



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

**ANNUAL PLAN
2021 / 2022**

Incorporating the 2019/20-2022/23 Statement of Intent and
2021/22 Statement of Performance Expectations

***ʻI rere kau mai te awanui mai i te kāhui maunga ki Tangaroa.
Ko au te awa, ko te awa ko au.ʻ***

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



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 Rangī.

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 Rangī 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 Rangī.

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 Rangī 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.

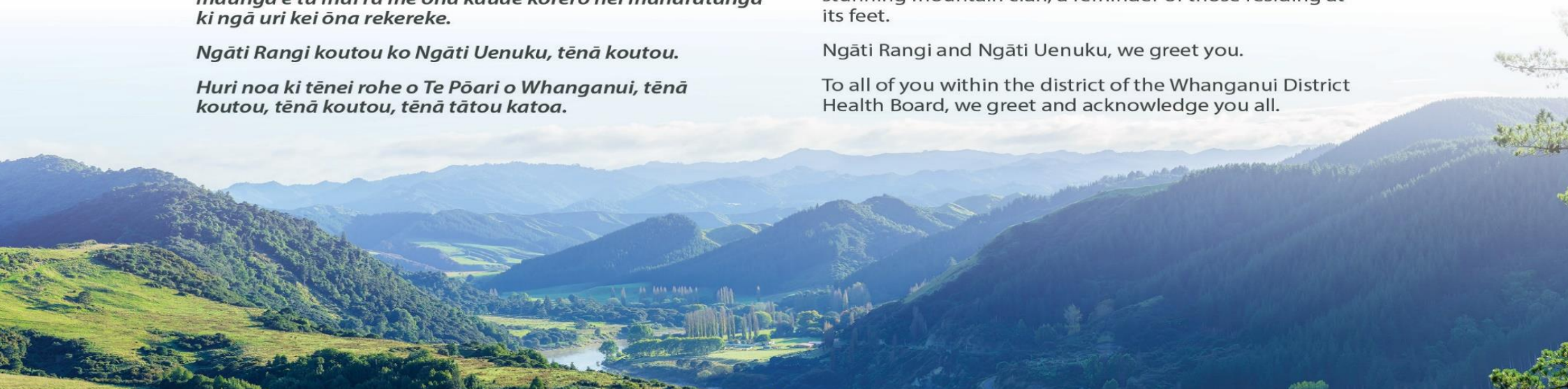


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Note: in this plan, the term 'rohe' refers to the geographic area covered by Whanganui District Health Board, as defined in the New Zealand Public Health and Disability Act (2000).

Message from the Whanganui District Health Board Chair and Chief Executive

Tēnā koutou katoa, this 2021/22 Annual Plan sets out Whanganui DHB's plan for the new financial year at a time where continued international and local health, other social, financial and political systems are being challenged on an unprecedented scale as a result of COVID-19. Locally, the recent announcements around the way healthcare in New Zealand will be delivered into the future as a result of the New Zealand Health and Disability Systems review, has led to a renewed sense of purpose for the Whanganui District Health Board. Preparing and partnering closely with our communities to ensure that together we can build resilient communities, empowering whānau and individuals to determine their own wellbeing has been part of our strategy for the past two years. It was pleasing to note that the Whanganui District Health Board's He Hāpori Ora Thriving Communities strategic direction aligns so closely with the changes that the transition unit and Cabinet identified as necessary for the new operating model for health in the future.

Whilst COVID -19 remains a threat, we have fast-tracked intelligence gathering and learnings analysis from our response to COVID, and have transitioned these into longer term programmes of work – such as the formation of the Impact Collective Rangitikei, Ruapehu, South Taranaki and Whanganui, where local governance support local solutions to local issues. This collective governance team is a clear example of how crown agencies, communities and providers can work together to ensure that their communities thrive – focused on addressing social, economic and environmental factors that contribute to an individuals, whānau and community wellbeing.

In a post level 4 lockdown environment, our strategic focus areas of Pro-Equity, Social Governance and Healthy at Home – Every bed matters (69,000 beds) continue to guide the decisions made by the Whanganui District Health Board. This focus enabled a community response to the COVID vaccination rollout where the DHB, PHOs, and Iwi health providers came together to deliver a programme which aligned to the Ministry of Health guidelines as well as insured that our most vulnerable had access to the vaccination. By having these key working relationships, we have been able to walk alongside our communities to support the uptake of the COVID-19 vaccine.

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 2021/22 and subsequent letter following the Health and Disability systems review announcement.

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. Through the Impact Collective Rangitikei, Ruapehu, South Taranaki and Whanganui we will have a greater understanding of the communities strengths and aspirations through the 'stats and stories' being outlined in the Community Equity and Wellbeing reports to be presented in the 2021/22 year.

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 how our strategic direction serves to not only address the concerns of the Pro-Equity audit, but to give practical effect to Whakamaua: the Māori Health Action Plan 2020-2025 within our rohe.

69,000 Beds reflects the Government's commitment to wellbeing, prevention, sustainability and better support for primary healthcare. The Masters Games was held in Whanganui at the beginning of 2021. This afforded the DHB the ability to encourage COVID QR Tracer app utilisation on a large scale with our business community, and enabled the development of a community partnership that will deliver a mobile health bus to service our vulnerable and rural communities through health screening, immunisation and vaccination programmes as well as preventative health clinics in 2021. We will continue to investigate new models of care with our community partners and ensure that the significant gains in digital innovations in health as a result of COVID-19 are harnessed into sustainable changes in our delivery and care options for our communities. This will enable our communities to have access to a comprehensive range of services, including equitable access to high quality emergency and specialist care, that are closer to home.

We appreciate the recognition of our population increase through an up-lift in Government funding for 2021/22 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. It is acknowledged that although the DHB is to be dissolved heading into

the 2022/23 year, that stewardship of the DHB is a necessity to put it in the best position heading into the new structure.

Included in this plan is our Statement of Performance Expectations for 2021/22, 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, community led and delivered services, improved patient experiences and the best use of resources, we will contribute to a high-quality, strong and equitable public health and disability system – moving the pendulum from illness to wellness alongside our communities, iwi, individuals and whānau.

Nā mātou noa, nā / Yours sincerely



Ken Whelan
Toihau
Board Chair



Russell Simpson
Kaihautū Hauora
Chief Executive

Message from the Hauora ā Iwi chair

“He pai te tirohanga ki ngā mahara mō ngā rā mua
Engari Ka puta te māramtanga i runga i te titiro whakamua”
It is ok to reminisce of days past

But wisdom comes from being able to prepare opportunities for the future.

Tēnā tātou e ngā tini ahuatanga o te wā, e ngā mate i runga rawa haere, haere, oti atu.

E te Poari matua o Whanganui, ko tēnei te kupu kōrero o Hauora ā Iwi, ki te tau e heke mai nei 2021 - 2022. Ko te tumanako ka taea e tatou katoa te whakatutuki i ngā whaainga.

The new health system reforms will bring new and brave challenges to health service provision in 2021 - 2022 and beyond. They also signal new opportunities to address inequities prevalent in Māori Health. Hauora ā Iwi, are ready to work in partnership to meet the challenge.

He Hāpori Ora, Thriving Communities, strategy 2020-2023 commit to honouring Te Tiriti o Waitangi by:

- Guarantee of Tino Rangatiranga
 - 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'. He Korowai Oranga 2014.
- Equity
 - Crown, through WDHB, duty to act with fairness and justice to all citizens.
 - Commitment to achieving equitable health outcomes for Māori
 - Guarantee of freedom from discrimination
- Active Protection
 - Crown, through WDHB, to act to the fullest extent practicable for equity
 - Ensure its agents and Treaty partners are well informed on Māori health outcomes
 - 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 utmost good faith

With these commitments the future is positive.

Hauora ā Iwi support the Whanganui DHB Annual Plan 2021-2022. The 'wero' has been laid down as we move to implement the recommendations from the reforms and discussions with the 'Transition Unit' Hauora ā Iwi, will continue the partnership with the DHB over the duration of this Annual Plan.

'Ehara taku toa i te toa takitahi, engari taku toa he toa takatini'
Success is not the work of one but the work of many.



Sharlene Tapa-Mosen
Chair
Hauora ā Iwi

Hon Andrew Little

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



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

30 SEP 2021

Tenā koe Ken

Whanganui District Health Board 2021/22 Annual Plan

This letter is to advise you that we have jointly approved and signed Whanganui District Health Board's (DHB's) 2021/21 annual plan (Plan) for one year.

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

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

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

More broadly, we also acknowledge the importance of your Board delivering on the Plan in a fiscally prudent way.

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

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

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

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

Ngā mihi nui


Hon Andrew Little
Minister of Health


Hon Grant Robertson
Minister of Finance

Cc Russell Simpson
Chief Executive

Signature Page

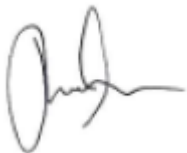
This plan is signed on behalf of the Whanganui District Health Board this 10th day of August 2021



Ken Whelan
Toihau
Board Chair



Annette Main
Board Member



Russell Simpson
Kaihautū Hauora
Chief Executive

Minister of Health

Minister of Finance

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 section 38 of 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 care services
- 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.

Strong clinical leadership, supporting services that meet local needs of our population, and participation in regional and national planning of health services ensuring system sustainability and equity of access to services.

Out year planning, takes into consideration future population health needs, and in line with the proposed reforms to the health and disability systems review.

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'. *He Korowai Oranga 2014.*
- Equity
 - Crown, through WDHB, duty to act with fairness and justice to all citizens.
 - Commitment to achieving equitable health outcomes for Māori
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 - Crown, through WDHB, to act to the fullest extent practicable for equity and ensure its agents and 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 utmost good faith.

Our commitment to the Treaty and application of the principles starts with the governance partnership between the WDHB Board and Hauora ā Iwi. 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 Oranga 2014

WDHB is committed to the Māori Health Strategy: He Korowai Oranga 2014, with the overall aim of Pae ora – healthy futures and incorporating the three interconnected elements of:

- 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 where individuals of all ages are healthy.

He Korowai Oranga sets the direction for Māori health development and is operationalised by Whakamaua – the Māori Health Action Plan 2020-2025. Whakamaua outlines a suite of objectives and priority areas to achieve four outcomes through collective action over five years:

Figure 1



Ministry of Health Whakamaua 2020

In addition, WDHB's strategic direction is framed by:

- The New Zealand Health Strategy
- The Healthy Ageing Strategy
- The United Nations Convention on the Rights of Persons with Disabilities
- The NZ Disability Strategy and Whāia Te Ao Marama: The Māori Disability Action Plan
- Ola Manuia 2020 – 2025: Pacific Health and Wellbeing Action Plan

And influenced by the findings and learnings in:

- The Wai 2575 Health Services and Outcomes Kaupapa Inquiry findings
- The Health and Disability Review

He Hāpori Ora – Thriving Communities 2020-2023

WDHB's strategy is contained in our strategy document He Hāpori Ora - Thriving Communities.

He Hāpori Ora is underpinned by acknowledgement that no matter where we work in the community, we are all in the waka together, equally valued and ensuring the health and wellbeing of people and their whānau are at the centre of all we do.

Endorsed by both partnership boards, WDHB board and Hauora ā Iwi, He Hāpori Ora sets out our vision for the people of the rohe to live their healthiest lives possible in thriving communities.

He Hāpori Ora – Thriving Communities: Our Vision

The people in WDHB rohe live their healthiest lives possible in thriving communities

Ki tāea e te whānau me te hāpori i tōna ake tino rangatiratanga: Our Mission

Together we build resilient communities, empowering whānau and individuals to determine their own wellbeing.

We will ensure health care places people and their 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 authentic partnership with other health care providers, iwi, government, social and community agencies to build strong, resilient, connected people and whānau.

As part of WDHB's commitment to Whānau Ora, our vision and mission recognises that to achieve healthy communities, all people – regardless of income or social status – 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.

Ko au ko toku whānau, ko toku whānau ko au
Nothing about me without me, and my whānau

He Tangata, He Tangata, He Tangata - The population we serve

Our rohe covers a total land area of 9742 square kilometres, much of which is sparsely populated. The terrain is mountainous with two major centres – Whanganui city and Marton. The major centres are supported by five smaller towns with a population less than 2000: Waiouru; Taihape; Bulls; Ohakune; and Raetihi. Figure 2 is a map of our rohe and the population that we serve.

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

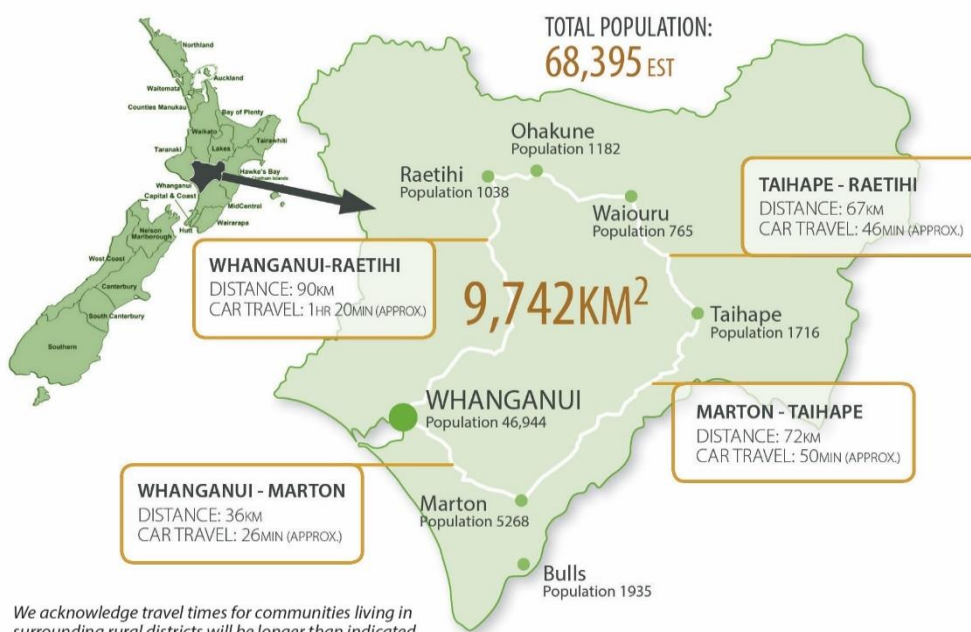
- a higher percentage of children and young people with 20% aged under 15 years, of which 43% are Māori.
- A higher than average population of older aged citizens with 20% aged over 65.
- Significantly higher percentage living in highly deprived conditions, with 63% in quintile 4 and 5.
- A relatively 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.

He Hāpori Ora is designed to take these unique demographic features, which make up our communities, into account and set a strategic direction to best address the significant health implications for our rohe so communities, whānau and individuals can thrive.

Figure 2

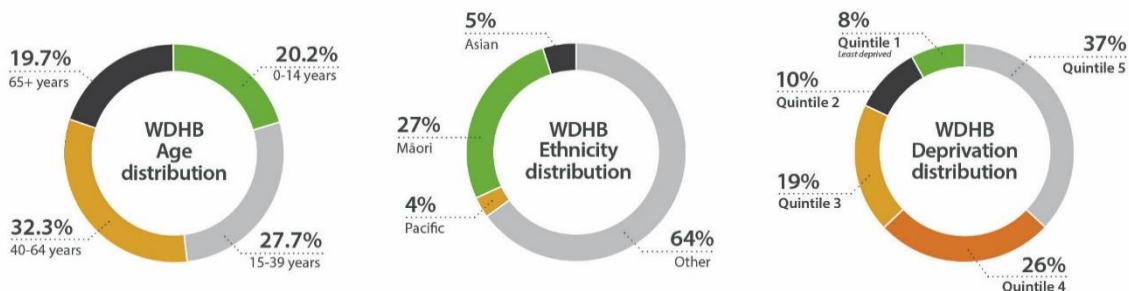
Map and demographics of the Whanganui rohe

OUR ROHE



** NB: Iwi and DHB boundaries are different so an iwi can cross over more than one DHB rohe.*

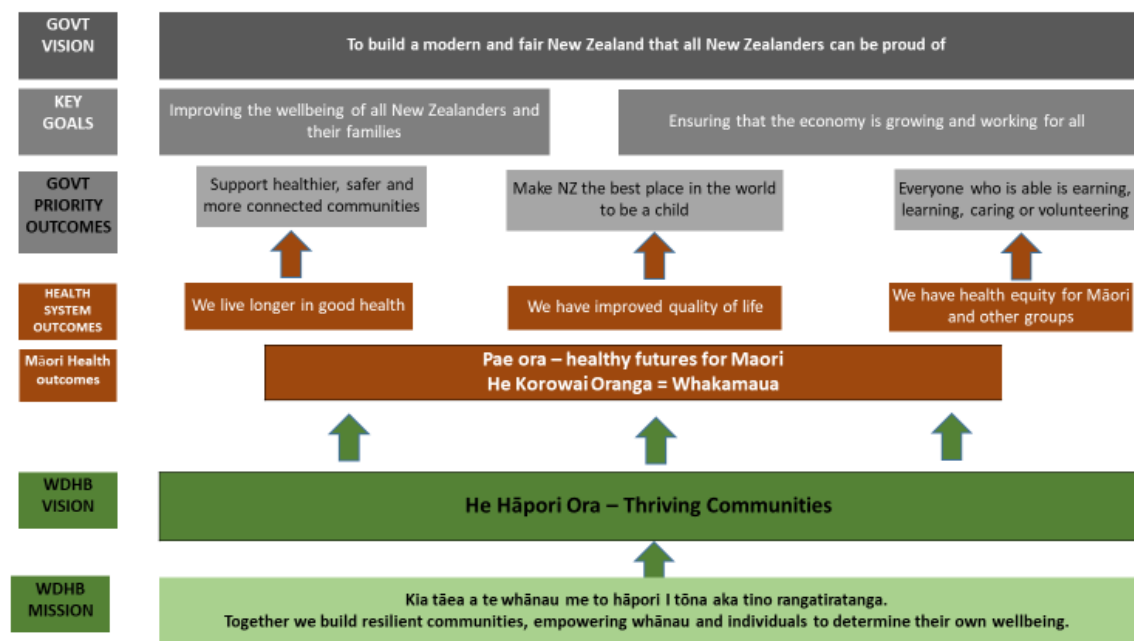
We acknowledge travel times for communities living in surrounding rural districts will be longer than indicated.



Outcomes and Strategy

Population health drives our intentions and we plan for alignment of those intentions with our statutory objectives and with the Government's key goal of *Improving the wellbeing of all New Zealanders and their families*. Alignment is depicted by our strategic outcomes framework (Figure 3), which shows the logic that connects the Government's key goals to our strategy based on the needs of our communities.

Figure 3



Strategic focus areas

He Hāpori Ora contributes to the Government priority outcomes, He Korowai Oranga's strategic direction and Whakamaua outcomes goals through four strategic drivers which form the foundation of the strategy and represent the overall outcomes required to achieve thriving communities.

He Hāpori Ora strategic drivers:

- Equitable outcomes.
- Integrated care
- Whānau and person-centred care
- Partnering for community wellbeing

These outcomes are accomplished through four strategic enablers:

- Collaborative governance and strategy
- Integrated vision, processes and technology
- Valuing and empowering our people
- Financial health matters.

These drivers and enablers are encompassed in three strategic focus areas: Pro-equity; Social Governance; and Health at Home - Every Bed Matters.

Mana Taurite – Pro-equity

Inequitable differences in health status can be by age, gender, socioeconomic position, ethnicity, impairment and geographical region.

We are committed to achieving equity of health outcomes, across all population groups, with a view of eliminating disparity, particularly for Māori. We are going beyond the language of 'equity', to be 'pro-equity'.

This means that we:

- Have an organisation and rohe-wide goal of health equity.
- Are putting systems and processes in place to support our health equity goal.
- Work across the wider determinants of health.
- Have a robust understanding of the drivers of inequities.
- Work in partnership with Māori across the district, starting with Hauora ā Iwi

Kāwanatanga Hāpori – Social governance

Across the WDHB rohe there are a range of organisations and government agencies working on outcomes and delivering services for the health and wellbeing of our communities.

Traditionally, community organisation and government agencies, including district health boards, have worked in isolation. The challenge laid down by the government is for these organisations to work in a more integrated and collaborative way. In response to this challenge we are championing social governance as a model to harness the collective power of these organisations to better serve the people of our rohe.

Social governance is a model where iwi, community, social and government organisations work together in support of local communities. Social governance for WDHB includes:

- Partnering for community wellbeing
- Supporting local leadership and local solutions to local problems
- Cooperation within the health and disability sector (such as between providers) and across sector boundaries which may challenge traditional methods of care
- Shared funding and investment approaches
- Share data, technology, knowledge and processes
- A commitment to achieving pro-equity outcomes
- A whānau /person-centred approach
- A focus on delivery and holding each other to account for the commitments we make.

Noho Ora Pai I Tōu aka Kāinga- Healthy at Home: Every Bed Matters

Using a social governance model where iwi, communities and agencies work together, we can make every bed matter by focussing on the transition to and from the hospital or community care setting and ensuring whānau are directly involved in decisions about their care.

Being healthy at home means the wider social determinants of health (such as housing, education and employment) are addressed through a social governance model, where community, social and government organisations work together on health and wellbeing outcomes for our communities.

It also means pro-equity is considered when questioning what the best care is, who should provide it and how. Enabling people to be healthy at home is wide-ranging within the health and disability sector: incorporating primary care providers, age residential care, home and community support services, kaupapa Māori health providers, health promotion activity, community mental health, whānau centred health and disability services delivered in the community. It also takes into consideration the social and economic factors which influence people's long-term health outcomes.

We recognise not everyone has a home or a bed, or that some people live in unsafe or unhealthy conditions, but by working in a social governance model and on pro-equity aspirations, the aim is to reduce homelessness, domestic violence and unsafe or unsanitary homes to ensure everyone has a safe place to call home.

Ngā Uarātanga: Values

Our organisation will be guided by four core values. These values come from the Whanganui District Health Board's 'waka' model' and represent the four corner panels of our tukutuku panel.

Aroha

The value of love, respect and empathy, demonstrating compassionate and non-judgemental relationships

Kōtahitanga

The value of unity and vision sharing where we demonstrate trust and collaboration

Manaakitanga

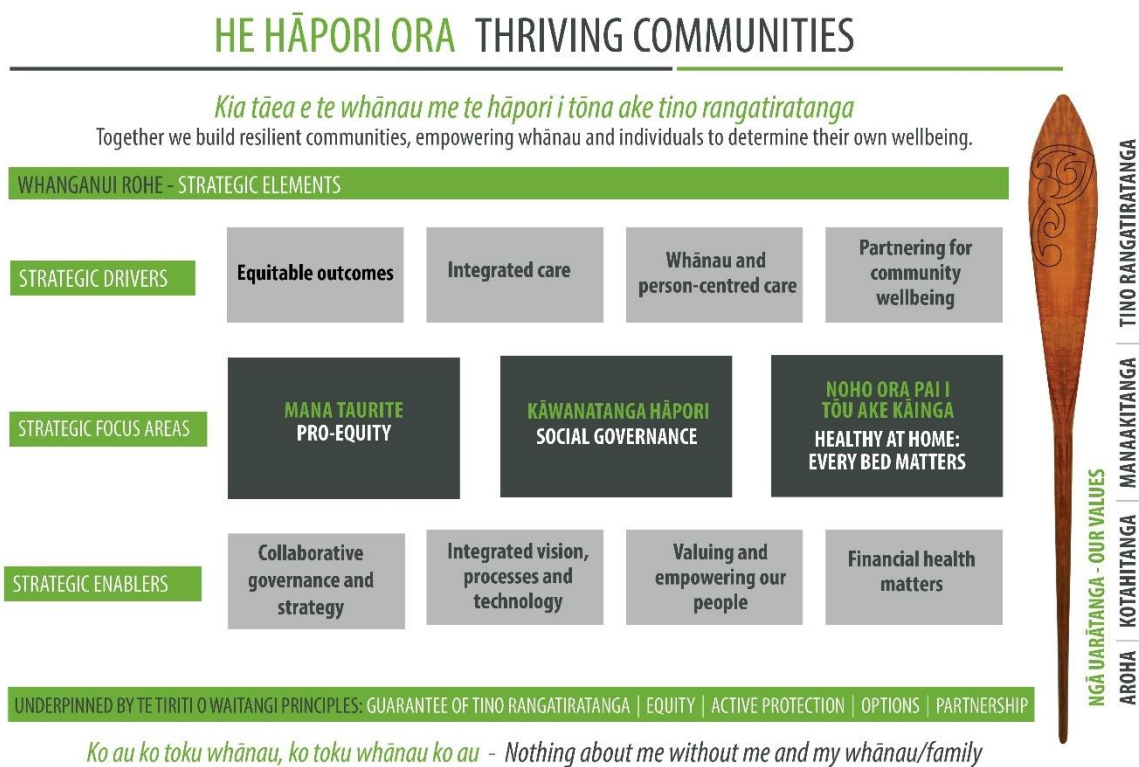
The value of respect, support and caring where we demonstrate doing our very best for others

Tino Rangatiratanga

The value of self-determination where we empower individual/whānau choice

As shown in the following diagram He Hāpori Ora and all activity of WDHB is influenced and guided by our values.

Figure 4



Together all these woven strands of He Hāpori Ora align directly with Whakamaua and the actions under them are designed to contribute to Whakamaua's eight priority areas for action:

- Māori-Crown partnership
- Māori leadership
- Māori health and disability workforce
- Māori health sector development
- Cross-sector action
- Quality and safety
- Insights and evidence
- Performance and accountability

How the sections in our Annual Plan are linked

Section 2: Delivering on priorities

Section 2 outlines activity in respect of short 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 "Financial Performance Summary".

Section 3: Service configuration

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 activity in Section 2.



Section 2: Delivering on priorities

Minister of Health's planning priorities

WDHB will deliver on the Government's priorities for 2021/22, as outlined in the Minister of Health's Letter of Expectations received, 10 February 2021 and subsequent letter received 21 April 2021. This section shows activity relating to those priorities:

WDHB notes the following key priorities as outlined the by the Minister in his letter dated 10 February 2021:

- WDHB is committed to supporting the roll out and success of the COVID-19 vaccination programme
- A safe and effective vaccine for COVID-19 is an essential part of how we protect our communities, and this will be a key piece of work for the WDHB during 2021/22
- WDHB will increase the pace and scale of implementation of the Care Capacity Demand Management Programme (CCDM) in 2021 to meet the expectations outlined in the 2018 NZNO DHB MEGA. Includes annual FTE calculations and ensuring agreed budgeted nursing and midwifery FTE are in place
- Use COVID-19 innovations to avoid pressure building up on existing services
- Develop an Asset Management Policy and Strategy and aligns with our asset management practices and with the MOH DHB sector Asset Management Framework
- Learnings and innovation, particularly for vulnerable populations from the COVID-19 pandemic response
- Readiness to respond to the Government's direction in regard to its response to the Health and Disability System Review

Alongside the following key priorities as outlined the by the Minister in his letter dated 21 April 2021:

- Equity for all New Zealanders so that people can achieve the same outcomes irrespective of who they are or where they live
- Sustainability through refocusing the system to prevent and reduce health needs with a focus of "wellness not illness"
- Person and whānau-centred care by empowering people to manage their own health and wellbeing
- Partnership through embedding the voice of Māori and other consumers into how the system plans and makes decisions
- Excellence by ensuring consistent, high quality care is available and harnessing leadership and innovation to benefit the whole population

These priorities are read alongside ongoing priorities for an equitable and sustainable health system including:

- Give practical effect to Whakamaua: the Māori Health Action Plan 2020-2025
- Improving sustainability
- Improving child wellbeing
- Improving mental wellbeing including a focus on the transformational direction for our approach to mental health and addiction through the agreed actions from the Mental Health and Addiction Inquiry
- Improving wellbeing through prevention
- Better population outcomes supported by a strong and equitable public health and disability system
- Better population health and outcomes supported by primary health care.

Furthermore, WDHB recognises:

- strong fiscal management is critical in supporting sustainability of the health system.

Māori health improvement

As outlined in Section 1, pro-equity is a key strategic focus area and stated goal of the WDHB Board and Hauora ā Iwi, confirmed in the Mana Whenua Agreement and our strategy document.

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 under the strategic focus areas of He Hāpori Ora are brought together through our commitment to whānau ora and whānau-centred care.

This influences what we do and more importantly how we do it and with whom we work.

Māori health improvement 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 WDHB provided services, and beyond (where feasible), a Haumoana service supports the delivery of whānau-centred care.

Achieving health equity

Under the pro-equity strategic focus area in He Hāpori Ora, WDHB and Hauora ā Iwi have identified four priority areas to address inequities in health outcomes for Māori.

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.

Components for success:

- Strengthen partnership with Hauora ā Iwi
- Increasing engagement with Māori health and community expertise to influence and guide DHB development
- 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.

Pivotal to pro-equity is Hauora ā Iwi and WDHB's relationship which is built on trust and respect and is outlined in the Mana Whenua Agreement.

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 need to 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, investment, growing Māori workforce capability and capacity and staff development.

Key local health provider partners

WDHB has a strong relationship with local Kaupapa Māori hauora providers - Nga Waihua O Paerangi, 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).

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

Engagement and obligations as a Treaty partner

The New Zealand Public Health and Disability Act 2000 (NZPHD Act) specifies DHBs' Te Tiriti o Waitangi obligations. WDHB is committed to those obligations and honouring the five principles: Guarantee of Tino Rangatiratanga; Equity; Active Protection; Options; and Partnership. Our Strategy Document He Hāpori Ora Thriving Communities 2020 – 2023 is co-signed by Hauora ā Iwi, mana whenua partnership board

Prior to COVID-19, WDHB had adopted a Social Governance approach to collectively working with Iwi, community, social and government organisations to support the needs of our local communities. Our review from the rohe COVID-19 response to date has reinforced this approach and has been the catalyst for stronger relationships, ways of working and expectation for future partnership.

WDHB's governance has two boards: the DHB board; and Hauora ā Iwi. Hauora ā Iwi will be involved in all WDHB responses to the Health and Disability Review implementation in line with their Mana Whenua Agreement 2020-21.

Action(s)	Milestone(s)
<p>Strategic</p> <p>Maintain partnership and close working relationships between Hauora ā Iwi (HAI) and WDHB through:</p> <ul style="list-style-type: none"> ▪ Regular joint and Chair to Chair hui. ▪ Enact the Mana Whenua Agreement strengthening partnership and active engagement. ▪ Involvement of HAI members in all key DHB strategic discussions and decisions. ▪ Involvement of HAI in decision making related to the implementation of the recommendations from the H&DS review 2020. ▪ Engagement of HAI in monitoring the implementation of He Hāpori Ora action plan. <ul style="list-style-type: none"> - Regular reporting to joint board hui ▪ Message from HAI included in the foreword of the WDHB 2020/21 annual report. <ul style="list-style-type: none"> - Annual report published ▪ Joint board monitoring of equity measures in WDHB Annual Plan and pro-equity implementation work plan. <ul style="list-style-type: none"> - 6 monthly reporting ▪ MOHAG representation on all interviews for executive positions. ▪ HAI representation on combined statutory advisory committees and performance review for chief executive. 	<p>Q1 ongoing through to Q4</p> <p>Q2 & Q4</p> <p>Q4</p> <p>Q2 &4</p>
<p>Waitangi Tribunal</p> <ul style="list-style-type: none"> ▪ Plan and begin the roll out of embedding obligations under the five Treaty principles in updating key policies and procedures. ▪ Continue to participate in the design and implementation of the Ministry of Health's Treaty framework, 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. 	<p>Q3</p> <p>Q1-4</p>
<p>Partnership</p> <ul style="list-style-type: none"> ▪ Six months post implementation of the WDHB consumer group Te Pukaea new structure with at least 50% Māori membership, review progress and what further support is required. 	<p>Q2</p>

<ul style="list-style-type: none"> ▪ 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. <ul style="list-style-type: none"> - ToR in place and regular hui undertaken ▪ Engage and work with the Māori Health Alliance to implement the recommendations from the commissioning for kaupapa Māori health services work plan 2020-21 and review of services that are achieving equity in health outcomes for Māori ▪ 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. <ul style="list-style-type: none"> - Work plan agreed ▪ 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. ▪ Continue participation in the Central Region GM Māori forum to influence across the region and share learnings and initiatives. ▪ Continue participation in national Māori health leadership forum Tumu Whakarae. ▪ Involve HAI in all decision making that is responding to the Health and Disability Review. 	<p>Q3 Q1</p> <p>Q1 Q2</p> <p>Q1-4</p> <p>Q1-4 Q1-Q4</p>
<p>Pro-equity Continue to implement the WDHB Pro-equity Implementation Plan, under He Hāpori Ora implementation, for 2021 – 2023 under the four priority areas:</p> <ul style="list-style-type: none"> ▪ Strengthen organisational leadership and accountability for equity. ▪ Build Māori workforce and Māori health and equity capability (refer to workforce section page 98) ▪ Improve transparency in data and decision making. ▪ Support more authentic partnership with Māori. 	<p>Q1-4</p>
<p>Implementing and monitoring whānau centred approaches to care and services.</p> <ul style="list-style-type: none"> ▪ Include whānau hui in service delivery with the support of Te Hau Ranga Ora Haumoana Service for DHB provided services. <ul style="list-style-type: none"> - Evidenced in tracer audits ▪ Ongoing implementation and monitoring of Korero Mai. <ul style="list-style-type: none"> - Korero Mai seeks to enable patients and whānau to communicate concerns about a patient's deteriorating condition. - Evidenced in tracer audits - Introduce Whakarongo Mai – listen to what we are saying as whānau to complement Korero Mai 	<p>Q4 Q1-4 Q4 Q2</p>
<p>Improve transparency in data and decision making:</p> <ul style="list-style-type: none"> ▪ share equity analysis widely and include it in decision making. <ul style="list-style-type: none"> - Equity dashboard reported to joint boards ▪ transparency in resource allocation, including equity analysis in all publicly reported data. <ul style="list-style-type: none"> - Evidenced in commissioning processes - Evidenced in media reporting and WDHB public documents 	<p>Q2 & Q4</p> <p>Q4 Q4</p>
<p>Leadership</p> <ul style="list-style-type: none"> ▪ 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. 	<p>Q1-4</p>

<ul style="list-style-type: none"> ▪ Introduce on-going mechanisms to support Māori staff, if they have been victims of racism, as leadership and the organization address the impacts of racism. 	Q2
<ul style="list-style-type: none"> ▪ Continue to support equity professional development to local provider partner leaders. 	Q1-4
<ul style="list-style-type: none"> ▪ Apply equity methodology and monitoring to decision-making processes including commissioning, service delivery models and service changes. <ul style="list-style-type: none"> - Evidenced through commission processes 	Q1-4
<ul style="list-style-type: none"> ▪ 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. 	Q4
<ul style="list-style-type: none"> ▪ Continue to provide cultural safety education as part of WDHB board member local induction programme. 	Q4
<ul style="list-style-type: none"> ▪ Support the embedding of He Hāpori Ora and the WDHB values and WDHB tikanga o Whanganui practices. <ul style="list-style-type: none"> - Evidenced in tracer audits, accreditation review, consumer and whānau feedback – compliments and complaints 	Q4

Whakamaua: Māori Health Action Plan 2020-2025

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

For WDHB with a relatively high Māori population, our strategy document He Hāpori Ora has been developed to under the strategic direction of He Korowai Oranga and therefore the priority areas under each of the strategic focus areas: Pro-Equity; Social Governance; and Health at Home, align with actions in Whakamaua’s eight priority areas for action.

Therefore the implementation of Whakamaua in Whanganui DHB is a whole of organisation commitment and obligation. Whakamaua aligned activities are integrated throughout this Annual Plan and cross-referenced in this section.

Action(s)	Milestone(s)
<p>Whakamaua Objective: Accelerate and spread the delivery of kaupapa Māori and whānau centred care</p> <p>Action 3.1 Māori workforce (refer Health Workforce page 74)</p> <ul style="list-style-type: none"> a. 100% of Māori engaged in study to mahi initiatives with Youth Employment Success programme and Kia Ora Hauora are offered career progression support by Te Hau Ranga Ora (WDHB Māori health team) b. WDHB recruitment and retention is aligned with mahi with Kia Ora Hauora, YES kaupapa, Rangatahi focused pathways – Ara ki te mahi Hauora <p>Action 4.4 Kaupapa Māori Primary Mental Health & Addiction</p> <ul style="list-style-type: none"> a. Implement recommendations from the WDHB Kaupapa Māori Services Commissioning Review to ensure that kaupapa Māori contract documents support, recognise and enable the delivery of whānau ora and are: <ul style="list-style-type: none"> ▪ Enablers for equitable outcomes for Māori ▪ An enabler for sharing consented information across agencies ▪ Supportive of kaupapa providers to build and maintain capability and capacity to design and deliver services ▪ Aligned across agencies e.g. DHB, Te Puni Kokiri and Whānau Ora Commissioning Agencies b. Implement the second tranche of the Integrated Primary Mental Health and Addiction Services to kaupapa Māori general practice <p>Action 6.1 Support Māori patients and their whānau to navigate their health journeys</p> <ul style="list-style-type: none"> a. Planned clinics around telehealth options, including access in rural localities etc: <ul style="list-style-type: none"> ▪ Increase in remote consultation through video conferencing rather than patients, whānau or staff having to travel. ▪ Engagement and process taking into account cultural values and practices including options for whānau hui b. Introduction of wider suite of telehealth options for patients and clinicians included telephone, secure video conferencing and supported remote clinics. 	<p></p> <p>Q2</p> <p>Q4</p> <p>Q4</p> <p>Q4</p> <p>Q2</p> <p>Q4</p>

<p>b. Refresh the WHDB action plan ensure Māori representation in working group proportionate to the population and includes representation from consumers.</p>	<p>Q4</p>
<p>Action 8.5 Major funding frameworks adjustment for unmet need and equitable distribution of resource</p>	
<p>a. Support introduction of Whakarongo Mai – listen to what we are saying as whānau to complement Korero Mai – and link into commissioning processes to identify and respond to unmet need.</p>	<p>Q2</p>
<p>b. Channel funding opportunities to the introduction of “inequity breaker” programme targeting “intensification” or “simplification” of service as appropriate</p>	<p>From Q1</p>

2.5.2 Improving sustainability (confirming the path to breakeven)

Short term focus 2021/22	
<p>Throughout the COVID-19 response period the WDHB team participated in wide ranging community engagement. Through a process of analysis, a number of opportunities for health within our rohe were identified including the extended use of telehealth services. National analytics have highlighted two major opportunities for WDHB: high readmission rates and high standardised intervention rates. The latter will be addressed within the programme of strengthening production planning for planned care.</p>	
Action(s)	Milestone(s)
<p>Increased use of Telehealth will provide significant positive impact on our communities and the DHBs financial sustainability. This will potentially reduce the impacts of travel and work inequities in our communities, the levels of DNAs and enable greater flexibility for clinician time and clinic administration.</p> <ul style="list-style-type: none"> ▪ Recruit a Telehealth Project Manager to drive both clinical and patient engagement to increase usage of telehealth ▪ Project plan in place ▪ Uptake of telehealth has increased equitable access to communities across the rohe ▪ Clinical uptake and usage of telehealth has increased <p>Estimated Financial Impact year one \$84K</p>	<p>Q1 Q2 Q3 Q4</p>
<p>WDHB has a high rate of readmissions. A patient flow programme has been implemented with a reduction of readmission rates as one of the key objectives.</p> <ul style="list-style-type: none"> ▪ Integrated Discharge Navigator <ul style="list-style-type: none"> - A one-year pilot role for integrated discharge navigator position will be recruited. The programme is aligned to the strategic focus on Healthy at Home: Every Bed Matters. Role will ensure systems and processes are in place to aid timely patient discharges, understanding and removing barriers to discharge and reviewing complex cases to support better health outcomes. - Develop programme with PHO's to review "frequent flyers" into ED in order to establish wrap around primary care services <p>Estimated Financial Impact year one \$96K,</p>	<p>Q3 Q4</p>
<p>WDHB regularly delivers an intervention rate across some surgical specialties that is significantly higher than the national average. We are using service redesign funding to align capacity and production planning models with patient focussed service delivery and improving access to services. Year one value is not quantifiable; however</p> <ul style="list-style-type: none"> - capacity will be made available to regional partners via IDF inflow - WDHB will engage with Central Region to implement actions from the orthopaedic surgical patient common pathway programme. 	<p>Q4 Q4</p>

Medium term focus (three years)

Over several years, WDHB has experience ongoing growth in acute hospitalisation. Our Thriving Communities strategy, includes the mission “Ki 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.”

One of our strategic focus areas is “Noho Ora Pai I Tōu aka Kāinga- Healthy at Home: Every Bed Matters” setting up a principle that self care is best. Over the medium term, this will contribute to sustainability by integrating community and hospital services more effectively and empowering people, whānau and communities to thrive.

Action(s)

Healthy at Home – every bed matters. Integrating community and hospital services driven by a core principle that the best bed for a person is their own one. A programme of work to address congestion in the hospital and collectively reduce acute hospitalisation. Elements of the programme and key actions across the next 3 years include:

- Driving effectiveness in urgent care before it reaches the hospital front door (This set of measures is informed by the experiences during COVID-19 and the need for effective primary and community response for wellbeing. The strengthening of Primary Care is the most significant impact we can take to a reduction in cost growth over the next three years and is essential to sustain our path to breakeven).
 - Year 1 – implement alternative care settings for non-urgent care in A&M (\$292K)
 - Complete planning
 - Alternative care settings in place for 2 client groups
 - Year 2 - Design and implement consistent urgent care model across the district (\$296K)
 - Year 3 – embed community informed wellbeing hub into primary healthcare systems (\$301K)
- This action will have a significant impact on medium term sustainability by not only reducing ED presentations, but reducing acute admissions through earlier intervention, and long term cost growth.
- Strengthening and integrating patient-flow systems within the hospital
 - Year 1 – embed integrated discharge navigator (\$96K)
 - Confirm model of care and system
 - Embed into practice
 - Year 2 – implement regional standardised intervention rates (\$101K)
 - Year 3 – integrate and standardise regional and sub-regional models (\$102K)
- Optimising community transitional and support services
 - Year 1 – Complete model of care change for intermediate care services (\$0)
 - Planning complete
 - New model of care operational
 - Year 2 – implement nationally consistent home and community support services model (\$dependent on model of care)
 - Year 3 – Embed community-informed tier 1 service commissioning (\$dependent on model of care)

2.5.3 Improving maternal, child and youth wellbeing

Maternity care 2021-22

The focus for maternity services is twofold:

- Integration and collaboration of services across the continuum of maternity care to facilitate early and seamless access to care, to support and protect the health and wellbeing of our wāhine/māmā's, *pēpi* and whānau.
- To encourage and enable consumer engagement, especially from Māori living in our rohe, to actively participate in decisions about their health care and maternity services, to help us meet their needs and develop safe, quality services

Action(s)	Milestone(s)
<p>COVID-19 learnings:</p> <ul style="list-style-type: none"> ▪ Importance of consistent and timely communication to support service delivery, work with COMMs to ensure messaging is consistent and clear. ▪ Importance of enabling a dedicated support person to stay with the woman throughout her inpatient maternity stay ▪ Ensure community LMC's are supported to continue with homebirths through provision of and education on correct use of personal protective equipment (PPE) ▪ The DHB will provide a homebirth kit for LMC's including disposal, laundry and sterilization of equipment ▪ Maintain continuity of care for rural women and whānau - primary Waimarino Maternity Service is fully staffed and operating 24/7. 	<p>Q1</p> <p>Q1</p> <p>Q1</p> <p>Q2</p> <p>Q2</p>
<p>Midwifery Accord actions:</p> <ul style="list-style-type: none"> ▪ Support new graduate midwives to choose DHB employment ▪ FTE calculations are completed in accordance with CCDM <p>The WDHB will support new graduate midwives:</p> <ul style="list-style-type: none"> ▪ employ at two new graduate midwives 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) ▪ Seek to employ a Clinical Coach as per Accord recommendations to clinically support all new graduate midwives with their hospital orientation and DHB specific competencies 	<p>Q2</p> <p>Q3</p> <p>Q1</p> <p>Q4</p>
<p>PMMRC recommendations:</p> <p>The Maternity Quality and Safety Programme (MQSP) will develop a detailed three-year work plan based on PMMRC recommendations prioritizing those that are urgent</p> <ul style="list-style-type: none"> ▪ Begin implementation of actions in the plan: ▪ Implementation of HQSC maternal morbidity review tool kit and SAC rating (PMMRC) 	<p>Q1</p> <p>Q2</p>

<ul style="list-style-type: none"> ▪ Implementation of Hypertension guideline, with a review/re-stock of medications to ensure easy availability & administration in acute care settings (PMMRC) ▪ Interdisciplinary fetal surveillance education for all clinicians involved with intrapartum care (PMMRC) ▪ MEWS audit and case review Associated morbidity review identified through trigger tool (MMWG recommendation) ▪ Further develop cultural competency in practice workshops for all Maternity Service staff (PMMRC) 	<p>Q2</p> <p>Q3</p> <p>Q3</p> <p>Q4</p>
<p>An integration working group (includes LMCs, general practitioner, PHOs, DHB maternity, WCTO, child health services, Māori health) has been established to investigate and gain a whole of system view of equity, access issues and opportunities across the maternal and child health system (will include actions to improve access to social services, ultrasound, parenting education, WCTO and screening programs).</p> <ul style="list-style-type: none"> ▪ Develop a 3-year work plan based on the insights gained from a whole of system engagement process. 	<p>Q2</p>
<p>Ambulatory sensitive hospitalisations for children age (0-4) (SLM)</p> <ul style="list-style-type: none"> ▪ 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. <ul style="list-style-type: none"> - Develop and implement childhood asthma pathway - Embed Best Start Tool across general practice 	<p>Q4</p> <p>Q4</p>

Immunisation

Whanganui DHB is committed to ensuring all children receive their immunisation on time. Childhood immunisation rates have fallen despite best efforts from the outreach team, with Māori rates also declining. Addressing peoples' hesitancy around vaccinations, increased anti-vax media coverage have impacted on the rates. Though issues affect all DHBs, we have observed the value of collaboration across sectors as this has proven a successful approach to larger scale immunisation as evidenced in the programme of work undertaken during COVID-19 lockdown. Improved and joint collaboration along with consistent culturally appropriate messaging that is locally driven are areas that can have a positive effect on the immunisation rates.

Action(s)	Milestone(s)
<p>The aim of the plan is to improve childhood immunisation coverage from infancy to age 5.</p> <p>Immunisation engagement and communication plan, taken from the revised engagement plan, following learnings from rollout of COVID-19. To ensure immunisation is maintained during COVID-19 rollout within the WDHb the engagement plan has a locally driven focus on:</p> <ul style="list-style-type: none"> - collaboration with community providers - focused resourcing - consistent culturally appropriate messaging <ul style="list-style-type: none"> ▪ Working with key stakeholders to develop and implement an immunisation engagement and communications plan ▪ Ensuring plan delivers key, consistent and culturally appropriate messages. ▪ Develop, in collaboration with Māori, Pacific and consumer participation. ▪ Focus on health literacy and how we deliver our messaging in different populations, and within a context of Te Ao Māori. 	<p>Q2 Q2 Q3 Q4</p>
<p>COVID-19 learnings: By working collaboratively with kaupapa Māori health providers and Māori communities, the teams were able to target those hard to reach people, deliver to them in their own communities, provide mobile and pop up clinics in various locations. Develop joint work plans that will target hard to reach, high dep and Māori population and ensure that the approach is Māori-led, Māori-focused.</p>	<p>Q3</p>
<p>Actions to improve 2-year-old immunisation uptake:</p> <ul style="list-style-type: none"> ▪ Work closely with general practices: <ul style="list-style-type: none"> - use practice specific data to monitor progress of uptake of immunisation, - provide feedback and clinical support as required at a practice level - ensure teams are focused on meeting their targets - ensure resources and knowledge are available to engage with Māori whānau. ▪ Work with general practice teams to develop their own initiatives, for their enrolled populations, to increase childhood immunisations rates that focus on uptake for Māori. ▪ Immunisation outreach will work across the system, so that childhood immunisations are prioritised when children interface with hospital services and other sector partners. 	<p>Q2 Q4 Q4</p>

<ul style="list-style-type: none">▪ Increase opportunistic vaccinations and education in hospital departments supported by the outreach team <p>(Contributory measures to monitor progress: Infants who have received all WCTO core contacts due in their first year, babies in smokefree homes at 3 months, monitor and follow up DNA at GP and outreach team, monitor update in Whānau Ora Services)</p>	Q4
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Youth health and wellbeing

The Whanganui DHB will continue to work collaboratively with sector partners and whānau to provide and enhance the range of services for youth, focusing on the needs of Māori. (SBHS = school based health service)

Action(s)	Milestone(s)
Undertake the design of a pathway in response to our gender diverse population in schools that will increase awareness of agencies and networks to students. Promote and support Rainbow friendly environments in schools.	Q4
Action from the; 'A framework for continuous quality improvement in each school'. Facilitate Public health nurse's having protected time and dedicated resources for professional development and supervision. <ul style="list-style-type: none"> Having 75% PHN's access to supervision. Report staff uptake of training and supervision. 	Q2
Improve IT process by having HEEADSSS documentation to be accessed via Clinical Portal (CP). <ul style="list-style-type: none"> Develop a form to improve data collection required for quality improvement in the future. <ul style="list-style-type: none"> Measure: 100% of HEEADSSS assessments completed on CP form. 	Q2 & 4
<ul style="list-style-type: none"> Improve data collection in WebPas for SBHS Ministry of Health reporting using PDSA cycle. Analyse clinic data to evaluate and identify changes required. 	Q1 Q3
PDSA cycle – Changes implemented in how SBHS will assess the young person's satisfaction within the service regularly. Partnering with students to obtain their voice through surveys, conversations. Priority sourcing high risk population, Māori, Pacifica student's in schools. <ul style="list-style-type: none"> Identify barriers to access service. Develop a method of creating a student focus group for feedback, two focus groups completed and reporting from PHN's survey results for evaluation. 	Q2 Q4
Undertake work providing school leavers with information and enrolment opportunities of PHO's and other relevant agencies to improve Māori health and achieve health equity and wellbeing. (restrictions in 2020 due to COVID-19, promoting the resources will occur in 2021). <ul style="list-style-type: none"> Facilitate process to distribute to each school the resources and any opportunistic times to provide to students. <ul style="list-style-type: none"> 10 schools and Alt Education Centre's have the resources. 	Q2 Q4
<ul style="list-style-type: none"> Enhance range of health services offered by Youth One Stop Shop (YOSS) that meets the needs of our diverse community including Māori, Pasifika and Rainbow communities by partnering with other providers including Iwi and kaupapa providers and specialist mental health and addiction services 	Q4
<ul style="list-style-type: none"> Implement the second tranche of the Integrated Primary Mental Health and Addiction Services for General Practices and report on youth and youth Māori utilisation. 	Q4

Family violence and sexual violence

Action(s)	Milestone(s)
<p>Staff as victims of violence training and support – implementation of training programme for managers Māori staff at the WDHB make up 13%</p> <ul style="list-style-type: none"> ▪ Consultation to occur with training providers (SHINE) and Māori Health Team to ensure that all staff are supported appropriately and that Tikanga and protocols are followed in respect of working with our staff who are victims of family harm within the proposed training package. <ul style="list-style-type: none"> - Feedback from consultation actioned 	<p>Q3</p> <p>Q4</p>
<p>Purchase training package.</p> <ul style="list-style-type: none"> ▪ The training package has been purchased from SHINE and will be delivered with a People and performance staff member, and the VIP coordinator. The training package will be localised before delivery and covers the DV FREE tick for organisations to be responsive to staff who are victims or perpetrators of family harm. ▪ Implement training package ▪ Policy & Procedures are developed with People and Performance ▪ Policy & Procedure implemented 	<p>Q1</p> <p>Q2</p> <p>Q3</p> <p>Q4</p>
<ul style="list-style-type: none"> ▪ Support People & Performance Manager and Te Hau Ranga Ora Kaitakitaki (WDHB Māori health services manager) to identify appropriate attendees for first responder training. ▪ People & Performance identify a staff member responsible for providing guidance to managers in dealing with difficult situations ▪ People and Performance to source legal advice for managing staff who are perpetrators and victims of family harm. ▪ First responder (up to 20 participants) training relates to family and sexual violence as staff are victims of both. There is evidence of the high correlation between physical and sexual violence. The first responders are designated people within the DHB for employees to contact if they are impacted by domestic violence (or have children living with them that have been impacted by family harm) who may want workplace safety and support. First responders may also provide support and guidance for managers who are managing an employee impacted by family harm or perpetrating family harm. The first responder roles is not to address or resolve the source of violence but rather to ensure that employees are provided with appropriate support and workplace safety planning, as well as facilitated access to specialist family harm agencies. This training is part of the DV FREE package that WDHB have purchased. 	<p>Q1</p> <p>Q2</p> <p>Q3</p>
<ul style="list-style-type: none"> ▪ Ensure all employees have access to support within the workplace. <ul style="list-style-type: none"> - 50% of managers have received training on how to support staff experiencing family harm and how to manage staff suspected or known to be perpetrating family harm during work time or using work resources. This will encompass safety planning, confidentiality and professional boundaries. 	<p>Q2</p>

<ul style="list-style-type: none"> ▪ WDHB to have received DVFREE tick and be supported by Te Hau Ranga Ora. ▪ The DVFREE training package (as above) includes training for first responders who are identified staff members available for impacted staff to contact. First responders will provide support to engage staff members with appropriate agencies and resources to support them to meet their needs and continue employment. 	<p>Q4</p> <p>Q4</p>
<p>COVID-19 Recovery and embedded key learnings</p> <ul style="list-style-type: none"> ▪ Executive Leadership Team (ELT) formalise process whereby WDHB provide safe alternate work spaces for staff who have identified it is unsafe for them to work from home due to family harm. <ul style="list-style-type: none"> - Paper provided for endorsement to ELT including procedure 	<p>Q1</p>

2.5.4 Improving mental wellbeing

Improving mental wellbeing by Expanding Primary Health and Addiction Support in the Community

WDHB supports the commitment to the transformation of New Zealand's approach to supporting mental wellbeing and ensuring that people are able to get the help they need, when and where they need it. This includes:

- Enhanced support available in a range of settings, at no cost to the service user
- Layers of support available for all people, based on what they need, including linking to ongoing support
- Improved resilience and mental health, addiction and wellbeing outcomes for the DHB's population
- Greater equity of access and outcomes – built on new ways of partnering – with Māori, Pacific peoples, young people and other population groups experiencing inequitable outcomes, no matter where you live in the rohe
- Development of new and diverse workforces (including Kaiāwhina, Health Coaches and Peer Support Workers) to better respond to tangata whaiora / people's mental health, addiction and wellbeing needs wherever they live and work.

Action(s)	Milestone(s)
Implementing the second tranche of the Integrated Primary Mental Health and Addiction Services for General Practices including kaupapa Māori general practice.	Q4
Expand range of General Practices that specialist Mental Health clinicians are working within	Q4
Enhance range of health services offered by Youth One Stop Shop (YOSS) that meets the needs of our diverse community including Māori, Pasifika and Rainbow communities by partnering with other providers including Iwi and kaupapa Māori health and Māori community providers and specialist mental health and addiction services	Q4

Improving mental wellbeing by Strengthening Specialist Services

Specialist services are essential for the health of tangata whaiora / people with complex or enduring mental health and addiction issues. WDHB is committed to seamless access to care between community services, primary care and hospital services and enhancing the range of supports such as peer support, group therapies and telemedicine.

The voices and stories of people with lived experience of specialist services, and their whānau, will be a central to decision-making to implementing change

Action(s)	Milestone(s)
Improving crisis response by scoping a peer-led community alternative to acute admissions	Q2
Implementing Mental Health and Court Reviews through technology	Q3
Extending the age range for specialist mental health service access for youth for 18 to 25 years to enhance access to more flexible and responsive services for the needs of this age group by youth and adult specialist mental health clinicians working in an integrated partnership approach	Q2

The vision is to grow a sustainable, diverse and equitable, competent and confident mental health and addiction workforce

Action(s)	Milestone(s)
Build understanding through workforce education based on data, including QLIK and analytics including senior medical officers	Q1
Engage medical clinicians with improvement projects including KPI, and HQSC initiatives	Q1
Includes Capacity Assessment in up-dated Mental Health Act training	Q1
All DHB staff working in mental health and addiction services attend cultural education which includes Hapai te Hoe, He Waka Hourua and addressing bias and racism training.	Q4
Maternal mental health specialists provide intentional upskilling of all the district's general practice teams to include what services are available for mothers including community based kaupapa Māori services such as He Puna Ora.	Q4

Effective follow up of service users who have been discharged from inpatient services

The vision is all service users are followed up within 7 days of discharge. This follow-up is important for the prevention of suicide, self-harm, and other negative outcomes such as readmissions

Action(s)	Milestone(s)
All service users and their whānau receive a copy of their Transition Plan before they leave the inpatient unit following their Hui Whai Ora and the Transition Plan is communicated in a way that meets health literacy and equity standards.	Q1
Clinical Education (includes SMO and RMOs) has a focus on best practice for follow-ups and the importance of these activities being recorded electronically.	Q2

Suicide prevention

Growing Collective Wellbeing: A whole of community – whole of system approach to the prevention of suicide within the Whanganui, Rangitikei Ruapehu rohe by increasing community wellbeing and to amplify and accelerate systems changes through stakeholders and community working together

Action(s)	Milestone(s)
Work with and support Healthy Families Whanganui, Rangitikei Ruapehu to finalise the operating model and year one implementation plan for collective wellbeing.	Q4

Section 29

To reverse the over representation of Māori compared to Non-Māori under the Mental Health Act Section 29

Action(s)	Milestone(s)
WDHB will partner with MHOAG Māori health Outcomes Advisory Group Alliance (leaders of five kaupapa Māori provider organisations in the rohe) to progress Maturanga 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.	Q4
A focus on supported decision making by senior medical officers with an expectation that they work closely with service user advocates, community based kaupapa Māori providers and Haumoana (WDHB Māori health service navigators).	Q1

COVID-19**Action(s)**

Continue to identify, design and implement equitable access and use of telehealth opportunities.

Milestone(s)

Q4

2.5.5 Improving wellbeing through prevention

Communicable Diseases	
<p>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</p>	
Action(s)	Milestone(s)
<p>COVID -19 Recovery Support: Ministry of Health (MoH) events sector voluntary code has been developed to outline how to safely deliver events by following best practice expectations, guidance and behaviours to prevent/reduce COVID-19 related risks.</p> <p>Public Health – Kaihoe Health Promotion will continue to focus on proven preventive measures and early intervention to ensure significant health gains from a population approach.</p> <ul style="list-style-type: none"> ▪ Review, evaluate and make quality improvements to our large events and gathering initiatives <ul style="list-style-type: none"> - Review & Evaluation Plan completed ▪ Provide ongoing communication support to events happening throughout the rohe. <ul style="list-style-type: none"> - Develop Quality improvements plan ▪ Ensure a public health literacy approach over COVID-19 population health key information and preventative measures (provided from Ministry of Health). ▪ Ensure the community can obtain, process, understand, evaluate, and act on information needed to make public health decisions that benefit the community. <ul style="list-style-type: none"> - New programme operational in community - Public Health COVID-19 information Resource 	<p>Q1</p> <p>Q2</p> <p>Q2</p> <p>Q3</p>
<p>MidCentral DHB Public Health Unit continue to undertake disease surveillance for Whanganui DHB by collecting, analysing and interpreting communicable disease data for the purpose of preventing, identifying and responding to existing and emerging communicable disease risks.</p> <ul style="list-style-type: none"> - PHU reports on communicable disease activity 	<p>Q2, Q4</p>
<p>WDHB facilitate an awareness campaign in Māori and Pasifica communities of the link between streptococcus bacteria and rheumatic fever</p> <ul style="list-style-type: none"> - Awareness campaign delivered in Māori and Pasifica communities 	<p>Q3</p>

Environmental sustainability

WDHB has an ongoing commitment to ensuring that our actions consider environmental sustainability and that we seek to reduce our impact on the environment wherever possible.

Action(s)	Milestone(s)
<p>Increasing use of video conferencing and virtual consultation to reduce patient and staff travel and reduce pool car usage.</p> <ul style="list-style-type: none"> ▪ A key learning from COVID-19 is that a significant amount of travel is unnecessary. Monitoring fleet bookings and hours booked across the first 2 quarters of 2020/21 shows a steady decline in pool car usage. In addition there have been valuable savings on travel and associated costs (staff). This will continue as a focus in 2021/22. <ul style="list-style-type: none"> - Limit staff travel by promoting virtual attendance where possible - Monitor travel savings and fleet usage 	<p>Q2 Q4</p>
<p>COVID-19 learnings: Prior to COVID-19, WDHB had adopted a Social Governance approach to collectively working with Iwi, community, social and government organisations to support the needs of our local communities. Our review from the rohe COVID-19 response to date has reinforced this approach and has been the catalyst for stronger relationships, ways of working and expectation for future partnership.</p> <ul style="list-style-type: none"> - Monitoring the implementation of He Hāpori Ora 	<p>Q4</p>
<p>WDHB will meet their obligations under the CNGP, including readiness to report emissions from 1 July 2022 and set reduction targets and plans for 2025 and 2030. To achieve this WDHB will:</p> <ul style="list-style-type: none"> ▪ engage an ECCA approved consultant under their Energy Transition Accelerator program to assist WDHB to transition away from using fossil fuel ▪ Develop data system monitoring <p>Engage a company that specializes in converting coal boilers to a renewable resource for our Taihape site</p> <ul style="list-style-type: none"> ▪ Report to be received and learnings actioned 	<p>Q1 Q2 Q4</p>

Antimicrobial resistance

Preventing antimicrobial resistance remains a focus for our health and safety team, driven by a multi-disciplinary infection prevention committee. Educational seminars are provided for health professionals to promote optimal use of antibiotics supported by best practice.

Action(s)	Milestone(s)
Infection Prevention and Control education is delivered to general practitioners via the PRHN monthly interprofessional forums. Information to promote optimal use of antibiotics supported by best practice is available via the WDHB intranet and staff are orientated as to where to locate this information.	Q2
Increased hand hygiene gold auditors have been rolled out into the community health facilities AMR is a topic that is covered in the IPC study day. Immunisations are encouraged as part of AMR <ul style="list-style-type: none"> Develop targets to measure success of plan All areas have reached the required 80% of target 	Q1 Q2
Audit of antibiotic use in the WDHB occurs twice yearly. <ul style="list-style-type: none"> Continue education to primary care nurses and medical staff; de-labelling testing and patient education Identify areas of focus in consultation with primary care and ARC for auditing to access compliance and antibiotic resistance rates Report result of audit of antibiotic usage to Clinical Governance 6 monthly Recommendations from the HQSC AMR surveillance audit will be implemented. Explore opportunities with Primary care services and ARC facilities to implement the antibiotic usage and point prevalence survey's (PPS) 	ongoing Q2 Q2, Q4 Q4 Q2
Extend the contract with CCDHB infectious diseases (ID) team so that all patients' SMO have access to ID advice and support if required. This is both inpatients and outpatients. <ul style="list-style-type: none"> New contract in place 	Q2
Equity is ensured through surveillance and identifying ethnic groups who are disproportionately affected by Methicillin-resistant Staphylococcus aureus (MRSA), Carbapenemase-producing Enterobacteriaceae (CPE), Vancomycin Resistance(VMR), C. difficile rates, TB (MDR), Drug resistant N. gonorrhoeae etc. <ul style="list-style-type: none"> Reported to Clinical Governance board every 6 months 	Q1 Q2, Q4
AMR is a topic that is covered in the IPC study day. Immunisations are encouraged as part of AMR and this is expected to result in increased vaccination rates among the health workforce <ul style="list-style-type: none"> Monitor vaccination rates among health workforce 	Quarterly

Drinking water

A Drinking Water Technical Advice Service is co-ordinated through the health protection service within MidCentral DHB's public health unit (PHU). Note that MidCentral PHU covers the Manawatu-Whanganui region, incorporating the Whanganui DHB district.

Action(s)	Milestone(s)
Mid Central DHB – PHU will ensure the supply of high quality drinking water by undertaking drinking water duties as required by the Health Act 1956. Activities and associated reporting will be delivered in with the Drinking Water section of the Environmental and Border Health exemplar <ul style="list-style-type: none">Narrative report on delivery against exemplar measures as per reporting template	Q2 & Q4
Mid Central DHB - PHU to identify and develop improvement plans requirements for rural areas across Manawatu-Whanganui with a high proportion of Māori populations, to improve the quality of water supply <ul style="list-style-type: none">Three rural communities and key stakeholders are identifiedThree consultation completed and requirement identifiedThree improvement plans in place by 30th June 2022	Q2 Q3 Q4

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. Note that MidCentral PHU covers the Manawatu-Whanganui region, incorporating the Whanganui DHB district.

Action(s)	Milestone(s)
MidCentral DHB's PHU will undertake compliance and enforcement activities relating to the Health Act 1956 and other environmental and boarder health legislation by delivering on the activities and reporting using the vital few report on the performance measures contained in the Environmental and Border Health exemplar	Quarterly
MidCentral DHB's PHU to review that Whanganui DHB has adequate and appropriate sufficient numbers of statutory officers and other health protection staff to carry out service delivery and capacity to respond to incident and emergencies 24 hours per day <ul style="list-style-type: none">Review report completed	Q2
MidCentral DHB's PHU to engage and work in collaboration with Whanganui DHB Emergency Planner and Māori communities during the review process for Whanganui Public Health Plans. (EOA) <ul style="list-style-type: none">Review report completed	Q4

Healthy food and drink environments

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 role.

Action(s)	Milestone(s)
<p>Public Health – Kaihoe Health Promotion to communicate and consult with all staff across the DHB about changes to local policy that will align with National Healthy Food and Drink Policy 2019</p> <ul style="list-style-type: none"> ▪ Implement changes to local DHB food policy in consultation with staff, that is consistent with the National Healthy Food and Drink Policy 	Q2
<p>To ensure all new, qualifying funder contracts with health service providers include a clause that stipulates an expectation that they develop a Healthy Food and Drink Policy will be required to align with the Ministry of Health's <i>Healthy Food and Drink Policy for Organisations</i>.</p> <ul style="list-style-type: none"> ▪ Full compliance confirmed 	Q2
<p>Continue to implement Healthy Active Learning (HAL):</p> <p>WDHB to engage with Sport Whanganui to develop a collaborative approach to deliver healthy eating and physical activity in schools, kura, kohanga reo and early learning services to create supportive environments priority populations and settings.</p> <ul style="list-style-type: none"> ▪ Plan agreed and actioned 	Q4

Smokefree 2025

The ongoing commitment of WDHB to Smokefree 2025 will focus on reducing inequities in smoking prevalence, particularly for young Māori women (includes pregnant women, babies and their whānau). Working with the community through a co-designed approach, we want to build the foundation for supporting whānau across continuums and providing more support to targeted groups to quit and prevent uptake in a way that best matches their needs and aspirations.

Action(s)	Milestone(s)
<p>Complete 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.</p> <ul style="list-style-type: none"> ▪ Needs Analysis Report completed and published by 31 December 2021 <p>In collaboration with key partners 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</p> <ul style="list-style-type: none"> ▪ Tobacco Control Strategic Plan endorsed by MoH and Joint Boards Hauora ā Iwi and WDHB by 31 March 2022 	<p>Q2</p> <p>Q3</p>
<p>Facilitate a co-designed system change to address the fragmentation across the system with hapū mama (from conception to 6 weeks) at the core through the Tobacco Advisory Group, Well Child Tamariki Ora network, Primary Care and Maternal Governance Groups.</p> <ul style="list-style-type: none"> ▪ Insights Report developed ▪ Scope implementation plan based on feedback from Insights Report 	<p>Q3</p> <p>Q4</p>

Breast Screening	
Action(s)	Milestone(s)
<p>During the COVID-19 lockdown the Outreach Service was delayed which impacted on the uptake of screening across the region. In mitigation of the delay, the following actions will be undertaken:</p> <ul style="list-style-type: none"> ▪ Proactive collaboration between breast screening programme and outreach services ▪ Ensure flexibility of appointments ▪ Support for Wāhine to attend appointments ▪ Quarterly monitoring of increase in performance against national target 	<p>Q1 - ongoing ongoing ongoing (EOA) Q1 – Q4</p>
<p>Focus on a campaign to raise the awareness within their population regarding the importance of screening, early intervention and early warning signs of cancer.</p> <ul style="list-style-type: none"> ▪ Invest in Kaupapa Māori services – wraparound and support ▪ Invest in a campaign developed with other stakeholders ▪ Monitor uptake screening locally against the national target of 70% 	<p>Q2 (EOA) Q3 Q2 (EOA)</p>
<p>Increased focus on health promotion for priority population groups (Māori & Pacific) across community settings.</p> <ul style="list-style-type: none"> ▪ Engage with local networks i.e. Samoan Churches, Pasifika Early Childhood Centre and schools, community events and Kohanga Reo ▪ Monitor improvement locally against the national target of 70% 	<p>Q3</p>
<ul style="list-style-type: none"> ▪ BreastScreen Coast to Coast equity role committed to support the local outreach team 	<p>Q4</p>
<p>Raise awareness among whānau in the community – to encourage women to be screened including engagement of local champions in messaging</p> <ul style="list-style-type: none"> ▪ Improvement in national target from 63.8% (Sep 20) 	<p>Q4</p>

Cervical Screening

WDHB is committed to a long-term strategic goal of being healthy at home with a priority that health care is accessible in the right setting and environment. Our integrated approach is expected to reduce barriers for women alongside robust health promotion and messaging which will support screening for priority group women (Māori, Pacific Island and Asian women).

The equity ratio is improving between Māori and non-Māori women eligible for cervical screening between ages of 25-69 years. Reduced from 1.12 in 2017 to 1.10 in 2018 to 1.07 in 2019 and 1.08 in 2020 (noting the impact of COVID-19)

Action(s)	Milestone(s)																												
<ul style="list-style-type: none"> ▪ Expand opportunistic screening outreach services in other settings including introduction of the mobile outreach service/bus to the community ▪ Increase access to screening after work hours ▪ Focussed support provided to general practices with the highest outstanding smears ▪ Invest in Māori screener training <p>Expected outcomes are an improvement against baseline March 2021 performance of 2%</p> <table border="1"> <thead> <tr> <th colspan="4">*Baseline December 2020</th> </tr> <tr> <th>Ethnicity</th> <th>Screens completed</th> <th>Population</th> <th>3 year coverage</th> </tr> </thead> <tbody> <tr> <td>Māori</td> <td>2,847</td> <td>4,265</td> <td>66.8%</td> </tr> <tr> <td>Pacific</td> <td>248</td> <td>377</td> <td>65.8%</td> </tr> <tr> <td>Asian</td> <td>510</td> <td>750</td> <td>68.0%</td> </tr> <tr> <td>Other</td> <td>8,507</td> <td>11,858</td> <td>71.7%</td> </tr> <tr> <td>All</td> <td>12,112</td> <td>17,250</td> <td>70.2%</td> </tr> </tbody> </table> <p><i>*The baseline is measured using available data in late 2020 or early 2021 from DHB colposcopy units.</i></p>	*Baseline December 2020				Ethnicity	Screens completed	Population	3 year coverage	Māori	2,847	4,265	66.8%	Pacific	248	377	65.8%	Asian	510	750	68.0%	Other	8,507	11,858	71.7%	All	12,112	17,250	70.2%	Q4, EOA
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Ethnicity	Screens completed	Population	3 year coverage																										
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<ul style="list-style-type: none"> ▪ Focus a robust health promotion on priority population groups (Māori & Pacific) such as through community events and networks i.e. Samoan Churches, Pasifika Early Childhood Centre and schools, community events and Kohanga Reo ▪ Develop simple, clear localised screening messages and information appropriate for Māori, Pacific and Asian women based on consumer survey feedback. Include raising awareness among tane in the community to encourage women to screening ▪ Invest more in successful local 'Smear your Mea' campaign across rural and urban districts <ul style="list-style-type: none"> - Expected improvement against baseline February and March 2021 performance 	Q4, EOA																												
<ul style="list-style-type: none"> ▪ Access by priority groups to colposcopy services will be analysed, and an understanding of drivers of failed appointments will be developed. Using co-design principles with iwi, service providers and service users barriers to access will be removed, with a focus on younger women where significant disparities in access exist. <ul style="list-style-type: none"> - Improvement in equitable access to diagnostic and treatment colposcopies for priority groups referred with a high-grade result 	Q4, EOA																												

Reducing alcohol related harm

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

Action(s)	Milestone(s)
<p>Public Health to lead and coordinate raising awareness of FASD and the risks of drinking during pregnancy to increase preventive and population health approaches within Primary, Secondary and Community Providers.</p> <ul style="list-style-type: none"> ▪ Completed two FASD presentations within Primary Care, Secondary Care and Community Providers 	Q2
<p>To scope, develop FASD training to support lead maternity carers and undergraduate midwifery students including: Te Pou's 'An Introduction to Fetal Alcohol Spectrum Brief Intervention Training' aligned with 5+ Solutions reducing alcohol related harm</p> <ul style="list-style-type: none"> ▪ Local implementation of the FASD training 	Q4
<p>Collaborate with MidCentral and police-led Controlled Purchase Operations (CPOs), to reduce sale of alcohol to minors within Whanganui DHB priority populations and settings. (Note: One CPO equals one total organised operation that targets a number of premises).</p> <ul style="list-style-type: none"> ▪ CPO completed within Whanganui DHB. 	Q2
<p>Strengthen WDHB partnership with MidCentral Health Protection Licencing applications procedure for all on-, off-, club, renewals and special licencing application within Whanganui DHB district. Include Whanganui Health Promotion within their checklist procedure ensuring a population equity health lens.</p> <ul style="list-style-type: none"> ▪ Whanganui DHB established within the Licencing Application checklist procedure 	Q1

Sexual and reproductive health

Whanganui DHB is committed to ensuring access to sexual and reproductive health services with a focus on ensuring equitable access for Māori and rural communities

Action(s)	Milestone(s)
<p>WDHB National Syphilis Plan shared with primary care clinicians on national syphilis screening guidelines for service delivery consistency.</p> <ul style="list-style-type: none"> Education sessions delivered within the primary health care practices through up skilling of RMOs and GPs and practice nurses with annual updates provided. Improved syphilis referral processes from primary to secondary specialist's care with evidence of required clinical information 	<p>Q2</p> <p>Q2</p>
<p>Increase access to sexual health services for Māori across the WDHB rohe. Focusing on the 15 -24-year-old Māori age group, increase service options through a kaupapa Māori sexual health service</p> <ul style="list-style-type: none"> Scope kaupapa Māori sexual health service HPV catch up programme completed for 15-24-year-old Māori 95% of all Māori clients aged between 12-24 will be screened and offered the HPV immunisation 	<p>Q1</p> <p>Q3</p> <p>From Q1</p>
<p>Develop pathway across primary secondary services to establish one contact point for gender diverse clients in the WDHB rohe:</p> <ul style="list-style-type: none"> Develop the pathway Review uptake 	<p>Q1</p> <p>Q4</p>
<p>Increase access to Pre-exposure Prophylaxis (PrEP)</p> <ul style="list-style-type: none"> implement clinical guidelines in accordance with the NZ Sexual Health Society 80% of HIV presenting client receive PrEP 	<p>Q1</p> <p>Q4</p>

Cross Sectoral Collaboration including Health in All Policies

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 Healthy at Home: Every bed matters.

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

Health and wellbeing for the population of WDHB rohe 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).

Action(s)	Milestone(s)
<p>Thriving Together Impact Collective: the Integrated Recovery Team continue to engage with Whanganui DHB communities and undertake the analysis of the completed focus group sessions, community and organisational surveys.</p> <ul style="list-style-type: none"> ▪ Complete the analysis report ▪ Identify insights, including COVID-19 learnings ▪ Report to the WDHB and HAI joint boards 	<p>Q2 Q3 Q4</p>
<p>Whanganui PHU will utilise a HiAP approach to enhance and improve equity and health outcomes in planning processes with Whanganui district councils, Regional council and other agencies (e.g. Police, MSD, iwi) including active transport, urban planning.</p> <ul style="list-style-type: none"> ▪ Kaihoe health promotion maintains relationship and engagement in Safer Whanganui. ▪ Provide leadership and support to community partners for health promotion activities. ▪ Development of the Safer Whanganui HiAP project plan ▪ Implementation of the plan 	<p>Q1 Q2 Q4</p>
<p>Scope and determine public health – health promotion cross sectoral collaboration opportunities with a focus on determinants of health, particularly in rural centres (Marton, Taihape, Ohakune, Raetihi and Waiouru)</p> <ul style="list-style-type: none"> ▪ Scoping report completed ▪ Engagement with community ▪ Project identified and plan developed 	<p>Q1 Q3 Q4</p>

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

Delivery of Whānau Ora	
<p>WDHB Vision, Mission and Strategic Focus Areas (Pro-equity; Social Governance; and Health at Home) are all underpinned by the DHB's commitment to whānau-centred care and whānau-centred services. Our organisational whakatauki is 'Ko au ko toku whānau, ko toku whānau ko au: Nothing about me without me, and my whānau/family'.</p> <p>WDHB's approach to whānau-centredness has been reinforced from the key findings from reviewing the COVID-19 response. Our communities expect us to work with iwi, across sectors and agencies, to provide equitable services as close to the communities as possible. Services that recognise and build on potential and are strength-based and whānau-led.</p>	
Action(s)	Milestone(s)
<p>Implement recommendations from the WDHB Kaupapa Māori Services Commissioning Review to ensure that kaupapa Māori contract documents support, recognise and enable the delivery of whānau ora and are:</p> <ul style="list-style-type: none"> ▪ Enablers for equitable outcomes for Māori ▪ An enabler for sharing consented information across agencies ▪ Supportive of kaupapa providers to build and maintain capability and capacity to design and deliver services ▪ Aligned across agencies e.g. DHB, Te Puni Kokiri and Whānau Ora Commissioning Agencies <p><i>This approach is endorsed by the Māori Health Outcomes Advisory Group (MHOAG).</i></p> <ul style="list-style-type: none"> ▪ Kaupapa Māori commissioning process is completed in partnership with MHOAG. ▪ Implementation commenced 	<p>Q2 Q4</p>
<p>In conjunction with the Whanganui rohe Collective Impact Group and Māori providers, localise the whānau ora outcomes framework using the seven elements of Whānau Ora.</p> <ul style="list-style-type: none"> ▪ Outcomes framework developed and agreed 	<p>Q4</p>
<ul style="list-style-type: none"> ▪ Ensure provision of information for Māori whānau meets the guidelines for health literacy. 	<p>Ongoing</p>

Care Capacity and Demand Management (CCDM)

Action(s)	Milestone(s)
<p>Key results : Implementation 87% as at June 2021 When the Whanganui DHB receives the CCDM full implementation evaluation report from The Safe Staffing Healthy Workforce (SSHW) unit we will action findings in parallel to the activities below:</p> <p>Key actions:</p> <p>Governance</p> <ul style="list-style-type: none"> ▪ The quarterly governance and operational meetings are structured and well attended. Minutes are circulated and widely available. This process is undertaken in partnership with the unions. The governance structure will continue and include health discussions to ensure Whanganui DHB has safe staffing and good patient outcomes. <p>Patient acuity data</p> <ul style="list-style-type: none"> ▪ The patient acuity data and tool (TrendCare) is well embedded and utilised throughout the hospital. <ul style="list-style-type: none"> - IRR testing will be undertaken yearly to ensure compliance and data accuracy. ▪ TrendCare champions continue to operate <ul style="list-style-type: none"> - DHB will hold Trendcare upskilling sessions and monitor data validity. - Staff levels monitored by utilisation of TrendCare daily reports. <p>Core data set</p> <ul style="list-style-type: none"> ▪ Core data set measures are in place moving towards an embedded local data council within wards/units. <ul style="list-style-type: none"> - Review 'Power BI' Data ensuring it is transparent and accessible at ward meetings with minutes reflecting evidence of actions. ▪ Data is visible throughout data on screens and is used to inform IoC decision making alongside other data sets. <ul style="list-style-type: none"> - Install an appropriate large screen into ED <p>Automation of CCDM core data sets:</p> <ul style="list-style-type: none"> ▪ Identify ways in which CCDM measures are automated for 'live' and easily accessibility <ul style="list-style-type: none"> - Local data councils to be developed and in two wards / units <p>Variance response management Reporting methodology has improved with the use of live data. Formal weekly and monthly reporting is in place and under constant review. Staff are deployed daily to support patients' needs and this is controlled through the operations meeting and duty manager leadership.</p> <ul style="list-style-type: none"> - Develop ways of supporting a variance response capability pm/nights/weekends to work alongside Duty Manager. 	<p>Q1,Q2,Q3,Q4</p> <p>Q1</p> <p>Q2, Q4</p> <p>Q1, Q2, Q3, Q4</p> <p>Q2, Q4</p> <p>Q2</p>

FTE calculations

Continue CCDM FTE Methodology.

- 6 FTE calculations have been completed
 - Maternity requiring an FTE increase. 2.03 FTE (actual) required in maternity and to be recruited to, recruitment of midwives remains a challenge however process is underway.

Q4

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

The WDHB's Pacific population remains at around 3% of the total population with 55% currently living within our rural communities. The development of a WDHB Pacific Health Action Plan will outline priorities which align with our own strategy He Hāpori Ora, Thriving Communities where we work together for the wellbeing of the whole community.

Action(s)	Milestone(s)
<ul style="list-style-type: none">▪ Develop in partnership with Pacifica communities a WDHB Pacific Health Action Plan that is culturally responsive▪ Implement the plan	Q1 Q4

Health outcomes for disabled people

Ensure disability represented in all strategy and workforce planning within the DHB

Action(s)	Milestone(s)
Establish an Executive Lead for disability	Q1
Establish working group led by the Executive Lead for disability. Ensure Māori representation in working group proportionate to the population and includes representation from consumers. <ul style="list-style-type: none">Group established	Q1
Develop a disability action plan for the DHB <ul style="list-style-type: none">action plan is complete and written in accordance with Te Tiriti o Waitangi principles	Q4

Planned care

Whanganui DHB will continue with our Three Year Planned Care Plan, supporting the overall vision of planned care "New Zealanders receive equitable and timely access to Planned Care Services in the most appropriate setting, which supports improved health outcomes"

Action(s)	Milestone(s)
<p>Planned Care Three Year Plan action</p> <p>Strategic Priority #1 Improve understanding of local health needs:</p> <ul style="list-style-type: none"> ▪ Use the results of the post-COVID-19 consumer engagement surveys to highlight community preference ▪ Engage meaningfully with our community and iwi to understand what and where services will meet their needs and aspirations of health care ▪ Gap analysis of where we need to implement service and model of care change. ▪ Service model design in a co-design environment with stakeholders including community care partners, service users and iwi 	<p>Q3</p> <p>Q3</p> <p>Q4</p>
<p>Strategic Priority #2: Balancing national consistency and local context</p> <ul style="list-style-type: none"> ▪ Development of service delivery options and models of care in a co-design environment ▪ Maintain delivery rates that are consistent with national standard intervention ratios ▪ Assessing models of care and how these are delivered in context of our local community ▪ Define options for requisite adjustments, ensuring a focus on the equity impacts of changing delivery ▪ Understanding and documentation of: <ul style="list-style-type: none"> - where our services vary from nationally delivered, - impacts on equity and access - service change designed <p>CONTRIBUTORY MEASURE – STANDARD INTERVENTION RATES FOR SURGICAL SERVICES</p>	<p>Q4</p>
<p>Strategic Priority #3: Support consumers to navigate their health journeys</p> <p>Planned clinics around telehealth options for patients, including access in rural localities etc:</p> <ul style="list-style-type: none"> ▪ Increase in remote consultation through video conferencing rather than patients, whānau or staff having to travel. ▪ Engagement and process taking into account cultural values and practices including options for whānau hui ▪ Introduction of wider suite of telehealth options for patients and clinicians included telephone, secure video conferencing and supported remote clinics. <p>CONTRIBUTORY MEASURE – SECONDARY CARE SERVICES - PATIENT EXPERIENCE OF CARE</p>	<p>Q2</p> <p>Q2</p> <p>Q2</p>

<p>Strategic priority #4: Optimising sector capacity and capability</p> <ul style="list-style-type: none"> ▪ 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. ▪ Work with secondary services, general practice and community providers to shift volumes <ul style="list-style-type: none"> - Assessment of what services can be moved to community provision, and understanding of patient preferences - Shift of delivery including contracting with providers 	<p>Q4 Q4</p>
<p>Strategic Priority #5: Ensure the Planned Care system and supports are sustainable and designed to be fit for the future</p> <p>Understanding of where early intervention will make a difference to outcomes for patients</p> <ul style="list-style-type: none"> ▪ Develop pathways that reduce reliance on secondary services. ▪ Engage with stakeholders including SMO's, primary care and community services. ▪ Develop and assess potential pathways and service delivery plans including changed location and mode of delivery ▪ Moving service delivery including service development and funding options 	<p>Q4 Q4 Q4 Q4</p>

Acute demand

Whanganui DHB is committed to strengthening pro-equity through partnering with Māori and other partners in care to develop systems for ongoing service improvement to manage acute patient flow across primary & community, and emergency care in secondary services, reducing demand for acute services. This will be achieved and enhanced by implementing the findings from the Integrated Response Team Report - Community Engagement findings.

Action(s)	Milestone(s)
<p>Acute Data Capture: SNOMED data will advise WDHB on improving health pathways for long term conditions e.g. diabetes, respiratory conditions that could be managed in the community with a focus on equity.</p> <ul style="list-style-type: none"> WDHB continue to develop plans with MidCentral Health and Wairapa DHBs and will introduce SNOMED standards with careful planning and change management 	Q1-Q4
<p>Acute Hospital Bed Days per Capita 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.</p> <ul style="list-style-type: none"> Develop and implement childhood asthma pathway Embed Best Start Tool across general practice 	Q3 Q4
<p>WDHB will continue to streamline patient flow between emergency department presentations, and lower acuity urgent care. The focus will be on implementing the Hospital Patient Flow Plan. Working closely with partners in care across the system.</p> <ul style="list-style-type: none"> Streamline triage processes in ED Continue to develop streamlined processes and protocols for early identification of patients that are likely to be an acute admission with direct referral from GP and fast tracking them to a ward and specialist team Explore the potential to expand the interprofessional disciplinary resource in ED WDHB to work in collaboration with Primary care partners to develop appropriate and timely diagnostic access pathways Redirect appropriate patients from ED to Whanganui Accident & Medical 	Q2 Q2 Q2 Q4 Q4
<p>WDHB to work in partnership with Primary care to Implement COPD/Asthma health pathways and associated programmes of care. Embedding changes to COPD management through revision of cross systems approach;</p> <ul style="list-style-type: none"> Health pathway development completed; Implementation of health pathway and associated programme of care including socialisation and linking of Kaiawhina and Clinical Nurse Specialist role, and ambulance services 	Q3 Q4
<p>COVID-19 Response - Improvement to acute flow in respond to COVID-19 recovery</p> <ul style="list-style-type: none"> Post community engagement develop pathways to support community response for vulnerable and deteriorating patients in the community in partnership with iwi, Primary care and NGOs. 	Q1
<ul style="list-style-type: none"> Continue to enable clinicians to deliver care using virtual consultations 	Q3
<ul style="list-style-type: none"> Explore the feasibility of expanding a Clinical pharmacist's role to focus on outreach for intermediate care patients in rest homes. 	Q3
<p>Explore funding models to enable a more preventative model of care in primary care at first point of contact. e.g. MSK to reduce unnecessary diagnostic imaging/specialist referrals.</p> <ul style="list-style-type: none"> Through prioritising and developing MSK pathways using a co-design methodology 	Q1

<ul style="list-style-type: none"> ▪ Development of a frailty pathway, led by general practice, using a co-design approach with Māori, Pacifica and secondary services to recognise and respond to frailty. ▪ Primary care partners to take a lead in promoting frailty screening at all touch points with health and social care providers to identify patients most likely to present as an acute admission and provide proactive advice and information to prevent admission. 	Q3
<ul style="list-style-type: none"> ▪ Support the PHO to create a new community wellbeing hub to ease the burden of a diminishing GP workforce and divert volumes of inappropriate urgent care away from accident and medical service <ul style="list-style-type: none"> - Support primary health care providers to establish connector roles to guide and enable patients in managing their own health and social needs and reduce the likelihood of acute presentations e.g. MSD Community connector roles 	Q2-Q4
<p>Strengthen urgent care services across the district focusing on access and equity in-hours and after hours</p> <ul style="list-style-type: none"> ▪ Work with PHOs and general practices to embed a redesigned model for urgent care 	Q4
<p>Continue to develop community transitional models of care, using service redesign with partners in care, social services, and NGO's i.e "wrap" around patients discharging who require greater support at home and short-term reablement services</p>	Q4
<p>Continuing to embed gout programme (refer to System Level Measures Plan, Appendix 1, Page 116)</p> <ul style="list-style-type: none"> ▪ Refer Primary Care - Page 81 ▪ Refer Pharmacy - Page 82 	Q1-Q4
<p>Mental Health presentation to ED: Improve access to mental health services and wait times for patients requiring mental health and addiction services who present to ED or who access community based providers:</p> <ul style="list-style-type: none"> ▪ Appoint a 0.4 FTE Educator role in Emergency Department <ul style="list-style-type: none"> - Continue to provide support and education to the staff in the Emergency Department (ED), engaging with Māori and Pacific health leaders in the development - Delivery and evaluation of the education programmes 	Q2
<ul style="list-style-type: none"> ▪ Explore opportunities for non-clinical staff to undertake the Mental health foundation MH 101 training 	Q2
<ul style="list-style-type: none"> ▪ Identify and develop resources to support training and education for staff and tangata whaiora who present to ED 	Q2
<ul style="list-style-type: none"> ▪ Improve access to Community Mental Health Crisis Team through supporting and monitoring telephone crisis service 	Q2
<ul style="list-style-type: none"> ▪ Improve access to services through ethnicity and cultural competence training and inclusion of Māori models of health and wellbeing in service planning and delivery 	Q4, EOA
<ul style="list-style-type: none"> ▪ Explore establishing a pilot which will have a Mental Health Clinician located with the local Police to improve responsiveness to patients in crisis 	Q3

Rural health

Approximately 40% of WDHBS population live in rural settings across a relatively large geographical area across the rohe. WDHBS 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, in partnership with our communities.

Action(s)	Milestone(s)
<p>Waimarino</p> <ul style="list-style-type: none"> ▪ Continue to support community led and engagement with iwi, staff and community providers for the redesign of the Waimarino Health Centre, (Wellness Centre), building on work undertaken to date that supported greater integration and enhanced models of care to improve access to health and support services for the Waimarino community <ul style="list-style-type: none"> - Progress service redesign and models of care as part of finalising the Wellness Centre facility design, including telehealth facilities 	<p>Q2, EOA</p>
<p>Telehealth for Rural Communities</p> <ul style="list-style-type: none"> ▪ Continue to improve access to telehealth service through increased use of telehealth for rural communities based on Clinical and Patient Telehealth experience survey findings. ▪ Identify and address any barriers for patients/family/whānau to accessing telehealth ▪ Measure and monitor the access rates to telehealth services, and associated improvement in appointment attendance and health outcomes for rural communities 	<p>Q3 Q2 Q3</p>
<p>Community/Specialist nursing</p> <ul style="list-style-type: none"> ▪ Implement recommendations from review of specialist nursing teams working with primary care ▪ Explore development of community-based rehabilitation programmes that will be self-sufficient to support those with LTC focussed on Māori and Pacifica. ▪ Support the use of Telehealth for GPs and Nurse Practitioners to complete case reviews via virtual consultations. 	<p>Q1 Q3 Q4</p>

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

WDHB's goal is a whole of system approach for our population from prevention and wellness through actively promoting the LifeCurve approach to improve the populations aging journey by adding 'years of able life'

Action(s)	Milestone(s)
Strengthen the Healthy Aging Service Level Alliance <ul style="list-style-type: none"> - integrate with the district's Councils' Positive Aging Forums, - engage with Māori and Pasifika communities and intentionally include younger people, aged from 30s onwards 	Q1 Q2
Develop a messaging campaign based on the LifeCurve for the promotion of prevention and wellness	Q3
Implement the recommendations of the WDHB Falls Service Evaluation by: <ul style="list-style-type: none"> - focus on prevention of injury from falls 	Q2
Community services that serve older people are fully prepared for a pandemic outbreak: Expand telehealth roll out to include Aged Residential Care providers <ul style="list-style-type: none"> - Identify and engage with local aged residential care providers who are early adopters of telehealth and use of the WDHB telehealth solution with these providers first. Develop and implement a coordinated district wide Advance Care Planning/Serious Illness Action Plan based on the DHB's strategy <ul style="list-style-type: none"> - Includes consistent messaging and communication plan for vulnerable people by using ACP communication tools especially during COVID-19 pandemic - Implement the COVID-19 Contact Assessment as appropriate for the district's vulnerable populations - Fully implement the Mini-ACE as the cognitive impairment screening tool - Engage with key kaupapa Māori providers to be early adopters of the cognitive assessment tool MANA for Māori - Support people with dementia who have behaviour and psychological symptoms of dementia, their whānau and services have access to behaviour consultation at the right time 	Q4 Q2 Q1 Q4 Q3 Q2
Acute and Restorative Care The DHB will have an integrated system across primary, community and specialist services care for older people and their whānau with a restorative/rehabilitation partnership approach beginning at discharge and including Māori and kaupapa providers <ul style="list-style-type: none"> - Implementing the new home and community support services, ensuring meeting the needs of Māori - Implementing Non-Acute Rehabilitation Pathways - Adapt to change based on the learnings from the WDHB pilot of an Integrated Discharge Navigator role with a focus on equity 	Q4 Q4 Q4

Implementation of the New Zealand Framework for Dementia Care

- Progress the implementation of the New Zealand Framework for Dementia Care by continuing to implement findings from regional stocktake of dementia services by:
 - Support regional pre-frailty programme for older people through raising awareness of raising physical activity as a modifiable risk factor for dementia
 - Support the regional promotion and education of the Māori assessment of Neurological Ability (MANA) tool
 - Support the regional revising and updating of Health Pathways for cognitive impairment
 - Participate in the regional dementia reference group focus on equity for Māori.

Q4

Q4

Q3

Q4

Health quality & safety (quality improvement)

WDHB are working with partners in care to develop system level measures to improve the quality and safety of the services we deliver. Preventing antimicrobial resistance remains a focus and this is driven by a multi-disciplinary infection prevention committee. Our work is informed and shaped by the values and belief systems of our community.

Action(s)	Milestone(s)
<p>HQSC QSMs are monitored and results are available on the national dashboard, first upload 31 March 2021:</p> <ul style="list-style-type: none"> ▪ monitor ethnicity variations and develop plans to improve equity where inequities are identified ▪ action plans are developed where results are below the national average 	<p>(EOA) Q1, Q3 Q1, Q3</p>
<p>Use data gained from the national inpatient survey to drive quality improvement activities.</p> <ul style="list-style-type: none"> ▪ action plans are developed where results are below the national average 	<p>(EOA) Q2</p>
<p>Monitor and measure the consumer engagement quality and safety marker (QSM):</p> <ul style="list-style-type: none"> ▪ progress the actions of the WDHB consumer engagement review 2020 ▪ continue to engage with consumers and apply co-design principles in all service improvement activities. 	<p>Q1, Q3 Q1 – Q4</p>
<p>Reducing seclusion</p> <ul style="list-style-type: none"> ▪ Staff continue to work in a trauma informed way ▪ Improve use of sensory modulation, as evidenced through increased episodes ▪ Use of Māori sensory modulation kits <ul style="list-style-type: none"> - Evaluate the effectiveness of this intervention. ▪ Continue to monitor the national KPI for seclusion hours and events 	<p>Q3 Q2 Q2 Q4</p>
<p>Service transition</p> <ul style="list-style-type: none"> ▪ Monitor the implementation of the connecting care project <ul style="list-style-type: none"> - Effectiveness of the transition role from Community Mental Health & Addiction Services to General Practice ▪ Integrated Discharge Navigator <ul style="list-style-type: none"> - Monitor effectiveness of the collaboration with key stakeholders to influence and remove barriers to discharge 	<p>Q2, Q4 Q4</p>
<p>Adverse events</p> <ul style="list-style-type: none"> ▪ Continue to undertake CSA/RCA/Case/London Protocol review for all SAC1/2 adverse events ▪ Enact learnings and recommendations from adverse events to improve practice 	<p>Q2, Q4 Q3</p>

Te Aho o Te Kahu – Cancer Control Agency

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

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

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

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

Whanganui DHB will continue to work with Te Aho o te Kahu and the regional hub on the implementation of the New Zealand Cancer Action Plan. This will be in conjunction with MidCentral DHB as our regional cancer treatment service and Capital and Coast DHB as our tertiary partner.

Action(s)	Milestone(s)
New Zealanders have a system that delivers consistent and modern cancer care – He pūnaha atawahi	
Whanganui DHB will work with Te Aho o Te Kahu to plan and implement the adoption of the cancer-related Health Information Standards Organisation (HISO) standards, to be issued via Data and Digital, Ministry of Health <ul style="list-style-type: none"> ▪ Our DHB will demonstrate evidence of implementation and compliance of the HISO standards as they are rolled out starting with the published Cancer Multi Disciplinary Meeting data standard, by ensuring all required patient data is presented to the MDMs as appropriate and any variances are identified and issues corrected. 	Q2
New Zealanders experience equitable cancer outcomes – He taurite ngā huanga	
Whanganui DHB will participate in Te Aho o Te Kahu travel and accommodation project that aims to improve cancer patient equity of access and support to cancer services/treatment for local and for inter-district patient flow. Our DHB is committed to implementing the recommendations of this project, particularly those that ensure equity of access for Māori and rural communities who currently experience inequitable access to cancer services.	As required
Whanganui DHB will identify at least two actions specifically to address inequity of health outcomes and access to diagnosis and care for Māori and Pacific patients. <ul style="list-style-type: none"> ▪ Consider Te Aho o Te Kahu report and recommendations based on feedback from 15 Māori community hui and agree an action plan. The findings from these hui will also be used to develop the future model for cancer services in Whanganui, with a focus on developing services that are culturally safe for Māori. 	Q2

<ul style="list-style-type: none"> ▪ Whanganui DHB will facilitate locally driven community-based initiatives with cancer patients and their whānau to drive service improvements. This includes the continuation of our “deep dive” case studies where clinical case review is linked with patient experience interviews to give a 360 degree view of the patient journey. This will inform our ongoing service design. This is led by our Māori health team and sponsored by our Faster Cancer Treatment steering group. 	Q1 – Q4
New Zealanders have fewer cancers – He iti iho te mate pukupuku	
<p>Whanganui DHB will undertake activities that address the modifiable risk factor for cancer as referenced in the following sections</p> <ul style="list-style-type: none"> - Tobacco Control - Reducing Alcohol Related Harm - Healthy Food & Drink 	
<p>Whanganui DHB will also support an increase in activities and programmes aimed at improving Māori and Pacific participation in National Screening Programmes as referenced in the following sections</p> <ul style="list-style-type: none"> - Breast Screening - Cervical Screening - Bowel Screening 	
New Zealanders have better cancer survival, supportive care and end-of-life care- He hiki ake i te o ranga	
<p>Whanganui DHB will continue to implement and report progress against our Bowel Cancer Service Improvement Plan (Bowel Cancer Quality Improvement Plan, 2020; Bowel Cancer Quality Improvement Report, March 2019).</p> <ul style="list-style-type: none"> ▪ Whanganui DHB will build the five recommendations from the Bowel Cancer Service Improvement Plan into our work plan for the 2021-2022 year including: <ul style="list-style-type: none"> - Review of patient cases where death occurred within 90 days of colorectal surgery, with the aim of identifying contributing factors and patterns in the patient journey; - Development of enhanced pre-surgery assessment and education plans for those patients identified in the at risk group; - Ensuring the specific needs of Māori and Pacific people and their whānau are included in our wider DNA programme aimed at increasing attendance and improved patient journeys through engagement and education. - Revise and update our DHB Bowel Cancer Quality Service Improvement Plan following publication of the second national bowel cancer QPI’s results in quarter 3 2020-21. 	<p>Q1 – Q4</p> <p>Q1</p>
<p>Develop a DHB Lung Cancer Service Improvement Plan based on the results of the Lung Cancer Quality Improvement Monitoring Report (QPIs 2020) and the impending national Lung Cancer Quality Improvement Plan (2021).</p> <ul style="list-style-type: none"> ▪ Lung cancer has been identified as a significant equity issue for Whanganui with incidence rates for Māori being significantly higher than non-Māori and health outcomes for Māori being significantly poorer (due to a combination of factors including late presentation and access barriers to out of region diagnostic and interventional services. As a result of this the Lung Cancer Service Quality Improvement Plan will incorporate a strong equity focus, identifying how service access and delivery can be improved for Māori specifically. ▪ Whanganui DHB will select the QPIs where our DHB is outside the national average (underperforming) to drive improvements. This includes low uptake of systemic therapies for both small cell and non-small cell cancers where we are below regional and 	Q1 – Q4

<p>national rates. WDHB is developing a local chemotherapy facility in conjunction with the Regional Cancer Treatment Service that will improve accessibility of systemic therapy to Whanganui domiciled patients.</p>	
<p>Develop a DHB Prostate Cancer Service Improvement Plan based on the results of the impending Prostate Cancer Quality Improvement Monitoring Report (QPIs 2021) and the impending national Prostate Cancer Quality Improvement Plan (2021).</p> <ul style="list-style-type: none"> ▪ Whanganui DHB will select the QPIs where our DHB is outside the national average (underperforming) to drive improvements. Prostate cancer rates are higher for Māori than non-Māori and health outcomes for Māori are typically poorer. As a result of this the Prostate Cancer Service Quality Improvement Plan will incorporate a strong equity focus, identifying how service access and delivery can be improved for Māori specifically. 	Q1 – Q4
<p>Whanganui DHB will ensure that the 31-day and 62-day cancer treatment wait time measures are met. Our DHB will implement service improvements to improve timely access and demonstrate effective engagement with Māori, Pacific, our consumer network (Te Pukaea) and other key stakeholders that support local improvement initiatives. This work will be facilitated by our Faster Cancer Treatment Steering Group.</p> <ul style="list-style-type: none"> ▪ We will work in partnership with Te Aho o Te Kahu and Ministry of Health to improve the FCT data quality and business rule changes as required 	Q1 – Q4
<p>Whanganui DHB will plan to implement the cancer COVID-19 guidance developed by Te Aho o Te Kahu should there be a COVID-19 resurgence to ensure minimal impact on cancer diagnostics and treatment services for patients/whānau</p>	As required

Bowel screening and colonoscopy wait times	
Action(s)	Milestone(s)
Continue to monitor and report on performance against urgent, non-urgent and surveillance colonoscopy waiting times	Q1-Q4
Include 'recommended and maximum wait time performance' as a standard agenda item at monthly endoscopy user group meetings. <ul style="list-style-type: none"> - Identify and implement mitigations strategies 	Monthly
Develop a Bowel Screening COVID-19 policy that includes a communication plan to inform internal and external stakeholders of changes to bowel screening during a COVID-19 outbreak <ul style="list-style-type: none"> - Develop and distribute messaging to community 	Q1-Q2
<ul style="list-style-type: none"> ▪ 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 ▪ Ensure no equity gap for Māori and Pacific populations 	Q1-Q4 (EOA)
<ul style="list-style-type: none"> ▪ Ensure at least 60% of eligible bowel screening population participate in the programme, ▪ Ensure no equity gap for Māori and Pacific populations 	Q1-Q4 (EOA)
<ul style="list-style-type: none"> ▪ Review 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. <ul style="list-style-type: none"> - Identify and implement mitigation or service improvement actions 	Q1-Q4 (EOA)
<ul style="list-style-type: none"> ▪ 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. 	Q1-Q4 (EOA)

Health workforce

Whanganui District Health Board is committed to operating within its means and providing sustainable health services that meet the needs of our community. The WDHB is committed to strengthening our workforce and ensuring a sufficient and sustainable supply of skilled workers to deliver high-quality health services in a timely manner, driving equity and system improvement. As an equal employment opportunity (EEO) employer the WDHB is committed to further increase and develop an inclusive workforce.

The WDHB works in partnership with primary care, Māori health organisations, community health organisation and unions to support achieving equity in health outcomes for Māori and across communities.

Embracing diversity and expanding our pro-equity actions creates the foundation of our workforce plan. Recruitment, retention, development and supporting the Māori workforce are the key elements of the workforce plan. This is supported by workforce planning to:

- Anticipate and predict future workforce requirements to meet changing strategic direction.
- Respond to emerging models of service delivery as part of the ongoing strategic planning of the organisation.
- Highlight and respond to potential workforce risks to the organisation.
- Plan workforce changes required.

Applying an equity lens to all workforce actions, including an explicit focus on addressing bias, racism and discrimination, in all its forms, across all aspects of the WDHB operations underpins our actions.

Our focus on cultural safety, the health and wellness of our staff, growing leadership and embedding the values of our organisation in our work remains a priority in 2021-22.

New ways of working, providing support for vulnerable people and workers and improving our preparedness for a pandemic outbreak (and COVID-19 resurgence) are front of mind in working towards protecting our communities and services.

Action(s)	Milestone(s)
COVID-19 Workforce Flexibility <ul style="list-style-type: none"> ▪ Hold debrief session with staff involved in COVID-19 response to implement COVID learnings (i.e. staff redeployment, repurpose and mobilisation) ▪ Telehealth solution developed and monitoring undertaken of changes in service delivery, and reduction in DNAs ▪ Review communications team structure to shift from primarily written content to digital, audio and visual content 	Q2 Q3 Q2
COVID-19 Sustainability, vaccination workforce <ul style="list-style-type: none"> ▪ Program run to train retired / non-clinical staff to vaccinate ▪ Program run with MSD to appoint admin support staff (targeting Maori) returning to workforce in vaccination centres ▪ Clinics using collaborative workforces are run, in community settings, rural areas and up the Awa to ensure that communities who are isolated and/or high decile can access COVID vaccination. 	Q1 Q1 Q4
Increased diversity in leadership or decision-making roles <ul style="list-style-type: none"> ▪ Identify and utilise specific development opportunities for Maori in leadership or decision-making roles. ▪ Cultural support component added to Leaders/managers yearly performance reviews that assess how they have supported Māori into the workforce and into leadership/management roles 	Q2 Q4

<ul style="list-style-type: none"> Support framework developed for Māori nurse leaders to attend Ngā Manukura o Āpōpō 	Q2
<p>Professional Standards of cultural competency and safety</p> <ul style="list-style-type: none"> Clinical staff annual performance appraisals include cultural and Treaty of Waitangi competencies Ucol tutor engaged to support students/graduates regarding clinical and cultural safety, Whānau centred care and values in wards. Cultural Supervision available for all Māori staff Development of an organisational wellbeing framework to ensure improved health and wellbeing for Māori staff 	Q2 Q2 Q1 Q4
<p>Ensure the health and safety of workforce</p> <ul style="list-style-type: none"> Health and safety strategy developed and authorised by ELT Retain Tertiary Level Accredited Employers Programme Audit All areas of the DHB have dedicated Health and Safety representative. Health and Safety Management report to DHB Board and Clinical Governance quarterly 	Q4 Q1 Q2 Q4
<p>Sustainable workforce – health and safety wellbeing, including mental wellbeing</p> <ul style="list-style-type: none"> Evaluation report produced from trial of an occupational health Clinical Nurse Specialist role for 9 months to support health and safety and return to work. 	Q4
<p>Engagement with unions when considering or developing new initiative to increase workforce flexibility and mobility to respond to COVID-19</p> <ul style="list-style-type: none"> Introduction of a combined union forum for WDHB leadership and union organisers to collaborate on workforce initiatives, future models of care, staff engagement, productivity and deployment, and local implementation of national workforce initiatives. 	Q2
<p>Whakamaua Māori Health Action Plan 2020-2025</p> <ul style="list-style-type: none"> 2.5% increase in Māori workforce across the district WDHB staff turnover rate for Māori staff is less than turnover for all staff Increase the proportion of Māori in the WDHB workforce to 13.5% in 2021/22. 100% of Māori applicants who meet the minimum eligibility criteria for any role are shortlisted for interview 	Q4 Q1 Q4 Q2
<p>Planning - Whakamaua</p> <ul style="list-style-type: none"> Develop a forecasting model to guide target determination and monitoring to grow a Māori workforce across the health district Workforce planning guide developed with specific outcomes that support retention strategies for Māori staff Scope Māori workforce capacity and capability WDHB and contractor provider services 	Q4 Q4 Q4
<p>Rangatahi Career Development - Whakamaua</p> <ul style="list-style-type: none"> All Kia Ora Hauora graduates that wish to work in the WDHB are employed 	Q2

<ul style="list-style-type: none"> ▪ WDHB recruitment and retention is aligned with Kia Ora Hauora, YES kaupapa, Rangatahi focused pathways – Ara ki te mahi Hauora ▪ 100% of Māori engaged in study to mahi initiatives with Youth Employment Success programme and Kia Ora Hauora are offered career progression support by Te Hau Ranga Ora 	<p>Q2</p> <p>Q3</p>
<p>Growing Māori Workforce - Whakamaua</p> <ul style="list-style-type: none"> ▪ Tools and support available to assist Māori students in application and interview processes ▪ Education committee leads workforce development plan to support students from kura kaupapa and kura auraki entering health careers ▪ Kinesthetic/small group learning is promoted as a different method of delivering science programmes in local schools ▪ Implementation of identified actions to talent identify, attract, develop and grow the Māori workforce across the WDHB district ▪ Explore opportunities to support Māori staff beyond nursing and utilise the model and learnings from Te Uru Pounamu ▪ Human Resources policies, procedures and practice supports pro-equity and targeted recruitment ▪ Managers receive training in best practice recruitment ▪ Managers trained to identify and challenge their own biases, challenge others' behaviour and lead change for increased equity in practice. 	<p>Q2</p> <p>Q3</p> <p>Q3</p> <p>Q4</p> <p>Q4</p> <p>Q3</p> <p>Q4</p> <p>Q4</p>
<p>Extending local Māori nursing development model – Te Uru Pounamu - Whakamaua</p> <ul style="list-style-type: none"> ▪ Cultural Supervision available for Māori staff ▪ Introduce a new model of support for Māori Nursing staff that encompasses all levels of nursing practice. ▪ NETP/NESP continue to use an accelerated approach to employment of Māori nursing staff ▪ Nursing recruitment has an accelerated process for Māori applying for Nursing/Health Care Assistant positions ▪ Review support provided to students/graduates regarding cultural safety, whānau centred care and values ▪ Clinical staff demonstrate cultural safety competencies in their annual performance appraisal and competency review ▪ Develop Whānau Ora nursing models of care which are tailored to individuals and their whānau including community settings 	<p>Q1</p> <p>Q3</p> <p>Q2</p> <p>Q3</p> <p>Q2</p> <p>Q4</p> <p>Q3</p>
<p>Demonstrating cultural leadership - Whakamaua</p> <ul style="list-style-type: none"> ▪ Use and embed Mātauranga Māori, Tikanga Māori and Māori Models of health ▪ Expand existing programmes that build on organisation culture and values to include action on racism and institutional bias, support Whakamaua Action Shifting Cultural Norms and enable employees to reflect on how their own views and biases impact on their clinical interactions and the care they provide to patients ▪ KPI's for clinical leaders are evident in WDHB Patient and whānau Centred Care Quality Framework. ▪ Seventy percent of current professionals meet standards of cultural competence and safety ▪ Increased capacity for clinical staff to relate to those with whom they work supporting client/whānau empowerment and ownership of care – measured by client/whānau feedback and reduction in numbers of complaints 	<p>Q2</p> <p>Q1</p> <p>Q3</p> <p>Q4</p> <p>Q3</p>
<p>Leadership development – Whakamaua</p> <ul style="list-style-type: none"> ▪ Clinical leaders have career development plan which includes leadership development by creating a professional development (and career progression) framework ▪ Development of a manager toolkit to increase management skill 	<p>Q3</p>

<ul style="list-style-type: none"> ▪ Leaders/managers have yearly performance reviews that assess how they have supported Māori into the workforce and into leadership/management roles ▪ Managers and leaders actively use pro-equity tools/data to ensure the care we are providing is whānau centred and supports a community centred approach to care delivery – sustainability ▪ Leadership development aligned with the National Ministry of Health leadership development programme ▪ Leadership development actions prioritising and targeting Māori staff 	<p>Q4 Q4</p> <p>Q2</p> <p>Q3 Q3</p>
<p>Education & Professional Development</p> <ul style="list-style-type: none"> ▪ WDHB education committee established ▪ Committee leads workforce development plan, education and professional development pathways. ▪ Continue to work alongside central region to standardise programmes, education and training opportunities ▪ Partner with regional DHBs and learning institutions to deliver training ▪ Workforce development plan incorporates priority areas in the He Hāpori Ora Thriving Communities Strategy and MoH Raranga Tupuake – Māori Workforce Development Plan 	<p>Q1 Q2 Q4 Q3 Q3</p>

Data and digital enablement

Whanganui DHB is committed to digital transformation to enable new ways of health service delivery in response to changing technology and clinical needs. Our digital goals align with the national and regional strategic direction for Data and Digital.

New initiatives will follow our strategy of 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 optimising a right sized workforce.

Action(s)	Milestone(s)
<p>Microsoft Office and Teams</p> <ul style="list-style-type: none"> ▪ Progress report quarterly to updated Microsoft Office and Teams rollout project <ul style="list-style-type: none"> - MS 365 E5 providing collaboration tools and access from anywhere on any device. Promotes working remotely. Provides advanced threat protection features. - Microsoft Telephony (Cloud) with Vodafone to replace the PBX system improving communication with chat and desk to desk video. - All staff working in Office 365 rather than on previous Office products - Decommission the old PBX with all staff using MS telephony ▪ Project rollout complete which will enable: <ul style="list-style-type: none"> - 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 - Follows national recommendations to move to cloud. - Has the potential to create the conditions for equity through facilitating the design and delivery of services that 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. 	<p>Q1, Q2, Q3</p> <p>Q4</p>
<p>Telehealth</p> <p>The activities outlined below have the potential to improve access to services by providing choice for remote consultation through video conferencing (Microsoft Teams) rather than patients, whānau or staff having to travel. Further it will improve digital inclusion for our communities and support the COVID-19 recovery by improving digital inclusion:</p>	

<ul style="list-style-type: none"> ▪ Report quarterly to update progress on roll out of the Telehealth system ▪ A Telehealth solution has been built with DXC integrating workflow in the regional webPAS system with Microsoft teams. <ul style="list-style-type: none"> - Work with clinicians to realise value from the solution - Increase uptake of telehealth improving access for rural communities and primary and secondary clinical collaboration 	<p>Q1, Q2, Q3</p> <p>Q2</p>
<p>Electronic referrals and triage</p> <p>Phase 1 will ensure completion, legibility and standardisation of referrals by supporting GP's to provide accurate and relevant referrals. Phase 2 will remove the manually intensive effort and reduce risks associated with the current processes and align with Regional and National transfer of care, and also supports collaboration with primary and community:</p> <ul style="list-style-type: none"> ▪ Implement electronic referrals and triage <ul style="list-style-type: none"> - Phase 1 - an electronic referral form is available to GPs from within their GP practice systems and to other providers via a portal. The referral is sent to the DHB who continue with their manual practice. - Phase 2 – automation of the triage and associated workflow at the DHB with integration into webPAS and Clinical Portal 	<p>Q2</p> <p>Q3</p>
<ul style="list-style-type: none"> ▪ Enable Health services to support COVID-19 <ul style="list-style-type: none"> - Move off webPAS as our booking/scheduling system for COVID 19 vaccinations onto the national booking/scheduling system once integrated to CIR - Identify and action digital initiatives that been delayed by COVID-19. 	<p>Q1</p> <p>Q1</p>
<ul style="list-style-type: none"> ▪ Develop strategies that will ensure that there is no delay in initiatives owing to COVID-19 	<p>Q4</p>
<p>Data enablement</p> <ul style="list-style-type: none"> ▪ The rollout of Microsoft 365 to the organisation has enabled whole of organisation access to PowerBI, Microsoft's flagship business intelligence tool. <ul style="list-style-type: none"> - Continue to develop and deploy PowerBI reporting to improve business intelligence. Include comprehensive Care Capacity Demand planning, analysis of activity across provider services, dashboards to inform executive management and reporting to the board. - Expand ability to dynamically calculate age standardised rates within PowerBI deliveries. This will enable the DHB to monitor equity at a level never possible before. - Increase volume of PowerBI reporting, examine impact on aging SQL Server Reporting Services delivery. Where possible, replace functionality of static SQL Reporting Services deliveries with rationalised, user-driven content. ▪ Key deliverables within the 2021/22 year (with target quarter for delivery): <ul style="list-style-type: none"> - Peer review of age standardisation process with external expert to gain endorsement of new approach - Delivery of additional reporting to WDHB via PowerBI: - Workforce including sick leave, turnover, education, workforce trending, etc. 	<p>Q1</p> <p>Q1</p> <p>Q1</p> <p>Q3</p> <p>Q1</p>

<ul style="list-style-type: none"> - Quality, Risk and Patient Safety - Radiology Services - Inpatient Waiting List - Outpatient Services including referrals, activity, etc. - DHB Financials - Expansion of CCDM delivery to include workforce and quality markers - Implementation of new age standardisation process across all applicable reporting to enable one-click equity comparisons and insights <ul style="list-style-type: none"> ▪ This lays the foundations for much improved collaboration with our primary care partners. Creation of a semantic layer across many of our complex DHB datasets will facilitate consumption of that data by a wider audience and more rapid delivery of intelligence. ▪ Integrated deliveries will allow an improved lens to be applied to support the acute demand programme across the whole system and provide decision support for required changes. <p>Key deliverables within the 2021/22 year (with target quarter for delivery) are:</p> <ul style="list-style-type: none"> - Establishment of data sharing foundations with the PHOs for integration work - Education of primary data analyst workforce within PHOs on DHB data sources - Scoping of deliverables to inform improved view of acute demand within WDHB - Development of outputs for analysis and decision support 	<p>Q3 Q2 Q3 Q3 Q1 Q1 Q3</p> <p>Q1 Q1 Q1 Q1, Q2</p>
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Implementing the New Zealand Health Research Strategy

WDHB will 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.

Action(s)	Milestone(s)
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.	Q4
WDHB's research policies and procedures will be used 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.	Q3
WDHB will follow 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 includes sign off of all research applications by a member of Te Hau Ranga Ora, Māori Māori health service. <ul style="list-style-type: none"> ▪ A WDHB research strategy is used, 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 is included within the research strategy. 	Q1
WDHB will provide an annual update on progress to the WDHB Clinical Board.	Q4
Work within local alliance structure to support establishment of community focused, kaupapa-oriented research collaborative.	From Q1

2.5.7 Better population health outcomes supported by primary health care

Primary care	
Community health pathways are prioritised and implemented based on equity, acute demand and national work programmes.	
Learnings from the GoutSTOP programme (to improve the quality of life of Māori living with Gout Arthritis) will inform changes in how we improve the quality of life of Māori living with COPD/Asthma.	
Action(s)	Milestone(s)
<p>Through implementation of an updated digital strategy in primary care, greater connectivity will occur with secondary care with the ability to work remotely and support virtual consultations.</p> <p>Implemented planned roll out new general practice and urgent care PMS (Evolution)</p> <ul style="list-style-type: none"> ▪ Implement links with DHB e-referrals <ul style="list-style-type: none"> - Migration of existing PMS systems - Education and training - Implementation - Iterative changes as issues arise 	<p>Q1 Q1-3 Q1-4 Q1-4</p>
<p>The GoutStop Programme was rolled out across the WDHB region in late 2020-21. Ongoing focus and support is required to ensure the programme is embedded across the region including:</p> <ul style="list-style-type: none"> ▪ Monitoring of general practice data to enable iterative changes to improve the number of Māori males receiving regular uric acid testing. ▪ Monitoring of TUKU data (patients enrolled in the programme by pharmacists and referrals to kaiawhina) to enable improvements of process/patient journey to support patients and to achieve target uric acid levels. <ul style="list-style-type: none"> - Monitor gout programme data - Implement district wide community education, communications plan and resources - Establish a gout consumer group to inform any changes to current programme and resources 	<p>Q1-4 Q3 Q1</p>
<p>Implement and embed COPD/Asthma health pathways and associated programmes of care building on learnings from GoutStop programme</p> <ul style="list-style-type: none"> - Health pathway development completed - Embedding changes to COPD management through revision of cross systems approach - Revise associated programme of care including; <ul style="list-style-type: none"> - Identify gaps in existing services - Co-design a revised program of care to support improved health literacy and self-management - Build and socialise cross functional teams working in partnership to support individual and whānau 	<p>Q2 Q3-4 Q3-4</p>

Reconfiguration of the National Air Ambulance Service Project – Phase Two

Cabinet have endorsed a two-phased 10-year reconfiguration of the national air ambulance service. Phase one is complete, preparation for phase two has begun. DHBs are expected to actively support and participate in the above project, led by the National Ambulance Sector Office (NASO).

Action(s)

WDHB is committed to actively participating with the National Ambulance Sector Office (NASO) in phase two of the reconfiguration project and will identify a nominated person to participate in project meetings and workshops. Participation will support NASO to develop a service that is optimised to improve clinical effectiveness and standards and achieve better patient outcomes for our population.

- DHB lead identified
- Ongoing engagement and participation in the project

Milestone(s)

Q1
Q1-Q4

Long term conditions	
Action(s)	Milestone(s)
<ul style="list-style-type: none"> ▪ Review the Green Prescription service model to ensure the programme is targeted to priority groups (pregnant women, Māori, Pacific with diabetes, rural communities) <ul style="list-style-type: none"> - Review complete 	Q3
<ul style="list-style-type: none"> ▪ Review Cardio rehab programme including relocation to a central location to target priority groups <ul style="list-style-type: none"> - Review complete - Implementation of programme 	Q2 Q4
<p>Strengthen identification, intervention and recall of people with high and moderate risk through early risk assessment and use of PHO/practice level data to inform quality improvement and more equitable access to services. Power BI data supports general practice teams to utilise data for quality improvement.</p> <ul style="list-style-type: none"> ▪ COVID-19 learning is utilisation of data to identify the most vulnerable population to inform roll out of vaccination programmes including for COVID-19 vaccination. <ul style="list-style-type: none"> - COVID-19 Vaccination programme underway ▪ Continue to embed and monitor the GoutStop programme is an example of use of data to improve the quality of life for person living with gout arthritis <ul style="list-style-type: none"> - Monitor gout programme data 	Q1 Q1-4
<p>Improving the management of people with long term conditions through actions such as those provided by multi-disciplinary teams (including allied health and kaiawhina) to support improved service delivery in primary care, with self-management, equitable access, identification and prioritisation of high-risk groups, support and education.</p> <p>The GoutStop Programme was rolled out across the WDHB region in late 2020-21. Ongoing focus and support is required to ensure the programme is embedded across the region including:</p> <ul style="list-style-type: none"> ▪ Monitoring of general practice data to enable iterative changes to improve the number of Māori males receiving regular uric acid testing. ▪ Monitoring of TUKU data (patients enrolled in the programme by pharmacists and referrals to kaiawhina) to enable improvements of process/patient journey to support patients and to achieve target uric acid levels. <ul style="list-style-type: none"> - Monitor gout programme data - Implement district wide community education, communications plan and resources - Establish a gout consumer group to inform any changes to current programme and resources 	Q1-4 Q3 Q1

<p>Supporting the delivery of the regional hepatitis C work and objectives and supporting implementation of key priorities in the National Hepatitis C Action Plan (once the plan is published).</p> <ul style="list-style-type: none"> - Localised Hepatitis C pathway to be developed - Pathway developed and implementation commenced 	<p>Q2 Q4</p>
<p>Continuation of vaccine programme for people over the age of 65 & vulnerable populations</p> <ul style="list-style-type: none"> - Ongoing vaccination programmes including COVID-19 	<p>Q1-4</p>
<p>Implement and embed COPD/Asthma health pathways and associated programmes of care building on learnings from GoutStop programme</p> <p>Contributory measures:</p> <ul style="list-style-type: none"> ▪ Ambulatory Sensitive Hospitalisation (ASH) rate per 100,000 population for 45-64 years, by ethnicity ▪ All general practice will meet or exceed national target of 75% for >65 years for influenza vaccine <ul style="list-style-type: none"> - Health pathway development completed - Embedding changes to COPD management through revision of cross systems approach - Revise associated programme of care including; <ul style="list-style-type: none"> - Identify gaps in existing services - Co-design a revised program of care to support improved health literacy and self-management - Build and socialise cross functional teams working in partnership to support individual and whānau 	<p>Q2 Q3, Q4 Q3, Q4</p>

2.6 Financial performance summary

Annual Plan 2021/22 - Financial performance summary

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

The Whanganui DHB is planning an operating deficit of \$4.9 million in 2021/22. This deficit includes anticipated budgeted expenditure increases outside of its direct control, such as movement in Holiday Act provision, CCDM costs, IDF price uplift, and pharmaceutical price increases. The financial plan for 2021/2022 to 2024/25 is set out below:

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

Statement of prospective Financial Performance for the four years to 30 June 2025

	Actual 2019/20 \$000	Forecast 2020/21 \$000	Plan 2021/22 \$000	Plan 2022/23 \$000	Plan 2023/24 \$000	Plan 2024/25 \$000
Provider (deficit)	(12,932)	(7,252)	(4,807)	(6,414)	(8,142)	(8,904)
Governance and Funding Administration surplus/ (deficit)	573	198	(141)	-	-	-
Provider / Governance and funding (deficit)	(12,359)	(7,054)	(4,948)	(6,414)	(8,142)	(8,904)
Funder Arm surplus / (deficit)	(3,045)	2,539	3	2,625	4,328	4,920
Base net (deficit)	(15,404)	(4,515)	(4,945)	(3,789)	(3,814)	(3,984)
Consolidated net (deficit) for year	(15,404)	(4,515)	(4,945)	(3,789)	(3,814)	(3,984)

Financial trend and deficit drivers

Financial results over the past few years have shown a worsening trend as the cost base has increased faster than revenue. However, with the increase in funding for the 2020/21 year's budget, the WDHB put a plan in place to significantly improve the deficit position to \$4.5 million and the 2021/22 deficit position of \$4.9 million has been maintained at a similar level. It is the aim of the WDHB to move towards a breakeven position. This aim may be difficult to budget for as costs continue to rise. The main drivers for maintaining this deficit position include:

- Revenue:
 - major revenue impact on 2021/22 budget from the 2020/21 forecast
 - Population Based Funding Increased \$11.8m.
 - Planned care additional funding \$682k
 - Capital changed for 30 Jun 2021 revaluation \$451k (offset by increase in capital charged)
 - No price uplift increase in ACC revenue.
 - Increased inter-district inflow \$638k mainly impact of national price uplift.
- Personnel costs – no increase for wages over \$100k.
- Clinical Supplies have increased by \$864k, mainly due to cost pressure increases of \$378k and demand driven increases of \$360k (mainly theatre and pharmaceutical drugs)
- Non-clinical supplies have increased by \$3.2m with the largest driver being a new facilities contract entered into, which includes hotel and maintenance services. Also anticipated is an increase in building insurance of \$100k.
- IT license cost increases related to Microsoft licensing and moving applications to the cloud \$475k.
- Operating costs related to IT systems (medical management \$100k, Telehealth, e-Referral and triage \$100k, and telecommunication networking \$110k.)
- Depreciation has increased by \$1m, mainly relating to the regional patient management system \$329k, clinical equipment \$316k (radiology equipment replacement programme) and building revaluation \$370k.
- Other health providers commissioning costs have increased by \$0.8m due mostly to price uplift between 2-3% for on national and local contracts.
- Health of older people has demand driven volume and cost increases of \$2.5m.
- Investment in pro-equity programme of \$1.0m.

There are a number of cost increases that the Whanganui DHB cannot avoid, that are largely beyond our control. These include:

- Care capacity management (CCDM) cost increases of \$1m (10 additional nursing FTE relating to increased leave requirements and additional maternity staffing).
- IDF – overall increased in IDF \$3.5m which equates to 8% increased cost pressure.
- Pharmaceutical costs have significantly increased due to global supply and demand issues and potentially could increase \$1.8m
- Holiday Act compliance cost increases of \$558K to the provision.
- Funding of additional bed capacity in aged residential care of \$400K.

Key assumptions

The following are the key assumptions applied in the development of the 2021/22 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 service coverage.

Assumption	
PBF funding	\$11.8 m
Planned Care funding	\$682k 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 <ul style="list-style-type: none"> • MECA agreements • IEA 	1.5% uplift on expiry No increase for staff earning over \$100K
Contracted providers (non-DHB) <ul style="list-style-type: none"> • National agreements • Local agreements • Investment in pro-equity Programme 	2% to 3% depending on cost drivers & related revenue growth 2% to 3% depending on related revenue growth \$1m
Inter-district flow (IDF) <ul style="list-style-type: none"> • Planned and unplanned 	3% to 10% based on national advice and calculations
Covid-19	Assumes that all Covid-19 costs will be reimbursed.

Sustainability

Whanganui DHB is working on a long-term financial and clinical sustainability programme to move towards break even. The forecast deficit for 2021/22 is \$4.9 million and we are planning on continuing to implement a number of initiatives started this year to work towards the aim of achieving close to break even. 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 focused, preventative model of healthcare that is more effective and efficient including improved management of health of older people
- Radiology efficiencies
- Theatre facilities capacity management
- Revenue growth budgeted for providing elective service to other DHBs.

These initiatives are estimated to achieve over \$5 million in savings or revenue in year 3.

Capital Expenditure

Capital Expenditure

\$000s	Actual 2019/20	Actual 2020/21	Plan 2021/22	Plan 2022/23	Plan 2023/24	Plan 2024/25	Plan 2025/26	Plan 2026/27	Plan 2027/28	Plan 2028/29	Plan 2029/30	Plan 2030/31
Buildings & Plant	702	2,414	5,550	5,942	4,141	3,411	1,097	880	1,780	1,180	1,380	1,380
Clinical Equipment	1,247	3,286	4,474	2,535	1,858	2,091	2,309	2,733	2,122	2,068	2,074	2,351
Other Equipment	46	201	210	410	400	400	400	400	400	400	400	400
Information Technology	239	1,197	1,015	550	560	663	370	505	885	653	655	655
Purchase of software	838	1,484	3,273	1,737	887	887	937	857	887	977	977	977
Motor Vehicles	38	101	240	200	200	200	200	200	200	200	200	200
Total Capital Expenditure	3,110	8,683	14,762	11,374	8,046	7,652	5,313	5,575	6,274	5,478	5,686	5,963

Capital expenditure includes Ministry of Health funded project for Waimarino facility upgrade \$2.1m (2021-22 \$0.4m, 2022-23 \$1.5m, 2023-24 \$0.2m), community health building \$500k (2021-22), and Infusion units \$800k (2021-22)

Statement of prospective comprehensive revenue and expense for the four years to 30 June 2025

	Actual 2019/20 000	Actual 2020/21 \$000	Plan 2021/22 \$000	Plan 2022/23 \$000	Plan 2023/24 \$000	Plan 2024/25 \$000
Revenue						
Revenue from non-exchange transactions	246,546	272,043	285,685	297,105	306,907	318,389
Revenue from exchange transactions	32,811	30,854	33,262	33,927	34,606	35,298
Other Revenue	322	303	346	346	346	346
Total Revenue	279,679	303,200	319,293	331,378	341,859	354,033
Expenses						
Wages, salaries and employee benefit costs	(97,994)	(99,658)	(102,809)	(106,469)	(110,460)	(114,586)
Outsourced services	(16,753)	(16,926)	(15,808)	(16,582)	(17,387)	(18,122)
Depreciation and amortisation expense	(5,566)	(6,324)	(7,349)	(7,778)	(8,492)	(8,828)
Capital charge	(3,507)	(2,935)	(3,126)	(3,114)	(3,192)	(3,048)
Finance costs	(19)	(16)	(115)	(115)	(115)	(115)
Other expenses	(171,339)	(181,941)	(195,116)	(201,196)	(206,116)	(213,409)
Total expenses	(295,178)	(307,800)	(324,323)	(335,254)	(345,762)	(358,108)
Share of Profit of Associate	95	85	85	87	89	91
Surplus / (deficit)	(15,404)	(4,515)	(4,945)	(3,789)	(3,814)	(3,984)
Other Comprehensive revenue and expense						
Gain on property revaluation	6,670	9,026	-	-	-	-
Total other comprehensive revenue and expense	6,670	9,026	-	-	-	-
Total comprehensive revenue and expense	(8,734)	4,511	(4,945)	(3,789)	(3,814)	(3,984)

Statement of prospective financial position as at year end for four years to 30 June 2025

	Actual 2019/20 000	Actual 2020/21 \$000	Plan 2021/22 \$000	Plan 2022/23 \$000	Plan 2023/24 \$000	Plan 2024/25 \$000
ASSETS						
<i>Current assets</i>						
Cash and cash equivalents	3,813	5	5	5	5	5
Receivables from non-exchange transactions	352	160	160	160	160	160
Receivables from exchange transactions	5,923	6,285	6,415	6,515	6,675	6,795
Prepayments	-	-	-	-	-	-
Investments	-	-	-	-	-	-
Inventories	1,617	1,617	1,617	1,617	1,617	1,617
Trust /special funds	190	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	11,899	8,261	8,390	8,490	8,650	8,770
<i>Non current assets</i>						
Property, plant and equipment	79,602	90,824	96,445	99,875	100,298	100,098
Intangible assets	11,741	11,630	13,422	13,588	12,719	11,743
Investments in associates	1,185	1,220	1,255	1,280	1,305	1,330
Other financial assets	-	-	-	-	-	-
Total non current assets	92,528	103,674	111,122	114,743	114,322	113,171
Total assets	104,427	111,935	119,512	123,233	122,972	121,941
LIABILITIES						
<i>Current Liabilities</i>						
Bank Overdraft	-	1,232	8,577	6,695	4,559	8,524
Payables under non-exchange transitions	2,296	2,235	3,426	4,140	4,224	4,311
Payables under exchange transitions	18,204	17,757	18,100	18,794	19,158	19,572
Borrowings	198	100	103	107	110	66
Employee entitlements	21,955	24,643	27,299	28,099	31,160	29,969
Provisions	-	-	-	-	-	-
Total current liabilities	42,653	45,967	57,505	57,835	59,211	62,442
<i>Non-current liabilities</i>						
Borrowings	486	385	282	175	65	-
Employee entitlements	839	784	729	674	619	564
Provisions	-	-	-	-	-	-
Total non current liabilities	1,325	1,169	1,011	849	684	564
Total liabilities	43,978	47,136	58,516	58,684	59,895	63,006
Net Assets	60,449	64,799	60,996	64,549	63,077	58,935
EQUITY						
<i>Equity</i>						
Contributed Capital	112,409	112,251	113,393	120,735	123,077	122,919
Accumulated surplus / (deficit)	(82,698)	(87,224)	(92,169)	(95,958)	(99,772)	(103,756)
Property revaluation reserves	30,551	39,577	39,577	39,577	39,577	39,577
Hospital special funds	187	195	195	195	195	195
Total equity	60,449	64,799	60,996	64,549	63,077	58,935

Statement of changes in equity

	Actual 2019-20 000	Actual 2020/21 \$000	Plan 2021/22 \$000	Plan 2022/23 \$000	Plan 2023/24 \$000	Plan 2024/25 \$000
Contributed capital						
Balance at 1 July	105,567	112,409	112,251	113,393	120,735	123,077
Capital contribution	7,000	-	1,300	7,500	2,500	-
Repayable of capital	(158)	(158)	(158)	(158)	(158)	(158)
Balance at 30 June	112,409	112,251	113,393	120,735	123,077	122,919
Accumulated surplus /(deficit)						
Balance at 1 July	(67,287)	(82,698)	(87,224)	(92,169)	(95,958)	(99,772)
Properties revaluation reserved transfer on disposal	-	-	-	-	-	-
Other reserved movements	(7)	(11)	-	-	-	-
Surplus(deficit) for the year	(15,404)	(4,515)	(4,945)	(3,789)	(3,814)	(3,984)
Balance at 30 June	(82,698)	(87,224)	(92,169)	(95,958)	(99,772)	(103,756)
Property and Plant revaluation reserves						
Balance at 1 Jul	23,881	30,551	39,577	39,577	39,577	39,577
Revaluation	6,670	9,026	-	-	-	-
Transfer to general funds on disposal	-	-	-	-	-	-
Balance at 30 June	30,551	39,577	39,577	39,577	39,577	39,577
Property and Plant revaluation reserves consist of:						
Lands	1,800	2,795	2,795	2,795	2,795	2,795
Buildings	28,751	36,782	36,782	36,782	36,782	36,782
Total Property and Plant revaluation reserves	30,551	39,577	39,577	39,577	39,577	39,577
Financial assets at fair value through other comprehensive revenue and expense reserves						
Balance at 1 Jul	-	-	-	-	-	-
net change in fair value	-	-	-	-	-	-
Transfer to surplus/(deficit) on disposal	-	-	-	-	-	-
Balance at 30 June	-	-	-	-	-	-
Hospital Special Funds						
Balance at 1 Jul	180	187	195	195	195	195
Transfer from retained earnings in respect of:						
Interest	3	3	4	4	4	4
Donations and fund received	4	5	2	2	2	2
Transfer from retained earnings in respect of:						
Fund spent	-	-	(6)	(6)	(6)	(6)
Balance at 30 June	187	195	195	195	195	195
Total statement of changes in equity	60,449	64,799	60,996	64,549	63,077	58,935

Statement of prospective cash flows for the year end for four years to 30 June 2025

	Actual 2019/20 000	Actual 2020/21 000	Plan 2021/22 \$000	Plan 2022/23 \$000	Plan 2023/24 \$000	Plan 2024/25 \$000
Cash flows from Operating Activities						
Receipts from the Crown	279,252	300,468	315,201	327,022	337,737	349,951
Interest Received	108	49	53	53	53	53
Receipt from other revenue	1,318	1,519	3,909	3,909	3,909	3,909
Payment to Supplies	(187,171)	(197,852)	(210,611)	(217,393)	(223,176)	(231,152)
Payment to Employees	(92,821)	(97,036)	(99,004)	(104,422)	(107,346)	(115,721)
Interest Paid	(19)	(16)	(13)	(13)	(13)	(13)
Payment to capital charged	(3,507)	(2,935)	(3,126)	(3,114)	(3,192)	(3,048)
GST (net)	179	(159)	-	-	-	-
Net Cash inflow/(outflow) from operating activities	(2,661)	4,038	6,409	6,042	7,972	3,979
Cash flows from Investing Activities						
Receipts from sale of property, plant and equipment	-	-	-	-	-	-
Purchase of property, plant and equipment	(2,272)	(7,199)	(11,489)	(9,637)	(7,159)	(6,765)
Purchase of intangible assets	(838)	(1,484)	(3,273)	(1,737)	(887)	(887)
Receipts from maturity of investments	(39)	(35)	(35)	(25)	(25)	(25)
Net appropriation from trust funds	(9)	-	1	-	-	-
Net Cash inflow/(outflow) from investing activities	(3,158)	(8,718)	(14,796)	(11,399)	(8,071)	(7,677)
Cash flows from Financing Activities						
Capital contribution	7,000	-	1,300	7,500	2,500	-
Payment of finance lease	(95)	(98)	(100)	(103)	(107)	(109)
Repayment of Capital	(158)	(158)	(158)	(158)	(158)	(158)
Payment of loans	(135)	(101)	-	-	-	-
Net Cash inflow/(outflow) from financing activities	6,612	(360)	1,042	7,239	2,235	(267)
Net increase/(decreased) in cash and cash equivalents	793	(5,040)	(7,345)	1,882	2,136	(3,965)
Cash and cash equivalents at beginning of year	3,020	3,813	(1,227)	(8,572)	(6,690)	(4,554)
Cash and cash equivalents at end of year	3,813	(1,227)	(8,572)	(6,690)	(4,554)	(8,519)

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 not proposing any major service changes that require notification in line with the terms of the Operational Policy Framework, therefore there are no FTE changes to be notified due to service change.

Changes in FTE include:

2020-21 Plan	936.40
Plus	
CCDM implementation 2021-22	10.00
COVID -19 programme annualised	6.41
Funded Sustainability Initiatives (Planned Care + Sustainability)	2.25
Savings due to model of care changes across services (reduced planned overtime etc)	(4.56)
2021-22 Plan	950.50

If, through the implementation of the Health and Disability Sector review any major service changes proposed, we will work with the Ministry and any subsequently authorised agency on these changes.

Wāhanga 4: Kaitiakitanga

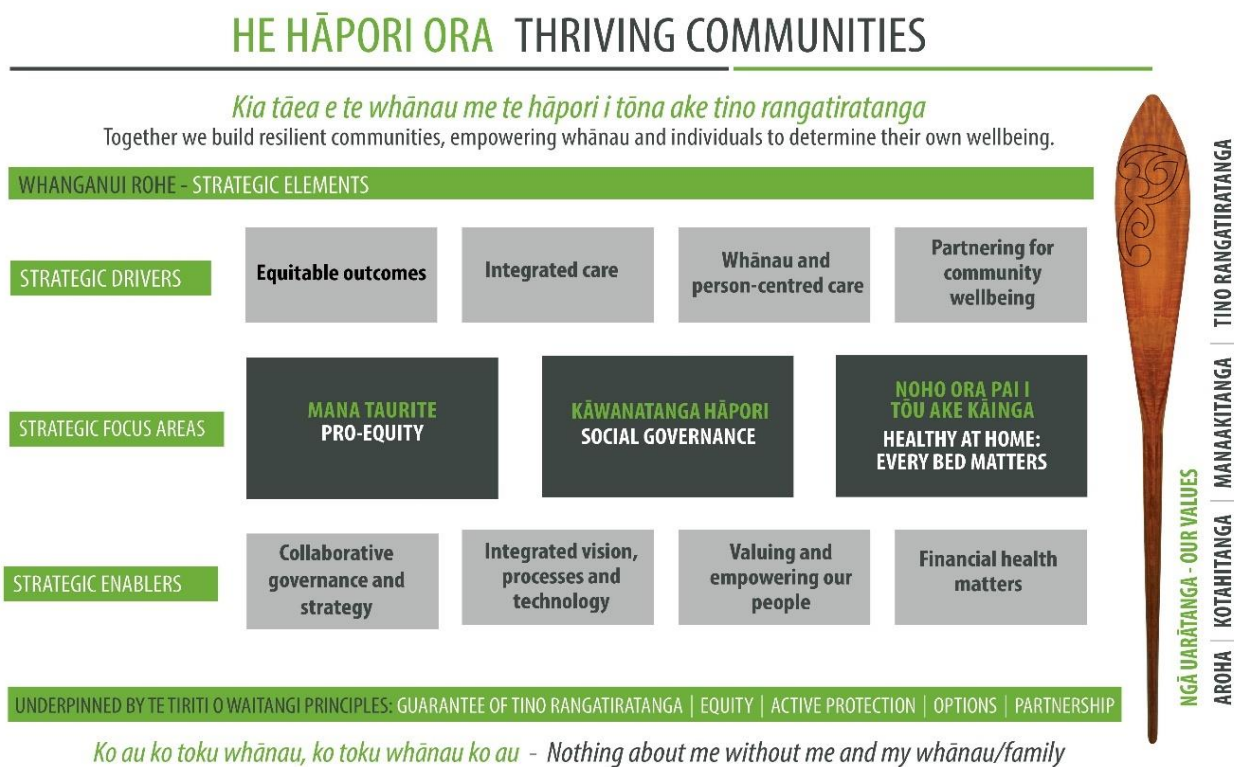


Section 4: Stewardship

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 strategic framework, (Figure 3) our strategic response to our Stewardship function is show in Figure 4.

This graphic 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 matter – innovation in high cost areas to rebalance funding for longer term health gain.

4.1 Managing our Business

Organisational performance management

WDHB has a comprehensive performance management program and process in place. Progress is monitored by management leaders and governance including Māori Relationship Board. Power BI reporting is developed to support service teams and departments to monitor progress and service improvement.

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 2021/22 and out years is contained in the financial performance summary of our Annual Plan (section 2.6) and in our Statement of Performance Expectations (TBC).

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.

Commitment to improving health and safety across the health workforce (refer Health Workforce page 76)

The health and safety of our workforce is integral to all that we do.

WDHB will enhance its commitment to improving health and safety across the health workforce by developing a preventative model of health care for the WDHB district health carers to support the sustainability, and the health and safety/wellbeing including mental wellbeing of our workforce

4.2 Building Capability

Capital and infrastructure development

In response to national COVID-19 recovery plans, WDHB prioritized two “shovel-ready” projects in 2020/21 that were not phased for that year. In addition, the Regional Digital Health Strategy (formerly the Regional Health Informatics Programme) continues to require significant information technology investment. The scale of the expenditure puts pressure on all other aspects of the capital budget spend, however, this is manageable over this timeframe. All investment into Regional Digital Health Strategy projects are subject to normal business approval processes with the Ministry of Health.

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

- The Waimarino Community Health Centre – an integrated health centre to be built in Raetihi with an estimated capital cost of \$2.1M;
- The Te Kōpae building will undergo structural strengthening and refurbishment \$500K.
- 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 \$800K.

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 and in the Central Region’s Digital Health Strategy.

Cooperative developments

For WDHB, the commitment to social governance as one of our strategic focus areas, builds on our organisation’s fundamental partnership with Hauora ā Iwi and the Board to work with other government, social and community organisations and leaders.

Healthy people and connected whānau and communities with control over their lives contribute to the wider health and wellbeing of our entire region. When people have options and sufficient means to participate in society, as well as access to support and meaningful activities, they are more like to take their health and the health of their whānau into their own hands and make healthy living a priority.

Through social governance, the people of Whanganui rohe will see community leaders and support services working towards the same social, health and wellbeing outcomes, with regular input and collaboration from our communities.

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

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.

- **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 2020/21 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 addressing and improving the determinants of health. 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.

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 that support the Health workforce action plan pages 73 to 76:

Whakamaua – Priority Areas 2 & 3

- Proactively grow the Māori workforce across the health district that proportionally reflects the WDHB district Māori population (EOA):
 - implement and monitor progress to the six agreed Māori workforce targets (EOA)
 - determine local targets and action plans
 - 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 Korero Mai 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 Rārangā 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)

COVID-19 Sustainability, vaccination workforce

- Implement learnings from COVID pandemic response by continuing to work collaboratively with Primary Care unions, and Māori Health Provider workforces.

Education & Professional Development

- Establish an education committee to identify areas of staff development to align with health gain areas for the district ie: service to older people and their whānau.
- Build on current data collection processes and continues within the context of existing sub-regional service developments and national workforce programmes.
- Improve the learning culture within the DHB through cementing the new relationship with the University of Otago Wellington for training interns

Increased diversity in leadership or decision-making

- Continue to grow clinical leadership across medical, nursing and allied health.

Professional Standards of cultural competency and safety

- 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

Health and Safety of workforce, including mental wellbeing

- Whanganui District Health Board is committed to providing and maintaining a safe and healthy working environment for its workers and other persons at the workplace.

Sustainable workforce

- Growing a future-proof workforce.
- Implement equity and pay parity agreements.
- 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.

4.4 Information Technology

WDHB's information technology (ICT) 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

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 (≥ 95 percent of pre-school children (aged 0-4 years of age) will be enrolled in the COHS)	Year 1 ≥ 95%
			Year 2 ≥ 95%
		Children (0-12) not examined according to planned recall (≤ 10 percent of pre-school and primary school children enrolled with the COHS will be overdue for their scheduled examinations with the COHS.)	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 fully immunised.	
		95% of five-year-olds have completed all age-appropriate immunisations due between birth and five year of age.	
		75% of girls and boys fully immunised – HPV vaccine.	
		75% of 65+ year olds immunised – flu vaccine.	
CW06	Child Health (Breastfeeding)	70% of infants are exclusively or fully breastfed at three months.	
CW07	Newborn enrolment with General Practice	The DHB has reached the "Total population" target for children enrolled with a general practice by 6 weeks of age (55%) and by 3 months of age (85%) and has delivered all the actions and milestones identified for the period in its annual plan and has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group, for both targets.	
CW08	Increased immunisation at two years	95% of two-year-olds have completed all age-appropriate immunisations due between birth and age two years.	
CW09	Better help for smokers to quit (maternity)	90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.	

CW10	Raising healthy kids	95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.		
CW12	Youth mental health initiatives	Focus area 1 (Youth SLAT): Provide reports as required		
		Focus area 2 (School Based Health Services): Provide reports as required		
		Focus area 3: (Youth Primary Mental Health services) refer MH04		
MH01	Improving the health status of people with severe mental illness through improved access	Age (0-19)	Māori	5.5%
			Other	5.5%
			Total	5.5%
		Age (20-64)	Māori	7%
			Other	7%
			Total	7%
		Age (65+)	Māori	3%
			Other	3%
			Total	3%
MH02	Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan.		
		95% of audited files meet accepted good practice.		
MH03	Shorter waits for mental health services for under 25-year olds	Provide reports as specified		
MH04	Rising to the Challenge: The Mental Health and Addiction Service Development Plan	Provide reports as specified		
MH05	Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.		
MH06	Output delivery against plan	Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.		
MH07	Improving the health status of people with severe mental illness through improved acute inpatient post discharge community care	Provide reports as specified		
PV01	Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall.		
PV02	Improving cervical screening coverage	80% coverage for all ethnic groups and overall.		

SS01	Faster cancer treatment – 31 day indicator	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.		
SS03	Ensuring delivery of Service Coverage	Provide reports as specified		
SS04	Delivery of actions to improve Wrap Around Services for Older People	Provide reports as specified		
SS05	Ambulatory sensitive hospitalisations (ASH adult)	< 5,691per 100,000		
SS06	Better help for smokers to quit in public hospitals (previous health target)	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.	Only applies to specified DHBs	
SS07	Planned Care Measures	Planned Care Measure 1:		
		<i>Planned Care Interventions</i>		
		<i>Elective Service Patient Flow Indicators</i>	ESPI 1	100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less)
			ESPI 2	0% – no patients are waiting over four months for FSA
			ESPI 3	0% - zero patients in Active Review with a priority score above the actual Treatment Threshold (aTT)
			ESPI 5	0% - zero patients are waiting over 120 days for treatment
			ESPI 8	100% - all patients were prioritised using an approved national or nationally recognised prioritisation tool
		Planned Care Measure 3:	Coronary Angiography	95% of patients with accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)
<i>Diagnostics waiting times</i>	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).		

			Magnetic Resonance Imaging (MRI)	90% of patients with accepted referrals for MRI scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).
		Planned Care Measure 4: <i>Ophthalmology Follow-up Waiting Times</i>	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.	
		Planned Care Measure 5: <i>Cardiac Urgency Waiting Times</i>	All patients (both acute and elective) will receive their cardiac surgery within the urgency timeframe based on their clinical urgency.	
		Planned Care Measure 6: <i>Acute Readmissions</i>	The proportion of patients who were acutely re-admitted post discharge improves from base levels.	< 13.3%
		Planned Care Measure 7: Did Not Attend Rates (DNA) for First Specialist Assessment (FSA) by Ethnicity (Developmental)	Note: There will not be a Target Rate identified for this measure. It will be developmental for establishing baseline rates in the 2020/21 year.	
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)	> 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 with a non-specific value	>0.5% and < or equal to 2%
			Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and < or equal to 85%
			Invalid NHI data updates	Still to be confirmed

		Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NN PAC and NMDS for FSA and planned inpatient procedures.	Greater than or equal to 90% and less than 95%
			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 85% and less than 95%
		Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)		Provide reports as specified
SS10	Shorter stays in Emergency Departments	95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.		
SS11	Faster Cancer Treatment (62 days)	90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.		
SS12	Engagement and obligations as a Treaty partner	Reports provided and obligations met as specified		
SS13	Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	Focus Area 1: Long term conditions	Report on actions, milestones and measures 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.	
			Ascertainment: target 95-105% and no inequity	
			HbA1c <64mmols: target 60% and no inequity	
			No HbA1c result: target 7-8% and no inequity	
	Focus Area 3: Cardiovascular health	Provide reports as specified		
	Focus Area 4: Acute heart service	<p>Indicator 1: Door to cath - Door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram.</p> <p>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</p> <p>Indicator 2b: ≥ 99% within 3 months.</p>		

			<p>Indicator 3: ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (i.e. have had an echocardiogram or LVgram).</p> <p>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</p> <ul style="list-style-type: none"> - Aspirin*, a 2nd anti-platelet agent*, and a 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). <p>* An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.</p> <p>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.</p> <p>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.</p>
	Focus Area 5: Stroke services		<p>Indicator 1 ASU:</p> <p>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</p>
	Provide confirmation report according to the template provided		<p>Indicator 2 Reperfusion Thrombolysis /Stroke Clot Retrieval:</p> <p>12% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile, (Service provision 24/7)</p> <p>Indicator 3: In-patient rehabilitation: 80% patients admitted with acute stroke are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission</p> <p>Indicator 4: Community rehabilitation:</p>

		60% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.
SS15	Improving waiting times for Colonoscopy	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less 100% within 30 days or less.
		70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less.
		70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less.
		95% of people who returned a positive FIT have a first offered diagnostic date that is within 45 working days or less of their FIT result being recorded in the NBSP IT system.
SS17	Delivery of Whānau ora	Appropriate progress identified in all areas of the measure deliverable.
PH01	Delivery of actions to improve SLMs	Provide reports as specified
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers	All PHOs in the region have implemented, trained staff and audited the quality of ethnicity data using EDAT within the past three-year period and the current results from Stage 3 EDAT show a level of match in ethnicity data of greater than 90 percent.
PH03	Access to Care (PHO Enrolments)	The DHB has an enrolled Māori population of 95 percent or above
PH04	Primary health care: Better help for smokers to quit (primary care)	90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months
Annual plan actions – status update reports		Provide reports as specified



APPENDIX 1

STATEMENT OF PERFORMANCE EXPECTATIONS

2021-2022

The Statement of Performance Expectations is a requirement of the Crown Entities Act 2004 as amended by the Crown Entities amendment Act 2013 and sets the annual performance expectations of Whanganui District Health Board. The Statement of Performance Expectations is an integral part of the DHB Annual Plan, however, in order to meet the requirements of Section 149(L) of the Crown Entities Act 2004 we are pleased to present the following information which forms the 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 2021/22	Plan 2022/23	Plan 2023/24	Plan 2024/25
Revenue				
Crown	7,111	7,353	7,574	7,828
Other Income	408	408	408	408
Inter-district Inflows	57	59	61	63
Total Revenue	7,576	7,820	8,043	8,299
Expenditure				
Personnel	(3,215)	(3,329)	(3,454)	(3,583)
Capital charge	(227)	(223)	(219)	(191)
Depreciation	(17)	(18)	(20)	(21)
Other	(1,037)	(1,097)	(1,154)	(1,205)
Other Provider Payments	(4,278)	(4,401)	(4,537)	(4,689)
Inter-district Inflows	(47)	(48)	(47)	(48)
Overheads	-	-	-	-
Total Expenditure	(8,821)	(9,116)	(9,431)	(9,737)
Net Surplus (Deficit)	(1,245)	(1,296)	(1,388)	(1,438)

Prevention Services					
Measure description	Ethnicity	2019/20 Actual	2020/21 Forecast	2021/22 Target	2022/23 Outlook
Ambulatory sensitive hospitalisations for children 0 – 4 years of age (compared with the national rate)	All	94%	89%	≤110%	110%
	Māori	126%	111%	≤115%	115%
	Non-Māori	67%	71%	≤110%	110%
Children caries free at 5 years of age	All	58.6%	59.2%	≥58%	58%
	Māori	40.9%	41.4%	≥58%	58%
	Non-Māori	64.8%	68.9%	≥58%	58%
Immunisation coverage rate at 8 months of age	All	85.8%	79.6%	≥95%	95%
	Māori	79.4%	66.7%	≥95%	95%
	Non-Māori	91.2%	91.3%	≥95%	95%
Babies in a Smokefree household at 6 weeks of age	All	48.1%	38.3%	≥38%	38%
	Māori	32.9%	23.2%	≥28%	28%
	Non-Māori	60.3%	51.1%	≥58%	58%
Proportion of youth who have received HPV vaccine	All	69.50%	70.50%	≥75%	75%
	Māori	68.10%	68.00%	≥75%	75%
	Non-Māori	70.50%	72.20%	≥75%	75%
Cervical screening three-year coverage rate for women aged 25-69 years	All	74.5%	69.70%	≥80%	80%
	Māori	73.9%	65.50%	≥80%	80%
	Non-Māori	74.7%	71.10%	≥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	88.30%	75.30%	≥95%	95%
	Māori	88.20%	77.40%	≥95%	95%
	Non-Māori	88.30%	73.60%	≥95%	95%
Number of extended consults delivered by a GP or practice nurse	Total	1290	1185	2228	2228
	Youth	152	161	446	446
	Youth	11.8%	13.5%	20%	20%
	Adult	1138	1025	1782	1782
	Adult	88.2%	86.5%	80%	80%
Percentage of enrolled population 65 years + who have the flu vaccination	All	77.6%	63.7%	≥75%	75%
	Māori	84.7%	62.8%	≥75%	75%
	Non-Māori	79.6%	65.6%	≥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 2021/22	Plan 2022/23	Plan 2023/24	Plan 2024/25
Revenue				
Crown	65,734	68,057	70,001	72,317
Other Income	1,519	1,519	1,519	1,519
Inter-district Inflows	1,946	2,004	2,064	2,126
Total Revenue	69,199	71,580	73,584	75,962
Expenditure				
Personnel	(12,553)	(12,999)	(13,485)	(13,988)
Capital charge	(421)	(424)	(447)	(452)
Depreciation	(488)	(516)	(563)	(585)
Other	(9,058)	(9,574)	(10,067)	(10,506)
Other Provider Payments	(45,636)	(46,995)	(48,475)	(50,130)
Inter-district Inflows	(3,922)	(3,965)	(3,915)	(4,032)
Overheads	-	-	-	-
Total Expenditure	(72,078)	(74,473)	(76,952)	(79,693)
Net Surplus (Deficit)	(2,879)	(2,893)	(3,368)	(3,731)

Early Detection and Management					
Measure description	Ethnicity	2019/20 Actual	2020/21 Forecast	2021/22 Target	2022/23 Outlook
Proportion of pregnant women accessing DHB funded pregnancy and parenting education	All	19.6%	18.5%	≥40.0%	>40.0%
	Māori	13.3%	14.6%	≥40.0%	>40.0%
	Non Māori	24.7%	21.3%	≥40.0%	>40.0%
Proportion of adolescent population utilising DHB-funded dental services	All	77.0%	77.0%	≥85.0%	85%
Proportion of children enrolled in the community oral health service who have treatment according to plan	All	94.3%	99.8%	≥90%	90%
	Māori	93.3%	97.6%	≥90%	90%
	Non-Māori	95.0%	101.6%	≥90%	90%
Proportion of youth (12-19 years olds) seen each quarter by primary mental health services	All	1.4%	3.3%	≥2.0%	2.00%
	Māori	2.0%	2.9%	≥2.0%	2.00%
	Non-Māori	1.1%	3.6%	≥2.0%	2.00%
Shorter waits for non-urgent mental health and addiction services (0-19 yrs)	< 3 weeks- All	81.6%	82.7%	≥80%	80%
	Māori	78.2%	81.5%	≥80%	
	Non-Māori	83.8%	83.9%	≥80%	
	3-8 weeks- All	98.3%	94.7%	≥95%	95%
	Māori	98.2%	94.3%	≥95%	
	Non-Māori	98.4%	94.9%	≥95%	
	> 8 weeks- All	100.0%	100.0%	100%	100%
Ambulatory Sensitive Hospitalisations (ASH) rates for 45-64 years of age relative to national rate	All	162.90%	161.10%	≤170%	170%
	Māori	265%	269%	≤151%	151%
	Non-Māori	137.40%	132.50%	≤166%	166%
Proportion of patients with good or acceptable glycaemic control (HbA1C < 64 mmol/mol)	All	55.30%	56.00%	≥60%	60%
	Māori	48.40%	47.40%	≥60%	60%
	Non-Māori	58.8%	61.3%	≥60%	60%
Percentage of people accepted for an urgent diagnostic colonoscopy received their procedure within 14 days	All	93.5%	95.0%	≥90%	90%
Percentage of long term clients with mental illness who have an up-to-date relapse prevention plan	Child	100.0%	100.0%	≥95%	95%
	Adult	98.9%	100.0%	≥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 2021/22	Plan 2022/23	Plan 2023/24	Plan 2024/25
Revenue				
Crown	185,204	192,827	199,497	207,155
Other Income	2,010	2,010	2,011	2,011
Inter-district Inflows	5,296	5,455	5,617	5,785
Total Revenue	192,510	200,292	207,125	214,951
Expenditure				
Personnel	(82,463)	(85,402)	(88,607)	(91,921)
Capital charge	(2,094)	(2,080)	(2,125)	(2,011)
Depreciation	(6,689)	(7,083)	(7,732)	(8,039)
Other	(41,127)	(43,508)	(45,753)	(47,781)
Other Provider Payments	(16,672)	(17,173)	(17,715)	(18,322)
Inter-district Inflows	(44,645)	(45,139)	(44,576)	(45,913)
Overheads	-	-	-	-
Total Expenditure	(193,690)	(200,385)	(206,508)	(213,987)
Net Surplus (Deficit)	(1,180)	(93)	617	964

Early Detection and Management

Measure description	Ethnicity	2019/20 Actual	2020/21 Forecast	2021/22 Target	2022/23 Outlook
Proportion of pregnant women accessing DHB funded pregnancy and parenting education	All	19.6%	18.5%	≥40.0%	>40.0%
	Māori	13.3%	14.6%	≥40.0%	>40.0%
	Non Māori	24.7%	21.3%	≥40.0%	>40.0%
Proportion of adolescent population utilising DHB-funded dental services	All	77.0%	77.0%	≥85.0%	85%
Proportion of children enrolled in the community oral health service who have treatment according to plan	All	94.3%	99.8%	≥90%	90%
	Māori	93.3%	97.6%	≥90%	90%
	Non-Māori	95.0%	101.6%	≥90%	90%
Proportion of youth (12-19 years olds) seen each quarter by primary mental health services	All	1.4%	3.3%	≥2.0%	2.00%
	Māori	2.0%	2.9%	≥2.0%	2.00%
	Non-Māori	1.1%	3.6%	≥2.0%	2.00%
Shorter waits for non-urgent mental health and addiction services (0-19 yrs)	< 3 weeks-All	81.6%	82.7%	≥80%	80%
	Māori	78.2%	81.5%	≥80%	
	Non-Māori	83.8%	83.9%	≥80%	
	3-8 weeks-All	98.3%	94.7%	≥95%	95%
	Māori	98.2%	94.3%	≥95%	
	Non-Māori	98.4%	94.9%	≥95%	
	> 8 weeks-All	100.0%	100.0%	100%	100%
Ambulatory Sensitive Hospitalisations (ASH) rates for 45-64 years of age relative to national rate	All	162.90%	161.10%	≤170%	170%
	Māori	265%	269%	≤151%	151%
	Non-Māori	137.40%	132.50%	≤166%	166%
Proportion of patients with good or acceptable glycaemic control (HbA1C < 64 mmol/mol)	All	55.30%	56.00%	≥60%	60%
	Māori	48.40%	47.40%	≥60%	60%
	Non-Māori	58.8%	61.3%	≥60%	60%
Percentage of people accepted for an urgent diagnostic colonoscopy received their procedure within 14 days	All	93.5%	95.0%	≥90%	90%
Percentage of long term clients with mental illness who have an up-to-date relapse prevention plan	Child	100.0%	100.0%	≥95%	95%
	Adult	98.9%	100.0%	≥95%	95%

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 2021/22	Plan 2022/23	Plan 2023/24	Plan 2024/25
Revenue				
Crown	48,796	50,438	51,822	53,498
Other Income	25	25	24	24
Inter-district Inflows	1,187	1,223	1,261	1,299
Total Revenue	50,008	51,686	53,107	54,821
Expenditure				
Personnel	(4,578)	(4,739)	(4,914)	(5,094)
Capital charge	(384)	(387)	(401)	(394)
Depreciation	(155)	(161)	(177)	(183)
Other	(4,324)	(4,564)	(4,798)	(5,000)
Other Provider Payments	(36,817)	(37,914)	(39,107)	(40,442)
Inter-district Inflows	(3,391)	(3,428)	(3,385)	(3,487)
Overheads	-	-	-	-
Total Expenditure	(49,649)	(51,193)	(52,782)	(54,600)
Net Surplus (Deficit)	359	493	325	221

Rehabilitation and Support					
Measure description	Ethnicity	2019/20 Actual	2020/21 Forecast	2021/22 Target	2022/23 Outlook
Percentage of mental health & addictions service users receiving community care within seven days following their discharge (KPI 19)	All	62.0%	74.0%	≥75%	75%
	Māori	60.4%	74.5%	≥75%	75%
	Non-Māori	63.8%	73.6%	≥75%	75%
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	89.6%	97.0%	≥95%	95%
Number of older people receiving in-home strength and balance programmes	All	230	507	199	199
Percentage of potentially eligible stroke patients thrombolysed (ind 2)	All	17.0%	19.2%	≥10.0%	10%
	Māori	25.0%	27.3%	-	
	Non-Māori	16.3%	18.2%	-	
Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway (ind 1)	All	95.3%	93.5%	≥80%	80%
	Māori	76.9%	83.3%	-	
	Non-Māori	97.8%	94.7%	-	
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	57.7%	53.8%	≥70%	70%
Proportion of over 64 year olds who are prescribed 11 or more medications	All	2.3%	2.4%	≤2.0%	2.00%
	Māori	2.9%	3.4%	≤2.0%	2.00%
	Non-Māori	2.3%	2.3%	≤2.0%	2.00%
Proportion of population aged 65+ years receiving DHB funded support in ARC facilities over the year	All	4.3%	4.3%	4.4%	4.40%
	Māori	2.9%	2.3%	3.0%	3.00%
	Non-Māori	4.5%	4.5%	4.5%	4.50%



National
Hauora Coalition



APPENDIX 2

SYSTEM LEVEL MEASURES IMPROVEMENT PLAN (SLM) 2021-2022



Whanganui District Health Board

System Level Measures Improvement Plan (SLM) 2021 – 2022

Russell Simpson
Chief Executive
Whanganui District Health Board

Simon Royal
Chief Executive
National Hauora Coalition

Jude MacDonald
Chief Executive
Whanganui Regional Health Network



National
Hauora Coalition



Whanganui Regional
Health Network

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, maximising the use of resources for planned care rather than acute care and addressing inequities.

SLM 2021/22 Improvement Milestone:

Acute bed days per 1000 population. Further reduce the inequity for Māori by reducing acute bed days for Māori aged 45-64, by 10% from 683 (Sept 2019) to 615

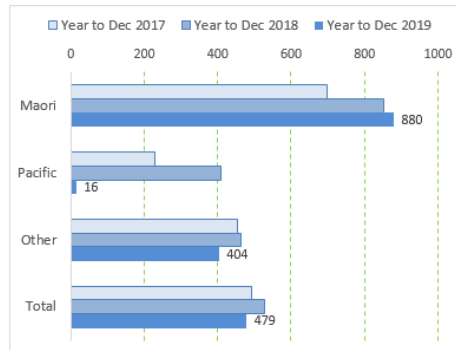
Report for DHB of Domicile, December 2019

Ethnic Group Data - Actual Acute Bed Days per Capita Rates

Whanganui DHB of Domicile

Year	Estimated Popn	Acute Stays	Acute Bed Days	Actual Acute Bed Days per 1,000 Popn		
	Year to Dec 2019	Year to Dec 2019	Year to Dec 2019	Year to Dec 2017	Year to Dec 2018	Year to Dec 2019
Maori	790	233	695	697	852	880
Pacific	65	4	1	230	408	16
Other	3,820	587	1,545	455	463	404
Total	4,675	824	2,241	492	527	479

Whanganui DHB of Domicile



Contributory Measures

Ambulatory Sensitive Hospitalisation (ASH) rate per 100,000 population for 45-64 years, by ethnicity

Influenza vaccinations for 65 years and over by ethnicity

Acute readmissions to hospital for Māori 45-64 years (0-28 days)

Actions

As evidence shows, early intervention with multidisciplinary response will reduce average length of stay and readmissions. Actions outlined will continue to progress the acute demand programme of work including:

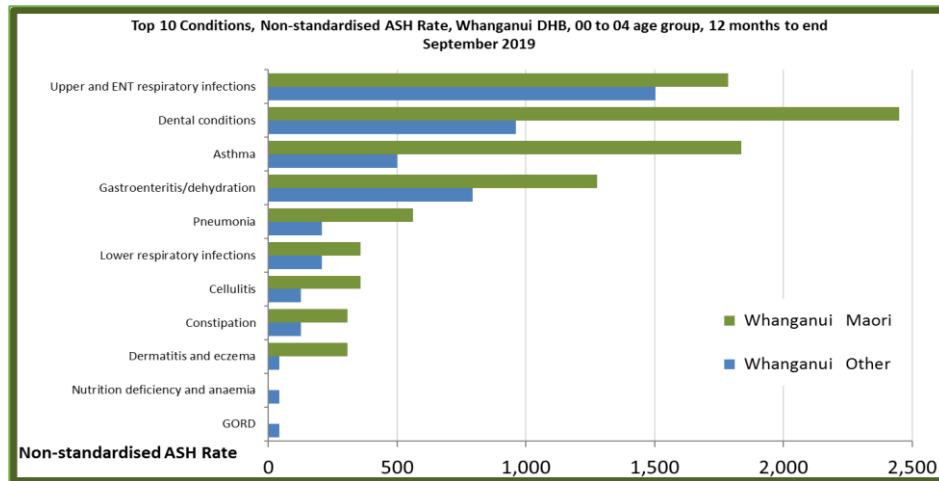
- Implementation of revised urgent care model
 - o Allied health as first point of contact for musculoskeletal (MSK) presentations in Whanganui Accident & Medical Clinic (WAM)
 - o Implementation of the Community Connector role within WAM with eventual co-design model
- Embed phase one of Community funding options programme (CFOP) for IV therapy
 - o Increase general practice access to diagnostics in alignment with best practice to reduce inappropriate referrals to emergency department
 - o Implement COPD/Asthma Health Pathways and associated programmes of care
 - o Continue vaccine programme for people over 65 years and vulnerable populations
- Continuation of the development of Readmission data analysis toolkit enabling a deep dive on those areas of readmission that we can influence (i.e. readmissions for same or related conditions)

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 was significantly higher than European/Other. Māori were more likely to be hospitalised for ambulatory care-sensitive conditions compared with Non-Māori.

SLM 2021/22 Improvement Milestone:

ASH for Māori children aged 0-4 years reduce the rate by 10% from 6659 to 5993



Contributory Measures

New-borns enrolled in a Primary Health Organisation (Māori and Pacific) by three months

Caries free at five years

B4 school checks are started before children are 4.5 years old

Hospital admissions for children aged under two years with dental caries as primary diagnosis

Hospital admissions for children aged five years with a primary diagnosis of asthma

Pre-school children enrolled in oral health service

Actions

- Maternal & Child Integration Group plan to improve timely transfer of care between maternity services, Well Child Tamariki Ora and Primary Care (GP and LMC)
- Develop and implement childhood asthma pathway
- Embed Best Start Tool across general practice
- Undertake collaborative system-wide redesign of the oral health service to confirm service model that meets the needs of our high dep population Māori/Pacific including improved engagement with Kura Kaupapa and early childhood education on dental education

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.

SLM 2021/22 Improvement Milestone:

Reduce the equity gap between Māori & non-Māori from 1.94 times to < 1.5 times by 2023

Contributory Measures

Reduced unplanned admissions (ASH rates) for 45-64 years Māori and Pacific

Reduced unplanned admissions for 45-65 years Māori / Pacific COPD/cellulitis

Increased # of Māori males prescribed urate lowering therapy in the last 12 months

Increased % of Māori with good gout management and other long-term conditions including CVD

Increased % of PHO enrolled people within the eligible population who have had a CVD risk recorded as per the national CVD guidelines. (inclusive of monitoring by ethnicity and age group)

Actions

The GoutStop programme underpins the development of an approach working collaboratively to find new ways to support individuals with long term conditions expected to roll out across other conditions. Embedding the GoutStop programme across the community will improve levels of engagement and support for those patients with Metabolic Syndrome, Chronic Kidney Disease and Cardio-Vascular Disease This includes:

- Monitoring & analysis of programme data to enable iterative changes to improve the number of Māori males receiving regular uric acid testing
- Monitoring TUKU data (patients enrolled in the programme by pharmacists and referrals to kaiawhina) to enable improvements of process/patient journey to support patients and to achieve target uric acid levels
- Implementation of district wide community education and communications plan and resources
- Establishment of a gout consumer group to inform any changes to current programme and resources
- Continue to develop priority health pathways and implement associate system redesign within agreed time frames
- Implement COPD & Asthma pathways

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.

Secondary Care Patient Experience

Our work is informed and shaped by the values and belief systems of our community using data gained from the national inpatient experience survey and the consumer engagement marker to drive quality improvement activities.

SLM 2021/22 Improvement Milestones: Primary patient experience score "after treatment or care plan, were you contacted?" improved by 5% and Adult Inpatient: Achieve score above national average in all indicators

Contributory Measures

Hospitalised patients completing an adult in-patient survey

Patients registered to use general practice portals

GP practices offering an e portal

Improve patient experience in understanding Gout treatment and care

Actions

Primary – We aim to increase practice understanding of PES tools and data access to inform areas doing well, for improvement and actions to undertake quality improvement

- Identify existing usage of PES data in practices and any barriers to access
- Promote and coordinate training across primary care for new and existing users
- Align areas for improvement with Cornerstone and Foundation Standards, by exploring ways of incorporating objectives into existing projects, clinics and systems
- The quarterly week long Patient Experience Survey (PES) will be supported by PHO Provider Networks to increase participation of Māori, Pacific and quintile 5 enrolled patients

Secondary –We will use data from the national patient experience survey to

- identify indicators where we score below average and determine actions that will improve results in this area
- Communicate to inform potential respondents prior to each quarterly survey collection
- Develop action plans to correct any areas where WDHB lags nationally.
- Monitor invitations sent by ethnicity to ensure that the sample is representative of the inpatient population and send a Māori and Pacific a paired invite (SMS & email) where possible
- Monitor response to surveys by Māori and Pasifika to ensure it matches the WDHB demographic develop equity response where required

Engage with consumers and apply co-design principles in all quality improvement activities

- Ensure that the QSM results for consumer engagement are peer reviewed by consumers and improvement plans are in place for identified gaps.

Youth Access to Preventative Services

Reduce hospitalisations from deliberate self-harm for Māori youth. Māori youth and those living in high deprivation in particular, are at risk of self-harm hospitalisations. They are over-represented in our data and this over-representation has increased in the past year. The WDHb commissioned Health Families Whanganui, Ruapehu, Rangitikei to facilitate the co-design of a whole of community, whole of system approach to the regional suicide prevention strategy and action plan.

SLM 2021/22 Improvement Milestone:

Reduce self-harm hospitalisations for Māori aged 10-24 years to a rate of less than 80 per 10,000 population

Whanganui DHB of Domicile

Ethnicity	Population	Number of Self Harm Hospitalisations – Total	Actual Self Harm Hospitalisation Rate (per 10,000 popn)	Age Standardised Self Harm Hospitalisation Rate (per 10,000 population)		
				Year to Sep 2018	Year to Sep 2019	Year to Sep 2020
	Year to Sep 2020	Year to Sep 2020	Year to Sep 2020			
Māori	5,000	43	86.0	64.4	67.5	93.1
Pacific	510	0	0.0	22.9	43.9	0.0
Other	6,945	37	53.3	42.9	58.2	54.6
Total	12,455	80	64.2	50.4	61.3	67.3

Contributory Measure

ED presentations resulting from deliberate self-harm

IPMH data – Rangitahi accessing HIP and HC services

Actions

- Increase access for youth to early intervention primary mental health care through the expansion of the Integrated Primary Health and Addictions initiative
- Embed the new service He Puna Ora (Hapū māmā with AOD issues) by providing clinical consultations, education and attendance at clinical MDTs
- Increase range and availability of early intervention youth mental health services by providing additional resource at Youth Services Trust
- WDHb will work with partners in care to implement the district suicide prevention plan

Babies Living in Smokefree Homes at 6 weeks

There has been a decline in this measure for 2020/21. The aim for 2021/22 is to reduce the rate of infant exposure to cigarette smoke by focussing attention beyond maternal smoking to the home and family/whānau environment. This measure aligns with the first core contact which is the handover from maternity to Well Child Tamariki Ora (WCTO) providers and general practitioners.

SLM 2021/22 Improvement Milestone:

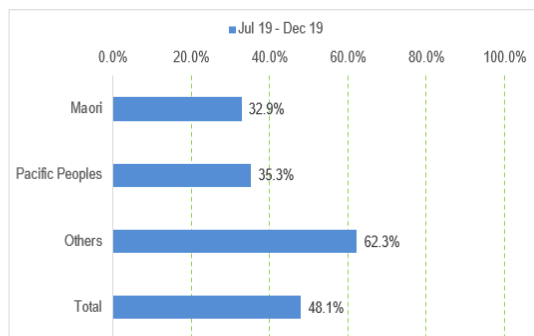
Halve the inequity gap by raising the number of Māori babies living in smokefree homes at six weeks post-natal to 40%

Ethnic Group Data - Babies living in smokefree homes at 6 weeks post natal

Whanganui DHB of Domicile

Year	Num		Denom		Rate of Smokefree Homes	
	Jul 19 - Dec 19	Jul 19 - Dec 19	Jul 19 - Dec 19	Jul 19 - Dec 19	Jul 19 - Dec 19	Jul 19 - Dec 19
Maori	68	207			32.9%	
Pacific Peoples	6	17			35.3%	
Others	149	239			62.3%	
Total	223	464			48.1%	

Whanganui DHB of Domicile



Contributory Measures

Pregnant Māori women who identify as smokers on registration with Best start and/or MMPO by ethnicity

Hapū māmā registered with an LMC within first trimester of pregnancy by ethnicity

New-borns enrolled in a Primary Health Organisation by three months

PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months

Actions

- Embed and monitor use of the GEN2040 Best Start Koware Tool across general practice to promote identification of smoking risk factors in Māori hapū māmā or pēpē allowing earlier targeted whānau conversations and interventions.
- Hapū māmā and whānau identified as smokers are supported to engage with quit smoking services locally and/or vape to quit
- Continue to support health pathway development for GEN2040 modules including monthly review of Hapū Mama Māori utilisation and outcomes
- Monitor new-born enrolment with active follow up of pēpē/māmā not enrolled with general practice by four weeks of age and refer to Outreach Service
- Create process to ensure all babies are enrolled with GP and WCTO on discharge from LMC with focus on Māori & Pacific
- Facilitate a co-designed system change to address the fragmentation across the system with hapū māmā (from conception to 6 weeks) at the core through the Tobacco Advisory Group, Well Child Tamariki Ora network, Primary Care and Maternal Governance Group