WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

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

2019/2020 Annual Plan

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

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

Whanganui District Health Board Annual Plan

(Issued under Section 38 of the
New Zealand Public Health and Disability Act 2018)

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

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

Rārangi Kiko
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Wāhanga 1:
Te Kitenga Whānui o Ngā Rautaki-Matua

Section 1:
Overview of strategic priorities

1.1 Strategic intentions

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

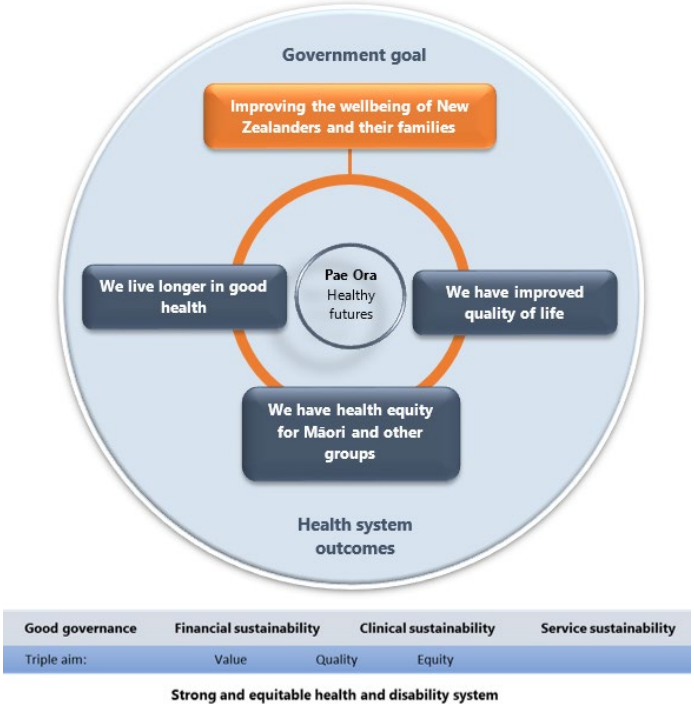
District health boards, as Crown agents, are also considered Crown entities, and covered by the Crown Entities Act 2004.

The statutory objectives of Whanganui DHB 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.

We align our intentions to our statutory objectives and to the Government's key goal of *Improving the wellbeing of New Zealanders and their families,* recognising the connections to the priority outcomes as set out in Figure 1.

Figure 1: Connection between Government priority outcomes and health system outcomes



Our activities are carried out within the context of an outcomes framework (refer to Figure 3 on page 6) that aligns our activities with relevant international and national obligations, regional and national direction. These include the following.

Te Tiriti o Waitangi

Commitment to the principles of partnership, participation and protection that underpin the relationship between the Government and Māori under Te Tiriti o Waitangi:

- **Partnership** involves working together with Iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.
- **Participation** requires Māori to be involved at all levels of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services.
- **Protection** involves the Government working to ensure Māori have equitable health outcomes, and safeguarding Māori cultural concepts, values and practices.

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

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

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

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

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

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

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

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

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

Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018 – commitment to facilitate the delivery of high quality health services that meet the needs of Pacific peoples.

Annual strategic discussions – we hold annual discussions with the Ministry of Health to confirm our planning intentions and to agree on the context of our focus areas. These are outlined further in Section 2.1.

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

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

The triple aim is depicted in Figure 2 below and the way we manage our work within this framework is further outlined in Section 4.

Figure 2: The New Zealand Triple Aim

The population we serve

Our district is home to just under 65,000 people and we need to ensure they have access to a wide range of health and disability support services. We aim to meet our statutory objectives by engaging with our communities to assess health status and need, and to determine what resources should be directed to preventing illness, to detecting and managing illness, to providing intensive assessment and treatment, and to providing rehabilitation and support.

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

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

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

Whanganui DHB aims to eliminate inequity, integrate care, partner for community wellbeing and empower whānau and individuals to make healthy choices. We are accountable for public health services delivered to the population of the Whanganui district as defined by the NZ Public Health and Disability Act.

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

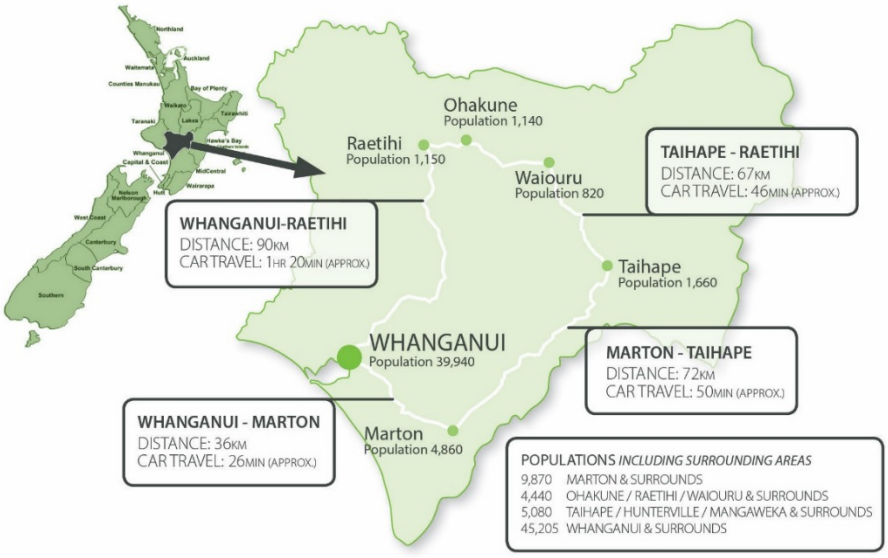
THE POPULATION WE SERVE

HE TANGATA, HE TANGATA, HE TANGATA

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

WHANGANUI DHB DISTRICT | TOTAL POPULATION: 64,595 estimate | 9,742KM²

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




Whanganui

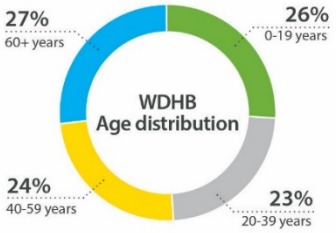

Ngā Rauru Kitahi

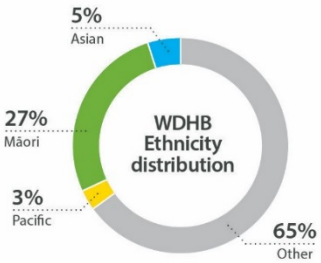

Ngāti Hauiti

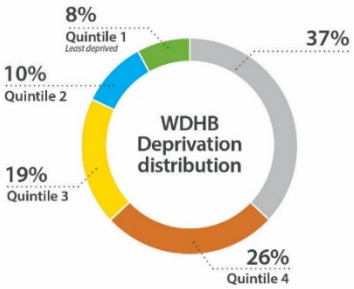

Ngā Wairiki Ngāti Apa


Mōkai Pātea


Ngāti Rangi







POPULATION AGE DISTRIBUTION - ALL NZ	
0-19 years	25%
20-39 years	28%
40-59 years	25%
60+ years	21%

ETHNICITY DISTRIBUTION - ALL NZ	
Māori	16%
Pacific	6%
Asian	16%
Other	62%

DEPRIVATION DISTRIBUTION - ALL NZ	
Quintile 1	20%
Quintile 2	20%
Quintile 3	20%
Quintile 4	20%
Quintile 5	20%

Linking the Government's priorities to our population needs

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

We aim to deliver our vision by focusing on four key strategic drivers:

- Eliminating inequity – by targeting vulnerability, understanding need and measuring what matters, and focusing on access.
- Integrating care – by shifting to community and primary health care, reducing hospitalisation, and focusing on public health, health promotion, protection and prevention.
- Partnering for community wellbeing – by broad, integrated social mobilisation across all communities; good communication to keep the population engaged with the health sector.
- Empowering whānau and individuals to make healthy choices – by supporting wellness through Whānau Ora; promoting the '65,000 beds' campaign, and using helpful planning and case management tools.

Figure 3: Our Outcomes Framework

Our way of working

As outlined in the framework, we are committed to achieving equity in health outcomes for Māori and improving the health of our community. This influences what we do and more importantly, how we do it, including:

- applying the philosophy of Whānau Ora as a key principle in how we partner with all health consumers and their families/whānau and how we understand and acknowledge their cultural values and beliefs.
- applying the equity lens and Whānau Ora philosophy ensures that governance, leadership and our wider workforce understand their responsibilities and are culturally aware and supported in their cultural practice.
    - Whānau-centred care guides our view of best practice.

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

- investing in sustainable kaupapa Māori services, to provide whānau choice and support the building of the capacity and capability of the Māori workforce cross our system.

Equity in health outcomes

In December 2018 we completed a 'Pro-equity check-up' to identify actions that we can take as an organisation to create a strong foundation for the work that must happen as we work to eliminate inequity. The check-up provided us with an independent, unbiased view of where we were at, to inform our implementation work plan. The work plan outlines actions to focus efforts for the most sustained impact.

Hauora A Iwi (Māori relationship board) was engaged in the check-up process and has endorsed the recommendations in the report.

The report identified 11 findings under four themes: Organisational leadership and accountability for equity; Māori workforce and Māori health and workforce capability; transparency in data and decision-making; and authentic partnership with Māori.

Acknowledging our population demographics, improving Māori health is our primary equity challenge.

1.2 Message from the board chair and chief executive

The 2019/20 Annual Plan comes at a time when there is significant reflection across health and social services in New Zealand. The Government's first 'Wellbeing budget' has been delivered, the inquiry into mental health and addictions has been reported on and the review of the health and disability sector is well underway. These are just three of the many important evaluations that will impact on the way the health system serves New Zealanders this year and in the future.

The 2018/19 year was characterised by reflection and review for Whanganui District Health Board (WDHB) too. Our board has reviewed and updated our strategic direction and there have been a number of changes in our clinical and management leadership, including a new chief executive in early 2018.

Pro-equity has been a significant focus of the 2018/19 year and this will continue into 2019/20 and beyond. Whanganui DHB is committed to eliminating inequities that continue to exist in the health system. The recent Waitangi Tribunal Health Services and Outcomes Inquiry highlighted the significant gap in health outcomes for Māori, and it is clear that improving Māori health and achieving equity for Māori is the primary and most urgent equity challenge for our nation. The independent Pro-equity audit conducted at the end of 2018 (and endorsed by the board in February 2019) assessed how well we are embedding a pro-equity approach into our work. A number of opportunities to strengthen our DHB systems and approach to equity in four key areas were identified and these are reflected in this annual plan.

Child wellbeing is a Government priority and continues to be of great importance in the Whanganui district too. We expect 830 births in 2019/20 and want to fully embrace the Government's vision of making New Zealand the best place in the world for children and young people. This means a strengthened focus on the first 1000 days of life so all children get the best start. And that must be followed up by strong performance across the many programmes and services that support ongoing wellness of children as they grow.

Mental health and addictions is a significant challenge for the health and social system. Following the Government Inquiry into mental health and addictions our specialist teams, community providers and primary care partners, will be working with service users to implement initiatives around the recommendations of the report to achieve gains in this area. It takes a long-term, ongoing effort and cross-sectoral approach for the advances we are striving for to be realised and we are dedicated to driving positive change and investing time and resource into this critical health issue.

Acute demand remains a focus with work being carried out in conjunction with the Whanganui Alliance Leadership Team. We are examining reasons behind increases in acute demand presentations to emergency and urgent care services, and will develop a system-wide response to reduce avoidable presentations and to modify demand, where possible.

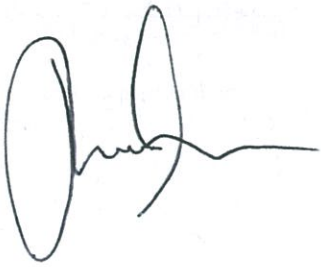
While the 2019/20 year will present some challenges, we are confident that our strategic approach, whānau centred-care, strength of relationships in cross-sectoral collaborations, ability to innovate, adapt and our drive to continuously improve will ensure we see measurable gains in both the short and long-term.

For the 2019/20 year we are continuing with our journey to make the organisation more outward-focusing so our communities are more empowered to self-manage and less reliant on hospital-based services. The '65,000 beds' campaign (the best bed for a person is their own one) is at the centre of this strategy and will be achieved by striving to further strengthen our relationships with other health providers, support services and community organisations and collaborate where possible to provide the best support and clinical care to our patients, their whānau and the wider community.

This annual plan ties together the planning priorities as outlined in the Minister's Letter of Expectations for 2019/20, and our response to national, regional and local strategies. It includes our Statement of Intent and Statement of Performance Expectations, shows anticipated areas of service change and the anticipated financial outcomes for the 2019/20 year and forecasts for the next two years. We are

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

Dot McKinnon, QSM
Toihau
Board Chair



Russell Simpson
Kaihautū Hauora
Chief Executive

Stuart Hylton
Board Member

Hon Dr David Clark
Minister of Health

Wāhanga 2:
Ngā Whakataunga Rautaki Matua

Section 2:
Delivering on strategic priorities

2.1 Government planning priorities

Whanganui DHB will deliver on the Government's priorities for 2019/20, as outlined in the Minister of Health's Letter of Expectations, December 2018. This section shows activity relating to those priorities, which are:

- improving child wellbeing
- improving mental wellbeing
- improving wellbeing through prevention
- better population health outcomes supported by a strong and equitable public health and disability system
- better population health outcomes supported by primary health care
- strong fiscal management.

Equity is a key theme across all aspects of the work that we do. Our working definition of equity is taken from the 2018 Health and Disability Review panel:

> *"In Aotearoa New Zealand people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes."*[1]

Eliminating inequities is one of our strategic drivers. With a significantly higher than average Māori population, and in honour of our Treaty obligations, the primary response to equity for Whanganui DHB is in the area of Māori health.

Other areas for equity consideration at Whanganui DHB include rural populations, youth and people suffering from mental ill-health and addictions.

Regional service planning

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

Focal points for local planning

In addition to the national priorities outlined above, in the 2019/20 year we will also develop some key strategic themes that we have agreed with the Ministry of Health. These include:

- Financial sustainability – current and future challenges linked to our relatively high deprivation profiles, rurality and economies-of-scale impact on our financial performance and we are engaging in a number of initiatives to gain better control and drive improvement.

[1] www.health.govt.nz, accessed 22/03/19

- Social governance – we are providing leadership and support to bring multiple agencies and community leaders together to create sustainable change, recognising that health and wellbeing is impacted by the multifaceted complexity of socio-economic status.
- Achieving equity – given the demographics of our population, Māori health is our primary equity challenge and we will respond to this challenge by delivering on our pro-equity aspirations.
- Primary and community care – building on the strong relationships that have been developed with primary and community stakeholders, we will drive better collaboration with whānau and families through prioritisation of enhanced community-based models of care.
- 65,000 beds – this strategy links primary and community care with improving wrap–around support for those who need it most, while simplifying access and empowering people to enhance their self-management where necessary.
- Capacity and demand – there are aspects of public health service coverage requirements that may result in capacity excess from time-to-time and we are working to establish arrangements that make the optimum use of those times so as to fully service our population whilst also making best use of public resources.
- Benchmarking with other DHBs – relating to the clinical and financial sustainability challenges outlined in our plan, we are intending to embark on benchmarking exercises with other DHBs that have similar profiles (population and /or service structures) to ours so that we can target areas of discrepancy for further consideration and improvement.

The points above were discussed with the Ministry of Health in the lead up to production of this annual plan and have been agreed as important strategic considerations for Whanganui DHB.

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

2.1.1 Improving child wellbeing

Immunisation		
Whanganui DHB is consistently very close to meeting the national measures for immunisation, with very small numbers missing the target, often due to timing issues. In the last three quarters, the numbers of opt off and decliners has seen a slight increase, in part due to the anti-vaxxers gaining prominence. We continue to provide outreach services to the community wherever feasible.		
DHB activity	**Milestone**	**Measure**
▪ Conduct opportunistic childhood vaccination when people interface with secondary services, with a specific focus on Whanganui Accident and Medical Clinic and Whanganui DHB paediatric department. Co-develop a protocol with these two services to ensure that all tamariki are offered appropriate vaccinations. Review activity data at quarter 3.	Quarter 1 & 3	CW05/08
▪ Work alongside interagency networks, communities, to support an increase in Māori childhood immunisation coverage. Develop an engagement plan that targets groups/agencies (Well Child Tamariki Ora, kaupapa Māori services, WINZ, Ōranga Tamariki, early childhood education) who interface with Māori tamariki. Ensure messaging is consistent, up-to-date and a pathway for ease of access.	Quarter 2	CW05/08
▪ Develop a regional immunisation communication plan to correspond with Immunisation Week 2020 and influenza season. Use different technology and channels to connect with the population in various and innovative ways to increase awareness and how to access.	Quarter 4	CW05/08
▪ HPV immunisation targets will include coverage for both boys and girls.	Quarter 1	CWO5
Further information can be found in: ▪ Public Health Plan ▪ Maternity Quality Safety Programme Plan.		

School-based health services

Whanganui DHB delivers the Health Promoting Schools (HPS) programme in primary schools (year 1 to 8) from decile 1 to 4.

Whanganui DHB delivers the School-Based Health Services programme in all decile 1-4 secondary schools eligible for the programme.

DHB activity	Milestone	Measure
Progression of Rubric with HPS schools. Provide regular reports to ascertain HPS is delivered to 78.6% of schools in the WDHB district. Increase the rubric and health and wellbeing interactions to ensure ten schools receive this initiative.	Quarter 2 & 4	PH01
Whanganui DHB will provide services under the SBHS contract that enhances linkages with primary care for students health and wellbeing needs by engaging with PHOs to encourage GP enrolment of those students identified as not enrolled.	Quarters 1, 2, 3, 4	PH01
Services in secondary schools provide nurse-led clinics that offer assessment, referral to other services, and/or treatment under standing orders. Equity of access to HEEADSSS assessments for Māori (focusing on the 5% that fall outside the 95% target for assessment.	Quarter 4	PH01
Public health teams within schools will evaluate the effectiveness of the service by carrying out two PDSA cycles within the year, that are aimed at increasing access and equity to school health services.	Quarters 2 & 4	PH01
Involve secondary school students in ensuring that the services that are provided for youth are youth friendly, confidential and private by surveying students. 100% of student feedback states that service is confidential and private.	Quarter 3	PH01
Incorporate the Te Whare Tapa Whā Model to assist youth in the development of positive health and wellbeing messages to all students, family/whānau and the wider school community. Students' utilisation of the Te Whare Tapa Whā Model in sharing health messages through their social media.	Quarter4	PH01
Maintain awareness of rheumatic fever within schools. Liaison with Māori and Pacific Island whānau regarding background history on rheumatic fever with an emphasis on prevention. Report on other opportunities created to work with Māori and Pacific Island whānau.	Quarter 3	CW13
Develop a programme co-designed with students that supports education and self-managed activities that mitigates future risk associated with pre-diabetes. Involvement of students as key stakeholders in the planning of programmes that support weight reduction.	Quarter 4	PH01

Whanganui DHB commits to providing quantitative reports in quarter two and four on the implementation of school based health services (SBHS) in decile 1 to 4 secondary schools, decile 5 secondary schools (where applicable), teen parent units and alternative education facilities.	Quarters 1,2,3,4	PP39
Whanganui DHB commits to providing quarterly narrative reports on the actions of the SLAT to improve health of the DHB's youth population.	Quarters 1,2,3,4	SLAT

Midwifery workforce – hospital and Lead Maternity Carer (LMC)

Workforce development is a key enabler for New Zealand's DHBs and has a significant impact on service delivery and DHB outcomes.

The DHB employed midwifery workforce and LMC workforce is under pressure nationally and is facing widespread workforce challenges. There is a recognised lack of midwives nationally, problems with understaffed maternity units struggling to meet demand for midwifery services, as well as difficulty retaining and recruiting midwives.

DHB activity	Milestone	Measure
Attract and recruit an appropriately skilled Midwifery advisory leader to manage workforce development and drive governance across midwifery services.	Quarter 1	CW11
Working closely with primary and community providers to clarify LMC gaps, co-design and establish a sustainable model to meet the anticipated need.		
Co-design completed Model implemented	Quarter 2 Quarter 3-4	
When the advisory leader appointment is in position (hospital and community) establish a project team to: ▪ Develop a longer-term midwifery workforce plan (which will have equity focus including cultural competency and increased Māori participation in the workforce) ▪ Ensure service delivery mechanisms make the best use of other health workforces to support pregnant people and midwifery roles ▪ Implement the midwifery workforce plan ▪ Evaluate the midwifery workforce plan.	 Quarter 2 Quarter 2 Quarter 3 Quarter 4	
Please also refer to CCDM – page 45.		

First 1000 days (conception to around 2 years of age)

Whanganui DHB will use data, co-design, and an equity lens to ensure that we are addressing specific risk factors for the first 1000 days of life. The WhanganuiDHB district has a population with higher than average levels of deprivation, poor statistics for babies living in smokefree homes and high levels of family stress.

DHB activity	Milestone	Measure
First 1000 days		
The maternal, child and youth governance group will lead the development of a three to five-year strategic plan that will identify priorities and develop an implementation plan for an integrated whole of system approach (primary, secondary, cross-sector, community) for the first 1000 days of a child's life that aligns to the child wellbeing strategy.	Quarters 1-4	CW11
Targeted activities		
Te Rerenga Tahi (TRT) – Maternal care and wellbeing group will:		
▪ Develop an engagement plan to educate identified agencies/groups/people about TRT and its referral process to increase early referrals.	Quarters 1-4	
▪ Will increase consented referrals to 100%.	Quarter 1	CW11
▪ Develop a protocol to include an advisory component for non-consented referrals based on the privacy commission escalation ladder.	Quarter 3	PP44
Well Child Tamariki Ora (WCTO):		
▪ Participate in the national Well Child Tamariki Ora service review. Implement recommendations within Ministry of Health timeframes		
▪ Raise awareness on key SUDI modifiable risk factors, protective factors, treatment and support services with a focus on at risk, vulnerable tamariki and whānau	Ongoing	CW11 & SL13
▪ Participate in the TAS-led Whanganui WCTO Smokerlyser Improvement Plan aimed to reduce the number of infants exposed to tobacco smoke, by supporting household members to stop smoking.	Quarter 1	Data from Quit Clinic on referrals from WCTO
▪ Targeted professional development opportunities to increase skill level in motivational interviewing, safe sleep space as the two modifiable risk factors focus areas	Quarter 2 & 3	
▪ Continue to work on smooth transition from midwifery care to the WCTO services		
▪ Participate in the TAS-led SUDI prevention programme.		

Pregnancy and parenting: ▪ Work alongside interagency networks, communities in particular kaupapa Māori services, LMCs to secure early referrals. ▪ Provide education to agencies and groups who interact with pregnant women around key educational messages important in pregnancy and early childhood. ▪ Collaborate with Iwi to ensure support empowers Māori whānau and enhances programmes in terms of cultural responsiveness.	Ongoing	CW11
Access to appointments: ▪ Analyse data reporting on missed appointments for children, with a focus on equity. ▪ Explore effective ways of communication with whānau to ensure appropriate appointments are offered.	Quarter 2 Quarter 4	CW11
Please also refer to: ▪ Immunisation service – page 13 ▪ SUDI section – page 21 ▪ Maternal mental health – page 30.		
Healthy weight in children		
Whanganui DHB will implement the Growth Assessment Protocol: ▪ Develop work plan ▪ Provide the GROW-App ▪ Training and accreditation of all staff involved in maternity care ▪ Adoption of evidence based protocols and guidelines ▪ Rolling audit, reporting and benchmarking of performance.	Quarter 1 Quarter 2 Quarter 3/4 Quarter 2 Quarter 2/3	CW11

Family Violence and Sexual Violence (FVSV)

Whanganui DHB works alongside interagency networks, communities and key stakeholders to strengthen collaboration and respond to family and sexual violence.

We have an established Violence Intervention Programme (VIP) with a VIP coordinator and a child protection coordinator who lead much of the cross-sector collaboration.

DHB activity	Milestone	Measure
Cross-sectoral collaboration: Maintain and strengthen existing networks: ▪ MoU with the Police and Ōranga Tamariki for information sharing and integrated work around child abuse and neglect ▪ Member of the Violence Intervention Network, inter-sector networking, joint project work ▪ WDHB VIP Governance Group, comprising of sector partners, kaupapa Māori organisations, with a strategic and integration focus ▪ Family Violence Interagency Response System (manage cases of family violence reported by the Police). Whanganui DHB social workers respond to all situations where a pregnant women is involved		
▪ White Ribbon Day – Whanganui DHB and sector partners develop local awareness-raising response.	Quarter 3	CW11
Ensure continued commitment of Whanganui DHB in the development of the Police initiative (interagency collaboration aimed at victims and perpetrators) and contribute to opportunities for service development and integration across sectors and co-designed with Iwi. Report on progress.	Quarter 2	
Whanganui DHB has fluctuating screening rates for family violence. In order to improve the screening rates and the confidence and competence of clinical staff to respond to incidences of family violence and child abuse and neglect, the aim is to have 100% of clinical staff attend core VIP training (includes intimate partner violence and child abuse and neglect) and participate in regular refresher training. Staff from Te Hau Ranga Ora, Māori Health are involved in development and presentation of the training. Report on rates in quarter 4.	Quarter 4	
It is recognised that Whanganui DHB staff members may also be victims or perpetrators of family/sexual violence. 100% of all Whanganui DHB staff who work with children have workers safety checks in accordance with the Children's Act. New guidelines for Whanganui DHB managers will be developed to assist them to support staff who may be victims and provide guidance on how to respond to alleged perpetrators. In addition to the guidelines, a training package will developed and delivered to managers.		
▪ Guideline developed. ▪ Develop training package for manager. ▪ Roll out of training to managers.	Quarter 1 Quarter 3 Quarter 4	

Whanganui DHB has one of the highest incidences of elder abuse and neglect in New Zealand. The Whanganui DHB Elder Abuse and Neglect (EAN) Policy and Procedure will be updated, and a training package will be developed and rolled out to staff. Further exploration of the potential to include external providers in the training will occur once implemented across the DHB. A communication plan will be developed for the initial phase of the roll out. Staff from Te Hau Ranga Ora, Māori Health are involved in the development and presentation of the training and policy. Quarter 1 – policy and procedure for EAN updated to reflect national guidelines Quarter 2 – training developed Quarter 3 – training team identified third quarter and delivered first training Quarter 4 – deliver EAN in the training, including Iwi organisations. Shaken baby prevention – Power to Protect programme: ▪ Six-monthly report on utilisation of ED child protection checklist ▪ Six-monthly report on hospital-based activities and WRHN antenatal education programme. Please also refer to: ▪ Family Violence Health Promotion – page 19 ▪ Maternal mental health – page 30.	Quarter 1 Quarter 2 Quarter 3 Quarter 4 Quarter 2 & 4 Quarter 2 & 4	CW11

Sudden Unexpected Death in Infancy (SUDI)

With a 2017 rate of 2.6 per 1,000, Whanganui DHB has the third highest national SUDI rate. The DHB is committed to focusing on key modifiable risk factors and working in partnership with Iwi to find local solutions that address these risk factors.

DHB activity	Milestone	Measure
The maternal, child and youth governance group will lead the development a 3-5 year strategic plan that will identify priorities and develop an implementation plan for an integrated whole of system approach (primary, secondary, cross-sector, community) for the first 1000 days of a child's life that aligns to the child wellbeing strategy.	Quarter 1-4	CW11
Well Child Tamariki Ora (WCTO) participate in the TAS led Whanganui WCTO Smokelyser Improvement Plan aimed to reduce the number of infants exposed to tobacco smoke, by supporting household members to stop smoking.	Quarter 1 & 2	
WCTO participate in the TAS led SUDI prevention programme. Participate in the 2019 SUDI prevention impact project	Quarter 1 & 2	
SUDI coordinator will develop an engagement plan to link regularly with groups/agencies/providers to provide consistent education on the modifiable risk factors of SUDI, to increase early referrals for pregnancy and parenting programmes, safe sleep devices, healthy homes information. The minimum number of sleep safe devices that we aim to distribute in the financial year is 300 units. Workforce development will follow the TAS regional plan. Please also refer to: ▪ Maternal mental health – page 30.	Quarter 1	

2.1.2 Improving mental wellbeing

Inquiry into mental health and addiction		
Whanganui DHB is committed to supporting the national approach to mental health wellbeing for our local population.		
DHB activity	**Milestone**	**Measure**
Whanganui DHB is committed to implementing the outcomes of the Government Inquiry into mental health and addictions (*He Ara Oranga)* based on guidance received. Whanganui Rising to the Challenge Mental Health and Addiction Service Framework outlined the future development of the district's mental health and addiction services. The framework highlights the importance of building resilient communities across the district by providing communities with the tools to enable them to address issues and concerns.		MH01 Improving the Health status of people with severe mental illness though improved access
Whanganui DHB will work with sector partners on how 'social mobilisation' could assist with building community resilience and wellbeing.	Quarter 1-4	
Whanganui DHB will continue to work with sector partners addressing housing/accommodation issues across the district. These issues are impacting on services and service users/tangata whaiora.	Quarter 1-4	
Whanganui DHB will work in partnership with Māori, people with lived experience, NGOs, primary and community organisations, and other stakeholders to build a whole-of-system, integrated approach to mental health, addiction and wellbeing that provides options for New Zealanders across the full continuum of need.	Quarter 1-4	
Whanganui DHB will work with the Ministry of Health to implement agreed actions following the Mental Health and Addiction Inquiry and implement relevant Budget 2019 initiatives.	Quarter 1-4	
Whanganui DHB will outline actions contributing to the direction signalled by the Government in response to *He Ara Oranga*.		
Whanganui DHB will identify opportunities to build on existing foundations and include actions in relation to improving and/or addressing all of these areas of focus.		
Embedding a wellbeing focus ▪ Demonstrate a focus on wellbeing and equity at all points of the system. ▪ Improve the physical health outcomes for people with mental health and addiction conditions.	Quarter 1-4	

Building the continuum / increasing access and choice ▪ Work in partnership with the Ministry, Māori, Pacific people, young people, people with lived experience, NGOs, primary and community organisations, and other stakeholders to plan an integrated approach to mental health, addiction and wellbeing and roll out new primary level responses from Budget 2019. ▪ Strengthen and increase focus on mental health promotion, prevention, identification and early intervention. ▪ Continue existing initiatives that contribute to primary mental health and addiction outcomes and align with the future direction set by *He Ara Ōranga,* including strengthening delivery of psychological therapies. ▪ Identify options to strengthen connections and build support across the full continuum of care, including in the primary and community mental health and addiction space.	Quarter 1-2	
Suicide prevention ▪ Contribute to the implementation of the Suicide Prevention Strategy, and any associated plans. ▪ Continue existing suicide prevention and postvention efforts to provide a range of activities such as mental health literacy and suicide prevention training, community-led prevention and postvention initiatives (ie, bereavement counselling) and integration of mental health and addiction services.	Quarter 1-4	
Crisis response ▪ Improve options for acute responses including improving crisis and home treatment team responses and improved respite options, and work with the Ministry to plan future responses.	Quarter 1-2	
NGOs ▪ Work alongside the kaupapa Māori AOD provider in improving equity of access and engagement for tangata whaiora and whānau. Include the kaupapa Māori, peer support (Balance Network) and family/whānau support providers (Mental Health and Wellbeing Foundation) in the design and implementation of both acute and planned detoxification facilities in the Whanganui district. Include provision of support for professional education and travel costs to ensure participation by the NGO workforce and particularly the kaupapa Māori NGO workforce in programmes and co-design projects.	Quarter 1-4	

Workforce ▪ Work in partnership with workforce centres to strengthen current workforces, including a focus on retention, recruitment and training. Focus on recruitment and retention of a workforce that matches the population, with particular attention to Māori and Pasifika workforce. Partner with primary care to develop opportunities for employment of nursing and allied health roles in primary care so as to increase access to generalist mental health and addictions care with strong linkages to specialist support when needed. ▪ Demonstrate a commitment to lived experience and whānau support roles being supported and deployed across all services. ▪ Support workforce development of the appropriate knowledge and skills to support people with mental health and addiction needs, for example through use of the Let's Get Real framework. **Mental Health and Wellbeing Commission** ▪ Work collaboratively with any new Commission. **Forensics** ▪ Work with the Ministry to improve and expand the capacity of forensic responses from Budget 2019 including engaging and contributing to the Forensic Framework project.	Quarter 1-4 Once established Quarter 1-4	

Population mental health

Whanganui DHB is committed to the integration of primary and specialist services through a network approach. We support increasing the capability of the primary mental health and addiction workforce.

DHB activity	Milestone	Measure
Continue with implementation of the specialist adult mental health and addiction network model of care (hubs link all general practice teams to secondary teams and includes kaupapa Māori NGO partners). The model supports integration of MH&As with physical health care, including transition across the continuum of care. Includes coordination of community resources to improve equity for Māori, Pacific and all service users/tangata whaiora regarding their overall wellbeing.	Ongoing	MH04 Mental Health and Addiction Services Development
Associated initiatives include: ▪ Implementation of a single point of coordination for urgent and community mental health services (adult) within a strengthened intake team aligned to the Network Model of Care (person centred, integrated, seamless, stepped care, outcome focused, evidence based and adaptable).	Quarter 2	Focus Area 3
▪ Implementation of new triage and urgent crisis assessment processes.	Quarter 2	Focus Area 3
▪ Implementation of recommendation derived from an audit or review of the DHB's crisis intervention and intensive treatment service, Mental Health Assessment and Home Treatment Team (MHAHT) (Quality Improvement Project).	Quarter 4	Focus Area 3
▪ Review of Mental Health and Addiction NASC model.	Quarter 2	
Schedule evaluation of the Network Model of Care for 2020/21.		
Adapt best practice approaches for early intervention psychosis to the local context, with a particular focus for meeting the needs of Māori in order to develop an Early Intervention Service. This will initially focus on provision of services for 18 to 25-year-olds.	Quarter 4	Focus Area 3
Ensure that consideration of employment, education and training options for service users/tangata whaiora with low prevalence conditions are included as part of the DHB's specialist service multidisciplinary processes. This will occur in partnership with service users/tangata whaiora, whānau and NGOs when developing the service user's individual care plan.	Quarter 1	Focus Area 5
Develop a district-wide suicide prevention and post-vention strategy and action plan, through a partnership approach that ensures an integrated cross-agency and community response to suicide in the WDHB district. Healthy Families Whanganui Rangitikei Ruapehu will be providing governance (includes Whanganui DHB).	Quarter 4	Focus Area 2

Consider options for care of the acutely unwell child and youth closer to home in a manner that better supports them and their whānau.	Quarter 4	Focus Area 4
The Whanganui DHB is developing a strategy for the first 1000 days of a child's life and will include Infant, Child, Maternal, Mental Health and Addiction Services.	Quarter 4	Focus Area 4
Consider options for supporting youth with mental health and addiction issues who are in crisis, including respite, home-based care and other alternatives to inpatient admission.	Quarter 4	Focus Area 4

Mental health and addictions improvement activities

Whanganui DHB is committed to ongoing quality improvement with a focus of improving tangata whaiora and whānau experience of mental health and addiction services.

DHB activity	Milestone	Measure
Continued commitment to the key Health Quality Safety Commission (HQSC) priority projects		
Minimising restrictive care is well underway and includes the following activities: ▪ Reducing the use of seclusion; plus use of restraint reduction tools, for example training in the use of Broset Violence Checklist, sensory modulation, trauma-informed care. ▪ Develop structured seclusion and restraint debriefing: Includes analysis of all incidents to ensure use of best practice including utilisation of peer support for debriefing service users/tangata whaiora. ▪ Continue with the evaluation and improvement work to review and establish best practice guidelines for debriefing for staff, service users/tangata whaiora and whānau. ▪ Deliver formal and targeted seclusion reduction training: Driven by the implementation of SPEC; and Broset Violence Checklist training and associated interventions. ▪ Developing a focused, proactive community intervention for service users who have a past history of seclusion to support these service users better in the community. ▪ Continue to record and analyse extensive demographic information about individuals secluded: Ensuring all staff are familiar with the data and associated trends including community and medical staff. ▪ Improved integration and collaboration between other health and social services for co-existing problems, for example closer collaboration with Corrections, probation and Iwi provider services to improve access to Mental Health and Addiction Services resources and interventions.	Ongoing	MH04 Mental Health and Addiction Services Development

Improving service transition has commenced and activities include the following: ▪ Deliberate focus and actions on building the MH&A workforce capability across the transitions of care. This includes specialist, NGOs and Iwi partners, and general practice. ▪ Describing all aspects and functions of stepped care. ▪ Mapping patient flow. ▪ Development of single point of entry. ▪ Regular review of network model of care with reporting to ensure positive outcomes and sustained service quality improvement. ▪ Partnering with colleagues in physical health and the NGO kaupapa Māori to develop a local inpatient alcohol detoxification service and step-up and step-down placements linked to regional acute intervention services. **Whanganui DHB will be actively engaged in the following HQSC improvement projects as these are progressed:** 1. Learning from Serious Adverse Events and Consumer Experience 2. Maximising Physical Health 3. Improving Medication Management and Prescribing.	Ongoing	MHO2 Improving mental health services using wellness and transition planning

Addiction

Whanganui DHB is committed to ensuring that all addiction services are responsive, effective and are meeting the needs of our population.

DHB activity	Milestone	Measure
The DHB will do a stocktake of existing and planned Alcohol and Other Drug (AOD) services including for women, Māori and Pacific, older people, opioid substitution, criminal justice clients and LGBTQI communities, with a focus on equity.	Quarter 1	MH03 short wait times for non-urgent mental health and addiction services
Continue with implementation of the specialist adult mental health and addiction network model of care (hubs link all general practice teams and includes kaupapa Māori NGO partners). The model supports integration of mental health and addiction, as well as mental health and addiction with physical health care, including transition across the continuum of care.	Ongoing	
To support engagement and equitable access for service users/tangata whaiora to the new regional intensive AOD services, local kaupapa NGO alcohol and other drug services have been reconfigured to include an AOD day treatment and prevention programme, community support with accommodation (including step-up and step-down from regional AOD services) and kaupapa AOD resource. This service in turn is to work in partnership with the network model of care, bridging from primary to secondary Mental Health and Addiction Services.	Ongoing	
To improve access to alcohol screening and risk assessment of older adults with co-morbidities, the Whanganui Regional Health Network (WRHN) is engaged in a collaborative research project in association with Massey University and Auckland University. The project focuses on use of a cultural wellbeing framework for alcohol related conversations, due to the high prevalence of co-morbidities for Māori and the significant risks involved when there is alcohol use by people with long-term health conditions.	Quarter 4	
The reconfigured kaupapa NGO alcohol and other drug service and the impact of the network model of care will be closely monitored to ensure these integrated arrangements are meeting the AOD specific demand with appropriate access and outcomes.	Ongoing	
Embed provision of planned inpatient managed withdrawal services within the district.	Quarter 4	
Finalise and implement the Whanganui DHB's Acute Drug Harm Response Plan to enable a local response for accessing the Acute Drug Harm Response Discretionary Fund as a mitigation of acute drug harm associated with synthetic cannabinoids.		
Stocktake of services (primary and specialist) for youth across the district including youth access to addiction services.	Quarter 4	PP25

Maternal mental health services

Whanganui DHB is committed to providing maternal mental health (MMH) services that are responsive to the needs of women, and are linked and integrated with other key service providers such as kaupapa providers using the expertise of the Māori Health Outcomes Advisory Group (MHOAG)

DHB activity	Milestone	Measure
▪ Whanganui DHB to provide the Perinatal Ministry of Health report quarterly. ▪ Maternal mental health clinicians will complete the stocktake of all primary mental health services within the Whanganui district and plan targeted engagement with providers/groups to ensure early referrals, equity of access and outcomes for Māori and Pacific women. ▪ Collect ethnicity data and measure progress of outcomes from care plans. ▪ Complete the network model pathway for maternal mental health. ▪ Maternal mental health team to integrate with Infant Child Adolescent Mental Health and Addictions Service (ICAMHS) to ensure seamlessness across the care continuum; and provide easier access to ICAMHS services (including attachment based therapies and Supporting Parents Healthy Children (SPHC – formerly COPMIA). ▪ Explore recruitment of a Pacific midwife/nurse/community worker to assist with the engagement with this growing population group and improve their access to MH&A services.	Quarter 1	Maternal MH PP44
▪ Te Rākau (rural hub) have a large percentage of women of Pasifika ethnicity. To increase staff knowledge the mental health and addictions service will ensure all staff, particularly rural clinicians, have access to Pasifika training via Le Va. ▪ Collect ethnicity data. ▪ Strengthen engagement with the regional MMH team for ongoing training opportunities e.g. via Perinatal Anxiety and Depression Aotearoa (PADA). ▪ Pathway for MMH between primary and secondary services. Schedule MMH presentation for Whanganui Inter-Professional Education (WIPE) forum to increase awareness and integration between primary and secondary services. ▪ Report on activities that support the integration across primary, specialist and community, in particular, regular attendance at the Te Rerenga Tahi (Maternal Care and Wellbeing Group).	Quarter 2	Maternal MH PP44
▪ Introduction of a connecting care role coupled with the mental health and addiction link coordinator role within community mental health and addiction services (CMH&AS) will assist the MMH clinical staff with promoting perinatal services for service user/tangata whaiora within the WDHB district including via MHOAG, probation and the wider community.	Quarter 3	Maternal MH PP44 MH04 Mental Health and Addiction Services Development Focus area 4

▪ Collect ethnicity data. ▪ Provide file audit to indicate whether Supporting Parents Healthy Children processes are being followed at every engagement with women in the perinatal period. ▪ Collate ethnicity data to inform 2020 activities for MMH. ▪ Using the data productively to review MMH services.	Quarter 4	Maternal MH PP44

2.1.3 Improving wellbeing through prevention

Cross-sectoral collaboration		
Cross-sectoral collaboration is a cornerstone of Whanganui DHB's '65,000 beds' campaign. As explained elsewhere, the campaign mantra is that the best bed for everyone is their own one – not one in the hospital. To support this view, we are refocusing DHB activity to have a clear community orientation and the DHB is strengthening its participation in cross-sector collaboration. Some examples are highlighted below.		
DHB activity	**Milestone**	**Measure**
Healthy Homes The DHB is engaged in in the development of the Whanganui Housing Strategy being led by the Whanganui District Council. ▪ Consultation completed.	Quarter 1	DHB participation
Family violence and sexual violence See page 19, which refers to collaboration with Police, Ōranga Tamariki and community agencies to focus on reducing family harm.		
Age Friendly Whanganui An initiative led by Whanganui District Council to gain age-friendly status for Whanganui city. ▪ DHB actions quantified. ▪ DHB lead and supporting actions included in plans for 2020 onwards.	Quarter 2 Quarter 4	Actions agreed
Te Puni Kōkiri Clarify level of support being provided through Whānau Ora to the WDHB district and ensure DHB involvement continues to empower whānau.		
▪ Ruapehu Whānau Transformation: Continue to engage with and provide support to community development initiatives as required by the Raetihi-Ohakune-Waiouru collaboration.	Quarters 1-4	

Climate change

Whanganui DHB commits to making efforts to reduce carbon emissions and, promote the adoption of CEMARS (or other carbon neutral scheme). This will require individual and collective efforts.

DHB activity	Milestone	Measure
Undertake a stocktake to identify what actions are already occurring, including through procurement, that are expected to positively mitigate or adapt to the effects of climate change. Ministry of Health survey completed November 2018. Areas identified to date include: ▪ Reduce carbon emissions via composition and use of vehicle fleet (over three years). ▪ Develop a sustainability plan.	 Ongoing Quarter 2	PP40: Responding to climate change

Waste disposal

Whanganui DHB commits to raising awareness and actively promoting the use environmentally friendly waste disposal methods and practices.

DHB activity	Milestone	Measure
Undertake a stocktake to determine what actions are required to support appropriate and safe disposal of hospital and community waste products, including cytotoxic waste. Audit of waste streams completed October 2018. Areas identified to date include: ▪ Develop plan to implement audit recommendations. ▪ DHB campus recycling programme. Considering proposal to recycle all waste on site (excluding cytotoxic) into a building product to be used in construction. Increase awareness through public education programme to support the community pharmaceutical waste management and disposal process already in place.	 Quarter 2 Quarter 3	PP41: Waste disposal

Drinking water		
Drinking water 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 protection services across the Manawatu-Whanganui region. Although these activities are provided by another DHB, Whanganui DHB is works closely with the MidCentral PHU and is committed to supporting these activities and working to improve drinking water quality in communities across our district.		
DHB activity ▪ Whanganui DHB Public Health Service will meet regularly with the Drinking Water Technical Advice Service from MidCentral DHB's PHU to understand and support drinking water activities. ▪ Participate in the environmental health exemplar (PHU) and activities with a focus on improving drinking water quality in Māori and isolated communities.	**Milestone** Reporting for end of Quarters 2 & 4	**Measure**

Healthy food and drink

Whanganui DHB is committed to promoting and leading implementation of healthier food and drink environments as a protective factor to preventing health loss in our district.

Two priority areas of focus for the next 12 months will be:

1. Whanganui DHB modelling healthy food and drink environments
2. Supporting education settings to improve Māori health outcomes, promote and model healthy food and drink environments.

DHB activity	Milestone	Measure
Development and Adoption of Healthy Food and Drink policy - Whanganui DHB		
▪ Review Whanganui DHB nutrition policy to strengthen and align to the National Healthy Food and Drink Policy.	End of quarter 1	
▪ Development of Whanganui DHB Healthy food and Drink policy alongside review of food environment for alignment.	End of quarter 2	
▪ Gain commitment from both Whanganui DHB and food contract provider to adopt and implement policy	End of quarter 3	100% implemented
▪ Work towards all providers/others that contract to the Whanganui DHB who supply food or drink having a healthy food and drink clause in their contract.	Reporting for end of quarters 2 & 4	Total number/ proportion of contracts
Create supportive environments for healthy eating across settings – focus on education settings		
▪ Undertake a stocktake to identify and report on number of early learning settings, primary, intermediate and secondary schools within the WDHB district that have a current: 1) Water-only (including plain milk) policy, and 2) Healthy food policy. Actively promote and support implementation of policies in: 1) Kōhanga reo and other early learning settings 2) All schools.	Reporting for end of quarters 2 & 4	Total number/ proportion of formal policies.

Smokefree 2025

The prevalence of smoking in the WDHB district continues to be higher than the national average. While we have seen an improvement in smoking rates amongst some population groups, there has been minimal reduction in smoking status of Māori, pregnant women and people with mental health conditions.

Our overarching priority is to eliminate inequity for Māori, who are over-represented in smoking rates, along with pregnant women and people with mental health conditions. Therefore our intention is to redesign the current framework and focus on a model underpinned by a Whānau Ora concept to shift the focus from smoking cessation to providing a person-centred pathway to being smokefree.

DHB activity	Milestone	Measure
Undertake external evaluation to inform development of a framework/model underpinned by the Whānau Ora concept to shift focus from smoking cessation to providing a person-centred pathway to smokefree and including a shift from cessation focus to addressing barriers to quit.	Framework developed by end of Quarter 2 with timeframes for the activity identified	SS05 CW09 PH04
Explore Whānau Ora approach based on learnings and recommendations from the Kaiwhakatere Ōranga initiative (kaiāwhina) in priority areas, maternity, Māori, mental health and stop smoking services.		90% primary care target
Introduce motivational interviewing training in priority areas including maternity settings.	Training programme identified end of Quarter 2	95% hospital target
Implement automatic referral to stop smoking services from lead maternity carers for all pregnant women who smoke.	Referral pathway from LMC to stop smoking services established by end of Quarter 3	90% maternity target
Identify an integrated primary care approach within current programmes including healthy homes, outreach, pregnancy and parenting to include linkages and support to stop smoking services.		
Undertake cessation opportunities in other settings including workplaces, Marae and sports venues, targeted at priority groups.		
Identify support for and active engagement with rangatahi targeting high risk and need, for example within alternative education settings.		

Work alongside interagency networks, communities and key settings to raise awareness on the importance of quitting/being smokefree. Localise smokefree messaging targeting priority groups.	Collective communications plan developed by end of Quarter 3	

Breast screening		
The aim of the national breast screening programme is to reduce morbidity and mortality from breast cancer by the early detection and treatment of the disease. Actions will continue to focus on ensuring the equity gaps are eliminated for priority group (Māori and Pacific Island) women.		
DHB activity	**Milestone**	**Measure**
Increase breast screening rates focussed on priority populations (Māori and Pacific Island women) through:		75% coverage for Māori
▪ Māori health providers located across the region support women to screening including offering transport, information and support.	Ongoing	82% for Other
▪ Outreach service and Māori providers liaise with Breast Screen Coast to Coast (BSCC) to ensure scheduled mobile unit visits in Taihape and Ohakune are well attended.	Attendance rates consistent/exceed previous visit Quarter 2	70% Pacific
▪ Develop simple, clear localised screening messages and information appropriate for Māori, Pacific and Asian women through the combined communications network. A review of current client resources will be undertaken including engagement with women and key stakeholders.	Client resources reviewed Quarter 3	
▪ Local communities through Māori health providers and primary care/outreach service to identify local women for poster advertising of mobile service visits.	Champions identified Quarter 2	

Cervical screening		
An 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).		
DHB activity	**Milestone**	**Measure**
The Cervical Screening Action Plan 2019/20 outlines actions that aim to increase cervical screening rates focused on priority populations (Māori, Pacific Island and Asian) women. Activity includes: ▪ Develop simple, clear localised screening messages and information appropriate for Māori, Pacific and Asian women through the combined communications network. A review of current client resources will be undertaken including engagement with women and key stakeholders.	Quarter 2 client resources reviewed and updated	75% coverage for Māori 80% for Other
▪ Undertake regular stakeholder hui to ensure a collaborative approach that includes review of progress against the action plan.	Quarter 2 & Quarter 4 stakeholder hui undertaken	78% Pacific
▪ Further develop the integrated approach between specialist services, and the outreach team to identify and engage Māori women to colposcopy and cervical screening. Activity will include enhancing relationships between services, sharing wahine stories to inform service improvement and expanding smear taker training to include an improved understanding of the colposcopy pathway and how to improve attendance.	Quarter 2	60% Asian
▪ Raise awareness of cervical screening across the region led by the Health Promotion and Outreach Service through promotional activity including promotion of the Smear your Mea campaign in September 2019.	Quarter 1 Smear your Mea Campaign completed	
▪ Expand opportunistic screening outreach services in other settings including UCOL Whanganui campus and local intermediate schools (for teachers and parents/caregivers).	Outreach services undertaken in/by Quarter 3	
▪ Undertake a quality improvement initiative with a focus on high needs practices to improve utilisation of data and practice recall behaviour in priority group women.	Focused support to a minimum of four practices	

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

Engagement and obligations as a Treaty partner		
Whanganui DHB is a pro equity organisation with a commitment to achieving equity in health outcomes for Māori. We will continue to build on our established relationships and engage with Iwi, Māori communities and providers and to meet our obligations as a Treaty Partner under Te Tiriti o Waitangi. Board members and all Whanganui DHB staff attend 'Hāpai te Hoe' our cultural awareness and education programme. Leaders are being equipped through training on equity tools and methodologies, and equity is now a KPI for leaders. Equity training is being offered to local provider partner leaders and teams. Central Region Equity Framework will be integrated in commissioning processes. Our workforce continue to receive cultural training, including refresher courses, and Hāpai te Hoe has been extended to some external partners. Developing strong relationship with consumers through Te Pukaea (Whanganui DHB consumer council) and community leaders continues.		
DHB activity	**Milestone**	**Measure**
Maintain close working relationships between Whanganui DHB board and Hauora A Iwi (HAI), Māori relationship board, through: ▪ Regular joint hui – quarterly ▪ Review Memorandum of Understanding (MoU) between Whanganui DHB and HAI boards 2020 ▪ Involvement of HAI members in all key DHB strategic decisions ▪ Joint board monitoring of equity measures in Whanganui DHB Annual Plan and pro equity implementation work plan ▪ HAI representation on all interviews for executive positions ▪ HAI representation on combined committees and performance review for chief executive	Ongoing	Review complete, revised MoU signed , joint work plan agreed
▪ Implement the outcomes from the facilitated partnership hui as recommended in the Whanganui DHB Pro-equity Report.	Quarter 1	Agreed actions completed
Implement the Whanganui DHB Pro-equity Check-up Actions Implementation Plan – 2019-21report under the themes of: ▪ Organisational leadership and accountability for equity ▪ Māori workforce and Māori health and equity capability (linked to workforce development sections page 61 and 88) ▪ Transparency in data and decision making ▪ Authentic partnership with Māori.	Ongoing	Quarterly Reporting to Board and WALT

Waitangi Tribunal Wai 2575 outcomes		
▪ Review and update our Māori health policies and include a refresh of the Treaty Principles of Participation, Partnership and Protection to include the framing used by the Tribunal to assess Wai 2575.	Quarter 4	Review completed, revised policy endorsed by Whanganui DHB and Hauora A Iwi boards
▪ Participate in the design and implement the proposed Ministry of Health and or Central Region Treaty framework to ensure we meet the statutory obligations as prescribed by the Tribunal and their interpretation of the Treaty clauses under the NZ Public Health and Disability Act 2000.	Quarter 2-4	Participate in design and implement framework.
Leadership		
▪ Professional development (training) in equity tools and methodologies.	Quarter 4	Training sessions completed
▪ KPI-equity for all senior and executive leadership position descriptions on review/on recruitment.	Quarter 3	All executive and leadership staff have equity KPIs
▪ Extend equity professional development to local provider partner leaders.	Quarter 4	Partner organisations completed training
▪ Newly elected board members orientation programme includes cultural awareness and education and equity tools and methodology and impact of racism and colonisation on health outcomes for Māori whānau.	Quarter 2	Board orientation concluded
Data		
▪ Implement the Central Region Equity Framework and equity tools and methodology to guide decision making for investment and procurement.	Quarter 4	Dashboard developed, monitored and reported to the various boards six monthly
▪ Develop dashboard to monitor progress towards equity for Māori across priority indicators.	Quarter 2	Staff attend programme Evaluation indicates value to staff and culture change
Workforce		
▪ Continue Hāpai te Hoe (Whanganui DHB cultural awareness and education programme) programme for new staff and refresher for existing staff	Ongoing	50% of Te Pukaea membership is Māori

▪ External partners attend Hāpai te Hoe such as St John Ambulance Service, Hospice Whanganui staff.	Quarter 2-4	Group formed and engaged
Partnership		
▪ Increase number of Māori as members of Te Pukaea (Consumer Council) to equate to 50% of the total membership.	Quarter 3	MoU review complete
▪ Develop a Māori reference group – community and health expertise to feedback on service change and improvement, policy and process across the system related to Whānau Ora, services to Māori and equity in health outcomes for Māori whanau.	Quarter 1	Work plan developed and reported on quarterly at joint board hui
▪ Annual review of MoU between Whanganui DHB and Hauora A Iwi boards.	Quarter 4	
▪ Develop work programme between boards to measure improvement in equity for Māori across annual plan equity oriented activity (EOA) indicators.	Quarter 1	

Delivery of Whānau Ora

Whanganui DHB committed to Whānau Ora as an overarching philosophy and service delivery approach in 2014. This has informed our DHB values and continues to guide the way we work. Some significant activities in our work programme for 2019/20 that will contribute to Māori health advancement and achieve health equity for Māori whānau are outlined below.

DHB activity will:	**Milestone**	**Measure**
1 Contribute to the strategic change for Whānau Ora approaches within the DHB systems and services, across the district, and to demonstrate meaningful activity moving toward improved service delivery through:		
▪ Complete the review of MoU 2017-20 between Whanganui DHB and Hauora A Iwi (Māori relationship board).	Quarter 4	MoU goals and work plan endorsed
▪ Implement the actions outlined in the Whanganui DHB Pro-equity check-up report December 2018 work plan described in section 4.3.	Quarter 1-4	Implementation plan completed for year 1
▪ Formally review and apply the equity lens to service investments and actively reshape our investment for 2020/21 toward achieving equity in health outcomes for Māori whānau.	Quarter 3-4	Review completed investment plan identified for 2020/21
▪ Applying the equity lens and Whānau Ora philosophy to ensure that governance, leadership and our wider workforce understand their collective responsibilities for Māori health, are culturally aware, and supported in their practice.	Ongoing	KPIs for leadership
▪ Review investment in kaupapa Māori services, to ensure whānau choice and support building capacity and capability of Māori provider workforce across our system.	Quarter 3-4	Review completed investment plan identified for 2020/21
▪ Partner with our primary health organisations to establish two whānau centres – general practice and social service wrap around – one of which is kaupapa Māori. Implemented through a Whānau Ora - whānau centred model of care.	Quarter 4	Development plan completed and costed, options agreed

▪ Develop a Māori health reference group – made up of Māori health and social service professionals to provide advice to key services 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.	Quarter 2	Reference group in place and active
▪ Extend the Whanganui DHB Hāpai te Hoe Māori cultural education and awareness programme to general practice and community providers to build cultural understanding and improve the way Māori whānau receive and experience services.	Quarter 3-4	Programme underway for general practice and community providers
▪ Incorporate Te Whare Tapa Whā model to assist youth in the development of positive health and wellness messages to all students, whānau and the wider school. (Refer to school-based health services – page 13).	Quarter 4	Youth accessing co-designed health messages through social media
▪ Develop a whānau ora - whānau centred care scorecard (KPIs) for all Whanganui DHB service teams.	Quarter 2-3	Score card active
▪ Applying the philosophy of Whānau Ora as a key principle in how we partner with all health consumers and their whānau and how we understand and acknowledge their cultural beliefs – evaluate the introduction of the Kōrero Mai programme.	Quarter 4	Evaluation completed
▪ Implement the recommendations from the Whanganui DHB Health Literacy Review 2019 including information to Māori whānau in te reo Māori. (Refer to health literacy – page 65).	Quarter 4	Recommendation implemented
▪ Continue to work across systems to support whānau goals and aspirations and building resilience in whānau and the community through initiatives such as: ▪ Whānau Harm – participation in governance leadership of the whānau harm initiative led by the NZ Police in Whanganui city. ▪ Partnership in Suicide Prevention Strategy being developed on behalf of WDHB district by Healthy Families Whanganui-Ruapehi-Rangitikei. ▪ Exploring partnership approaches with MSD and TPK to improve oral health outcomes for Māori whānau.	Ongoing	Relationships and partnerships remain strong and outcomes are achieved
2 Support and collaborate, including through investment, with the Whānau Ora initiative and its commissioning agencies and partners, to identify opportunities for alignment through:		
▪ Actively explore investment and co-partnering opportunities with local Whānau Ora commissioning agencies and providers in the district.	Quarter 3-4	Hui undertaken; options explored and agreed actions completed

Care Capacity Demand Management (CCDM)

The CCDM programme is across all DHBs and Whanganui DHB is committed to fully implementing the programme in all nursing and midwifery services by June 2021. CCDM has a national reporting framework that enables Whanganui DHB to report progress against an agreed set of milestones.

Whanganui DHB began implementing CCDM in 2013. All inpatient wards (excluding mental health units) have now implemented CCDM. These mental health units are due to have CCDM implemented by 2021. Whanganui DHB has a CCDM Council in place who meet regularly to provide guidance.

DHB activity	Milestone	Measure
Whanganui DHB in conjunction with the CCDM Council are due to review aspects of CCDM as a project to enhance the consistency, transparency and vigour of the programme.	Quarter 2	SS03 - Ensuring delivery of Service Coverage
Governance There has been a change in the governance structure at Whanganui DHB. This includes a change in the chair for the CCDM Council, a change in the coordinator role and a review of roles and responsibilities and systems and processes. This will strengthen the programme and support the 2021 deadline.	Quarter 4	
Patient acuity data The patient acuity data is well implemented apart from mental health. There is a process in place to ensure the data entered is accurate to enable the FTE data to be appropriately calculated. This involves active engagement with leaders and education.	Quarter 2	
Annual FTE calculations There is some work being completed to ensure that the variables and factors matrix is correct for FTE calculations. All areas have had yearly calculations with one area (medical) requiring some figures to be reviewed prior to final sign off.	Quarter 4	
Variance response management for both nursing and midwifery Variance response plans have been implemented. This is to respond to shift-by-shift variance in terms of deployment and employment to hospital-wide responses. Whanganui DHB has linked the HaaG (Hospital at a Glance) screen to the duty nurse manager's pager as an alert when the organisation is going into orange or red. When FTE calculations are completed, the DHB considers the skill mix of nursing and midwifery staff. In the future Whanganui DHB will also consider the ethnic mix of nursing and midwifery staff to ensure we have appropriate ethnic staffing to care for the population using in our inpatient units.	Quarter 3	

Whanganui DHB has a programme (Health Careers Day) to educate and enhance nursing/midwifery/allied and medical as a career. The focus is particularly for Māori as we recognise that the percentage of Māori clinical staff employed does not reflect our population. The Nurse Entry to Practice and Nurse Entry to Specialist Practice programmes have an equity lens where all Māori are interviewed for nursing positions and we have a programme to support them during their first year of practice (Te Uru Pounamu). We are in the process of making this available for all Māori staff to support retention of staff (to be included in the Midwifery First Year of Practice).		

Disability

Whanganui DHB is committed to ensuring mechanisms and processes are in place to support people with a disability when they interact with our services. All work in this area will be conducted applying the pro-equity for Māori framework, as we continue to develop a better understanding of the issues for Māori whānau with disabilities and develop services and system that support access and engagement with health services.

DHB activity	Milestone	Measure
Completion of the e-Learning module for disability responsiveness by staff.	End of quarter 4	60% of staff completed
Strengthen participation of people with a disability in advisory roles particularly for Māori whānau with a disability.	End of quarter 3	Completed
Qualitative study with a consumer group to test the effectiveness/usefulness of the health passport in supporting their access and engagement.	End of quarter 3	Completed
Applying the Whanganui DHB pro-equity framework, co-design principles and a whole-of-system view, establish what patient information about impairment/disability needs are currently being gathered in Whanganui DHB through mechanisms such as the Whakataketake, Patient Status at a Glance (PSAG), Knowing Me, the bedside patient care plans and other assessment and recording tools.	End of quarter 3	Completed
Investigate and review other DHB systems and the potential for Clinical Portal and webPAS alerts to be used to notify staff of patient disability needs.	End of quarter 4	Completed

Planned Care

The Ministry of Health has completed a review of the elective services program. A major part of this review was to develop a less-restrictive framework whereby the sector is able to schedule services in a variety of settings. To recognise this change in emphasis the electives program has been replaced by the planned care program. Over the next three years, the new policy will enable DHBs to shift services to more appropriate settings, where relevant. Whanganui DHB will constructively engage with the Ministry of Health over the course of implementing the new policy framework.

DHB activity to reduce service delivery barriers:	**Milestone**	**Measure**
▪ Deliver services in least intensive setting - Planned gynaecology procedures currently performed in theatre will be reviewed with the aim to provide these services in an outpatient setting. We know that access rates to colposcopy clinics are inequitable for Maori and this review will aim to address barriers.	Specialists support for project achieved	Quarter 1
	Complete viability study	Quarter 2
	Implement from Quarter 4	Equitable access for colposcopy
▪ Ophthalmology follow-up appointment management. Recent staffing challenges have resulted in a growing waiting list. We will review follow-up appointment lists to identify patients that can be seen by allied health or nursing.	Optometrist time secured, specialist nurse in place	Quarter 1
	Develop patient flow model to optimise resources	Patients waiting appropriate time by Quarter 4
▪ Review the process used to allocate operating times for surgeons. This will assist in list planning as one component of improving service delivery.	Develop terms of reference	Quarter 2
	Agreed practices for, surgeon and nursing perspectives completed	Quarter 3
In 2019/20 Whanganui DHB will deliver 3227 surgical discharges and 1459 non-surgical interventions.	Monthly & quarterly reporting	

Acute demand

Whanganui DHB are committed to delivering service improvements to acute patient flow across primary and community care, and emergency care in secondary services. Our alliance leadership team and primary providers are developing services that will provide care in the right place at the right time, reducing the need to seek care from a hospital provider unless clinically appropriate.

DHB activity	Milestone	Measure
Acute data capturing SNOMED coding in the Emergency Department has regional implications due to our shared patient administration system. We are developing our plans in conjunction with MidCentral and Wairarapa DHBs. Our current planning is as follows: 1. An upgrade to the regional webPAS – currently underway (by March 2020) 2. An upgrade to 3M encoder (ICD 10 version) – ties in with the webPAS upgrade currently underway (by March 2020) 3. Switch over to SNOMED – still to be scoped as a regional project to meet 20/21 timeframes.	Ongoing	
Patient flow Whanganui DHB and the Whanganui Alliance Leadership Team (WALT) have embarked on a major programme of work around acute demand in the hospital and community. This work brings together primary care, community providers, Māori health services and the hospital to work together to improve patient care. The vision of the Whanganui Acute Demand Service Level Alliance (SLA) is that people living within the WDHB district should be able to access the right care, in the right place, at the right time, by the right workforce. We seek to understand the significant increase in acute unplanned care presentations to the hospital front door – Whanganui Accident and Medical Clinic (WAM) and Emergency Department (ED). We intend to co-construct a system-wide response to reduce avoidable presentations, and agree that a priority for this activity is to eliminate inequity for Māori and Pacific people who are over-represented in presentations to the hospital front door, and in many cases present with advanced disease. The goal of the acute demand SLA is to develop a more whānau-centred cohesive, accessible, efficient, safe and sustainable health system.	Ongoing	PH01 Delivery of actions to improve system integration and SLMs SS10 Shorter Stays in Emergency Departments SI1 Ambulatory sensitive hospitalisations (ASH) (adult)

It has been agreed that a phased approach will be taken to progress this complex but significant piece of work.

- **Phase one** – data collection/understanding patient flow. Examine and analyse the data associated with patient presentations at ED and WAM, with an equity focus.
- **Phase two** – undertake a work programme to address avoidable presentations.
- **Phase three** – undertake a process of quality improvement and review.

Phase one was completed in quarter three of 2018/19 and work on phase two will begin in quarter four 2018/19 and continue through the 2019/20 year. Work stream proposed to progress to phase two:

Fragmented health system driving episodic care	- Create interconnected relationships – Kōtahitanga – 'one team' across the system despite who we work for to create the basics of good care (acceptable, affordable and accessible). - Take learnings from rural models around how various providers work together and apply in the city. - Develop a connected clinical record and e-referral capability to improve transfer of information from all perspectives.
Reframe our response to elderly living at home and at aged residential care	- Develop a system response to the growing frail and older population, and agree on collaborative strategies that will be adopted and invested in to maintain elderly out of the hospital are being cared and managed where possible in their homes, aged residential care (ARC) and in their communities.
Reduce WAM and ED volumes	- Explore messaging/health literacy/better navigation through creating a connected health and social response with improved wrap around care for people. - Improve self-management and self-navigation in accessing right health care choices at the right time across general practice/WAM and hospital. - Review with St John ambulance service the response of going direct to ED, and develop other clinical pathways and models of care. - Remove ED as the sorting place for specialist preadmission and follow up activity. - Develop a collaborative health promotion messaging response for children and young families for common conditions, and improve education and capability. - Fully implement 'Choosing Wisely' in ED.

Threshold and access to services represents right place right time	- Review WAM/ED triage process. - Explore establishment of a general practice nurse-led type service in WAM, providing education, advice, navigation and connection to a general practice home. - Revisit primary options of care and move some clinical service access to primary care settings where that will ease congestion. - Review GP referrals for admission to ED/hospital and create other options and pathways for treatment and support.		
The system workforce is culturally responsive and competent to the population it is serving	- Agree on standards and develop a training and education framework that crosses the entire system. - Co-design a programme with rangatahi.		
General practice has capacity and capability to operate a whānau centred model of practice	- Whānau Ora operating in general practice through re-alignment and development of healthcare home models to drive workforce mix, and use of technological options to enhance communication and care.		
Enablers to change	- Contract definition and expectations provides a system lens approach rather than silo approach to investment. - Invest in technology capability. - Invest in communication capability. - Community is our active partner and are engaged, informed and participate in and understand change process.		
In parallel to activity under the acute demand work stream, other actions to improve patient flow in the short term include: 1. Reconfiguring our front door to better streaming of patients between Emergency Department presentations and lower acuity accident and medical patients. For mental health and addictions patients this will mean earlier identification, connection with appropriate clinical teams and treatment. Long-term conditions patients will prioritised for acute care and linked back to their community and primary care teams for ongoing care requirements. 2. Continuing with the dedicated haumoana (family/whānau navigator) service in the Emergency Department. This service operates 24 hours each day to support Māori whānau while they are in hospital from acute presentation to discharge. On site accommodation is available for the family/whānau of patients to enable them to be with patients during their stay. 3. Developing streamlined processes and protocols for early identification of those patients that are likely to be acutely admitted to hospital from ED and fast tracking those patients directly with the appropriate specialist team.			SS10 Shorter Stays in Emergency Departments

Rural health

Whanganui DHB continues to use existing networks including Māori Health Outcomes Advisory Group, Ruapehu Whānau Transformation Community Reference Group, primary care providers, primary health organisations, hospital services and communities to inform health services for rural populations

DHB activity	Milestone	Measure
Waimarino		
▪ Continue to support the community led consultation, design and implementation of future health services in Waimarino through the Ruapehu Whānau Transformation initiative. Phase Three will undertake the development of an innovative model of care informed by the needs and aspirations of whānau and community for integrated wellness services that are easily accessible and sustainably service the Ruapehu-Ohakune-Waiouru area.	Advisory group established Quarter 1 Draft model developed Quarter 4 for consultation	
Rural funding review		
▪ Review current primary rural funding distribution to ensure alliancing approach and provision of primary health care services and equitable access for rural in line with PHO Services Agreement.	Review completed Quarter 4 for implementation 2020-21	
Pharmacy		
▪ Implement flexible support for after-hours inpatient discharges to rural communities through medication dispensing by hospital pharmacy service.	Process implemented Quarter 1	
Community/specialist nursing		
▪ Explore purchasing approach for clinical consumables to support DHB funded primary care providers in rural areas supporting cost effective purchasing decisions.	Purchasing process identified and implemented in Taihape Health by Quarter 2	
▪ Expand community specialist nursing roles to support rural health facilities and primary care with staff development, workforce upskilling and education.	Whanganui DHB renal team funding model identified by Quarter 4	
Ruapehu Primary Care		
▪ DHB Waimarino Health Centre to support Ruapehu Health Ltd with the provision of facilities and equipment as approved by the incident controller during a health and/or civil defence emergency including formalisation of Memorandum of Understanding.	MOU developed Quarter 3	

Healthy ageing

Older people representing the diversity of our community are involved in all service design, co-development and review, and other decision-making processes in relation to healthy ageing actions.

DHB activity	Milestone	Measure
Whanganui City – an Age Friendly Community led by Whanganui District Council Whanganui DHB will continue to participate along with other key stakeholders to support the city becoming age friendly.	Ongoing	SS04 Implementing the Health Ageing Strategy
Dementia Friendly Ohakune led by Alzheimers Whanganui Whanganui DHB will continue to support Alzheimers Whanganui's dementia-friendly Ohakune initiative.	Ongoing	SS04 Implementing the Health Ageing Strategy
Implementation of the New Zealand Framework for Dementia Care		
▪ Provide input into a regional stocktake of dementia services and related activity, which will be completed and provided to the Ministry by the end of quarter two (via the S12 measure).	Quarter 2	S12
▪ Using the stocktake, work with your regional colleagues to identify and develop an approach to progress your DHB's priority areas for implementing the framework by the end of quarter four.	Quarter 4	
▪ Report on work to progress the implementation of the New Zealand Framework for Dementia Care in quarters three and four.	Quarter 3 and 4	
Live Stronger for Longer – Falls Prevention and Fragility Fracture Management Continue to work with ACC, HQSC and the Ministry of Health to promote and increase enrolment in the DHBs integrated falls and fracture prevention services as reflected in the 'Live Stronger for Longer' Outcome Framework, Healthy Ageing Strategy and Whanganui DHB whole of system approach.	Ongoing	ACC/WDHB Partnership Agreement
Pressure Injury Prevention and Management Whanganui DHB is working in partnership with ACC to progress pressure injury prevention and management programme across the WDHB district. This initiative includes linkages with age residential care, general practice and community providers.	Ongoing	ACC/WDHB Partnership Agreement

Home and community support – 65,000 beds Partner with an inclusive range of representatives from our communities to co-design an integrated and coordinated community model. Incorporating home and community support, community and specialist nursing, and allied health, working in partnership with general practice teams, to keep people well in the community. The model will be informed by the Home and Community Support Service Framework. Other funders such as ACC will be included. This work will also be a major contributor to assisting the DHB to address the drivers of acute demand for people aged 75 plus presenting at ED and urgent care services (including at lower ages for disadvantaged populations).	Quarter 4	SS04 Implementing the Health Ageing Strategy
Intermediate care – Transition of care in a residential setting Implement the recommendations of the 2018 Intermediate Care Review.	Quarter 2	SS04 Implementing the Health Ageing Strategy
Health literacy to improve equity ▪ Ensure patient information on long-term conditions, including information on self-management, are able to be read, understood and be useful for the person and their whānau. ▪ Introduce patient diary and health passport as other communication tools.	Quarter 3	SS04 Implementing the Health Ageing Strategy
Nursing agency The WDHB district does not have a local nursing agency that can be used by providers, including age residential care, as a resource. In partnership with stakeholders, Whanganui DHB will explore ways in which this can be addressed.	Quarter 3	SS04 Implementing the Health Ageing Strategy

Improving quality

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

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

DHB activity	**Milestone**	**Measure**
1. Work with partners in primary health care to improve equity of access to and outcomes from acute care. See System Level Measures improvement plan Appendix 1. 2. Improve patient experience.		
Improve the national inpatient (NIP) survey results for transition of care and education about medication to the national average or greater.	Quarter 3	NIP Survey results
Monitor all HQSC QSMs, including falls, pressure injuries and safe use of opioids and develop improvement plans where results are below the national average.	Ongoing	QSM results
Continue to use consumers and co-design principles in all service improvement activities.	Ongoing	Audit of service improvement activities demonstrates co-design/s
System level measures A system level measures plan is included as Appendix 1.		
Antimicrobial resistance		
Whanganui DHB has a contract in place for infectious diseases support from CCDHB.	Ongoing	Contract is in place
Whanganui DHB has a fully functioning infection prevention committee chaired by the medical officer for health. The committee includes primary and secondary care representation.	Ongoing	Committee is fully operational
An annual antibiogram is produced by MedLab Central microbiologists indicating resistance and sensitivity patterns. This is shared with all prescribers, including general practice.	Annually	Current antibiogram

Hand hygiene audited by Gold hand hygiene auditors in secondary care services.	Ongoing	QSM
Local antibiotic guidelines are in place and will be kept current.	Ongoing	Current guidelines
Monitoring of:	*Occurs:*	
▪ Staphylococcus aureas bacteraemia	Daily	Number of cases
▪ Surgical site infections	Quarterly	Number of cases
▪ Treatment injuries – infections	Annually	Number of cases
▪ Infections post appendicectomy	Annually	Number and nature of cases
▪ Daily monitoring of multi-drug resistant organisms	Daily	Number of cases
▪ IV site infections and IVC removals.	Daily	Report produced Number and nature of cases
Working proactively with ARC providers and general practice to ensure appropriate antibiotic use by:		
▪ Access for all ARC to Whanganui DHB policies and procedures and antibiotic guidelines on the intranet ▪ Use of the annual infection prevention study day, which is open to all community health providers including ARC providers this day will provide education on: - catheter related cares and UTIs - antibiotic use and the nurses role - antibiotic resistance education - antibiotic guidelines for all procedures - pressure injuries and preventions.	One study day run annually	Number of incidences of advice provided to ARC
Reporting to the clinical board against infection control Health and Disability standards	Quarter 1	Report produced
Participate in a lower north island regional approach to infection prevention practices.	Quarter 1	Report produced
Biannual monitoring of antibiotic compliance to guidelines completed in Whanganui DHB	Biannual	Report produced

Switch campaign from IV to oral prescription running at Whanganui DHB, with pharmacists reviewing each patient prescriptions daily	Daily	
The infection prevention clinical nurse specialists provide advice to aged residential care facilities on outbreaks or other questions.		Number of incidences of advice provided to ARC
Atlas of Healthcare Variation		
Gout		
Local practice data identified poor management and treatment for diagnosed patients, and volumes of untested patients has increased across all practices especially for Māori.	Daily	50% of practices
Quality improvement initiatives will include:		
▪ Undertaking patient audits to identify poor/untested patients	Quarter 4	50% of practices
▪ Complete patient recalls to implement gout management plans	Update completed Quarter 2	50% of practices
▪ Patient management dashboard updated to include gout alert	Ongoing	50% of practices
▪ Roll out text/email referral to Arthritis NZ	Trial completed Quarter 2	50% of practices
▪ Improve patient records to strengthen data collection	Ongoing	50% of practices
▪ Develop localised patient information to dispel myths and improve health literacy.	Quarter 3	

Cancer services

Whanganui DHB is committed to delivering sustainable service improvement activities to improve equity, access, timeliness and quality of cancer services. This includes addressing the equity issues at population health level, for example, late presentation and increased mortality rates for Māori. We will engage with Māori communities to identify and implement strategies to support the achievement of equity in screening rates for Māori.

The cancer coordination function will continue to lead improvement in the journey through the system for the patient and their whānau, and reduce the risk of people not getting access to care in the right place at the right time. We have made good progress in this area but still have more work to do connecting Māori to services and support earlier, and in supporting end of life care. This priority includes bowel screening, and the faster cancer treatment measures.

DHB activity	Milestone	Measure
▪ Whanganui DHB are committed to working with the Ministry of Health on implementation and delivery of a national cancer plan. Local actions and deliverables will be designed in conjunction with local and regional cancer networks following the announcement of the interim plan.	End of Quarter 4	
▪ Ensure people living in the WDHB district have a shared care plan developed by their multidisciplinary team with the person and their family/whānau, connected to hospital and community Māori health services. This includes linking of the patient, cancer nurse coordinator, Māori services and community based kaupapa Māori in the system early to support end to end care. This care plan will be developed to ensure post treatment planning and support is available to patients and family/whānau, with a range of health providers including psycho-social support, Māori health services or other community providers as appropriate.	End of Quarter 1	(DHBs select the most appropriate measure/s)
▪ Implement continual quality improvements identified through internal tracer audits of patient journeys that breached the 62-day target. This work will be led by a clinical team and include the cancer nurse coordinator and the Māori health team.	Ongoing	SS01 Faster Cancer Treatment
▪ Focus on priority population (Māori and Pacific) women including offering further opportunities to access cervical screening, alongside robust health promotion. This includes raising awareness at community events such as market days, UCOL orientation and annual Rātana celebration. Funded screening for priority women – Māori, Pacific and Asian and follow up through general practice outreach team.	Ongoing	SS01 Faster Cancer Treatment – 31 day indicator
▪ Continue to work with the Central Cancer Network to develop and promote the use of cancer pathways locally.	Ongoing	

▪ Request 2013-16 data used to inform Bowel Cancer Quality Improvement Report from the Ministry of Health. ▪ Extract 2017/18 data from local hospital systems to provide means for analysis of quality indicator results during this period. ▪ Review data to identify variances in quality indicator results for Māori vs non-Māori and ensure strategies to reduce inequity are addressed within quality improvement plan. ▪ Establish a team to coordinate a review of the Bowel Cancer Quality Improvement Report 2018 and associated data. ▪ Create a quality improvement plan for bowel cancer based on outcome of review.	End of Quarter 1 End of Quarter 1 End of Quarter 2 End of Quarter 2 End of Quarter 4	

Bowel screening

As Whanganui DHB prepares to join the National Bowel Screening Programme (NBSP) in October 2019, it is important that we ensure patients referred for urgent, non-urgent and surveillance colonoscopy are managed within the recommended and maximum colonoscopy wait times. Activity will focus on mechanisms for reporting and monitoring performance against the colonoscopy wait time target indicators, so that issues that may affect performance can be promptly identified and appropriate action taken.

DHB activity	Milestone	Measure
Achievement of wait time targets ▪ Create fortnightly colonoscopy production plans to support active management of demand, capacity and capability. ▪ Create monthly colonoscopy wait time target indicator reports to provide mechanism for monitoring performance against targets. ▪ Distribute monthly colonoscopy wait time target indicator reports to bowel screening steering group and relevant staff members. ▪ Discuss performance against colonoscopy wait time target indicators as standard agenda item at monthly bowel screening steering group and endoscopy users group meetings.	End of Quarters 1, 2, 3 & 4	SS PP29 Improving waiting times for diagnostic services
National bowel screening programme ▪ Review and discuss participation rates and screening colonoscopy wait time indicator results of individual priority groups at Whanganui DHB bowel screening equity working group meetings. ▪ Implement strategies for achievement of equitable access identified in Whanganui DHB's bowel screening equity plan. ▪ Work in partnership with the Māori Health Outcomes Advisory Group (MHOAG) and local kaupapa Māori health services to promote bowel screening in Māori communities and encourage participation in the programme. ▪ Work with local kaupapa Māori health services to provide outreach services to priority participants that have not returned their FIT kit. ▪ Attend and participate in regional and national equity hui/fono, to identify additional strategies for the achievement of equitable access. ▪ Implement strategies for engaging eligible populations and increasing participation identified in Whanganui DHB's bowel screening communication and engagement plan.		NBSP indicator 306 Time to first offered diagnostic assessment NBSP indicator 200 Participation

Workforce

Whanganui DHB is an equal employment opportunity (EEO) employer and is committed to increasing and developing an inclusive workforce that continues to embrace diversity. Whanganui DHB's organisational culture, leadership, workforce development and Māori workforce development initiatives include:

- Deliver on the Whanganui DHB pro-equity plan, increase our organisational equity capability and further increase understanding of Te Ao Māori.
- Continue to grow clinical leadership and developing future leaders.
- Proactively grow our Māori workforce across the health district that reflects proportionally for our Māori population.
- Be guided by the Ministry of Health Rāranga Tupuake – Māori Workforce Development Plan, provide tuakana/taina support for new graduate Māori nurses, expand Te Uru Pounamu to encourage connection between Māori health professionals and proactively promote Ministry of Health funding for Māori particularly in kura kaupapa settings.
- Establish an education centre to support our growing focus on workforce development
- Improve learning culture within the DHB and identify areas of staff development to align with health gain areas for the district.
- Strengthen training opportunities provided outside the hospital environment in a community based attachment, meet our training and facility accreditation requirements and cement new relationships.
- Further future proofing our workforce and developing a sustainable approach to nursing career pathways.
- Implement equity and pay parity agreements.
- Work closely with regional DHB shared services continuing work to identify the workforce requirements around the service delivery needs for services to older people and their family/whānau.
- Build on current data collection processes and continues within the context of existing sub-regional service developments and national workforce programmes.

Further detail about the Central Region approach to workforce is contained in the 2019/20 Central Region's Regional Services Plan.

Please also refer to:

- Care Capacity Demand Management – page 45
- Disability – page 47
- Workforce – page 88
- Health literacy – page 65.

DHB Activity	Milestone	Measure
Continue to grow clinical leadership across medical, nursing and allied health, scientific and technical staff.	Ongoing	▪ Talent mapping for tier 3 and 4 employees ▪ Develop whole of district workforce view
Proactively grow Māori workforce across the health district that reflects proportionally for our Māori population: ▪ Determine targets and action plans ▪ Maintain focus on Kia Ora Hauora ▪ Expand the existing cultural programmes ▪ Continue Te Reo 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. ▪ Whanganui DHB Speaking Up for Safety programme includes action on racism and institutional bias.	Ongoing	▪ Increase numbers of Māori Workforce ▪ Increased number of Māori in leadership ▪ Staff demographics and gender mix reflect our community ▪ Recruitment and retention strategy focussed on Māori staff ▪ Recruitment process is values based ▪ Māori representation on leadership recruitment panels ▪ Staff numbers gaining certificate in Te Reo (UCOL WDHB partnership ▪ Māori student numbers enrolled in Kia Ora Hauora ▪ Increased use of Te Reo Māori across the system ▪ Cultural competence and confidence of all staff in working with Māori whānau ▪ Report 6 monthly to Hauora A Iwi (Māori Partnership Board) on results.
Deliver on the Whanganui DHB pro-equity plan (year 1): ▪ Build Māori workforce and Māori health equity and equity capability.	Ongoing (year 1 or 2 year implementation plan)	▪ Governance executive management and leaders receive professional development – equity tools and methodologies ▪ Training and resources shared across the system with local partners and leaders ▪ Equity KPI introduced for all leaders ▪ Job descriptions reflect commitment to achieve equity for Māori and improved outcomes for our community.
Be guided by the Ministry of Health Rāranga Tupuake – Māori Workforce Development Plan.	Ongoing	▪ Guidance is reflected in actions.

Provide tuakana/taina support for new graduate Māori nurses through Te Uru Pounamu programme Expand Te Uru Pounamu to encourage connection between Māori health professionals.	Ongoing September 2019, February & May 2020	▪ All new graduate Māori nurses receive formal support. ▪ Three wānanga held for Māori staff per year.
Proactively promote Ministry of Health funding for Māori particularly in kura kaupapa settings.	Ongoing	▪ Awareness and uptake of Ministry of Health funding by kura kaupapa settings ▪ Number of Māori students from kura kaupapa entering health careers.
Growing a future proof workforce.	Ongoing	▪ Workforce strategy and pipeline ▪ Growing our own ▪ Practice Nurse credentialing programme ▪ Increased number of Nurse Practitioners ▪ Whanganui DHB Trainee Intern programme (Medical) ▪ Upskilling programmes / ongoing education uptake for staff ▪ Calderdale framework implemented ▪ Increased number of Māori rangatahi interested in health as a career ▪ Have annual Mental Health interns for Occupational Therapy and Social work ▪ Develop AH career pathway as per MECA.
Develop a sustainable approach to nursing career pathways.	Ongoing	▪ Support equitable funding for professional development for nurse practitioners.
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, Pharmacy Council.	Ongoing	▪ Accreditation requirements met. ▪ Education committee actively leads medical training at all levels within the DHB.
Improve learning culture within the DHB through cementing the new relationship with the University of Otago Wellington for training interns.	Annual placements commence November 2019	▪ Provide placements for training interns and accept students for annual placements with Whanganui DHB from November 2019.

Establish an education centre to support our growing focus on workforce development.	New education centre is opened October 2019	▪ Facilitate easy access to structured learning and strengthen a culture of learning within Whanganui DHB.
Community-based attachments are an important part of Whanganui DHB'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.	Establish an additional community based attachment to meet MCNZ requirements	▪ Prevocational interns receive training opportunities outside the hospital environment in a community based attachment.
Implement equity and pay parity agreements.	As per the agreed settlement timeframes	▪ As per the agreed settlement.
Identify areas of staff development to align with health gain areas for the district.	Ongoing	▪ Health literacy action plan implemented ▪ Whanganui DHB Pro-Equity Plan (year 1) implemented.
Work closely with regional DHB shared services continuing work to identify the workforce requirements around the service delivery needs for services to older people and their family/whānau.	Ongoing	▪ Deliver high quality, person and whānau centred care.
Builds on current data collection processes and continues within the context of existing sub-regional service developments and national workforce programmes.	Ongoing	▪ Improved workforce planning ▪ Focus on the primary, secondary and tertiary service requirements and endeavour to bring together the respective workforces needed to deliver these services effectively at the DHB, sub-regional and regional levels.

Health Literacy

Whanganui DHB's vision, values and strategic direction are underpinned by the recognition of the importance of health literacy. Work on health literacy is integrated within all improvement initiatives and business as usual activity. Health literacy is an enabler to achieving equity in health outcomes for Māori and Whanganui DHB is committed to becoming a health-literate organisation. Health literacy must be considered at a systems, service, social and individual level.

Health Literacy Levels

The Ministry of Health estimates more than 50% of the NZ population have poor health literacy skills with Māori and people living in rural areas likely to have poorer health literacy than others.

- Up to 80% of Māori men and 75% of Māori women have poor health literacy skills and are at risk of adverse outcomes.
  Kōrero Mārama: Health Literacy and Māori 2010.

DHB activity	Milestone	Measure
With consumers, develop a health literacy tool that integrates with the Pro-equity for Māori implementation plan, and can be used across service improvement. The tool will also ensure that health professionals are equipped to deliver health information in ways that are easily understood by patients and whānau.	End of Quarter 2	Health Literacy Tool developed
Based on Whanganui DHB Health Literacy Review, develop a Health Literacy Action Plan for a specific and priority work area that applies the above tool, and is focused on: ▪ Services being easy to access and navigate ▪ Effective health worker communication ▪ Clear and relevant health messages that empower everyone to make informed choices.	End of Quarter 4	Action plan developed
With consumers, develops a schedule for reviewing brochures applying the health literacy tool.	End of Quarter 4	Schedule developed
Health literacy is integrated across all patient-interaction with services in the DHB but is specifically recognised in the following: ▪ Workforce development ▪ Hāpai te Hoe and other staff training ▪ Whānau Ora ▪ Collective Communications (a cross agencies collaboration on key communications messaging) ▪ Suicide prevention/mental health literacy training or education ▪ Long-term conditions: cardiovascular and diabetes ▪ Cancer treatment		

▪ Kōrero Mai ▪ Bowel Screening ▪ Advance Care Planning ▪ Acute Demand ▪ Fit for Surgery ▪ Oral Health ▪ Wayfinding ▪ 'Social mobilisation' in mental health ▪ Public Health - Health Promotions activities: Smokefree; Safe Sleep; Healthy Homes; Family Violence ▪ Cervical and breast screening ▪ Integrated primary care ▪ Web-based developments such as Manage My Health and Patient Portal ▪ Speaking Up for Safety and Promoting Professional Accountability ▪ Disability responsiveness.		

Data and digital

We are developing a digital strategy to move systems to the cloud, leveraging cloud tools and security and gaining greater benefit from our investment in Microsoft 365.

Unified communications and Telephony from the cloud ties in with mobility, enabling our staff to communicate with each other by chat, voice, email or video.

Enhancing mobility will enable us to build a mobile workforce equipped to engage more with our community.

DHB activity	Milestone	Measure
▪ Continued participation in the development, upgrade and optimisation of clinical applications within the Regional Application Environment (RAE).	Full year programme	Quarterly reports
▪ Mobility – increase the use of mobile phones replacing desk phones to gain greater value from our Telephony as a Service (TaaS) mobile spend and provide the platform for future mobile apps to be delivered. Mobile device management will be applied to manage security.	Quarter 2	Project reports
▪ Unified Communications incorporating PBX system replacement. Unified Communication will enable new care delivery models as well as deliver improved and consistent data sharing and clinical collaboration anywhere, across any medium. Moving towards the TaaS direction as set by the Government chief digital officer.	Quarter 3	Project reports
▪ Office 365 – implement Office 365 providing collaboration tools to improve productivity and facilitate working remotely. This follows a national initiative with the NZ health sector Microsoft agreement and aligns to our strategy to move to cloud computing.	Quarter 4	Project reports
Bowel Cancer/Bowel Screening		
▪ Ensure all IT requirements are met ahead of bowel screening readiness assessment in July 2019.	End of Quarter 1	
▪ Work with Ministry of Health to ensure that the bowel screening National Screening Solution (NSS) is implemented by when available.	End of Quarter 4	

Collective improvement programme

DHB activity

Whanganui DHB is committed to supporting the collective improvement programme, once developed.

Delivery of Regional Service Plan (RSP) priorities

We are part of the Central Region, along with Wairarapa, Hawke's Bay, MidCentral, Hutt Valley, and Capital and Coast DHBs. We participate in regional activity formally through Technical Advisory Services (TAS) and informally through networks of clinical and managerial teams. Whanganui DHB participates in the Central Region's service planning forum that governs development of the RSP.

DHB activity	Milestone	Measure
1. Cancer: Participate in cancer work plan being led by the Central Cancer Network. 2. Cardiac: Enhance equity of access through implementation of appropriate components of the cardiac work plan; establish sub-regional networks for delivery of improved cardiac services; continue to submit data to ANZACS QI. 3. Radiology: Support development of overarching regional model for radiology by participation in steering group and/or expert groups; complete business case for trainee if appropriate; approve trainee MoU by Quarter 4; assist with development of RRIS report using Whanganui data; contribute to monitoring and review of equity data. 4. Regional care arrangements: Participate in regional response re orthopaedic and gynaecology services. 5. Mental health and addictions: Sponsor and encourage participation in regional forums for stakeholder sharing of best practice; respond to opportunities arising from the national inquiry and the Wellbeing Budget. 6. Major trauma: Enhance complex case management as agreed through regional planning process; implement regional destination policies; submit data to the NZ-MTR; adapt trauma guideline to meet Whanganui DHB requirements. 7. Digital health services: Support further roll-out of national and regional priority digital enhancements. 8. Workforce: Participate and implement work plan as led by regional GMs of HR and the regional director of workforce development; increase Māori workforce locally. 9. Hepatitis C: Implement integrated assessment and treatment services; implement regional pathways. 10. Stroke: Implement recommendations of evaluation of telestroke; assess early supported discharge model and implement if feasible; improve equity of access and outcomes for stroke victims; increase rate of thrombolysis. 11. Healthy ageing: Participate in activity of regional advance care planning reference group and regional dementia reference group; complete regional dementia care stocktake by end of Quarter 2 and use the stocktake to identify priorities for implementation by the end of Quarter 4.	As per the RSP	Reporting on the RSP will be provided by TAS on behalf of all Central Region DHBs

2.1.5 Better population health outcomes supported by primary health care

Primary health care integration		
Improving the health and wellbeing of the population is supported by the integration of health services, primary and secondary where access to the right care, in the right place, at the right time, by the right workforce is co-constructed through a system wide approach.		
DHB activity	**Milestone**	**Measure**
Models of care identified through the acute demand service-level alliance project will provide a system wide response to reduce avoidable presentations (please refer to acute demand – page 49).	See acute demand section (page 49)	PH01 SLM
Expand hospital pharmacist roles in mental health inpatient services to support multi-disciplinary approach and in Emergency department to support acute demand and ensure patient journey is seamless	Resource implemented Quarter 3	

Pharmacy

Whanganui DHB is committed to development of community pharmacist services in accordance with the Pharmacy Action Plan and the national contract for integrated community pharmacy services (ICPSA). A sector stakeholder group has recently been formed to provide local guidance and advice on co-design opportunities and to deliver on the potential for enhancing expertise in medications to help support achievement of system-wide improvements.

DHB activity	Milestone	Measure
▪ Support after-hours inpatient discharges to rural communities through medication dispensing Action: Identify process through community pharmacy contract within the DHB Pharmacy.		
▪ Collaborate with the pharmacy program to achieve the vision of the Integrated Community Pharmacy Services Agreement (ICPSA) - Coordinate participation of Whanganui district stakeholders in the national and regional work regarding the separation of dispensing services into separate ICPSA schedules. - Extend age limit for emergency contraception receiving funded services through community pharmacy to remove inequity of access ▪ Confirm funded/non-funded ratio in current service to identify extent of inequity ▪ Confirm amended age range and target group approach with next contract variation to remove inequity	Quarterly Reporting Quarter 1	PP22 Increased use of ECP
▪ Continue to develop hospital and community pharmacy workforce in line with Pharmacy Action Plan 2016-20 including collaboration on recruitment and workforce development with an emphasis on meeting the needs of rural populations and equity for Māori.		
▪ Engage with district pharmacy stakeholder group to receive advice and guidance on local decision making including: - Identification of pharmacy facilitation model. - Expansion of pharmacy technician role to optimise their scope of practice.		
▪ Develop greater awareness of pharmacist role in winter wellness. Promote access to influenza immunisation via community pharmacy. Improve vaccination coverage with a focus on those populations with lower coverage in the 2018/19 'flu season. Reduce inequity of coverage rates by increasing Maori and Pacific rates.	Quarters 3 & 4	Influenza vaccination rates

Diabetes and other long-term conditions

Whanganui DHB has high prevalence of heart disease and diabetes and high rates of obesity with the rise in incidence of long term conditions attributed to an increase in lifestyle risk factors, socioeconomic determinants and the ageing population. An integrated response will support better management of long term conditions, through patient centred approaches which empower patients, families/whānau to self-manage their conditions, provide proactive coordinated care and reduce disparities for Māori.

DHB activity	Milestone	Measure
Identify the most significant actions the DHB will take across the sector to strengthen public health promotion to focus on the prevention of diabetes and other long term conditions Formalise and resource the collective communications network to lead an integrated approach for consistent health messaging, patient information & a systematic engagement approach.	Work plan developed by Quarter 3	SS13 (was PP20)
Identify how the DHB will ensure all people with diabetes will have equitable access to culturally appropriate self-management education and support services Culture and attitudinal shift is required to focus the workforce on a Whānau Ora approach supporting patients and their family/whānau with appropriate self-management and support.		
▪ Embed well-being tool across general practice	Ongoing	
▪ Pilot a primary care / secondary specialist service integrated approach to increase capacity of general practice clinical workforce to support self-management and education improve equitable outcomes for diabetic, CVD and respiratory patients and to inform model and approach going forward.	Pilot evaluation Quarter 3	
Monitor PHO/practice level data to improve equitable service provision and inform quality improvement The specific focus for 2019/20 is to address patient barriers to access including ensuring services and support is delivered within primary care including general practice, kaupapa and other community settings:	RFP process completed by Quarter 4	
▪ Explore the development and implementation of a community based diabetes retinal screening service.	Quarter 4	

▪ Complete CVD risk assessments for Māori & Pacific men through targeted approaches across settings (live, learn, work & play). ▪ Embed national CVD risk assessment guidelines 2018 system changes within primary care including supporting infrastructure and workflow methodology to support data capture in line with best practice. ▪ Close the equity gap for Māori in diabetes/CVD screening & management. ▪ LTC governance group monitors PHO/practice level data to identify areas of greatest need to identify areas for improvement and/or target quality improvement initiatives. ▪ LTC governance group to revise local framework and implementation plan to align with MOH framework and within a collaborative local context.	100% of practices by Quarter 4 Ongoing Ongoing Review completed Quarter 3	

2.2 Financial performance summary

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

The Whanganui DHB is planning a deficit of 12.6 million in 2019/20.

The financial plan for 2019/20 to 2022/23 is set out below:

Statement of prospective Financial Performance for the four years to 30 June 2023

	Actual 2017/18 $000	Forecast 2018/19 $000	Plan 2019/20 $000	Plan 2020/21 $000	Plan 2021/22 $000	Plan 2022/23 $000
Provider (deficit)	(4,314)	(12,958)	(9,702)	(11,039)	(11,694)	(11,962)
Governance and Funding Administration surplus/ (deficit)	501	457	-	-	-	-
Provider/Governance and funding (deficit)	**(3,813)**	**(12,501)**	**(9,702)**	**(11,039)**	**(11,694)**	**(11,962)**
Funder Arm surplus / (deficit)	(366)	(1,153)	(2,895)	(1,435)	(707)	(36)
Base net (deficit)	**(4,179)**	**(13,654)**	**(12,597)**	**(12,474)**	**(12,401)**	**(11,998)**
Mental Health Ring Fence expenditure from prior year	-	-	-	-	-	-
Asset write down & other	-	-	-	-	-	-
Consolidated net (deficit) for year	**(4,179)**	**(13,654)**	**(12,597)**	**(12,474)**	**(12,401)**	**(11,998)**

Funding increases

Whanganui DHB received a funding increase of 4.2% or $9.53m inclusive of $2.28m for MECA settlements.

The underlying funding increase for 2019/20 is 2.9% against last year 3.2%. The underlying funding increase has been impacted by a decrease of $0.76m in transitional funding due to a change in population growth patterns.

Whilst Whanganui has seen positive population growth the increase is still running lower than the national average resulting in our population based funding share dropping to 1.63%. Most provincial DHBs are similarly impacted and this trend is expected to continue due to higher population growth in major urban centres.

Budgeted revenue has increased over last year actuals by a net of 3.7%, which is less than the 4.2% stated above, due to non-recurring revenue items in 2018/19.

Statement of Financial Performance
CONSOLIDATED

	Actual 2013-14	Actual 2014-15	Actual 2015-16	Actual 2016-17	Actual 2017-18	Actual 2018-19	Budget 2019-20	Variance 2018-19 Actual to 2019-20 Budget	Variance 2018-19 Actual to 2019-20 Budget % change	
Revenue % change		2.6%	2.2%	2.2%	4.9%	4.6%	3.7%			
Revenue	226,061	231,953	236,976	242,230	254,206	265,799	275,764	9,965	3.7%	F
Personnel costs	(70,824)	(72,486)	(74,978)	(78,280)	(83,456)	(90,483)	(97,407)	(6,924)	-7.7%	U
Outsourced service provider	(13,077)	(13,662)	(13,861)	(13,590)	(14,397)	(15,122)	(14,360)	762	5.0%	F
Clinical supplies	(14,332)	(14,034)	(13,698)	(14,579)	(15,941)	(16,592)	(17,362)	(770)	-4.6%	U
Non-clinical supplies	(13,832)	(12,972)	(12,955)	(13,335)	(13,637)	(13,515)	(15,459)	(1,944)	-14.4%	U
Capital charge	(2,845)	(2,758)	(3,029)	(2,422)	(4,357)	(4,401)	(3,536)	865	19.7%	F
Interest	(2,052)	(1,924)	(1,548)	(967)	(10)	(22)	(55)	(33)	-150.0%	U
Depreciation	(4,788)	(4,744)	(4,541)	(4,687)	(4,720)	(5,417)	(5,858)	(441)	-8.1%	U
Other health provider	(69,345)	(72,824)	(75,026)	(76,829)	(80,733)	(85,467)	(91,034)	(5,567)	-6.5%	U
IDF outflow	(35,930)	(36,513)	(37,907)	(38,253)	(41,134)	(43,779)	(43,290)	489	1.1%	F
Total Costs	(227,025)	(231,917)	(237,543)	(242,942)	(258,385)	(274,798)	(288,361)	(13,563)	-4.9%	
Cost % Change		2.2%	2.4%	2.3%	6.4%	6.4%	4.9%			
Net Surplus / (Deficit)	**(964)**	**36**	**(567)**	**(712)**	**(4,179)**	**(8,999)**	**(12,597)**	**(3,598)**		

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

Financial trend and deficit drivers

The financial outlook shows a worsening trend as the cost base has grown faster than revenue. The gap between revenue and cost has grown over the last three years. Accepting that revenue is not going to change, drivers of the deficit include:

- growth in acute demand - grew 8% between 2016/17 and 2017/18 which has driven up staffing resources and the cost of clinical supplies.

- case-weighted outputs have moderated slightly in 2018/19 with a 1.6% drop in total case-weights being 4.2% reduction in Whanganui Hospital volumes offset by 6% increase in IDFs. Whanganui Hospital volumes have dropped mainly due to lower elective orthopaedic volumes whilst IDF growth has been driven by acute volumes.

Case-weight volumes	2016-17 Actual	2017-18 Actual	% Change	2018-19 Actual	% Change	2018-19 Budget
Medical Acute	5,238	5,953		5,877		5,948
Surgical Acute	3,044	2,993		2,783		2,888
Surgical elective	3,059	3,316		3,083		3,227
ACC elective	159	158		161		120
Total Whanganui Hospital	11,500	12,420	8.0%	11,903	-4.2%	12,183
IDF acute & elective	3,926	4,208	7.2%	4,464	6.1%	4,358
Total all provider	15,426	16,628	7.8%	16,367	-1.6%	16,541

- Staff cost reflect FTE growth as well as the impact of significant MECA changes across all clinical work groups. Higher personnel costs will be partially offset by lower outsourced service provision.

- Clinical Supplies reflect the impact of theatre supplies and equipment.

- Non clinical supplies have increased due to IT $540k (new systems), hotel and maintenance services ($545k) due to MECA costs which reflects movement to a living wage, accreditation (2 yearly), election costs (3 yearly), Insurance, consultant and legal fees which were low in 2018/19 have been budgeted at higher levels.

- Other health providers have increased by 6.5% or $5.6m. This is mostly due to price uplift on national contracts partly reflecting the impact of significant MECA changes.

The national context from 2017/18 through to budget 2019/20 is similar with worsening deficits across all DHBs.

Key assumptions

The following are the key assumptions applied in the development of the 2019/20 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	Cost factor
PBF funding	As per Ministry of Health May 2019 advice
Planned Care funding	As per Ministry of Health May 2019 advice
MOH Side contract	0% uplift
Primary care revenue	1.78% to 2.91% uplift
Provider Division price volume schedule (PVS)	2.92% to 3% uplift
SMO MECA	3% uplift from April 2020
RMOS MECA	2018-19 4% & 3% uplift from March 2020
Nursing MECA	August 2019 3% uplift + one additional step
PSA Allied MECA	November 2019 uplift 3%
PSA Clerical	March 2019 3% to 6.87% + June 2019 3.27 to 4.79% & 3% uplift from June 2020
XRAY MECA	March 2019 3% uplift + July 2019 3% uplift
Sonographers MECA	December 2019 3% uplift
Psychologists MECA	March 2019 3% + July 19 3% uplift
Clinical supplies & non-clinical supplies	1% uplift, if applicable
Primary care	July 2019 1.78% to 2.91% uplift
Dental	July 2019 1.43% uplift
Mental Health NGO	July 2019 1.78% to 2.91% uplift
Other NGO	July 2019 1.78% to 2.91% uplift
Home Support Long Term Household Management	July 2019 1.92% uplift + 6% growth
Residential Rest Homes (ARC) - Dementia	July 2019 3.2 % uplift + 13% growth
Residential - Hospitals (ARC)	July 2019 3.2 % uplift + 3% decline growth
Inter-district flow	July 2019 2.92% uplift
Impact of pay equity	The associated impacts will be cost neutral to the DHB, as it will be covered by Government settlement appropriations.
No revaluations of land and buildings in the 2018/19 year.	No financial impact.

Risks

The most significant financial risks lie in volume growth across aged care, community services, and inpatient volumes. This includes inpatient volumes at Whanganui Hospital and those patients transferred elsewhere for secondary and tertiary care. The underlying deficit has been reduced to take up these risks.

The risk profile is explained in more detail in the table below:

Schedule of risk not included in the financial deficit				
	$000s	**FTEs**	**Risk Level**	**Comments**
FTEs				
RMOs FTEs	$ 250	2.00	Moderate	
Nursing FTEs	$ 389	5.75	Moderate	
Allied FTEs	$ 659	8.00	Moderate	Moderated by vacancies
Management FTEs	$ 106	3.00	Moderate	
Total FTE reduction risk	$ 1,404	18.75		
Other costs				
Staff course and conference	$ 200		Moderate	
Clinical supplies	$ 100		Moderate	
PSA clerical MECA settlement	$ 181		Low	
Total Other risk	$ 481	-		
IDF		**CWD**		
IDF inflow for general surgery & orthopaedics - Taranaki DHB 55 CWS	$ 287	55.00	Moderate	
IDF outflow reduction for orthopaedics - MDHB 37 CWD	$ 193	37.00	Moderate	
IDF outflow reduction for Cardiology - CCDHB 17 CWD	$ 89	17.00	Moderate	
IDF outflow overall variance to 2018-19 actual	$ 376	72.00	High	
IDF outpatient	$ 215		High	Higher 18-19 trend IV Chemotherapy & Oncology -Radio-therapy
Total IDF Risk	$ 1,160	181.00		
Total Risk	$ 3,045			

Sustainability initiatives

Whanganui DHB is working on a long-term financial and clinical sustainability programme to move towards break even. To have a significant impact over time the level of hospitalisation would need to shift to less intensive alternative settings. Particular initiatives to improve sustainability are as follows:

Initiative	**Description**
Acute demand	To co-construct a system-wide response to reduce avoidable presentations. Understand why there is a significant volume of acute demand presentations and the impact of these presentations on capacity, capability, drivers of cost for the system. Likely savings to be realised through reduction in acute admissions. Goal of 10% reduction.
Benchmarking review Whanganui, South Canterbury and Tairāwhiti	Small DHBs have less scale but same service coverage requirements of larger DHBs. The purpose of the benchmarking is to discover how demographics influences service demand, how each are managing service demand and what operating models they have developed. There is an opportunity to review delivery cost structures to see where there are opportunities to do things differently and reduce costs.
Manage IDF outflows	Minimise IDF outflows to MCH that can be undertaken within scope of DHB medical staff. Ensure that acute IDFs charged to this DHB are appropriate Ensure that people visiting Whanganui who attend Whanganui Hospital are providing their normal residential address rather than temporary address.
Optimising Surgery	Manage elective surgical interventions regionally on a more equitable basis. Support other DHBs to deliver planned care services at Whanganui Hospital where capacity allows.
ACC revenue	Capture all ACC revenue that is chargeable under ACC contracts; and improve treatment injury claim systems. Correct identification of ACC status does provide patient with additional treatment options and does reduce cost for patient in primary care.
Staff course and conference fees	Contain conference and course fees within budget.
Informatics	Including improve availability of information to clinicians to support decision-making
Smart procurement	Standardisation of product, product substitution. This project aims to take advantage of the collective Government and national health sourcing (Pharmac and NZ Health Partnerships) programmes and identify savings opportunities through current spend.

Cash flows

The deficit over the last two years has been impacting on cash-flow to the extent that deficit support by way of equity injection will be required in the first half of 2019/20 year. The last time deficit support was received from the shareholder was 2012/13 year.

The cash flows assume that overdraft facilities available from the Bank of New Zealand through the sweep will be utilised to fund working capital requirements.

The proposed capital investment of $7.6m is greater than depreciation of $5.8m however there is a lag of capital projects that were budgeted 2018/19 and not spent which have now flowed into 2019/20 year.

Statement of prospective comprehensive revenue and expenses for the four years to 30 June 2023

	Actual 2017/18 000	Actual 2018/19 $000	Plan 2019/20 $000	Plan 2020/21 $000	Plan 2021/22 $000	Plan 2022/23 $000
Revenue						
Revenue from non-exchange transactions	222,111	232,616	241,436	250,443	258,978	267,813
Revenue from exchange transactions	31,627	32,811	33,990	34,278	34,627	34,984
Other Revenue	339	372	340	340	340	340
Total Revenue	**254,077**	**265,799**	**275,766**	**285,061**	**293,945**	**303,137**
Expenses						
Wages, salaries and employee benefit costs	(83,456)	(94,090)	(97,409)	(100,854)	(104,428)	(108,134)
Outsourced services	(14,397)	(15,122)	(14,360)	(14,768)	(15,195)	(15,636)
Depreciation and amortisation expense	(4,720)	(5,417)	(5,858)	(6,409)	(6,798)	(6,965)
Capital charge	(4,357)	(4,401)	(3,534)	(3,598)	(3,342)	(3,122)
Finance costs	(10)	(22)	(56)	(306)	(504)	(504)
Other expenses	(151,445)	(160,496)	(167,241)	(171,695)	(176,174)	(180,869)
Total expenses	**(258,385)**	**(279,548)**	**(288,458)**	**(297,630)**	**(306,441)**	**(315,230)**
Share of Profit of Associate	129	95	95	95	95	95
Surplus / (deficit)	**(4,179)**	**(13,654)**	**(12,597)**	**(12,474)**	**(12,401)**	**(11,998)**
Other Comprehensive revenue and expense						
Gain on property revaluation	**7,024**	**-**	**-**	**-**	**-**	**-**
Total other comprehensive revenue and expense	**7,024**	**-**	**-**	**-**	**-**	**-**
Total comprehensive revenue and expense	**2,845**	**(13,654)**	**(12,597)**	**(12,474)**	**(12,401)**	**(11,998)**

Statement of prospective financial position as at year end for four years to 30 June 2023

	Actual 2017/18 000	Actual 2018/19 $000	Plan 2019/20 $000	Plan 2020/21 $000	Plan 2021/22 $000	Plan 2022/23 $000
ASSETS						
Current assets						
Cash and cash equivalents	1,284	3,020	5	5	5	5
Receivables from non-exchange transactions	223	352	160	160	160	160
Receivables from exchange transactions	8,514	5,897	6,741	7,687	7,926	8,171
Prepayments	13	41	13	14	15	16
Investments	3,000	-	-	-	-	-
Inventories	1,412	1,427	1,437	1,390	1,390	1,390
Trust /special funds	141	181	180	180	180	180
Patient and restricted trust funds	4	4	4	4	4	4
Non- current assets held for sales	-	-	-	-	-	-
Total current assets	**14,591**	**10,922**	**8,540**	**9,440**	**9,680**	**9,926**
Non current assets						
Property, plant and equipment	76,766	75,230	76,138	78,208	79,523	78,318
Intangible assets	12,417	11,777	12,366	11,952	10,523	8,997
Investments in associates	1,121	1,146	1,171	1,196	1,221	1,246
Other financial assets	-	-	-	-	-	-
Total non current assets	**90,304**	**88,153**	**89,675**	**91,356**	**91,267**	**88,561**
Total assets	**104,895**	**99,075**	**98,215**	**100,796**	**100,947**	**98,487**
LIABILITIES						
Current Liabilities						
Bank Overdraft	-	-	6,918	8,826	12,291	12,604
Payables under non-exchange transitions	2,179	2,092	2,182	2,348	2,431	2,515
Payables under exchange transitions	11,743	16,142	13,722	12,802	13,201	13,614
Borrowings	227	230	198	100	103	107
Employee entitlements	12,874	16,713	18,181	15,370	15,933	16,422
Provisions	-	-	-	-	-	-
Total current liabilities	**27,023**	**35,177**	**41,201**	**39,446**	**43,959**	**45,262**
Non-current liabilities						
Borrowings	914	684	486	385	282	175
Employee entitlements	805	873	942	1,011	1,011	1,011
Provisions	-	-	-	-	-	-
Total non current liabilities	**1,719**	**1,557**	**1,428**	**1,396**	**1,293**	**1,186**
Total liabilities	**28,742**	**36,734**	**42,629**	**40,842**	**45,252**	**46,448**
Net Assets	**76,153**	**62,341**	**55,586**	**59,954**	**55,695**	**52,039**
EQUITY						
Equity						
Contributed Capital	105,725	105,567	111,409	128,251	136,393	144,735
Accumulated surplus / (deficit)	(53,594)	(67,287)	(79,884)	(92,358)	(104,759)	(116,757)
Property revaluation reserves	23,881	23,881	23,881	23,881	23,881	23,881
Hospital special funds	141	180	180	180	180	180
Total equity	**76,153**	**62,341**	**55,586**	**59,954**	**55,695**	**52,039**

Statement of prospective changes in equity for the year end for four years to 30 June 2023

	Actual 2017/18 000	Actual 2018/19 $000	Plan 2019/20 $000	Plan 2020/21 $000	Plan 2021/22 $000	Plan 2022/23 $000
Balance at 1 July	73,467	76,153	62,341	55,586	59,954	55,695
Total comprehensive revenue and expense for the year	2,845	(13,654)	(12,597)	(12,474)	(12,401)	(11,998)
Owners Transactions						
Capital contribution	-	-	6,000	17,000	8,300	8,500
Repayment of Capital	(159)	(158)	(158)	(158)	(158)	(158)
Balance at 30 June	**76,153**	**62,341**	**55,586**	**59,954**	**55,695**	**52,039**

Statement of prospective cash flows for the year end for four years to 30 June 2023

	Actual 2017/18 000	Actual 2018/19 000	Plan 2019/20 $000	Plan 2020/21 $000	Plan 2021/22 $000	Plan 2022/23 $000
Cash flows from Operating Activities						
Receipts from the Crown	248,493	266,128	273,684	283,001	292,592	301,778
Interest Received	509	321	57	4	4	4
Receipt from other revenue	1,934	1,655	1,110	1,110	1,110	1,110
Payment to Supplies	(164,496)	(169,917)	(183,571)	(187,498)	(191,313)	(196,434)
Payment to Employees	(81,344)	(90,183)	(95,854)	(103,596)	(103,865)	(107,645)
Interest Paid	(10)	(22)	(24)	(24)	(24)	(24)
Payment to capital charged	(4,357)	(4,401)	(3,534)	(3,598)	(3,342)	(3,122)
GST (net)	(91)	177	110	140	40	40
Net Cash inflow/(outflow) from operating activities	**638**	**3,758**	**(8,022)**	**(10,461)**	**(4,798)**	**(4,293)**
Cash flows from Investing Activities						
Receipts from sale of property, plant and equipment	38	-	-	-	-	-
Purchase of property, plant and equipment	(2,457)	(3,262)	(5,869)	(7,165)	(6,614)	(4,154)
Purchase of intangible assets	(3,983)	(1,310)	(1,630)	(900)	(70)	(80)
Receipts from maturity of investments	-	2,975	(25)	(25)	(25)	(25)
Net appropriation from trust funds	(7)	(40)	1	-	-	-
Net Cash inflow/(outflow) from investing activities	**(6,409)**	**(1,637)**	**(7,523)**	**(8,090)**	**(6,709)**	**(4,259)**
Cash flows from Financing Activities						
Capital contribution	-	-	6,000	17,000	8,300	8,500
Payment of finance lease	(57)	(92)	(95)	(98)	(100)	(103)
Repayment of Capital	(159)	(158)	(158)	(158)	(158)	(158)
Payment of loans	(135)	(135)	(135)	(101)	-	-
Net Cash inflow/(outflow) from financing activities	**(351)**	**(385)**	**5,612**	**16,643**	**8,042**	**8,239**
Net increase/(decreased) in cash and cash equivalents	(6,122)	1,736	(9,933)	(1,908)	(3,465)	(313)
Cash and cash equivalents at beginning of year	7,406	1,284	3,020	(6,913)	(8,821)	(12,286)
Cash and cash equivalents at end of year	**1,284**	**3,020**	**(6,913)**	**(8,821)**	**(12,286)**	**(12,599)**

Wāhanga 3: Rohe Ratonga Me Tōna Āhua

Section 3: Service configuration

3.1 Service coverage

Whanganui DHB 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, Whanganui DHB 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

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

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

The initiatives that may trigger the service change process in 2019/20 include:

Change	Description of Change	Benefits of Change	Dis-benefits of change	Driver	Change for local, regional or national reasons	Notes
Rebalancing surgical outputs	Planned care to be more aligned to national intervention rates in the absence of any evidence to suggest something different. This may mean some reduction compared to previous years.	More equitable intervention rates compared to rest of NZ. Refocus attention on those areas where intervention rates are low or where need is higher priority.	Some change of expectations will need to be managed.	Equity, efficiency, productivity		

Termination of pregnancy	Change of provider from out-of-district to closer to home.	Reduced travel burden and ability to offer more support services locally.	Increased need for local counselling.	Equity, access, local		
Community pharmacy	Refocusing of schedule 3 services to ensure local commissioning matches need and capability.	Stronger locally commissioned services; sustainability.	Lower value services may be discontinued.	Sustainability, productivity		
Sleep apnoea	Revised model of care to change access to sleep studies and funded/ assisted CPAP.	Funding flows more aligned to need.	Extra funding of sleep apnoea services may result in reprioritisation of something else.	Burden of disease, effectiveness		
Oral maxilo facial surgery	Reviewing model of care regionally with a view to a shared service model for elective, acute and on call components.	Increased sustainability of service across the region. Increased equity in service delivery - service should be postcode blind.	Funding and service governance model will require careful consideration. Costs may increase for some DHB's where they are currently not fairly allocated.	Equity, is sustainability		This is in early discussion stages with CCDHB, Hutt Valley DHB, NMDHB, Hawke's Bay DHB, Taranaki DHB
Audiology	Review model of care to reduce waiting. The service is likely to have a mix of public and private service provision.	Achieve a sustainable service.	Some adult access will no longer be publically available.	Equity, sustainability		
Home and community support services	Aligning home and community to support the new national framework and service specification for home and community support services.	Better aligned to support '65,000 beds'.	May change how some people are currently supported.	Standard, consistent approach that's efficient and effective		
DHB nursing agency	Explore development of a nursing agency that is a resource for NGOs including ARC providers.	No agency bureau locally which is a problem for local NGOs particularly when they require an RN as part of their service delivery.	Competing requirements for RNs by various providers.	Recruitment challenges		
Essential dental services	Develop contract for services in the community for	This is expected to reduce the demand on hospital dental	Potential additional cost	Equity, sustainability, early		

	essential/relief of pain dental for low income adults.	services, provide more immediate care to patients for relief of pain and encourage an ongoing relationship with dentists for patients.		intervention for patients		
Community midwifery	Integrated community based model to support LMC approach to support for pregnant women and new parents.	Pregnant women are able to access midwifery services.	May not be able to offer continuity of carer with one midwife.	Equity, access. Demand for LMCs in the community, pregnant women unable to access midwifery services.		
Regional acute inpatient child/youth beds at Rangatahi unit (CCDHB)	Psychiatrists are wanting to explore providing a local acute inpatient service for child/youth instead of these patients going to Wellington.	Closer to home and whānau support, can better link with local support services for on-going care.	Co-location at Te Awhina has some challenges, mixing adults with youth, availability of the family room.	Closer to home, access, equity		
Funded family care	Realign local policy to any changes in funded family care – national arrangements.	More targeted support.	Extra costs may be incurred.	National change	National	

Procurement of health and disability services

Whanganui DHB periodically re-tenders health and disability service contracts. Re-tendering may be undertaken for several reasons, including but not limited to improving patient access and/or quality of services, ensuring cost effectiveness and efficient service provision, or aligning to new or reconfigured service requirements. Such procurement processes are undertaken in line with the Government Rules of Sourcing, and may result in a change in provider arrangements.

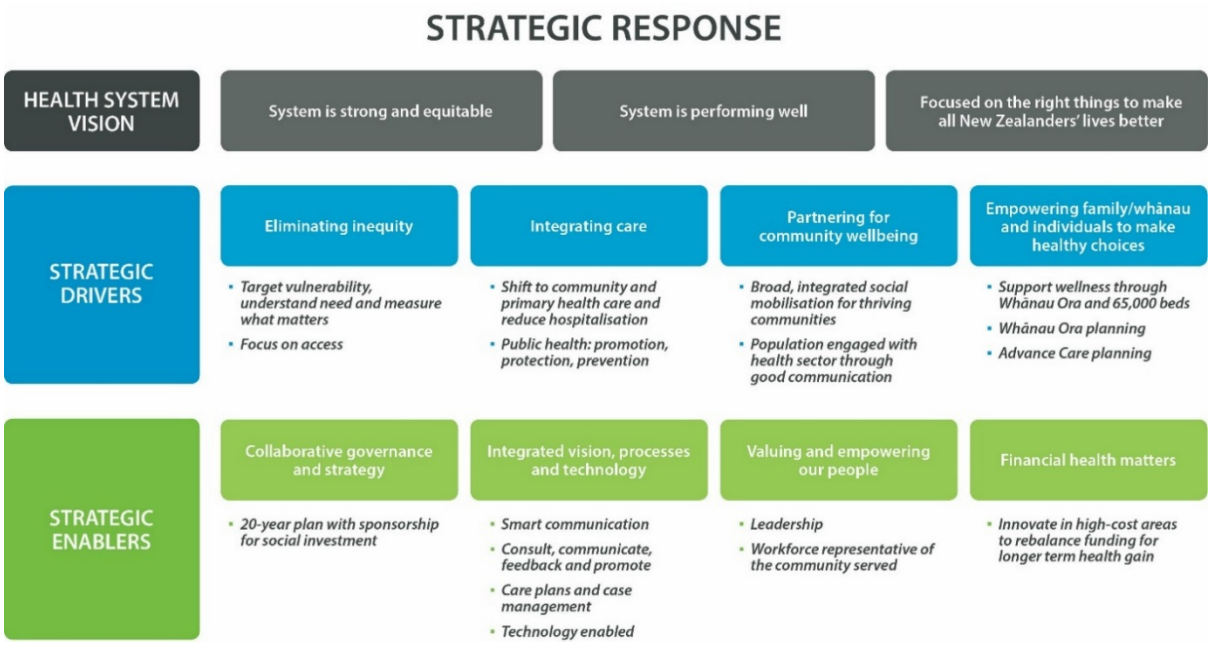
In 2019/20, this will include the ongoing process for re-tendering of pathology and laboratory services in conjunction with MidCentral DHB and possibly other DHBs. We will also be considering options for reprocurement of certain hotel and facilities management services.

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. Strategic enablers that underpin our approach to stewardship and support our strategic drivers, are depicted in Figure 4.

Figure 4

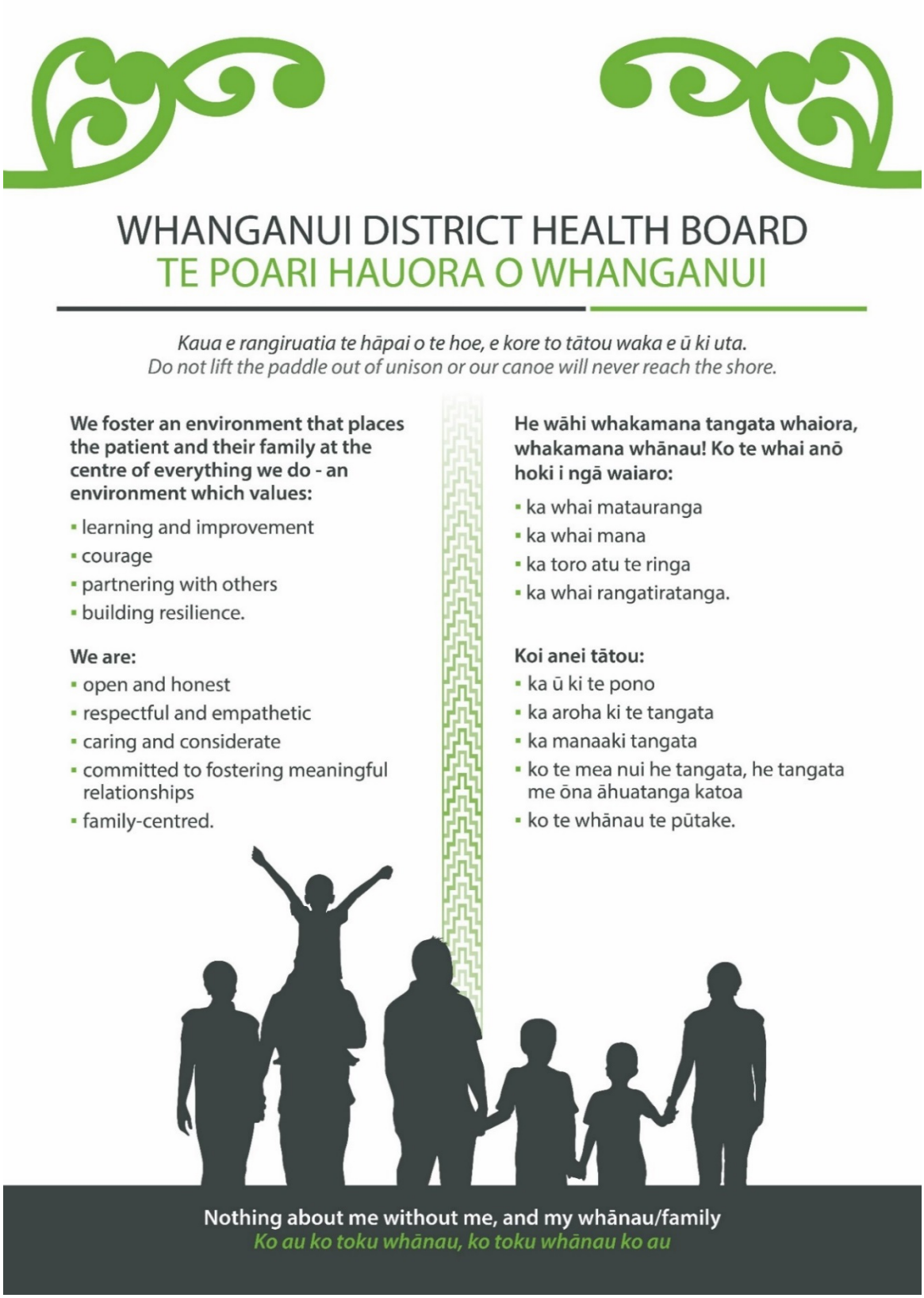


An effective national health system is crucial in our mission to eliminate inequity, integrate care, partner for community wellbeing and empower whānau and individuals to make healthy choices. Locally, to improve system effectiveness over the next three years, we are focused on the following system enablers:

- Collaborative governance and strategy – we are supporting local efforts to develop a 20-year plan with sponsorship for social investment in our community.
- Integrated vision, processes and technology – through smart communication; a commitment to consult, communicate, feedback and promote; comprehensive care plans and case management; and technology enablement.
- Valuing and empowering our people – through leadership and a workforce that is representative of the community served.
- Financial health – innovation in high cost areas to rebalance funding for longer term health gain.

Our values

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



4.1 Managing our business

Funding and financial management
Whanganui DHB's key financial indicators are reported through Whanganui DHB's performance management process to governance and management leaders on a regular basis. Further information about Whanganui DHB's planned financial position for 2019/20 and out years is contained in the financial performance summary of our Annual Plan (section 2.2) and in our Statement of Performance Expectations (Section 6).

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. Whanganui DHB's LTIP is available on our website at www.wdhb.org.nz.

Shared service arrangements and ownership interests
Whanganui DHB has a part ownership interest in Technical Advisory Services (TAS) and Allied Laundry Services Limited. Whanganui DHB 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
Whanganui DHB 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
Whanganui DHB's approach to quality assurance and improvement is in line with the New Zealand Triple Aim: Improved quality, safety and experience of care, improved health and equity for all populations, and best value for public health system resources. Contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits.

4.2 Building capability

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

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

4.3 Workforce

Whanganui DHB, 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 Whanganui DHB's organisational culture, leadership and workforce development initiatives:

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

Further detail about the region's approach to workforce is contained in the Central Region's Regional Services Plan.

Cooperative developments

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

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

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

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

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

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

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

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

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

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

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

Please refer to Section 2 – Workforce (page 61).

Wāhanga 5: Tātai Mahi

Section 5: Performance measures

5.1 Performance measures 2019/20

Introduction
This section reflects the current requirements of the District Health Board Performance Framework. As such, performance targets are set in accordance with annual guidance and Ministry expectations. In the future, we intend to align performance frameworks for the DHB more closely to the Living Standards Framework (LSF) developed by the New Zealand Treasury to inform how policy trade-offs affect everyone's living standards. The scope of work of a district health board encompasses the four capitals that make up the LSF (natural capital, human capital, social capital, and financial and physical capital) and trade-offs are inevitable in the prioritisation processes that we must employ.

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

- child wellbeing
- mental wellbeing
- strong and equitable health and disability system
- primary care and prevention.

The DHB monitoring framework and accountability measures have been updated for 2019/20 to provide a line of sight between DHB activity and the health system priorities that will support delivery of the Government's priority goals for New Zealand and the health system vision and outcomes, within a system that has a foundation of financial, clinical and service sustainability and strong governance.

Performance measure		Expectation		Target
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	0.81
			Year 2	0.81
CW03	Improving the number of children enrolled and accessing the community oral health service	Children (0-4) enrolled	Year 1	≥95%
			Year 2	≥95%
		Children (0-12) not examined according to planned recall	Year 1	≤10%
			Year 2	≤10%
CW04	Utilisation of DHB funded dental services by adolescents from school year 9 up to and including 17 years		Year 1	≥85%
			Year 2	≥85%

CW05	Immunisation coverage at eight months of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	95% of eight-month-olds olds fully immunised.	95%
		95% of five-year-olds have completed all age-appropriate immunisations due between birth and five years of age.	95%
		75% of girls and boys fully immunised – HPV vaccine.	75%
		75% of 65+ year olds immunised – flu vaccine.	75%
CW06	Child Health (Breastfeeding)	70% of infants are exclusively or fully breastfed at three months.	70%
CW07	Newborn enrolment with General Practice	55% of newborns enrolled in General Practice by six weeks of age.	55%
		85% of newborns enrolled in General Practice by three months of age.	85%
CW08	Increased immunisation at two years	95% of two-year-olds have completed all age-appropriate immunisations due between birth and age two years,	95%
CW09	Better help for smokers to quit (maternity)	90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.	90%
CW10	Raising healthy kids	95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	95%
CW11	Supporting child wellbeing	Provide report as per measure definition.	
CW12	Youth mental health initiatives	Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement *Youth Health Care in Secondary Schools: A framework for continuous quality improvement* in each school (or group of schools) with SBHS.	
		Initiative 3: Youth Primary Mental Health.	
		Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population.	
CW13	Reducing rheumatic fever	Reducing the Incidence of First Episode Rheumatic Fever to 1.1per 100,000	1.1 per 100,000
MH01	Improving the health status of people with severe mental illness through improved access	Age (0-19) Māori, other & total	5.5%
		Age (20-64) Māori, other & total	7.0%
		Age (65+) Māori, other &total	3.0%
MH02	Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan.	>95%
		95% of audited files meet accepted good practice.	>95%

MH03	Shorter waits for non-urgent mental health and addiction services	Mental health provider arm	80% of people seen within 3 weeks.	80%
			95% of people seen within 8 weeks.	95%
		Addictions (Provider Arm and NGO)	80% of people seen within 3 weeks.	80%
			95% of people seen within 8 weeks.	95%
MH04	Rising to the Challenge: The Mental Health and Addiction Service Development Plan	Provide reports as specified		
MH05	Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.		
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.		
PV01	Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall.		70%
PV02	Improving cervical Screening coverage	80% coverage for all ethnic groups and overall.		80%
SS01	Faster cancer treatment – 31 day indicator	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.		>85%
SS02	Ensuring delivery of Regional Service Plans	Provide reports as specified		
SS03	Ensuring delivery of Service Coverage	Provide reports as specified		
SS04	Delivery of actions to improve Wrap Around Services for Older People	Provide reports as specified		
SS05	Ambulatory sensitive hospitalisations (ASH adult)	Total 6,300/100,000		Total < 6,300 All Per 100,000
SS06	Better help for smokers to quit in public hospitals (previous health target)	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.		95%

SS07	Planned Care Measures	Planned Care Measure 1: *Planned Care Interventions*		100% of WDHB agreed Planned Care interventions for each quarter	5,330
		Planned Care Measure 2: *Elective Service Patient Flow Indicators*	ESPI 1	100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less)	100%
			ESPI 2	0% – no patients are waiting over four months for FSA	0%
			ESPI 3	0% - zero patients in Active Review with a priority score above the actual Treatment Threshold (aTT)	0%
			ESPI 5	0% - zero patients are waiting over 120 days for treatment	0%
			ESPI 8	100% - all patients were prioritised using an approved national or nationally recognised prioritisation tool	100%
		Planned Care Measure 3: *Diagnostics waiting times*	Coronary Angiography	95% of patients with accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)	95%
			Computed Tomography (CT)	95% of patients with accepted referrals for CT scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).	95%
			Magnetic Resonance Imaging (MRI)	90% of patients with accepted referrals for MRI scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).	90%
		Planned Care Measure 4: *Ophthalmology Follow-up Waiting Times*	No patient will wait more than or equal to 50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be		0%

			reviewed by the ophthalmology service.		
		Planned Care Measure 6: *Acute Readmissions*			<12.1%
SS08	Planned care three year plan	Provide reports as specified			
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1: Improving the quality of data within the NHI	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%	
			New NHI registration in error (duplication)	Group C >1.5% and <=6%	
			Invalid NHI data updates		
		Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC and NMDS for FSA and planned inpatient procedures.	Greater than or equal to 90% and less than95 %	
			National Collections completeness	Greater than or equal to 94.5% and less than 97.5 %	
			Assessment of data reported to the NMDS	Greater than or equal to 75%	
		Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)		Provide reports as specified	
SS10	Shorter stays in Emergency Departments	95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.			95%
SS11	Faster Cancer Treatment (62 days)	90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.			90%

SS12	Engagement and obligations as a Treaty partner	Reports provided and obligations met as specified		
SS13	Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	Focus Area 1: Long term conditions	Report on actions to: Support people with LTC to self-manage and build health literacy.	
		Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care.*	
			Ascertainment: target 95-105% and no inequity HbA1c<64mmols: target 60% and no inequity No HbA1c result: target 7-8% and no inequity	HbA1c 60%
		Focus Area 3: Cardiovascular health	Provide reports as specified	
		Focus Area 4: Acute heart service	**Indicator 1: Door to cath** - Door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram**.**	>70%
			Indicator 2a: Registry completion- >95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and **Indicator 2b:** ≥ 99% within 3 months.	> 95% ≥99%
			Indicator 3: ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (ie have had an echocardiogram or LVgram).	≥85%
			Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance >85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge: - Aspirin*, a 2nd anti-platelet agent*, statin and an ACEI/ARB (4 classes), and - LVEF<40% should also be on a beta-blocker (5-classes). ** An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents*.	≥85%

			Indicator 5: Device registry completion- ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device forms within 2 months of the procedure.	≥ 99%
		Focus Area 5: Stroke services	**Indicator 1** ASU: 80% of stroke patients admitted to a stroke unit or organised stroke service, with a demonstrated stroke pathway	80%
			Indicator 2 Thrombolysis: 10% of potentially eligible stroke patients thrombolysed 24/7	10%
			Indicator 3: In-patient rehabilitation: 80% patients admitted with acute stroke who are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission	80%
			Indicator 4: Community rehabilitation: 60 % of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.	60%
SS15	Improving waiting times for Colonoscopy	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less 100% within 30 days or less.		90%
		70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less.		70%
		70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less.		70%
		95% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system.		95%
SS16	Delivery of collective improvement plan	Deliverable tbc		
SS17	Delivery of Whānau ora	Provide reports as specified		
PH01	Delivery of actions to improve system integration and SLMs	Provide reports as specified		
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers	Provide reports as specified		
PH03	Access to Care (PHO Enrolments)	Meet and/or maintain the national average enrolment rate of 90%.		90%

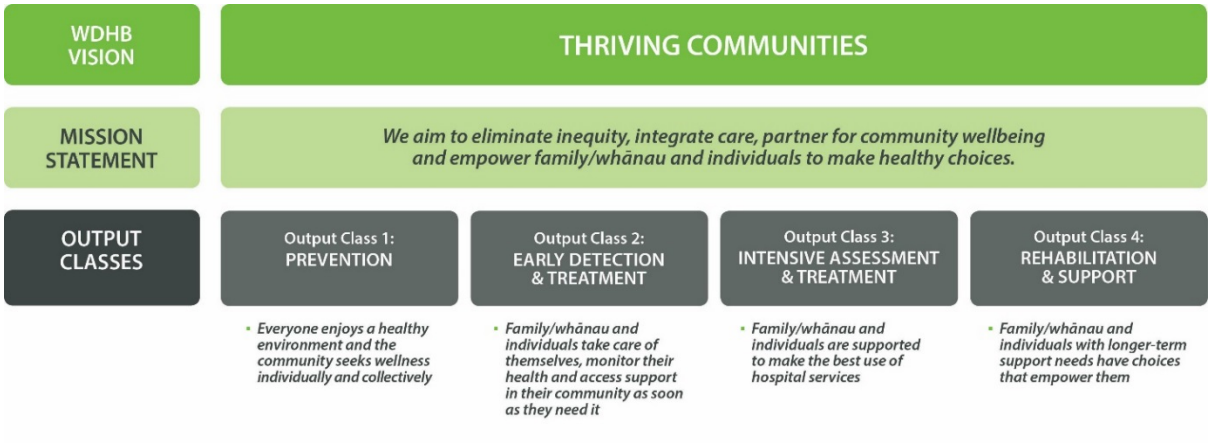
PH04	Primary health care: Better help for smokers to quit (primary care)	90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	90%
Annual plan actions – status update reports		Provide reports as specified	

Wāhanga 6: Te Tauāki o te Pūtanga Ake

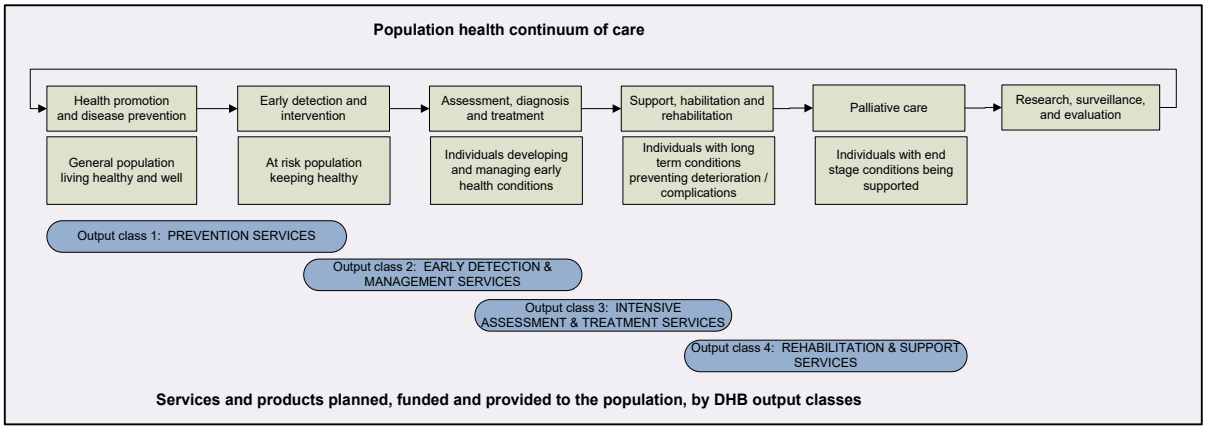
Section 6: Statement of Performance Expectations

This section outlines our performance expectations for the first year of our Statement of Intent. In the 2019/20 financial year we will closely monitor the measures outlined in this section as we pursue the targets we have set.

The diagram below illustrates the link between our vision and the work that we do for the population of our district, grouped into output classes.



Further, there is a relationship between the population health continuum of care and outputs. Simply, this means that as care needs intensify, so too does the required response from the health and disability system. This is shown in the following diagram.



This shows that the DHB has obligations to meet the health needs of the population it serves ranging from promoting healthy lifestyles to the general population right through to treating and supporting individuals and their family/whānau in end of life care. In doing so the DHB, as a Crown entity, must respond to the requirements of Parliament and the expectations and priorities of the Government for the public health sector.

Output classes

Output classes cover the full range of the services that we provide. The following is a brief description of each output class and the performance measures within each output class that we will target in the 2019/20 financial year.

The performance measures chosen are not an exhaustive list of all our activity but provide a good representation of the performance in key focus areas for 2019/20 and include some volume targets and some quality indicators. This reflects our performance measurement philosophy that accounts for "How much did we do" as well as "How well did we do it". The overarching quality framework that is applied comes from the Institute of Health Innovation and includes six domains:

1. safety
2. timeliness
3. efficiency
4. effectiveness
5. equity
6. patient-centredness.

Activity not mentioned in this section continues to be funded and monitored.

Reducing inequity in health outcomes, in particular health inequities experienced by Māori, is a key priority identified in the National Health Strategy and a key priority for the Whanganui DHB. Our intervention logic follows the principle that equity of outcome will only follow equity of access and engagement – hence much of our improvement activity focuses on how to attain and promote access to services and how to truly engage our population of all age-groups to be empowered owners of their own wellbeing.

To help understand the inequality in health outcomes between Māori and non-Māori an equity ratio can be calculated. An equity ratio would illustrate the relative gap between the health outcomes measured for Māori and non-Māori. For example, a ratio of two for a disease state would show that Māori are twice as likely to have the disease. A ratio of two for a screening service would illustrates that non-Māori population are screened at twice the rate of Māori. A lower ratio would indicate lower inequity and a ratio of one would result where the health outcomes and services measures for Māori and non-Māori are the same.

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 2019/20	Plan 2020/21	Plan 2021/22	Plan 2022/23
Revenue				
Crown	5,532	5,687	5,842	6,002
Other Income	6	5	5	5
Inter-district Inflows	43	44	45	46
Total Revenue	5,581	5,736	5,892	6,053
Expenditure				
Personnel	(3,331)	(3,449)	(3,571)	(3,698)
Capital charge	(240)	(258)	(239)	(221)
Depreciation	(14)	(15)	(16)	(16)
Other	(390)	(399)	(406)	(413)
Other Provider Payments	(3,197)	(3,288)	(3,384)	(3,482)
Inter-district Inflows	(54)	(56)	(58)	(60)
Overheads	0	0	0	0
Total Expenditure	(7,226)	(7,465)	(7,674)	(7,890)
Net Surplus (Deficit)	**(1,645)**	**(1,729)**	**(1,782)**	**(1,837)**

Prevention Services					
Measure description	**Ethnicity**	**2017/18 Actual**	**2018/19 Forecast**	**2019/20 Target**	**2021/22 Outlook**
Ambulatory sensitive hospitalisations for children 0 – 4 years of age (compared with the national rate)					
	All	120%	110%	≤110%	≤100%
	Māori	141%	143%	≤115%	≤100%
	Non-Māori	103%	84%	≤110%	≤100%
Children caries free at 5 years of age					
	All	55%	57%	≥58%	≥60%
	Māori	35%	35%	≥58%	≥60%
	Non-Māori	66%	64%	≥58%	≥60%
Immunisation coverage rate at 8 months of age					
	All	88%	88%	≥95%	≥95%
	Māori	87%	88%	≥95%	≥95%
	Non-Māori	89%	91%	≥95%	≥95%
Babies in a Smokefree household at 6 weeks of age					
	All	55%	38%	≥38%	≥60%
	Māori	31%	14%	≥28%	≥60%
	Non-Māori	73%	58%	≥58%	≥60%
Proportion of infants exclusively or fully breastfed at six weeks					
	All	71%	67%	≥70%	≥70%
	Māori	64%	64%	≥70%	≥70%
	Non-Māori	76%	72%	≥70%	≥70%
Proportion of youth who have received HPV vaccine					
	All	78%	N/A	≥75%	≥75%
	Māori	96%	N/A	≥75%	≥75%
	Non-Māori	67%	N/A	≥75%	≥75%
Cervical screening three-year coverage rate for women aged 25-69 years					
	All	76%	76%	≥80%	≥80%
	Māori	72%	72%	≥80%	≥80%
	Non-Māori	78%	77%	≥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	92%	90%	≥95%	≥95%
	Māori	N/A	90%	≥95%	≥95%
	Non-Māori	N/A	91%	≥95%	≥95%
Number of extended consults delivered by a GP or practice nurse					
	Total	1285	1964	2228	Target to be established: Youth 20% Adult 80%
	Youth	208	182	446	
	Adult	1077	1782	1782	
Percentage of enrolled population 65 years + who have the flu vaccination					
	All	63%	N/A	≥75%	≥75%
	Māori	59%	N/A	≥75%	≥75%
	Non-Māori	64%	N/A	≥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 2019/20	Plan 2020/21	Plan 2021/22	Plan 2022/23
Revenue				
Crown	59,962	61,782	63,453	65,213
Other Income	46	34	34	34
Inter-district Inflows	1,516	1,562	1,609	1,657
Total Revenue	61,524	63,378	65,096	66,904
Expenditure				
Personnel	(11,504)	(11,909)	(12,330)	(12,766)
Capital charge	(500)	(489)	(454)	(428)
Depreciation	(472)	(516)	(547)	(560)
Other	(9,151)	(9,364)	(9,548)	(9,717)
Other Provider Payments	(42,516)	(43,781)	(45,092)	(46,438)
Inter-district Inflows	(3,306)	(3,405)	(3,507)	(3,612)
Overheads	0	0	0	0
Total Expenditure	(67,449)	(69,464)	(71,478)	(73,521)
Net Surplus (Deficit)	**(5,925)**	**(6,086)**	**(6,382)**	**(6,617)**

Early Detection and Management					
Measure description	**Ethnicity**	**2017/18 Actual**	**2018/19 Forecast**	**2019/20 Target**	**2021/22 Outlook**
Proportion of pregnant women accessing DHB funded pregnancy and parenting education					
	All	24%	25% (est)	≥40.0%	≥40.0%
	Māori		Target to be established		
Proportion of adolescent population utilising DHB-funded dental services					
	All	79.4%	79.8%	≥85.0%	≥90%
	Māori		Target to be established		
Proportion of children enrolled in the community oral health service who have treatment according to plan					
	All	98%	97%	≥90%	≥90%
	Māori	98%	96%	≥90%	≥90%
	Non-Māori	98%	96%	≥90%	≥90%
Proportion of youth (12-19 years olds) seen each quarter by primary mental health services					
	All	1.8%	1.0%	≥2.0%	≥4.0%
	Māori	2.4%	0.8%	≥2.0%	≥4.0%
	Non-Māori	1.4%	1.1%	≥2.0%	≥4.0%
Shorter waits for non-urgent mental health and addiction services (0-19 yrs)					
	< 3 weeks	79.7%	84.2%	≥80%	≥80%
	3-8 weeks	19.9%	13.4%	≥95%	≥95%
	> 8 weeks	0.4%	2.4%	100%	100%
Ambulatory Sensitive Hospitalisations (ASH) rates for 45-64 years of age relative to national rate					
	All	161%	168%	≤170%	≤125%
	Māori	275%	295%	≤151%	≤125%
	Non-Māori	134%	138%	≤166%	≤125%
Proportion of patients with good or acceptable glycaemic control (HbA1C < 64 mmol/mol)					
	All	61%	61%	≥60%	≥60%
	Māori	51%	51%	≥60%	≥60%
	Non-Māori	65%	72%	≥60%	≥60%
Proportion of eligible population who have had their cardiovascular risk assessed in the last five-years					
	All	89%	89%	≥90%	≥90%
	Māori	88%	89% (est)	≥90%	≥90%
	Non-Māori	90%	89% (est)	≥90%	≥90%
Percentage of people accepted for an urgent diagnostic colonoscopy received their procedure within two-weeks (14 days)					
	All	90%	91%	≥90%	≥90%
Percentage of long term clients with mental illness who have an up-to-date relapse prevention plan					
	Child	100%	100% (est)	≥95%	≥95%
	Adult	96%	95%	≥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 2019/20	Plan 2020/21	Plan 2021/22	Plan 2022/23
Revenue				
Crown	161,815	167,850	173,637	179,560
Other Income	1,095	1,063	1,064	1,064
Inter-district Inflows	5,158	5,313	5,472	5,637
Total Revenue	168,068	174,226	180,173	186,261
Expenditure				
Personnel	(78,914)	(81,708)	(84,607)	(87,612)
Capital charge	(2,605)	(2,682)	(2,493)	(2,323)
Depreciation	(5,229)	(5,723)	(6,071)	(6,221)
Other	(34,367)	(35,174)	(35,884)	(36,525)
Other Provider Payments	(12,835)	(13,221)	(13,619)	(14,028)
Inter-district Inflows	(36,986)	(38,096)	(39,239)	(40,416)
Overheads	-	-	-	-
Total Expenditure	(170,936)	(176,604)	(181,913)	(187,125)
Net Surplus (Deficit)	**(2,868)**	**(2,378)**	**(1,740)**	**(864)**

Intensive Assessment and Treatment					
Measure description	**Ethnicity**	**2017/18 Actual**	**2018/19 Forecast**	**2019/20 Target**	**2021/22 Outlook**
Inpatient length of stay – ACUTE					
	All	2.2	2.2	≤2.2	≤2.1
Unplanned readmission rate at 28 days					
	All	13.9%	13.9%	≤12.1%	≤12.0%
	Māori	13.8%	13.4%	≤12.1%	≤12.0%
	Non-Māori	14.0%	14.1%	≤12.1%	≤12.0%
Faster Cancer Treatment (62-day indicator)					
	All	95.2	87.3%	≥90%	≥90%
Improving waiting times for diagnostic services		Computed Tomography (CT)			
	All	98%	94%	≥95%	≥95%
	Māori	98%	95%	≥95%	≥95%
	Non-Māori	98%	94%	≥95%	≥95%
Improving waiting times for diagnostic services		Magnetic Resonance Imaging (MRI)			
	All	98%	74%	≥90%	≥90%
	Māori	96%	80%	≥90%	≥90%
	Non-Māori	98%	73%	≥90%	≥90%
Percentage of service users receiving community care within seven days following their discharge (KPI 19)					
	All	56%	50%	≥75%	≥90%
	Māori	56%	50%	≥75%	≥90%
	Non-Māori	57%	50%	≥75%	≥90%
Rate per 100,000 population are committed to compulsory mental health treatment					
	All	127	151	≤135	≤120
	Māori	211	278	≤250	≤225
	Non-Māori	101	111	≤100	≤90
Standardised intervention rates		cardiac surgery and angioplasty/angiography			
	Cardiac (All)	4.8	5.4	≥6.5	≥6.5
	Angioplasty (All)	11.2	11.3	≥12.5	≥12.5
	Angiography (All)	26.5	29.1	≥34.7	≥34.7
Standardised intervention rates		cataracts and major joints			
	Cataracts (All)	18.2	25.7	≥27.0	≥27.0
	Major joints (All)	35.2	30.2	≤28.0	≤21.0
Hospital acquired cardiac complications per 10,000 inpatient episodes					
	All	50.5	31 (est)	≤40.0	≤40.0

Output Class 4: Rehabilitation and support

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

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

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

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

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

What outcomes are we contributing to?

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

Rehabilitation & Support	Plan 2019/20	Plan 2020/21	Plan 2021/22	Plan 2022/23
Revenue				
Crown	39,362	40,462	41,488	42,585
Other Income	20	12	11	11
Inter-district Inflows	1,211	1,247	1,285	1,323
Total Revenue	40,593	41,721	42,784	43,919
Expenditure				
Personnel	(3,660)	(3,788)	(3,920)	(4,058)
Capital charge	(189)	(169)	(156)	(150)
Depreciation	(143)	(155)	(164)	(168)
Other	(3,329)	(3,405)	(3,464)	(3,524)
Other Provider Payments	(32,487)	(33,453)	(34,454)	(35,482)
Inter-district Inflows	(2,944)	(3,032)	(3,123)	(3,217)
Overheads	0	0	0	0
Total Expenditure	(42,752)	(44,002)	(45,281)	(46,599)
Net Surplus (Deficit)	**(2,159)**	**(2,281)**	**(2,497)**	**(2,680)**

Rehabilitation and Support					
Measure description	**Ethnicity**	**2017/18 Actual**	**2018/19 Forecast**	**2019/20 Target**	**2021/22 Outlook**
Percentage of mental health & addictions service users receiving community care within seven days following their discharge (KPI 19)					
	All	56%	50%	≥75%	≥90%
	Māori	56%	50%	≥75%	≥90%
	Non-Māori	57%	50%	≥75%	≥90%
Percentage of older people in aged residential care by facility who have a second InterRAI Long-Term Conditions Facilities (LTCF) assessment completed 230 days after admission					
	All	90%	91%	≥95%	≥95%
Number of older people receiving in-home strength and balance programmes					
	All	151	179	199	≥199
Percentage of potentially eligible stroke patients thrombolysed					
	All	8.4%	8.0%	≥10.0%	≥12.0%
Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway					
	All	97%	100%	≥80%	≥80%
Percentage of people waiting for a surveillance or follow-up colonoscopy that wait no longer than 12 weeks (84 days) beyond the planned date					
	All	56%	67%	≥70%	≥70%
Proportion of over 64 year olds who are prescribed 11 or more medications					
	All	1.6%	2.0%	≤2.0%	≤2.0%
	Māori	N/A	2.2%	≤2.0%	≤2.0%
	Non-Māori	N/A	2.0%	≤2.0%	≤2.0%
Proportion of population aged 65+ years receiving DHB funded support in ARC facilities over the year					
	All	5.4%	4.9%	4.4%	4.4%
	Māori	3.6%	3.0%	3.0%	3.0%
	Non-Māori	5.6%	5.1%	4.5%	4.5%

Appendix

Āpitihanga 1:
SLM Māhere Whakawhanake o Whanganui DHB

Appendix 1:
System Level Measures (SLM) Improvement Plan

Whanganui District Health Board

System Level Measures Improvement Plan 2019 - 2020

Whanganui Regional Health Network

WHANGANUI DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

National Hauora Coalition

Rārāngi Kiko
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SECTION 1: Introduction

Whanganui Alliance Leadership Team (WALT) is an alliance of the District Health Board and the two primary health organisations operating in the Whanganui District. WALT is committed to a strategic approach informed by patient and whānau responsive care delivered locally. We are on a journey to create a connected and systemic approach to delivering health care, where at all times the patient and their whānau are at the centre of all decision making and transfer of care, no matter where they live in the district.

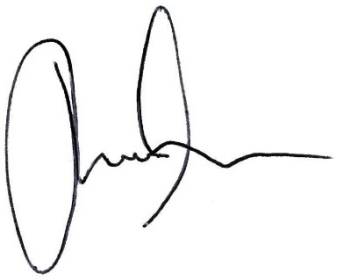
As an alliance leadership team, we intend to create a future health system that is cohesive, accessible, efficient, safe and sustainable. This journey will require a whole-of-system approach, with WALT operating as a unified team and sharing collective responsibility. It is also a multi-year journey, as we wish to build on the success of each year and create collective impact by taking all our partners and stakeholders on this journey. Success factors for this transformation journey include committed leadership, compelling communication and capability for change.

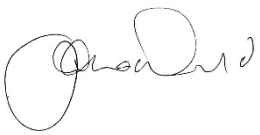
In following with WALT's intentions to create a connected and whānau-centered health system, an alliance sub-group has been created to reduce avoidable acute presentations. The vision of the Acute Demand Service Level Alliance (SLA) is that people living in the Whanganui DHB district should be able to access the right care, in the right place, at the right time, and by the right workforce.

With acute demand expected to continue increasing, a response that activates a system-wide, coordinated, engaged workforce, and enhances self-management in communities is required. The sub-group has undertaken comprehensive analysis of the significant increase in unplanned care presentations, and in doing so has been able to identify key areas of focus to reduce avoidable presentations; general practice, reducing flow to the front door, older persons, and connected care. A priority for this activity is to eliminate inequity for Māori, with all work streams being supported by a Māori leadership team and analysed from an equity lens to ensure that improved outcomes for Māori are fore-front in our approach.

WALT has agreed that the SLM improvement plan for 2019/20 will be closely aligned to the recommendations of this Acute Demand Service Level Alliance.

Engaging across sectors and communities will ensure we are aligned with communities at various points, working on matters that are important to communities, and measuring progress on actions that have a clear contribution to components of this plan. Our SLM activity will be significantly focused on older persons and children as these populations have been identified as high users of acute services. Māori are particularly represented in the growing population across our district, while older persons are represented in the city in a higher percentage than the national population average; therefore measures to manage and support this growth are critical.





Russell Simpson	Simon Royal	Judith MacDonald
Chief Executive	Chief Executive	Chief Executive
Whanganui District Health Board	National Hauora Coalition	Whanganui Regional Health Network

1.1 Executive summary

Building on from the work undertaken in the 2018/19 SLM, this document moves from a siloed activity work plan to a collaborative approach with a single improvement plan. Whanganui Alliance leadership Team (WALT) is committed to system-wide change, and fully endorse this SLM programme.

1.2 System Level Measures Governance

In 2018/19 an Acute Demand Service Level Alliance (SLA) was created in Whanganui, with the intention of working collaboratively to co-construct a system-wide response to reduce avoidable presentations in our community. The SLA will continue to have an overarching governance role for the implementation of the recommended and agreed work streams. WALT will support a project structure whereby the work streams managed by the SLA remain accountable to WALT. Therefore, monitoring and governance of the SLM programme will be coordinated through this SLA.

1.3 2019/20 Priorities for System Level Measures

Better management of acute demand will be a significant contributor to our overarching priority of equity for Māori in Whanganui DHB district. In many instances the rates of presentation to hospital and primary care by Māori are not representative of equitable access.

WDHB recently completed a pro-equity check-up, which identified opportunities where we can build a strong foundation for our pro-equity approach. It is the responsibility of everyone to progress this pro equity approach and drive equity for Māori as well as improved outcomes for all of our population.

The following work streams have been agreed as part of the acute demand programme of work:

- Connected care: Connecting the health system to ensure the patient journey is seamless and adds value to both the consumer, whānau and the health system.
- Older persons: Reframe our response to elderly living at home and in aged residential care.
- ED and WAM: Reduce acute volumes at the hospital front door (the Emergency Department and Whanganui Accident and Medical Clinic urgent care centre).
- General practice: General practice is agile and capable of responding to prevention and primary appropriate volumes, and is redesigned to consider a whānau-centred model which best fits with population need.
- Māori leadership group: Ensure the system is culturally responsive and competent for the population it is serving, and work streams address areas of inequity for Māori.

Each work stream will clearly link to enablers of the system or to contributory measures within the SLM, noting that the acute demand work streams may have a multi-year work plan. In some cases the SLMs detailed in the following pages also highlight areas incorporated in our local plan. Local plans are not formally part of the SLM Improvement Plan framework and do not have fiscal incentives attached to them. They are provided purely to provide context for the reader to understand the wider context against which this improvement plan is set.

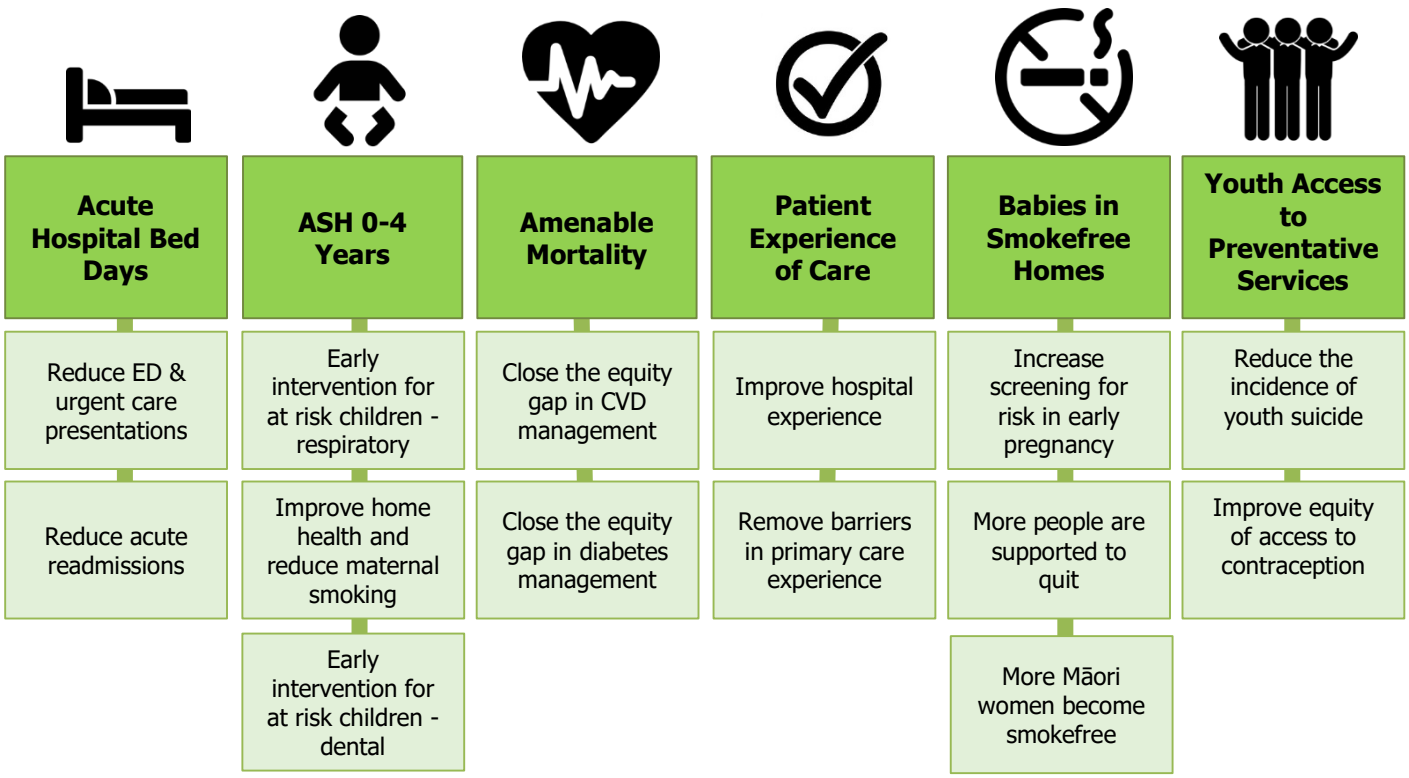
The development of new analytics within the DHB and a data-sharing agreement through WALT will support acute demand data exploration and SLM activity.

Alongside this work will be the implementation of two enablers;

- HealthPathways in collaboration with MidCentral District Health Board and Central PHO; and
- Health Care Home with early adopter general practices.

1.4 How it all fits together

System Level Measures Framework



1.5 Enablers to building capacity and capability

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

SECTION 2: WDHB System Level Measures Improvement Plan 2019 - 2020

2.1 Acute hospital bed days per capita

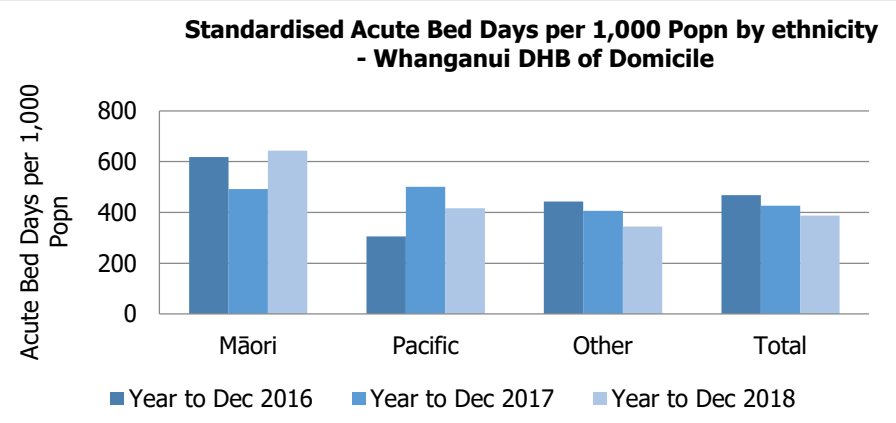
This measure is about using our health resources effectively. As a Whanganui health system we want our population to be well in the community, and to be supported to receive appropriate care when they are not well. We want to reduce the amount of time people need to spend in hospital through integrated care and collaboration across providers. This requires good communication and cooperation between primary and secondary care, and models of care which support greater capability in primary care. We know that better prevention and management of long term conditions is essential to support improvement against this target in the long term.

Currently a disproportionate amount of resource is spent on the 70+ years age group who have significantly higher acute bed day rates. We anticipate that by releasing resources currently pooled within this group and shifting them to community and primary care we can maximize the gain able to be received from such resource. This can assist in reducing acute hospital bed days for Māori who currently experience higher rates than non-Māori, and optimise appropriate and equitable hospitalisation.

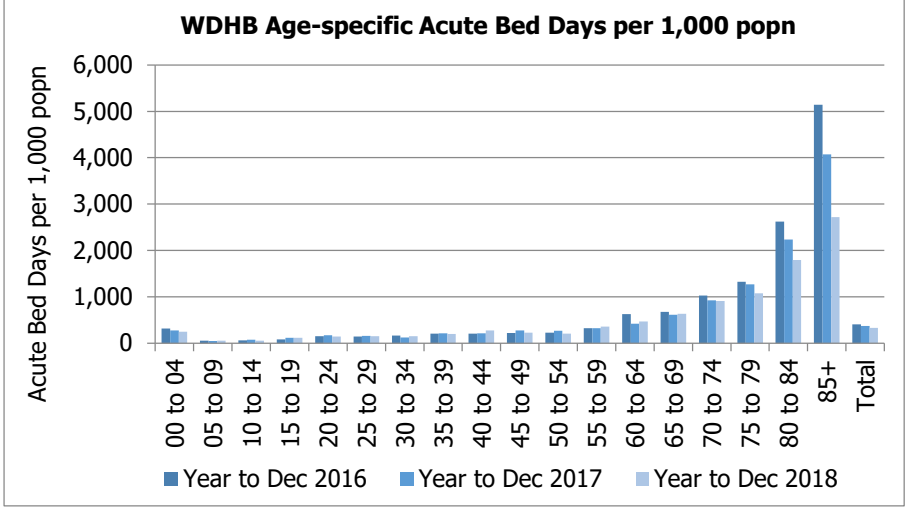
The objectives of the Acute Demand SLA and related work streams will form the basis of the objectives and measures for acute hospital bed days in the 2019/20 SLM plan. This strategy supports our focus on implementing a collaborative and system-wide approach to acute demand management and achieving equity in access and outcomes for Māori. The actions from the Acute Demand SLA will be developed over a multi-year period, therefore measures will be initially based on activity milestones which we hope to develop more specifically in coming years.

Where are we now?

While the standardised rate of acute bed days has decreased over the last two years for Whanganui DHB's total population, rates for Māori have increased and are significantly higher.



The rates of acute bed days for the population aged 70+ years remain considerably higher than all other age groups.



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

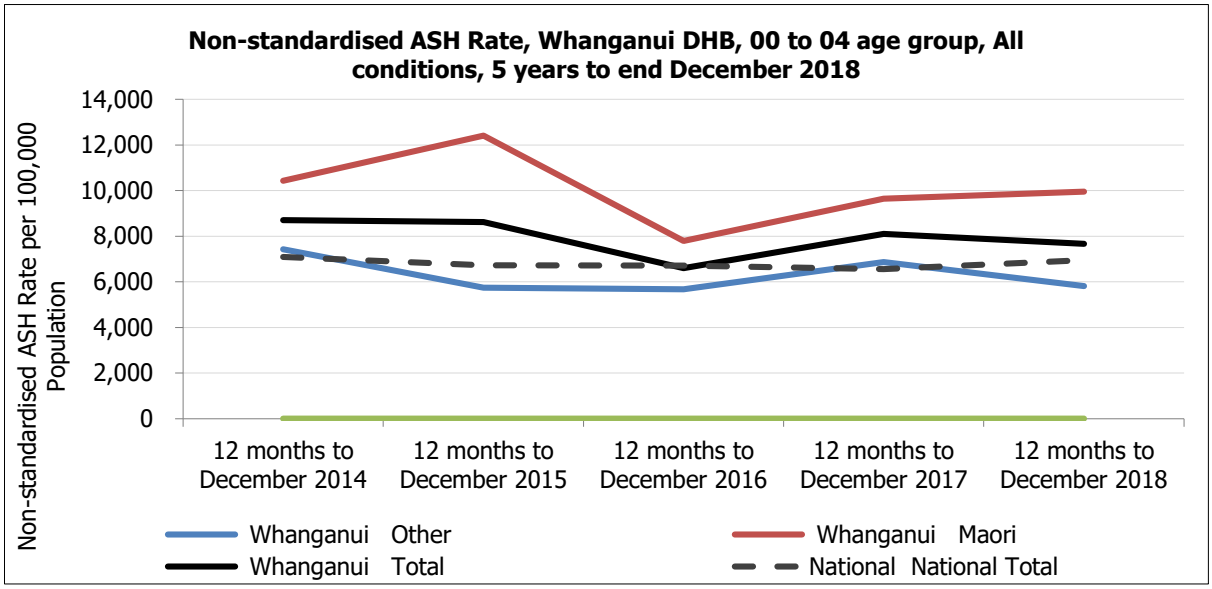
Acute Hospital Bed Days			
Improvement milestone: Acute bed days per 1000 population. Reduce the inequity ratio for Māori 70 – 74 years from 1.85 (December 2018) to <1.5.			
Objectives	**Actions/Activity**	**Contributory measures**	**Responsibility**
Reduce emergency department and urgent care presentations	**Over a three-year period:** Undertake a work programme to address avoidable presentations to ED and urgent care (WAM), including; • Review with St John Ambulance service response directly into ED and develop other clinical pathways and models of care. • Remove ED as the sorting place for specialist preadmission and follow up activity for common conditions.	Action plan for programme of work established by end of September 2019.	Acute Demand SLA ED and WAM Work stream
Reduce acute readmissions	• Investigate 7 and 28-day readmission rates. Understand causes, improve visibility of data, and work with general practice to improve readmission rates. • Review triage process and understand patient journey. • Explore options for primary acute care and movement of some clinical service access to primary care.	Reduce acute readmission rates for all age groups over 70 years.	
Local plan			
Reduce presentations by older people to ED and WAM	Identification and coding of older persons with frailty (includes dementia) based on interRAI CHESS and MAPLe scores.	50% of general practices access interRAI assessments for their patients.	Older Persons work stream
	Education with general practice teams on early recognition of mild cognitive impairment and dementia, and ensuring patients have Advance Care Plans completed.	Baseline classifications of mild cognitive impairment and dementia will increase to reflect national predictions.	HOP Nurse Practitioner
	Explore screening assessment tools such as the interRAI Contact Assessment which provide clinical information to support decision making about the need and urgency for a comprehensive assessment. Includes application across specialty and primary care.	Uptake of a screening assessment tool across the system.	Older Persons work stream
	Improve the identification of fragility fractures and subsequent appropriate management, including DEXA scans and GP follow-up to reduce consequent fractures including hip fractures. Explore the provision of aclasta infusions in the community.	Audit number of DEXA scans and treatment post results. Monitor biosphosphonate/ vitamin D prescriptions.	Falls Steering Group

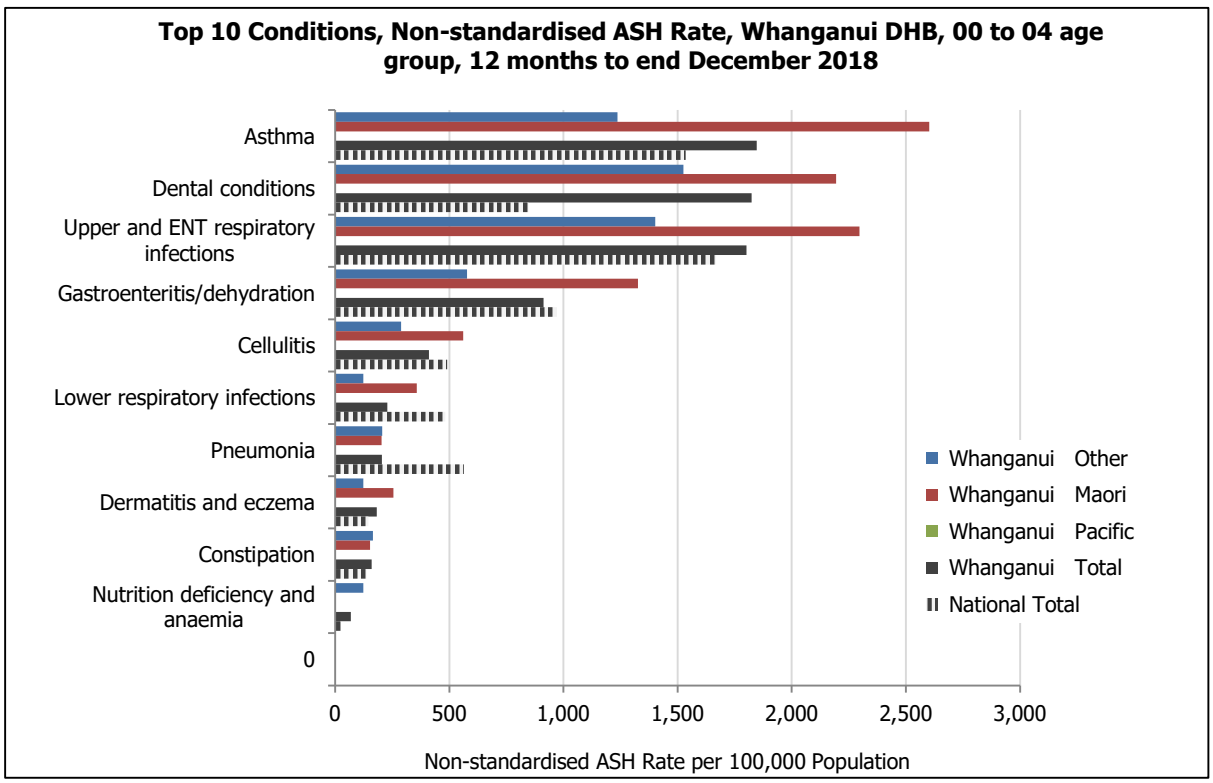
2.2 Ambulatory Sensitive Hospitalisations (ASH) 0 – 4 Years

As a Whanganui health system we want our children to have a healthy start in life. This will reduce the burden of disease in childhood and place a strong focus on health equity, as data indicates that Māori pēpi and tamariki are over represented in hospital admissions.

One of the DHB's strategic goals is to improve child health and advance Māori health outcomes in the Whanganui health district. We recognise that improvements within the system that achieve gains for Māori will see gains for the total population as well. Therefore while we have chosen to focus on all children for this measure, it is expected that all actions will focus on reducing the equity gap for Māori.

Where are we now?
Asthma, dental and respiratory conditions were the top three contributory conditions for ASH rates 0-4 years in Whanganui DHB in 2018. Rates for Māori are higher than those of non-Māori, and are above the national total rate per 100,000 population.





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

Ambulatory Sensitive Hospitalisations (ASH) 0 – 4 Years			
Improvement milestone: ASH for Māori children aged 0-4 years (raw rate): reduce the inequity ratio from 1.7 (December 2018) to < 1.5			
Objectives	**Actions/Activity**	**Contributory measures**	**Responsibility**
Early/timely intervention for at risk children - respiratory	Promote maternal influenza and pertussis vaccination as best protection for very young babies from respiratory illness by: - Improve use of the Early Pregnancy Assessment Tool as a pregnancy register in primary care. - Identify pregnant women through booking and set immunisation recalls in primary care. - Opportunistic immunisation at antenatal clinics. - Promotion of pregnancy immunisation especially to Māori women in primary care, pharmacy, self-employed midwives.	Influenza and pertussis vaccine coverage rates for pregnant Māori women. Target 20%	PHOs General practice and immunisation services
	Increase uptake of children's influenza vaccination to prevent respiratory admissions by: - Improving vaccination rates in primary care for children aged 0-4 years at risk of, or with previous, respiratory admissions through the provision of data, practice-level improvement activities, and following up vaccination data provided throughout the season. - Prioritised vaccination of eligible Māori children.	Influenza vaccination rates for eligible Māori children. Target (20%)	PHOs General practice and immunisation services
Improve home health Reduce maternal smoking	Support a decrease in respiratory admissions with social determinants by: - Increasing referral rates from primary care to healthy housing programmes by identifying practices with low referral rates and using the early pregnancy assessment tool, with a focus on pregnant low income, Māori whānau. - Supporting mothers and whānau of babies to live in Smokefree homes – *see Babies in Smokefree homes below.*	Baseline measurement of referrals to healthy housing programmes. 50% of referrals are Māori whānau	PHOs General practice
Early/timely intervention for at risk children - dental	Identify general practices that have the highest volume of dental admissions and registered children with dental caries, and work across the system to reduce hospitalisation.	Hospital admissions for children aged five years and under with dental caries as primary diagnosis – establish baseline.	

Local plan			
Acute Demand SLA	Undertake a programme of work within the Acute Demand SLA to reduce avoidable presentations to urgent care (WAM) by under 5's. • Improve self-management and self-navigation in accessing right health care choices at the right time. • Develop a health promotion messaging response for children and young families for common conditions.	Progression of programme of work by end of quarter 4, 2020.	Acute Demand SLA
Oral health	School oral health service and general practice working together to better understand the at-risk population, barriers to access, capturing data and including all partners to inform a programme of work to improve access. Te Oranganui initiative going into Kōhanga Reo with oral health education resources. 'Baby Teeth Matter' WDHB initiative improving whole whānau access to school dental caravans.	Co-design a plan of action with community partners Q1 & Q2. Progression of programme of work by Q3.	Community entities and School Oral Health Service
Milestones: The Ambulatory Sensitive Hospitalisations for 0-4 years, Amenable Mortality, Babies in Smokefree Homes and Acute Hospital Bed Day milestones will be improved by these activities			

2.3 Amenable mortality

This measure is about prevention and early detection to reduce premature death. Amenable mortality is defined as premature deaths (deaths under age 75) that could potentially be avoided, given effective and timely healthcare. That is, early deaths from causes (diseases or injuries) for which effective health care interventions exist and are accessible to New Zealanders in need.

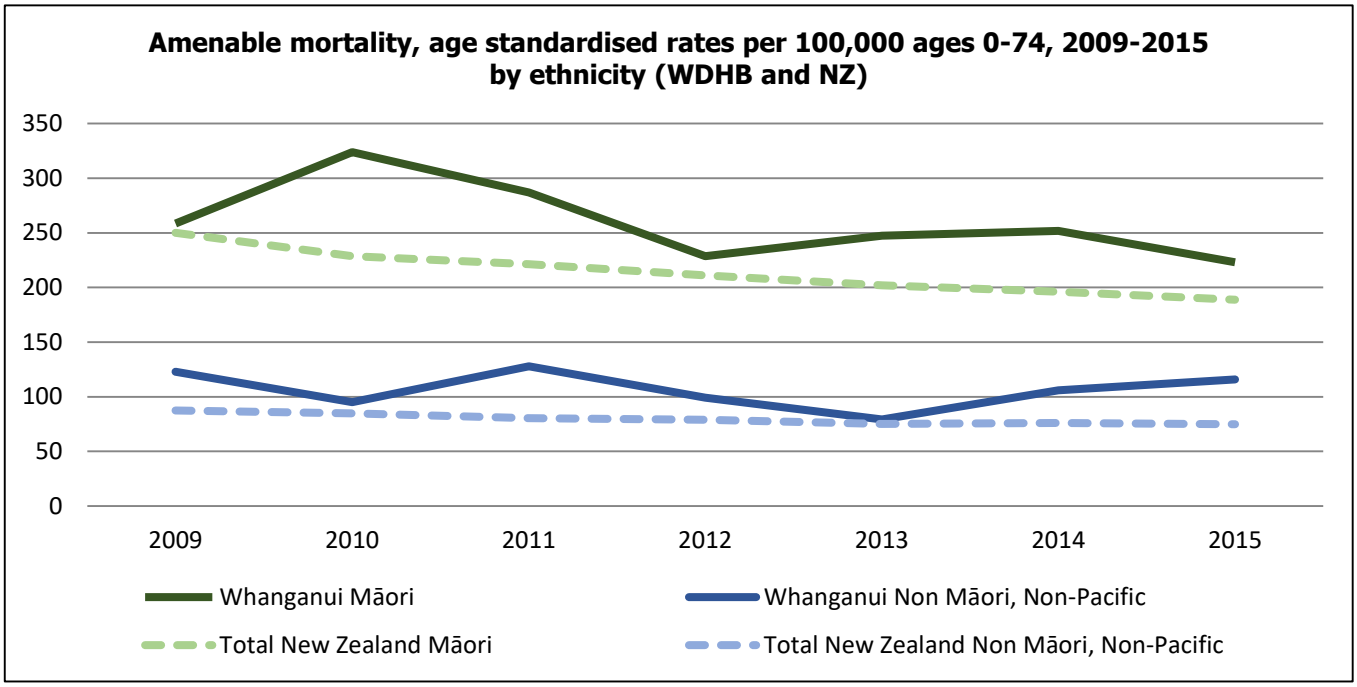
Not all deaths from these causes could be avoided in practice, for example, because of comorbidity, frailty and patient preference. However, a higher than expected rate of such deaths in a DHB may indicate that improvements are needed with access to care, or quality of care. We know that the prevention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

Activity outlined in this measure will be informed by data analysis and work streams arising from the acute demand service level alliance and community models of care, and will incorporate consistent health messaging to support healthy lifestyles. This aligns with the district-wide focus on 65,000 beds, whereby the best bed is your own, and every bed counts.

As the amenable mortality data is three years old we have taken the 2019 ASH data as a more useful proxy of areas for improvement. The highest volumes being those of respiratory and cardiac which in Whanganui are higher than the national average rates, and significantly higher rates for Māori compared with non-Māori.

Where are we now?

Amenable mortality rates have been declining in the Whanganui district from 2009 to 2015; though remain higher than the total NZ rates. Disparities continue to exist between Māori and non-Māori, non-Pacific.



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

Amenable mortality			
Improvement milestone: Reduce the equity gap between Māori & non-Māori from 1.94 times to < 1.5 times.			
Objectives	**Actions/Activity**	**Contributory measures**	**Responsibility**
Close the equity gap in cardiovascular disease management and diabetes management.	Reporting and improvement of clinical management through prescribing is facilitated through: - Continued development of NHI level reporting in secondary prevention - Comparing prescribing data across practices and identifying opportunities for improvement Improved outcomes for patients with a high risk of CVD event are sought by: - Patients who have previously had a CVD event and who are eligible receive the funded influenza vaccination: Monitored by DHB and ethnicity. Coverage will be monitored for the 65-74 year age group - Interventions to improve uptake of triple therapy for Māori people.	Prescribing rates for CVD management medications show no inequity between Māori and Others at a practice level by Q4. Influenza vaccination rate for patients with a prior CVD event under 65 years of age: Target 25% % Māori with risk over 20% prescribed triple therapy: Target 50%	General Practice
Close the equity gap in diabetes management	Improve diabetes detections and follow up: - Enrolled patients with diabetes monitor their HbA1c levels. - Enrolled patients with diabetes have an annual review.	More than 90% of Māori with diabetes have an HbA1c recorded. More than 60 % of Māori diabetics have good control (HbA1c ≤ 64 mmol).	General practice
Local plan			
To improve local public awareness and health literacy	Improve cross system connections that support healthy lifestyle changes. Implementing localised collective communications network for: - collective health messaging, - consistent patient information, - Systematic engagement approach. Collective communications network report campaign summaries to WALT. Continue to embed the 'Where should I be?' campaign.	Quarterly report	
To improve alcohol screening in older Māori and non-Māori in Whanganui with LTCs	Implement culturally responsive Motivational Conversation skills development training (Takitaki mai).	Clinician engagement in training. Screening for alcohol by ethnicity – aiming for no or positive equity gap.	

Improve management of long term conditions	Early engagement with GP and specialist mental health service.	Increased metabolic monitoring for targeted cohort.	
	Piloting shared care approach being delivered within general practice setting • Accurate data collection CKD. • Shared care approach to supporting person with CKD.	Evaluation demonstrates applicability across: • Reduction in progression of person presenting acutely with CKD. • Number of person who choose palliation option. • Reduction in persons receiving triple whammy meds.	
Milestones: The Amenable Mortality and Acute Hospital Bed Day milestones will be improved by these activities			

2.4 Patient experience of care

This measure is about our commitment to 'Whānau, person-centred care'. As a Whanganui health system we encourage patient involvement and feedback to support service development and improvement, leading to improved patient experience of care. We recognise that the way in which people experience health care can be influenced by all parts of the system, and by the people who provide the care. Integration has not happened until people experience it. We want to gain a better understanding of the patient experience from the patients and their whānau themselves, and to improve access for those accessing general practice teams.

We are committed to making sure our services are responsive to those with the highest needs, as we know that if we get it right for this group, we are well on the way to getting it right for everyone. Our focus therefore will be in three areas:

- Data analysis of primary and DHB PES information informs practice and system-wide initiatives.
- Improved cultural responsiveness.
- Increase uptake and utilisation of patient portal.

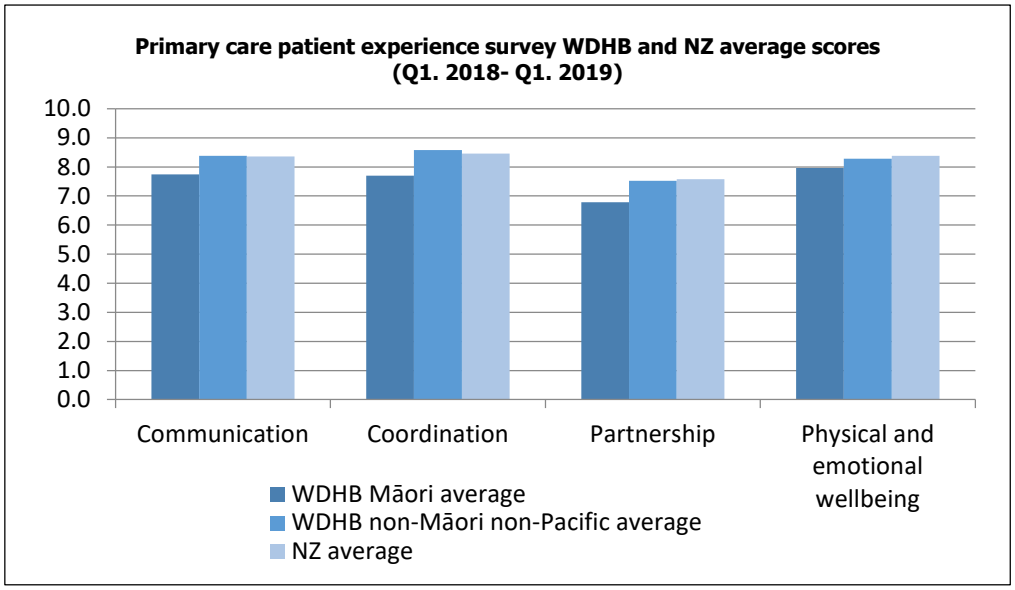
As a district with a high Māori population and high levels of social deprivation, there is a strong emphasis on making sure services are culturally appropriate.

Where are we now?
Patient experience measures are now routinely in place for hospitals and in primary care. Feedback about the care received in public hospitals/primary care is a valuable indicator of how well health services are working for patients and their families.

Primary care patient experience
The primary care patient experience survey is designed to find out what patients' experience in primary care is like and how their overall care is managed between their general practice, diagnostic services, specialists, and/or hospital staff. The information will be used to improve the quality of service delivery and patient safety. Whanganui has two primary health organisations, with Whanganui Regional Health Network an earlier adopter of the PES pilot.

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

The average primary care survey responses for Quarter 1 2018 to Quarter 1 2019 are shown below for Whanganui DHB Māori, non-Māori/non-Pacific, and the NZ average.

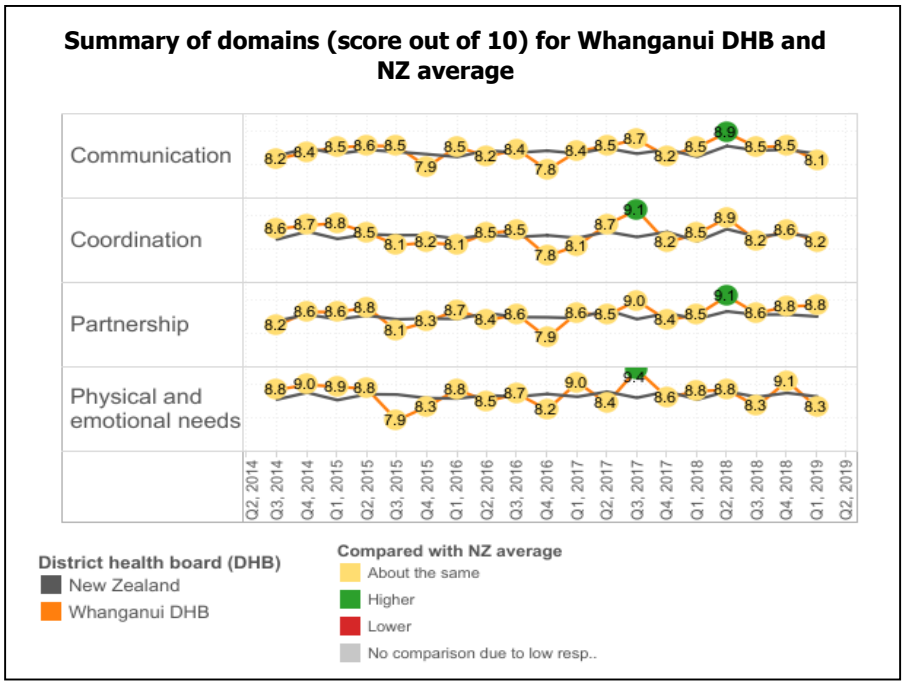


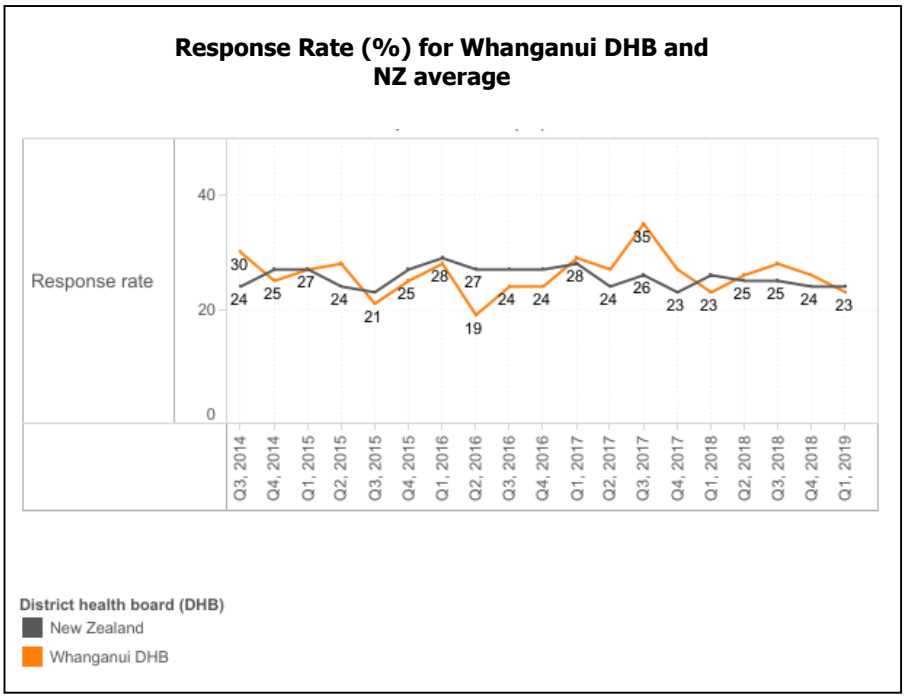
Adult inpatient experience

The Health Quality and Safety Commission has designed a new 20 item adult inpatient survey that began in August 2014. This survey runs quarterly in all district health boards and covers four key domains of patient experience: communication, partnership, coordination and physical and emotional needs.

A selection of adult patients who spent at least one night in hospital are sent an invitation via email, text or post inviting them to participate in the national survey on at least a quarterly basis. The survey responses are anonymous unless patients choose to provide their contact details.

The response rate and scores for the four domains at Whanganui DHB are similar to the national average. Our focus will be on the lowest scoring questions – being coordination of care and education on medication.





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

Patient experience of care			
Goal: Patient encountering our services experience safe, effective, quality patient/whānau-centred care. **Primary care target:** Primary patient experience score 'barriers to care' improved from 8.0 > 8.4. **Health Quality and Safety target:** Improve all scores in the national inpatient survey to average or above.			
Objectives	**Actions/Activity**	**Contributory measures**	**Responsibility**
Improve experience in hospital.	Understand the drivers behind the lowest scoring questions (coordination of care and education on medication). Share learnings with clinical leaders and staff and develop service improvements.	Percentage of respondent's response to individual questions. Percentage of respondents who are Māori. Target 25%.	Patient Quality and Safety
Improve rating for 'barriers to care' in primary care patient experience survey.	Undertake an analysis of the local primary care survey respondents by lowest rating questions, age band and ethnicity to identify any population cohorts that are underrepresented and establish baseline data and common themes on respondents.	An incremental increase rating in lowest rating questions 3.9 to be more reflective of national average national average 4.6. Percentage of respondents who are Māori. Target 25%.	PHO
Local plan			
Increase uptake and utilisation of patient portal.	Increase uptake and utilisation of patient e-portal. Establish a base line by age band and ethnicity to identify any population cohorts that are underrepresented and establish baseline data.	At least 75% of practices are offering access to e-portal by 30 June 2020. Percentage of Māori or high needs patients enrolled in e-portal.	
Improve cultural responsiveness.	Communication skills and cultural responsiveness training skills development across primary care workers.	Primary care cultural education programme agreed by Q2. Percentage of primary care workers completing training.	

2.5 Youth access to preventative services

Health needs for youth are different to those of other age groups, with youth often having unmet healthcare needs and low utilisation of health services. Whanganui has focused on the domain Mental Health and Wellbeing - self-harm hospitalisations, as intentional self-harm is a mal-adaptive coping mechanism which indicates that young people and are coping with distress in an unhealthy way and have unmet needs. Suicide furthermore is devastating for those affected and tragic given it is preventable. The suicide rate in the Whanganui district is significantly higher than the overall NZ rate, with young people, Māori and socioeconomically disadvantaged people having a higher risk than the general population.

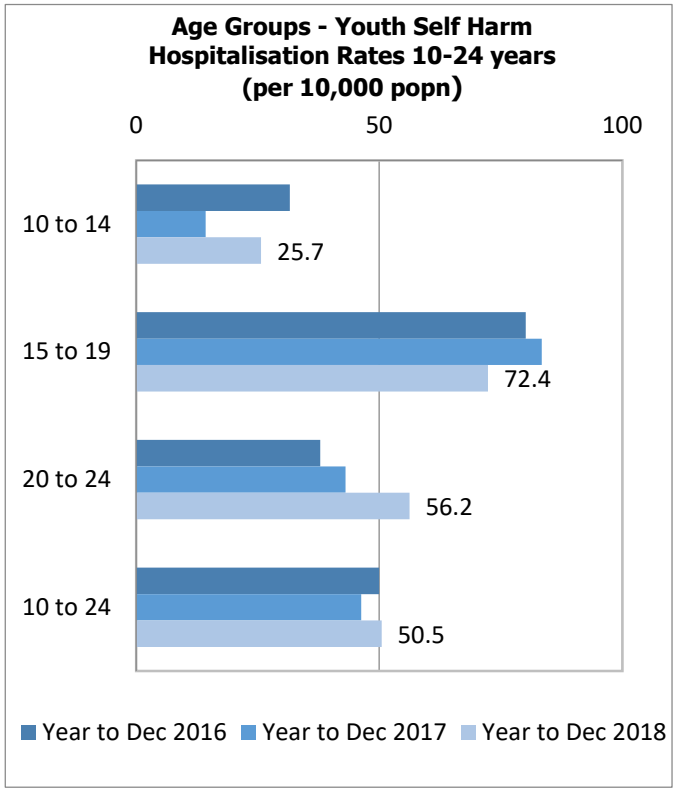
To address this, the DHB with Te Oranganui, an Iwi-led organisation delivering health and social services in the Whanganui DHB district, is developing a district-wide suicide prevention strategy with a focus on access and utilisation of appropriate health services. The approach being taken is to consult and collaborate with whānau, community and key local stakeholders to co-design a strategy from the bottom-up that is informed by and tailored to local needs and resources. In doing so, it seeks to create a foundation for genuine collaboration and lasting solutions that prevent suicide and reduce rates.

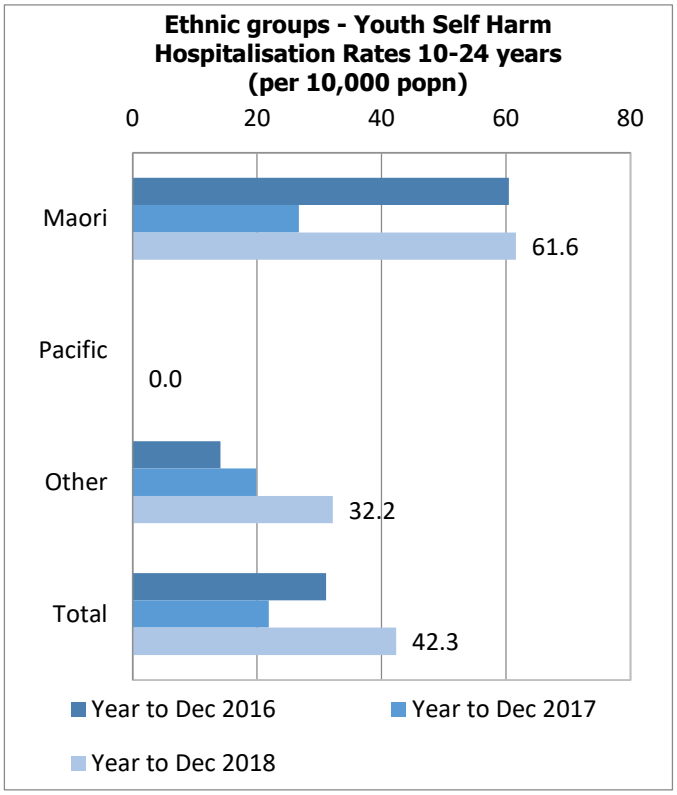
Due to difficulties with suicide data timeliness and low numbers, our SLM improvement milestone is to reduce self-harm hospitalisations, which also leads into our acute demand work reducing avoidable presentations. Our contributory measure will focus on the development of the Whanganui suicide prevention strategy, and through these actions our objective is to reduce the incidence of youth suicide.

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

Where are we now?

The overall hospitalisation rates for young people following self-harm in the Whanganui district is 51.9 per 10,000 people for the year to December 2018. This is higher than both previous years where the rates were 47.5 and 50.1 respectively. As seen below, Māori have significantly higher rates than non-Māori, and those aged 15-19 years have a higher rate than other age groups.





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

Youth access to preventative services			
Improvement milestone: Reduce self-harm hospitalisations for Māori aged 10-24 years to a three-year rate of less than 50 per 10,000 population.			
Objectives	**Actions/Activity**	**Contributory measures**	**Responsibility**
Reduce incidence of youth suicide.	Develop a district-wide suicide prevention and post-vention strategy and action plan. This is developed through a partnership approach that ensures an integrated cross-agency and community response to suicide in the WDHB district.	Whanganui suicide prevention strategy action plan completed July 2020.	Whanganui suicide prevention strategy working group – Healthy Families, WDHB and Te Oranganui.
	Review youth mental health primary care services, to obtain a clearer picture of population need.	Produce a set of recommendations to improve youth mental health services in primary care. - By end of quarter 2, 2019 - Establish baseline ethnicity date by Q3	PHO Planning and Funding
Improve equity of access to contraception for low income women in primary care settings.	Implement access to contraception for low income and/or people who are at higher risk of unplanned pregnancy and poor health and social outcomes.	Contraceptive dispensing Service agreement implemented end of Q1.	General Practice Planning and Funding

2.6 Babies living in smokefree homes at six weeks

The impact of smoking on our whole population is well understood, but children are more at risk if they breathe in secondhand smoke due to having smaller and more delicate lungs. In addition, they are often unable to get away from the smoke.

Children exposed to smoke are more likely to go to hospital, develop coughs, colds and wheezes, and are off school more often, while infants have a significantly higher risk of SUDI. Children whose parents smoke have double the risk of lower respiratory illnesses like bronchitis and pneumonia compared to children of parents who do not smoke.

Data measure change

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

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

This measure aims to reduce the rate of infant exposure to cigarette smoke by focussing attention beyond maternal smoking to the home and family/whānau environment. The measure aligns with the first core contact which is the handover from maternity to Well Child Tamariki Ora (WCTO) providers and general practitioners.

Our SLM plan will also focus on developing motivational conversation skills among all health professionals working with pregnant mums and babies to support patients being able to better manage their own health. Previous research has shown that Māori women aged between 18 and 24 years stand out as a group of particular concern, with 42.7% of this group reporting regular (daily) smoking, compared with 8.6% of non- Māori women of the same age group. Young Māori women who are regular smokers are three times more likely to live in a household where there are other smokers compared with those who do not smoke. Therefore focus needs to be on reducing equity gaps between Māori and non-Māori.

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

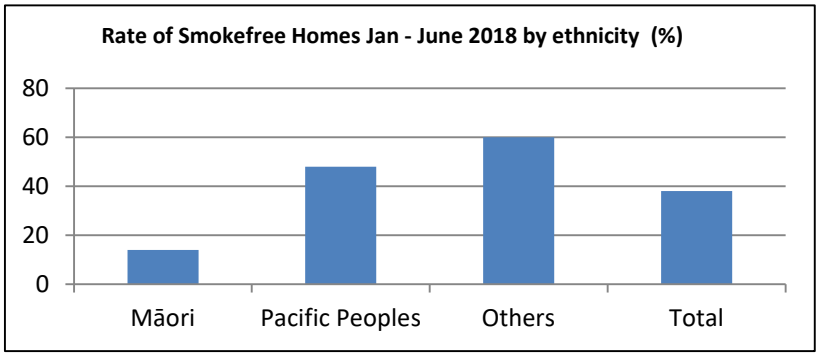
The Ministry has been working with the WCTO providers to improve the quality and accuracy of this data. Changes being implemented to improve the quality and accuracy of data will take some time. This data is provided for implementation of the System Level Measures programme and therefore should only be used for quality improvement purposes.

Where are we now?

The overall rate of smokefree homes in the Whanganui district was 38% for January to June 2018, which is lower than the national average of 53.8%.

This is significantly lower again for Māori in Whanganui among whom only 14% of children live in smokefree households at around six weeks old.

Rate of smokefree homes January 2018 – June 2018 (Whanganui)			
Ethnicity	**Numerator**	**Denominator**	**Rate of Smoke-free Homes**
Māori	27	193	14%
Pacific	12	25	48%
Others	121	203	59%
Total	**160**	**421**	**38%**



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

Babies living in smokefree homes at six weeks			
Improvement milestone: Babies living in a smokefree household at six weeks post-natal (up to 56 days of age). Double the number of Māori babies living in a smokefree household – from 27 (six months to June 2018) to 54.			
Objective	**Actions/Activity**	**Contributory measures**	**Responsibility**
Increase screening for risk in early pregnancy	Ensure pregnant women are registered with an LMC or midwife within the first trimester. Refresh use of the early pregnancy assessment tool to as a pregnancy register in primary care.	Percentage of pregnant women registered with a midwife within the first trimester.	Midwives, LMCs, General practice
More people are supported to quit	Ensure all smokers are identified, and receive support to quit. - Complete review of smoking cessation pilot to identify processes that work - Implement the most successful processes from the smoking cessation pilot to embed an effective programme of support to quit.	PHO enrolled patients who smoke have been offered help to quit smoking by a health care professional in the last 15 months. Establish new approach by end of Q2.	General practice
More Māori women become smokefree	Extend support for pregnant women to quit smoking, including, if required, Vape to Quit. - Incentivise referrals to quit services with a focus on hapū wahine Māori.	Number of pregnant Māori women enrolling in Stop Smoking Service. Percentage of Māori women enrolling increases by 10% in Q3 and by 20% in Q4	General practice, LMCs, other referrers, Stop Smoking service
Local Plan			
An integrated approach for smoke free homes within the 1st 1000 days	Promote healthy messaging relating to SUDI and smokefree homes. Strengthen referral pathways to stop smoking services from lead maternity carers and WCTO providers to encourage specialised support to quit smoking for whole whānau. Stop Smoking service focus on support during pathway to cessation. Support smokers to address barriers and increase cessation resilience. Improving the collection and integrity of data.	Mothers who are smokefree at two weeks and six weeks post-natal. Babies whose families/whānau referred from their Midwife or Lead Maternity Carer to a Well Child Tamariki Ora provider. Number of pregnant women enrolling in Stop Smoking Service. The smoking status of pregnant women enrolled in Stop smoking service. *Numerator:* The proportion of pregnant women who, at the 4-week follow–up, have not had a single puff in the previous 2 weeks; this includes smoking status that is self-reported or carbon monoxide (CO) validated.	

		Volume of referrals from LMCs / WCTO to local smokefree services and other support to quit.	
	Develop motivational conversations skills. All health professionals working with pregnant mums and babies have had training in motivational conversations and healthy conversations, and are able to provide brief quit advice. Support access to motivational conversations skills for Māori.	Identify the workforce that requires training and progress to achieve 100% training rate.	
Milestones: The Ambulatory Sensitive Hospitalisations for 0-4 years, Amenable Mortality and Babies in Smokefree Homes milestones will be improved by these activities			

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

16 DEC 2019

FILE COPY

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

Dear Ken

Whanganui District Health Board 2019/20 Annual Plan

This letter is to advise you I have approved and signed Whanganui District Health Board's (DHB's) 2019/20 Annual Plan for one year.

I have made my expectations on improving financial performance very clear. Current DHB financial performance is not sustainable, despite Government providing significant funding growth to DHBs in the past two Budgets. I am approving your plan with the expectation that you will continue to focus on opportunities for improving financial results for 2019/20 and into 2020/21 and beyond. The out-years have not been approved.

I am aware that you have advised the Ministry of Health (Ministry) of a positive out-years position. However, I have asked the Ministry to request detail on the development of your savings plans for out-years as part of your 2019/20 quarter two report. I expect this report will include a granular and phased focus on cost containment, productivity and efficiency, quality, safety, and Māori health and equity.

It is critical that a strong and deliberate approach is taken to out-year financial plans including your operating revenue, expenditure budgets and specific sustainable savings plans.

It is expected that as Chair, along with your Board, you will continually manage and monitor your cash position on a monthly basis with an ongoing year forecast. Should the DHB experience liquidity issues, please keep the Ministry informed of the likely timing of the need for liquidity support. Signalling the need for equity in the Annual Plan does not imply that an equity request will be approved. The available equity is limited and applications for equity support will be subject to a rigorous prioritisation and approval process.

I am aware you are planning a number of service reviews in the 2019/20 year. My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry. Please ensure

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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 that have not been approved through the normal process.

It is really important that the health sector continues to deliver timely and effective services so that we can provide high quality and equitable outcomes for New Zealanders that will deliver on our Government's Wellbeing priorities.

I am looking forward to seeing continued support and progress in these priority areas and ask that you maintain a strong oversight of your team against the actions identified in your Annual Plan.

I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population and wish you every success with the implementation of your 2019/20 Annual Plan. I look forward to seeing your achievements.

Please ensure that a copy of this letter is attached to the copy of your signed Annual Plan held by the Board and to all copies of the Annual Plan made available to the public.

Yours sincerely

Hon Dr David Clark
Minister of Health

cc Mr Russell Simpson
Chief Executive
Whanganui District Health Board
russell.simpson@wdhb.org.nz