Te Māhere Tau me Tōna Tākune
Me Te Tauāki Mahi o te Pūtanga Ake

2020 / 2021
ANNUAL PLAN

Incorporating the 2020/21 Statement of Performance Expectations

'I rere kau mai te awanui mai i te kāhui maunga ki Tangaroa.
Ko au te awa, ko te awa ko au.'

The river flows from the mountain to the sea. I am the river and the river is me.

Whanganui District Health Board Annual Plan

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

HE MIHI WHAKATAU – OUR STORY

Tihei mauri ora. Nei rā Ko Te Pōari o Whanganui e tuku mihi atu kingā uri o te rohe nei ki a koutou o Whanganui, Ngā Wairiki, Ngāti Apa, Ngāti Hauiti, Ngā Rauru-kītahi, Mōkai Pātea me koutou o Ngāti Rangi.

Mai i ngā matapihi taku titiro atu ki te awa o Waitōtara, ki te mana o Ngā Rauru-kītahi, ka huri au ki a koe e te Awa Tipua e rere kau ana i runga anō i ngā kōrero 'Ko au te awa, ko te awa ko au.'

E rere kau atu te wai ki ngā ngaru e aki ana ki a Whangaehu heke atu ki a Turakina awa me ngā whenua o Ngā Wairiki me Ngāti Apa.

Ka huri taku kanohi kia whaia e au i a Rangitikei awa ki ngā whānau o Ngāti Hauiti me Mōkai Pātea. Ko te kāhui maunga e tū mai rā me ōna kauae kōrero hei māharatanga ki ngā uri kei ōna rekereke.

Ngāti Rangi koutou ko Ngāti Uenuku, tēnā koutou.

Huri noa ki tēnei rohe o Te Pōari o Whanganui, tēnā koutou, tēnā koutou, tēnā tātou katoa.

We of the Whanganui District Health Board make acknowledgments to the descendants of Whanganui, Ngā Wairiki, Ngāti Apa, Ngāti Hauiti, Ngā Rauru-kītahi, Mōkai Pātea and Ngāti Rangi.

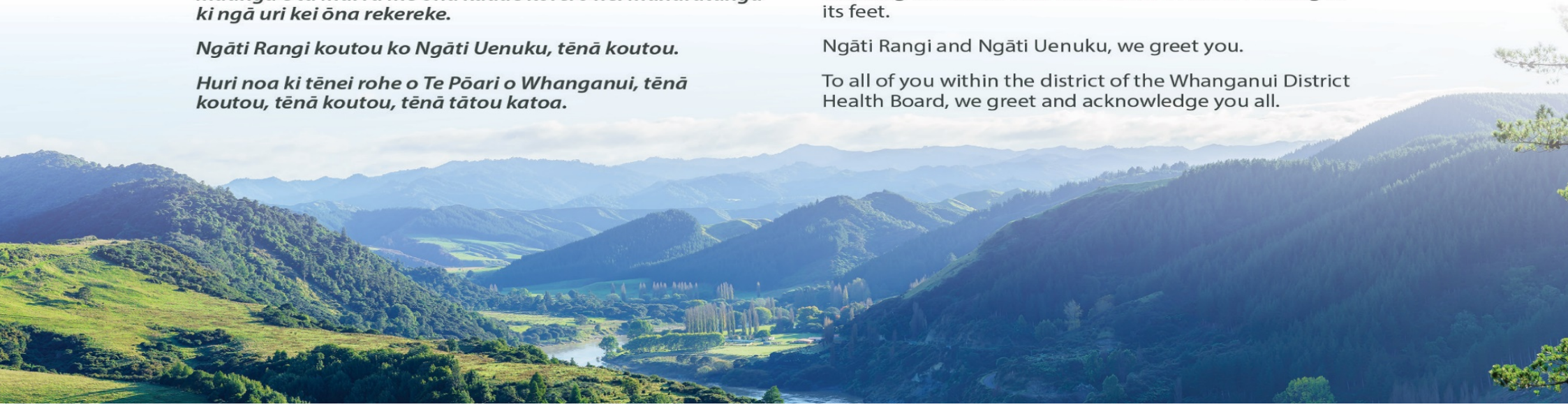
From our window we watch as the Waitōtara flows through themajestic Ngā Rauru Kītahi district. I turn to you the great river of Whanganui that flows with all its grace and acknowledge that 'I am the river, and the river is me.'

The river continues to flow and the waves break at Whangaehu and Turakina through the lands of Ngā Wairiki and Ngāti Apa.

I turn to follow the Rangitikei to the families of Ngāti Hauiti and Mōkai Pātea. From here we have a clear view of the stunning mountain clan, a reminder of those residing at its feet.

Ngāti Rangi and Ngāti Uenuku, we greet you.

To all of you within the district of the Whanganui District Health Board, we greet and acknowledge you all.



Rārangi Kiko
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Message from the Whanganui District Health Board Chair and Chief Executive

Tēnā koutou katoa, this 2020/21 Annual Plan sets out Whanganui DHB's plan for the new financial year at a significant time where international and local health, other social, financial and political systems are being challenged on an unprecedented scale for modern times. As well in New Zealand, the Health and Disability System Review has released its Final Report Pūronga Whakamutunga recommending far reaching change focused on equity, community engagement and sustainability.

Locally pre-COVID -19, WDHB has worked with our communities to develop a strategy; 'He Hāpori Ora: Thriving Communities', which determines three strategic focus areas: Social Governance; Pro-Equity and 69,000 Beds. Internally, we have successfully implemented Transition 2019, transitioning structures to be more outward facing, enabling authentic partnerships, improved work across systems, and bringing to life the strategy that supports our functions across population health, equity, sustainability and serving and strengthening the communities of the WDHB rohe.

In March to June 2020, WDHB's COVID -19 response was defined by our strategic focus areas. These were tested and found to provide powerful, clear and instructional guidance and direction for our work with partners in care, to ensure an effective, empowering, coordinated, district-wide response.

Whilst COVID -19 remains a threat, we have fast-tracked intelligence gathering and learnings analysis from our initial response to bring together a socially governed Reset, Redesign - Recovery strategy and team. This involves coordinating effort with iwi, territorial authorities and other agencies to work on an integrated model across health, social and economic activity to bring about immediate, medium-term and long-term holistic regeneration and enhancement of our communities.

The major themes of this annual plan are set within this wider context and tie together our DHB, and communities', strategic focus areas, our commitment and responsibility for good governance, service and financial performance and sustainability, and the Minister of Health's expectations that we deliver on the system priorities outlined in his Letter of Expectations for 2020/21.

Social Governance is being championed by WDHB as a model to harness the collective power of iwi, community, social and government organisations to work together in new and innovative ways to define priorities and begin to plan equitable, sustainable solutions.

Pro-equity has been a significant focus for WDHB since the board endorsed an independent Pro-equity audit in 2019. With Hauora ā Iwi, we are committed to partnering with Māori as our foundation for success in embedding Te Tiriti o Waitangi and achieving pae ora. In this annual plan we highlight some of the processes and practices that will demonstrate accountability for equity.

69,000 Beds reflects the Government's commitment to wellbeing, prevention, sustainability and better support for primary healthcare. Across our rohe, there are approximately 69,000 people, therefore the term '69,000 beds' reinforces our commitment to keeping people well in their own homes and enabling whānau/person-centred care at home and in the community. 69,000 beds connects across the spectrum of self-care to community care and aims to build primary healthcare providers, including kaupapa Māori providers and other whānau/patient-centred health and disability services.

Child wellbeing is a Government priority and continues to be of great importance in the Whanganui rohe as reflected in the activities in this plan. We expect more than 800 births in 2020/21 and seek to fully embrace the Government's vision of making New Zealand the best place in the world for children and young people with the strengthened focus on the first 1000 days of life so all children get the best start.

Mental wellbeing has had clear direction from the Government and we have engaged with our communities to set out an ambitious programme of work in this plan that seeks to improve mental wellbeing across people's different stages of life and level of need.

We appreciate the recognition of our population increase through an up-lift in Government funding for 2020/21 and will continue to provide sound financial management of this funding package. Within the DHB, we seek to challenge traditional service funding models to ensure community-led activity that is developed by engaging with primary and community providers to transform services.

Included in this plan is our Statement of Performance Expectations for 2020/21, which shows our accountability targets for some priority areas and the anticipated financial outcomes for the 2020/21 year and forecasts for the next two years.

We are committed to our important role as stewards of significant Crown assets and of the necessity to have strong fiscal management. By balancing population health gains, improved patient experience and best use of resources, we will contribute to a high-quality, strong and equitable public health and disability system.

Nā mātou noa, nā / Yours sincerely

Ken Whelan
Toihau
Board Chair

Russell Simpson
Kaihautū Hauora
Chief Executive

Message from the Hauora ā Iwi chair

E te Poari, tēnei te reo o ngā mana whenua o tō tātou rohe e maioha atu ana ki a koutou katoa.
Ko ngā mate kua huri ki tua o pae maumahara, rātou kua okioki.
Ki a tātou, ngā morehurehu, tēnā tātou katoa

Over the past 2 years Hauora ā Iwi has worked alongside the Whanganui District Health Board in the development of *"He Hāpori Ora: Thriving Communities"* strategy 2020-2023. The Annual Plan 2020-2021 sets the foundation for implementation of the strategy by introducing three strategic focus areas; Kāwanatanga Hāpori: Social Governance, Mana Taurite: Pro-Equity, 69,000 Ngā Moenga: 69,000 beds. The Annual Plan addresses the priorities set by the Minister's Letter of Expectations 2020-2021 and acknowledges the recommendations from the recently released Health and Disability System Review Final Report Pūrongo Whakamutunga.

COVID-19 was a significant challenge for our health system in 2020 however our rohe response demonstrated how collaboration and focus can make a significant difference to those we serve; the most vulnerable populations and isolated, disadvantaged and hard to reach communities. Iwi mobilsed to ensure whānau and hapū were well informed and able to access the services they needed. The entire health system joined forces to keep communities safe, introducing mobile services, virtual consultations and other models of care that had whānau wellbeing at the core. In the analysis of how well we did, we must acknowledge and find those we missed, those who went under the radar and those who continue to suffer in silence for reasons unknown.

The system has a lot to learn from our collective experience of and from the ngāngara that is COVID-19; it is incumbent on us to challenge and disrupt, to adapt and transform the health system to meet the needs of today's and tomorrow's worlds. The Health and Disability System Review suggests a pathway forward, a journey that Hauora ā Iwi and the Whanganui DHB began well before the Review was announced. We support the kōrero from a number of our national Māori leaders; calling for a more ambitious approach by Government to health reform if we really want to alter the trajectory of Māori health inequalities.

We are committed to staying the course; to leading new initiatives that create sustainable change, that address equity, racism and bias; implementing solutions that are community generated and led; weaving intergenerational tapestries that provide whānau with a range of options and choices when determining their own holistic well being; and driving multi dimensional strategies that are supported and resourced through a Whānau Ora approach that is more acceptably described as Social Governance.

Hauora ā Iwi supports the approach taken in the Whanganui DHB Annual Plan 2020-2021. The DHB is commited to a change agenda that will test, among other things, funding arrangements, service delivery, models of care and best use of resources. Hauora ā Iwi commend that approach and will provide advice and support to further those initiatives. We will continue to challenge and draw strength from our partnership with the DHB over the duration of this Annual Plan and beyond. In the coming year we will pay particular attention to the equity agenda and the changes needed to achieve health equity and better outcomes, more especially for Māori.

He aha te mea nui o te ao. He tāngata, he tāngata, he tāngata.

Nā mātou noa, nā

Mary Bennett
Hauora ā Iwi
Board Chair

This plan is signed on behalf of the Whanganui District Health Board this 31st day of July 2020

Ken Whelan
Toihau
Board Chair

Annette Main
Board Member

Russell Simpson
Kaihautū Hauora
Chief Executive

Hon Chris Hipkins
Minister of Health

Wāhanga 1:
Te Kitenga Whānui o Ngā Rautaki-Matua

Section 1:
Overview of strategic priorities

Whanganui is one of 20 district health boards (DHBs) in New Zealand established under the New Zealand Public Health and Disability Act 2000. The Act sets out the roles and functions of DHBs.

District health boards, as Crown agents, are also considered Crown entities, and covered by the Crown Entities Act 2004.

The statutory objectives of Whanganui DHB (WDHB) include:
- improving, promoting and protecting the health of communities
- promoting the integration of health services, especially primary and secondary careservices
- promoting effective care or support of those in need of personal health services or disability support
- funding and providing public health services.

Our activities are carried out within the context of an outcomes framework that aligns our activities with relevant international and national obligations, and with national and regional direction. These include the following.

Te Tiriti o Waitangi

We are committed to honouring our obligations under Te Tiriti o Waitangi.

- Guarantee of tino rangatiratanga
  - Self-determination in design, delivery and monitoring of health services
  - Enabling whānau, hapū and Iwi to exercise control over their own health and well-being, as well as the direction and shape of their own institutions, communities and development as people

- Equity
  - A duty as a Crown Entity to act with fairness and justice to all citizens
  - Commitment to achieving equitable health outcomes for Māori
  - Guarantee of freedom from discrimination

- Active protection
  - Action on equity and ensuring our Treaty partners are well informed on Māori health outcomes and equity
  - Health services are culturally safe
  - Specific targeting of disparities

- Options
  - As Treaty partners, Māori have the right to choose their social and cultural path
  - Protect the availability and viability of kaupapa Māori solutions
  - Ensure development and maintenance of mainstream services so these are equitable and work alongside kaupapa Māori health services

- Partnership
  - Obligation to act with the utmost good faith

Our commitment to the Treaty and application of the principles starts with the governance partnership between WDHB Board and Hauora ā Iwi (a board made up of representatives from Iwi throughout the rohe). Section 2 provides more detail about how our governance partnership supports effective working relationships with iwi, hapū, whānau and Māori communities and links to implementation of our pro-equity strategy.

He Korowai Ōranga 2014

Commitment to Māori Health Strategy: He Korowai Ōranga 2014, with the overall aim of Pae ora – healthy futures, which incorporates three interconnected elements:

- Whānau ora – healthy families – whānau wellbeing and support, participation in Māori culture and Te Reo.
- Wai ora – healthy environments – education, work, income, housing and deprivation.
- Mauri ora – healthy individuals – life stage from pepi/tamariki to rangatahi then pakeke and a section that includes individuals of all ages.

He Korowai Ōranga incorporates four pathways of action that are not mutually exclusive and are intended to work as an integrated whole:

Te Ara Tuatahi	Pathway One	Development of whānau, hapū, Iwi and Māori communities.
Te Ara Tuarua	Pathway Two	Māori participation in the health and disability sector.
Te Ara Tuatoru	Pathway Three	Effective health and disability services.
Te Ara Tuawhā	Pathway Four	Working across sectors.

We endorse the seven principles of Whānau Ora - that whānau are:

- self-managing and empowered leaders
- leading healthy lifestyles
- confidently participating in te ao Māori (the Māori world)
- participating fully in society
- economically secure and successfully involved in wealth creation
- cohesive, resilient and nurturing
- responsible stewards of their living and natural environment.

The New Zealand Health Strategy – incorporating five strategic themes (people-powered, care closer to home, high value and performance, one team, smart system).

The Healthy Ageing Strategy – commitment to the vision that 'Older people live well, age well, and have a respectful end of life in age-friendly communities'.

The United Nations Convention on the Rights of Persons with Disabilities – commitment to the aim of 'promoting, protecting and ensuring the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity'.

Ola Manuia 2020 – 2025: Pacific Health and Wellbeing Action Plan – commitment to facilitate the delivery of high quality health services that meet the needs of Pacific peoples.

The New Zealand triple-aim

A strong and equitable health and disability system is delivered through good governance and sustainability – clinical, financial and service sustainability. WDHB is guided by the New Zealand triple aim in our prioritisation processes, keeping us focused on all these aspects. The triple aim has been developed by the Health Quality and Safety Commission as a framework for quality improvement – it includes three dimensions:

1. improved quality, safety and experience of care (individual and whānau dimension)
2. improved health and equity for all populations (population dimension)
3. best value for public health & disability system resources (system dimension).

The triple aim is depicted in Figure 1 below. It highlights how a quality improvement approach can support the objective of optimising resource allocation to achieve sustainability. Optimising resource allocation relies on a range of ongoing prioritisation activity that includes community engagement with the population we serve alongside clinical leadership, enhanced integration, regional partnerships and regular review of the status quo. Clinical leadership and out-year planning, within this framework, is further outlined through the planning priorities across section 2 and in Section 4 (Stewardship).

Figure 1: The New Zealand Triple Aim

The population we serve

Our district is home to just under 69,000 people and we need to ensure they have access to a wide range of health and disability support services. We aim to meet our statutory objectives by engaging with our communities to assess health status and need, and to determine what resources should be directed to preventing illness, to detecting and managing illness, to providing intensive assessment and treatment, and to providing rehabilitation and support.

The infographic on the next page is an overview of our district and the population that we serve.

Our population has a unique profile compared to the rest of New Zealand:

- modest growth historically, with a recent surge, impacting on the share of funding received
- high rates of relative deprivation, which correlates to poor health status and high health need
- a higher proportion of Māori
- a higher proportion of people aged over 65
- a relatively large geographical area with some pockets of isolated, small rural populations
- a small hospital servicing a widely dispersed population base
- significant travel distances to hospitals that provide us with some key specialist services.

WDHB aims to partner with our communities to build resilience, empower whānau and individuals to determine their own wellbeing. We are accountable for public health services delivered to the population of the Whanganui district as defined by the NZ Public Health and Disability Act.

WDHB works with many other organisations and communities inside and outside the health sector, to deliver on local, regional and national health priorities.

Note: in the following tables, the term "WDHB rohe" is used to refer to the whole geographic area covered by Whanganui District Health Board, as defined in the New Zealand Public Health and Disability Act (2000).

THE POPULATION WE SERVE

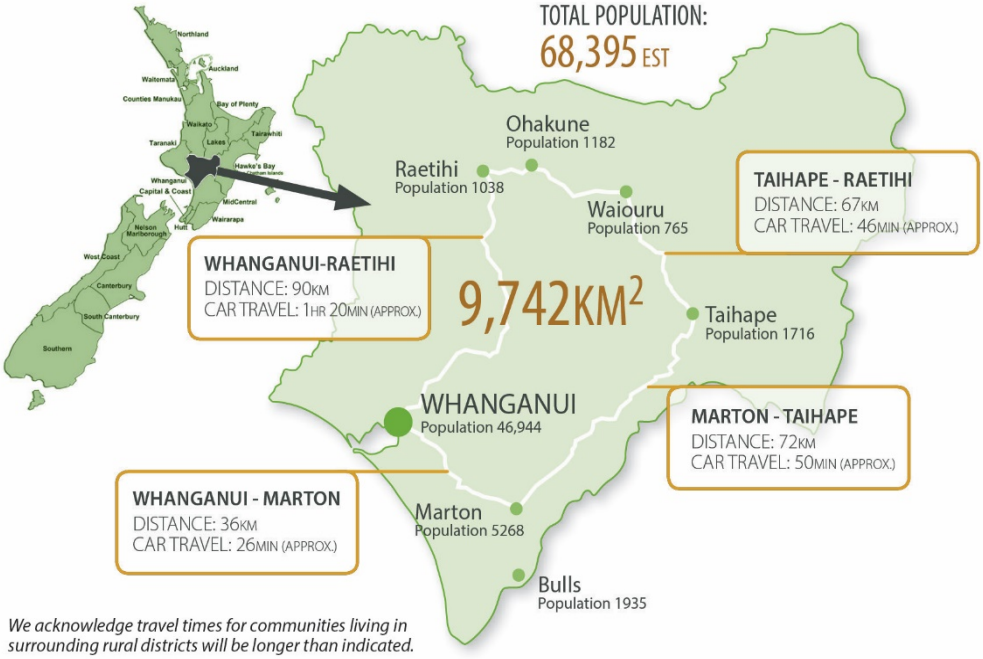
HE TANGATA, HE TANGATA, HE TANGATA

One of 20 district health boards (DHBs) in New Zealand, Whanganui District Health Board (WDHB) was established under the New Zealand Public Health and Disability Act 2000. This Act sets out the roles and functions of district health boards.

WHANGANUI DHB DISTRICT | TOTAL POPULATION: 68,395 estimate | 9,742KM²

We acknowledge travel times for communities living in surrounding rural districts will be longer than indicated.

OUR ROHE




Whanganui

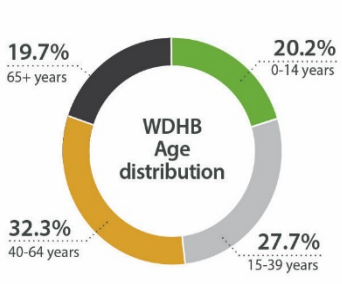

Ngā Rauru Kītahi

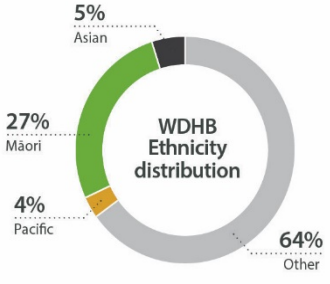

Ngāti Hauiti

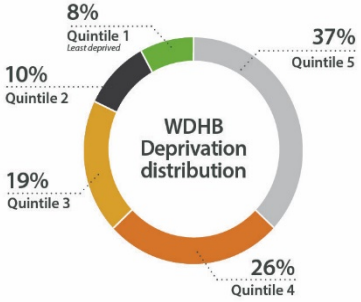

Ngā Wairiki Ngāti Apa


Mōkai Pātea


Ngāti Rangi







Outcomes and Strategy

The health and disability system outcomes framework supports a stable system by clearly articulating what outcomes the system intends to achieve for New Zealanders, and the key elements that contribute to achievement of the goal. This is depicted in Figure 1.

Figure 1: The health and disability system outcomes framework elements

Population health drives our intentions and we must ensure alignment of those intentions with our statutory objectives and with the Government's key goal of *Improving the wellbeing of New Zealanders and their families.* Alignment is depicted by our outcomes framework (Figure 2), which shows the logic that connects our strategy and the Government's key goals, and highlights the key elements between them.

Our vision is *He Hāpori Ora - Thriving Communities*.

The people in Whanganui District Health Board rohe live their fullest lives possible in thriving communities.

Four key strategic drivers inform the outcomes that are required to achieve thriving communities:

- Eliminating inequity – by targeting vulnerability, understanding need and measuring what matters, and focusing on access.
- Integrating care – by shifting to community and primary healthcare, reducing hospitalisation, and focusing on public health, health promotion, protection and prevention.
- Partnering for community wellbeing – by broad, integrated social mobilisation across all communities; good communication to keep the population engaged with the health sector.
- Empowering whānau and individuals to make healthy choices – by supporting wellness and self-care through Whānau Ora; and using helpful planning and case management tools.

Figure 2: Our Outcomes Framework

Our way of working

Our mission is kia tāea e te whānau me te hāpori i tōna ake tino rangatiratanga – together we build resilient communities, empowering whānau and individuals to determine their own wellbeing.

We will ensure health care places people and whānau at the centre of everything we do with and for them. We will support and empower individuals and whānau to determine their own wellbeing. We are committed to working in partnership with other healthcare providers, Iwi, government, social and community agencies and clinical leadership to build strong, resilient, connected communities.

Strategic focus areas

Acknowledging our strategic drivers and the outcomes that we want to achieve, our mission will be actioned through three strategic focus areas.

- **Mana Taurite – Pro-equity**
  We are committed to achieving equity of health outcomes for Māori and across all population groups

- **Kāwanatanga Hāpori – Social governance**
  Across the WDHB rohe there are a range of ogranisations and government agencies working to achieve outcomes and deliver services for the wellbeing of our communities. We are championing social governance as a model to harness the collective power of these organisations to better serve the people of our rohe.

- **69,000 Ngā Moenga – 69,000 Beds**
  Across our rohe, there are approximately 69,000 people. This focus area reinforces our commitment to Whānau Ora, supporting self-care, keeping people well in their own homes and enabling whānau/person-centred care at home or in the community, where appropriate. It also recognises when people need to be in hospital, they are empowered partners in the delivery of whānau/person-centred care, they receive high quality health services and are supported in a timely transition back to their own home.

How the sections in our Annual Plan are linked

Sections 2 and 3: Delivering on priorities

Sections 2 and 3 below outline activity in respect of near- and medium-term priorities focusing specifically on guidance received through the Minister's Letter of Expectations. Activity is linked to timelines for delivery and to our performance framework where relevant. This forms the basis of our regular accountability reporting to the Ministry of Health. Our financial plans and targets are also included in Section 2.

Within section 2 the code EF refers to Equity Focused activity and EOA refers to Equitable Outcome Actions. See section 2, Achieving Health Equity for further detail.

Section 4: Connecting to strategic enablers

Section 4 is titled Stewardship. That section completes our outcomes framework by showing the connections between our strategic drivers and our strategic enablers, illustrating how we deliver on our priorities through our system stewardship functions.

Section 5: Performance Measures

This section provides the detail of the performance measures that are shown relating to the activity in section 2.

Wāhanga 2:
Ngā Whakataunga Rautaki Matua

Section 2:
Delivering on priorities

Minister of Health's planning priorities

WDHB will deliver on the Government's priorities for 2020/21, as outlined in the Minister of Health's Letter of Expectations received, 10 March 2020. This section shows activity relating to those priorities, grouped as follows:

- Give practical effect to He Korowai Oranga – the Māori Health Strategy
- Improving sustainability
- Improving child wellbeing – improving maternal, child and youth 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.

In addition, through our established partnerships and processes and supported by our strategic focus areas, WDHB is well-positioned to respond to the Government's advice in respect of the Health and Disability System Review Final Report Pūrongo Whakamutunga.

Māori health improvement

Pro-equity is a key strategic focus area and stated goal of the WDHB Board and our Treaty partnership board Hauora ā Iwi .

Our vision and mission explicitly recognises that, to achieve thriving communities, all people in the Whanganui rohe, need to live in healthy homes and environments, where people feel safe, connected, resilient and able to determine their own needs and the needs of their whānau. Actions are brought together through our commitment to whānau ora and whānau centred care.

This influences what we do and more importantly, guides how we do it, including:

- applying the philosophy of Whānau Ora as a key principle in how we partner with all health consumers and their whānau and how we understand and acknowledge their cultural values and beliefs.

- applying the equity lens and Whānau Ora philosophy ensures that governance, leadership and our wider workforce understand their responsibilities and are culturally aware and supported in their cultural practice.

- Whānau centred care guides our view of best practice.

- applied to planning and service improvement, the equity lens and whānau-centeredness requires whānau, clinicians and the community to work together to build an understanding of what is happening and what needs to be done differently. This requires working across systems to support whānau goals and aspirations and building resilience in whānau and the community.

- investing in sustainable kaupapa Māori services, to provide whānau choice and support

building of capacity and capability of the Māori workforce across our system including for people living in isolated communities.

This work is structurally supported within the organisation through Te Hau Ranga Ora (the DHB's Māori Health and Equity Service) and with the placement of kaitakitaki in the leadership teams of each of the DHB's Service Groups. Within our own services, and beyond where feasible, our haumoana service supports the delivery of whānau centred care.

Achieving health equity

For WDHB achieving equity is a central expectation of everything we do and our overarching goal. Our Board has explicitly agreed that we will focus on equitable outcomes for Māori.

We have a clear pro-equity implementation plan with four priority areas:

- **Strengthen Leadership and Accountability for Equity**
  For sustained success, Whanganui District Health Boards Leadership must be champions of a pro-equity approach and take on an organisational leadership role to this effect.

  Components for success:
  - Publicly commit to an equity goal
  - Creating a learning environment and building leadership commitment
  - Commit to a training budget to support equity skill development.

- **Build Māori workforce and Māori health and equity capability**
  Whanganui District Health Board needs the right skills to drive Māori health equity, and a workforce that is fit for purpose to meet the needs of the population that they serve. This includes more Māori staff (particularly in senior roles) and contemporary Māori health and equity expertise across the Whanganui health workforce (not limited to DHB staff).

  Components for success:
  - Recruitment and retention strategy focused on Māori staff
  - Strengthen the role and size of the Māori health services team
  - Staff led, health equity competencies
  - Continued strengthening and extension of Hāpai te Hoe.

- **Improve transparency in data and decision making**
  Improving transparency in decision making will support the Whanganui District Health Board to demonstrate a pro-equity approach and be held accountable (by the Board, Hauora ā Iwi and the wider community) in its pursuit of equitable health outcomes.

  Components for success:
  - Build capability in equity data analysis
  - Share equity analysis widely and include it in all decision making
  - Transparency in resource allocation - include equity analysis in all publicly reported data.

- **Support more authentic partnership with Māori**
  The Whanganui District Health Board will work with iwi, hapū and whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services. This needs to be turned into action to avoid appearing to be rhetoric, which could undermine the promise provided by the Hauora ā Iwi Memorandum of Understanding (MoU).

  Components for success:
  - Strengthen partnership with Hauora ā Iwi
  - Increasing use of Māori health and community expertise by the DHB
  - Meaningful participation in the design of services and interventions to support Māori self-determination and Whānau Ora.

Our pro-equity approach is endorsed by Hauora ā Iwi and is reflected with an equity lens to be applied to all planning priority areas. This approach is underpinned by an organisational commitment to address discrimination and racism.

Consistent with WDHB's pro-equity strategic focus area, we acknowledge that achieving equity in Māori health outcomes is a multi-year programme that is broad and must stretch across and beyond the health system. Iwi, hapū and whānau, government agencies and other organisations must partner to address inequities in the full range of health determinants and this will be supported by our social governance strategic focus area.

In our sphere of influence, activities that are developed to address a specific gap in equity, for an identifiable population, with measurable and monitored results are called **Equitable Outcome Actions** and coded **EOA** in the plan.

However, WDHB also recognises that the path to equity requires some essential activities to create the conditions for equity, rather than achieving a measurable change in equity outcomes in this plan's timeframe, such as improving data collection, creating partnerships, staff development etc. These activities are coded **Equity Focused (EF)** to signal they are part of the DHB's pro-equity shift and a necessary pre-requisite to future EOAs.

Regional services planning

WDHB is one of the six DHBs of the Central Region, along with Wairarapa, Hawke's Bay, MidCentral, Hutt Valley, and Capital and Coast. Our tertiary centre is Capital and Coast DHB and we also have strong sub-regional arrangements, through the centralAlliance, with MidCentral DHB.

Regular planning, monitoring and service support takes place continuously through formal and informal networks of clinicians and managers.

The six Central Region DHBs are co-shareholders of Central Region's Technical Advisory Services Ltd (TAS), which provides a range of strategic, advisory and programme management services to the whole public health sector. TAS co-ordinates most of the regional work including production of the annual Central Region Regional Services Plan (RSP).

Further details of the priorities for the 2020/21 RSP are outlined in section 2.6.16 below.

Key local health provider partners

WDHB has broad contractual relationships with five hauora providers - Ngati Rangi Community Health Centre Incorporated, Nga Iwi o Mokai Patea Services Trust, Te Puke Karanga Hauora, Te Oranganui Trust, and Te Kotuku Hauora Ltd. Collectively the hauora providers make up the Māori Health Outcomes Advisory Group (MHOAG), who meet regularly with the DHB and other entities to contribute to service planning, development and monitoring.

The district is served by two Primary Health Organisations (PHOs) – the Whanganui Regional Health Network (WRHN) and the National Hauora Coalition (NHC).

2.1 Give practical effect to He Korowai Ōranga – the Māori Health Strategy

2.1.1 Engagement and obligations as a treaty partner		
DHB activity	**Milestone**	**Measure**
Listed here are strategic level activities or those that work across the organisation and the system in partnership with others.		
Strategic Maintain partnership and close working relationships between WDHB and Hauora Iwi (HAI), through: ▪ Regular joint hui (EF) ▪ Review Memorandum of Understanding (MoU) between WDHB and HAI boards in 2020 (EF) ▪ Involvement of HAI members in all key DHB strategic discussions and decisions (EF) ▪ Consultation with HAI and joint board endorsement of the new WDHB He Hāpori Ora Thriving Communities Strategy Document 2020 – 2023 (EF) ▪ Message from HAI included in the foreword of the WDHB 2020/21 annual report (EF) ▪ Joint board monitoring of equity measures in WDHB Annual Plan and pro-equity implementation work plan (EF) ▪ HAI representation on all interviews for executive positions (EF) ▪ HAI representation on combined statutory advisory committees and performance review for chief executive (EF) ▪ A follow-up facilitated partnership hui, with WDHB board and HAI, to further embed responsibilities under the Treaty, the five principles, pro-equity and monitoring processes. (EF)	Q1 – Q4 Q3 Ongoing Q1 Q1 Q2 & Q4 Ongoing Ongoing Q1	SS12
Waitangi Tribunal ▪ Plan and begin the roll out of embedding obligations under the five Treaty principles in updating key policies and procedures. (EF) ▪ Continue to participate in the design and implementation of the proposed Ministry of Health Treaty framework, to be set out in the new Māori Health Action Plan, to ensure WDHB meets its statutory obligations, as prescribed by the Tribunal and its interpretation of the Treaty clauses under the NZ Public Health and Disability Act 2000. (EF)	Q1 - Q4 Ongoing	SS12

Partnership ▪ Implement recommendations from the WDHB consumer involvement review 2020, including Te Pukaea and grow the number of Māori members to 50% of the total membership (EOA) ▪ Implement Term of Reference for a Māori reference group to provide Māori community and health expertise advice to key service developments, service improvements, development of Māori health policy and frameworks to ensure that we have a wider Te Ao Māori lens applied to our work (EF) ▪ Develop a work programme between the WDHB and HAI boards to measure improvement in equity for Māori across annual plan equity-oriented activity indicators and the WDHB pro-equity work programme (EF) ▪ Continue support for the Central Region's Iwi relationship boards Te Whiti ki te Uru forum and their alliance with the Central Region CEs and Chairs (EF) ▪ Continue participation in the Central Region GM Māori forum to influence across the region and share learnings and initiatives. (EF) ▪ Continue participation in national Māori health leadership forum Tumu Whakarae. (EF)	Q4 Q4 Q2 Ongoing	SS12
Pro-equity Continue to implement the WDHB Pro-equity Check-up Actions Implementation Plan 2019-21 report under 5 recommendations: ▪ Strengthen organisational leadership and accountability for equity (EF) ▪ Build Māori workforce and Māori health and equity capability (linked to workforce development) (EOA) ▪ Improve transparency in data and decision making (EOA) ▪ Support more authentic partnership with Māori. (EF)	Ongoing	SS12
Leadership ▪ Continue to provide professional development (training) for DHB leadership on the impact of racism, impact on colleagues and workforce, the impact on quality outcomes for patients and their whānau, and the use of equity tools and methodologies. (EOA) ▪ Introduce mechanisms that will be there to support Māori staff, if they have been victims of racism, as leadership and the organization addresses the impacts of racism (EF) ▪ Continue to support equity professional development to local provider partner leaders (EOA) ▪ Apply equity methodology and monitoring to decision-making processes including commissioning, service delivery models and service changes (EOA) ▪ Continue to support development and provision of education for elected board and committee members in understanding the impact of racism and colonisation on health outcomes for Māori whānau and the use of equity tools and methodologies. (EOA) ▪ Continue to provide cultural safety education as part of WDHB board member local induction programme (EOA) ▪ Continue to role model WDHB values and WDHB tikanga o Whanganui practices. (EF)	Q2 Q2 Ongoing	SS12

2.1.2 Māori Health Action Plan (MHAP) - accelerate the spread and delivery of Kaupapa Māori services		
DHB activity	**Milestone**	**Measure**
Identify initiatives and opportunities to accelerate the spread of kaupapa Māori services and commissioning for whānau ora outcomes by:		SS12
▪ applying equity methodologies to commissioning process across all new and expiring contracts for service and identify initiatives and opportunities to confirm and maximize investment that meets the needs of Māori (EOA)	Q2 & Q4	
▪ continuing to work in partnership with Iwi health organisations through the Māori Health Outcomes Advisory Group (MHOAG) to develop services that meet the needs of Māori whānau (EOA)	Ongoing	
▪ review (MHOAG) Terms of Reference (EF)	Q2	
▪ continuing to contract with kaupapa Māori service providers to maximise the use of whānau ora outcomes focused contracts:	Ongoing	
– maximise opportunities presented through the COVID -19 response to improve funding models and models of care and delivery (EF)	Q2	
– implement any changes (EF)		
▪ constantly seeking opportunities to provide a service in a kaupapa Māori setting/way, especially with any new initiative and funding opportunities (EF)	Q4 Ongoing	

2.1.3 MHAP – shifting cultural and social norms

WDHB Pro-equity Check Up implementation plan identifies a programme of work that builds on what the DHB is already undertaking to shift cultural and social norms.

WDHB has been focused on this work for some time and has a well embedded cultural education programme (Hapai te Hoe) building staff knowledge and confidence to enable them to work effectively with Māori whānau. We have a strong Māori leadership team supporting and advising leader colleagues and the executive leadership team. Building on our staff acknowledgment of Te Ao Māori values and beliefs and deeper understanding of the impact of colonisation on local Whanganui Iwi, through Hāpai te Hoe. We have started to introduce specific education and tools to address bias and racism in our workplace that affects best practice in health outcomes and staff wellbeing.

All leaders Māori or non-Māori have responsibility to role model DHB values, call out and act on racism and discrimination in all forms and support and expect staff to do the same. In addition, to support staff who are impacted by racism and discrimination.

DHB activity	Milestone	Measure
Build the knowledge of all DHB staff in Te Tiriti o Waitangi: ▪ continue to deliver Hapai te Hoe to all new staff prior to commencing work and as the first two days of the DHB orientation programme (EF) ▪ continue to include key community partners and external agencies i.e. St John, Hospice Whanganui, UCOL Tutors Nursing Faculty, UCAL Nursing students, NZ Police, Coronial Transport Services and Local Funeral Directors (EF) ▪ develop and implement Hāpai te Hoe extension course (Te Waka Hourua) that builds on orientation HTH and focusses on whānau ora models of care and DHB values (EF) ▪ support the implementation of health discipline specific cultural frameworks to support professional development and best practice. (EF)	Ongoing Q1 Ongoing	SS12
Addressing bias in decision making: ▪ initiate a more focused programme on biases in best practice that affects patient outcomes – building on the examples from medical bodies and programmes in other DHBs. Establish an ongoing forum for Māori staff to meet and feedback on activities that achieve equity in health outcomes for Māori whānau, WDHB Māori health strategy and policy initiatives and whānau focused models of service delivery – monitoring and audit (EF) ▪ continue to provide a professional development (training) for DHB leadership and staff on the impact of racism, impact on colleagues and workforce, the impact on quality outcomes for patients and their whānau (EF) ▪ include learnings from other DHBs on programmes, speakers and tools to support staff. (EF)	Q4 Ongoing	SS12

Enabling staff to participate in cultural competence and cultural safety training and development: ▪ continue Hāpai te Hoe programme – WDHB policy confirms mandatory attendance for all WDHB staff and board members (EF) ▪ enable the role of Kaitakitaki, Te Hau Ranga Ora (WDHB Māori health services team), in providing advice and support to executive leads and their teams (EF) ▪ maintain the role of the Haumoana service (WDHB Māori health service) across all services to support whānau (Māori and non- Māori) and provide cultural support for staff 24 hours, seven days per week (EF) ▪ ensure leaders 'walk the talk 'and more specifically addresses racism and discrimination within the frame of the organisation's values and expectation that racism and discrimination of any sort is unacceptable. (EF)	Ongoing	SS12

2.1.4 MHAP – reducing health inequities – the burden of disease for Māori		
DHB activity *(Equity focused activities not specified elsewhere in the plan)*	**Milestone**	**Measure**
Data ▪ develop and implement pro-equity tools and methodology to guide decision making for investment and procurement (EF) ▪ support development of a dashboard to monitor progress towards equity for Māori across priority indicators. (EF) Reporting ▪ reporting for equity to the statutory advisory committees and the Joint boards of WDHB and HAI. (EF)	Q2 Q1 Quarterly	SS12

2.1.5 MHAP – strengthening system settings		
DHB activity *(Equity focused activities not specified elsewhere in the plan)*	**Milestone**	**Measure**
▪ Driving a commitment to pro-equity approach through governance support and executive leadership. (EF) ▪ Development of clearer prioritisation frameworks that embed equitable outcomes actions, ethnicity in all data and equity in all data analysis which have governance endorsement and that inform annual prioritisation planning. (EF) ▪ Use contractual opportunities to increase equity-based reporting from contracted providers	Ongoing Q2 Ongoing	SS12

2.2 Improving sustainability

2.2.1 Improved out year planning processes

WDHB aims to continuously improve planning (and other) processes. To support long-term sustainability, we identify some actions for 2020/21 year with the most significant near-term actions shown in bold.
These actions support our pro-equity approach through governance support and executive leadership

DHB activity	Milestone	Measure
- **Development of clearer prioritisation frameworks that have governance endorsement and that inform annual prioritisation planning** • Prioritisation framework agreed	**Q2**	
- **Development of 3 to 5 year rolling operational plans that can inform integrated annual planning with clearer impacts on capital, workforce requirements and opportunities for service redesign** • Draft completed • Finalised for 2020/21 view	**Q2** Q3	
- **Quality review across Provider Arm service level agreement (price volume schedule) to confirm accuracy of data collections and better inform monitoring and planning**	**Q2**	
- Enhanced senior management involvement to ensure planning assumptions are robust and that executive leadership is clear on the business impact of outer year forecasts.	Q2	
- Enhanced decision support tools and improved forecasting and budgeting to achieve better stakeholder engagement • Better and more consistent monitoring across service groups • Consistent service group dashboards in place • Better decision support informs forecasting and budgeting for 2021/22	Q3 Q2	
- Co-ordinated project management for clearer alignment of strategic activity, improved allocation of resources and better monitoring of the strategic agenda		

2.2.2 Savings plans

WDHB has an ongoing commitment to reviewing our financial performance. The initiatives below are highlighted to demonstrate some key focus areas where we believe there are opportunities over the next 3 financial years. Initiatives and plans that focus on workforce also consider efficiency and effectiveness. Those initiatives are included in sections 2.2.3, 2.3.1, 2.4.1 and 2.6.13.

DHB activity	Milestone	Measure
FTE Management WDHB will improve management of staffing resources to minimise the need for staff replacements and new staff appointments. WDHB has an average annual FTE turnover of 7.33%. By carefully managing the replacement of staff as they resign or retire, previous growth can be reversed. Target 2.5% in FTE management improvement per annum – adjust by 50% for timing. All staff appointments to be signed off by Finance, ELT member and Chief Executive. Opportunities will be sought for combining of roles & better use of technology to gain efficiency.	From Q1	Y1: $985,000 Y2: $985,000 Y3: $985,000
Intensive IDF Management WDHB will intensively manage its IDF inflows and outflow to maximise the use of resources within the WDHB and minimise the cost of out of region care. ▪ Intensify management of monthly IDF results to ensure accuracy of in- & outflow monthly data and inform care decisions ▪ Reduce elective IDF net outflow & return care to WDHB in support of local surgical productivity ▪ Redesign community care & regional arrangements to reduce out of district travel where possible ▪ Enhanced planning of non-washed up elements with improved annual reconciliation, redesign and renegotiation	Ongoing	Y1: $1,010,000 Y2: $1,835,000 Y3: $2,170,000

"69,000 Beds" WDHB is providing a community focussed, preventative model of healthcare that is more effective and efficient. ▪ Avoid unnecessary hospital admissions ▪ Streamline line care across Community Health Providers to reflect patient and Whānau centred health care system ▪ Increase access to Community Care and reduce waitlist for community support ▪ Implement wellness/prevention model of care for reducing future cost including those at risk of hospital admission/readmission ▪ Hospital in the home models of care, partnering across social services/NGOs other partners.	From Q1	Y1: $290,000 Y2: $655,000 Y3: $810,000
Radiology efficiencies WDHB aim to reduce costs associated with out of hours radiology. ▪ Reduce costs associated with out of hours radiology Monday-Friday by initially extending general x-ray on site hours to 11pm, and reducing out of hours CT examinations that are not considered urgent. ▪ Streamline pathway for Community Radiology referrals by establishing joint service improvement groups between Radiology, Emergency department and community including GPs. ▪ Reference to National Criteria to Access Community Radiology	From Q1	Y1: $145,000 Y2: $145,000 Y3: $145,000
Theatre facility capacity management WDHB aims to improve the efficiency and utilization of theatres to reduce costs and to maximise funding and revenue opportunities. ▪ Review acute theatre utilisation with a view to reduce cancellation and OT costs; includes reduce readmissions ▪ Review throughput per session by speciality to maximise resources. ▪ Preference standardisation ▪ Manage medical devices and consumables to budget ▪ Complete a theatre production plan to ensure DHB drives efficiencies and meets compliance rates. ▪ Create a flexible workforce, and reconfigure the working day (activities, ie ward rounds/OP etc).	From Q1	SS07 SS08 Y1: up to $1,000,000 Y2: $1m to $2.5m Y3: $1m to $2.5m

2.2.3 Consideration of innovative models of care and the scope of practice for the workforce to support system sustainability		
DHB activity	**Milestone**	**Measure**
Support the roll out of early responses to mental health needs in primary care settings ▪ Our district mental health and addictions service level alliance co-designed a response to the primary mental health RFP in 2019 and were successful in gaining funding for an approach that will see two local general practices having health coaches and health improvement practitioners support enrolled populations ▪ Respond to any further RFPs and evaluate impact for consideration of expansion	From Q1 Q1 – Q4	
Partner with Arthritis NZ and the PHO to trial a kaiawhina role supporting a targeted approach to gout management ▪ In 2020/21 we will progress a proposal for a gout management programme combining culturally appropriate education along with a kaiawhina approach that will support improved access to medication management and engagement with pharmacy and general practice	From Q1	
Introducing the role of Clinical Informatician to drive clinical engagement in informatics ▪ Reallocation of resources to support a role that works between clinicians, data specialists and information technology to enhance clinical engagement and leadership in digital and data developments	From Q1	
Dual purpose clinic supports winter plan and readiness for re-establishment of COVID testing capability ▪ Continue to run the central community based assessment centre (CBAC) using primary care capacity at the hospital front door through to September 2020 ▪ Clinic deals with all influenza-like illness as a pre-urgent care and pre-emergency department pathway ▪ Screening of patients in their cars before guiding to definitive treatment in the clinic or referral to urgent care or emergency department ▪ Provides capacity for ad hoc or regular COVID testing if necessary ▪ Reevaluate for continuation and consideration of role in future winter plan	From Q1 Q2	
Establish kaupapa Māori service response for intensive pregnancy and parenting support ▪ Using principles of Waitemata model of intensive outreach service for women (see mental health and addictions sections)	From Q1	
Establish peer support model to support a more sustainable and holistic response to tangata whaiora in acute and emergency mental health settings ▪ Respond to anticipated RFP for acute mental health solutions	Q1 – Q4	

Expand regional telestroke service ▪ In 2017, the Central Region established an after hours regional telestroke service whereby stroke physicians at Capital & Coast DHB were able to provide after hours clinical oversight remotely to local emergency departments to carry out thrombolysis on eligible stroke patients. The scheme has been so successful that currently rates of thrombolysis after hours are better than those in-hours. The Central Region is now expanding the service to cover all hours. This will increase the capacity of the sub-specialty at some hospitals in the region so that thrombolysis can be guided at all the region's hospitals at any time of the day or night using remote technology.	From Q1	

2.2.4 Working with sector partners to support sustainable system improvements

WDHB is committed to working strategically with our partners (Māori relationship board, intersectoral, Māori health providers, NGOs, private enterprise) to support sector sustainability. This is clearly articulated in our strategic focus areas.

DHB activity	Milestone	Measure
Implement a strategic dashboard to monitor progress of our strategic agenda to include: ▪ strategic outcomes through collective action and shared intelligence. We will work in partnership with iwi and our social governance partners to support our communities health and wellness aspirations (EF) ▪ strategic innovations using our commissioning framework to ensure that all business cases clearly demonstrate equity thinking and methodology and investigate partnership opportunities for how services are funded and provided (EF) ▪ strategic processes as per our commissioning framework, review and identify accelerating the design and implementation of kaupapa Māori services through collective actions and continue to work with providers to improve sustainability (financially and environmentally) through innovative procurement and contracting opportunities. (EF)	Q4	SS03 SS12 SS17

Improving child wellbeing

2.3.1 Maternity and Midwifery workforce

DHB activity	Milestone	Measure
Attract and recruit an appropriately skilled Director of Midwifery (DoM) to manage workforce development and drive governance across midwifery services.	Q1	CW status update report
When the DoM appointment is in position (hospital and community) establish a project team to: ▪ develop longer-term midwifery workforce plan that has an equity focus including cultural competency and increased Māori participation in the workforce (EOA) ▪ ensure service delivery mechanisms make the best use of other health workforces to support pregnant women and midwifery roles (EOA) ▪ implement the midwifery workforce plan (EOA) ▪ evaluate the midwifery workforce plan. (EOA)	Q2 Q3 Q3 Q4	
Develop a plan for the Whanganui rohe recruitment and retention of Lead Maternity Carers with a focus on recruiting Māori LMCs. (EOA)	Q3	CW status update report
The WDHB will support undergraduate midwifery students: ▪ facilitate and support Otago Polytechnic's satellite midwifery school ▪ named preceptor for all midwifery student on placements ▪ student offered equal opportunities to participate in any local midwifery education ▪ employ at least one new graduate midwife from this programme (EF) ▪ support and encourage participation in the Midwifery First Year of Practice programme (MFYP) ▪ encourage Māori new graduate midwives to engage in Te Urupounamu, cultural Supervision. (EF)	Q2, Q4	CW status update report

Activities that address service delivery due to predicted seasonal changes in service demands: ▪ establish LMC capacity and leave dates for December/January/February ▪ re-establish DHB primary midwifery service for women unable to secure LMC services ▪ ensure maternity service staffing establishment is adequate for additional unit labours & births, using the CCDM framework ▪ establish LMC capacity to provide postnatal care for women under the DHB primary service or establish a DHB postnatal service (EF) ▪ communicate to the local community. (EF)	Q2, Q4	CW status update report

2.3.2 Maternity and early years

DHB activity	Milestone	Measure
Develop and implement a Maternity and Early Years Key Stakeholder database (community and services) for the WDHB region : ▪ develop baseline database that has ethnicity in all data and equity in all analysis including: (EOA) - number of current stakeholders engaged with Maternity and early years - number of Māori and Non-Māori community stakeholders - number of Māori and Non-Māori service providers - number of kaupapa Māori services. ▪ evaluate baseline database for gap stakeholders: (EOA) - identification and number of gap stakeholder.	Q2	CW status update report
Provide intensive intervention to pregnant women and whānau with children under 3 years with co-existing alcohol and other drug issues with a using on a kaupapa Māori model: (EOA) ▪ develop kaupapa Māori service model ▪ implement new service tranche 1 ▪ implement new service tranche 2 & 3.	Q1 Q2 Q4	CW status update report MH04
Use quality improvement processes with equity lens to examine, implement, review and evaluate newborn enrolment and transfer of care processes within the WDHB region. (EOA)	Q4	CW07
▪ Women with risk factors are identified early in pregnancy and referred to appropriate services. ▪ Local implementation of Generation 2040 early pregnancy tool in general practices. (Note: links to Immunisation and Te Rerenga Tahi service). (EOA) ▪ Develop PDSA that focuses on reducing inequity of access to ultrasound scanning. ▪ Target 10% increase in newborn enrolments at 6 weeks. (EOA)	Q3 & 4 Q3	CW07
Implement safe sleep activities/strategies delivered through wānanga in alignment with the Whanganui Sudden Unexpected Death in Infancy (SUDI) Plan for the WDHB rohe. (EOA) Objectives: ▪ increase number of pregnant women and/ their whānau referred to Stop Smoking Service ▪ increase number of safe sleep devices distributed to Māori whānau with risk factors.	Q2 & 4	CW09 PH04
Implement the recommendations of the WCTO review. (EOA)	On-going	CW status update report

Improve access to pregnant Māori women and their whānau and deliver hapū mama wānanga in rural areas. (EOA) Objective: ▪ Increase the number of hapū mama and whānau attending the wānanga.	Q3	CW09 CW06 CW status update report
Shaken Baby Prevention Programme (Power to Protect) (EOA) ▪ Establish and document identified Power to Protect related activities including education, training, key messages and community programmes with a focus on Māori providers and working collaboratively with them on meeting their population's needs. (EOA) ▪ Power to Protect programme implemented for service and community providers/support providers.	Q2 Q4	CW status update report

2.3.3 SUDI component		
DHB activity	**Milestone**	**Measure**
Implement safe sleep activities/strategies through wānanga in alignment with local SUDI plan for the Whanganui DHB region: three hapu mama and whānau wānanga will be delivered throughout the DHB rohe over the year, includes two rurals and one urban setting: EOA - increase the number of hapu mama and their whānau referred to stop smoking services (EOA) - increase number of safe sleep devices distributed to Māori whānau with risk factors. (EOA)	Q4	CW09 PH04
Health promotion activities promote SUDI messaging and overall safe sleep, smoke free and breastfeeding messaging that is designed to reach priority populations. (EOA)	Q4	CW status update report

2.3.4 Immunisation

All DHBs contribute to healthier populations by establishing innovative solutions to improve and maintain high immunisation rates at all childhood milestones from infancy to age 5 years

DHB activity	Milestone	Measure
Regional immunisation communication plan aligns to Immunisation week 2020/2021 and influenza season. Protected Together #Immunise: ▪ develop a joint health promotion and communication plan with the WDHB and the Whanganui Regional Health Network that covers Immunisation week and a long lead in time using various tech and channels to reach priority populations. (EOA) ▪ undertake review of media files including social media available for use in the regional communication plan (EF) ▪ evaluation use of social media in the community and views recorded. (EF)	Q2	CW05 CW08
▪ Conduct opportunistic childhood vaccination with a focus on Māori when they interface with community and secondary services. (EOA) ▪ Undertake a data review on the number of children under 5 years presenting at Whanganui Accident and Medical (WAM) and the WDHB emergency, paediatric and dental departments. (EOA)	Q2	CW05 CW08
Work alongside interagency networks, communities, to support an increase in Māori childhood immunisation coverage. (EOA) ▪ undertake review of participants immunisation status ▪ provide onsite immunisations when able ▪ provide statistics for both WINZ and WDHB.	Q3	CW05 CW08
Provide HPV immunisation catch up for year 9-13 students in conjunction with the National MMR Campaign: (EOA) ▪ develop and implement plan ▪ facilitate discussion between WINZ young parenting course and immunisation services to focus on the immunisation uptake of the young participants and their children ▪ facilitate resources to support the implementation of this programme ▪ provide immunisation clinics between July-November 2020.	Q1 Q2, Q4	CW05

COVID -19 Response ▪ work alongside general practices to establish what the new normal is for COVID -19 level one for immunisation. (EF) ▪ highlight safety of the new normal and communicate to whānau using multi media/joint communications (WDHB and PHOs) to encourage and have confidence in returning for immunisation and focus on priority population (complements the national campaign). (EOA) ▪ work with general practices to identify, trial, pilot innovative approaches to reaching target populations, ie different places, times. etc. Review and evaluate success of approaches. Feedback data in a responsive way via practice facilitators (EF) ▪ Whanganui Regional Health Network and Te Oranganui health provider are trialing Saturday wellness clinics at ▪ Te Oranganui that will include immunisation, though targeted for high needs populations and Iwi based, it is open to all. Includes a media campaign. (EOA)	Q1, Q2 Q1 Q4	CW05 CW08

2.3.5 School based health services		
DHB activity	**Milestone**	**Measure**
Provide quantitative reporting on the implementation of school based health services (SBHS) in decile 1 to 4 secondary schools, and decile 5, teen parent units and alternative education facilities. (EOA)	Q2, Q4	CW12
Public Health Nursing actively involves secondary school students in partnering with them to get their voice through surveys. Objective: ▪ student's ideas and recommendations will be incorporated in planning ensuring that the services that are provided for youth are youth friendly, confidential and private as desired by students and culturally appropriate. (EOA)	Q1 - Q4	CW12
Promote health messages and awareness of health services available to youth, inclusive of where to access emergency contraception, after hour's medical care and surrounding agencies and networks. Ensure inclusion of rural areas. (EF)	Q4	CW12
Provide school leavers with information and enrolment opportunities of PHOs, agencies and networks available in their surrounding communities. (EF)	Q1 - Q4	CW12
Contribute to the rohe-wide youth services networks by attending and collaborating at a multidisciplinary level to ensure that health of our youth population is at the centre of their care. (EF)	Q2, Q4	CW12
▪ Increase appointment attendance rates for students, in particular Māori students attending appointments at MICAMHAS and Youth Services Trust. (EOA) ▪ Increase service access to students using telehealth. Lesson learned from COVID -19, the nurses will pilot alongside students to get their views on expanding service delivery and engagement via telehealth. (EOA)	Q3 Q2	CW12
▪ Collaborate with SBHS providers to identify three areas of quality improvement and develop a plan to advance. (EF) ▪ Youth Service Level Alliance Team to be incorporated into new Maternal child and youth service level alliance. TOR developed and recruitment of members in process, youth population priorities identified. (EF)	Q3 Q2	CW12 CW12

Psychosocial/wellbeing assessments post COVID -19: Priority population of students with high risk needs in all schools has been identified from the SBHS data, collated and actions to support them prioritised. For the identified priority population students, HEADSSS assessment will continue to be carried out and students have: (EF) ▪ referred to counsellors, MICAMHAS and other relevant providers ▪ hygiene issues have been identified as of concern and the nurses working with schools and some church groups to put together hygiene packs and supply these to students in need ▪ sanitary products have been ordered and will be made available to students in need ▪ exploring the possibility of breakfast clubs in schools. ▪ in order to catch up on the assessments, 2 additional FTE for 6 months will be employed. Teams of nurses will prioritise HEEADSS assessments for the identified priority populations, including alternative education students. (EF) ▪ resource detailing all WDHB region youth health services will be updated and made available to all students at consultation time, and be available in school canteens, libraries, schools, alternative educations centres, school web sites etc. (EF)	Q1, Q2	CW12

2.3.6 Family violence and sexual violence

WDHB is committed to ensuring collaborative local and regional partnerships for the implementation of family violence and sexual violence prevention strategies and their alignment with national programmes for the WDHB rohe. WDHB Family Violence and Sexual Violence Prevention activities for 2020/2021 Plan have been prioritised to focus on service delivery, education and training of service professionals.

WDHB is a governance partner in the NZ police and Iwi led whānau harm-reduction initiative (FLOW) alongside other health and social agencies.

DHB activity	Milestone	Measure
Violence Intervention Prevention (VIP) Reference Group: (EF) The WDHB VIP Reference Group is set up comprising kaupapa Māori organisations, other sector partners, and WDHB senior management with a strategic and integration focus that prioritises equity. This reference group will assist to strengthen and maintain intersectoral partnerships within the field of family harm in the WDHB community. ▪ Clinical managers identify opportunities for VIP development within their teams minutes.	Q2	CW status update reports
Cross-sectoral collaboration: (EF) Maintain and strengthen existing networks: ▪ MoU with the Police and Oranga Tamariki for information sharing and integrated work around child abuse and neglect to be reviewed by National leads. Ensure WDHB has had input into the National MoU review.	Q4	CW status update reports
FLOW: (EF) Police lead a community response to family harm in our community. This has been supported by WDHB VIP co-ordinator who has been on the working party to operationalise this new initiative. Objective: ▪ Regular meeting with police, Iwi and community attended by WDHB with changes implemented and reviewed in 6 months. ▪ Report on` the number of hours and days a week the coordinator and other staff are participating in these meetings.	Q3	CW status update reports

Strategic Leadership Group (SLG) oversees the work that is being done in this area along with an interagency management group from the community sector. We are committed to providing opportunities for service development and integration across sectors (EF) Objective: ▪ Ensure FLOW referrals to Te Rerenga Tahi as appropriate ▪ Ensure Māori health and social service representation at Te Reretanga Tahi	Q1	CW status update reports
All pregnant women who are present when Police attend a family harm incident, are referred to the Te Rerenga Tahi (vulnerable pregnancy) group with the aim of providing wrap around support for them. (EOA) Objective: ▪ Better life outcomes for children and whānau. ▪ Ensure that processes and responses are equitable for hapū wāhine and whānau ▪ Develop enhanced relationships and referral pathways with iwi, whānau ora providers and Kaupapa Māori services	Q4	CW status update reports
Elder Abuse and Neglect training (EOA) Objectives ▪ integrate WDHB trainings with a specific focus on the elderly including a focus on the context for Māori ▪ work with other service providers who work with the elderly to deliver specific focused training to WDHB staff and, Māori health services and community partners ▪ increase workforce capacity and capability across our community ▪ build strong relationships between Māori and other community providers and WDHB staff.	Q4	Status update reports
Staff as victims of violence: (EF) ▪ ongoing work developing WDHB response to staff as victims of violence ▪ review current guideline with Te Hau Ranga Ora equity workforce development officer ▪ implementation of training package for managers to respond to staff victims of violence, which is being led by People and Culture. Objective: ▪ training plan for managers in place and implemented ▪ introduction of a flow chart for staff which will guide acceptable responses.	Q2	CW status update reports

Improving mental wellbeing

2.4.1 Mental health and addiction system transformation		
DHB Activity	**Milestone**	**Measure**
Continue to build a whole-of-system integrated approach to mental health, addiction and wellbeing that provides holistic options across the continuum of need that place tangata whaiora with lived experience and whānau at the centre, with pro-equity in Māori health outcomes. (EF) ▪ Establish the Whanganui Mental Health and Addiction Service Level Alliance to address challenges in mental health and addictions outcomes with a specific focus on Māori, by enabling a system-wide and multi-perspective approach to service design/redesign to focus on sustainable approachable services optimized across the care continuum. Objectives: - build on the foundation set in Whanganui Rising to the Challenge, which outlined the future development of the district's whole-of-system mental health, addiction and wellbeing options - consider the full continuum of need for the Whanganui rohe - include participation and perspectives of people with lived experience - enable co-design and iwi/community engagement from diverse communities - provide recommendations to primary and secondary fund-holders.	Q1 - Q4	MH04
Placing people, whānau and tangata whaiora at the centre of all service planning, implementation and monitoring programmes**:** ▪ support mechanisms that enable real time feedback from tangata whaiora and their whānau into quality programmes by improved utilisation and uptake of Marama Real Time Feedback and participation in the Conversation Cafe (EF) ▪ ensure that individual care planning meetings involve a supported decision making focus which enables feedback from tangata whaiora and their whānau directly into their own care (EF) ▪ focus on how we address equity for Māori, Pacific, young people, rainbow community and other population groups who experience disproportionately poorer outcomes (EF) ▪ actively partner with the Māori Health Outcomes Advisory Group (MHOAG) to facilitate efficacy of the Matauranga Māori qualitative research (EF) ▪ development of a mental health and addiction measures dashboard to enable effective monitoring including of equity. (EF)	Q1 - Q4	MH04 MH06

Embedding a wellbeing and equity focus: ▪ strengthen our focus on mental wellbeing through healthy active learning, (sleeping, physical activity and healthy food and drink) by health promotion, prevention, identification and early intervention (EF) ▪ work with the Health Quality Safety Commission (HQSC), wellbeing focus for people with serious mental illness including the tangata whaiora in forensic units in our district inpatient unit and wider community (EF) ▪ implement 'Supporting Parents, Healthy Children' to support early intervention in the life course (EF) ▪ collaborate and work with the Ministry, the Mental Health and Wellbeing Commission, the Suicide Prevention Office and other leadership bodies and key partners to drive transformation in line with He Ara Oranga. (EF) ▪ Target people with low prevalence conditions to be a priority for DHBs funded employment, education and training resource (EF) Other planned activity includes: ▪ resuming the Equally Well project to improve the physical health outcomes for people with mental health and addiction conditions (EF) ▪ improving responses to co-existing problems via stronger integration and collaboration between other health and social services. (EF)	Q1 – Q4	MH01 MH02 MH04
Increasing access and choice of sustainable, quality, integrated services across the continuum: WDHB's Mental Health Service Level Alliance will: ▪ work in partnership with the Ministry, Māori, Pacific people, young people, rainbow community and people with lived experience, NGOs, primary and community organisations, and other stakeholders to review and strengthen the integrated approach to mental health, addiction and wellbeing ▪ pass on maximum cost pressure funding to DHB funded mental health and addiction NGOs as of 1 July 2020 ▪ enhance respite options to include an emphasis on therapeutic programs and smooth transitions of care ▪ support the roll out of new primary level responses (EOA) ▪ strengthen and increase focus on mental health promotion, prevention, identification and early intervention (EF) ▪ support our Community Mental Health and Addictions Service (CMHAS) team to: (EF) - remodel crisis team to improve response time and enable service users direct and timely contact with a clinician - review the current delivery of home treatment and assertive outreach and consider day therapeutic programme options - implement commitment to resourcing Emergency Department with a specialist mental health and addiction educator to build capability of front line staff - work alongside other colleagues to modify the Whakataketake combined risk assessment screening questions to incorporate mental health risk screening for depression and suicidality - in the Network model of care, clinical psychologists in each hub provide support to primary care clinicians in order to	Q1- Q4 Q1-Q2 Q3-Q4 Q2	MH03 MH04 MH06

- share knowledge and expertise and increase access. - will develop use of virtual consultations to expand access and to include the health improvement practitioners as these are appointed to primary provider practices, with effective triage through the SPOE (Single Point of Entry) matching tangata whaiora need and most appropriate level of service provision.		
Suicide prevention Continue to support the development of a Whanganui district suicide prevention strategic enabling framework which explicitly aligns with the national framework 'Every Life Matters'. The framework embeds a district context that has been developed in partnership with *Healthy Families Ruapehu, Rangitīkei, Whanganui* and Te Oranganui (EF) ▪ co-design high level action plans with community leaders and communities ▪ implement from 1 July 2020 applying equity thinking and methodology at every touch point.	Q1 - Q4	MH04
Workforce (note links to section 2.6.13 and 4.3): ▪ work towards developing a workforce that reflects the community (EOA) ▪ encourage the use of Supported Decision Making (SDM) principles by all mental health clinicians across all practice settings in preparation for the changes which are forecast in the Guidelines to the Mental Health Act ▪ require all psychiatrists, psychiatry SMOs and trainees to improve their education and training in the use of SDM principles including consumer rights, to clearly identify differences between shared and supported decision-making either via the training package, online training module or other suitable training opportunities. ▪ prioritise workforce education and upskilling of clinicians in psychological therapies as well as supporting primary care clinicians to upskill (EF) ▪ continue to build the knowledge of all WDHB staff in Te Tiriti o Waitangi, pro-equity and impacts of racism (EF) ▪ ensure all staff have completed the WDHB cultural education programme Hapai te Hoe (EF) ▪ encourage participation in WDHB run Te Reo courses require all front-line staff to complete and implement learning on addressing bias in decision making. (eg via HQSC website) (EF) ▪ enable staff to participate in cultural competence and cultural safety training and development, including supporting clinicians in the implementation of the Medical Council of NZ Statement on Cultural Safety (October 2019) and MCNZ He Ara Hauora Māori: A Pathway to Māori Health Equity (EF) ▪ work in partnership with workforce centres to strengthen current workforces, including a focus on retention, recruitment, training, and wellbeing (EF) ▪ support workforce development of the appropriate knowledge and skills to support people with mental health and addiction needs, including those with co-existing needs, for example through use of the Let's Get Real framework. (EF)	Q2, Q4 Q1 - Q4	SS12 MH01 MH02 MH03 MH04 MH05 MH06

Forensics ▪ Work with MOH and DHBs to improve and expand the capacity of forensic responses from budget investment. Commitment to demonstrating quality services and positive outcomes: ▪ Explore options for health informatics using platforms such as Power BI or similar (Qliksense) to enable collection of data regarding practice and to permit the measurement of outcomes. (EF) ▪ Develop new measures alongside providing reporting on priority measures, and addressing equity, including: (EF) - access - comparative data to allow for assurance of equity for Māori and youth - reducing waiting times - completion of transition/discharge plans and care plans - mental health and addiction service development - reducing inequities ▪ The DHB and contracted providers will continue reporting through PRIMHD.	Q1 - Q4	SS09 MH01 MH02 MH03 MH04 MH05 MH06

2.4.2 Mental health and addiction improvement activities

DHB Activity	Milestone	Measure
Continue to participate in quality improvement activity, including the key Health Quality Safety Commission (HQSC) priority projects (Connecting Care; Learning from Serious Adverse Events and Consumer Experience: Maximising Physical Health; and Improving Medication Management and Prescribing) (EF) The following are the key work streams for 2020/21 that have been identified as making a significant difference including: ▪ facilitate Matauranga Māori research into the lived experience and whānau experience for Māori under section 29 compulsory treatment orders (CTO). This will lead to better understanding on how the number of Māori under CTOs can be reduced (EF) ▪ the DHB will partner with MHOAG to facilitate Matauranga Māori research into the lived experience and whānau experience for Māori under Section 29 compulsory treatment orders (CTO), both those who have previously and do currently experience this form of compulsory treatment. This will assist us to meet the Ministry's requirement to reduce the number of Māori under Section 29 CTO by 10% by the end of the period (EOA) ▪ implementing the new primary level responses following successful WDHB rohe tenders for new funding relating to the 2019 wellbeing budget (EF) ▪ continue to support responses to further RFPs where local gaps exist and capacity is available for development ▪ ongoing work with sector partners addressing housing accommodation issues across the district, to counter the impact on tangata whaiora, particularly those with low prevalence conditions, co-existing problems and chronic conditions. (EF)	Q1 - Q4	SS12 MH05

2.4.3 Addiction

DHB Activity	Milestone	Measure
Activity to improve waiting times includes: ▪ a focus on adults and older people. Includes introduction of new coordination and urgent referral seen on the same day or next (EF) ▪ embed provision of planned tangata whaiora managed withdrawal services within the district (EF) ▪ plans have been developed for back-up from regional specialist physician to provide support for local physicians who undertake planned detox of tangata whaiora in Whanganui Hospital (EF) ▪ enhanced local kaupapa Māori NGO alcohol and other drug services - include AOD day treatment and prevention programme, community support with accommodation (including step-up and step-down from regional AOD services) and kaupapa Māori AOD resource. (EF) Activity to support integration: ▪ work alongside interagency networks and communities to advocate for healthy public policy, and implementation of legislation or regulatory requirements for alcohol and/or other drug addictions related activities in the Whanganui District (EF) ▪ facilitate brief intervention training programme for health professionals and community relapse prevention groups in the WDHB rohe (EF) ▪ continue with implementation of the specialist adult mental health and addiction Network Model of Care (hubs to link all general practice teams, kaupapa Māori services and NGO partners) (EF) ▪ support equitable access for tangata whaiora to regional intensive residential AOD services (EOA)	Q2, Q4 Q1 - Q4	MH01 MH02 MH03 MH04 MH06
Key work streams for new initiatives in 2020/21: ▪ partner with iwi health providers, police, MSD, people with lived experience and other key stakeholders in the community to explore the potential for co-production and implementation of a methamphetamine harm and demand reduction project in the Whanganui district. (EF)		

2.4.4 Maternal mental health services

Maternal Mental Health is now included in the department known as Maternal, Infant, Child & Adolescent Mental Health and Addiction service (MICAMHAS). The department is part of Maternal, Child & Youth service group.

DHB Activity	Milestone	Measure
Maternal mental health will work alongside the infant/child clinicians to provide early intervention and improve mother/whānau and baby access to wrap around services such as attachment based therapies and Supporting Families Healthy Children. ▪ Report on whānau involvement in service. (EF) ▪ Links with primary maternal mental health will be ensured by attendance at inter sector group Te Rerenga Tahi (vulnerable pregnant women), regular contact with agencies (Adopt an agency initiative), Plunket, WCTO providers and the development and provision of education sessions provided with primary agencies and Māori providers. (EF)	Q4	MH Status update report
Develop intensive intervention for pregnant women and whānau with children under 3 years with co-existing alcohol and other drug issues using a kaupapa Māori model: (EOA) (Note: link to 2.3.1) ▪ develop kaupapa Māori service model ▪ implement new service tranche 1 ▪ implement new service tranche 2 & 3	Q1 Q2 Q4	CW12 MH status update report
Provide the Perinatal Ministry of Health report: ▪ collect ethnicity data to measure effectiveness of programmes targeted at equity (EF) ▪ support development of the new Pregnancy and Parenting service by reporting on specific activities undertaken and evidence to develop integration and referral pathways across both areas of the new service with a focus on equity. (EOA)	Q1 - Q4 Q1 Q3	MH04
Engage the Pasifika community especially, in rural areas, to improve their access to MH&A Services. (EF)	Q2	MH status update report
Continue engagement with the regional MMH team for ongoing training and knowledge sharing opportunities e.g. via Perinatal Anxiety and Depression Aotearoa (PADA) (EF)	Q2	MH status update report

Improving wellbeing through prevention

2.5.1 Environmental sustainability		
DHB Activity	**Milestone**	**Measure**
Develop the WDHB Sustainability Strategy which will outline our commitment to procuring goods and services with suppliers that support environmental sustainability as well as identifying opportunities for WDHB to improve our environmental impacts.	Q4	
Ensure that the Procurement Policy is updated to include WDHB's commitment to Broader Outcomes as per the Government Rules of Procurement.	Q1	

2.5.2 Antimicrobial Resistance (AMR)

DHB Activity	Milestone	Measure
WDHB has a contract in place for infectious diseases support from CCDHB.	Q1	
WDHB has a fully functioning infection prevention committee chaired by the medical officer for health. The committee includes primary, Māori health and secondary care representation. (EF) Monthly meetings will be held, a minimum of 10 times per year	Q1 Q4	
An annual antibiogram is produced by Medlab Central microbiologists indicating resistance and sensitivity patterns. This is shared with all prescribers, including general practice and infectious diseases physicians CCDHB.	Q3	
Monitoring of the following with all infection rates are within national benchmarks: (EF) ▪ hospital acquired Staphylococcus aureus bacteremia ▪ surgical site infections ▪ treatment injuries – infections ▪ daily monitoring of multi-drug resistant organisms ▪ IV site infections and IVC removals ▪ infections in Māori and Pacific patients Where inequalities are identified, a service improvement plan will be implemented to address these.	Q4	
Hand hygiene is audited by gold hand hygiene auditors in secondary care. This training has been extended to primary care including Hospices, GP practices, aged care and home based support providers. A minimum of two gold hand hygiene training sessions will be offered to primary care providers each year. One training will be offered in Q1/2 and one in Q3/4 All staff at WDHB are required to complete hand hygiene training though hand hygiene New Zealand site with 95% of clinical staff to have attended hand hygiene training and completed the end of training test.	Q4 Q2/4	

All antibiotic resistance results from the community and hospital are sent to infection prevention CNS for alerts to be added to the national file an alert added to the patient's file. Community resistance numbers and patterns will be monitored and reported through the infection control committee. Action plans will be developed around any trends.	Q3 Q2/4	
Infection prevention policies and procedures are available to prevent antibiotic resistance spread. Working proactively with ARC providers and general practice to ensure appropriate antibiotic use by:	Q2	
Access for all ARC to WDHB policies and procedures and antibiotic guidelines on the intranet Use of the annual infection prevention study day, which is open to all community health providers including ARC providers this day will provide education on: ▪ catheter related cares and UTIs with prevention methods ▪ antibiotic resistance education ▪ New Zealand Healthcare standards ▪ immunisation ▪ outbreak management ▪ antibiotic guidelines are current and based on CCDHB. Biannual monitoring of antibiotic compliance to guidelines completed in WDHB This audit is reported by ethnicity (EF) and includes: ▪ Level of compliance with guidelines by ethnicity The report is shared with drug and therapeutic committee, infection prevention committee and all heads of departments. Action plans will be developed around any variances (none seen in 2019/20)	Q3 Q2/4	
All infection prevention reporting is based against the New Zealand Health and Disability Standards Infection prevention is a member of the regional collaborate for collaborate approach to infection prevention: ▪ switch campaigns from IV to oral prescription running at WDHB, with pharmacists reviewing each patient prescriptions daily ▪ the infection prevention clinical nurse specialists provide advice and education to ages residential care facilities, primary health and regional health networks as required ▪ reporting against the HDSS is made to the clinical board within the past six months.	Q4	

2.5.3 Drinking Water

A Drinking Water Technical Advice Service is co-ordinated through the health protection service within MidCentral DHB's public health unit (PHU).

DHB Activity	Milestone	Measure
Drinking water: Health Promotion activity at WDHB includes: Meet regularly with the Drinking Water Technical Advice Service from MidCentral DHB's PHU to understand and support drinking water activities. (EF) Participate in the environmental health exemplar (PHU) and activities with a focus on improving drinking water quality in Māori and isolated communities. (EF)	Q2, Q4	

2.5.4 Environmental and border health

Environmental and border health is a public health function, provided to Whanganui district by the health protection service within MidCentral DHB's PHU.

DHB Activity	Milestone	Measure
Regular contact with the Medical Officer of Health and other members of the MidCentral DHB PHU to understand and support environmental and border health activities.	Q1 - Q4	

2.5.5 Healthy food and drink

WDHB is committed to promoting and leading implementation of healthier food and drink environments as a protective factor to preventing health loss in our district. Strengthening community responses and reducing health inequities requires a multifaceted approach engaging all sectors of the community for overall improvement in the WDHB rohe.

DHB Activity	Milestone	Measure
Within the DHB: WorkWell is an initiative designed to help workplaces conduct their everyday business in a way that leads to improved staff wellbeing through development of a healthy working environment. The programme provides a framework for improving organisational, environmental and individual facets of staff wellbeing. In 2020/21 we will: ▪ review the WDHB Nutrition Policy to ensure WDHB is compliant with the National Healthy Food and Drink Policy and identify any opportunities to strengthening our local policy and make amendments ▪ review and revise WDHB Workwell advisory group and programme and develop a Workwell action plan to progress from Bronze to Silver accreditation	Q4 Q2	
Across community settings: ▪ We will work alongside a Kohanga Reo initiative creating supportive and enabling environments from a holistic approach that empowers and encourages the health and wellbeing of tamariki and whānau (EF) - to develop a Results Based Accountability (RBA) pilot project. evaluation and communication plan	Q1	
Across contracted providers: ▪ WDHB contracts with over 150 providers. - use contracting mechanisms to influence development of healthy food and drink policies amongst other health-related services (EF) - identify those contracts that are relevant for a healthy food and drink clause. - Ensure the next contract renewal date is noted and flagged for the change - Report on percentage of contracts that have a healthy food and drink clause included.	Q2, Q4	

Implement Healthy Active Learning (HAL): ▪ use the Health Equity Assessment Tool in collaboration with key stakeholders to determine which schools/Early Learning Services (ELS), Kohanga Reo and Kura they will engage with ▪ identify what Healthy Food & Drink policies is already in place to support active and healthy food environments (EOA) - Determine baseline number of schools/Early Learning Services (ELS), Kohanga Reo and Kura with a policy within the Whanganui region(EOA) - To achieve a 10% increase in the number of Early Learning Services, Kura, Kohanga Reo and schools that have healthy food and water-only (including plain milk) policies (EOA) ▪ provide specialist nutrition advice and support to enhance staff and caterers practice to increase the number of healthy food and drink environments and policies consistent with the Ministry of Health Healthy Food and Drink Guidelines (EF) ▪ partner with other key HAL providers to ensure a coordinated collaborative approach including with the HAL Evaluation provider (EF) ▪ provide health promotion support and guidance to the Regional Sport Trust HAL advisors (EF) ▪ collaborate with other providers – NGOs, local government, Healthy Families, Heart Foundation that are working in schools and learning services (EF) ▪ leverage onsite health services such as Public Health Nurses and Community Oral Health services, to promote benefits of relevant policies in educational services (EF) ▪ work with and complete required reporting to the HAL National Coordination Service (EF)	Q2, Q4	

2.5.6 Smokefree 2025

WDHB is committed to the government's goal of Smokefree 2025. We work across the system to lead on Health Promotion activity and to collaborate with all providers on other tobacco control and Smokefree activity.
Smoking is a key risk factor for health and is an important equity matter for WDHB.

DHB Activity	Milestone	Measure
WDHB is committed to ensure Leadership, Coordination and Collaboration		
▪ To complete a Needs Assessment to inform Tobacco Control planning, investment and commissioning of new services and activities contributing towards achieving a Smokefree Whanganui and the Government Goal Smokefree Aotearoa 2025		
- Needs Analysis Report completed and published by 31 December 2020	Q2	
▪ In collaboration with key partners to develop an integrated Tobacco Control Strategic Plan to provide leadership, coordination and service development across all local Smokefree/Tobacco Control activities for the period 1 July 2021 – 30 June 2025. –		
- Tobacco Control Strategic Plan endorsed by MoH and Joint Boards Hauora a Iwi and WDHB by 30 June 2021	Q4	
▪ To support regional and local stop smoking services to ensure an effective integrated approach for wrap around stop smoking services for Māori, Pacific people and hapū wāhine		
- Increased engagement, referrals and outcomes for Māori, Pacific people and pregnant women	Q1 and ongoing	
▪ Support priority settings where Māori live, learn, work and play to create supportive health promoting environments		
- Advocate and support the development of healthy public policy that supports smokefree and vapefree environments		
▪ To promote and raise the awareness and knowledge of a Smokefree Aotearoa 2025 goal		
- Smokefree Aotearoa 2025 logo and messages included across Smokefree projects, communication and resources		

WDHB is committed to sustain performance against the secondary, primary care and maternity targets for 'Better help for smokers to quit'. ▪ Review hospital based current services procedures all patients who smoke are Asked about their smoking status, given brief advice to stop smoking and are offered/given effective smoking cessation support. - Procedures review report and Action Plan completed - Monitor 95% of Hospital Māori patients who smoke and seen by a health practitioner are offered brief advice and support to quit smoking - To promote and monitor the use and access of Nicotine Replacement Therapy and smoking cessation medicines within the hospital and hospital based maternity services - Monitor the number of patients/clients referred to specialist stop smoking services	Q2 Q3 Q4	SS06
▪ Review Lead Maternity Carers (LMCs) procedure's that support a systematic process to ensure pregnant women who smoke are Asked about their smoking status, given brief advice to stop smoking and are offered/given effective smoking cessation support. - Procedures review report and Action Plan completed - Monitor 90% of Māori 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	Q2 Q3 Q4	CW09
▪ Explore and agree options with the PHO to review current activities to achieve and maintain 'Better help for Smokers to quit'. - Agreed quality improvement actions plan completed - 90% of PHO enrolled Māori patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	Q2 Q3 Q4	PH04
Tobacco Smokefree enforcement officers to undertake compliance and enforcement activities relating to the Smoke-free Environments Act 1990 ▪ Education visits carried out with retailers prior to Controlled Purchase Operations (CPOs), and as new legislation requires ▪ Carry out CPOs in the Whanganui region to monitor and enforce the provisions in the SFE Act relating to the sale of tobacco smoking products to minors - 6 monthly reporting on the % tobacco Control retailers that are compliant at CPOs	PHU Reporting	

2.5.7 Breast screening

Improving uptake of the breast cancer screening programme by Māori and Pacific women is a key priority of the National Screening Unit (NSU) as part of its commitment to achieving equity and are considered priority populations for the programme. Coverage rates are monitored closely for these two groups who are known to be at increased risk of developing breast cancer and have significantly higher mortality rates from breast cancer.
Women who screen regularly have a lower risk of dying from breast cancer than those who screen less regularly. Rescreening rates are calculated as the number of women rescreened within 20-27 months of their previous screen as a percentage of the number of women eligible for a rescreen.

WDHB is focused on increasing participation rates for Māori, Pacific and Asian women and eliminating equity gaps. In Q2, Whanganui will host the Breastscreen Coast to Coast regional planning hui. The impact of COVID -19 including the transition back to normal, the retrospective catch-up required & capacity of services to undertake and the unknown effects on the population (e.g.anxiety) may have implications on performance

DHB Activity	Milestone	Measure
Significant inequity in screening rates persist in Whanganui rohe despite achieving the national target overall. To improve equity we aim for a 10% increase for priority populations in completed screens on the previous 12 months by: (EOA)		PV01
▪ Identifying barriers and address the needs of Māori & Pacific women through: (EF) - data analysis of general practice registers, Trendly and Breast screen Coast to Coast data to identify Māori & Pacific women who need screening and identify focused approaches - proactive follow up by general practice, outreach service and Iwi health providers - Māori health providers located across the region to support women to screening including offering transport, information	Q2 Ongoing	
▪ Improving access to Pacific women through community networks focused on Rangitikei population: (EF) - consider Pacific 'kaiawhina role' including completing population profile and needs and scoping requirements with key stakeholders	Q2-Q3	
▪ Increase screening rates for Asian women through identification of practice registers and providing targeted outreach approach: (EF) - develop relationship with Asian nursing workforce to inform approach	Q3	
▪ Use population-specific health promotion approaches to encourage uptake of screening opportunities: (EF) - develop one communication flyer with key messaging in Te Reo, Pacific and Asian	Q2	

2.5.8 Cervical screening

Cervical cancer is one of the most preventable forms of cancer and regular cervical screening ensures the earliest possible intervention. The National Cervical Screening Programme (NCSP) through service providers, provides support to screening services for women who are less likely to have cervical screening.

Achieving equitable access is a key priority for the NCSP as Māori, Pacific and Asian women and people living in our most deprived areas have participation rates lower than other groups. Implementation of the Equity and Performance Matrix by National Screening Unit which measures both performance against a target and the equity gap between population groups provides a visual picture of any equity gaps that exists and how effective health services are being delivered. Clear accountability for equity is a priority

WDHB is focused on increasing participation rates and eliminating equity gaps for priority group women

DHB Activity	Milestone	Measure
Significant inequity in screening rates persist in Whanganui rohe. To improve equity we aim for a 10% increase in completed screens by priority populations on the previous 12 months by:		PV02
▪ Improving screening rates for Māori & Pacific women through: (EOA) - data analysis of general practice registers, Trendly and NSU data to include age, ethnicity and location of women to inform targeted approaches for Māori & Pacific women - identification of appropriate screening venues e.g. workplaces, Marae & community settings	Q2	
▪ Develop / pilot an iwi led clinic (once a month over six months) including Māori smear takers as an alternative entry point for screening on weekends and after hours. Promoted widely across social/media and networks. (EOA)	Q2, Q4	
▪ Explore development of a mobile outreach service for rural and isolated communities to provide screening, assessment and vaccination services based from a mobile unit (based on learnings from COVID -19) (EOA) - Concept paper developed for Executive Leadership Team & next steps confirmed	Q3	
▪ Develop Māori health professional smear takers to reflect GP population and increase number of Māori screen takers against baseline: (EF) - liaise with MOH & Family Planning NZ to identify and confirm educators to undertake accessible training sessions & confirm training calendar - engage with Māori nursing workforce including Te Uru Pounamu and other nursing roopu to support upskilling	Q1	
▪ Review investment into cervical screening against equity tool to inform development of appropriate model and align provider agreements with confirmed approach. (EF)	Q2	

2.5.9 Reducing alcohol related harm		
DHB Activity	**Milestone**	**Measure**
▪ Cohesive relationship between Public Health, Health Protection and the Alcohol Licensing Cluster Group for monitoring and surveillance of the Whanganui District Alcohol Licensing accord and related activities - Quarterly monitoring and reporting surveillance of alcohol-related hospital presentations including improving maintaining the processes of data capturing within the DHB	Q1 ongoing	
▪ Determine activities develop an action plan that aligned with the 5+ Solution approach to alcohol related harm within WDHB position statement on alcohol by 30 June 2020	Q2	MHO4
▪ In partnership with community probation service, community Mental Health & Addictions, Te Oranganui and WDHB develop a sustainable Brief Intervention Programme for Community Corrections (EOA) - To consult and co-design a Brief Intervention programme with key stakeholders and other interested parties	Q2	
▪ Raising awareness on preventing Fetal Alcohol spectrum disorder (FASD) - Public Health, Kaihoe-Health Promotion to Facilitate FASD) Network Group - To deliver FASD Awareness presentations within the community for identified priority populations (EOA) - In collaboration with partner's support FASD Awareness Day on the 9 September 2020	Q2	

2.5.10 Sexual Health		
DHB Activity	**Milestone**	**Measure**
▪ Implementation of the WDHB and Mid-Central Health joint action plan for the delivery of the national guidelines for management of sexually transmitted infections (STI) across the rohe: (EF) - primary and secondary quantitative reports completed available from July 2020 - monitor 95% of all Māori clients aged between 12-29 will be screened and offered the HPV immunisation (EOA) - review quantitative reports to assess any emerging indicators or trends for sexually transmitted infections (STIs) in the rohe	Q2, Q4	
▪ Provide sexual health clinical services that are culturally safe and meet the needs of our population: (EF) ▪ Continue to work collaboratively with interagency networks, urban and rural communities and sexual diversity support groups to include targeted communication strategies for sexual and reproductive issues, STI's, teenage pregnancy support and sexual diversity issues. (EF) ▪ Provide information that is culturally appropriate and meets the NZ health literacy standards. (EF) ▪ Analyse clinic data to identify emerging trends (EF) ▪ Collate and forward data to Environment Surveillance Reporting (ESR) to contribute to wider surveillance trends and contact tracing (EF) ▪ Use clinic data to evaluate communication strategies and amend where necessary. (EF)	Q2 Q3, Q4	
▪ Progress towards the implementation of one contact point for gender diverse clients in the WDHB rohe: - in the designing and responsiveness to our gender diverse population and the implementation of one contact point, the Health Equity Assessment tool (HEAT) will be applied to ensure equity for all. (EF) - identify and acknowledge appropriate first point of contact (EF) - promote and support as appropriate. (EF)	Q2	

2.5.11 Communicable diseases

Communicable Diseases activities within the WDHB district are provided by MidCentral DHB's public health unit (PHU), who are contracted by the Ministry of Health to provide Health Assessment and Surveillance services across the Manawatu-Whanganui region. Although these activities are provided by another DHB, WDHB works closely with the MidCentral PHU and is committed to supporting these activities and working collaboratively in communities across our district.

DHB Activity	Milestone	Measure
Maintain collaborative partnership with MidCentral PHU Health Protection Team for communicable disease surveillance, monitoring, management and reporting for the WDHB rohe: (EF) ▪ reports of small, isolated and pandemic outbreaks are provided as required	Q2	
Rheumatic fever ▪ maintain awareness within Kura and Schools deciles 1-4 (EF) ▪ liaison with Māori and Pacific Island whānau with history of rheumatic fever with an emphasis on prevention (EF) ▪ clients have an annual hauora assessment and 95% completed including a review or referral for: - Sore throats for whānau, GP, dentist, healthy homes, community dietitians, green prescription, long term condition clinical nurse specialist, specialist stop smoking service and family violence (EF) ▪ monitor rheumatic fever prevalence and incidence. (EF)	Q2, Q3	

2.5.12 Cross sectoral collaboration including health in all policies (HiAP)

Cross-sectoral collaboration is a cornerstone of Whanganui's strategic direction He Hāpori Ora Thriving Communities and the three strategic focus areas: Pro-equity, Social Governance and 69,000 Beds.

We are focusing DHB activity to have a clear community orientation and the DHB is strengthening its participation in cross-sector collaboration.

Good health and wellbeing for the population of WDHB region is influenced by the wider determinants of health such as income, education, employment, housing and quality health care. Improvement in health status of those identified with disadvantaged determinants of health in the WDHB rohe can be prioritised and addressed through implementing collaborative cross sectoral approaches in population health and health promotion activities including community strategies, operational deliverables and influencing public policy in all levels (local, regional and national).

DHB Activity	Milestone	Measure
Ministry of Health and WDHB contracted providers		
▪ Ensure that opportunities for HiAP is promoted through our own contracting processes. Where appropriate, we require contracted providers to develop policies that promote and support good health amongst their own staff and through the services that they provide. (EF)	Q3 & Q4	
▪ Facilitate the utilization of Health Equity Assessment Tool (HEAT) with HAL partners Ministry of Education and Sport Whanganui to prioritise schools/Early Learning Services (ELS), Kohanga Reo and Kura within deciles 1-4. (EF)	Q2 Q3	

Opportunity to drive and/or support HiAP approach. HiAP have a key role in supporting effective collaboration across different sectors to improve and address population health issues and achieve health equity. Across inter-sectoral collaboration projects, Health Promotion has a role in providing population health leadership to advocate for effective policy changes and activities that will address the complexity of social, cultural and economic health determinants. Existing inter-sectoral collaboration is already underway through, for example: ▪ The integrated Reset, Redesign – Recovery approach following the first wave of COVID -19, has led to WDHB rohe working alongside Iwi, local government and other social sector entities; - Public Health, Kaihoe Health Promotion to participate and collaborate with key stakeholder's ensuring a population health approach within the Integrated Recovery Strategy ▪ Safer Whanganui is a community led coalition working in partnership to provide leadership and direction for the promotion of community safety in Whanganui City. The coalition includes representatives from Council, Iwi, Ministry of Education, NZ Police, Horizons Regional Council, WDHB, Sport Whanganui, MSD, Fire and Emergency, NZ Corrections and children's, business and community representatives. There are seven specialist reference groups addressing: - Road safety, family violence, safety and well-being, alcohol and drugs, emergency planning, justice and housing - Public Health, Kaihoe Health Promotion to support existing processes and provide specialist population health advice as required with a focus on equity (EF)		
Development of more intensive support for HiAP will require professional development. In 2020/21 WDHB will investigate: Increasing professional development of Public Health staff in Policy and Legislation ▪ Identify and recruit a student undertaking current health policy studies ▪ Scoping report completed for student Internship for a Policy Assistant position at Public Health (EF) ▪ Approval of internship and criteria for Policy Assistant completed by January 2021 (EF) ▪ Establish Student Internship for a Policy Assistant position at Public Health by June 2021 (EF) Increasing expertise in the HiAP model and its applicability to other areas of WDHB activity ▪ Identify subject matter expert ▪ Scope relevant consultation and engagement pathways ▪ Draft action plan Develop a strategic analysis by 31 March 2021 to highlight the opportunities for supporting inclusion of HiAP across the public sector.	Q1 – Q4 Q1 – Q4 Q4	

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

2.6.1 Delivery of Whānau Ora

The WDHB Board in collaboration with HAI is committed to whānau ora centred approaches within the DHB and across all services with a goal of equity in Māori health outcomes.

(For related information refer to sections 2.1.2 – Accelerate the spread of kaupapa Māori services, and 2.6.13 Workforce)

DHB Activity	Milestone	Measure
Establish effective relationship with Te Puni Kokiri locally. (EF) ▪ Support and explore collaborative opportunities with Te Pou Matakana and partners, and alignment of initiatives with local Whānau Ora initiatives. (EF)	Q2	SS17
Waimarino development ▪ Ongoing work with the communities of Waiouru, Ōhakune and Raetihi to bring to fruition the Ruapehu Whānau Transformation health plan. (EF) ▪ Participate in development of collaborative community driven whānau centred services to identify impact on Waimarino Health Centre development. (EF) ▪ Co-develop design work and complete business cases (EF) - Establish project group - Service redesign and models of care completed - Facility design completed.	 Q1 Q3 Q4	
Implementing and monitoring whānau centred approaches to care and services. ▪ Include whānau hui in service delivery with the support of Te Hau Ranga Ora Haumoana Service for DHB provided services. (EOA) ▪ Explore opportunity to partner with the PHOs to establish two whānau centred general practice and social service wrap around, one of which is kaupapa Māori, implemented through a whānau ora model of care. (EF) ▪ Ongoing implementation and monitoring of Korero Mai (EF) - Korero Mai seeks to enable patients and whānau to communicate concerns about a patient's deteriorating condition - Reporting of results	Ongoing Quarterly	SS17

Pro-equity priority areas: ▪ Improve transparency in data and decision making: (EF) - share equity analysis widely and include it in decision making - transparency in resource allocation, including equity analysis in all publicly reported data ▪ Support more authentic partnership with Māori: (EF) - meaningful participation in the design of services and interventions to support Māori self-determination and whānau ora.	Ongoing	SS12
Ensure provision of information for Māori whānau meets the guidelines for health literacy. (EF)	Ongoing	SS17

2.6.2 Pacific health action plan

The WDHB Pacific population is 3 percent of the total population with a 50 percent increase since 2013 and 33% currently living within our rural communities.

We are committed to the objectives of Ola Manuia 2020-2025: Pacific Health and Wellbeing Action Plan and improving health outcomes through a partnership approach with Pacific communities and ensuring services meet the needs of our Pacific people.

DHB Activity	Milestone	Measure
▪ Scope population profile and health needs to inform development of a Pacific Health Action Plan through a collaborative approach with the Pasifika community. (EF) o Scoping completed	Q3	
▪ Ensure consistency with Ola Manuia 2020-2025: Pacific Health and Wellbeing Action Plan. (EF) o WDHB Pacific Action plan completed	Q4	

2.6.3 Care Capacity Demand (CCDM)

WDHB is committed to fully implementing the CCDM in all nursing and midwifery services by June 2021. CCDM has a national reporting framework that enables us to report progress against an agreed set of milestones. WDHB has a CCDM Council in place who meet regularly to provide guidance.

As at January 2020 the DHB overall implementation rate was 67%. As at June 2020, WDHB is 85% completed (preliminary).

DHB Activity	Milestone	Measure
DHB activity Ongoing monitoring of CCDM and TrendCare work plans through CCDM Council. (EF)	Ongoing	SSO3
WDHB is employing an allied health informatics role which will be the key link to advance allied health CCDM further.	Q4	
Governance There has been a change in the governance structure at WDHB. This includes a change in the chair for CCDM council, a change in the coordinator role to the ADON and a review of roles and responsibilities and systems and processes. This will strengthen the programme and support the 2021 deadline. The governance and operational meetings are formalised and well attended.	Q2	
Patient acuity data The patient acuity data is well implemented across the system now including mental health. There is a process in place to ensure the data entered is accurate to enable the FTE data to be appropriately calculated. This involves active engagement with leaders and education. IRR testing is in place. Focus areas for improving TrendCare data: ▪ Education and upskilling of TrendCare champions ▪ Improve accuracy of activity data across teams Automation of CCDM data metrics into scorecards ▪ CCDM agreed measurements currently collected ▪ CCDM dashboard completed, visibility report ▪ Facilitate improved monthly reporting and presentation at CCDM Council.	Q4	

Annual FTE calculations These have been completed and are visible to inform the annual budget round. FTE calculation exclusions include Paediatrics and SCBU as they are on minimal baseline staffing. The staffing calculations show adequate resource with minimal changes required; calculations will be redone quarter 3.	Q3	
Variance response management for both nursing and midwifery Variance response plans have been implemented. This is to respond to shift-by-shift variance in terms of deployment and employment to hospital wide responses. WDHB has just linked the HaaG screen to the Duty Nurse Manager pager as an alert when the organisation is going into orange or red. Focus: Improved variance response management (VRM) ▪ Operations centre is running and shift reporting done actively and in a 'live' manner. ▪ Review analytics to ensure we are collecting the correct data to respond appropriately to staffing deficit. ▪ Align VRM to emergency response plans. WDHB has a programme (Health Careers Day) to educate and enhance nursing/midwifery/allied and medical as a career. The focus is particularly for Māori as we recognise that the percentage of Māori clinical staff employed does not reflect our population. The Nurse Entry to Practice and Nurse Entry to Specialist Practice programmes have an equity lens where all Māori are interviewed for nursing positions and we have a programme to support them during their first year of practice (Te Urupounamu).	ongoing	

2.6.4 Disability Action Plan		
DHB Activity	**Milestone**	**Measure**
▪ Identify and engage with key stakeholders across the district, including tāngata whaikaha / people with lived experience of disability, and Iwi health providers, to scope what is required in a disability plan for the Whanganui district and whether a regional or district plan would be advised approach. (EF)	Q3	PH02
▪ Enter discussions with regional partners on their preferred approach to disability planning. (EF)	Q4	
▪ Engage with the Ministry of Health in deciding best approach to developing a Disability Action Plan. (EF)	Q4	

2.6.5 Disability		
DHB Activity	**Milestone**	**Measure**
▪ Continue to promote the mandatory completion of the e-Learning module for disability responsiveness for all new staff and any staff who have not completed with a 75% completion rate. (EF)	Q4	
▪ Enter discussion with other DHBs who have signaled they will be reviewing the e-learning module to decide if the WDHB module should be refreshed. (EF)	Q2	
▪ Review the use of webPAS to record if a patient has a disability and communicates this to staff. (EF)	Q3	
▪ Engage with the Ministry of Health on the recommended approach to ensure that key health information for the public and public health alerts and warnings are accessible by people with a disability. (EF)	Q4	
▪ Set up reporting for the number of key public health information messages, public health alerts and warnings issued each year and the number of translated into NZ sign language. (EF)	Q4	

2.6.6 Planned Care		
DHB Activity	**Milestone**	**Measure**
Strategic Priority 1 - Improve understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed. (EF) • Analyse and benchmark intervention ratios to show potential focus areas • Include equity analysis within intervention ratios • Use the results of the post-COVID consumer engagement surveys to highlight preference where applicable • Work with primary and community care providers to capture opportunities for alternative settings and models of care	Q1	SS07
Strategic Priority 2 - Balance national consistency and the local context Maintain delivery rates that are consistent with national standard intervention ratios – this includes assessing models of care and how these are delivered in context of our local community. • Engage governance and clinical leadership on the potential impact of the national consistency approach • Define options for requisite adjustments • Work with sub-regional partners to consider mutually beneficial approaches	Q1 – Q4	SS07
Strategic Priority 3 - Support consumers to navigate their health journeys: (EF) • Review systems for booking and contacting patients regarding inpatient and outpatient events to ensure timely advice of pending treatment and reducing missed appointments (EOA) - Review service models and identify potential services for change - Review completion with recommendations - Understand impacts and plan for implementation of accepted recommendations • Collaborative Community Health Pathways - Localise 70 pathways for use in general practice	Q2 Q4	SS07

Strategic Priority 4 - Optimise sector capacity and capability • Deliver services in least intensive setting – continue to review what procedures can be undertaken in outpatient and community settings where patients have fewer barriers to access: (EF) - Work with secondary services, general practice and community providers to shift volumes • Review the process used to allocate operating times for surgeons. This will assist in list planning as one component of improving service delivery: - Develop Terms of Reference - Agreed practices for surgeons and nursing perspectives completed - Plan for implementation from Q3 2021/22	 Q1 Q3	SS03
Strategic Priority 5 - Ensure the Planned Care systems and supports are sustainable and designed to be fit for the future • Commission a comprehensive theatre productivity review to ensure theatre use is optimised and emerging opportunities for improved planned care can be implemented - Review throughput - Reduce cancellations - Develop robust production plan - Consider flexible working arrangements and better integration with other hospital activity	Q2	SS07

2.6.7 Acute Demand

Whanganui DHB is committed to delivering service improvements to acute patient flow across primary and community care, and emergency care in secondary services. Our alliance leadership team and primary providers were focused on understanding the drivers of acute demand in 2019/20 but that work was interrupted with the COVID -19 pandemic. Our strategic focus area, 69,000 beds is an important enabling strategy for further development of acute demand work and our benchmarking shows that we have high hospitalisation rates and high ambulatory sensitive hospitalisations (ASH), particularly in the 45-64 year old age groups. These are likely to be linked to long-term conditions and to amenable mortality. There are known inequities across all these areas.

DHB Activity	Milestone	Measure
Acute data capturing SNOMED coding in the Emergency Department has regional implications due to our shared patient administration system and we have been developing our plans in conjunction with MidCentral and Wairarapa DHBs. In 2019/20 we completed an upgrade to webPAS that also enabled an upgrade to 3M encoder (ICD 10 version). ▪ Switch over to SNOMED – still to be scoped as a regional project to meet 2020/21 timeframes.	Q4	
Patient flow activity • In the post-COVID environment we will continue to run an "influenza" clinic/workstream at the hospital front-door. This will be based on the CBAC model that existed through alert levels 2 – 4 and will ensure better streaming of patients, isolation of winter ills and the ability to re-establish a swabbing regime if necessary • Other initiatives continue to further streamline patient flow of patients between Emergency Department presentations and lower acuity accident and medical patients. For mental health and addictions patients we are developing options for earlier identification and rapid connection with appropriate clinical teams and treatment. Long-term conditions patients will prioritised for acute care and linked back to their community and primary care teams for ongoing care requirements through development of primary care pathways and the introduction of funded community options. • Continuing with the dedicated haumoana (family/whānau navigator) service in the Emergency Department. This service operates 24 hours each day to support Māori whānau while they are in hospital from acute presentation to discharge. On site accommodation is available for the family/whānau of patients to enable them to be with patients during their stay. • Developing streamlined processes and protocols for early identification of those patients that are likely to be acutely admitted to hospital from ED and fast tracking those patients directly with the appropriate specialist team. • See also Healthy Ageing section	Q1 – Q4 Q3 Ongoing	

Understanding demand during COVID 19 and responding in new ways • Post-COVID 19, the district has embarked on an intensive community engagement process along with our recovery partners. Together we are asking the community for feedback on their experiences of the COVID pandemic across health, social and economic perspectives. The pandemic resulted in many acute services having a significant drop in attendance that we need to understand. Alternative methods of serving that demand or of avoiding it altogether will be identified. - A significant amount of acute demand was responded to through virtual consultations – WDHB will be embedding the ability for DHB clinicians to safely deliver virtual consultations	Q1	
69,000 beds • Avoid unnecessary hospital admissions by allowing/developing responsive support in the community • Streamline care across community health providers - Enable community and Whānau centred care - Reduce "doubling up" of community services by stronger integration models - Enable faster access to services by reducing silos created between systems - Home and community support services review and redesign • Implement wellness/prevention model of care for reducing future costs - Enhance support for patient groups identified at risk of hospital admission/readmission - Develop hospital in the home models of care, partnering across social services and NGOs.	Q1 – Q4	

2.6.8 Rural Health

Approximately forty percent (40%) of WDHB's population live in rural settings geographically spread across the rohe. WDHB is committed to addressing the needs of rural populations and to improve access to a range of services in these areas through enhanced integration of services and increased use of technology.

DHB Activity	Milestone	Measure
Waimarino • Support community led consultation, and engagement with iwi, staff and community providers for the redesign of the Waimarino Health Centre. The focus will be on identifying the needs of the Waimarino community, building on work undertaken as part of the Ruapehu Whānau Transformation Plan to develop a Wellness Centre that supports greater integration and enhanced models of care to improve access to health and support services for the Waimarino community – *(see also section 2.6.1 Whānau Ora):* (EF) - Project Group Established - Service redesign and models of care are determined as part of finalising the Wellness Centre facility design - Wellness Centre design are completed.	 Q2 Q3 Q4	
Telehealth for Rural communities Improve access to health services through the use of telehealth for rural communities: (EF) • Establishment of a pilot to improve access to Massey Psychology services as part of the Central Cancer Network • Develop new model of care to test with other services • Explore feasibility to extend telehealth services to other rural communities such as Taihape, and Marton	 Q1 Q2 Q4	
Community/Specialist Nursing • Taking a whole of sector approach explore further the development of a new model of care for Community/Specialist Nursing teams working with GPs, practice teams and community providers. (EF) - Improved Management for long Term Conditions, (CVD, Acute heart health, Diabetes and Stroke). - Support people with LTC to self-manage and build health literacy.		SS13

2.6.9 Healthy Ageing Healthy Aging seeks to maximise health and wellbeing for all older people.		
DHB Activity	**Milestone**	**Measure**
Live Stronger for Longer – Falls Prevention and Fragility Fracture Management (EF) Continue to work with ACC, HQSC and the Ministry of Health to promote and increase enrolments in strength and balance programs and improvement in data driven osteoporosis management the as reflected in the 'Live Stronger for Longer' Outcome Framework, Healthy Ageing Strategy and DHB district whole of system approach. The DHB in partnership with ACC and other key stakeholders will be undertaking an evaluation of the current programs for falls prevention and fragility fracture management. This evaluation will include identifying options for innovative delivery for community strength and balance and data driven bisphosphonate prescribing by primary care. This will be completed prior to December 2020 (EF)	Quarterly	SS04
Pressure Injury Prevention and Management (EF) The DHB is working in partnership with ACC to progress pressure injury prevention and management programme across the WDHB district. This initiative includes linkages with age residential care, general practice and community providers. The DHB in partnership with ACC and other key stakeholders will be undertaking an evaluation of the programs currently being offered. This will be completed prior to December 2020	Quarterly	SS04
Home and community support – 69,000 beds (EOA) Over the next two years partner with an inclusive range of representatives from our communities to redesign through co-design an integrated and coordinated community model incorporating home and community support, iwi providers, community NGOs, district nursing, specialist nursing and allied health, working in partnership with general practice teams focused on keeping people well in the community. The model will be informed by the Home and Community Support Service Framework and Service Specification outcomes from Live Stronger for Longer and Pressure Injury Review Other funders such as ACC will be included. This work will also be a major contributor to assisting the DHB to address the drivers of acute demand for people aged 75 plus presenting at ED and urgent care services (including at lower ages for disadvantaged populations).	Quarterly	SS04

The approach will include a kaupapa Māori approach for kaumatua and includes working in partnership with interRAI NZ as they undertake a national review of interRAI by Māori and include other key stakeholders. (EF) The first steps are to scope this commissioning project and agree the national standard bulk funding approach for home and community support services. **ACC Non-Acute Rehabilitation** (EF) Support non-acute rehabilitation that helps older people regain or maintain their ability to manage their day-to-day needs following an acute injury by: Develop pathways/service for rehabilitation in the community and align with other community-based developments to encompass ACC non-Acute rehab (NAR).	Quarterly	SS04
Carer Strategy (EF) Work in partnership with Ministry of Health and other keys stakeholders to progress locally three national priority areas that include: • more accessible respite • management of continence • Funded Family Care	Quarterly	SS04
Addressing Frail and Vulnerable Older People (EF) Supporting primary and community care settings to identify fail vulnerable older people (younger for Māori and Pacific) as part of a broader three-year work programme of keeping people well in their own home and communities by better prevention and management of long-term conditions and reducing acute demand by: • review with St Johns Ambulance service directly into ED by developing clinical pathways and models of care including home based support services, community providers and non-acute rehabilitation (supported discharge and transitions of care) • implement Health Pathways supported by planned care and community care funding options • continue to work closely with HQSC and support locally Advance Care Planning and Serious Illness Conversations • implement frailty health pathway • ensuring quality ethnicity data is included and results interrogated for equity in Māori Health outcomes	Quarterly Quarterly	SS04 SS04
Implementing Dementia Framework (EF) Support a regional approach to implementing the Dementia Framework locally.		

2.6.10 Improving Quality

WDHB are working with our partners in care to develop system level measures and improve the experience for our patients. Preventing antimicrobial resistance remains a focus and this is driven by a multi-disciplinary infection prevention committee.

Review of the Atlas of Healthcare Variation patterns has identified a need to focus on gout and a quality improvement plan has been put in place around thi

DHB Activity	Milestone	Measure
Implement the new national inpatient survey once this is released by HQSC: • action plans are developed where results are below the national average (EF) • action plans have been developed to address inequities identified in the survey returns and results. (EF)	Q1 Q4 Q4	
Monitor all HQSC QSMs, including falls, pressure injuries and safe use of opioids and develop improvement plans where results are below the national average. HQSC QSMs are monitored and results are available on the national dashboard: • monitor ethnicity variations and develop plans to improve equity where inequities are identified (EF)	Q2	
Implement, monitor and measure the consumer engagement quality and safety marker (QSM): • implement the actions of the WDHB consumer engagement review 2020 (EF) • continue to engage with consumers and apply co-design principles in all service improvement activities. (EF)	Q4 Q2	
Reducing seclusion • Staff continue to work in a trauma informed way • Improve use of sensory modulation, as evidenced through increased episodes (EF) • Use of Māori sensory modulation kits (EF). Application of PDSA to implementation. • Continue to monitor the national KPI for seclusion hours and events	Q2	
Service transition • Continue to implement connecting care projects • Transition role from CMHAS to GP is in place • Implement a discharge nurse position (general health)	Q3 Q1	
Adverse events • Continue to undertake CSA/RCA/Case/London Protocol review for all SAC1/2 adverse events • Implement the national mental health adverse event template/process when this is available	Q2/4	

2.6.11 New Zealand Cancer Action Plan 2019-2029 The Ministry has established a National Cancer Control Agency and appointed a Chief Executive. DHBs are required to work with and take direction from the Cancer Control Agency. The Agency has a leadership and monitoring function and will be required to report progress against performance of the Plan to the Minister. The Plan requires that services are delivered against nationally agreed standards of care and that quality improvements will be made for agreed quality performance indicators as they are further developed across all tumour streams.		
DHB Activity	**Milestone**	**Measure**
Current Performance Actions • WDHB will continue the patient tracer audit programme and implementation of continual quality improvements identified in patient journeys that breach the 62-day target. (EF) • WDHB has a Haumoana specifically to work with Māori and Whānau to provide support to assist them to navigate health services through their journey and to ensure equitable outcomes. This work will be led by a clinical team and include the cancer nurse coordinator and the Māori health team. (EF) Further planning initiatives will be developed in line with the National Cancer Action Plan and national cancer agency guidance.	Q1 – Q4 Q1-Q4	SS01 SS11
Local cancer services The Regional Cancer Treatment Services (RCTS) located and provided from MidCentral DHB includes provision of radiation oncology and chemotherapy to Whanganui DHB patients. Limited chemotherapy services are available locally. In 2019/20 WDHB was allocated capital funding to develop a local chemotherapy and infusions unit. Planning is underway to have this established by 2021/22. It is anticipated that the current limited local chemotherapy options will be expanded significantly by having a local service and that this will reduce the need for WDHB residents to travel to Palmerston North for those procedures. Radiation oncology will continue to be based at the RCTS. Service business case completed • Facility business case completed • Tender for build	 Q1 Q2 Q4	

2.6.12 Bowel screening and colonoscopy wait times		
DHB Activity	**Milestone**	**Measure**
• Continue to monitor and report on performance against urgent, non-urgent and surveillance colonoscopy waiting times (EF) • Discuss recommended and maximum wait time performance as standard agenda item at monthly endoscopy user group meetings. (EF) • Develop policy for management of endoscopy waiting list that includes escalation process for patients at risk of exceeding maximum wait time. (EF) • Develop report that identifies all patients that are waiting for colonoscopy by ethnicity and triage category. Include acuity index calculation, so that patients at risk of exceeding maximum wait time can be easily identified. (EF) • Ensure 95% of bowel screening participants who return a positive FIT have a first offered diagnostic date that is within 45 working days of their result being recorded in the NBSP IT system, with no equity gap for Māori and Pacific populations (EOA) • Ensure at least 60% of eligible bowel screening population participate in the programme, with no equity gap for Māori and Pacific Island populations (EOA) • Review and discuss bowel screening participation rates and bowel screening colonoscopy wait time results by ethnicity (Māori, Pacific Island, Asian, Other) at bowel screening equity working group meetings. (EF) • Facilitate the delivery of health promotion activities identified through the bowel screening equity working group, the bowel screening communication and engagement plan, and the bowel screening equity plan. (EF)	Q1 – Q4	SS15

2.6.13 Workforce

WDHB as an equal employment opportunity (EEO) employer is committed to increasing and developing an inclusive workforce that continues to embrace diversity. We are committed to implementing our Pro-equity Plan recommendations related to Māori workforce development, which aligns well with te Tumu Whakarae position statement on increasing Māori participation in workforce and the associated six targets are included in our work programme.

Working in partnership with primary care, Māori health organisations and community health organisations to embed a district wide Workforce Development Plan that will support achieving equity in health outcomes for Māori and across our community is a priority over the next 12 months. One of the strands of this strategy will be increasing Māori participation, recruitment and retention in the health workforce.

Our focus on cultural safety, the wellbeing of our staff, continuing to grow leadership across disciplines and across the district and embedding the values of our organisation in all aspects of our work remains a priority for us in 2020-21.

Further detail about the central regional approach to workforce is contained in the 2020/21 Central Regional Service Plan.

Family and Sexual Violence:
Ongoing work developing WDHB response to staff as victims of violence
Implementation of training package for managers to respond to staff victims of violence
– (see also section 2.8.3d Family Violence and Sexual Violence)

DHB Activity	Milestone	Measure
Leadership. Continue to grow clinical leadership across medical, nursing and allied health, scientific and technical staff. • Complete Talent Mapping for WDHB tier 2 employees completed	Q2	
Grow leadership across administration and non-clinical professional staff. • Ongoing individualised development of tier 3 and 4 employees	Q4	

Equity. Develop a whole of district workforce plan. (EF)		
Deliver on the WDHB pro-equity plan where the conditions for equity are created. (EF) • Equity KPIs agreed for all leadership / management roles • Agree equity targets to proactively grow Māori workforce across the health district that reflects proportionally for our Māori population by 2030 • Use of Te Reo Māori reflected in all WDHB communication and formal interactions	Q1 Q1	
Create environments where our people are well supported and enabled to thrive and deliver the best care to our patients, whānau and communities. (EOA)	Ongoing	
Realise cultural safety throughout the entire workforce. (EOA) • All staff, Board , management and leadership will continue to demonstrate participation in cultural competence training • Cultural safety monitored against changes to individual clinical practice which ensures Māori receive optimum care • Expand existing programmes that build on organisation culture and values to include action on racism and institutional bias	Ongoing	
Strengthen and maintain focus on Kia Ora Hauora. (EOA) • All Kia Ora Hauora graduates that wished to work in the WDHB are employed.	Ongoing	
Make our environment conducive to greater uptake by Māori to improve recruitment and retention of Māori. (EOA) • Increased interview rate for Māori applicants – 100% of Māori applicants who meet the minimum eligibility criteria for any role are shortlisted for interview (EOA)	Ongoing	
Develop a retention and recruitment strategy that includes health providers across the district that is focused on Māori staff. (EOA) • Recruitment and Retention strategy for Māori staff developed • Implement the WDHB recruitment and retention strategy focused on Māori staff. (EOA) ○ Increase number of Māori staff working in health across the district	Q2	
Support and remind staff to update their ethnicity status. (EOA) • Review and update ethnicity collection so that the DHB has 0% employees who have their ethnicity recorded as unknown.	Ongoing	PH02

Deliver the Central Region Equity Plan. (EF) Develop a data collection model, approach and tools to create understanding of the district workforce and unique characteristics of the different communities. (EF) Develop a strategy to support employment of a Māori workforce: ▪ that reflects the Māori population proportionality for the WDHB region by 2030 (EOA) ▪ with occupational groupings that reflect the Māori population proportionality for the WDHB region by 2040 (EOA) ▪ Strategy developed that focus on ensuring strong local supply to meet future health needs Understand barriers experienced at schools hindering delivery of science programmes. (EOA) ▪ Work with schools and education providers to identify alternative delivery methods for science programmes. Develop mechanisms to measure retention within the health system beyond DHB employment. (EOA) • 100% of Māori applicants who meet the minimum eligibility criteria for any role are shortlisted for interview. (EOA) • Turnover for Māori staff will be no greater than the DHB turnover for all staff • Staff with occupational groupings that reflect the Māori population proportionality for the WDHB region by 2040 • Mechanisms and measures agreed.	Q3 Q4 Q4 Q4 Q4	
Workforce response to COVID-19 – Reset, Redesign - Recovery Develop an Integrated Social Governance framework to minimise the impact on service delivery that results from matters such as COVID-19. • Integrated Thriving Communities Team will support leading the WDHB's Integrated Social Governance framework (collaborative team comprising of representation from Whanganui District Health Board, Whanganui District Council, Rangitikei District Council, Ruapehu District Council, Whanganui Regional Health Network, iwi and supporting agencies) • Feedback from the community on the impacts of COVID-19 and the lessons learned from the response to the virus, as well as what keeps their communities healthy and well. • Develop a scoping report that outlines through qualitative and quantitative analysis an outline of our communities. • Integrated Social Governance framework developed based on three specific areas of recovery – economic, health and social. Adoption and implementation of '*He Hāpori Ora Thriving Communities*' strategy. • Social, economic and pro-equity factors considered in the wider determinants of health. • Develop an Action Plan based on the priority focus areas of the '*He Hāpori Ora Thriving Communities'* strategy.	Q4 Q4 Q4	

Be guided by the MoH Raranga Tupuake – Māori Workforce Development Plan. (EF) • Guidance is reflected in actions	Ongoing from Q1	
Provide tuākana tāina support for new graduate Māori nurses through Te Uru Pounamu programme. (EOA) • All new graduate Māori nurses receive formal support Expand Te Uru Pounamu to encourage connection between Māori health professionals. (EOA) • Three wānanga held for Māori staff per year	Ongoing from Q1 Q2,3,4	
Proactively promote Ministry of Health funding for Māori particularly in kura kaupapa and kura auraki settings. (EOA) • Monitor awareness and uptake of Ministry of Health funding by kura kaupapa and kura auraki settings • Increase the number of Māori students from kura kaupapa and kura auraki entering health careers	Q1 – Q4 Q4	
Develop a sustainable approach to nursing career pathways. • Equitable funding for professional development for nurse practitioners	Ongoing	
Development • Meet all of our training and facility accreditation requirements from regulatory and professional bodies, including New Zealand Nursing Council, Medical Council of New Zealand, New Zealand Dental Council, Pharmacy Council and Medical Colleges • Accreditation requirements met. • Education committee actively leads training at all levels within the DHB.	Ongoing from Q1 Ongoing from Q2	
Continue with placing training interns at the WDHB. • Work with managers and executives to support expansion of the programme placing training interns at the WDHB.	Ongoing	
Establish an additional community based attachment to meet MCNZ requirements. Establish training opportunities outside the hospital environment in a community based attachment for prevocational interns.	Q4	
Establish an education centre to support our growing focus on workforce development and a culture of learning within WDHB. • New education centre fully functional	Q4	
Align staff development with health gain areas for the district. • Include health literacy as core component of staff training. (EF)	Ongoing from Q2	
Gender Equity. Implement equity and pay parity agreements as per the agreed settlement timeframes.	Ongoing	

Data. Build on current data collection processes and continue within the context of existing sub-regional service developments and national workforce programmes. • Workforce planning data informs business and investment decisions • Improved workforce planning for the district	Q4	
Wellbeing. Develop a preventative model of health care for the WDHB district health carers.	Q4	
Health Literacy (EF) WDHB's strategic direction He Hāpori Ora - Thriving Communities requires that we build resilient communities, with empowered whānau and individuals to determine their own wellbeing. Health Literacy is inherent in resilience, empowerment and the capacity for decision making that enables people to determine their own wellbeing. Health Literacy is a significant enabler in achieving WDHB goal of equity in Māori health outcomes. WDHB takes a systems-wide view of health literacy which recognises individuals and their families/whānau operate within a context or total system. Health literacy is therefore considered across four levels: systems - cross sectoral and cross agency, service; social and individual/whānau. WDHB recognises health literacy is directly related to cultural competence and knowledge of the impact of racism and discrimination in all its forms. The DHB has a long-term commitment to cultural competence and has specific work planned on addressing racism. These activities are dealt with in other sections of this plan. ▪ Continue work to develop a Health Literacy Action Plan with a focus on the pro-equity and 69,000 bed strategic focus areas. ▪ With consumers, continue work to develop a health literacy tool and a schedule for reviewing DHB provided and develop patient and whānau information. ▪ Health literacy is integrated across all patient-interaction with services in the DHB but is specifically recognised in the following: – The Collective Communications work – Delivery of whānau ora and whānau centred models of care – Workforce development (for non-clinical; and clinical; staff) – Health promotions messaging – Screening programmes – Appointment-related communications – Posters, brochures and other leaflets – Wayfinding signage and maps – Website, social media and media	Q4 Q4 On-going	

- Long-term conditions information for patients and whānau - Mental Health Suicide prevention - Maternal and child work - Healthy Ageing activities - Pharmacy initiatives - Rural health initiatives in telehealth - Korero Mai - Shorter Stays in the Emergency Department		

2.6.14 Data and digital

Whanganui DHB's information technology (IT) and communication systems goals align with the national and regional strategic direction for Data and Digital.

New initiatives will follow our strategy of Digital and Cloud First with Infrastructure and Software as a Service as the default. This will improve access, timeliness and having data available at the right place. Cloud based systems will provide tools to empower our staff and give us the ability to better manage our infrastructure, security and compliance and enable us to respond more quickly to changing business requirements.

DHB Activity	Milestone	Measure
Key activities in 2020/21:		
Alignment to regional strategy (ISSP) : • Contribute at workshop and executive level to optimise service delivery through a new regional operating model • Have representation on regional clinical governance to ensure measurable clinical value • Involved in a refresh of the regional strategy with a modern digital context	Ongoing	
Collaboration across community, primary and secondary care: • eReferrals will digitise, streamline and optimise the referral process between primary and secondary care • MS Teams supports greater collaboration with community and other external agencies • Data sharing with main PHO generates shared insights • Shared electronic health record makes primary care patient portal available to hospital clinicians	Ongoing	
Consumer access to health information: • While no specific plans this year for providing direct patient access to their health information the Telehealth project will provide patient choice as to their clinical engagement • Deliver technology solution • Change management completion	Q1 Q3	
Digital Maturity Assessment programme • WDHB commit to commence taking part in this programme at the earliest opportunity.		

IT security. To improve our security across digital systems: • Recommendations from Security Assessments will be reviewed and implemented where possible. • Enhanced security features available through our MS e5 licensing will be implemented • Upgrade operating systems and replace aged hardware. DHB ICT investment portfolio: • WDHB commit to providing quarterly reports to Data and Digital directorate Fax machines. In removing fax machines WDHB will: • Provide secure email supported by SMS text messaging • Utilise secure links through MS teams to provide collaboration access to files • Deconfigure fax access in multifunction printers with fax components. • Implement eReferrals to replace the current fax process.	Q2 Q2 Q2 Q2	
Infrastructure as a Service (IaaS) Move server infrastructure from WDHB computer room to the cloud. Benefits are: • The ability to quickly scale up system resources as required and down when not required. • The ability to consolidate resources to control costs. • Agility to implement new infrastructure quickly • Higher spec hardware and security available in IaaS than could be afforded in a local DHB datacentre. • Provider delivered high technical skill sets no longer required at DHB level. This activity: • Follows national recommendations to move to IaaS and to the cloud • Reduction of costs associated with the DHB computer room Better visibility around ICT costs with improved reporting from the cloud • Reduced risk of obsolete hardware	Completion Q4	

Embedding gains from changes introduced during Covid-19: • *Roll out of Microsoft Office and Teams* • *Creating technical capability for roll-out of telehealth within DHB-provided services* This includes: • Office 365 E3 and E5 (cloud) providing collaboration tools and access from anywhere on any device. Promotes working remotely. • Microsoft Telephony (Cloud) to replace the PBX system improving communication with chat and desk to desk video. This activity: • Aligns with activity of other DHBs regionally and Nationally • Opens new collaboration channels with primary and community across the sector through use of "Teams". • Promotes telehealth through desk to desk video, improved access to service for patients and whānau • Enables improved working remotely for staff • Reduces the need for staff to travel for regional and national meetings • Utilises E5 advanced threat protection and compliance improving security maturity • Follows national recommendations to move to cloud. We will measure success by monitoring: • In conjunction with telehealth this has the potential to improve access to services by providing choice for patients and staff • Increase in remote consultation through video conferencing (Microsoft Teams) rather than patients, whānau or staff having to travel. • Contribution to conditions for equity through facilitating the design and delivery of services that do impact on equity of health outcomes for Māori, people living rurally, people with lived experience of disability or for other people who face barriers to their access of health services. (EF)	Q2 Q1	

2.6.15 Implementing the New Zealand Health Research Strategy

Build and strengthen pathways for translating research findings into policy and practice
Research and innovation, analytics and technology are all crucial for achieving an equitable, sustainable health system and better patient outcomes.

DHB Activity	Milestone	Measure
• WDHB commits to working with the Ministry of Health to co-design and co-invest in a programme of work to support the implementation of the New Zealand Health Research Strategy through building the capacity and capability across DHBs to enhance research and innovation. (EF)	Q1	
• WDHB will identify regional networks to create research and analytics networks to support staff engaged with research and innovation and build capacity and capability. (EF) – Regional networks will report to ELT and Clinical Board	Q2	
• WDHB's research policies and procedures will be updated to provide clinical staff with a supportive framework to engage in research and innovation activities. The patient safety, quality and innovation team will continue to provide support for staff engaging in research and quality improvement activities. (EF)	Q3	
• WDHB will develop a research strategy which has an equity focus with clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes. This will include sign off of all research applications by a member of Te Hau Ranga Ora, Māori Māori health service. (EF) – A WDHB research strategy is in place, including approval by Te Hau Ranga Ora – WDHB will work alongside Māori stakeholders (researchers, iwi, hapū, groups and communities) to develop an 'ara' (pathway) for Hauora Māori research. This will be included within the research strategy.	Q3	
• WDHB will provide an annual update on progress to the WDHB Board.	Q4	

2.6.16 Delivery of regional service plan (RSP) priorities and relevant national service plans

WDHB participates in national and regional services planning through a number of forums. TAS is our shared services agency for the 20 DHBs and is the regional technical advisory service for the Central Region DHBs. TAS provides support, advice and programme management for most national and regional services planning.

Sub-regionally, WDHB is in partnership with MidCentral DHB through the centralAlliance. This alliance governs some specific services where a combined approach has been developed. The Boards of both DHBs are supportive of expanding centralAlliance activity.

DHB Activity	Milestone	Measure
2020/21 Regional Services plan Details of the RSP are available on the TAS website: www.tas.health.nz . Like this Annual Plan, the RSP is produced pursuant to the planning regulations within the NZ Public Health and Disability Act 2000 and must respond to the Minister of Health's priorities for regional planning. In addition, the Central Region has a regional planning framework and associated workplan that ensures a focus on multi-year priorities of the region. For 2020/21 these include: • Stroke services • Cardiac services • Healthy ageing • Radiology • Regional workforce • Regional digital health plan • Regional clinical services plan • Regional trauma services • Hepatitis C – a community health pathway is being developed by Hutt Valley DHB for regional adoption in 2020/21. WDHB is an active participant in all aspects of the RSP.	Ongoing	
2020/21 centralAlliance Current priorities include: • Urology • Ophthalmology • Renal services • Chemotherapy services • Collaborative Community Health Pathways • Joint procurement	Ongoing	

Better population health outcomes supported by primary health care

2.7.1 Primary health care integration		
DHB Activity	**Milestone**	**Measure**
• Improving patient flow through hospital services to allow a community focus with interprofessional practice as a priority (EF)	Q2-4	PH01
• Broadening use of the workforce in community settings (EF)		
• Implementation of supported discharge, transition of care and coordination of home and community support services for older persons (disability) (EF)	Q2-4 Q2-4	
• Develop understanding of, and develop strategies to address, barriers to broadening primary care workforce to reflect the population and create the conditions for equity of health outcomes for Māori. (EF)	Q2-4	
• Review service models where appropriate to identify changes that would better serve the population and create conditions for equity including seeking opportunities for development of kaupapa Māori services in consultation with Māori Health Outcomes Advisory Group (MHOAG) (EF)	Q2-4	
• Health Pathways supported by planned care and community care funding options (EF)		
• Grow capacity in primary care through implementation of innovative models of care that provide options for Māori, are sustainable and affordable (EF)	Q4	PH02
• Implement the RFP mental health services and addictions - See mental health section.	Ongoing	PH03

2.7.2 Pharmacy		
DHB Activity	**Milestone**	**Measure**
Review community pharmacy facilitation roles to ensure alignment with identified priorities including: (EF) • Ensuring Aged Residential Care have access to medicines optimization expertise of pharmacists • Recommendations agreed and updated service agreement completed	Q3	
Consider community pharmacy group respiratory health & gout proposals with an equity lens and identify equity outcomes. (EF) - Gout service model confirmed & establishment commenced - Respiratory service model confirmed	Ongoing	
Explore the feasibility of establishing a mental health pharmacist to work across primary and secondary health (EF) - Complete consultation with psychiatric and pharmaceutical services and other relevant parties - Develop job description - Complete recruitment process	Q1 Q4	
Implement community pharmacy component of MMR Campaign Strategy (EF)	Q1	
Monitoring and MOH reporting requirements are met in line with WDHB Project Plan		
During COVID -19, relationships were developed across secondary and community services to support a whole of systems approach which will continue to be developed through the co design of a local pharmacy alert response framework. (EF) - Review of current emergency planning completed to inform framework - Framework developed and agreed	Q1 Q2	
Provision of education and process links to general practice to develop the capacity of community pharmacies for gout, COPD, MUR and vaccination (EF) - Online Gout training course completed by participating pharmacies - Implementation of health pathways and associated quality improvement activities for adult asthma and COPD	Q4 Ongoing	

2.7.3 Long term conditions including diabetes		
DHB Activity	**Milestone**	**Measure**
Revise recall guidelines to reduce inequities (PREDICT) and ensure effectiveness and equity. (EOA)	Q2	SS13
Review LTC approach, information and programs to ensure it supports whānau ora, meets health literacy guidelines, and best practice: (EF)	Q1	
- Consider proposal for Gout management programme combining culturally appropriate education along with a kaiawhina approach will support improved access to medication management and engagement with pharmacy and general practice	Q2	
- Implement programme across the region	Q2-3	
Chronic kidney disease Ruapehu project to reduce progression of CKD for identified patients with high BP, diabetes, uric acid: (EOA)	Q4	
- Develop service model through a co-design approach with communities		
- Progress implementation of new service model	Q2	
Explore the delivery of retinal screening in the community including identification of appropriate service model: (EF)		
- Consider use of other staffing groups (e.g. non-regulated) to undertake parts of the screening	Q4	
- Consider use of artificial intelligence to identify those screenings that require secondary reading from an Ophthalmologist.		
- Implement new service model	Q1	
Measure equity for CVD & Diabetes (through POWER BI) and link to equity measures for adoption by general practice: (EOA)		
- Data analysis completed to inform activity		
- General practice service to improve access programme confirmed, implementation progressing and outcomes analysed.	Q3	

2.7.4 Air Ambulance Centralised Tasking		
DHB Activity	**Milestone**	**Measure**
WDHB is committed to actively participate with the National Ambulance Sector Office (NAS) in the design and planning phases to centralise tasking of aeromedical assets in New Zealand. It is anticipated that this will not change the clinical co-ordination function currently undertaken by DHB staff.		

2.8 Financial performance summary

Whanganui DHB remains committed to operating within annual funding over the long term, and to delivering on the agreed financial plan, supported by clinical and executive leadership.

The Whanganui DHB is planning a deficit of $3.25 million in 2020/21.

The financial plan for 2020/21 to 2023/24 is set out below:

Statement of prospective Financial Performance for the four years to 30 June 2024

	Actual 2018/19 $000	Forecast 2019/20 $000	Plan 2020/21 $000	Plan 2021/22 $000	Plan 2022/23 $000	Plan 2023/24 $000
Provider (deficit)	(12,958)	(11,865)	(4,257)	(4,558)	(5,659)	(5,447)
Governance and Funding Administration surplus/ (deficit)	457	234	(3)	–	–	–
Provider / Governance and funding (deficit)	**(12,501)**	**(11,631)**	**(4,260)**	**(4,558)**	**(5,659)**	**(5,447)**
Funder Arm surplus / (deficit)	(1,153)	(4,174)	1,010	4,558	7,345	7,518
Base net (deficit)	**(13,654)**	**(15,805)**	**(3,250)**	**–**	**1,686**	**2,071**
Mental Health Ring Fence expenditure from prior year	–	–	–	–	–	–
Asset write down & other	–	–	–	–	–	–
Consolidated net (deficit) for year	**(13,654)**	**(15,805)**	**(3,250)**	**–**	**1,686**	**2,071**

Funding increases

Total Vote Health funding increased to $20.3 billion for 2020/21, with an increase of $1.3 billion appropriated to District Health Boards. For WDHB this has resulted in an increase of core crown funding of $20.1 million to $261.1 million. Most of this is attributable to an increase in our population based funding of $15.6 million, equating to a 7.1% increase over 2019/20.

Further significant funding was received for underlying cost pressure funding relating to funding of secondary and tertiary services ($4.6 million) with the remainder being a combination of reduced transitional funding and net increases to national top slices.

Whanganui has recorded positive population growth confirmed following the 2018 census with the increase now running above the national average. This has resulted in our raw population share increasing from 1.31% to 1.36% of the national population, and our population based funding share increasing from 1.63% to 1.71% of the national pool.

STATEMENT OF FINANCIAL PERFORMANCE
CONSOLIDATED

	Actual 2014-15	Actual 2015-16	Actual 2016-17	Actual 2017-18	Actual 2018-19	Forecast 2019-20	Budget 20-21	Var 19-20 Act to 20-21 Bud	Var 19-20 Act to 20-21 Bud % change	
Revenue % change		2.2%	2.2%	4.9%	4.6%	5.2%	6.9%			
Revenue	231,953	236,976	242,230	254,206	265,799	279,649	298,971	19,322	6.9%	F
Personnel costs	(72,486)	(74,978)	(78,280)	(83,456)	(94,090)	(98,311)	(99,522)	(1,211)	-1.2%	U
Outsourced service provider	(13,662)	(13,861)	(13,590)	(14,397)	(15,122)	(16,234)	(14,439)	1,795	11.1%	F
Clinical supplies	(14,034)	(13,698)	(14,579)	(15,941)	(16,592)	(16,986)	(17,316)	(330)	-1.9%	U
Non-clinical supplies	(12,972)	(12,955)	(13,335)	(13,637)	(14,561)	(15,983)	(16,945)	(962)	-6.0%	U
Capital Charge	(2,758)	(3,029)	(2,422)	(4,357)	(4,401)	(3,507)	(3,133)	374	10.7%	F
Interest	(1,924)	(1,548)	(967)	(10)	(22)	(19)	(16)	3	15.8%	F
Depreciation	(4,744)	(4,541)	(4,687)	(4,720)	(5,417)	(5,549)	(6,201)	(652)	-11.7%	U
Other health provider	(72,824)	(75,026)	(76,829)	(80,733)	(85,470)	(94,705)	(96,459)	(1,754)	-1.9%	U
IDF outflow	(36,513)	(37,907)	(38,253)	(41,134)	(43,778)	(44,160)	(48,189)	(4,029)	-9.1%	U
Total Costs	(231,917)	(237,543)	(242,942)	(258,385)	(279,453)	(295,454)	(302,220)	(6,766)	-2.3%	
Cost % Change	2.2%	2.4%	2.3%	6.4%	8.2%	5.7%	2.3%			
Net Surplus / (Deficit)	**36**	**(567)**	**(712)**	**(4,179)**	**(13,654)**	**(15,805)**	**(3,249)**	**12,556**		

Note :- F = Favourable variance; U = unfavourable variance

Financial trend and deficit drivers

The financial results over the past few years have shown a worsening trend as the cost base has grown faster than revenue, resulting in an increasing deficit over the last three years. However, with the lift in funding for this year's budget, WDHB has put plans in place to significantly improve the deficit position with an aim of moving to a breakeven situation in the next two years. The main drivers of this improved deficit position include:

- Revenue - major revenue impact on 2020-21 budget compared with 2019-20 forecast:
  - population based funding increased $16m
  - increase in ACC revenue $661k (loss of revenue in 2019-20 due to COVID-19)
  - mental health one-off AOD revenue from income in advance in 2019-20 $127k
  - increased inter-district inflow $348k mainly impact of uplift
  - loss of some Health Workforce revenue due to change in eligibility criteria $138k
  - additional revenue in 2020-21 for mental health pregnancy & parenting $800k, offset by equal amount cost
  - additional revenue in 2021-21 for Integrated Primary Mental Health & Addiction Service $761k, offset by equal amount of cost.

- Personnel cost (including outsourced personnel) - overall staff increased by 2.9% due to impact of MECA changes across all clinical work groups.

- Clinical Supplies have increased by $330k due to:
  - theatre supplies volume $832k (2019-20 under-spend due to COVID-19 $376k and $456k volume related to investment in planned care)
  - ward costs increased $237k
  - patient travel $109k
  - partial offset by COVID-19 costs in 2019-20 not budgeted in 2020-21 $558k and anticipated saving 69000 beds $290k.

- Non-clinical supplies have increased by $962k due to:
  - facility contract renewal hotel and maintenance services $753k including costs reflecting movement to a living wage
  - equipment IT relates to Microsoft license and moving to cloud $292k
  - telehealth and e-Referral and triage $154k
  - anticipated increases in building insurance $83k
  - partial offset by COVID-19 costs in 2019-20 not budgeted in 2020-21 $320k.

- Depreciation has increased by $652k, mainly relating to regional patient management system $537k and clinical equipment $115k

- Other health providers have increased by $1,754k mainly due to price uplift between 2% and 3.6% for national and local contracts. Other provider new contract cost of $1,738k for pregnancy and parenting and integrated primary mental health & addiction service (offset by revenue), and partial offset by COVID-19 costs in 2019-20 not budgeted in 2020-21 $3,465k.

- IDF – overall net increase in IDF $4,029k = 9.1% increase

- Personal health $3,697k increase made up of inpatient, outpatient and pharmaceutical cancer treatment (PCT) price uplift, offset by saving from better management of inpatient IDF outflow volume $1,010k.

- Mental Health $192k increase relating to other provider clinical rehabilitation and sub-acute extended care volumes increasing.

- Health of older people aged residential care $440k increase relates to volume growth and price uplift.

- **Key assumptions**

The following are the key assumptions applied in the development of the 2020/21 budget. Many of the cost increases have a high level of certainty as they are locked into MECA agreements or have been agreed as part of national contract negotiations. Investment is based on maintaining core servicecoverage.

Assumption	
PBF funding	$15.6m
Planned Care funding	$236k additional funding
MOH Side contract	0% uplift
Primary care revenue	3% uplift if applicable (match to cost)
Provider Division price volume schedule (PVS)	2% to 6.31% uplift
Personnel • MECA agreements • IEA	 Up to 1.9% uplift on expiry 0% uplift
Contracted providers (non-DHB) • National agreements • Local agreements	 2% - 3.6% depending on cost drivers & related revenue growth Up to 3% depending on related revenue growth
Inter-district flow (IDF) • Planned and unplanned	 2% to 19% based on national advice and calculations

Sustainability

Whanganui DHB is working on a long-term financial and clinical sustainability programme to move towards break even. The forecast deficit for 2019/20 is $15.8 million and we are planning to be close to break-even level in 2021/22 financial year. To have a significant impact over time the level of hospitalisation would need to shift to less intensive alternative settings. Through the social governance alliance, we are promoting investment in the social determinants of health.

The particular initiatives to improve sustainability are detailed in section 2.8.2 - Improving sustainability of this plan along with their impact on the out-years. These initiatives are:

- FTE management
- Intensive IDF management
- 69,000 beds - providing a community focussed, preventative model of healthcare that is more effective and efficient
- Radiology efficiencies
- Theatre facilities capacity management

These initiatives are estimated to achieve over $5.0 million in savings or revenue by year 3.

Cash flows

Whanganui District Health Board has received $7m deficit support from the Ministry of Health in 2019-20 financial year due to deteriorating financial performance that has resulted in increasing deficits over the past two financial years. Cash resources have declined and financial support will be required to meet the financial obligations of Whanganui District Health Board.

Statement of prospective comprehensive revenue and expense for the four years to 30 June 2024

	Actual 2018/19 000	Actual 2019/20 $000	Plan 2020/21 $000	Plan 2021/22 $000	Plan 2022/23 $000	Plan 2023/24 $000
Revenue						
Revenue from non-exchange transactions	232,616	245,484	268,056	279,184	288,710	298,570
Revenue from exchange transactions	32,811	33,841	30,571	30,645	30,990	31,344
Other Revenue	372	324	345	345	345	345
Total Revenue	**265,799**	**279,649**	**298,972**	**310,174**	**320,045**	**330,259**
Expenses						
Wages, salaries and employee benefit costs	(94,090)	(98,311)	(99,522)	(101,097)	(103,475)	(105,935)
Outsourced services	(15,122)	(16,234)	(14,439)	(14,911)	(15,407)	(15,923)
Depreciation and amortisation expense	(5,417)	(5,549)	(6,201)	(6,630)	(7,294)	(7,630)
Capital charge	(4,401)	(3,507)	(3,133)	(3,132)	(3,330)	(3,468)
Finance costs	(22)	(19)	(16)	(16)	(16)	(16)
Other expenses	(160,496)	(171,884)	(178,996)	(184,473)	(188,922)	(195,301)
Total expenses	**(279,548)**	**(295,504)**	**(302,307)**	**(310,259)**	**(318,444)**	**(328,273)**
Share of Profit of Associate	95	50	85	85	85	85
Surplus / (deficit)	**(13,654)**	**(15,805)**	**(3,250)**	–	**1,686**	**2,071**
Other Comprehensive revenue and expense						
Gain on property revaluation	–	–	–	–	–	–
Total other comprehensive revenue and expense	–	–	–	–	–	–
Total comprehensive revenue and expense	**(13,654)**	**(15,805)**	**(3,250)**	–	**1,686**	**2,071**

Statement of prospective financial position as at year end for four years to 30 June 2024

	Actual 2018/19 000	Actual 2019/20 $000	Plan 2020/21 $000	Plan 2021/22 $000	Plan 2022/23 $000	Plan 2023/24 $000
ASSETS						
Current assets						
Cash and cash equivalents	3,020	939	5	5	5	5
Receivables from non–exchange transactions	352	160	160	160	160	160
Receivables from exchange transactions	5,897	6,522	5,319	5,379	5,567	5,737
Prepayments	41	–	13	14	15	16
Investments	–	–	–	–	–	–
Inventories	1,427	1,617	1,617	1,617	1,617	1,617
Trust /special funds	181	190	189	189	189	189
Patient and restricted trust funds	4	4	4	4	4	4
Non– current assets held for sales	–	–	–	–	–	–
Total current assets	**10,922**	**9,432**	**7,307**	**7,368**	**7,557**	**7,728**
Non current assets						
Property, plant and equipment	75,230	75,319	78,310	83,419	83,584	83,673
Intangible assets	11,777	12,135	12,640	11,884	10,756	9,481
Investments in associates	1,146	1,077	1,102	1,127	1,152	1,177
Other financial assets	–	–	–	–	–	–
Total non current assets	**88,153**	**88,531**	**92,052**	**96,430**	**95,492**	**94,331**
Total assets	**99,075**	**97,963**	**99,359**	**103,798**	**103,049**	**102,059**
LABILITIES						
Current Liabilities						
Bank Overdraft	–	–	9,199	10,820	5,935	673
Payables under non–exchange transitions	2,092	3,299	2,135	2,978	3,916	4,021
Payables under exchange transitions	16,142	17,808	15,061	15,769	16,505	17,010
Borrowings	230	198	100	103	107	110
Employee entitlements	16,713	21,955	19,304	17,963	18,103	19,949
Provisions	–	–	–	–	–	–
Total current liabilities	**35,177**	**43,260**	**45,799**	**47,633**	**44,566**	**41,763**
Non–current liabilities						
Borrowings	684	486	385	282	66	–
Employee entitlements	873	839	805	771	737	703
Provisions	–	–	–	–	–	–
Total non current liabilities	**1,557**	**1,325**	**1,190**	**1,053**	**803**	**703**
Total liabilities	**36,734**	**44,585**	**46,989**	**48,686**	**45,369**	**42,466**
Net Assets	**62,341**	**53,378**	**52,370**	**55,112**	**57,680**	**59,593**
EQUITY						
Equity						
Contributed Capital	105,567	112,409	114,651	117,393	118,275	118,117
Accumulated surplus / (deficit)	(67,287)	(83,099)	(86,349)	(86,349)	(84,663)	(82,592)
Property revaluation reserves	23,881	23,881	23,881	23,881	23,881	23,881
Hospital special funds	180	187	187	187	187	187
Total equity	**62,341**	**53,378**	**52,370**	**55,112**	**57,680**	**59,593**

Statement of prospective changes in equity for the year end for four years to 30 June 2024

	Actual 2018/19 000	Actual 2019/20 $000	Plan 2020/21 $000	Plan 2021/22 $000	Plan 2022/23 $000	Plan 2023/24 $000
Balance at 1 July	76,153	62,341	53,378	52,370	55,112	57,680
Total comprehensive revenue and expense for the year	(13,654)	(15,805)	(3,250)	–	1,686	2,071
Owners Transactions	–	–				
Capital contribution	–	7,000	2,400	2,900	1,040	–
Repayment of Capital	(158)	(158)	(158)	(158)	(158)	(158)
Other Movement	–	–	–	–	–	–
Balance at 30 June	**62,341**	**53,378**	**52,370**	**55,112**	**57,680**	**59,593**

Statement of prospective cash flows for the year end for four years to 30 June 2024

	Actual 2018/19 000	Actual 2019/20 000	Plan 2020/21 $000	Plan 2021/22 $000	Plan 2022/23 $000	Plan 2023/24 $000
Cash flows from Operating Activities						
Receipts from the Crown	266,128	278,801	297,302	308,543	318,286	328,518
Interest Received	321	101	266	266	266	266
Receipt from other revenue	1,655	1,353	1,305	1,305	1,305	1,305
Payment to Supplies	(169,917)	(186,420)	(195,835)	(198,846)	(203,777)	(210,656)
Payment to Employees	(90,183)	(93,138)	(102,185)	(101,385)	(102,193)	(104,027)
Interest Paid	(22)	(19)	(16)	(16)	(16)	(16)
Payment to capital charged	(4,401)	(3,507)	(3,133)	(3,132)	(3,330)	(3,468)
GST (net)	177	179	(159)	10	30	30
Net Cash inflow/(outflow) from operating activities	**3,758**	**(2,650)**	**(2,455)**	**6,745**	**10,571**	**11,952**
Cash flows from Investing Activities						
Receipts from sale of property, plant and equipment	–	–	–	–	–	–
Purchase of property, plant and equipment	(3,262)	(4,710)	(7,802)	(10,199)	(5,734)	(5,887)
Purchase of intangible assets	(1,310)	(1,393)	(1,895)	(784)	(597)	(557)
Receipts from maturity of investments	(40)	69	(25)	(25)	(25)	(25)
Net appropriation from trust funds	2,975	(9)	1	–	–	–
Net Cash inflow/(outflow) from investing activities	**(1,637)**	**(6,043)**	**(9,721)**	**(11,008)**	**(6,356)**	**(6,469)**
Cash flows from Financing Activities						
Capital contribution	–	7,000	2,400	2,900	1,040	–
Payment of finance lease	(92)	(95)	(98)	(100)	(212)	(63)
Repayment of Capital	(158)	(158)	(158)	(158)	(158)	(158)
Payment of loans	(135)	(135)	(101)	–	–	–
Net Cash inflow/(outflow) from financing activities	**(385)**	**6,612**	**2,043**	**2,642**	**670**	**(221)**
Net increase/(decreased) in cash and cash equivalents	1,736	(2,081)	(10,133)	(1,621)	4,885	5,262
Cash and cash equivalents at beginning of year	1,284	3,020	939	(9,194)	(10,815)	(5,930)
Cash and cash equivalents at end of year	**3,020**	**939**	**(9,194)**	**(10,815)**	**(5,930)**	**(668)**

Wāhanga 3:
Rohe Ratonga Me Tōna Āhua

Section 3:
Service Configuration

3.1 Service coverage

WDHB is not seeking any exceptions to service coverage during the term of this plan. However, exceptions do arise from time-to-time and they are reported to the Ministry of Health, along with mitigation plans, if and when they occur.

Ability to enter into service agreements
In accordance with section 25(2) of the New Zealand Public Health and Disability Act, WDHB is permitted by this annual plan to:

a) negotiate and enter into service agreements containing any terms and conditions that may be agreed; and
b) negotiate and enter into agreements to amend service agreements.

3.2 Service change

WDHB is proposing to implement a range of initiatives to improve clinical and financial sustainability during the term of this plan.

Some of these measures may require further engagement with the Ministry of Health and could trigger the service change protocols as outlined in the Operational Policy Framework. Any material changes will be notified to the Ministry of Health in accordance with the service change process.

Change	Description of Change	Benefits of Change	Dis-benefits of change	Driver	Change for local, regional or national reasons	Notes
Youth respite	Existing provider has signalled an exit. The service will be recommissioned	Service continues with redesign to broaden offer	May be delay	Exit of provider	Local	
Falls and fracture programme	Potential change following evaluation: aspects of falls and fracture prevention programme may cease	Ineffective parts of the programme will stop being supported	Whole of system programme may be interrupted	ACC injury prevention partnership agreement with DHB ends December 2020	Programme being reviewed by DHB and nationally by ACC	
Pressure Injury prevention and management programme	Potential change following evaluation may necessitate a refocus of effort	Ineffective parts of the programme will stop being supported	System wide response may be interrupted	ACC injury prevention partnership agreement with DHB ends December 2020	Programme being reviewed by DHB	
Pregnancy and Parenting programme	Introduce new service focused on pregnancy and parenting for women with AOD issues and who have children under the age of 3 years	Increased support for vulnerable women and their young children	Refocus of some existing resource	New funding	Nationally supported	This is a new programme that has been funded from the 2019 "wellbeing" budget

Roll out of Integrated Primary Mental Health and Addiction Services	Increased FTE resource (clinical and non-clinical) for general practices	Increased access for people who have mental health and addiction stress (mild to moderate)	Refocus of some existing resource	New funding	Nationally supported	This is a new programme that has been funded from the 2019 "wellbeing" budget
RFP for youth primary mental health and addition service	Increased FTE resource (clinical and non-clinical) focused on youth	Increased access for youth who have mental health and addiction stress (mild to moderate)	Refocus of some existing resource	New funding (if successful)	Nationally supported	This is a new programme that has been funded from the 2019 "wellbeing" budget
Budget 2019 initiatives relating to forensic services	Forensic prison in-reach services, youth forensic services, and forensic workforce development	To meet increased demand for forensic mental health services for both adult and youth		New funding	Nationally supported	This is a new programme that has been funded from the 2019 "wellbeing" budget
Regional AOD investment	Increase clinical AOD FTE resource and additional regional residential treatment beds	Increase in skilled AOD workforce and increased access to regional residential AOD treatment beds	Refocus of existing resources	New funding	Nationally supported	
Continued rebalancing of surgical outputs with other interventions	Ensuring our planned care interventions are aligned to national expectations in respect of equitable share and ensuring equity in	More equitable intervention rates compared to rest of NZ. Refocus service delivery to areas where intervention is low or where we can	With rebalancing outputs there may be a decrease in some delivery levels to some services and ongoing expectations will need to be	Equity, efficiency, productivity	Local service delivery configurations	

	delivery. This may mean that our overall service mix changes across acute, planned and inpatient/outpatient activity.	provide outcomes with less intensive interventions.	managed and communicated.			
Acute Dental Services	Improve access to acute dental services in the community for high needs adults.	Priority criteria will ensure equity and fairness for priority populations.	Reduced service in hospital setting	Equity, efficiency	Local	Appropriate use of acute community dental services will improve access for patients requiring hospital based dental services.
Known FTE changes	Increase of 3 FTE dietitians; increase of 2 FTE biomedical engineering resulting from reprocurement – previously outsourced	In house services – improve alignment with DHB service delivery	Increase in FTE	Effectiveness Contract opportunity	Local	
Covid-19 service changes	Influenza clinic to screen pre ED and provide Covid-19 testing & surveillance	Provide testing capability Keep influenza illness out of ED and urgent care	Ongoing cost of separated patient stream	Infection control Provide capability for surge	Local	This approach will support any requirement for ongoing testing

Increase in virtual consults	Increase of virtual / non-contact consults in primary and secondary care	Better access with less waiting More choice Inter-disciplinary approaches supported Cost effective	Fewer in-person consults	Access Effectiveness Equity	Local responses to national direction	Targeting a shift in the proportion of consults that are completed virtually.
Reviews of Covid-19 responses	Integrated Recovery Team and social governance leadership group	District-wide, intersectoral review with local government and civil defence. Ongoing leadership of intersectoral responses	Costs associated with ongoing responses	Community engagement Long-term effectiveness Social determinants Equity	Local	Supports strategic pillar of social governance.

Wāhanga 4: Kaitiakitanga

Section 4: Stewardship

To be effective, the New Zealand health system must be strong and equitable, perform well and be focused on the right things to make all New Zealanders' lives better. Connected to our outcomes framework shown in Figure 3, our strategic response to our Stewardship function is show in Figure 4. This illustrates the connection between the strategic drivers outlined in Section 1 and the strategic enablers that are explained further in this section 4.

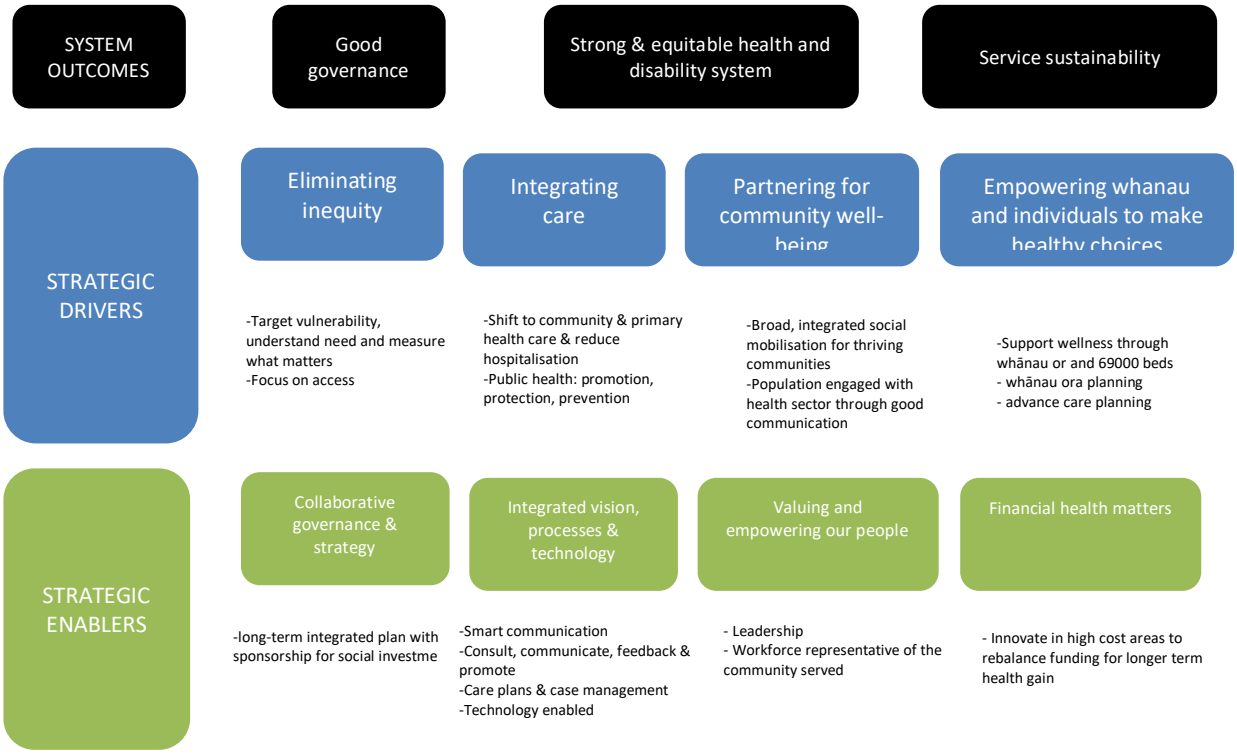


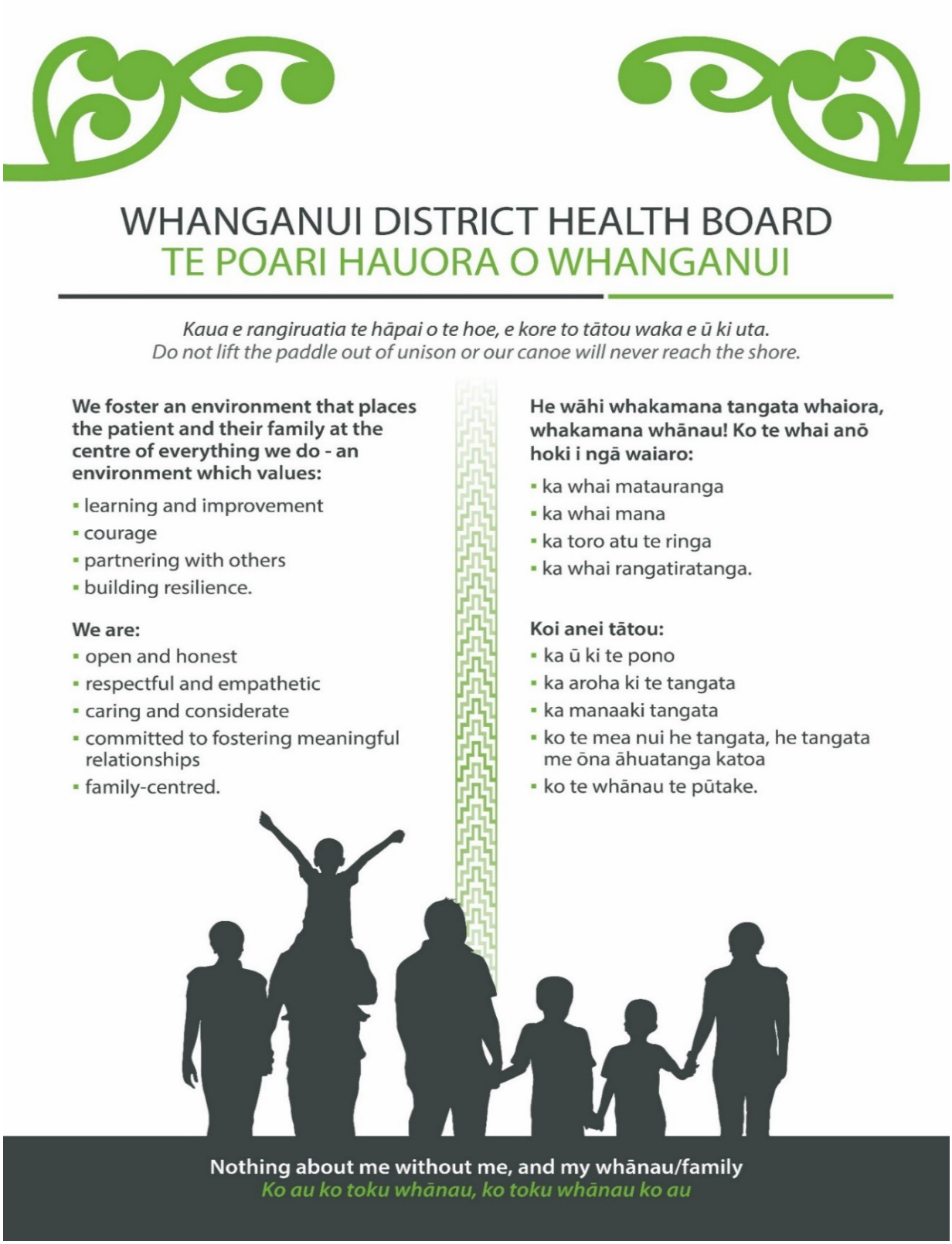
Figure 4

An effective national health system is crucial in our mission to eliminate inequity, integrate care, partner for community wellbeing and empower whānau and individuals to make healthy choices. Locally, to improve system effectiveness over the next three years, we are focused on the following system enablers:

- Collaborative governance and strategy – we are supporting local efforts to develop a long-term plan with sponsorship for social investment in our community.
- Integrated vision, processes and technology – through smart communication; a commitment to consult, communicate, feedback and promote; comprehensive care plans and case management; and technology enablement.
- Valuing and empowering our people – through leadership and a workforce that is representative of the community served.
- Financial health – innovation in high cost areas to rebalance funding for longer term health gain.

Our values

As a pro-equity organisation, committed to whānau-based care and support, our vision inspires and guides us and our values underpin everything we do. Our values are depicted in the following infographic.



4.1 Managing our business

Funding and financial management
WDHB's key financial indicators are reported through WDHB's performance management process to governance and management leaders on a regular basis. Further information about WDHB's planned financial position for 2020/21 and out years is contained in the financial performance summary of our Annual Plan (section 2.8) and in our Statement of Performance Expectations.

Investment and asset management
All DHBs are required to complete a stand-alone Long Term Investment Plan (LTIP) covering at least 10 years. LTIPs are part of the new Treasury system for monitoring investments across government, the Investment Management and Asset Management Performance (IMAP) system. WDHB's LTIP is available on our website at www.wdhb.org.nz.

Shared service arrangements and ownership interests
WDHB has a part ownership interest in Technical Advisory Services (TAS) and Allied Laundry Services Limited. WDHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time. Should it decide to do so, it would first consult with the Minister of Health.

Risk management
WDHB has a formal risk management and reporting system, which incorporates a process to regularly identify risks – both current and emerging – in order to implement strategies to minimise those risks. The DHB is committed to managing risk in accordance with the process set out in the Australian/New Zealand Joint Standard on Risk Management (AS/NZS ISO 31000:2009).

Quality assurance and improvement
WDHB's approach to quality assurance and improvement is in line with the New Zealand Triple Aim: Improved quality, safety and experience of care, improved health and equity for all populations, and best value for public health system resources. Contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits.

4.2 Building capability

Capital and infrastructure development
After heavy investment in building redevelopment in five out of the last six years, a reduction in capital expenditure might have been expected, however the Regional Digital Health Strategy (formerly the Regional Health Informatics Programme) requires significant information technology investment over the next three years. The scale of the expenditure will put pressure on all other aspects of the budget spend, however, this is manageable over this timeframe. The increased depreciation cost as a result of high investment in information technology will have a significant impact on the bottom line over the term of this plan. All investment into Regional Digital Health Strategy projects will be subject to normal business approval processes with the Ministry of Health.

Within the timeframe of this Annual Plan, WDHB intends to advance two significant capital projects:

- The Waimarino Community Health Centre – an integrated health centre to be built in Raetihi with an estimated capital cost of between $3 million and $5 million; and
- A chemotherapy and infusions unit – a medical day case facility to be developed on the site of the Whanganui Hospital to provide day case chemotherapy and infusions treatments. Estimated cost is $800,000.

Information technology and communication systems
WDHB's information technology (IT) and communication systems goals align with the national and regional strategic direction for IT. Further detail about WDHB's current IT initiatives are contained in section 2.6.14 and in the Central Region's Regional Service Plan

Cooperative developments

We recognise that to improve health and equity we need to work with other government and non-government partners. We know that health and wellbeing in the broader context is determined by income, employment, education, housing, culture and ethnicity, social cohesion, resilience and hope for the future. Examples of our work with other agencies includes:

- children and families at risk
- nutrition and physical activity
- smokefree environments
- family violence prevention
- safer communities
- healthy homes
- pathways to employment.

We also have formal contractual and funding arrangements with a range of health providers including general practice services, community pharmacies, rest homes, and community health providers. We are aware of, and make integral in our planning, the fact that the number of people who require hospital treatment is very small, compared to the number of individual interactions with health services in the community.

In all our work we are committed to partnering with individuals, their whānau, and broader communities, to fulfil our role and responsibilities, both as a DHB, and as members of our community.

- Partnership with Iwi and relationships with Māori: We recognise and respect the principles of the Treaty of Waitangi in accordance with the New Zealand Public Health and Disability Act 2000 and are committed to the advancement of Māori health priorities. The board recognises that partnership and participation are essential to enable Iwi to participate and contribute to strategies for Māori health improvement and to foster the development of Māori capacity to participate in the health and disability sector.

  The board's Memorandum of Understanding with Hauora A Iwi recognises this commitment. Hauora A Iwi, as the inter-tribal forum established by a confederation of six Iwi, is the highest-level strategic partner with the DHB.

- Community engagement: We are committed to working with local communities through an open and transparent planning and decision-making process. We aim to keep the community informed at all times through consultation, communication, public board and committee meetings and the regular release of information.

- Partnership with public health services: We recognise our statutory responsibilities to improve, promote and protect the health of people and communities. Our planning and provision of public health services is integrated with and informed by local population health priorities in addition to national and regional direction. The regulatory function of public health is provided to Whanganui DHB by MidCentral District Health Board through their Health Protection Service.

- Cross-DHB cooperation: We work closely with other DHBs in the region so the most effective and efficient configuration of services is achieved across the region. The 2019/20 Regional Service Plan sets out the vision and actions proposed for regional service development. In addition, we have a foundation agreement with MidCentral DHB (centralAlliance) that outlines mechanisms for the two DHBs to collaborate on planning and delivery of services, to support the long-term clinical and financial sustainability of both DHBs.

- Public sector cooperation: We recognise the importance of alliances with other agencies outside health and the crucial role other agencies play in assisting the board to address and improve the determinants of health.

- Private sector cooperation: We work with a range of private sector providers to deliver and coordinate services to the community. The majority of health and disability providers contracted are private providers and we ensure we meet the requirements of the Operational Policy Framework when entering into contractual arrangements with private providers.

4.3 Workforce

WDHB, as an equal employment opportunity (EEO) employer, is committed to increasing and developing an inclusive workforce that continues to embrace diversity. Below is a short summary of **WDHB's organisational culture, leadership and workforce development initiatives:**

- Continue to grow clinical leadership across medical, nursing and allied health.
- Proactively grow the Māori workforce across the health district that proportionally reflects the WDHB district Māori population (EOA):
  - determine targets and action plans
  - maintain focus on Kia Ora Hauora
  - expand the existing cultural safety programmes
  - continue Te Reo Māori programmes for staff on site
  - foster a working environment that attracts and values Māori staff
  - contracted providers – contract clause to enable reporting on Māori workforce capacity and capability introduced at time of review
- WDHB Speaking Up for Safety programme includes action on racism and institutional bias.
- Deliver on the WDHB pro-equity plan (EOA):
  - Build Māori workforce and Māori health equity and equity capability.
- Be guided by the Ministry of Health Rāranga Tupuake – Māori Workforce Development Plan. (EOA)
- Provide tuakana/taina support for new graduate Māori nurses through Te Uru Pounamu programme. (EOA)
- Expand Te Uru Pounamu to encourage connection between Māori health professionals. (EOA)
- Proactively promote HWNZ funding for Māori particularly in kura kaupapa and kura auraki settings. (EOA)
- Growing a future-proof workforce.
- Meet all of our training and facility accreditation requirements from regulatory bodies, including New Zealand Nursing Council, Medical Council of New Zealand, New Zealand Dental Council, and Pharmacy Council.
- Improve the learning culture within the DHB through cementing the new relationship with the University of Otago Wellington for training interns.
- Establish an education centre to support our growing focus on workforce development.
- Community-based attachments are an important part of WDHB's training towards our future medical workforce. We currently have two community-based attachments with a further one required over the next two years, in line with MCNZ requirements for general registration.
- Implement equity and pay parity agreements.
- Identify areas of staff development to align with health gain areas for the district.
- Work closely with regional DHB shared services continuing to identify the workforce requirements around the service delivery needs for services to older people and their family/whānau.
- Build on current data collection processes and continues within the context of existing sub-regional service developments and national workforce programmes.
- Further detail about the region's approach to workforce is contained in the Central Region's Regional Services Plan.

4.4 Information Technology

WDHB's information technology (IT) and communication systems goals align with the national and regional strategic direction for Data and Digital.

New initiatives will follow our strategy of Digital and Cloud First with Infrastructure and Software as a Service as the default. This will improve access, timeliness and having data available at the right place. Cloud based systems will provide tools to empower our staff and give us the ability to better manage our infrastructure, security and compliance and enable us to respond more quickly to changing business requirements.

Business Intelligence tools will allow us to present our data to provide better insights into our business and the automation of manual tasks will assist in optimizing a right sized workforce.

Wāhanga 5:
Tātai Mahi

Section 5:
Performance measures

5.1 Performance measures 2020/21

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 have been updated for 2020/21 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		58%
		Year 2		58%
CW02	Oral health: Mean DMFT score at school year 8	Year 1		<0.77
		Year 2		<0.77
CW03	Improving the number of children enrolled and accessing the Community Oral health service	Children (0-4) enrolled	Year 1	≥95%
			Year 2	≥95%
		Children (0-12) not examined according to planned recall	Year 1	≤10%
			Year 2	≤10%
CW04	Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	Year 1		≥85%
		Year 2		≥85%
CW05	Immunisation coverage at eight months of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	95% of eight-month-olds olds fully immunised.		≥95%
		95% of five-year-olds have completed all age-appropriate immunisations due between birth and five year of age.		≥95%
		75% of girls and boys fully immunised – HPV vaccine.		≥75%
		75% of 65+ year olds immunised – flu vaccine.		≥75%
CW06	Child Health (Breastfeeding)	70% of infants are exclusively or fully breastfed at three months.		≥70%
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 and by 3 months of age 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.		100%
CW08	Increased immunisation at two years	95% of two-year-olds have completed all age-appropriate immunisations due between birth and age two years,		≥95%
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.		≥90%

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.		≥95%
CW12	Youth mental health initiatives	Initiative 1: Report on implementation of school-based health services (SBHS) in decile one to four (and decile five after January 2020) secondary schools, teen parent units and alternative education facilities and actions undertaken to implement *Youth Health Care in Secondary Schools: A framework for continuous quality improvement* in each school (or group of schools) with SBHS.		
		Initiative 3: Youth Primary Mental Health.		
		Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population.		
MH01	Improving the health status of people with severe mental illness through improved access	Age (0-19) Māori, other & total		5.5%
		Age (20-64) Māori, other & total		7.0%
		Age (65+) Māori, other &total		3.0%
MH02	Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan.		≥95%
		95% of audited files meet accepted good practice.		≥95%
MH03	Shorter waits for non-urgent mental health and addiction services	Mental health provider arm	80% of people seen within 3 weeks.	≥80%
			95% of people seen within 8 weeks.	≥95%
		Addictions (Provider Arm and NGO)	80% of people seen within 3 weeks.	≥80%
			95% of people seen within 8 weeks.	≥95%
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.		Reduction of 10% by year end
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	(expectation to be confirmed by MOH)		
PV01	Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall.		70%
PV02	Improving cervical Screening coverage	80% coverage for all ethnic groups and overall.		80%
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.		>85%

SS02	Ensuring delivery of Regional Service Plans	Provide reports as specified			
SS03	Ensuring delivery of Service Coverage	Provide reports as specified			
SS04	Delivery of actions to improve Wrap Around Services for Older People	Provide reports as specified			
SS05	Ambulatory sensitive hospitalisationsan (ASH adult)				Total < 6,300 All Per 100,000
SS06	Better help for smokers to quit in public hospitals (previous health target)	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.		Only applies to specified DHBs	95%
SS07	Planned Care Measures	Planned Care Measure 1: *Planned Care Interventions*			TBC
		Planned Care Measure 2: *Elective Service Patient Flow Indicators*	ESPI 1	100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less)	100%
			ESPI 2	0% – no patients are waiting over four months for FSA	0%
			ESPI 3	0% - zero patients in Active Review with a priority score above the actual Treatment Threshold (aTT)	0%
			ESPI 5	0% - zero patients are waiting over 120 days for treatment	0%
			ESPI 8	100% - all patients were prioritised using an approved national or nationally recognised prioritisation tool	100%
		Planned Care Measure 3: *Diagnostics waiting times*	Coronary Angiography	95% of patients with accepted referrals for elective coronary angiography will receive	95%

				their procedure within 3 months (90 days)	
			Computed Tomography (CT)	95% of patients with accepted referrals for CT scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).	95%
	(Only the Five Cardiac units are required to report for this measure)		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).	90%
		Planned Care Measure 4: *Ophthalmology Follow-up 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 the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service.		0%
		Planned Care Measure 6: *Acute Readmissions*			<12.1%
		Planned Care Measure 7: Did Not Attend Rates (DNA) for First Specialist Assessment (FSA) by Ethnicity (Developmental)	DHBs will be required to identify actions underway to: 1. Ensure that the data used is complete and accurate, 2. Address the differences in DNA Rates of the respective populations. There will not be a Target Rate identified for this measure. It will be developmental for establishing baseline rates in the 2020/21 year.		
SS08	Planned care three year plan	Provide reports as specified			
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	New NHI registration in error (causing duplication)	Group C >1.5% and <=6%	
			Recording of non-specific ethnicity in new NHI registration	>0.5% and < or equal to 2%	
			Update of specific ethnicity value in existing NHI record	>0.5% and < or equal to 2%	

			with a non-specific value	
			Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and < or equal to 85%
			Invalid NHI data updates	Awaiting confirmation by MOH
		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 than95 %
			National Collections completeness	Greater than or equal to 94.5% and less than 97.5 %
			Assessment of data reported to the NMDS	Greater than or equal to 75%
		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.		95%
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.		90%
SS12	Engagement and obligations as a Treaty partner	Reports provided and obligations met as specified		
SS13	Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	Focus Area 1: Long term conditions	Report on actions to: Support people with LTC to self-manage and build health literacy.	
		Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care.*	
			Count of enrolled people aged 15-74 in the PHO who have completed a DAR in the previous 12 months.	
			Ascertainment: target 95-105% and no inequity HbA1c<64mmols: target >60% and no inequity No HbA1c result: target <7-8% and no inequity Diabetes Annual Review: Target >90% and no inequity	HbA1c 60%
		Focus Area 3: Cardiovascular health	Provide reports as specified	

		Focus Area 4: Acute heart service	**Indicator 1: Door to cath** - Door to cath within 3 days for ≥ 70% of ACS patients undergoing coronary angiogram**.**	≥ 70%
			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 **Indicator 2b:** ≥ 99% within 3 months.	≥ 95% ≥99%
			Indicator 3: ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (ie have had an echocardiogram or LVgram).	≥85%
			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 - 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.	≥85%
			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.	≥ 99%
			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.	≥ 99%
		Focus Area 5:	**Indicator 1 ASU:**	80%

		Stroke services	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 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)	12%
			Indicator 3: In-patient rehabilitation: 80% patients admitted with acute stroke who are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission	80%
			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.	60%
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.		90%
		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%
		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.		70%
		95% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system.		95%
SS17	Delivery of Whānau ora	Appropriate progress identified in all areas of the measure deliverable.		
SS18	Financial outyear planning & savings plan	Provide reports as specified		
SS19	Workforce outyear planning	Provide reports as specified		
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		95%
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		90%
Annual plan actions – status update reports		Provide reports as specified		

APPENDIX 1

Statement of performance expectations

Output Class 1: Prevention Services

Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising of services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability.

Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. They include:

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

On a continuum of care these services are population-wide preventative services.

Why is this output class significant?
The DHB will support people to take more responsibility for their own health and reduce the prevalence and impact of long-term illness or disease.

Reducing risk factors such as tobacco smoking, poor nutrition, low levels of physical activity and alcohol consumption together with health and environmental protection factors will contribute to an improved health status of our population overall and reduce the potential for untimely and avoidable death.

What outcomes are we contributing to?
- People/whānau enjoy healthy lifestyles within a healthy environment.
- The needs of specific age-related groups, e.g. older people, children/youth, are addressed.
- The healthy will remain well.

Prevention	Plan 2020/21	Plan 2021/22	Plan 2022/23	Plan 2023/24
Revenue				
Crown	5,223	5,397	5,550	5,709
Other Income	17	17	17	17
Inter-district Inflows	47	47	48	49
Total Revenue	5,287	5,461	5,615	5,775
Expenditure				
Personnel	(915)	(930)	(952)	(975)
Capital charge	(34)	(35)	(39)	(44)
Depreciation	(56)	(60)	(66)	(69)
Other	(450)	(474)	(497)	(516)
Other Provider Payments	(3,840)	(3,950)	(4,072)	(4,208)
Inter-district Inflows	(45)	(45)	(44)	(45)
Overheads	-	-	-	-
Total Expenditure	(5,340)	(5,494)	(5,670)	(5,857)
Net Surplus (Deficit)	**(53)**	**(33)**	**(55)**	**(82)**

Measure description	Ethnicity	2018/19 Actual	2019/20 Forecast	2020/21 Target	2022/23 Outlook
Ambulatory sensitive hospitalisations for children 0 – 4 years of age (compared with the national rate)					
	All	104.1%	93.5%	≤110%	≤100%
	Māori	142.4%	128.7%	≤115%	≤100%
	Non-Māori	73.1%	64.4%	≤110%	≤100%
Children caries free at 5 years of age					
	All	57%	59%	≥58%	≥60%
	Māori	35%	41%	≥58%	≥60%
	Non-Māori	64%	66%	≥58%	≥60%
Immunisation coverage rate at 8 months of age					
	All	87.1%	85.1%	≥95%	≥95%
	Māori	81.5%	78.7%	≥95%	≥95%
	Non-Māori	91.6%	89.4%	≥95%	≥95%
Babies in a Smokefree household at 6 weeks of age					
	All	49.2%	55.3%	≥38%	≥60%
	Māori	32.4%	32.4%	≥28%	≥60%
	Non-Māori	61.5%	61.5%	≥58%	≥60%
Proportion of infants exclusively or fully breastfed at six weeks					
	All	66.3%		≥70%	≥70%
	Māori	64.3%		≥70%	≥70%
	Non-Māori			≥70%	≥70%
Proportion of youth who have received HPV vaccine					
	All	77.3%	67.7%	≥75%	≥75%
	Māori	72.5%	66.6%	≥75%	≥75%
	Non-Māori	81.0%	68.5%	≥75%	≥75%
Cervical screening three-year coverage rate for women aged 25-69 years					
	All	76.2%	74.5%	≥80%	≥80%
	Māori	72.3%	73.9%	≥80%	≥80%
	Non-Māori	77.4%	74.7%	≥80%	≥80%
Percentage of PHO enrolled patients who smoke have been offered help to quit smoking by a healthcare practitioner in the last 15 months					
	All	90.3%	88.7%	≥95%	≥95%
	Māori	89.6%	88.4%	≥95%	≥95%
	Non-Māori	90.9%	89.0%	≥95%	≥95%
Number of extended consults delivered by a GP or practice nurse					
	Total	1791	1240	2228	Target to be established: Youth 20% Adult 80%
	Youth	152 (8.5%)	140(est) (11.3%)	446	
	Adult	1639 (91.5%)	1100(est) (88.7%)	1782	
Percentage of enrolled population 65 years + who have the flu vaccination					
	All	70.3%	68.5%	≥75%	≥75%
	Māori	73.1%	68.0%	≥75%	≥75%
	Non-Māori	70.0%	68.6%	≥75%	≥75%

Output Class 2: Early detection and management

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Includes general practice, community and Māori health services, pharmacist services, community pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.

These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

Why is this output class significant?
For most people, their general practice team is their first point of contact with health services. Primary care is also vital as a point of continuity and effective coordination across the continuum of care with the ability to deliver services sooner and closer to home.

Supporting primary care are a range of health professionals including midwives, community nurses, social workers, aged residential care providers, Māori health provider organisations and pharmacists who work in the community, often with the neediest families.

What outcomes are we contributing to?
- Health and disability services are accessible and delivered to those most in need.
- The health and wellbeing of Māori is equitable with non-Māori.
- The needs of specific age-related groups, including older people, vulnerable children and youth, and people with chronic conditions are addressed.
- The quality of life is enhanced for people with diabetes, cancer, respiratory illness, cardiovascular disease and other chronic (long duration) conditions.

Early Detection & Management	Plan 2020/21	Plan 2021/22	Plan 2022/23	Plan 2023/24
Revenue				
Crown	59,380	61,474	63,191	64,998
Other Income	168	168	168	168
Inter-district Inflows	1,751	1,751	1,803	1,857
Total Revenue	61,299	63,393	65,162	67,023
Expenditure				
Personnel	(8,802)	(8,945)	(9,157)	(9,376)
Capital charge	(348)	(360)	(413)	(480)
Depreciation	(535)	(572)	(629)	(658)
Other	(4,346)	(4,581)	(4,808)	(4,994)
Other Provider Payments	(43,640)	(44,936)	(46,353)	(47,933)
Inter-district Inflows	(3,817)	(3,848)	(3,786)	(3,900)
Overheads	-	-	-	-
Total Expenditure	(61,488)	(63,242)	(65,146)	(67,341)
Net Surplus (Deficit)	**(189)**	**151**	**16**	**(318)**

Early Detection and Management					
Measure description	**Ethnicity**	**2018/19 Actual**	**2019/20 Forecast**	**2020/21 Target**	**2022/23 Outlook**
Proportion of pregnant women accessing DHB funded pregnancy and parenting education					
Average number of mothers attending 75% of education per quarter/average new births per quarter.	**All**	24.7	22.7%	≥40.0%	≥40.0%
	Māori	N/A	14.6	Target to	be established
	Non-Maori	N/A	29.2	Target to	be established
Proportion of adolescent population utilising DHB-funded dental services **Only available Q4 for Calendar 19.**					
	All	69.2	N/A	≥85.0%	≥90%
	Māori	N/A	Target to be established		
Proportion of children enrolled in the community oral health service who have treatment according to plan					
	All	97.0%	94.3%	≥90%	≥90%
	Māori	96.2%	93.3%	≥90%	≥90%
	Non-Māori	97.5%	95.0%	≥90%	≥90%
Proportion of youth (12-19 years olds) seen each quarter by primary mental health services					
	All	1.2%	1.3%	≥2.0%	≥4.0%
	Māori	1.4%	1.7%	≥2.0%	≥4.0%
	Non-Māori	1.0%	1.0%	≥2.0%	≥4.0%
Shorter waits for non-urgent mental health and addiction services (0-19 yrs)					
Total Maori Non Maori	**< 3 weeks**	86.0% 84.9% 86.7%	84.5% 81.5% 86.0%	≥80%	≥80%
	3-8 weeks	97.3% 96.45 98.0%	98.3% 97.5% 98.6%	≥95%	≥95%
	> 8 weeks	100.0%	100.0%	100%	100%
Ambulatory Sensitive Hospitalisations (ASH) rates for 45-64 years of age relative to national rate					
	All	162.5%	161.4%	≤170%	≤125%
	Māori	298.5%	267.4%	≤151%	≤125%
	Non-Māori	131.1%	134.5%	≤166%	≤125%
Proportion of patients with good or acceptable glycaemic control (HbA1C < 64 mmol/mol)					
	All	61.3%	58.6%	≥60%	≥60%
	Māori	51.0%	49.6%	≥60%	≥60%
	Non-Māori	66.3%	62.9%	≥60%	≥60%
Proportion of eligible population who have had their cardiovascular risk assessed in the last five-years					
	All	87.6%	86.5%	≥90%	≥90%
	Māori	84.8%	84.0% est	≥90%	≥90%
	Non-Māori	88.4%	87.0%	≥90%	≥90%
Percentage of people accepted for an urgent diagnostic colonoscopy received their procedure within two-weeks (14 days)					
April(75%)	**All**	91.3%	91.7%	≥90%	≥90%
Percentage of long term clients with mental illness who have an up-to-date relapse prevention plan					
	Child	89.4%	100.0%	≥95%	≥95%
	Adult	All- 92.2%	98.96%	≥95%	≥95%

Output Class 3: Intensive assessment and treatment

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment such as a 'hospital'. These services are generally complex and provided by health care professionals that work closely together.

They include:
- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services.
- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services.
- Emergency Department services including triage, diagnostic, therapeutic and disposition services.

On a continuum of care these services are at the complex end of treatment services and focused on individuals.

Why is this output class significant?
Equitable, timely access to intensive assessment and treatment can significantly improve the quality of life for people through early intervention or through comprehensive, co-ordinated care.

Responsive services and timely treatment support improvements across the whole system and can give people confidence that complex intervention is available when needed.

Quality improvement in service delivery, systems and processes will improve the effectiveness of clinical practices and patient safety, reduce the number of events causing injury or harm and provide improved outcomes for people in our services.

What outcomes are we contributing to?
- Health and disability services are accessible and delivered to those most in need.
- The health and wellbeing of Māori is equitable with non-Māori.
- The quality of life is enhanced for people with diabetes, cancer, respiratory illness, cardiovascular disease and other chronic (long duration) conditions.
- People experiencing a mental illness receive care that maximises their independence and wellbeing.

Intensive Assessment & Treatment	Plan 2020/21	Plan 2021/22	Plan 2022/23	Plan 2023/24
Revenue				
Crown	180,891	188,349	194,896	201,605
Other Income	1,282	1,282	1,283	1,283
Inter-district Inflows	4,621	4,623	4,761	4,904
Total Revenue	186,794	194,254	200,940	207,792
Expenditure				
Personnel	(84,841)	(86,177)	(88,202)	(90,297)
Capital charge	(2,532)	(2,505)	(2,588)	(2,581)
Depreciation	(5,313)	(5,683)	(6,252)	(6,541)
Other	(41,458)	(43,764)	(45,999)	(47,673)
Other Provider Payments	(14,761)	(15,204)	(15,684)	(16,222)
Inter-district Inflows	(40,803)	(41,131)	(40,473)	(41,687)
Overheads	-	-	-	-
Total Expenditure	(189,708)	(194,464)	(199,198)	(205,001)
Net Surplus (Deficit)	**(2,914)**	**(210)**	**1,742**	**2,791**

Intensive Assessment and Treatment					
Measure description	**Ethnicity**	**2018/19 Actual**	**2019/20 Forecast**	**2020/21 Target**	**2022/23 Outlook**
Inpatient length of stay – ACUTE					
	All	2.24	2.26	≤2.2	≤2.1
Unplanned readmission rate at 28 days					
Standardised	**All**	13.2%	13.3%	≤12.1%	≤12.0%
	Māori	13.0%	13.3%	≤12.1%	≤12.0%
	Non-Māori	14.6%	13.1%	≤12.1%	≤12.0%
Faster Cancer Treatment (62-day indicator)					
	All	83.0%	100%	≥90%	≥90%
Improving waiting times for diagnostic services Computed Tomography (CT)					
	All	97.8%	96.8%	≥95%	≥95%
	Māori	98.2%	n/a	≥95%	≥95%
	Non-Māori	97.75	n/a	≥95%	≥95%
Improving waiting times for diagnostic services Magnetic Resonance Imaging (MRI)					
	All	98.1%	98.3%	≥90%	≥90%
	Māori	96.1%	n/a	≥90%	≥90%
	Non-Māori	98.4%	n/a	≥90%	≥90%
Percentage service users receiving community care within seven days post discharge (kpi19)					
	All	n/a	62.0%	≥75%	≥90%
	Māori	50.0%	60.4%	≥75%	≥90%
	Non-Māori	42.5%	63.8%	≥75%	≥90%
Rate per 100,000 population are committed to compulsory mental health treatment					
	All	174	138	≤135	≤120
	Māori	307	249	≤250	≤225
	Non-Māori	121	102	≤100	≤90
Standardised intervention rates					
	Cardiac (All)	5.5	4.41	≥6.5	≥6.5
	Angioplasty (All)	11.8	13.12	≥12.5	≥12.5
	Angiography (All)	30.3	30.5	≥34.7	≥34.7
Standardised intervention rates (cataracts & major joints)					
	Cataracts (All)	26.3	22.27	≥27.0	≥27.0
	Major joints (All)	26.3	23.20	≤28.0	≤21.0
Hospital acquired complications per 10,000 inpatient episodes					
	All	181	181	≤40.0	≤40.0

Output Class 4: Rehabilitation and support

Rehabilitation and support services are delivered following a 'needs assessment' process and co-ordination input by needs assessment and service coordination (NASC) services for a range of services including palliative care, home-based support and residential care services.

On a continuum of care these services will provide support for individuals.

Why is this output class significant?
Older people (aged 65+ years) have higher rates of mortality and hospitalisations for most chronic conditions, some infectious diseases and injuries (often from falls), all of which have a significant impact, not only for the individual and their family/whānau, but also on the capacity of health and social services to respond to the demands.

For people living with a disability or age-related illness, it is important they are supported to maintain their best possible functional independence and quality of life. It is also important that people who have end-stage conditions and their families are appropriately supported by palliative care services, so that the person is able to live comfortably, have their needs met in a holistic and respectful way, and die without undue pain and suffering.

Whanganui DHB is keen to place an emphasis on an increased proportion of older people living in their own home with their natural support system and if necessary supplemented by subsidised home-based support services, before aged residential care is pursued.

What outcomes are we contributing to?
- The needs of specific age-related groups, including older people, vulnerable children and youth, people with chronic conditions are addressed.
- The wider community and family/whānau support and enable older people and people with a disability to participate fully in society and enjoy maximum independence.

Rehabilitation & Support	Plan 2020/21	Plan 2021/22	Plan 2022/23	Plan 2023/24
Revenue				
Crown	44,264	45,738	46,963	48,266
Other Income	104	104	103	103
Inter-district Inflows	1,224	1,224	1,262	1,300
Total Revenue	45,592	47,066	48,328	49,669
Expenditure				
Personnel	(4,964)	(5,045)	(5,164)	(5,287)
Capital charge	(219)	(232)	(272)	(327)
Depreciation	(297)	(315)	(347)	(362)
Other	(2,463)	(2,595)	(2,722)	(2,829)
Other Provider Payments	(34,219)	(35,235)	(36,345)	(37,584)
Inter-district Inflows	(3,524)	(3,552)	(3,495)	(3,600)
Overheads	-	-	-	-
Total Expenditure	(45,686)	(46,974)	(48,345)	(49,989)
Net Surplus (Deficit)	**(94)**	**92**	**(17)**	**(320)**

Rehabilitation and Support					
Measure description	**Ethnicity**	**2018/19 Actual**	**2019/20 Forecast**	**2020/21 Target**	**2022/23 Outlook**
Percentage of mental health & addictions service users receiving community care within seven days following their discharge (KPI 19)					
	All	n/a	62.0%	≥75%	≥90%
	Māori	50.0%	60.4%	≥75%	≥90%
	Non-Māori	42.5%	63.8%	≥75%	≥90%
Percentage of older people in aged residential care by facility who have a second InterRAI Long-Term Conditions Facilities (LTCF) assessment completed 230 days after admission					
	All	91.2%	95%	≥95%	≥95%
Number of older people receiving in-home strength and balance programmes					
	All	n/a	199	199	≥199
Percentage of potentially eligible stroke patients thrombolysed					
	All	11.5%	8.0%	≥10.0%	≥12.0%
Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway					
	All	98.3%	97.0%	≥80%	≥80%
Percentage of people waiting for a surveillance or follow-up colonoscopy that wait no longer than 12 weeks (84 days) beyond the planned date					
	All	75.2%	59.9%	≥70%	≥70%
Proportion of over 64 year olds who are prescribed 11 or more medications					
	All	2.2%	2.3%	≤2.0%	≤2.0%
	Māori	2.7%	2.9%	≤2.0%	≤2.0%
	Non-Māori	2.1%	2.3%	≤2.0%	≤2.0%
Proportion of population aged 65+ years receiving DHB funded support in ARC facilities over the year					
	All	4.9%	4.3%	4.4%	4.4%
	Māori	3.3%	2.9%	3.0%	3.0%
	Non-Māori	5.1%	4.5%	4.5%	4.5%

Whanganui District Health Board

System Level Measures Improvement Plan 2020 – 2021

Whanganui Regional Health Network

WHANGANUI DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

National Hauora Coalition

Rārāngi Kiko
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WĀHANGA 1: He Kōrero Whakataki

SECTION 1: Introduction

This System Level Measures Improvement Plan has been developed and endorsed by the Whanganui Alliance Leadership Team (WALT). WALT is an Alliance of the Whanganui District Health Board and the two Primary Health Organisations operating in the Whanganui District, Whanganui Regional Health Network and the National Hauora Coalition.

The aim of System Level Measures (SLM) is to improve health outcomes for people by supporting collaboration between health system partners. Previous local SLM planning recognised the need to build and sustain strong relationships and connections and to collaboratively take a whole-of-system approach. Therefore, SLM planning is part of a multi-year programme of work with the SLM improvement plan building on the previous year's work as WALT continues to strengthen its collaborative approach to system integration and service planning.

SLM work is aligned to our combined commitment to Te Tiriti o Waitangi and specifically meeting the Minister of Health's wellbeing and equity expectations. For Whanganui district the equity goal is achieving equity in health outcomes for Māori.

SLM planning and implementation provides the opportunity to both endorse the approach for equity and measure progress through: authentic partnerships with Māori; consideration of the wider determinants of health and the drivers of inequity; and putting in place systems and processes that measure and report progress on health equity.

The WDHB Board recognises the need for transformation change across the system, as described in the WDHB's 'He Hāpori Ora Thriving Communities' strategy document 2020-2023 which states: 'no matter where we work in the community we are all in this waka together, equally valued, and ensuing the health and wellbeing of people and their whānau/families are at the centre of all we do'.

He Hāpori Ora identifies three strategic focus areas: Pro-equity; Social Governance - where by iwi, community, social and government organisations work together to achieve outcomes and deliver services for the wellbeing of our whole community; and 69,000 Beds - with its emphasis on keeping people well in their own homes, that the best bed for a person is their own, the need for improved transition from hospital to the community and a strong commitment to person/whānau-centred care throughout the care pathway.

This plan aims to build on the last year's initiatives and presents SLM for the Whanganui rohe that are strategically aligned both nationally and locally, evidence-based, well-supported, clear, measurable and meaningful to our people/whānau and our communities.

Getting to this stage is an encouraging reflection of strong local relationships, trust between health system partners and the development of our common vision However; there is a clear and shared understanding that whilst what is outlined here requires stretch and considerable combined effort - it reflects but a narrow slice of the progress required.

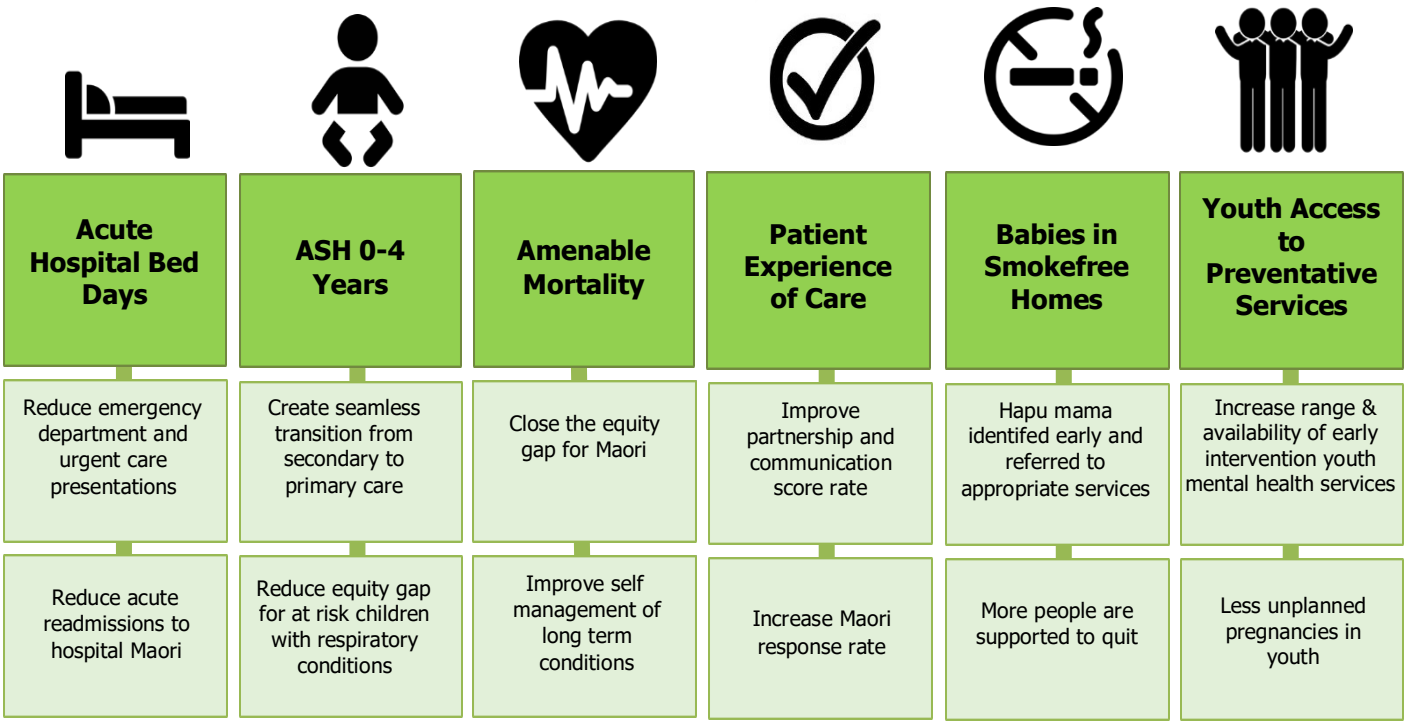
COVID-19 descended on New Zealand resulting in a rapidly changing environment that required immediate response across all sectors to ensure our community was safe and supported. In a post Covid-19 environment, sector wide learnings from our community and partners, will inform redesign approaches that match community and population needs.

Russell Simpson
Chief Executive
Whanganui District Health Board

Simon Royal
Chief Executive
National Hauora Coalition

Jude MacDonald
Chief Executive
Whanganui Regional Health Network

How it all fits together



Enablers to building capacity and capability

Enabler	Explanation
Capacity for change, right skills	▪ Consistent messaging ▪ Health literacy improvement ▪ Retraining consumers to self-navigate the system ▪ 'Choosing Wisely' ▪ Learnings inform collaborative provision of education and peer review ▪ Inter-professional district wide learning culture
Data Assessing and modelling big data to support decision making	▪ SLM data definitions, sourcing, analysis and reporting ▪ Ongoing use of local data sharing (e.g. Power BI) ▪ Increasing use of Health Roundtable data to inform implementation and improvement activities ▪ Advanced forms for improved data collection ▪ District wide commitment to equity view in data analysis, and identifying areas for gain for Māori, Pacific and persons with mental health
Systems and partnerships Across regional DHBs	▪ Health and social services integrated ▪ Lead Maternity Career solutions ▪ St John Ambulance ▪ Well Child Tamariki Ora ▪ Iwi health providers ▪ Pasifika health providers ▪ Ministry of Social Development (MSD) ▪ Accident Compensation Corporation (ACC) ▪ Alzheimer's NZ ▪ Aged residential care ▪ Education providers ▪ Age Concern ▪ Community as partners ▪ Home and community support providers ▪ Urgent care / ED partnership ▪ Pharmacy support ▪ Community laboratories ▪ Primary care teams ▪ Secondary care teams ▪ Health navigators and peer supporters ▪ School based health services ▪ Advance Care Planning national co-opt ▪ Community pharmacy
Quality improvement System enablers	▪ Health Care Home ▪ HealthPathways ▪ E referrals
Leadership Flexibility to solve problems as they arise	▪ Committed leadership ▪ Compelling communications ▪ Clear purpose and priorities
Cultural leadership Kotahitanga 'one team'	▪ Strategic cultural sponsorship ▪ Mentoring coaching leadership ▪ Tools to measure equity ▪ Strong Māori voice in every work stream ▪ Build capacity in whānau ora

SECTION 2: WDHB System Level Measures Improvement Plan 2020 - 2021

Acute Hospital Bed Days

Acute hospital bed days is a measure of acute demand and patient flow across the health system. It is about using health resources effectively and maximising the use of resources for planned care rather than acute care and addressing inequities.

This measure aligns well with WDHB's strategic direction of keeping people well in their homes and communities, recognising that the best bed is a person's own bed. It is especially important given we have a growing and ageing population within the Whanganui DHB, with a projected increase of the 65+ years population from 20% of the total population in 2019 to 26% in 2029 (Statistics NZ, 2018).

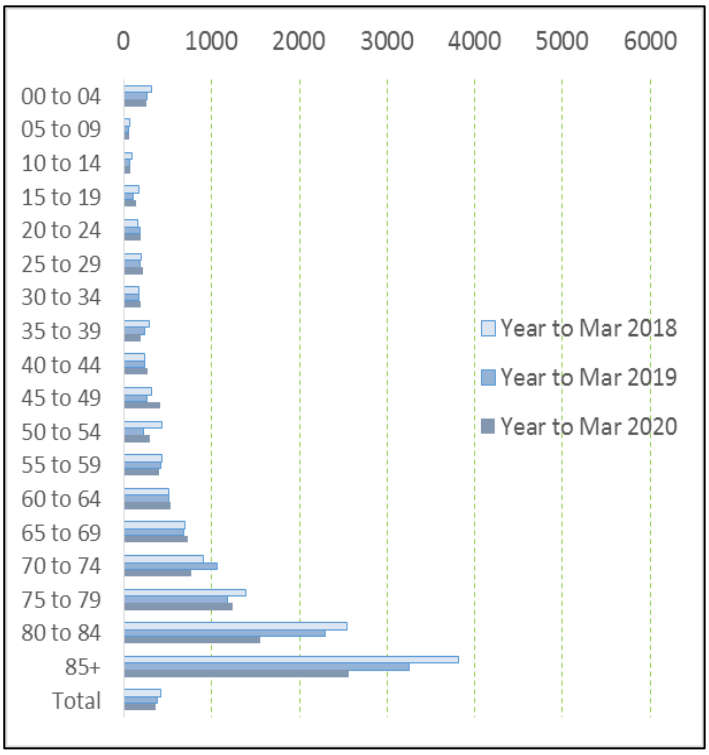
Improving acute demand management requires a whole-of-system view that considers both health and social determinants. Better prevention and management of long-term conditions is essential to keeping older persons well and cared for within homes, ARC and communities. We also need to improve the transition of care between community and hospital care through good communication between health care providers, access to diagnostic and community support services. Models of care which support greater capability and capacity in primary care are essential as primary care experiences increasing demands.

There is a focus on respiratory infections/inflammation as the data identifies that this contributes significantly to unplanned admissions, including the number of bed days and length of stay.

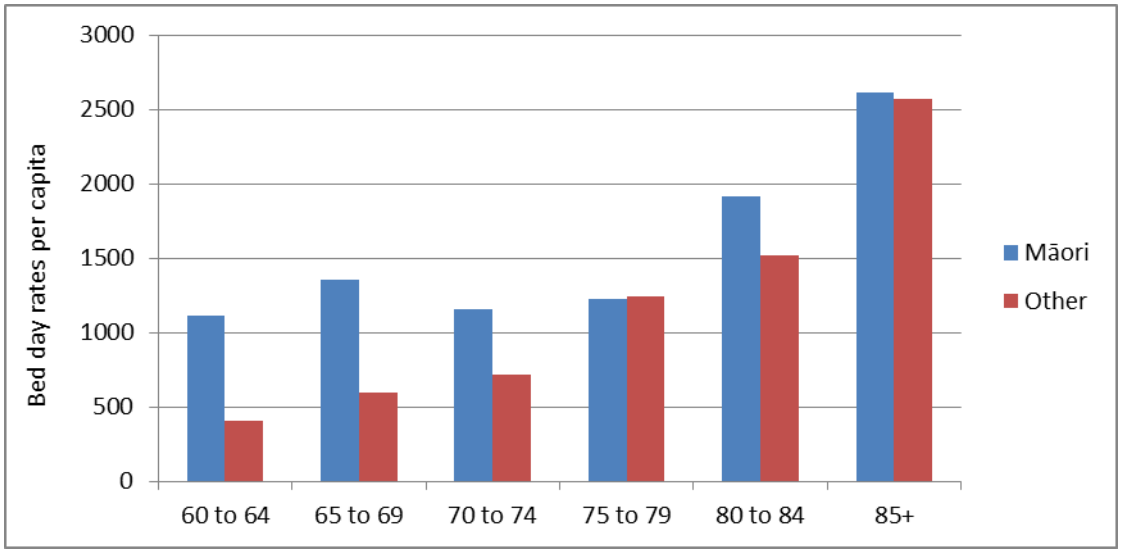
Where are we now?

Standardised acute bed day rates per capita for Whanganui DHB by age group and ethnicity

As identified by the data below, older persons spend a disproportionate amount of time in hospital compared to other age groups, and that the age of onset for long-term conditions is younger for Māori than non-Māori.



Standardised acute bed day rates per capita for Whanganui DHB by age ethnicity and age combined **Page 6**



Milestones and contributory measures
The areas of focus we believe will assist us to achieve the target, including the contributory measures that we will monitor are listed below.

Acute Hospital Bed Days		
Improvement milestone: Acute bed days per 1000 population. Reduce the inequity in acute bed days for Maori aged 60-64, by 10% from 966 by 869		
Objectives	**Actions**	**Contributory Measures**
Reduce emergency department and urgent care presentations	Undertake collaborative, system-wide, solutions across primary and secondary care, alongside Iwi, NGO's and the community, through the continuation of the acute demand programme of work. The work programme includes ▪ Continuation of the influenza vaccine programme for people over the age of 65 ▪ Implement an interdisciplinary team (Allied Health) that supports care in the community, working in partnership with primary health care ▪ Stratify populations to identify vulnerable people to enable proactive early interventions, such as: - Wrap-around services for vulnerable people - Primary and Community options to support general practice ▪ Progress implementation of a revised urgent care model that considers health, social and economic contributing factors. ▪ Focus on early preventions/interventions to delay exacerbations of respiratory disease in the community	Ambulatory Sensitive Hospitalisation (ASH) rate per 100,000 population for 60+ years, by ethnicity ED presentation rates by ethnicity To reduce unplanned bed days for respiratory infections by 20% and average length of stay by 30% All general practices will meet or exceed the national target of 75% for people over 65 for influenza vaccine
Reduce acute readmissions to hospital for Māori	Releasing capacity in hospital services to enable a supported discharge approach by: ▪ Coordinated follow up care arranged prior to discharge ▪ Discharge plans incorporate a health literacy approach for patients and their Whanau ▪ Transition of care information is provided to GP within one working day as part of the supported discharge process	Acute readmissions to hospital by ethnicity

Ambulatory Sensitive Hospitalisations (ASH) 0 – 4 Years

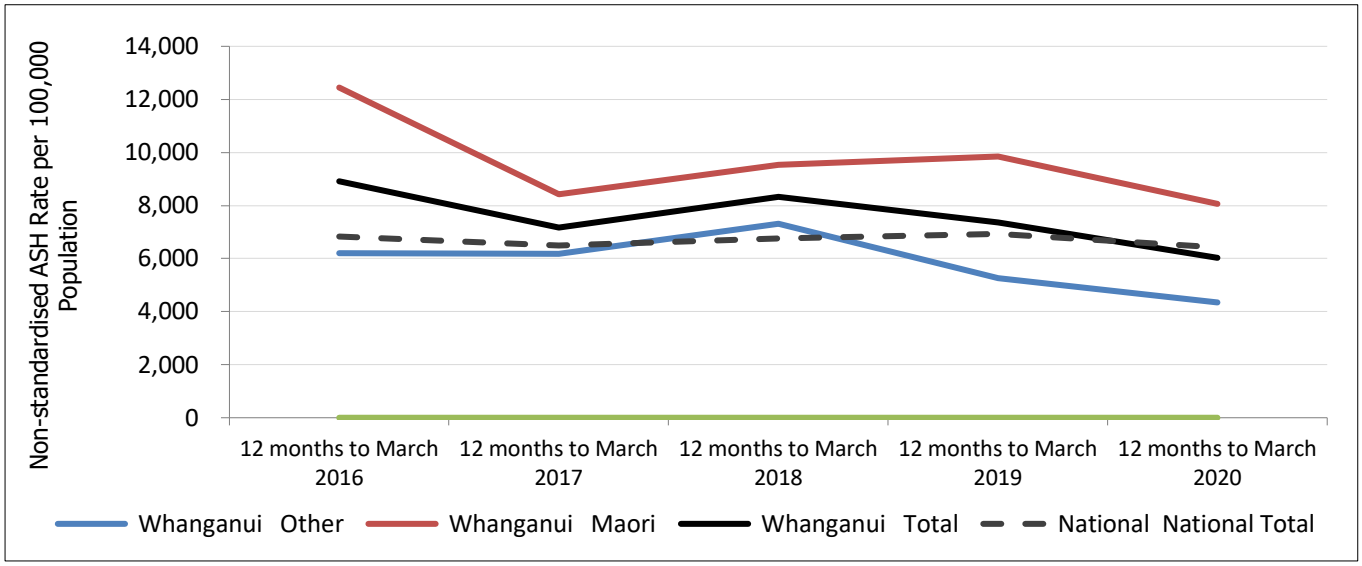
Rates of hospitalisation for ambulatory care-sensitive conditions were significantly higher for those residing in areas with the higher quintiles 2-5; deciles 3-10 (NZDep 2013 scores compared with quintile 1 (deciles 1-2).

For Whanganui DHB, the hospitalisation rate for Pacific and Māori 0-4-year olds were significantly higher than European/Other. Maori were more likely to be hospitalised for ambulatory care-sensitive conditions compared with Non-Māori.

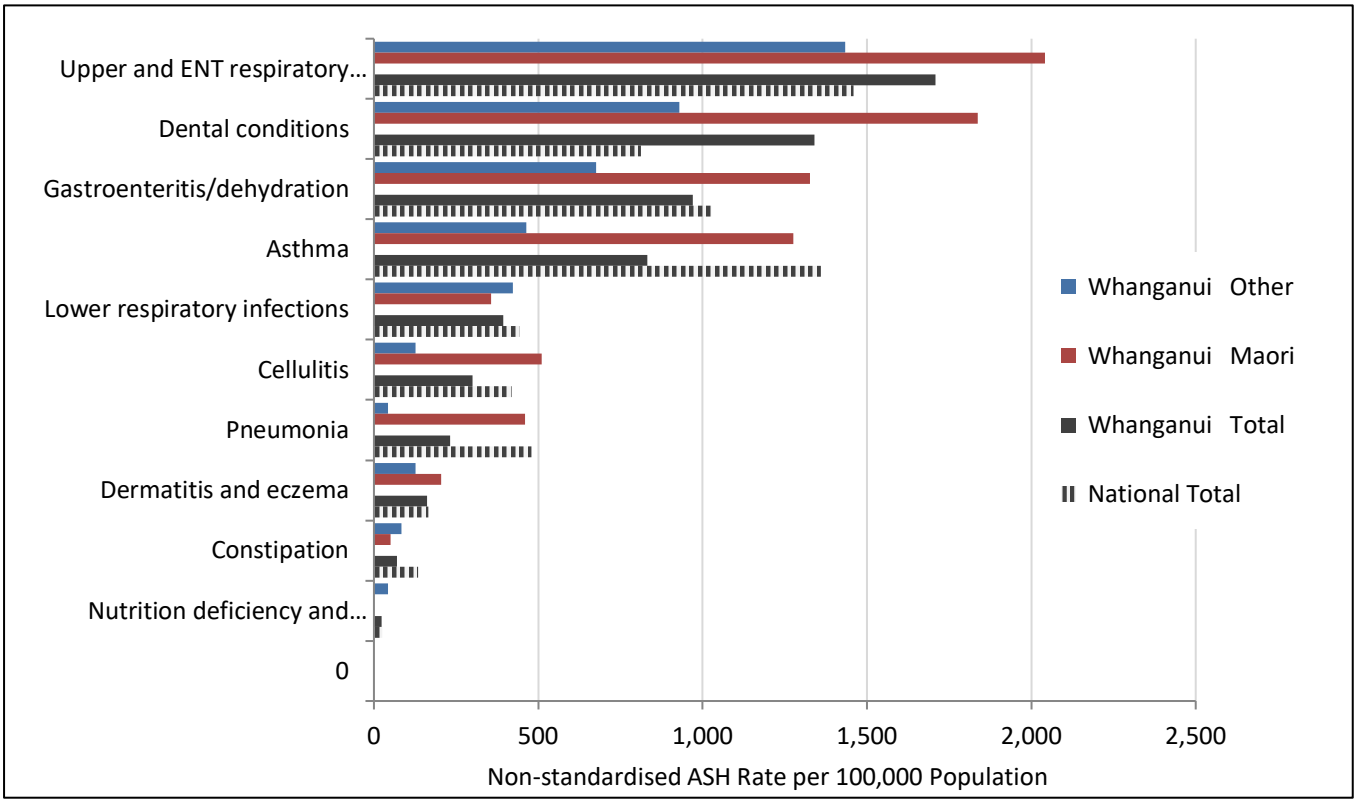
Where are we now

Respiratory, dental, gastroenteritis and asthma are among the top contributory conditions for ASH rates 0-4 years in Whanganui DHB in the 12 months from March 2019 to March 2020. Rates for Māori are higher than those of non-Māori for all these conditions, and most rates for Whanganui DHB are higher than the national total rate.

Non-standardised ASH Rate Whanganui DHB (domicile) 0-4 years, 2016-2020 by ethnicity



Non-standardised ASH Rate Whanganui DHB (domicile) 0-4 years, top 10 conditions, 12 months to end March 2020



Milestones and contributory measures

The areas of focus we believe will assist us to achieve the target, including the contributory measures that we will monitor are listed below.

Ambulatory Sensitive Hospitalisations (ASH) 0 – 4 Years		
Improvement milestone: ASH for Māori children aged 0-4 years (raw rate): reduce the inequity ratio from 1.27 (December 2019) to < 1.1		
Objectives	**Actions**	**Contributory Measures**
Create seamless transition from secondary to primary care through partnership and proactive referral at original point of contact	Partner with providers ward, WCTO and GP services to ensure all children: ▪ Are enrolled with a GP ▪ Receive Influenza vaccination where eligible ▪ Are referred to Healthy Homes team where indicated Appropriate integration between secondary and primary services to ensure continuity of care for Māori children with Asthma by: ▪ Implementing appropriate health pathways, including infant respiratory pathway rehydration of children in the community ▪ Engaging community pharmacies in early intervention and to help with improving health literacy. ▪ Specialist workforce are available for advice and consultation.	Newborns enrolled in a Primary Health Organisation (Māori and Pacific) Flu vaccination rates for Māori tamariki Number of referrals to Healthy Homes team Hospital admissions for children aged under five years with a primary diagnosis of asthma/respiratory illness

Reduce the equity gap for at risk children through Early/timely respiratory intervention -	Promote maternal influenza and pertussis vaccination as best protection for very young babies from respiratory illness by: ▪ Participate in national roll out of best start tool ▪ Localisation of health pathways to align with best start tool ▪ Identify and vaccinate pregnant women through booking and set immunisation recalls in primary care. ▪ Opportunistic immunisation at antenatal clinics. ▪ Localised health promotion campaign for pregnancy immunisation targeting Māori women through primary care, pharmacy, self-employed midwives.	Influenza and pertussis Vaccination coverage rates for pregnant Māori women. Number of pregnant Māori women enrolled through best start tool Hospital admission rates for respiratory conditions by ethnicity

Amenable Mortality

This measure is about prevention and early detection to reduce premature death. 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.

Not all deaths from these causes could be avoided in practice, for example, because of comorbidity, frailty and patient preference. However, a higher than expected rate of such deaths in a DHB may indicate that improvements are needed with access to care, or quality of care. We know that the prevention and management of risk factors is essential in reducing the development of morbidity.

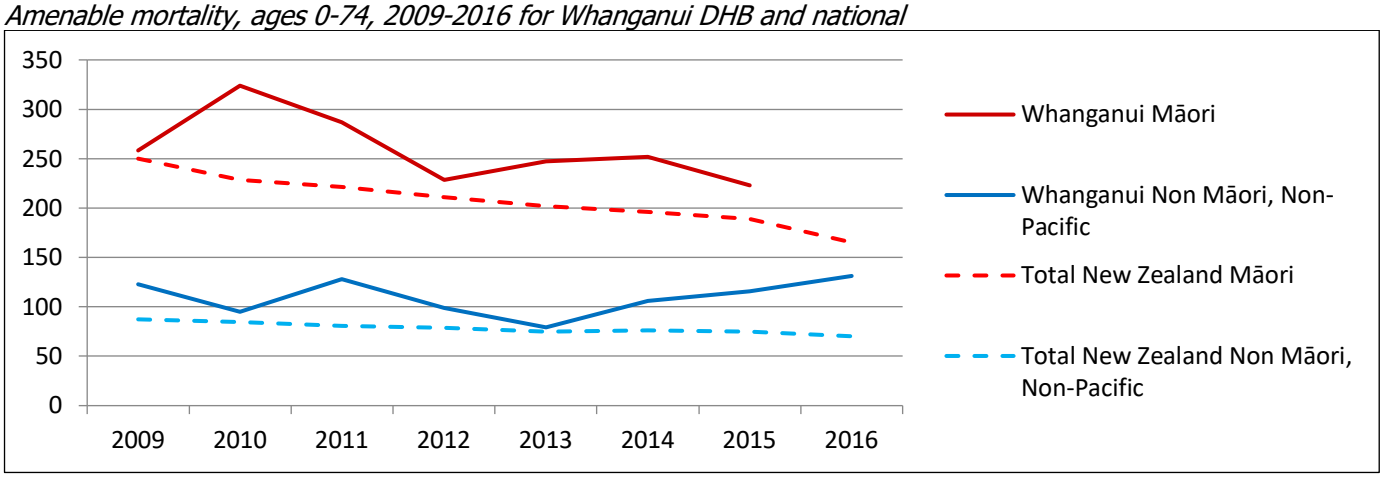
Activity outlined in this measure will be informed by data analysis and work streams arising from the acute demand service level alliance and community models of care and will incorporate consistent health messaging to support healthy lifestyles. This aligns with the district-wide focus on 69,000 beds, whereby the best bed is your own, and every bed counts.

Given the amenable mortality data is three years old, we have taken the 2020 ASH data as a more useful proxy of areas for improvement. The highest volumes being those of respiratory and cardiac which in Whanganui are higher than the national average rates, and significantly higher rates for Māori compared with non-Māori.

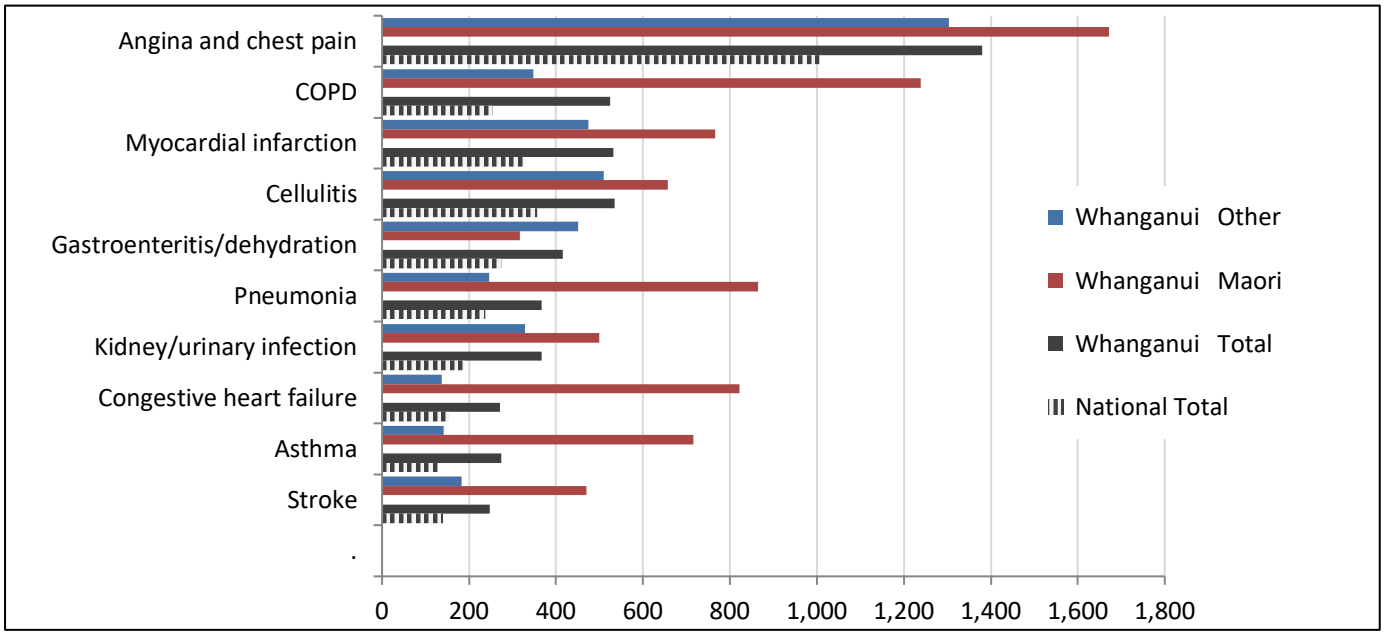
Where are we now?

Amenable mortality rates have been declining in the Whanganui district from 2009 to 2016; though remain higher than the total NZ rates. Disparities continue to exist between Māori and non-Māori, non-Pacific.

Amenable mortality, ages 0-74, 2009-2016 for Whanganui DHB and national



Top 10 conditions standardised ASH rate Whanganui DHB for 45-64 years, 12 months ending March 2020



Milestones and contributory measures
The areas of focus we believe will assist us to achieve the target, including the contributory measures that we will monitor are listed below.

Amenable Mortality		
Improvement milestone: Reduce the equity gap between Māori & non-Māori from 1.94 times to < 1.5 times by 2023		
Objectives	**Actions**	**Contributory Measures**
Improve self-management of long-term conditions	▪ Implement a collaborative approach with kaupapa Māori enabling clinically safe, culturally responsive and community centric engagement in well-being and prevention initiatives ▪ Develop and implement a local collaborative 'gout stop' programme. Programme includes: - establishment of a Kaiawhina role, - community pharmacy engagement, - GP recalls and monitoring. ▪ Take services out to the community to support people in their homes and working environment i.e. pop-up vaccination clinics. ▪ Improve the management of long-term conditions through implementation of priority health pathways that will reduce the equity gap, these include pathways for COPD and cellulitis	Reduced unplanned admissions (ASH rates) for 45-64 years Māori and Pacific Increased rate of Māori males with gout prescribed/dispensed urate lowering therapy The health priority pathways have been implemented and there is reduced unplanned admissions (ASH rates) for 45-64 years Māori and Pacific for COPD and cellulitis

Patient Experience of Care

The primary care patient experience survey is designed to find out what patients' experience in primary care is like and how their overall care is managed between their general practice, diagnostic services, specialists, and or hospital staff. The information will be used to improve the quality of service delivery and patient safety.

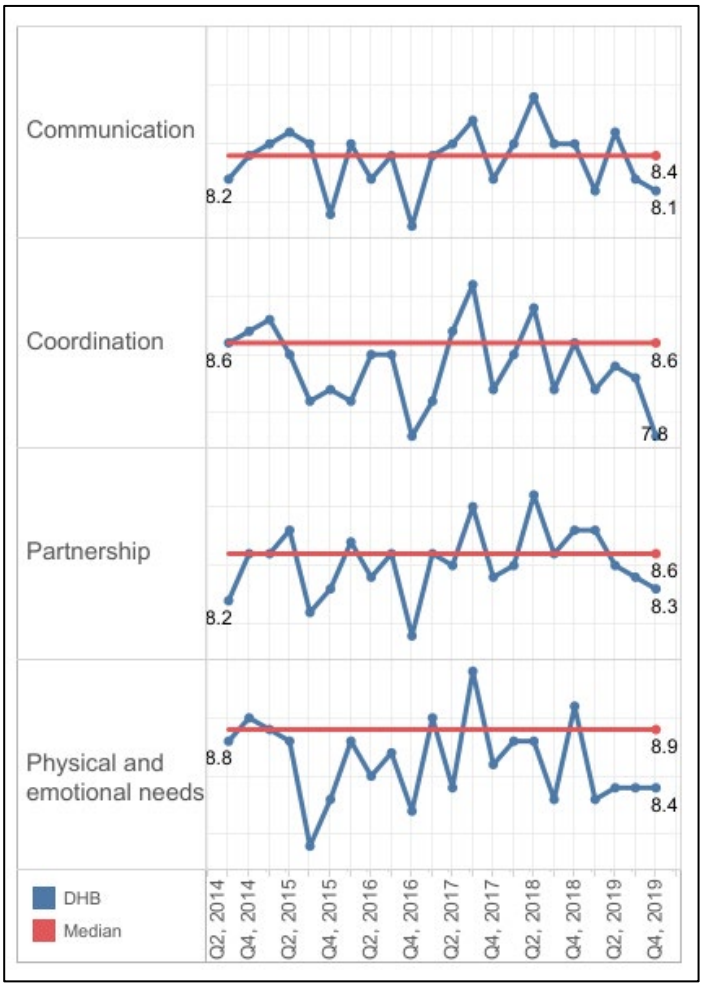
The focus has been on how data can be used to improve the patient's experience, with the key area of focus on understanding the 'Coordination' sub-domain – 'barriers to care'. Across primary care one of the lowest rating questions is "when you ring to make an appointment how quickly do you get to see your current GP?" Acute demand data exploration similarly identified difficulty getting a timely appointment at general practice and increasing general practice volumes year on year, which are linked with ED / WAM use.

The current PMS is being nationally reviewed and our focus will be on socialising the changes and encouraging improved uptake by Māori and rural patients. With the patient and the health provider engaged at partners in the health journey

Secondary Care Patient Experience
All of our survey documentation is currently under review to reflect a change in the survey provider and the data collection and reporting systems. Our aim is to ensure that patient experience is a part of our measurement of health care quality and safety. Patient experience remains a component of our quality and safety indicators framework.

The domain of partnership and the particular question "Were you involved as much as you wanted to be in discussions about your care and treatment?" is an opportunity for improvement, with only 50% of patients responding with a definite "Yes." The focus is also on ensuring a consistent national approach to collection, measurement and use of patient experience information on a regular basis.

Where are we now?
National patient experience survey: Results to November 2019 – Whanganui DHB and national average



Milestones and contributory measures
The areas of focus we believe will assist us to achieve the target, including the contributory measures that we will monitor are listed below.

Patient experience of care		
Improvement milestones: Goal: Patients value partnership **Primary Care:** Primary patient experience score "after treatment or care plan, were you contacted?" improved by 5% **Adult Inpatient:** Improve the coordination score in the national inpatient survey by at least 10%		
Objectives	**Actions**	**Contributory Measures**
Primary Increase the Māori response rate to better understand their perspective of the care they receive Improve partnership and communications score rate	Implement training with receptionist with each general practice teams through: ▪ Obtaining correct patient email details ▪ Developing and displaying localised survey flyers and posters ▪ Engaging receptionists in understanding consumer focused care Deliver a targeted campaign to increase the number of Māori enrolled in manage my health patient portal Use manage my health and other technology to support provision of alternatives to face to face communications	Maori response rate to Patient Experience Survey Number of Maori enrolled in Manage My Health patient portal
Secondary Development and introduction of a revised patient experience collection tool	Implement a consistent approach to collection, measurement and use of patient experience information on a regular basis. Continue to roll out Korero Mai, which provides an escalation process for patient concerns around care and treatment Improve response to surveys by Māori and Pasifika by implementing a four-week inpatient period rather than a two-week period.	Increase the number of patients (greater than 50%) with a positive confirmation that they were fully involved in decisions about their care and treatment

Youth Access to Preventative Services

Rangatahi Māori are an increasing population group in the Whanganui DHB rohe, consisting of 40 percent of WDHB's youth population. This is a reflection of the youthful age structure of the Māori population, with the median age of Māori within WDHB being 25 years compared with 41 years for the total WDHB population (Statistics NZ, 2019). Furthermore, health needs for youth are different to those of other age groups, with youth often having unmet healthcare needs and low utilisation of health services.

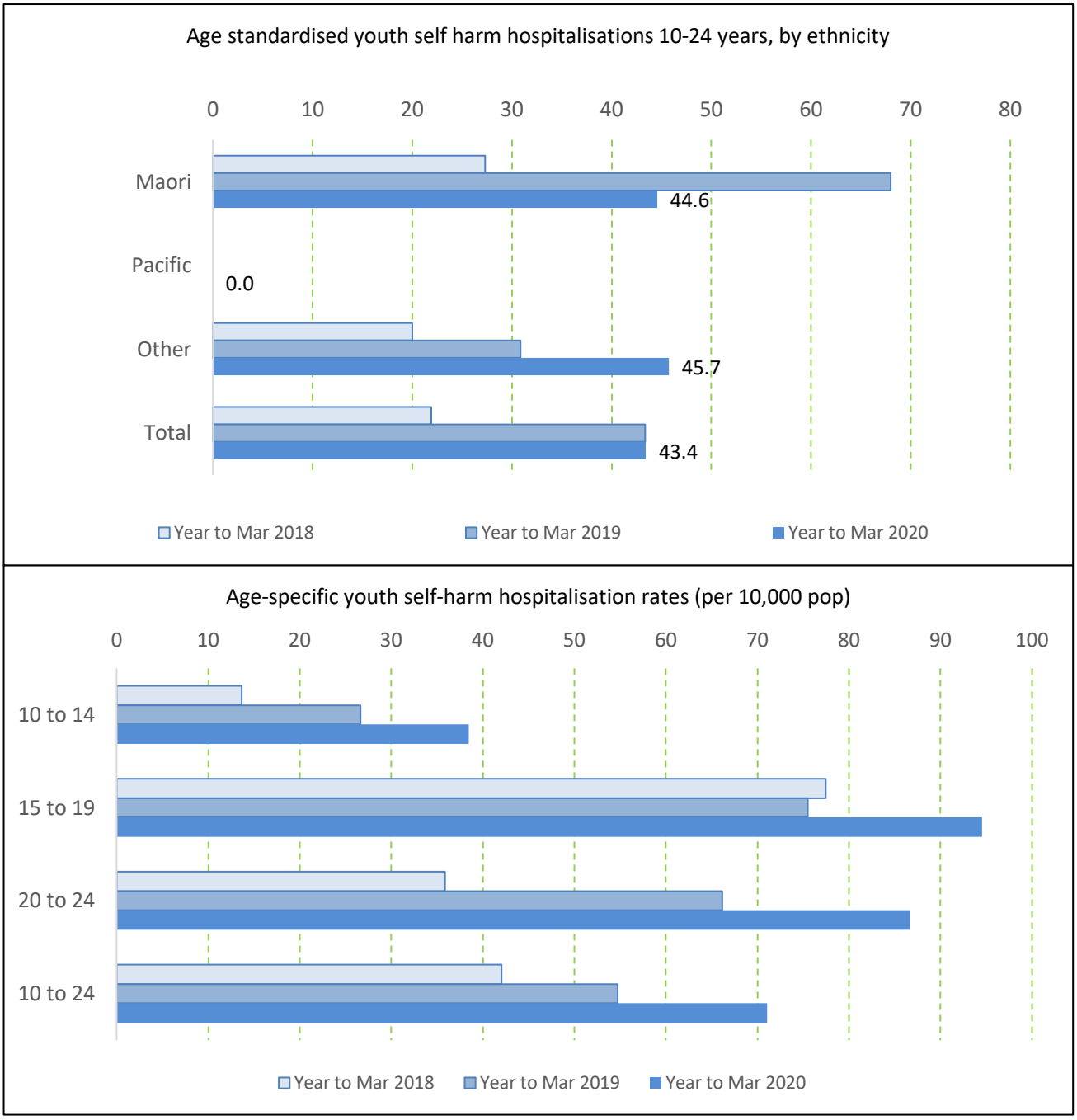
Whanganui has focused on the domain Mental Health and Wellbeing – self harm hospitalisations, as intentional self-harm is a mal-adaptive coping mechanism which indicates that young people and are coping with distress in an unhealthy way and have unmet needs. Suicide furthermore is devastating for those affected and tragic given it is preventable. The suicide rate in the Whanganui district is significantly higher than the overall NZ rate, with young people, Māori and socioeconomically disadvantaged people having a higher risk than the general population. Whanganui DHB with Te Oranganui, an iwi led organisation delivering health and social services in the Whanganui region, are developing a district-wide suicide prevention strategy, seeking to create a foundation for genuine collaboration and lasting solutions that prevent suicide and reduce rates. The actions outlined in this measure focus on improving access for vulnerable youth and early intervention initiatives in the community.

Our focus is also on increasing equity of access to contraception, with a goal to reducing rates of unplanned pregnancy. As an enabler to this, we have implemented the national long-acting contraception programme in primary care.

Unplanned pregnancies can have negative impacts on physical, mental and social wellbeing for mothers, as well as impacts on children born into environments that lack support for optimal health. Highest rates of unplanned pregnancy are among women living in quintile 5, young women, and Māori/Pacific women. Concentrating on areas of most need for our population in Whanganui would see a focus on young women who are either in quintile 5 or community service card holders and Māori/Pacific.

Where are we now?

Whanganui DHB youth self-harm hospitalisation rates per 10,000 population


Age standardised youth self harm hospitalisations 10-24 years, by ethnicity
0
10
20
30
40
50
60
70
80
Maori
44.6
Pacific
0.0
Other
45.7
Total
43.4
Year to Mar 2018
Year to Mar 2019
Year to Mar 2020
Age-specific youth self-harm hospitalisation rates (per 10,000 pop)
0
10
20
30
40
50
60
70
80
90
100
10 to 14
15 to 19
20 to 24
10 to 24
Year to Mar 2018
Year to Mar 2019
Year to Mar 2020

Milestones and contributory measures
The areas of focus we believe will assist us to achieve the target, including the contributory measures that we will monitor are listed below.

Youth access to preventative services		
Improvement milestone: Reduce self-harm hospitalisations for Māori aged 10-24 years to a three-year rate of less than 40 per 10,000 population. Annual Milestone Baseline: Māori: 44.6 per 10,000 popn. Target Māori: 40 per 10,000 popn. Other: 44.7 per 10,000 popn. Target other: 40 per 10,000 popn.		
Objectives	**Actions**	**Contributory Measures**
Increase range and availability of early intervention youth mental health services	Services to vulnerable youth are extended by: - Increase the range and access of services for Youth - Providing additional resource to the one stop shop (Youth Services Trust) - Develop and implement a Kaupapa Maori response to pregnant women that have co-existing AoD issues (which includes a youth cohort).	Percentage of youth enrolled in and utilising primary health care services
Fewer unplanned pregnancies in youth	Provision of training and mentoring in schools by public health teams working in schools on early unplanned pregnancies Development of an advanced form to monitor youth target populations; Maori, Pasifika, Quintile 5, CSC, vulnerable populations' access to LARC's.	Number of LARCs dispensed in primary care

Babies Living in Smokefree Homes at 6 weeks

The amended definition of the measure, effective from 1 Jan 2019 is:

- Numerator: number of new babies, up to 56 days of age, with 'No' recorded for their WCTO contact question: 'Is there anyone living in the house who is a tobacco smoker?' (Source: WCTO data set).
- Denominator: number of registered births by DHB of domicile (source: Ministry of Health NHI register).

This measure aims to reduce the rate of infant exposure to cigarette smoke by focussing attention beyond maternal smoking to the home and family/whānau environment. The measure aligns with the first core contact which is the handover from maternity to Well Child Tamariki Ora (WCTO) providers and general practitioners.
Our SLM plan will also focus on developing motivational conversation skills among all health professionals working with pregnant mums and babies to support patients being able to better manage their own health.

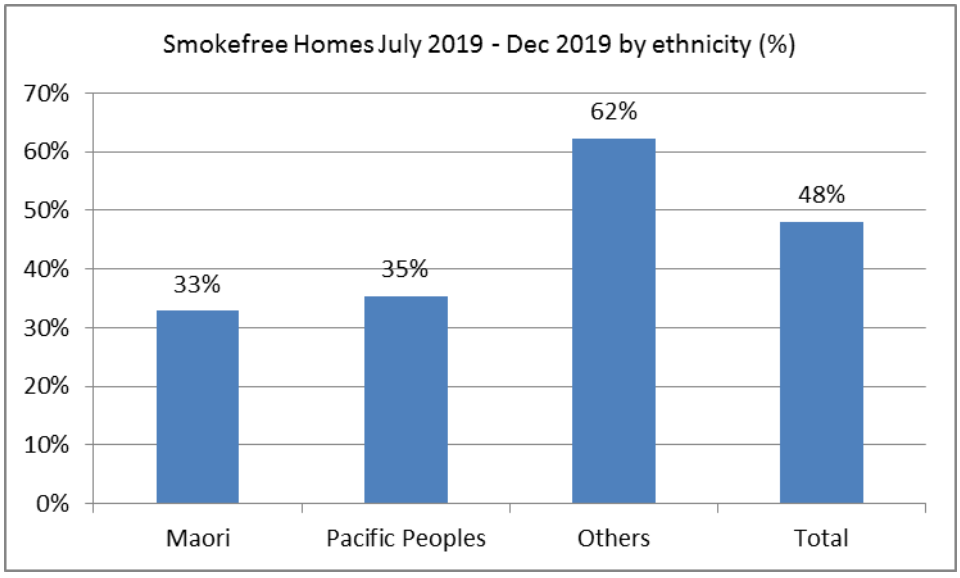
Previous research has shown that Māori women aged between 18 and 24 years stand out as a group of particular concern, with 42.7% of this group reporting regular (daily) smoking, compared with 8.6% of non- Māori women of the same age group. Young Māori women who are regular smokers are three times more likely to live in a household where there are other smokers compared with those who do not smoke. Therefore, focus needs to be on reducing inequity between Māori and non-Māori.

This measure promotes the roles which infant and child service providers collectively play in the infant's life, and the many opportunities for smoking interventions to occur. The benefit to the patient in this measure is a smokefree outcome for the baby's home and therefore infants are not exposed to cigarette smoke. This also benefits anyone who is smoking in the house becoming an ex-smoker.

Where are we now?

Whanganui DHB rate of smokefree homes July to December 2019

Ethnicity	Numerator	Denominator	Rate of Smoke-free Homes
Māori	68	207	32.9%
Pacific	6	17	35.3%
Others	149	239	62.3%
Total	223	464	48.1%



Milestones and contributory measures
The areas of focus we believe will assist us to achieve the target, including the contributory measures that we will monitor are listed below.

Babies living in smokefree homes at six weeks		
Improvement milestone: Increase the rate of Maori babies living in a smokefree household at six weeks post-natal (up to 56 days of age) by 5% by June 2021		
Objectives	**Actions**	**Contributory Measures**
Hapu mama who are identified early are referred to appropriate services	Progressively roll out training, socialise and encourage implementation of best start tool to general practice, well child tamariki ora and LMCs. *This will promote identification of smoking risk factors in Māori at confirmation of pregnancy, allowing earlier targeted whanau conversations and interventions.* Review of smoking quit services with focus on whānau support and engagement.	Number of Māori who have completed best start tool Pregnant women registered with an LMC within first trimester of pregnancy PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months

25 September 2020

Ken Whelan
Chair
Whanganui District Health Board
kenwhelan57@outlook.com

Dear Ken

Whanganui District Health Board 2020/21 Annual Plan

This letter is to advise you that I have approved and signed Whanganui District Health Board's (DHB's) 2020/21 Annual Plan (Plan) for one year.

I am pleased that your plan provides a strong platform to deliver on the priorities identified in the 2020/21 letter of expectation and focuses on equity, sustainability and addressing the population groups with the highest needs.

I encourage you to continue discussions with your fellow Chairs about how you can share skills and expertise in order to ensure that your financial performance is consistent with the agreed plan. I particularly encourage you to ensure that your senior executives maintain the tight fiscal controls that will be necessary to sustain improvements in the out years. Your focus on strengthening financial management and performance, including through collaboration with your fellow Chairs, remains critical to creating a sustainable financial path.

The Ministry will shortly engage with you on the $18.8 million of sustainability funding for DHB led improvement projects, that has been made available by the Government. I encourage you to accept offers from the Ministry to utilise this funding.

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, including changes in FTE. I expect you to continue to engage with the Ministry of Health to ensure you have a strong rationale for any adjustment to planned FTE during the year. 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 does not constitute approval of any capital business cases or requests for equity support that have not been approved through the normal process.

I am aware that an extension was provided to the requirements for finalising DHB planning documents required by the Crown Entities Act 2004 due to the impacts of COVID-19. If required, please update your published Statement of Performance expectations and Statement of Intent (if applicable) to align with your approved Plan.

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

Thank you for the work you and your team are doing to support equitable health outcomes for New Zealanders, during a time when our system has faced additional pressures from COVID-19.

I look forward to seeing further positive progress as you deliver your Plan.

Ngā mihi nui

Hon Chris Hipkins
Minister of Health

cc Russell Simpson
Chief Executive
Whanganui District Health Board