pricing adjustments must be passed on.
- Demographic revenue growth has been partially withheld to fund service change aimed at reducing acute demand. This imposes some risk around those service areas that have traditionally grown at rates higher than demographic growth:
    - Health of Older People - aged residential care services, home based support services, packages of care
    - Secondary care services – acute care, oncology and cardiology services
    - Level of services provided to Bay of Plenty residents out of the district.
- In line with Government expectations around pay restraint, increases for unsettled employment agreements have been assumed at 1.5% for 2021/22.
- Internal DHB services have been budgeted at levels that reflect continuing pressures from:
    - Ongoing tension between achieving waiting time expectations, access thresholds, acute demand and financial constraints
    - The requirement and duty of care to deliver safe and efficient / effective care within constrained budgets
    - The need to determine and provide an appropriate level of staffing at every clinical interface that enables us to be fair and reasonable to our staff and reduces the risk of staff harm
- Delivering ongoing procurement savings through national and regional arrangements.
- Managing the cost impacts of new medications and technologies for chronic condition treatment within budgeted cost structure

While the current assumptions include assumed costs associated with the Holidays Act remediation programme, these remain estimates and are subject to the findings of the completed programme.

Given the continuing projected deficit position, challenges are faced around the BOPDHB's projected cash position across the financial year and it is expected to end the projected period at $15.5m negative. Given the financial deterioration, BOP will be making regular use of cash flow support in terms of the Treasury Services Agreement with New Zealand Health Partnerships Limited and is at high risk of breaching those credit facility limits. Accordingly BOPDHB will be signalling a need for shareholder assistance during the year.

Outyear Assumptions

Revenue contained in forecasts/projections is based where possible on information supplied by the Ministry and otherwise on assumptions pending formal funding advice. The forecast for 2021/22 contains actual results till May 202 2and the forecasted result of June 2021. The outyear projections are based on simplified assumptions and use Ministry projections for demographic growth and current CPI where possible and appropriate. This is not considered a forecast in that it lacks a level of detail and is not necessarily representative of BOPDHB's expectations for those years.

Revenue

The projected Crown Revenue figures have been calculated using the Ministry methodology for the PBFF funding envelope of 2021/22.

The funding pool is assumed to be the prior year funding with an uplift equal to the Ministry's projected demographic growth of 1.96%, 1.93% and 1.99% for the years 2022/23, 2023/24 and 2024/25 respectively plus 2% for CPI each year. This figure is then adjusted for min/max rules.

BOPDHB's share of the pool is assumed to be the Ministry's projected PBFF % for those years being 6.02%, 6.03% and 6.05%.

The cap on funding is then applied. Top Slice funding is assumed to be the same each year, in reality any change in Top Slice funding will be offset by an equal and opposite movement in expenses, so this is a reasonable assumption.

All other Crown Revenue has been assumed to increase at a rate of 6.3% in line with recent trends.

Other Revenue is projected to increase in line with the Ministry's assumed demographic growth for BOP, being 2.1%, 2.1% and 2.3% plus 2% for CPI each year.

Salary & Wages

Salary & Wages is projected to increase at the same rate as total revenue. The basis for this assumption is that increased funding should be reflective of the increasing cost of delivering health services to the population and the volume pressures we face. We assume that the cost funding pressure will be mirrored in staff expenses and that volume will need to increase in line with the growing population volume, it follows that the increase in funding is a good approximation for the increase in salary costs we are likely to see. This is subtlety different than just applying a volume and price increase given the complexities of the funding calculation.

Other Expenses

All other expenses are projected to grow in line with the Ministry's assumed demographic growth for BOP, being 2.1%, 2.1% and 2.3% for years 2022/23 to 2024/25. We have also applied a CPI adjusted of 2% each year. This assumption is over simplified, as the needs of the population change the mix of services will also change and this can have a large impact on the expense budget but given the information available at this time the assumptions used appear to be reasonable.

Capital Expenditure Forecast

BOPDHB faces a number of issues with regards to Capital Expenditure and the budget allocated for 2021/22 and the following years is designed to bring the DHB's asset management of existing assets into a position which is sustainable and reduces any risk to patient safety. The budget does not allow for any significant investment in new buildings or infrastructure or to address any emergency situations requiring capital investment. If these needs eventuate it would require postponing replacement of clinical equipment past end of life, external funding, an increase in budget or a combination of these options. The Master Campus Plan is expected to be completed in the upcoming financial year and this will have a large impact on the expected capital expenditure going forward.

Balance Sheet Forecast

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

- The outyear projections assume creditor and debtor days will remain consistent, for example creditors will continue to be paid within 10 days.
- Inventory is assumed to increase in line with the Ministry's projected volume growth for BOPDHB.
- Employee entitlements and payroll accruals are assumed to grow in line with Salary & Wages expense.

- The net book value of fixed assets will go up over the annual plan period as a result of resolving an existing backlog of clinical equipment past useful life, addressing building and infrastructure issues and investment required in IT to meet the requirements of the DHB for day to day functionality and digital enhancement.
- Short term fluctuations in cash will continue to be managed through the sweep arrangement with NZHPL. There are significant concerns about the DHB's ability to live within the limits of the overdraft facility. This concern is heightened by an expectation this concern is shared by other DHBs, given that the sector shares an overdraft facility with an expectation that negative balances will be offset by positive balances elsewhere. If several DHBs are overdrawn at the same time this may impact the ability of the facility to meet the sectors needs.
  The cash balance is effectively a balancing figure once other changes and the assumed deficits are factored in.
- No equity injections have been assumed in the annual plan, however both the projected cash position of the DHB and the known issues which require capital expenditure over and above the current capital budget suggest equity injection are likely to be needed.

PROSPECTIVE STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2022, 2023, 2024, 2025

	2019/20 Actual	2020/21 Forecast	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan
ASSETS	$'000	$'000	$'000	$'000	$'000	$'000
Current Assets						
Cash and Cash Equivalents	2,430	9	10	-	-	-
Debtors & Other receivables	34,634	39,498	31,872	44,999	47,665	50,339
Prepayments	1,424	2,201	2,297	2,297	2,297	2,297
Inventory	3,134	3,133	3,249	3,316	3,461	3,461
Total Current Assets	**41,622**	**44,841**	**37,428**	**50,612**	**53,423**	**56,097**
Non Current Assets						
Property, Plant & Equipment	314,901	409,624	411,701	410,885	408,950	405,792
Intangible Assets	4,551	15,967	15,794	15,270	14,602	13,777
Investment in Joint Ventures / Associates	2,332	2,209	2,086	1,966	1,836	1,706
Total Non Current Assets	**321,784**	**427,800**	**429,581**	**428,121**	**425,388**	**421,275**
TOTAL ASSETS	**363,406**	**472,641**	**467,009**	**478,733**	**478,811**	**477,372**
LIABILITIES						
Current Liabilities						
Cash and Cash Equivalents	-	15,495	53,587	69,678	77,368	80,398
Trade & Other payables	47,888	55,810	41,831	49,732	45,060	38,871
Employee Benefits	61,711	64,911	66,002	69,881	74,688	79,494
Total Current Liabilities	**109,599**	**136,216**	**161,420**	**189,291**	**197,116**	**198,763**
Non Current Liabilities						

Employee Benefits	1,682	1,682	1,657	1,657	1,657	1,657
Term Loans	302	250	194	137	80	24
Total Non Current Liabilities	**1,984**	**1,932**	**1,851**	**1,794**	**1,737**	**1,681**
TOTAL LIABILITIES	**111,583**	**138,148**	**163,271**	**191,085**	**198,853**	**200,444**
NET ASSETS	**251,823**	**334,493**	**303,738**	**287,648**	**279,958**	**276,928**
EQUITY						
Crown Equity	223,269	224,059	224,059	224,060	224,060	224,060
Reserves	87,215	193,502	193,502	193,502	193,502	193,502
Retained Earnings	(58,661)	(83,068)	(113,823)	(129,914)	(137,604)	(140,634)
TOTAL EQUITY	**251,823**	**334,493**	**303,738**	**287,648**	**279,958**	**276,928**

Land and Building revaluations

A full revaluation of land and buildings took place for the year ended June 2021. This had a significant impact on the 2020/21 balance sheet, and the revaluation of $108m has been included in the 2021/22 budget. BOPDHB note that we are not required to undertake a full revaluation when the DHB transfers to Health NZ and no revaluations have been assumed in the outyear projections.

PROSPECTIVE COMPREHENSIVE REVENUE AND EXPENSE FOR THE YEAR ENDED 30 JUNE 2022, 2023, 2024, 2025						
	2019/20 Actual $'000	**2020/21 Forecast** $'000	**2021/22 Plan** $'000	**2022/23 Plan** $'000	**2023/24 Plan** $'000	**2024/25 Plan** $'000
Revenue						
Ministry of Health Revenue	857,837	942,831	1,005,846	1,074,320	1,136,535	1,194,597
Other Government Revenue	28,747	33,182	33,135	32,718	34,587	36,584
Other Revenue	9,616	8,665	6,288	7,415	7,719	8,051
Total Revenue	**896,200**	**984,679**	**1,045,269**	**1,114,453**	**1,178,840**	**1,239,232**
Expenditure						
Employee Costs	312,346	331,155	354,396	376,449	401,497	423,472
Outsourced Costs	37,897	57,424	52,835	55,295	57,581	60,057
Clinical Supplies	74,093	80,811	86,288	90,262	93,962	98,003
Infrastructure	78,372	79,281	93,784	99,688	103,776	108,238
Non-Health Board Provider Payments						
Personal Health	186,875	205,850	219,913	225,988	235,253	245,369
Mental Health	23,630	26,324	31,165	35,476	36,931	38,519
Disability Support	122,111	127,104	136,005	141,582	147,386	153,724
Public Health	7,125	6,124	2,964	3,085	3,212	3,350
Maori Health	4,965	5,746	5,483	5,708	5,942	6,198
Other District Health Boards	82,462	89,267	93,190	97,011	100,989	105,331
Total Expenditure	**929,876**	**1,009,086**	**1,076,024**	**1,130,544**	**1,186,530**	**1,242,262**
Surplus/(deficit)	**(33,676)**	**(24,407)**	**(30,755)**	**(16,091)**	**(7,690)**	**(3,030)**

PROSPECTIVE COMPREHENSIVE REVENUE & EXPENSE BY DIVISION FOR THE YEAR ENDED 30 JUNE 2022, 2023, 2024, 2025						
	2019/20 Actual $'000	**2020/21 Forecast** $'000	**2021/22 Plan** $'000	**2022/23 Plan** $'000	**2023/24 Plan** $'000	**2024/25 Plan** $'000
Provider Arm	(44,143)	(25,753)	(20,740)	(34,200)	(45,162)	(51,543)
Governance	1,127	(2,576)	27	333	648	766
Funds	9,340	3,922	(10,042)	17,776	36,825	47,748
TOTAL	**(33,676)**	**(24,407)**	**(30,755)**	**(16,091)**	**(7,690)**	**(3,030)**

PROSPECTIVE COMPREHENSIVE REVENUE AND EXPENSE BY OUTPUT CLASS
FOR THE YEAR ENDED 30 JUNE 2022, 2023, 2024, 2025

Output Class	2019/20 Actual $'000	2020/21 Forecast $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
Early Detection						
Total Revenue	244,022	259,754	275,737	293,987	310,972	326,903
Total Expenditure	253,192	266,192	283,850	298,232	313,001	327,703
Net Surplus / (Deficit)	**(9,170)**	**(6,438)**	**(8,113)**	**(4,245)**	**(2,028)**	**(799)**
Rehabilitation & Support						
Total Revenue	157,151	165,594	175,784	187,418	198,247	208,403
Total Expenditure	163,056	169,699	180,956	190,125	199,540	208,912
Net Surplus / (Deficit)	**(5,905)**	**(4,105)**	**(5,172)**	**(2,706)**	**(1,293)**	**(510)**
Prevention						
Total Revenue	11,985	12,074	12,817	13,665	14,455	15,196
Total Expenditure	12,436	12,373	13,194	13,863	14,549	15,233
Net Surplus / (Deficit)	**(451)**	**(299)**	**(377)**	**(197)**	**(94)**	**(37)**
Intensive Assessment & Treatment						
Total Revenue	483,045	547,257	580,931	619,382	655,166	688,730
Total Expenditure	501,196	560,822	598,024	628,325	659,440	690,414
Net Surplus / (Deficit)	**(18,151)**	**(13,565)**	**(17,093)**	**(8,943)**	**(4,274)**	**(1,684)**
Consolidated Surplus / (Deficit)	**(33,677)**	**(24,407)**	**(30,755)**	**(16,091)**	**(7,690)**	**(3,030)**

PROSPECTIVE STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2022, 2023, 2024, 2025

	2019/20 Actual $'000	2020/21 Forecast $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
CASHFLOW FROM OPERATING ACTIVITIES						
MOH & other Government / Crown	884,044	967,217	1,045,567	1,093,911	1,168,456	1,228,507
Other Income	8,875	8,110	7,244	7,309	7,627	7,955
Total Operating Cash inflow	**892,919**	**975,327**	**1,052,811**	**1,101,220**	**1,176,083**	**1,236,462**
Cash was applied to						
Payments for Personal	(293,533)	(324,808)	(353,331)	(372,549)	(396,691)	(418,666)
Payments for Supplies	(155,436)	(186,314)	(188,644)	(197,032)	(205,205)	(216,175)
Capital Charge Paid	(15,249)	(12,207)	(16,754)	(17,441)	(18,156)	(18,937)
Net GST paid	659	(454)	153	0	0	0
Payment to Providers & other DHB's	(429,617)	(450,140)	(502,854)	(500,950)	(534,386)	(556,384)
Total Operating Cash Outflow	**(893,176)**	**(973,923)**	**(1,061,430)**	**(1,087,972)**	**(1,154,438)**	**(1,210,162)**
NET CASHFLOW FROM OPERATING ACTIVITIES	**(257)**	**1,404**	**(8,619)**	**13,248**	**21,645**	**26,300**
INVESTING ACTIVITIES						
Cash was provided from						
Interest Revenue	774	221	64	67	70	73
Proeeds from Sale of Fixed Assets	88	128	20	21	22	23
Increase in Investments and Restricted & Trust Funds Assets	25	0	0	0	0	0
Total Investing Cash Outflow	**887**	**349**	**84**	**88**	**92**	**96**
Cash was applied to						
Capital Expenditure	(19,477)	(20,400)	(29,500)	(29,380)	(29,370)	(29,370)
NET CASHFLOW FROM INVESTING ACTIVITIES	**(18,590)**	**(20,051)**	**(29,416)**	**(29,292)**	**(29,278)**	**(29,274)**
FINANCING ACTIVITIES						
Cash was provided from						
Capital contributions from the Crown	0	788	0	0	0	0
Cash was applied to						
Payments of principal for finance leases	0	(57)	(57)	(57)	(57)	(57)
NET CASH FLOW FROM FINANCING ACTIVITIES	**0**	**731**	**(57)**	**(57)**	**(57)**	**(57)**
NET CASH INFLOW/ (OUTFLOW)	**(18,847)**	**(17,916)**	**(38,092)**	**(16,101)**	**(7,690)**	**(3,031)**
NET CASH FLOW						
Cash & Cash Equivalents at beginning of year	**21,277**	**2,430**	**(15,486)**	**(53,577)**	**(69,678)**	**(77,368)**
Cash & Cash Equivalents at end of year	**2,430**	**(15,486)**	**(53,577)**	**(69,678)**	**(77,368)**	**(80,398)**

SECTION THREE:

3.1 Service Configuration

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. BOPDHB 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 BOPDHB 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 2021/22.
BOPDHB 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.

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	Local	
Community Dental	BOPDHB will reconfigure the BOPDHB Community Dental Service in a COVID-19 environment, with an equity first approach will ensure priority scheduling for Māori and Pasifika children and adolescents, and then those with clinical urgency[40]. Additionally, the design and delivery of the oral health service will be actively monitored by ethnicity.	Improved access, reduced inequity, reduction in Dental ASH rates	Local	Nil
Cardiology	Opening of second Cath Lab to accommodate district volume growth.	Increased access to cardiology services and address inequity issues, adding critical capacity to the Te	Regional	1 FTE

[40] Emergency or urgent dental needs, those currently receiving treatment, those most overdue and those in their final year at intermediate school.

		Manawa Taki regional cardiology network		
Bowel Screening	Commencement of Bowel Screening Services.	Increased screening capability	Local	2.2 FTE
Radiotherapy service planning	Development of an optimal regional service and investment plan in the radiotherapy treatment of cancers.	Improved regional access, financial and clinical sustainability	Regional	
Disability confident employer status	Reorient service provision at a subregional 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	Subregional	Shared disability sector project support with Bay of Plenty DHB to develop plan – implementation to BAU teams
Community wellbeing	BOPDHB, in partnership with Kainga Ora, will be progressing the business case development of a multi-agency wellbeing centre on the Tauranga Hospital site.	Reduced load on secondary level services in a significantly changed model of holistic, wraparound case for our vulnerable populations.	Local	
Eastern Bay Wellbeing Network	The DHB, the BOP Health System Runanga and Eastern Bay PHA have agreed to the joint creation of the Eastern Bay of Plenty Wellbeing Network. This will progress during 21-22 in partnership with Eastern Bay Iwi, state sector services linked through the Waiariki Leadership group and local councils. Underneath this, 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. Turangi sits under the Lakes DHB area currently and therefore BOPDHB and Lakes DHB will work together with the Waiariki Leadership Group in these developments.	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 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.	Local	Possibly some additional project specific support but will be within System Implementation Resource (SP&F)

Papamoa growth development	Locality based health services hub in Papamoa area to serve rapidly growing population.	Improved access, reduced inequity, Improved community based co-ordinated health services.	Local	
Midland Clinical Portal Service Change	Potential transfer of Te Manawa Taki Clinical Portal IT maintenance, support and development functions to BOPDHB	System sustainability, support and ongoing development	Subregional	Circa 10FTE (Cost Neutral)
Health Māori Quality and Safety Coordination	Current fixed term role, to be implemented as a defined position. Focused and deliberate response to Māori health quality, safety and risk activity. Linked to Nga Au Rangi, expectations of Te Toi Ahorangi and DHB strategic intentions around culturally safe quality management and delivering against equity KPIs.	Equity improvements, upholding Tiriti partnership, improved quality & safety.	Local	1 FTE

INDICATIVE STAFF MOVEMENT - SUMMARY

	Medical Personnel	Nursing Personnel	Allied Health Personnel	Support Personnel	Management/Administration Personnel	Indicative Total Movement FTEs (Rounded)
19/20 Actual FTE June 2020	**385.2**	**1,312.4**	**549.8**	**120.8**	**554.4**	**2,922.5**
	38.3	94.1	34.3	3.8	23.7	**194.2**
	-	-	-	-	-	**-**
	-	-	-	-	-	**-**
	-	-	-	-	-	**-**
	-	-	-	-	-	**-**
	-	-	-	-	-	**-**
20/21 Forecast Full Year Average FTE	**423.5**	**1,406.4**	**584.0**	**124.7**	**578.2**	**3,116.8**
Annualisation of roles commenced prior year	1.5	9.8	1.6	(2.7)	3.6	**13.8**
Capacity demand	14.4	3.4	-	-	4.1	
Capital and projects - excluding Holidays Act	-	1.0	17.7		3.8	**22.5**
Holidays Act project fte	-	-	-	-	-	**-**
Incremental CCDM compliance FTE	-	20.4	-	-	-	**20.4**
Insourcing /Outsourcing movement	0.5	-	-	-	-	**0.5**
Mental Health specifically funded additional FTE	-	-	-	-	-	**-**
Ministry programme (excluding Covid related) Additional FTE						

Other New services	5.8	9.4	7.1		0.5	
RMO MECA Compliance	-	-	-	-	-	-
SMO MECA compliance	13.0					
Other MECA Compliance	5.5		5.8			
Support Services	-	-	-	1.4	-	**1.4**
Vacancies (Over Recruitment)	-	-	-	-	-	-
Impact of Efficiencies	-	(0.8)	0.1	-	-	**(0.8)**
Other	-	(0.3)	-		-	**(0.3)**
Supernumery New Graduates (NetP and RMO)	-	-	-	-	-	-
COVID-19 (e.g. MIQ, vaccination workforce)	-	-	-	-	-	-
INDICATIVE MOVEMENT FTEs - NET As submitted in 21/22 February Draft Annual Plan	**464.1**	**1,449.2**	**616.3**	**123.4**	**590.2**	**3,243.2**

SECTION FOUR: Stewardship

This section outlines the BOPDHB's stewardship of its assets, workforce, IT/IS and other infrastructure needed to deliver planned services.

As part of their stewardship role DHBs have statutory responsibilities to improve, promote and protect the health of people and communities.

4.1 Managing our Business

To deliver on the functions required as a DHB, the BOPDHB has a broad set of responsibilities and interacts with a diverse range of individuals and groups. To be as effective as possible, the BOPDHB must have capable leadership, an engaged workforce, a healthy organisational culture, sound relationships, robust and rigorous systems and the right infrastructure and assets. This section describes the resources necessary to provide the services of the BOPDHB.

a) Risk management

BOPDHB approach to risk identification has historically had an operational, rather than strategic focus The DHB proposes to build a structured risk management and assurance programme and culture that recognises risk as an integral part of "doing business" across all our functions. The proposed approach centres on a risk framework and assurance programme that integrates strategic objectives, dedicated resources, organisation wide risk assessment processes and proactive governance. The goal is an interconnected, organisation wide framework and assurance programme approved and reviewed at governance and executive management levels

b) Quality assurance and improvement:

In 2019-20 BOPDHB began a journey to improve connectedness between our Clinical Governance function, our Service Improvement Team, patient safety teams and risk management. During the year, investment has been made into new Clinical Governance leadership positions and our Service Improvement Team is now no longer solely a Provider Arm function but is evolving as a whole system improvement function. In the year ahead the DHB is aiming to link these developments, driven by health intelligence data and community feedback, to broaden our approach to quality assurance and continuous quality improvement.

Within the scope of this developing area, linking with our primary care partners, the DHB is aiming to evaluate its quality management (QMS) model including incident, customer feedback, risk management and improvement systems and mechanisms.

c) Investment and asset management

The BOPDHB lodged its second LTIP with Ministry of Health in October 2019. This was approved and fully supported by the BOPDHB's board of directors, particularly due to the significant strategic importance this plan will play in ensuring that the BOPDHB workforce continues to be a key enabler in delivering health care services to the Bay of Plenty region over the next 10 years.

Following capital requirement submissions to Ministry of Health at the start of 2020, BOPDHB has been informed that there has been a preliminary allocation of $45m to fund the replacement of the Mental Health facilities at our Whakatane (Te Toki Maurere New Build) and Tauranga campuses. This funding is subject to the submission of viable business cases and management is confident that it will be able to provide such to Ministry of Health in the near future.

Other significant capital investment BOPDHB is planning include a Central Sterilisation Unit upgrade of $6.7m in recognition of BOPDHB's commitment to quality and patient safety, and upgrades of the DHB's two kitchen facilities at Whakatane and Tauranga.

Cardiology, operating theatre capacity and necessary capacity for colonoscopy work as a result of the rollout of bowel screening are three additional areas of needed physical accommodation expansion due to our population growth. All three will be subject to business case proposals for consideration in the 21/22 year.

d) Work Health and Safety

BOPDHB 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).

The Bay of Plenty District Health Board (BOPDHB) and its Senior Management acknowledge and accept responsibility and commitment to Health and Safety in the workplace by:

- Providing a robust, sustainable, healthy and safe working environment to ensure the wellbeing, health and safety of all people in its workplaces through the identification, assessment and mitigation of health and safety risks:
- Working together to provide and maintain a healthy and safe working environment through continued active engagement and consultation with key stakeholders including employees, Health & Safety representatives, Māori and Union representatives in accordance with the Worker Participation Agreement.
- Regularly reviewing, maintaining and continuously improving its health and safety management systems.

Monthly Health and Safety reporting goes to the Board via its Finance Audit and Risk Management meetings and regular Board "walk arounds" of work areas are incorporated into the Board's monthly meeting programme. Elected Health and Safety Representatives are in place for all services at ~~all~~ DHB sites.

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.

The Board and Executive also use the recommendations emerging from such processes as the ACC Accredited Employer Programme audit and the Safe 365 assessment review, to assess progress towards meeting its obligations and identify Health and Safety improvement areas.

4.2 Building Capability

a) Capital and infrastructure development

The BOPDHB plans and implements capital upgrades and replacements in accordance with its current Asset Management Plan and its underlying Capital Intentions.

Historically the BOPDHB has used its annual depreciation to set the quantum available for capital investment. Due to the deficit trend of recent years, and consequent impact on cashflows, the ability to spend to this notional level has been compromised – in the last two financial years the level of expenditure has been approximately 67% of planned levels. This has led to a level of deferred capital expenditure for "business as usual" items. In addition, population growth and increased compliance requirements have led to an increasing gap between stewardship investment requirements and the DHB's ability to afford the level of investment.

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Other significant capital investment BOPDHB is planning include a Central Sterilisation Unit upgrade of $6.7m in recognition of BOPDHB's commitment to quality and patient safety, and upgrades of the DHB's two kitchen facilities at Whakatane and Tauranga.

b) Information technology (IT) and communications systems

The BOPDHB's information technology and communication systems goals align with the national and regional strategic direction for IT. Further detail about the BOPDHB's current IT initiatives is contained in the data and digital section of this document and in Te Manawa Taki Regional Services Plan 2021-2024.

c) Co-operative developments

The BOP Clinical Campus collaborates with nine tertiary institutions to help meet future workforce needs. The nature of these relationships is to ensure that under-graduate students in clinical professions receive appropriate support and teaching during their placements with BOPDHB. The 5th year medical students also participate in a Rural Health Interprofessional Programme (RHIP). Whakatane hospital is one of two sites in New Zealand that is funded by the Ministry of Health to provide Interprofessional and rural training for under-graduate students through the University of Auckland. This helps to strengthen the future rural workforce in New Zealand. The clinical campus provides significant support to students to ensure they feel included and part of the DHB's staffing from orientation and throughout their placement. Clinicians provide supervision, teaching, guidance, pastoral care and mentoring that is pivotal to ensure the students are well trained.

The BOPDHB's Whole of System Education Future State Project is currently underway to improve the sharing of education knowledge, learnings and resources. The aim is to develop a consistent approach to the development and delivery of education within the DHB so it becomes a resource for the Bay of Plenty health system to draw on in future years.

Led by the Bay of Plenty Strategic Health Services Plan and our work on Health in all Policies, the BOPDHB will continue to establish cross sector partnerships with central and local government agencies to reduce inequalities and address the social determinants of health.

4.3 Workforce

The BOPDHB recognises the importance of future planning and the development of the workforce, both internally and within the community base health services. During 2019-20 BOPDHB began to form a new approach to Workforce Strategy under the banner of our Toi Oranga Tikanga development area, focussing initially on increasing the number of Māori in our workforce and refreshing the DHB's approach to recruitment. Moving into 2021/22, the BOPDHB plans to assess current workforce capacity to inform a workforce development strategy for the next three years. BOPDHB will align with regional and national workforce development initiatives, whilst also considering the needs of our wider health workforce across the Bay of Plenty health and care services. The BOPDHB approach

to strengthening the health workforce is to take a cross sector approach in reviewing, planning and implementing workforce activities, which are further explained in the Workforce section of this plan, as well as Maternity and Midwifery Workforce, Te Toi Ahorangi workforce streams and the COVID-19 response.

Public Health Unit

BOPDHB is committed to working in partnership with our public health unit, Toi Te Ora, in its work on health 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 ensures 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	53.8%	
		Year 2	53.8%	
CW02	Oral health: Mean DMFT score at school year 8	Year 1	1.1	
		Year 2	1.1	
CW03	Improving the number of children enrolled and accessing the Community Oral health service	Children (0-4) enrolled	Year 1	> or = 95%
			Year 2	> or = 95%
		Children (0-12) not examined according to planned recall	Year 1	< or = 10%
			Year 2	< or = 10%
CW04	Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	Year 1	> or = 85%	
		Year 2	> or = 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	6.4%
			Other	5%
			Total	5.6%
		Age (20-64)	Māori	10.1%
			Other	4.4%
			Total	5.7%
		Age (65+)	Māori	5.1%
			Other	3.5%
			Total	3.5%
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		Only applies to specified DHBs
SS05	Ambulatory sensitive hospitalisations (ASH adult)	3691		TBC
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:	ESPI 3	100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less)
		Elective Service Patient Flow Indicators	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:	Magnetic Resonance Imaging (MRI)	95% of patients with accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)
		Diagnostics waiting times	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	95% of patients with accepted referrals for CT scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).

			the recommendation made by the 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.	11.9%
		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	>1% and ≤3%
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	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.		Report on actions, milestones and measures to:
SS12	Engagement and obligations as a Treaty partner	Reports provided and obligations met as specified		Support people with LTC to self-manage and build health literacy.
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) **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
		Provide confirmation report according to the template provided	**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		Provide reports as specified

APPENDIX 1: Statement of Performance Expectations including Financial Performance (for tabling as SPE)

This section is tabled in Parliament. All components of this section are mandatory under section 149C of the Crown Entities Act 2004[41](CE Act).

Statement of Performance Expectations (SPE)

(section 149B-G of the CE Act)

To ensure that the SPE meaningfully supports the key strategic outcomes and priorities of the BOPDHB's planned activities (as outlined in the previous Sections) and performance, clear intervention logic is expected to explain the link between the selected outputs and how they will contribute to impacts, and outcomes.

The SPE is to provide specific measures for the coming year, with comparative prior year and current year forecast (at a minimum).

Output classes

(section 149E of the CE Act)

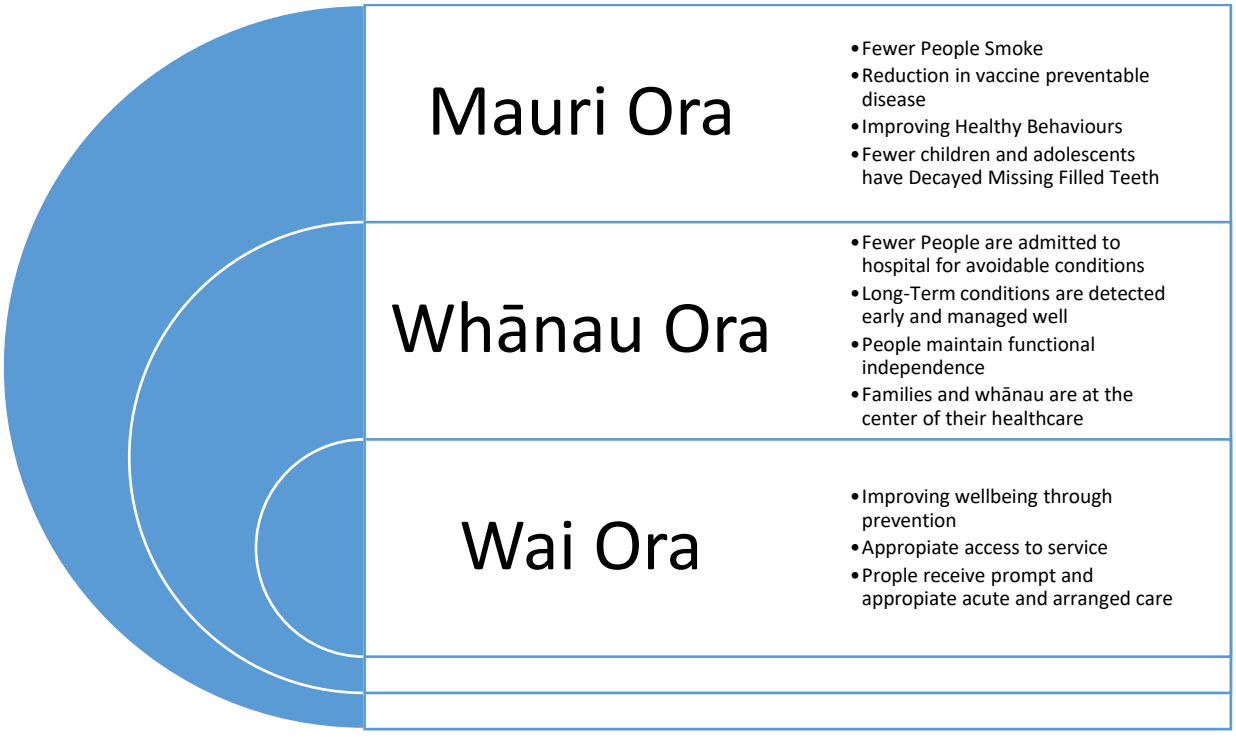
Four Output Classes are used by all DHBs to reflect the nature of services provided. There is a close correlation between these descriptions and the logic applied when mapping Purchase Unit Codes (PUCs) to each output class.

The Output Class categories are:

- Prevention
- Early Detection and Management
- Intensive Assessment and Treatment
- Rehabilitation and Support.

DHBs must describe services they plan, fund, provide, and promote within each Output Class. Include at least total expected revenue and proposed expenses for each Output Class that in total agree to your financial statements (section 149E of the CE Act).

Current strategies guide us to provide health services which better support people to stay well and manage their own health. For this Statement of Performance Expectation The Bay of Plenty Strategic Health Services Plan and Te Toi Ahorangi set the scene for what we need to focus on to support our communities to be healthy and thriving. Whenever possible, we track the equity gap between Māori and Non-Māori.



[41] Henceforth, 'CE Act' will be used when referring to the Crown Entities Act 2004.

3.2 Healthy Individuals – Mauri Ora

Healthy Individuals – Mauri Ora			
All people have healthy lifestyles with a good quality of life			**All children have the best start in life**
Fewer people smoke	Reduction in vaccine preventable diseases	Improving healthy behaviours	Fewer children and adolescents have Decayed Missing Filled Teeth

3.2.1 Fewer People Smoke

Outputs	Output Class	Measure Type	Baseline	Target 2021/22
Providing smokers who access primary services with smoking cessation advice and support **– PH04** • Total Population • Māori	1	qn/t	91% 89%	90%
Percentage 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 **– CW09** • Māori • Total	1	qn/t	95% 92%	90%
Māori babies who live in smokefree households at six weeks post-natal[42]	1	qn/t	52%	60%

3.2.2 Reduction in vaccine preventable diseases

Outputs	Output Class	Measure Type	Baseline	Target 2021/22
Children are fully immunised at two years of age **– CW08** • Māori • Total	1	qn/t	78% 83%	95% 95%
Children are fully immunised at five years of age **– CW05** • Māori • Total	1	qn/t	78% 83%	95% 95%

[42] This is a contributory measure in the System Level Measure Improvement Plan 2020/21

Outputs	Output Class	Measure Type	Baseline	Target 2021/22
Eight month olds will have their primary course of immunisation (six week, three months and five months immunisation events) on time – **CW05**	1	qn/t	86%	95%
Percentage of the population (>65 years) who have had the seasonal influenza immunisation • Total Population • Māori	1	qn/t	58% 54%	75% 75%
Percentage of the population (15-30) immunised for MMR. • Total Population • Māori	1	qn/t	%[43]	90%

3.2.3 Improving Healthy Behaviours

Outputs	Output Class	Measure Type	Baseline	Target 2021/22
Percentage 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 bases nutrition, activity, and lifestyle interventions **– CW10**	2	qn/t	99%	95%
Percentage of infants fully and exclusively breast fed at three months **– CW06** • Māori • Total	2	qn/t	50% 61%	70% 70%

3.2.4 Fewer Children and Adolescents have Decayed Missing Filled Teeth

Outputs	Output Class	Measure Type	Baseline	Target 2021/22
Percentage of children who are caries free at age five[44] **- CW01** • Māori • Total	2	qn/t	29% 50%	54% 54%

[43] This is a new measure that was included to track the MMR campaign.
[44] This information is reported annually for the school calendar year

Outputs	Output Class	Measure Type	Baseline	Target 2021/22
Percentage of adolescent utilisation of DHB funded dental services **- CW04**	2	qn/t	68%	>85%

3.3 Healthy Families – Whānau Ora

Healthy Families – Whānau Ora			
Family/whānau live well with long term conditions		**People are safe, well and healthy in their own homes and communities**	
Fewer people are admitted to hospital for avoidable conditions	Long-term conditions are detected early and managed well	People maintain functional independence	Families and whānau are at the centre of their healthcare

3.3.1 Fewer people are admitted to hospital for avoidable conditions

Outputs	Output Class	Measure Type	Baseline	Target 2021/22
Reduced ASH rates:[45] **- SS05** 45-64 years – Māori 45-64 years – Total 45-64 years - Other	2,3	qn	 7590 3731	 7309 3691 2879
Percentage of eligible population who have had their Before School Checks[46] (B4SC) completed • Total Population • High Needs	2	qn/t	 90% 90%	 90% 90%
Percentage of triage level 4 and 5s presenting to the Emergency Department (ED)[47]	3	qn/t	51%	≤65%

[45] Baseline has been calculated from the 2018 data. The baseline rate is per 100,000 population.
[46] A nationwide programme offering free health and development checks for four year olds. It aims to identify and address any health, behavioural, social or developmental concerns which could affect a child's ability to get the most benefit from school. Health checks include vision, hearing and oral. This service is provided by CCYHS (Community Child and Youth Health Service and Nga Mataapuna Oranga PHO.
[47] ED services in New Zealand utilise a scale of 1-5 triage, with 1 being the most urgent. These principally determine who should be seen first. This is a quality measure because triage categories 4 and 5 may be more appropriately seen in the primary sector and poor performance in this area impacts on our capacity to provide quality services for triage 1-3.

3.3.2 Long-term conditions are detected early and managed well

Outputs	Output Class	Measure Type	Baseline	Target 2021/22
Percentage of population enrolled with a Primary Health Organisation (PHO)[48] – **PH03** • Māori • Total Population	2	qn/t	96% 99%	95% 90%
Woman enrolled in a PHO aged 25-69 years who have had a cervical sample taken in the past three years **– PV02** • Māori • Non-Māori • Total Population	1	qn/t	71% 83% 81%	80% 80% 80%
Women enrolled in a PHO aged 50-69 years who are enrolled in the Breast Screening Programme with Breast screen Midland **– PV01** • Māori • Non-Māori • Total	1	qn/t	61% 74% 71%	70% 70% 70%
Focus area 2 - Diabetes Services (HbA1c) Improve, or where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1C indicator) **– SS13 FA2**	2	qn/t	66%	80%

3.3.3 People Maintain Functional Independence

Outputs	Output Class	Measure Type	Baseline	Target 2021/22
Maintain current percentage of population over 65 years who have accessed aged residential care (ARC)	3	qn/t	5.7%	5.0%
Percentage of the population 65+ years that access Home Based Support Services (HBSS)	3	qn/t	11.9%	12.15%

[48] Access to primary care has been shown to have positive benefits in maintaining good health, including early detection, and managing long term conditions. It also reduces the economic cost of ill health and is key in reducing disparities in health.

3.3.4 Families and whānau are at the centre of their healthcare

Outputs	Output Class	Measure Type	Baseline	Target 2021/22
% of contracted Whānau ora providers that are using the Whānau ora and/or Tūāpapa model.	2	qn/t	New measure	TBC

3.4 Healthy Environments – Wai Ora

Healthy Environments – Wai Ora		
All people live, learn, work and play in an environment that supports and sustains a healthy life	**Our population is enabled to self-manage**	**All people receive timely, seamless and appropriate care**
Improving wellbeing through prevention	Appropriate access to services	People receive prompt and appropriate acute and arranged care

3.4.1 Improving wellbeing though prevention

Outputs	Output Class	Measure Type	Baseline	Target 2021/22
LARC insertions for priority groups	1	qn		450[49]

[49] Target set by MoH.

3.4.2 Appropriate Access to Services

Outputs	Output Class	Measure Type	Baseline	Target 2021/22
Number of inpatient surgical discharges under elective initiative **SS07 Measure1**	3	qn	12,112	TBC
ESPIs (Elective Services Patient Flow Indicators):[50] - **SS07 Measure 2** • **ESPI 2** - Patients waiting longer than four months for their first specialist assessment (FSA)	3	qn/t	0%	0% (no patients) are waiting over four months for FSA
Did-not Attend (DNA) rate for outpatient services[51] SS07-Measure 7. • Māori • Non-Māori • Total Population	3	qn/t	14.6% 3.9% 6.3%	Not required for 20/21
Number of clients supported by specialist palliative care	3	qn	1490	769

Outputs	Output Class	Measure Type	Baseline	Target 2021/22
Number of community pharmacy prescriptions	2	qn	3,666,354	3,676,982[52]
Improved wait times for diagnostic services – accepted referrals receive their scan for - **SS07 Measure 3** • **Coronary Angiography** (within 90 days) • **Computing Tomography** (CT) (within six weeks) • **Magnetic Resonance Imaging** (MRI) (within six weeks)	3	qn/t	92% 98% 91%	95% 95% 90%
Improving waiting time for Colonoscopy – **SS15** • **Diagnostic Colonoscopy** (within two weeks) • **Diagnostic Colonoscopy** (within six weeks) • **Surveillance Colonoscopy** (within 84 days)	3	qn/t	82% 44% 39%	90% 70% 70%
Total number of community referred radiology Relative Value Units (RVUs)[53]	3	qn	76,942	72,090
Total number of community laboratory tests	2	qn	1,524,521[54]	1,450,000

[50] ESPIs are seen as quality measures for elective services because underperformance against any of these indicators has the potential to impact negatively on patient outcomes.
[51] This is a quality measure because by reducing our DNA rate, we free up a lot of capacity for people who require treatment. The targets are lower than the baseline, because fewer DNAs means less resources are wasted.
[52] This calculation is based on the current intent of the new community pharmacy service model with zero growth in total dispensing items. It is expected to have initial items growth between 2.5% and 5% with a significant reduction in repeats dispensing. As the service model is expected to change, the actual volume will vary from the target. Note this is also a quality measure, as by managing demand / volume to this level, it demonstrates effectiveness in implementation of the new pharmacy service model.
[53] An individual operative / diagnostic / assessment according to the Royal Australian and New Zealand College of Radiologists.
[54] Baseline is calculated on actual delivery in the community

Access rates to mental health and addiction services across DHB and NGO services.[55]	2	qn/t	New measure	Under development
Chlamydia testing coverage for 15-24 year olds.[56]	2	qn/t	New measure	Under development

3.4.3 People receive prompt and appropriate acute and arranged care

Outputs	Output Class	Measure Type	Baseline	Target 2021/22
Percentage of patients admitted, discharged or transferred from an ED within six hours **– SS10**	3	qn/t	94%	95%
Faster Cancer Treatment – 62-day indicator - proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment (or other management) within 62 days of decision-to-treat **– SS11**	3	qn/t	94%	90%
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 – **SS01**	3	qn/t	90%	85%

[55] This is based on the 2021/22 Service Coverage Schedule
[56] This is a milestone within the youth domain of the System Level Measure Improvement 2020/21.

Bay of Plenty Health System Level Measures Plan 2021-2022

System Level Measures Plan Signatories

Agreement for the BOPDHB SLM Plan 2021/22 dated June 2021, between:

Pete Chandler
Chief Executive Officer
Bay of Plenty District Health Board

Greig Dean
Chief Executive Officer
Eastern Bay Primary Health Alliance

Lindsey Webber
Chief Executive Officer
Western Bay of Plenty PHO

Andrea Baker
Actong General Manager, Planning and Funding
Bay Of Plenty District Health Board

Janice Kuka
Chief Executive Officer
Ngā Mataapuna Oranga

Stewart Ngatai
Acting Manukura, Executive Director Toi Ora, Māori Health Gains and Development

Executive Summary

This document outlines how improvements will be made across the System Level Measures (SLM) in 2021/22 and applied across the Bay of Plenty region. It summarises how improvement will be measured for each SLM and identifies high-level activities that will be fundamental to this improvement. This plan has been collaboratively developed by the Bay of Plenty District Health Board and its Primary Health Organisation partners.

System Level Measures provide a way of looking at how different parts of the health care system work together to improve health outcomes for all people. This can include care provided in the community, for example by General Practice, midwives and School Based Health Services, as well as hospital-based services.

By working together in this way, we hope to improve the overall health and the experience of health care better for whānau. There is a focus on children, youth, and people with high health needs and ensuring that all patients get the best care at the right time and right place for them, including preventative and pro-active care.

There are six SLMs that ensure an equity focus on a wide range of improvement activities. The Ministry of Health worked closely with the health sector to co-develop the System Level Measures, which are:

- Acute hospital bed days per capita (using health resources effectively)
- Ambulatory Sensitive Hospitalisation (ASH) rates for 0–4-year-olds (keeping children out of hospital)
- amenable mortality rates (prevention and early detection)
- Youth access to and utilisation of youth appropriate health services (youth are healthy, safe and supported).
- Babies living in smoke-free homes (a healthy start)

Links with our Strategies

This System Level Measures Plan is underpinned by the direction for health for the Bay of Plenty as set out in our strategic documents, Te Toi Ahorangi (TTA) and The Bay of Plenty Strategic Health Services Plan 2017-27 (SHSP). The Bay of Plenty District Health Board and the Māori Health Rūnanga (our eighteen iwi governance representatives of Te Moana ā Toi), affirmed our Te Tiriti o Waitangi partnership by advancing a brave new Māori Health strategy - Te Toi Ahorangi - that aims to transform our health system and realise our collective aspirations for Toi Ora. Te Toi Ahorangi aims to provide a strategic framework that describes our unified vision, voice and intention to successfully influence health and wellbeing outcomes for tangata whenua and all people living in Te Moana ā Toi, from preconception throughout the life course. To view the full strategy, see here.

The SHSP sets the scene for what we need to focus on to support our communities to be healthy and thriving. It guides us to provide health services which better support people to stay well and manage their own health with a focus on prevention and services closer to home, and high-quality hospital care when needed. To view the full plan, see here. Further information can also be found in the BOPDHB 20/21 annual plan within the statement of intent.


Strategic Priorities
Te Toi Ahorangi 2030
UPHOLD TE TIRITI O WAITANGI & OUR INDIGENOUS RIGHTS
BE A TOI ORA CHANGE LEADER
ILLUMINATE & ADVANCE TOI ORA SYSTEM PERFORMANCE
ELEVATE WAI ORA & REDUCE ACUTE DEMAND
WHAKAMANA WHĀNAU WITH SOLUTIONS EMBEDDED IN AROHA
SUPPORT IWI LED DEVELOPMENT
DEVELOP OUR TOI ORA LEADERS, WORKFORCE & PROVIDERS
INVEST IN TOI ORA INNOVATION
Toi Oranga Mokopuna Child Wellbeing
Toi Oranga Ake Integrated Care
Mental Health Toi Oranga Ngākau
Toi Oranga Tikanga Business Redesign
Toi Ora
Healthy, Thriving Communities.
Whole of System
Strategic Health Services Plan
COMMUNITY BASED ACUTE CARE
AVOIDABLE HOSPITAL ADMISSIONS
CARE IN THE COMMUNITY
AMBULATORY CHILD HEALTH
MENTAL HEALTH & ADDICTIONS REDESIGN
EVOLVING OUR CULTURE
AGILE BUSINESS CULTURE & PROCESSES
WORKFORCE WELLBEING SUPPORT TEAM
COORDINATED TRANSFORMATION
LEADERSHIP EVOLUTION
FINANCIAL SUSTAINABILITY
QUALITY & SAFETY IMPROVEMENT

Primary Health Organisations

The BOPDHB region has three PHOs with a direct head agreement, being Western Bay of Plenty PHOs (201,400 enrolled service users), Eastern Bay PHA (29,400 enrolled service users) and a kaupapa service, Nga Mataapuna Oranga (10,500 enrolled service users). The DHB has also approved geographic location service areas with Waikato DHB and Lakes DHB respectively for a GP practice in Waihi Beach and the GP practice in Murupara. The PHOs are represented by one PHO CEO on the DHB Executive leadership Team.

SLM Implementation and reporting structure

Successful implementation of the SLM Plan Improvement Plan is dependent on collaboration across primary and secondary care, good clinical engagement, supported by a programme management approach. Some working groups are 'virtual' so as not to duplicate existing efforts in Acute Flow and Integrated Care programmes. Working group membership combines primary and secondary clinical expertise with PHO and DHB Planning and Funding representatives. DHB Innovation + Improvement Programme Managers and Performance Analysts provide programme co-ordination and quality improvement support to working groups and undertake quarterly reporting responsibilities through Annual Plan IDP reporting.

Toi Oranga Ake - Integrated Care

Toi Oranga Ake represents our growing range of Integrated Healthcare developments. This SLM Plan aims to build on the core tenets of our integrated care initiatives that the DHB and PHOs are investing in together. A number of these initiatives are referenced in the Annual Plan and our 3 year Planned Care plan. We are seeking to ensure they are linked and mutually enhancing, rather than separate initiatives which might add new silos and boundaries and thereby impede our intention of seamless care. The Whakatane Model of Practice – Mahia to Mahi, Community Care Co-ordination and Keeping me Well initiatives link closely with the established Healthcare Home model and the developing Tūāpapa approach, all focussed on supporting wellness at home and providing care and support in communities through the care of GPs and community-based services wherever possible.

Toi Oranga Mokopuna – Child Well-being

Toi Oranga Mokopuna – Child Wellbeing represents one of our strategic priorities with a vision that the Bay of Plenty is the best place for children to grow up and have the best start in life. Similar to Toi Oranga Ake – Integrated Care, this SLM Plan aims to build on the programme of initiatives aimed at improving child well-being. Our goals is to ensure that actions outlined in the SLM Plan aimed at improving ASH rates for Māori children aged 0-4 and Babies Living in Smoke-Free households are seen as part of a comprehensive programme to improve child well-being. Linked initiatives referenced in the 2021/22 Annual Plan include a continued focus on improving childhood immunisations rates, Well-Child Tamariki Ora improvement programmes, an innovation project to integrate Child Development Services to improve access to specialist assessment services and the development of a child hub model with potential co-location of DHB delivered child health services to reduce fragmentation and improve co-ordination.

Impact of Covid-19

The current pandemic situation means we will need to remain vigilant. This means we plan to focus our efforts on fewer actions for this years' SLM Plan, ensure that our actions are linked with strategic efforts, and that we do fewer things well.

Shared data and Digital Information System Enablers

In the Bay of Plenty it is recognised that smartly applied health technologies and information systems are pivotal enablers in our transition to a 'one system' patient directed world. The Bay of Plenty Information Systems Group (BOPIS), provides information system governance, advice and support for Alliance projects focused on whole of system information sharing. As part of their mandate, BOPIS supports and enables delivery of the SLM programme by ensuring systems are in place to share patient information safely, to assist clinical decision-making and make healthcare more co-ordinated and integrated.

The membership of BOPIS Group comprises the Chief Information Officers of the DHB and the PHOs, the DHB Chief Medical Information Officer, Clinical Director of Quality and Patient Safety, Māori Health Gains and Development, Primary care and Pharmacy Clinical Representatives, Business Intelligence and Performance Analysts. The Group has been working together since 2015.

Cross Sector Health intelligence

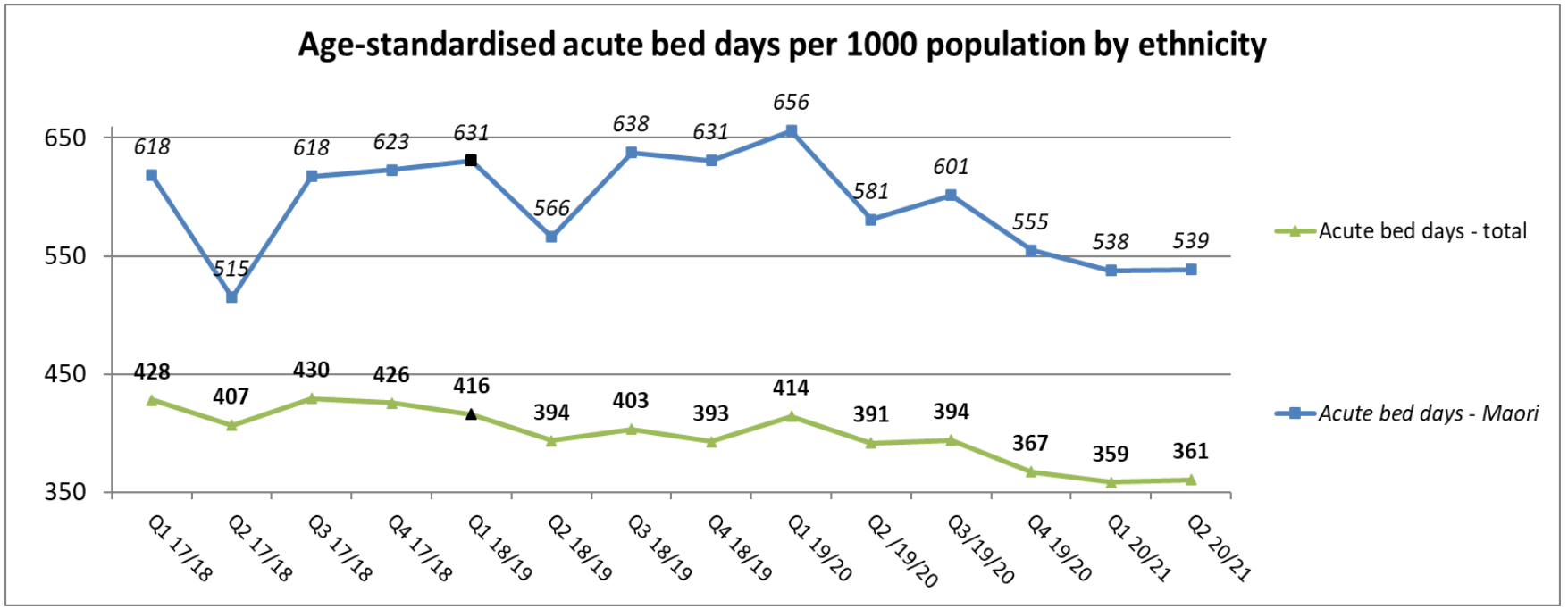
In 2021-22 the BOPDHB and WBPHOs continues to further enhance its health intelligence capabilities through the appointment of a Cross Sector Digital Architect. This shared role which commenced on 1 July 2020 will enable us to build the architecture for improved data sharing capability between the PHOs, the DHB, Toi Te Ora Public Health, PathLab and other community services which will strengthen our efforts towards a more joined up system.

Developing a Contributory Measures Data Set

Data for the SLMs is generally at a very high level and insufficiently granular to demonstrate whether changes being made at a local level are resulting in the desired improvement. The SLM milestones are contributed to by a suite of measures at a local level. During 2021-22 we will develop a dashboard of contributory measures for each of the SLM milestone activities to provide working groups with more relevant and timely data for rapid evaluation of improvement efforts.

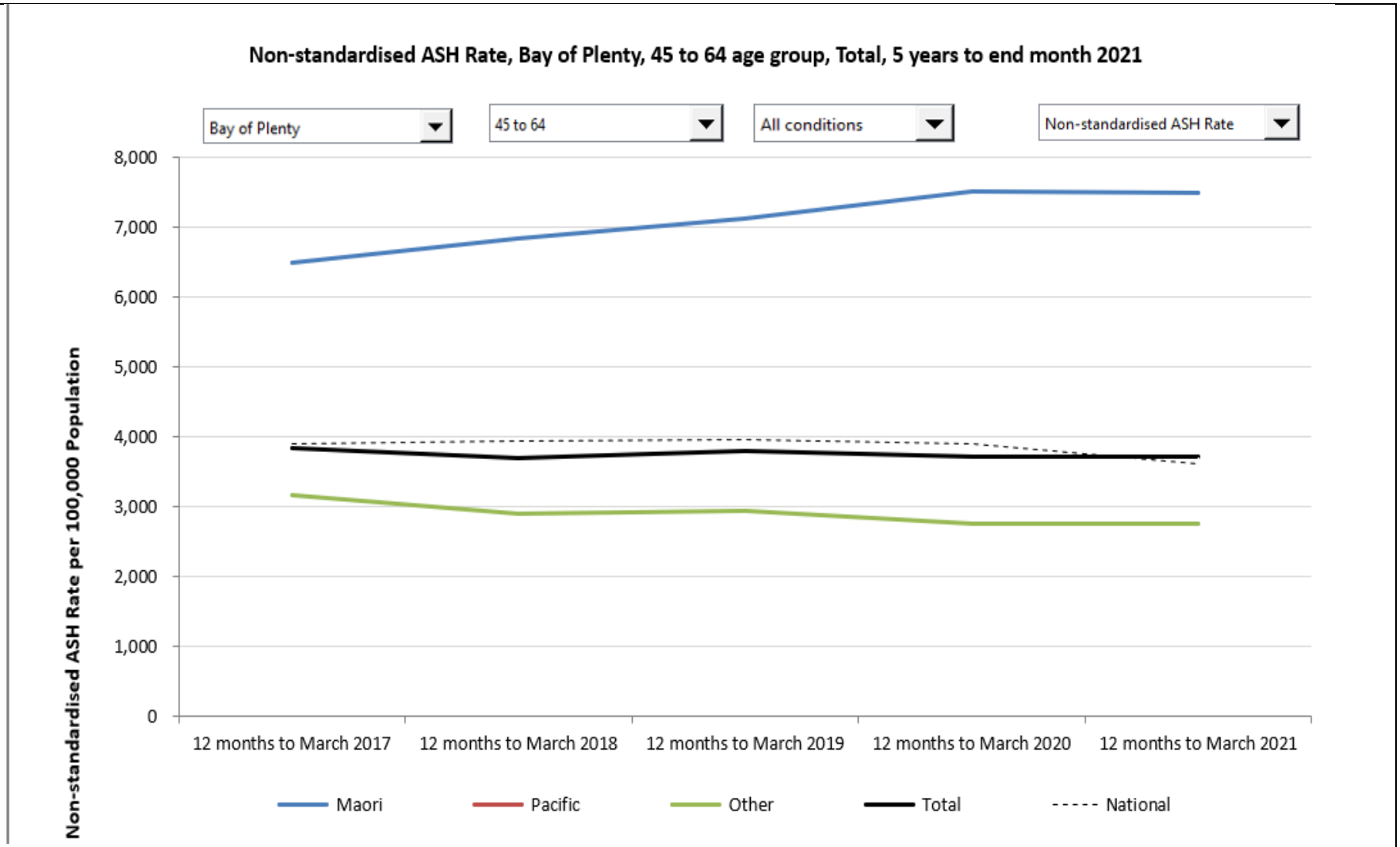
System Level Measures Action Plan – Overview

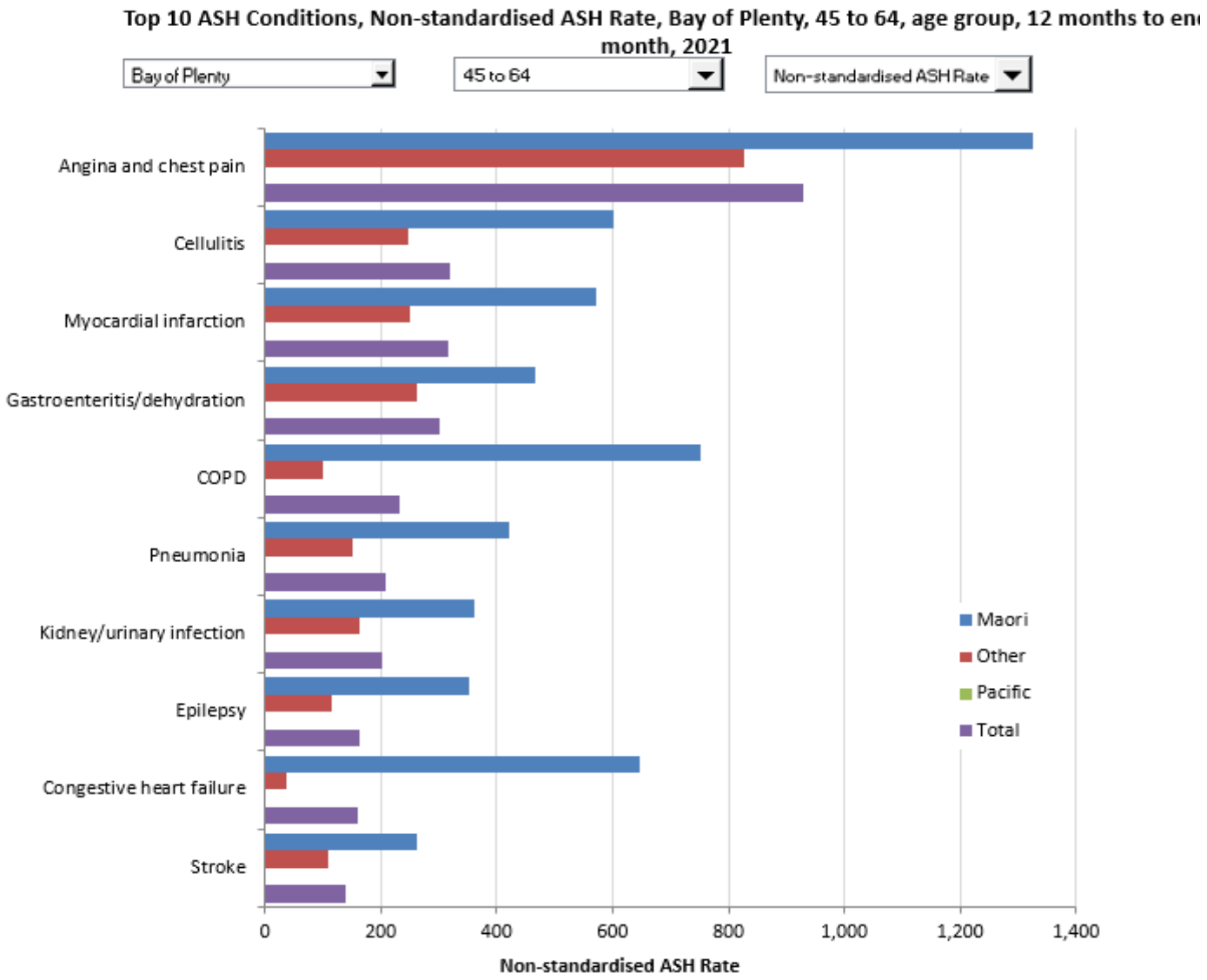
SLM Action Plans

Acute Hospital Bed Days – Using health resources effectively.	
Where to act *Acute bed day rates are higher for Māori than non- Māori*	

Māori 45-64 year olds are more likely to present with an ASH condition and the rate is growing faster than for the total population

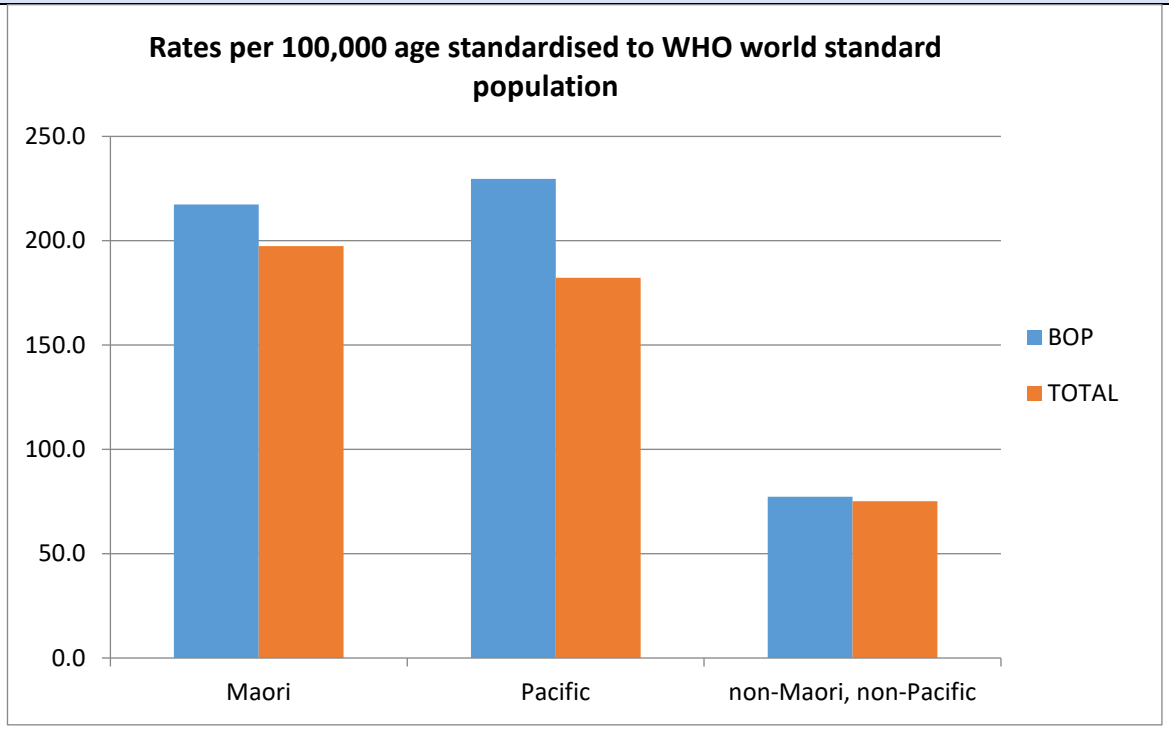
The main reasons for preventable hospitalisations for Māori are; Angina and chest pain, cellulitis respiratory conditions





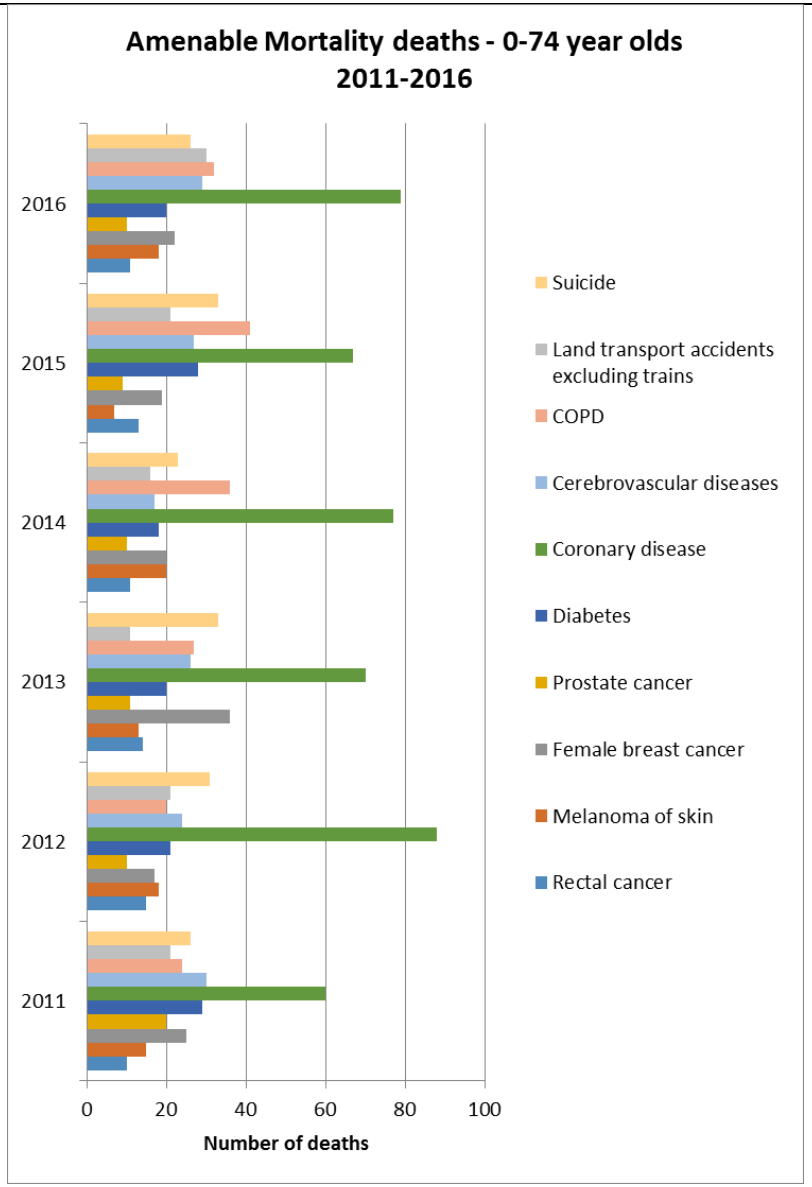
Why do we need to act?	Acute admissions to hospital indicate increased risk of poor health outcomes, both as a result of the underlying condition(s) and from adverse events in hospital settings. Some of these admissions can be moderated by population health initiatives such as early health care intervention and effective primary and community care and co-ordination with social services as described in Toi Oranga Ake – Integrated Care. The Acute Hospital bed days measure is also about using healthcare resources wisely. BOP has higher rates of acute hospitalisation than the NZ rate. (BOP Health and Service Profile 2016).

	Our data tells us that: Māori 45–64-year-olds have a higher rate of ASH admissions than non-Māori and that cardiovascular conditions, respiratory conditions and cellulitis are the main cause.
What are we aiming to achieve?	We aim to reduce acute bed day rates by: • Proactively identifying patients at risk of admission to hospital in localities with a high Māori population such as Te Puke and Kawerau; • Address chronic conditions through a self-management and early intervention approach in primary care. • Enabling efficient and effective flow through the hospital with supported transfer of care as soon as possible. • Provide access to early advice and alternative options for patients who are acutely unwell to be treated in a primary and/or community setting.
Actions we are taking	1. Implement Cellulitis Primary Care management pilot within the Eastern Bay of Plenty (EBOP) that removes cost barriers to patients for effective management of cellulitis patients within a primary care setting. 2. Progress the full rollout of the 'Keeping Me Well' programme which commenced in Te Puke in February 2020 across all parts of the BOP, focused on highest risk patients using risk stratification data and local knowledge. 3. Develop and implement a COPD Primary Care Management Programme within the EBOP, building off the success of the WBOP Primary Care Management Programme. *4.* Support our General Practice Networks to embed the New Zealand CVD Guidelines (2018) that further identifies at risk patients within refined age bands and recall timeframes based on assessed risk levels.
How will we know we've made an improvement	**Contributory Measures** • Reduction in length of stay for Māori 45-64 years with COPD. • Greater time period between readmission for Māori 45-64 years / reduction in readmission rates. • Māori ASH Rate 45-64 years • Admissions to hospital for specified patient groups participating in the Keeping Me Well enablement tests
System Level Measure Milestone	**Overall SLM Milestone improvement:** 5% improvement on forecast growth in Māori **Acute Hospital Bed Day rate** by 30 June 2022. 2% improvement in the overall Acute Hospital Bed Days rate for people aged 65 years and older by June 2022.

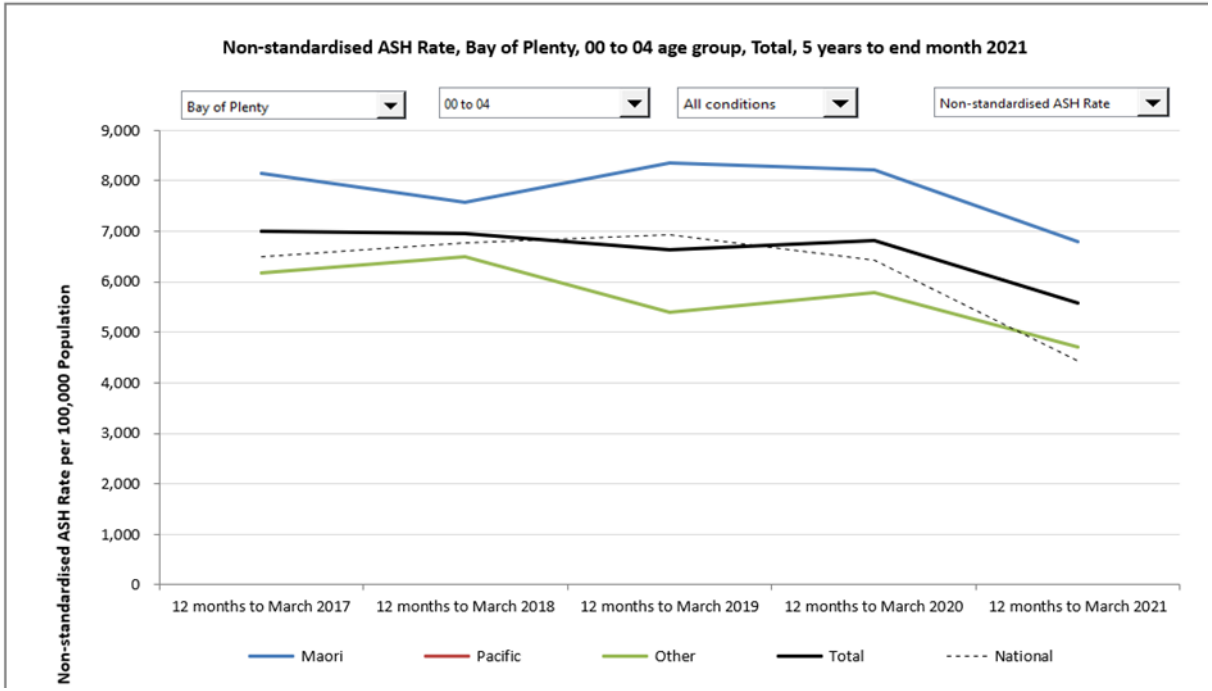
Amendable Mortality – Prevention and Early Detection	
Where to act *Amenable mortality higher for Māori than non- Māori*	

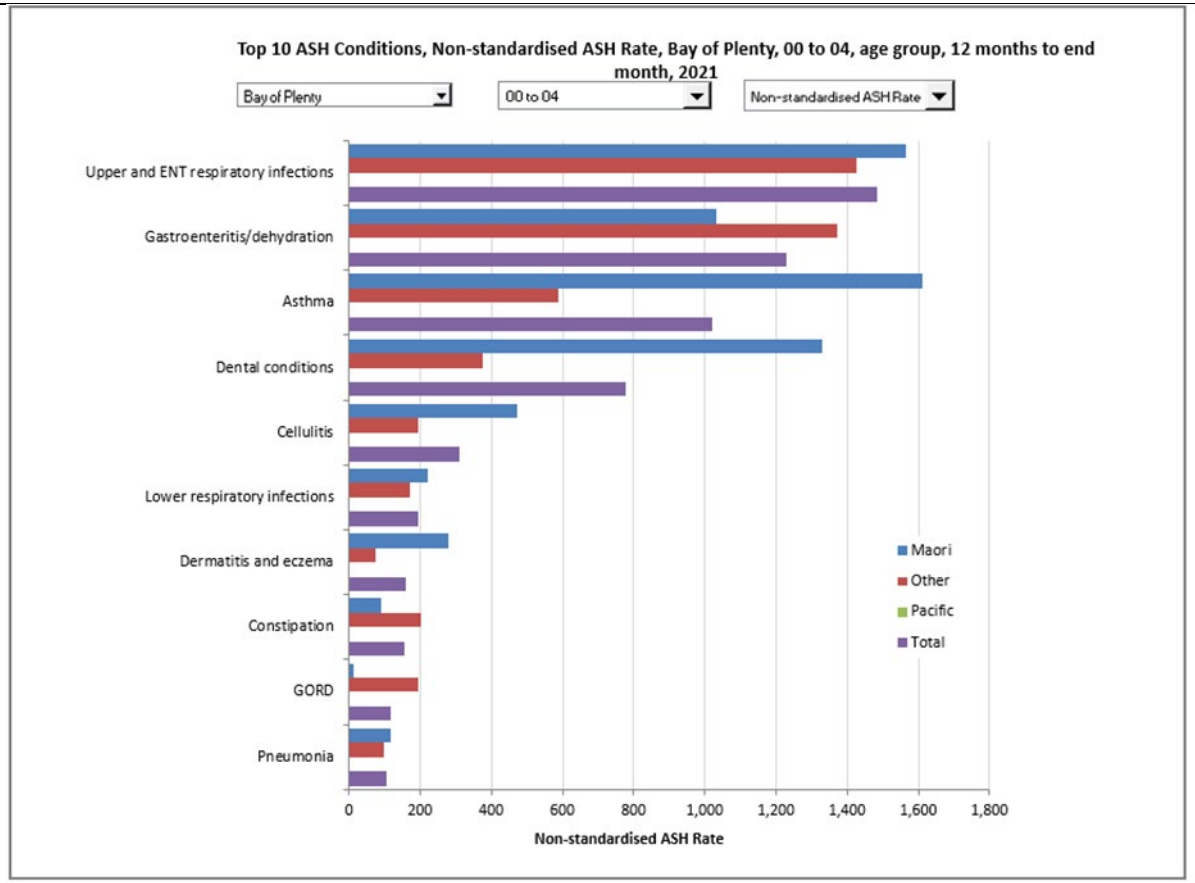
Coronary disease, Diabetes & COPD show highest rates for Māori

Smoking is a major risk factor for CVD and COPD

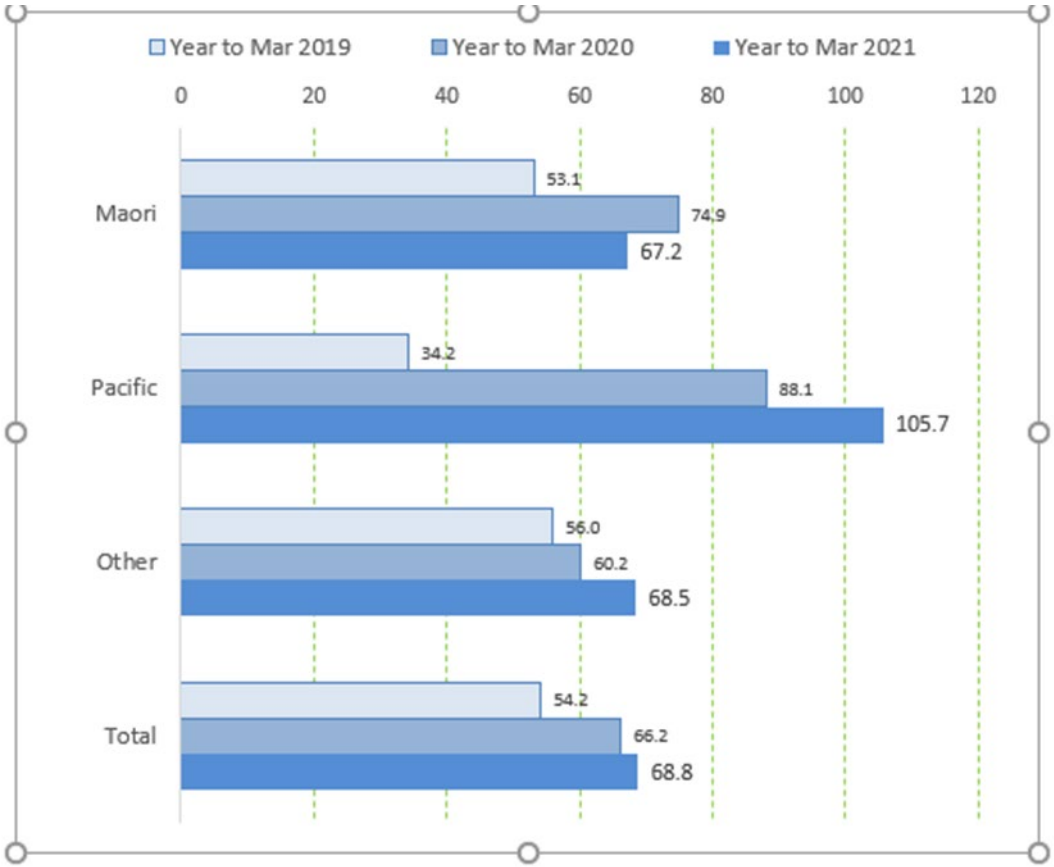


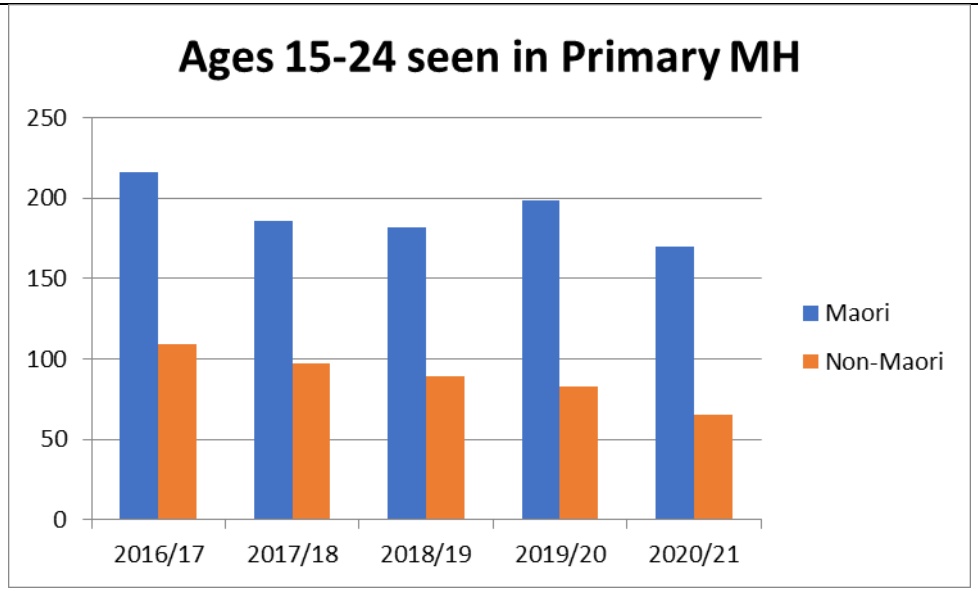
Why do we need to act?	Amenable mortality is defined as 'premature deaths (deaths under age 75) that could potentially be avoided, given effective and timely healthcare. That is, early deaths from causes (diseases or injuries) for which effective health care interventions exist and are accessible to New Zealanders in need.' (*Defining Amenable Mortality* – Ministry of Health NZ, 2016) **Our data tells us that:** • Standardised rates of amenable mortality are more than double for Māori compared to non-Māori in BOPDHB, and that coronary disease, diabetes, suicide and COPD are the main reasons for this. • Female breast cancer rates are higher for Māori wahine compared to non-Māori in BOPDHB.
What are we aiming to achieve?	We aim to reduce standardised amenable mortality rates for Māori by: • Reducing smoking rates – a contributor to most of our amenable mortality conditions. • Improving access to current screening programmes (breast and cervical) to support prevention and early detection for Māori wahine as well as engagement with primary care. • Improve equity for people with diabetes and cardio-vascular disease.
Actions we are taking	1. Enhance and intensify the Support to Screening Services programme to ensure maximisation of coverage and reach for Breast and cervical screening, with an emphasis on our most vulnerable populations. 2. Improve equity in diabetes management with a strengthened approach on prevention and early intervention for at risk, pre-diabetic patients through access to outreach Diabetes Nurse Specialist resource. Focus would be on; - patients with HbA1c 45-49mmol/mol (within previous 12 months); and - aged between 15 and 76 years; and - either a CSC holder, Māori, Pacific, or Asian ethnicity. - Not classified as having type 1 or type 2 diabetes and/or taking short term steroids. 3. Build on success of 2020 mobile outreach Seasonal Influenza campaign for 65+ Māori and other vulnerable populations and deliver intensified campaign over 2021-22. 4. Implement and monitor effectiveness of the Te Ahunga Whanau Community Nurse / Kaiawhina outreach service pilot within two WBOPPHO practice clusters, focusing on Long term Condition Management and contributing factors (including smoking and other lifestyle choices) for vulnerable populations
How will we know we've made an improvement	**Contributory Measures** • Breast screening rates for Māori wahine. • Cervical screening rates for Māori wahine. • Rate of inpatients with diabetes previously seen by Diabetes Nurse Specialist within the community. • Influenza vaccination rates for Māori
SLM Milestone	We will achieve a 10% reduction in standardised amenable mortality rates for Māori by 30 June 2023.

Ambulatory Sensitive Hospital Admissions (ASH) Ages 0-4 – Keeping Children out of hospital	
Where to act *BOP Māori have a higher rate of ASH (0-4) admissions than BOP non-Māori and is higher than the national rate.*	

The main conditions where there are disparities between Māori and non-Māori *are: Respiratory, dental and skin conditions*	
Why do we need to act?	Children aged 0 – 4 year are vulnerable to higher risk of poor health outcomes and are reliant on caregivers to access services (e.g. because of cost, health, literacy, transport). Adverse health events during childhood and youth can be related to poor health and social outcomes later in life. Timely interventions can reduce risk of lasting harm and premature mortality. (BOP Health and Service Profile 2016). **Our data tells us that:** BOP Māori proportionally have a higher rate of ASH admissions than BOP non-Māori and that skin infections, respiratory and dental conditions are the main areas of disparity for our high need and priority populations.
What are we aiming to achieve?	We aim to eliminate the equity gap and reduce overall rate for ASH (0-4 years) conditions by preventing or reducing hospital admissions for children most at risk of being admitted to hospital for respiratory condition due to un-healthy housing

Actions we are taking	**Respiratory/Asthma/Oral Health** 1. Enhance risk identification and enable intensive support/education programmes to reduce prevalence of Emergency Department presentations, resulting in avoidable admissions. 2. Identify contributing factors at home for asthma suffers to reduce admissions. 3. Promote and strengthen service availability to increase asthma referrals to healthy homes from primary care. 4. Continue to work in a COVID-19 environment with a commitment to achieving equity in oral health outcomes and equity in access to oral health services for our BOP children.
How will we know we've made an improvement	**Contributory Measures** • Treatment interventions for Māori children aged 0-4 enrolled with the Community Oral Health service who have received treatment. • Failed to Attend rate for Oral Health appointments for Māori Children aged 0-4. • Percentage of children who present to ED 0-4 or are frequent attenders with respiratory issues who are contacted by their General Practice team post discharge for ongoing management. • Primary and secondary referrals rates to the Healthy Housing Initiative, re, for children with respiratory conditions admitted to hospital.
System Level Measure Milestone	**Overall SLM Milestone change** We will reduce the childhood ASH rates for Māori by 5% by the 30 June 2022.

Youth Health – Youth are healthy, safe and supported	
Where to act Aged standardised self-harm hospitalisations are greater for Māori and Pacifica compared to the total population Access to primary mental by young Māori in the Bay of Plenty has	Age Standardised self Harm Hospitalisation Rate(per 10,000 population by ethnicity(2019-2021) 

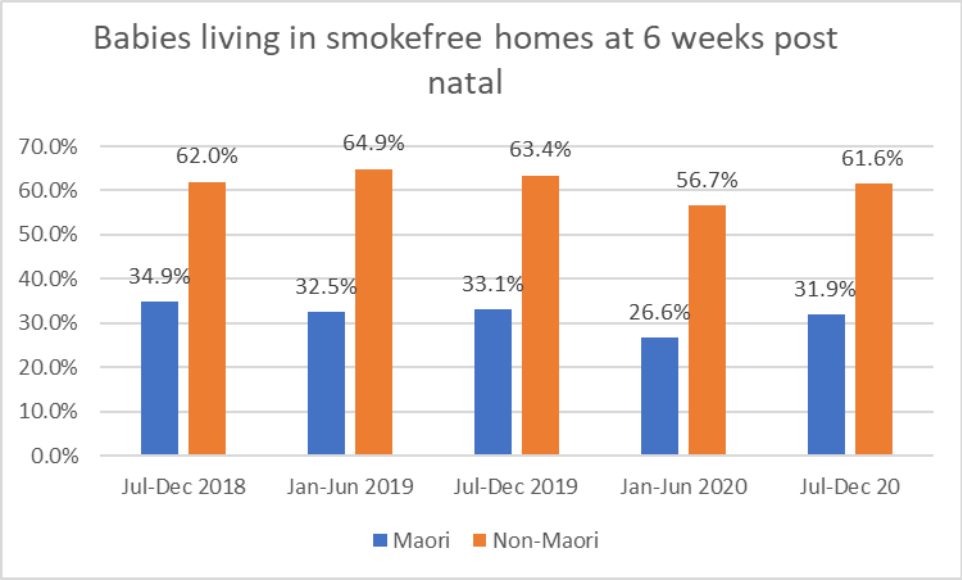
improved since 2017	
Why do we need to act?	Youth have their own specific health needs as they transition to adulthood. Most youth in New Zealand successfully transition to adulthood, but some do not. This is mainly due to a complex interplay of individual, family and community stressors and circumstances, or 'risk factors'. Evidence shows that youth cope with illness with advice from friends and whānau, as opposed to engaging with health services or a registered health practitioner; attending a health clinic is often viewed as a last resort instead of a reasonable first choice. (Health Quality Measures NZ website). **Our data shows that:** • Māori youth and Pacifica have higher rates of self-harm hospitalisations than other ethnicities and this is increasing. • Māori youth have accessed more primary mental health services since 2017;
What are we aiming to achieve?	Our focus will be on our youth's mental health: • to improve the knowledge and skill of those working with vulnerable youth to identify mental health and addiction issues early and refer to appropriate services.
Actions we are taking	1. Complete the mapping exercise of youth mental health services in Bay of Plenty, what they do, the access routes and common links between various services utilising Health Point as our on-line provider directory to improve knowledge of services available. 2. Strengthen capacity for our School-based Health Services personnel to maximise capabilities to offer youth a variety of supportive and self-access options in respect to mental health issues.

	Note: While there continue to be delays in the release of a dedicated Youth Mental Health funding RFP at a national level, the implementation of Integrated Primary Mental Health and Addition Services across the BOP in a joined up and collaborative manner from September 2021, will enhance access to services delivered within primary care.
How will we know we've made an improvement	**Contributory Measures** • Number of Māori youth seen in primary care mental health services. • Number of youth accessing IPMH&A services within primary care following implementation of these services. • Number of youth utilising promoted self-help technologies
System Level Measure Milestone	**Overall SLM Milestone changes** • 5% reduction in Age Standardised youth self-harm hospitalisation rates for Māori by 30 June 2022.

Patient Experience of Care – Patient, family and whanau-centred care	
Where to act Our data shows communication and co-ordination are the lowest scoring domains in the In-Patient experience survey in 2020.	 BOPDHB In-patient survey results – comparison of domain scores 2014-2020 – all
Why do we need to act?	Patient experience is a vital but complex area. Growing evidence suggests patient experience is a good indicator of the quality of health services. Better experience, stronger partnerships with consumers, and patient and family-centred care have been linked to improved outcomes across health, clinical, financial, service and satisfaction domains. (Health Quality Measures NZ website). The

	revised national inpatient and primary care surveys provided by IPSOS were rolled out in August 2020. The opportunity now exists to build on historic baselines to improve both uptake/participation and responsiveness to survey outcome. **Our data shows that:** At a provider level, the greatest opportunities to improve are in cultural responsiveness, communication and co-ordination. Driving a greater awareness of the impact these service aspects can have on overall patient satisfaction is paramount to underpinning activity within these areas of improvement.
What are we aiming to achieve?	We aim to improve overall outcomes from the Inpatient Experience of Care surveys through improving awareness where improved communication and co-ordination with patients enable them to better engage in decisions about their care through: • Improving our provider network's awareness and understanding of culturally appropriate behaviors to maximise the patient experience. • improving our practice of shared care planning and co-design with patients and whanau and • improving the ability for patients to access their own health information
Actions we are taking	1. BOPDHB are undertaking a "People-centred Experience at BOPDHB" programme focusing on: • Engagement/Te Tūhononga • Responsiveness/Te Noho Urupare • Experience/Wheako 2. BOPDHB have GP liaison staff for improved patient care and transition between primary and inpatient settings 3. Patient Experience data is sent to the Clinical Governance Committee for discussion and actioning 4. Communication improvement activities: Working with Pare o Toi to set up restorative communication process (Te Hohou Te Rongopai) 5. Increase our work with inpatient services to develop Shared Care Plans with a focus on people who have long term conditions and/or who have frequent attendances to the Emergency Department (as part of BOPDHB Planned Care programme) 6. Work with General Practice to increase the uptake of patient portals with a particular focus for Māori patients. 7. Patient Experience relating to primary and acute care: transfer of care documentation improvement activities that WBPHO are undertaking.
How will we know we've made an improvement	**Contributory Measures** • Number of Shared Care Plans completed and uploaded to hospital patient records with BOPDHB • Percentage of Māori enrolled with a PHO who can access their patient portal. • Percentage of enrolled Māori who are actively using their patient portal.

	• Percentage of enrolled Māori in the target population who have a shared care plan
System Level Measure Milestone	**Overall SLM Milestone change** We will improve our participation rates by at least 10% in the experience of care survey by 30 June 2022 for both Māori and non-Māori.

Babies Living in Smoke Free Homes – A healthy start	
Where to act *Māori infants are almost 4x more likely* *to reside in a household with a smoker present than for non-Māori*	
Why do we need to act?	This measure is focused on the total reduction of infant exposure to cigarette smoke. The measure shifts attention beyond maternal smoking to also encompass the home and family/ whānau environment, which requires an integrated approach between lead maternity carers, Well Child Tamariki Ora (WCTO) providers and primary care. The measure targets the collective environment an infant will be exposed to during pregnancy and in the early stages following birth, including the home environment where they are raised. **Our data shows that:** • Over 60% of Māori infants in the BOPDHB region live in households where they are exposed to smoking. • Māori infants are almost two times more likely to live in a household where they are exposed to smoking than non-Māori infants.
What are we aiming to achieve?	We aim to reduce the number of Māori children exposed to smoking in their home environment by targeting Stop Smoking services (Hāpainga and Ukaipo) to Hapu Mama. We will also work with Well Child Tamariki Ora providers to improve data capture for the question used to measure performance against this SLM.

Actions we are taking	The stop-smoking initiatives in the BOP Smoke Free Action Plan 2020-2025 and associated annual planning initiatives aim to improve the proportion of Māori babies living in smoke free homes. The three key objectives of tobacco control activities are to reduce smoking initiation, increase quitting, and reduce exposure to second-hand smoke. The overarching aims of the Smokefree strategy are to focus our resources and services towards those groups with the highest rates and numbers of smokers, with a special focus and priority on reducing smoking in Māori and Pacifica, women during pregnancy and people experiencing Mental Illness. Four actions relate to women during pregnancy /hapū māmā: • Stop smoking incentive programmes for pregnant women are reviewed and extended • Lead Maternity Carers who are Quitcard holders have access to a free supply of Nicotine Replacement Therapy • Opt-out referral pathways trialed in BOPDHB secondary maternity services • Pregnancy Sonographers are supported to provide brief stop smoking advice and refer to Hāpainga
How will we know we've made an improvement	**Contributory Measures** • Percentage of Māori Mothers who are smokefree at two weeks post-natal • Reduction in the proportion of Māori 'Unknown' responses to the household smoking status question • Percentage of mothers who smoke that are enrolled with the Regional Hāpainga programme
System Level Measure Milestone	We will improve the proportion of Māori Babies Living in Smokefree Homes to 45% or more by 30 June 2022 We will ensure that babies that babies are enrolled with Well Child Tamariki Ora and have their core contact by 56 days.

Appendix 3: Information related to Annual Plan activities

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[i] **Optimising Leadership & Management of Acute Demand and;**

[i] **The SBHS model and telehealth for youth in BOPDHB**

SBHS are nurse-led clinics working under standing orders. Approx. 1 RN: 750 students. Nationwide, 93% of SBHS are provided by registered nurses. The other 7% of SBHS are run by enrolled nurses or health staff/parents with basic qualifications only i.e. training in first aid.

Eligible schools in the BOP Region (Decile 1-4 Secondary Schools)

Total students - 4921

Edgecumbe College- (207)
Tarawera High School – (410)
Opotiki College – (443)
Te Whānau-A-Apanui Area School- (89)
Te Kura Mana Māori o Whangaparaoa – (46)
Trident High School – 1114
(Number of students at each school)

Whakatane High School - 737
Te Wharekura o Ruatoki- 154
Murupara Area School – 294
TKKM o Huiarau – 72
Te Kura Māori-a-Rohe o Waiohau- 33
Te Kura Toitu o Te Whaiti-nui-a-Toi– 34

The case for change

NZ is in the midst of a nursing shortage. One in five New Zealand nurses will be looking to retire in the next five years, threatening a potential staffing crisis for health services. 43 per cent of nurses are aged 50 years or over. Almost 20 per cent of them are 60 years or older.

School based nursing is often seen as a less desirable career choice for registered nurses because:

- School based nurses face issues of professional isolation, boredom and lack of support. One third of school based nurses do not receive any clinical supervision or collegial support.
- School based nurses are required to work independently, compared to practice nursing who always work under the guidance of a GP.
- There is poor clarification of the role of the school nurse and an absence of an health career pathway specifically for school based nurses
- A wide salary gap exists between Practice nurses and School based nurses. Nurses take a big pay cut to become a school nurse which is discouraging for nurses considering the profession.

[iii] Community Care Coordination increased uptake for Primary Care requesting Short-term home help services, with wrap around assessment to reduce the risk of an unnecessary admission to hospital. This is reflected below in the uptake of this service: