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Wairarapa DHB Annual Plan 2021/22

Incorporating the 2021/22 Statement of Performance Expectations

Presented to the House of Representatives pursuant to section 149(L) of the Crown Entities Act 2004.
(Issued under Section 38 of the New Zealand Public Health and Disability Act 2000).

Together we MAKE a difference

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

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Minister's 2021/22 Letter of Approval to Wairarapa DHB

Hon Andrew Little

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

Sir Paul Collins
Chair
Wairarapa District Health Board
paul@aehl.co.nz

30 SEP 2021

Tenā koe Sir Paul

Wairarapa District Health Board 2021/22 Annual Plan

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

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

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

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

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

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

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

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

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

Ngā mihi nui

Hon Andrew Little
Minister of Health

Hon Grant Robertson
Minister of Finance

Cc Dale Oliff
Chief Executive

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SECTION 1: Overview of Strategic Priorities

1.1 Strategic Direction

The 2020/21 annual plan was about change for the Wairarapa DHB but we certainly did not foresee and could not have predicted the impact that Covid-19 had on our plans, our lifestyles and the way we think about delivering health services to our people. This year we kick off with a renewed vim and vigour having successfully managed under the weight of the Covid-19 outbreak.

In 2021/22 we will be guided by our recently released ten year strategic direction 'Hauora Mō Tātou, 2020-2030', and look forward to the completion of the ensuing The WrDHB Health System Plan (Clinical Services Plan), Maōri Health Plan and Population Health Living Well Plan. Wairarapa DHB's vision is 'Well Wairarapa: Better Health for All' and our mission is to improve, promote, and protect the health status of the people of the Wairarapa, and the independent living of those with disabilities, by supporting and encouraging healthy choices.

To deliver on our vision, we are developing and implementing a health system that best meets the needs of our people and communities. This means applying our resources in the most effective manner to achieve equitable health outcomes and to advance improvements in health outcomes. To achieve this we are organising our system to ensure that service delivery occurs in the most appropriate settings for our people across the entire community. We recognise the role we play in providing and funding health services and we also acknowledge the very important role of that communities, neighbourhoods and families play in their own health and wellbeing. Wairarapa DHB is also committed to supporting regional and national health initiatives that strengthen the wider health system beyond our district.

Finally we want to recognise the work that our staff, local Iwi and the many providers of health and social services, without the people on the frontline connecting with those in need, supporting individuals and families on a day to day, hour by hour basis we most certainly would not have come through 2020/21 with such strong resolve.

1.1.1 Te Tiriti o Waitangi

Te Tiriti o Waitangi is the founding document of Aotearoa-New Zealand as we know it today, it is a historically significant document and as we learn more about its place in our day to day lives - we understand its significance as a living document. The Wairarapa DHB has a formal relationship with Iwi Māori through its formation of a local Iwi board of directors who represent both Rangitane o Wairarapa and Kahungunu ki Wairarapa at our governance level. There are also Iwi representatives appointed to the Wairarapa DHB Board of Directors to provide an Iwi Māori voice into decision making across the Wairarapa DHB.

This year 2021/22 marks a significant year in the history of Māori Health in the Wairarapa region. We will undertake a comprehensive Māori Health inquiry alongside the Wairarapa Branch of the Māori Women's Welfare League, J.R. Mckenzie Trust, and Local Iwi Māori – to better understand expenditure and outcomes across all the current service provision within our region and other services we pay for that should benefit our local population. It's expected the inquiry will be completed and recommendations tabled in 2022/23.

1.1.2 Our Values

Together we MAKE a difference

MANAAKITANGA **Respect**	We care for each other, showing kindness and empathy in all that we do
AUAHA **Innovation**	We are committed to finding future focused solution and take personal responsibility to be better every day
KOTAHITANGA **Relationships**	Our diversity is our strength, we back each other and work together in partnership
EKE TAUMATA **Equity**	We are committed to doing the right thing by ensuring equity and Hauora are at the heart of everything we do

1.1.3 Strategic Objectives

There are eight broad areas of activity where change is needed in order to shift to a responsive, effective health system that achieves equitable outcomes for all people in our communities. These are the broad actions that drive our strategic direction.

Integrating health and social services

We will work with whānau, as well as individuals, and tap into the resilience that exists within whānau and communities. There is opportunity to have a whole of system culture shift, to work as a wider, multi-disciplinary, multi-agency team. The players in our system will be closely linked with each other, with iwi, with communities, and with other agencies.

Strengthening primary care

There is opportunity to renew our way of working- and to have cohesive system supporting general practice. Using more allied health support in primary care (e.g. social work, whānau ora navigators, and clinical pharmacists) will enable us to make best use of our general practitioners.

Excellence in older persons' services

We will evolve how our system responds to the ageing population, and think differently about how we deliver services to the growing population of older Māori. Key care management will be based in primary care and supported by specialist services. Aged residential care will have better support out-of-hours to manage acute exacerbations and new problems.

Improving access to health and disability services

Our communities will be able to access the services they need, when they need them. We need to get smarter in how we design services and where we place them so they are more people centred.

Close connections between primary and secondary care

People's healthcare journey will be seamless, with services closer to home and practitioners working as "one team". The pathways through the health system will be clear —for people going into and coming out of hospital. More services and/or clinicians will be reorganised into community settings (not everyone needs to come to hospital) and we will make sure they're well-coordinated with primary care.

Creating a fit-for-purpose hospital

We will determine what sort of hospital we need in Wairarapa that is contemporary for our population but also clinically sustainable. We will work with other DHBs where we don't have the scale to provide services to our own population.

Building a sustainable workforce

With our workforce ageing in both our hospital and in primary care we will find ways to increase our workforce pipeline and retain our newer workforces. We will invest more in areas such as allied health to create a more diverse workforce and which more reflects the population it services -including Māori workforce development.

Tamariki-Mokopuna, our children and young people are our future

Children and young people in Wairarapa are our future. We have a relatively small child and youth population which means we can do something transformational if we purposefully plan and resource child and youth health services to the right level. We all know from experience that getting it right early leads to better outcomes in later life and enables us to use our resources upstream rather than in expensive hospital services and other supports.

1.1.4 Equity as a focus area

The disparities experienced by some parts of our community are unacceptable, Māori and Pacific peoples consistently suffer greater disadvantage yet have limited access to the services they need. Our fresh focus on equity seeks to address some of these barriers to health care, we are at the early stages of designing new ways of working

in and with communities. We are also getting a much clearer picture of where the efficiency gains are within our current system and working on how we disentangle resources to re-invest in equity.

1.1.5 Our commitment to key legislation and national strategies

In all that we do we are guided by key overarching national strategies and international conventions as shown in the table below:

The Treaty of Waitangi	Improving equity is a key goal for Wairarapa DHB. We prioritise actions which improve equity of health outcomes for Māori
The New Zealand Health Strategy	We ensure our plans and actions are aligned with the New Zealand Health Strategy
He Korowai Oranga and Whakamaua 2020-25	In all that we do we aim for Pae ora, Wai ora, Whānau ora, and Mauri ora.
The Healthy Aging Strategy	We ensure our work in aged care and improving management of long term conditions promotes and supports healthy aging and independence
UN Convention on the Rights of Persons with Disabilities and the Disability Strategy	We are continuing to develop systems and supports to promote respect for the independence and needs of people with disabilities
Ola Manuia 2020-2025: Pacific Health and Well-being Action Plan	In partnership with our small Pacific community we work to ensure their appropriate utilisation of social and health services.

1.1.6 Health and Disability System Reform

In June 2020 the final report of the Health and Disability System Review (the Review) was released. The Minister of Health commissioned the Review to make key recommendations to the Government on developing a more sustainable health system that improves health outcomes for Māori, shifts the balance from treatment of illness towards health and wellbeing, and responds to the needs of all New Zealanders.

In April 2021, the Minister of Health announced the new structure for the health and disability system in New Zealand:

- All 20 DHBs will be replaced with a new Crown entity, Health New Zealand, which will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions.
- A new Māori Health Authority will have the power to commission health services, monitor the state of Māori health and develop policy.
- The Ministry of Health will be strengthened and will continue to monitor performance and advise Government on health and disability policy. Responsibility for public health issues will rest with a new Public Health Authority.

Reform of the health and disability sector will take a number of years to implement. However, changes are likely over 2021/22 and Wairarapa DHB expects to be fully engaged in the change process to help ensure the reforms are successfully implemented and achieve benefits for our populations.

Our strategic approach is aligned with the goals of the reform. We are focused on achieving equity for Māori and collaborating across the system to improve health and wellbeing outcomes. We work closely with the other DHBs in the Central Region to coordinate how we plan and deliver services across the region.[1]

We will continue to ensure our out-year planning is robust and support improving system sustainability throughout the system change programme.

[1] Central Region comprises six DHBs (Capital & Coast, Hawkes' Bay, Hutt Valley, MidCentral, Wairarapa and Whanganui).

1.1.7 COVID-19 response and recovery

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

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

The Ministry is engaging with DHBs to design and implement a national public health response where we will more effectively share limited resources, standardise operating procedures, avoid duplication and increase the agility with which we mount a surge response anywhere in the country and/or address future challenges.

The COVID-19 emergency response, while necessary, also created a backlog of patients waiting to be seen and treated in our system. This recovery requires careful planning and increased effort to correct. The demand for mental health services in our district is growing in line with planned development but also affected by the impact of COVID-19.

Priorities for 2021/22 include working with the Ministry to continually improve the COVID-19 response system, roll out the COVID-19 immunisation programme, and implement our COVID-19 recovery plans to ensure that our patients receive the care they need.

A safe and effective vaccine for COVID-19 is an essential part of how we protect our communities. Distributing the vaccine and immunising the population is an important focus for the health sector. We have strengthened our immunisation team and added extra resource to ensure a successful roll out continues in 21/22. Wairarapa DHB is committed to supporting the roll out and success of the COVID-19 vaccination programme.

1.2 Message from the Board Chair and Chief Executive

In reflecting on the year we leave behind us we are reminded of the introduction to our 2020/21 Annual Plan, where we recognised it had been 'a year like no other'. This year with no less conviction we can echo the same statement.

The pandemic that has taken its toll globally, both literally and metaphorically speaking, has put extraordinary pressure on health services and this is felt most keenly in the smaller district health boards. All members of the extended Wairarapa health system have however risen to this challenge. Our health service providers have proved to be both resilient and dynamic – adapting to new ways of working to accommodate the restrictions that were forced upon us. Learnings from the COVID-19 response have been captured and incorporated into this Plan: embedding the positive changes that have evolved including increased virtual services, greater cross-service collaboration and more flexible working arrangements.

As Health New Zealand takes shape, and we await clarity of what that looks like for our district, we keep our focus on our goals at hand. We have a bold strategic direction and we are committed to the eight key goals it describes: integrating health and social services, bolstering primary care by developing a more synergistic system, bringing primary and secondary care together as one team, meeting the needs of our growing older population, improving access to health and disability services, addressing our workforce challenges, transforming the future for our mokupuna, and creating a fit for purpose hospital.

Wairarapa is a proud rural region known for its practical, no-nonsense, can-do attitude and its resilience in the face of adversity. It is this community's strength that we draw from in designing and delivering the services we provide for the population, and in shaping the future we want for our tamariki. People don't like change as a rule, but change is inevitable. It is our role, as health leaders, to be the architects of the best change – the right change – for the people we serve.
Wairarapa is invested in its healthcare service. We saw this a generation ago with the 'hands around the hospital' campaign and we see it no less passionately today. Our people tell us when they feel there is room to improve, and we are held to account. That close scrutiny is a welcome reminder of our key purpose – to grow a well Wairarapa and provide better health for all.

Naturally, this region cannot provide every service for every person within our boundary fence. But we can ensure that every service required by every person can be accessed by our population in the best way possible. This is what we strive for. The fundamental premise of every decision we make, and every direction we take, is that it will lead to better health outcomes for our community.

Collaborating closely with our healthcare partners, across sectors and with our wider community, we work together as one team with that one goal – to grow a well Wairarapa. Sir Mason Durie's celebrated Te Whare Tapa Wha model uses the strength of the four walls of the wharenui (meeting house) to describe wellness, illustrating how the essential balance of the four dimensions of wellbeing – taha tinana (physical health), taha wairua (spiritual health), taha whānau (family health) and taha hinengaro (mental health) – makes up the substantive, healthy whole. At Wairarapa District Health Board we strive to keep our wharenui strong, recognising the valuable contribution of each of the four cornerstones of health at every level – for the individual, families, communities and for our Wairarapa region.

We will address our low health literacy and support our people to self-manage. We have invested in consultation with our people and we know our Māori value their health and are ready for solutions that will make a difference. Not only that, they are ready to help us design those solutions. Co-designing our service delivery is key to our success, and we celebrate the importance of teamwork. Through excellent relationships and meaningful collaboration we will enable a supportive, networked healthcare system that works for the consumer and that truly makes a difference.

While we await the year ahead and the changes we can expect, we continue to make sound investment choices; building a blueprint for our region that speaks of equity and trust, improved outcomes and better futures for our

tangata whenua. And we will do this while holding tight to the purse strings in our carefully managed fiscal environment.

We set the bar high when it comes to our service delivery and equally when it comes to our expectations of our staff and our performance. Our values lead us in everything we do. We work tirelessly as a board and management team to ensure that we continue to kick over our gold standard goalposts, while staying within the confines of our budget spend and delivering on our promise to reduce our deficit. We have successfully managed our 20/21 financial performance to a forecast $2.7m deficit excluding Holidays Act and COVID-19 costs, which is $0.3m favourable to budget. We are committed to continue our pathway to break-even, targeting a $2.1m deficit (including Holidays Act but excluding COVID-19 costs) in 21/22 and achieving break-even in 22/23.

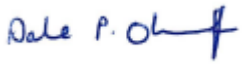
Being exacting financial stewards requires hard decision making. Investment choices are not made lightly. The need to do better, while spending less, and delivering more is challenging to say the least.

Some might call the challenge of serving our community in a pandemic environment while all the while working harder and smarter an unenviable task. But this District Health Board is fortunate to serve a resilient and resolute region, blessed with a supportive community and a unified, engaged and dynamic healthcare team. We take our strength from the Wairarapa collective.

We go forward into the new year as one team and together, with our partners as champions, we look forward to leading Wairarapa into the future of local health services with confidence and commitment.

Nga mihi

Sir Paul Collins
Board Chair



Dale Oliff
Chief Executive

1.3 Message from Te Oranga o Te Iwi Kainga Chair

Te Oranga o Te Iwi Kainga – the Māori Partnership Board to the Wairarapa District Health Board, would like to commend this Annual Plan to the people of Wairarapa. This plan will be one of the last of its type before we enter a massive restructure of the health system. Despite the pending change this plan represents a commitment to and continuity of services, tailored to the needs of our population.

Te Iwi Kainga's focus now is on ensuring that the health sector changes really do meet the expectations of tangata whenua and particularly those whose health needs are far greater than other New Zealanders. We need to take a long-term view of the horizon to see what a great system looks like and then imagine the steps to get us to that point. It might take a generation to achieve this vision.

The current health system is struggling. Our emergency departments are overwhelmed, our health workers are feeling the strain, our GP doctors are diminishing at an alarming rate and we are in the midst of a global pandemic. The solutions are a capable and resilient population; an investment in preventative health and wellbeing, a huge recruitment into the health sector, particularly Māori; and a restructure that puts people and whanau at the centre and that cares for its workforce. Success will require us to work even harder together to plan a better future for all.

Mauriora ki a koutou

Deborah Davidson
Chairperson
Te Oranga o Te Iwi Kainga

Agreement for the Wairarapa DHB 2021-22 Annual Plan between

27 September 2021

Hon. Andrew Little
Minister of Health

Date

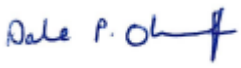
26 September 2021

Hon. Grant Robertson
Minister of Finance

Date

Sir Paul Collins
Board Chair
Wairarapa District Health Board

Date: 10 August 2021



Dale Oliff
Chief Executive
Wairarapa District Health Board

Date: 10 August 2021

Deborah Davidson
Chair
Te Oranga o Te Iwi Kainga

Date: 10 August 2021

SECTION 2: Delivering on Minister Priorities

This section demonstrates Wairarapa DHB's commitments to the Minister's Letter of Expectations and to the agreed Planning Priorities.

The focus for our Annual Plan in 2021/22 is on COVID-19 recovery/learnings and equity and a shift away from business as usual.

2.1 Minister of Health's Planning Priorities

The Minister's Letter of Expectations sets out the planning priorities for 2021/22, which are:

- Achieving health equity and wellbeing for Māori by giving practical effect to Whakamaua: the Māori Health Action Plan 2020-2025
- Improving sustainability
- Improving child wellbeing
- Improving mental wellbeing including a focus on the transformational direction for our approach to mental health and addictions through the agreed actions from the Mental Health and Addictions Inquiry
- 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

DHBs are asked to continue to build on these areas of focus, so we improve equity for our vulnerable populations while also ensuring COVID-19 lessons and innovations are captured.

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

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

2.2 Māori health improvement in DHB Annual Plans

The health sector is facing major reviews and challenges in terms of its delivery of services to Māori and the consistent inequity experienced by Māori in their health status. The Health and Disability Review, 2019, the Mental Health review 2019 and the recommendations of the WAI2575 Claim Primary Care 2019 all highlight the need for more attention to be paid toward reducing inequities for Māori and investing in solutions the work for Māori. This will require a closer and more strategic approach to working in partnership with Iwi Māori.

The 2021/22 annual plan builds on our previous plans with the knowledge of much broader systemic change that will impact on the way we organise, provide and deliver health services into the future. Rangitāne o Wairarapa are well into their Post-Settlement phase whilst Ngāti Kahungunu ki Wairarapa edge towards ratification for their settlement. These settlements also mark an important period of time for Iwi Māori and our community as we move into a new era of our treaty relationship.

National data analysis shows Māori consistently have worse health outcomes than all other ethnicities and their general access to health services is convoluted, and their access to the same treatment, tests and medicines as others is lower. It is more likely that if you are Māori you will receive, less time with health professionals, less options for treatment, not given standard tests and assessments and less likely to be prescribed the medicine you need. We need major changes to our current system if we want to see major changes in the quality of life and health status of Māori.

2.3 Achieving Health Equity in DHB Annual Plans

The concept of equity in health is an ethical principle, closely related to human rights --in particular, the right to good health. Equity is also a fundamental arm of the Triple Aim for quality improvement and a priority in our refreshed strategic direction. The Ministry of Health defines equity below:
"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." MOH 2019

The Wairarapa DHB is committed to achieving equity as defined here, in the first instance for Māori, as tangata whenua and partners with the Crown under Te Tiriti o Waitangi, but also for the many populations and diverse groups that make up our place. Equality is 'sameness', while equity is an ethical construct that recognises that different groups may require different approaches and resources to achieve the same outcomes.

Inequities in health exist between ethnic and socioeconomic groups, people living closer to town and those further from town, people belonging to different age groups, and between males and females. These inequities are not random, socially disadvantaged and marginalised groups, across the board, have poorer health outcomes, greater health risks, and counterintuitively - less access to health services. In addition to this Māori and Pacific peoples tend to have poorer health outcomes than all other groups in New Zealand.

A one size fits all approach does not work and uniformity fails to account for the contextual differences between people. We expect that the initiatives within this plan and our work programme across the district, will help improve health equity within our district.

2.4 Government Planning Priorities

The tables below set out the annual plan activity.

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

Engagement and obligations as a Treaty Partner	
Action(s) (include one action and milestone per row)	**Milestone(s)**
1. Undertake a DHB wide Māori Health Inquiry alongside key partners Wairarapa Māori Women's Welfare League, Rangitane o Wairarapa, Kahungunu ki Wairarapa, Te Oranga o te Iwi Kainga and the Local Māori Community. 2. Contracting with a range of providers with the view to growing Māori Health providership, building up to contracting relationships with Iwi Māori. 3. Providing high spec development and training opportunities to Māori DHB board members and Iwi Partnership Board. 4. Supporting the Iwi Partnership Board with Principal Advisory support on a consistent basis. 5. Building a more robust communication line with different levels of Māori (hau kainga, Taurahere mai, dis-engaged)	1. Q1 - Crowd-fund and complete a district wide Māori Health inquiry. 2. Q4 - Table the recommendations from the Māori Health inquiry to the DHB, MOH & PHO. 3. Q1-Q4: Measure the number and financial level of contracting done with Māori health Providers or for Māori Health outcomes. 4. Q1-Q4: Number and quality of development and training opportunities provided to the Iwi Board of Directors. 5. Q4 - survey Iwi for satisfaction around DHB engagement and support
Whakamaua: Māori Health Action Plan 2020-2025	
Action(s) (include one action and milestone per row)	**Milestone(s)**
1. Support the implementation of Kia Ora Hauora by investing in a DHB/Māori specific co-ordination role. 2. Work closely with existing kaupapa Māori primary mental health and addictions providers to grow their capacity and capability. 3. Investigate viability of telehealth, virtual consults and remote monitoring in the Wairarapa starting with whānau Māori, specifically in rurally remote locations 4. Design and implement a comprehensive development programme for the Māori Health workforce utilising a Māori specific co-ordination role. 5. Continue to increase investment in Pae Ora tobacco control, antenatal programming, breastfeeding, nutrition, parenting, immunisation and screening programmes to increase equitable access and outcomes for Māori. 6. Launch the 2020-2030 strategic direction 'Hauora Mō Tātou', the 2021 -2026 Māori Health Plan, the 2021-2026 Clinical Services Plan & the 2021- 2031 Population Health Living Well Strategy. 7. Provide additional resource within the Office of the Chief Executive to oversee progression and communicate with Iwi Partnership Board, Iwi Māori and the Māori Community on a consistent and ongoing basis.	1. Q4 A Māori Health workforce specific role is employed 2. Q1-Q4 The personal preferences of Māori primary mental health and addictions by the Māori community are understood 3. Q4 Māori primary mental health and addictions providers have a clear plan for increasing their capacity and capability 4. Q4 A workforce development programme is designed for Māori

8. Engage with the Iwi Partnership Board, Iwi Māori and the Māori Community on major capital business cases where and when it is viable and applicable. 9. Alongside the Māori Health inquiry commission services to engage with existing and potential connected networks of providers to design a way forward. 10. Work with the Iwi Partnership Board and key Māori stakeholders on the delivery of Whāia te Ao Mārama 2018-2022: The Māori Disability Action Plan. 11. Design a commissioning framework that can consider and adjust for unmet need and the equitable distribution of resources to Māori. 12. Implement the Disability Equity E-learning module to strengthen cultural competency within the 3DHBs Refer also to Disability section 13. Undertake community engagement with Māori and Māori with disability to advise / develop a revised 3DHB Disability strategy and action plan. Refer also to Disability section	5. Q4 Investment in Pae Ora is increased (subject to funding) 6. Q1 Resource the Principal Advisory positions to explicitly work on supporting Iwi Kainga and the connected Māori network (Iwi, Taurahere) (subject to funding) 7. Q1-Q4 Where appropriate Iwi Partnership Board, Iwi Māori and the Māori Community work in partnership on major capital business cases 8. Q4 A plan for implementation of the Whāia te Ao Mārama 2018-2022: The Māori Disability Action Plan is designed with key Māori stakeholders 9. Q4 A commissioning framework is designed with Iwi Māori and incorporated into DHB future commissioning decisions. 10. Q1-Q4 11. Q4 12. Q2 & Q4 Narrative report including module completion 13. Q2 & Q4 Narrative report

2.5.2 Improving sustainability (confirming the path to breakeven)

Short term focus 2021/22	
Action(s) (include one action and milestone per row)	**Milestone(s)**
1. **General**: We are closely managing our path to breakeven in 2022/23, improving our budget deficit from -$2.7m (excluding Holidays Act liability) in 2020/21 to -$2.1m (including Holidays Act liability) in 2021/22 and breakeven ($0m) in 2022/23.	1. -$2.1m deficit 2021/22 and break even ($0m) in 2022/23.
2. The **sustainability action group** (set up in 2020) will continue to identify and lead the delivery of savings initiatives that support our path to breakeven. These initiatives include one-off short term benefits as well as long(er) term recurring benefits through changes in creating a cost and risk intelligent culture, such as: a. Labour cost analysis and savings initiatives for increased efficiency, optimised sourcing and allocation and overall reduction of waste in using our workforce, through better planning, workflow and process management, use of (smart) technology and aligned roles and responsibilities (target savings $500k). b. Care protocol analysis and savings initiatives for improved efficiency in patient flow, workforce planning and reduction of avoidable intervention rates / IDF outflows etc. and collaboration with our primary care partners to lower unnecessary hospitalisation (target savings $500K). Part of this plan is the 'Outpatient capacity and workflow project'. Following a 20/21 review on our patient care models and funded through the MoH infrastructure capex program ($900k), we are optimizing our outpatient capacity and (front of door) workflow to increase speed to care but at the same time avoiding unnecessary hospitalization and length of stay. This will be done in collaboration with our regional (primary) care partners. This will likely contribute savings starting in the 22/23 financial year. c. Clinical supply chain analysis and savings initiatives for reduction of waste through leveraging product change opportunities from PHARMAC hospital devices, implementation of Choosing Wisely program, trading disposables for reusable supplies, improving team/staff 'waste awareness' (target savings $100k). Part of this initiative is the implementation of the Health Systems Catalogue (HSC)**.** We are working closely with New Zealand Health Partnership to develop and implement a National Health Systems Catalogue that will enable us to optimize our supply chain / procurement through consolidation of suppliers, standardization of medical devices, increased process efficiency and commercial effectiveness. The implementation will likely be part of the migration to the national Oracle solution (FPIM) planned to take place between September 2021 and December 2022. d. Unfavorable contracts analysis and savings initiatives to improve performance by exiting contracts that no longer meet the strategic direction and/or meet the service customer requirements, better managing all contacts to agreed volumes and service levels, pursuing opportunities for smart local contract negotiations, partnering with other DHB's and blocking preferential physician supplies (target savings $100k).	2. Sustainability action group: • Q1-4: fortnightly action group meetings. • Q1: renegotiation Public Private partnership agreement with Selina Sutherland Hospital. • Q2-3 Implementation of Outpatient capacity and workflow (Capex) Project. • Q2 kick-off HSC project (aligned with FPIM transition). • Q3: business case development sourcing of radiology services through a public / private partnership model • Q4 Sale of surplus assets 'Greytown property' • Q2-Q4: overall delivery of $1.5m savings target ($0.5m per quarter).

e. Review of our operational footprint and assets to identify, optimize or dispose of surplus assets (target savings $100k). f. Review of our external revenue and or funding generating / capturing capability (e.g. Selina Sutherland Hospital, ACC, eligibility, donations, public / private partnerships etc) (target savings $200k). 3. **MOH Sustainability program**. Of the MOH funded $229k we will use $200k for developing an onsite tertiary training facility with UCOL. The balance of $29K is to pay the Wairarapa DHB share for a number of regional projects being administered by TAS.	3. Q2 completion of business case. Q3 start implementation.

Medium term focus (three years)	
Action(s) (include one action and milestone per row)	**Milestone(s)**
1. **Covid-19 learnings: optimisation of workforce and footprint through technology and flexible working arrangements.** COVID-19 thought us that workforce resilience and our ability to attract and retain high skilled workers in a rural environment is highly dependent on our ability to provide staff with technology and working arrangements to allow for remote and flexible work. Not only will this help us to increase our attractiveness as an employer of choice. And it will also allow us to optimize our footprint (m2, transportation / CO2 etc.) and overall well-being of our workforce (work life balance, commuting etc.) 2. **Sustainable system improvements: creating a cost and risk intelligent culture.** The foundation of achieving and sustaining a breakeven operations is the creation of a cost and risk intelligent culture. Information, leadership, education, control and cross organizational engagement is essential. The establishment of a sustainability action group, implementation of the 'health systems catalogue' and systems that provide insights in our cost structure will enable us to identify areas and contracts where we can improve our cost to serve. 3. **Path to break even**. The 21/22 budget targets a -$2.1m deficit, and in order to achieve that we have included $4m savings initiatives. Of this $ 2.5m is quantified to specific actions (below): a. Vacancies / staffing $0.4m b. Improved ACC revenue $0.2m c. Engagement with community to raise donations $0.1m d. Revaluation buildings $1.2m e. Improved return on external contracts $0.3m f. Recovery of overhead expenses for services transferred to 3DHB $0.3m $1.5m of the 21/22 savings program is yet unquantified to actions. We have identified the following high level areas where we will find these savings: $0.2m IDF and outsourced services, $0.3m SMO recruitment and quality improvements, $0.5m nursing, reduction of bed days / use of minders and overtime and $0.5m clinical supplies (health system catalogue, product standardisation / supplier consolidation). Where possible we will retain (roll-over) achieved savings to future budget years. That said, we target a break-even ($0m) result for the 22/23 year. The additional $1.5m savings in 22/23 to achieve this have not yet been quantified to actions.	**1. Optimisation of workforce and footprint** Year 1: - Q3: strategic footprint analysis (develop master site plan) - Q3: sale of surplus assets (Greytown) - Q1-Q4: roll out of digital workplace program (3DHB ICT) Year 2: - Q4: develop plan to exit current off-site leases and co-locate clinical services in a 'fit for purpose' building. - Q1-Q4: roll out of digital workplace program (3DHB ICT) Year 3: - Q4: Execute plan to co-locate clinical services in a 'fit for purpose' building. - Q1-Q4: roll out of digital workplace program (3DHB ICT) **2. Cost and risk intelligent culture** Year 1: - Q1-Q4: Re-instate fortnightly meetings Sustainability Action Group - Q1-Q4: implementation of the Health Systems Catalogue project and 'speed to value' reporting - Q1-Q4: establish cost price reporting model (dashboard) using the CostPro product suite. Year 2: - Q1-Q4: stocktake and review of key contracts to identify unfavourable contracts to improve or exit.

Once we've achieved break-even we will aim at sustaining our operations at a positive $2m net return. The additional $2m savings to achieve this have not yet been quantified to actions.	- Q1-Q4: create insights and identify areas/actions to improve our 'cost to serve' using the price reporting model (dashboard). Year 3: - Q1-Q4: execute plan to improve / exit unfavourable contracts. - Q1-Q4: create insights and identify areas/actions to improve our 'cost to serve' using the price reporting model (dashboard). **3. Path to break even** Year 1: - Q1: assign specific actions / milestone to the yet unquantified $1.5m savings target. - Q1-Q4: deliver on $4m 21/22 savings program Year 2: - Q1: assign specific actions / milestone to the yet unquantified $1.5m savings target. - Q1-Q4: deliver on 22/23 savings program including roll over of 21/22 savings where possible. Year 3: - Q1: assign specific actions / milestone to the yet unquantified $2.0m savings target. - Q1-Q4: deliver on 23/24 savings program including roll over of 22/23 savings where possible.

2.5.3 Improving maternal, child and youth wellbeing

Ambulatory Sensitive Hospital Admissions for children (0-4 years)	
Please see our System Level Measures Improvement Plan (SLM) later in this document. We have set a target for 2021/22 to reduce non-standardised Māori ASH rates for 0-4 year olds from 4,574 per 100,000 to <4,000 and our SLM has a range of actions to help us achieve this. Two key improvement actions in our SLM that are expected to have the most significant impact on performance improvement are as follows: 1. a) Embed the enhanced model of care that increases the number of children proactively having fluoride applied biannually by the dental service. Prioritising high needs children. b) Action: Employ a dedicated Kaiawhina Oral Health Role to work alongside clinical services, solely focusing on supporting families to access services, providing practical support and health education and promotion to help whānau minimise ongoing oral health issues. 2. Maintain the pathways for children with repeat childhood respiratory presentations	Q1-Q4 1(a): Q2 and Q4 - Report on activities that have occurred 1(b): Q2 Dedicated Kaiawhina Oral Health Role appointed. 2. Q2 and Q4 – Report on activities that have occurred

Maternity care	
Action(s) (include one action and milestone per row)	**Milestone(s)**
COVID-19 learnings, 1. Since COVID-19, consumer feedback has shown interest from some to reinvigorate a homebirthing support group in the Wairarapa region. The success of homebirthing during COVID was a response to whanau being unable to visit the hospital. The option to promote homebirthing and a support group will hopefully drive an increase in homebirthing by Q3 21/22.	Q3 -
2. Implement the Kura Pounamu kaupapa Māori antenatal programme across Wairarapa marae alongside maternity, midwifery and the Wairarapa Māori Women's Welfare League	Q2 Recruit programme coordinator and whānau to attend kaupapa Māori antenatal programme. Q4 Complete three kaupapa Māori antenatal programmes on three marae across Wairarapa.
3. **Introduce an electronic system in Maternity**	Q2

Implement the national Maternity Clinical Information System to provide an end-to-end electronic record of all aspects of maternity care, admission to discharge planning, consistent and aligned data collection systems. The system is designed to interface between primary and secondary care settings following the care of the women. Women have access to an app interfacing with the system and allowing women to have access to hand held records at all times. It will ensure consistent approach to data collection and reporting. Improved record keeping, information sharing between maternity service, primary care, GP and support services when women and babies have care transferred between providers.	
Integrated service models 4. **Secondary ANC Midwife** Maintain secondary midwifery clinic interfacing between primary and secondary services with the ability to accommodate primary women that have been unable to access an LMC midwife. Further establish a diabetic specialist component. 5. Some Hospital based primary and secondary clinics to be located in the South Wairarapa, for ease of access to South Wairarapa women. To be in place during Q1 21/22. 6. Recommend the examination and planning of introduction to the MCIS into WrDHB maternity unit. ICT involvement in the project plan and financial commitment will be sought by Q3 21/22.	Q1-Q4 Q1 Q3
Sustainable Workforce 7. Research potential pilot of employed caseload team designed to wrap around hapu mama and whanau in their community and provide structured continuity of care across primary and secondary throughout pregnancy, labour and birth with access to obstetric, anaesthetic and paediatric services. Inviting employment conditions would offer sustainability in the workforce and maintain a healthy state of midwifery for the Wairarapa region. In providing an option of employed caseloading, the focus to grow our own local midwives with an emphasis on attracting Māori wahine to the profession will impact on outcomes for mama and babies in our community. 8. Develop a draft Midwifery Workforce Strategy document inclusive of new graduate support across 3 DHB's, the midwifery career pathway, and ensuring a midwifery workforce that have capacity and capability to be responsive to Māori and continue to recruit Māori midwives with a process that values their cultural and clinical expertise. 9. Explore the opportunity to pilot an employed caseloading midwifery team with a focus of recruitment and retention to the Wairarapa region. This pilot will be forward thinking of the new health system, the document produced will reflect women and whanau centred care in their communities.	Q1-Q4 Q2 Q4

Recommendations from Perinatal Maternity Mortality Review Committee 10. PROMPT (PRactical Obstetric Multi-Professional Training) training for trainers will be completed in Q1 21/22 11. PROMPT training days in WrDHB being provided by Q3 21/22 12. Investigate the opportunity to implement models of care that meet the needs of Indian women. Engagement with Indian consumers through recruitment to MCGG and facilitating meetings with Indian Mothers in progression to understanding what a model of care may look like. Q2 21/22.	Q1 Q3 Q2
Immunisation	
Action(s) (include one action and milestone per row)	**Milestone(s)**
Increase the number of children in vulnerable families vaccinated through the Outreach Immunisation Service (OIS) 1. Continue to support and promote early referral pathways to Outreach Immunisation Service (OIS). 2. Six monthly stakeholder hui to facilitate improved referral volumes.	Q2 Q4; Status report
Maintain immunisation coverage during the COVID-19 immunisation programme 3. Continue to keep the focus of OIS on childhood immunisations. 4. Support primary care providers to focus on prioritising immunisation service delivery.	Q2 Q4; Status report
Develop and implement a comprehensive immunisation engagement and communications plan in collaboration with Māori, Pasifika and consumer voices in the community with a focus on reaching priority populations which will include; 5. Making planned contact with key Māori and Pasifika partners within the region to harness their influence to ensure that positive, consistent and culturally appropriate messaging is delivered consistently across the region. 6. Delivering a programme of immunisation education sessions in various settings including marae, schools, Te Kōhanga, early childhood centres and at community events.	Q2 Q4; Status report
Māori Led Influenza Immunisation Programme 7. Partner with Māori Women's Welfare League (MWWL) to support promotion of Māori influenza immunisation rates.	Q2 Q4; Status report
Improve childhood immunisation coverage from infancy to age 5 with a focus on increased immunisation at 2 years 8. Partner with MWWL to enable a Maori-led approach to improving immunisation, focussing on innovative approaches, building of networks and improving equitable immunisation coverage for Māori populations 9. Strengthen the coordination of immunisation services and refresh membership, terms of reference and action plan of the Wairarapa Immunisation Advisory Group. 10. Support the development of the PHO Child Health Coordinator role. Contributory measures include newborn enrolment and children aged 2 years are fully immunised	Q1 Wairarapa Immunisation Group hui Q2 Q3 Q4 Status report

Youth health and wellbeing	
Action(s) (include one action and milestone per row)	**Milestone(s)**
See also our System Level Measures Improvement Plan 2021/22 for other youth-focused activities and initiatives in the section "Youth access to and utilisation of youth appropriate health services".	
Following a youth service review in 2018/19, recommendations include both specific formation of advisory and governance groups, but also activity that can be co-ordinated by this group for more effective outcomes: 1. Reforming and redesigning the local Youth Health Community Group (YHCG) into a steering group / collaborative, with involvement from key stakeholders and appropriate agencies delivery care. A co-design approach will be used. 2. The redesigned local YHCG group will be responsible for: • Shared governance for system review of quality, safety and effectiveness • Point of reference and co-ordination for strategic development of services and COVID 19 response for youth • Develop data sharing protocols • Links with other non-provider agencies as a wider reference network	1. Q1 Complete reforming of collaborative group 2. Q2 -Q4 Review existing resource (direct and indirect both digitally and in person) 3. Quarterly updates of what services are available across the community 4. Q1 – Q4 Support development of community response to COVID 19
In order to support youth to develop their ability to self-manage and engage effectively with health services, multi-platform communications need to be considered for a generational group that rely alternative strategies to more traditional methods of engagement. 1. Engage youth participants in steering group with a development of alternative platforms including digital, telehealth, utilisation of web based resources 2. Review of available resources, and modes of access 3. Development of implementation plan and information sharing across the region	1. Q1 Create workplan as part of steering group activity 2. Q2 – Q4 Engage youth in review of available resource 3. Q3 – Q4 Work with local groups and resources to consider access modes to service to maximise 'closer to home' as well as face to face engagement
Family violence and sexual violence	
Action(s) (include one action and milestone per row)	**Milestone(s)**
1. Work alongside the Masterton police station domestic violence unit, engaging whānau, specifically working with perpetrators of violence. 2. Continue to resource and evaluate suicide prevention wananga in the district that work with local men.	1. Q4 Number of hui and joint projects completed with the domestic violence unit 2. Q4 Number of wananga and attendees conducted and ensuing reports

2.5.4 Improving mental wellbeing

Action(s) (include one action and milestone per row)	**Milestone(s)**
Activities: **COVID-19 Recovery Response** 1. All MHAIDS COVID resurgence plans will be updated by end of Q1 and will be updated as 'living documents' in cases of re-emergence or alert level response changes. 2. Review the protocols and agreements with all providers involved in the collective provider and stakeholder forum that was implemented to respond to the COVID 19 and lockdown early in 2020. 3. MHAIDS leadership team will continue to be engaged with the wider 3DHB data and digital, including telehealth, development of updated applications and technologies from the learnings of the DHBs COVID response in 2020. 4. Surveys were conducted post lockdown with service users and staff. The findings of these surveys will be reviewed in Q1 to determine the next steps. 5. Marama Real Time Feedback has been rolled out across MHAIDS and is now our BAU service user family/whanau feedback tool. Due to COVID lockdown, as well as wanting to ensure we have appropriate methods of collection for our different consumer demographics we will now implement a number of different collection methods in Q1 e.g. paper surveys, QR codes, posters and automated text/emails following attended appointments. 6. Reform and redesign the local MH&A advisory group into a steering group / collaborative, with clinical and operational leadership with PHO, local governmental / social agencies. A co-design approach will be used (Wai). The redesigned local MH&A group will be responsible for (Wai): i. Activity contributing to governance of service delivery across the Wairarapa ii. Providing point of co-ordination for strategic development of psychosocial response process / protocols, and synchronized service delivery during any state of emergency, including pandemic such as COVID – 19 iii. Links with other non-provider agencies as a wider reference network. 7. Establish a MoH funded MHAC (Mental Health and Addiction Crisis Support) role within the Emergency Department, based at Wairarapa Hospital.	1. Q1 2. Q1 3. Q1-4 4. Q1 5. Q1 6. Q1-2– Reforming of the collaborative group Q1 -4 – Progress update reports 7. Q 1-4

8. Support development of Nurse Specialist role within NGO based addiction service to improve local governance and service delivery.	8. Q 1-4
9. The Wairarapa has the highest per capita population of older people in New Zealand and to recognize the increasing need for MH services for this age group, complete a review of current service provision. Using a co-design process, create recommendation for future development of service delivery across all providers and develop an implementation strategy.	9. Q 1-4
10. In the Wairarapa, there is a dearth of available and dedicated consumer / peer support for service development and delivery. Complete assessment of the need for development of formal consumer advisor activity and develop a strategy for supporting any recommendations made from this.	10.Q 1-4
Integration of primary and specialist services	
11. The MHAIDS GP Liaison Service's dedicated Senior Medical Officer, who can be contacted directly by GPs for advice, will provide 1:1 advice and education on Special Mental Health via Video Conference sessions to GPs across the 3DHBs.	11.Q 1-4
12. Work with local community and key stakeholders to review existing provision of acute / crisis respite care and out of hours service provision, in line with the MHAIDS Acute Care review, and recommendations from review completed in 2020 within WrDHB (Ref: P Boyles)	12.Q 4
Improve our cultural response, focusing on Māori and Pasifika	
13. MHAIDS will continue to participate in the national project "Toward Zero Seclusion'. Maori are over represented in seclusion figures and this project aims to reduce and stop the incidence of seclusion. Over the last 5 years (Jul 2015 to June 2020), 35% of all those admitted to acute MH facilities from the Wairarapa are Māori, with a community population base of 17%. Other ethnic groups make up 80% of the local population but comprise just over 60% of all admissions. This over representation is compounded by Māori people being discharged under a CTO (community treatment order – Mental Health Act, 1992) just over five times more likely than non-Māori. The reason for this is not clear.	13.Q 1-4
14. Using a project focus aligned with the MHAIDS and NGO local services, develop an assessment of the issues driving this disparity in service delivery, and consider recommendations regarding service development to address any identified gaps, model of care issues, or resource shortfall.	14.Q 1-4
15. Using co-design, develop a model of service delivery that refocused initial MH&A engagement and assessment from a principally clinical orientation, to an appropriate collaborative model of holistic assessment, informed by Māori model of health care.	15.Q 1-4

Follow up within seven days post discharge 16. Adult Community Mental Health and Addiction Services will monitor all inpatient discharges to ensure a community service contact is made and recorded in the seven days immediately following that discharge 17. Implement a policy and pathway that embeds practices to monitor and respond to any variation/issues in post-discharge. 18. Focus on data quality and completeness aiming for 100% PRIMHD data quality compliance by Q4. 19. Action to implement appointment reminder automation at Wai/CCDHB by Q2. **Two locally selected contributory measures:** • *DNA rates* – focus and target to reduce DNA rates as a measure of improving service user engagement. Approximately 9 percent of all scheduled MHAIDS community appointments result in a 'Did Not Attend' (DNA). MHAIDS has set a focus on reducing its DNA rate to a target of 5 percent. DNA rate is one way of measuring service user engagement with MHAIDS. By focusing on DNAs we can identify barriers for our service users and make improvements for accessibility. Fewer DNAs will have a positive impact on wait times and less clinical time will be lost. Our Hutt Valley based services send automated appointment reminders to service users. Action to implement this automation at Wai/CCDHB by Q2. • *Pre-admission care* - Adult Community Mental Health and Addiction Services monitor this measure along with the seven day follow up measure. Additional MoH advised measure: MH03: Transition/discharge planning. Compliance and quality audits will be completed quarterly.	16.Q 1-4 17.Q 1-4 18.Q4 19.Q2

2.5.5 Improving wellbeing through prevention

Communicable Diseases	
Action(s) (include one action and milestone per row)	**Milestone(s)**
Provide a notifiable communicable disease programme to reduce the impact of illness and reduce avoidable hospital admissions of our priority populations including, Māori, Pacific, recently arrived refugees, elderly, immuno-compromised, and young children. Prevent, identify and respond to existing/emerging communicable diseases including prompt follow up of notifiable communicable diseases; detect and control of outbreaks; facilitate TB drug regimens completion; and promote infection prevention, control and immunisation in community and healthcare settings. (RPH: core function – Health Promotion, Health Protection, Health Assessment & Surveillance, Public Health Capacity Development and Preventive Interventions)	Q2 & Q4
The RPH Māori and Pacific COVID-19 Response leads will support Māori and Pacific communities to identify and lead COVID-19 recovery projects/plans, including those to improve access to infectious disease related services for Māori and Pacific Peoples (RPH -core function: health promotion) (EOA). This is a cross service opportunity.	Q2 & Q4
Environmental sustainability	
Action(s) (include one action and milestone per row)	**Milestone(s)**
1. Optimisation of vehicle fleet by reducing our fleet by 30% and replacement with vehicles that have 20% less CO2 emission than our current vehicles. With the consolidation of Regional Public Health and Mental Health there is opportunity to pool our vehicles regionally allowing the reduction of a 'stand-alone' Wairarapa DHB vehicle fleet. Further, review of alternative newer models has shown that we can replace vehicles that are at end of life with vehicles that have a 20% lower emission. 2. Establishment of an environmental sustainability action group to advise and provide leadership for initiatives aimed at environmental sustainability and associated equity. 3. Perform a baseline carbon emission calculation to understand our carbon footprint 4. Develop a plan / targets for emission measurement and reporting and setting reduction targets/plans for 2025-2030	1. Q4 Fleet size reduced by 30% and remaining vehicles replaced by 20% less CO2 emitting vehicles. 2. Q1 establishment of environmental sustainability action group. 3. Q2 baseline carbon emission calculation done. 4. Q4 environmental sustainability strategy document with key objectives and action plan to start measuring, reporting on CO2 emissions and setting reduction targets/plans for 2025-2030.

Antimicrobial resistance	
Action(s) (include one action and milestone per row) section yet to be completed	**Milestone(s)**
1. Update of the hospital antibiotic guidelines and community cellulitis pathway (3DHB). 2. Weekly hospital antimicrobial stewardship rounds – conducted via telemedicine with offsite Infectious Diseases/Clinical microbiology specialists. 3. Education for hospital and community nurses on Infection Control and AMR at an annual study day. 4. Hospital antibiotic consumption data collated and reported to the IPCC.	1. Q3 – availability online and mobile app 2. Q1-Q4 – reporting to AMS committee 3. Q2 4. Q3 – reporting to IPCC
Drinking water	
Action(s) (include one action and milestone per row)	**Milestone(s)**
Facilitate the transfer of drinking water regulatory work including all water supplier records to the new drinking water regulator Taumata Arowai.	Q1-Q4
The RPH Māori and Pacific COVID-19 Response leads will support Marae, schools and vulnerable communities (including communities with high Māori and Pacific Peoples populations) with their own water supplies to identify and lead COVID-19 recovery projects/plans around drinking water (EOA) (RPH) (Core function-health protection) (3DHB) or any other post COVID-19 public health issue. This is a cross service opportunity.	Q2 & Q4
Undertake a Drinking Water Plan alongside Ngāti Kahungunu and Rangitāne to understand iwi perspective on water values and cultural impacts.	Q1-Q4
Complete the annual review compliance reporting for 2020/21 during Quarter 1	Q1
Environmental and border health	
Action(s) (include one action and milestone per row)	**Milestone(s)**
Undertake activities as per the Environmental and Border Health Exemplar for Public Health Units including hazardous substances; border health; emergency planning and response; resource management, regulatory environments and sanitary works; and other regulatory issues. (RPH) (Core function - health protection)	Q2 & Q4
Assess the DHB/RPH's ability and processes in relation to encouraging Territorial Authorities (TAs) to always consider improvement of Māori and Pacific health and achievement of equity when the TAs are developing their district and long-term plans so that the DHB/RPH can optimise its input into the TA planning processes in relation to improving Māori and Pacific health and achieving equity. **(EOA)**	Q2 & Q4

Healthy food and drink environments	
Action(s) (include one action and milestone per row)	**Milestone(s)**
Support the appointment of a new Chair of the **3DHB Healthy Foods and Drink Environments Implementation Group**.	Q2
Implement a DHB staff consultation to align the National Healthy Food and Drink Policy with policy requirements for fundraising and gifts within the DHB	Q2 & Q4
The RPH Māori and Pacific COVID-19 Response leads will support Māori and Pacific communities to identify and lead COVID-19 recovery projects/plans, including those to improve access to reliable healthy food options (RPH -core function: health promotion) (EOA) (3DHB). This is a cross service opportunity.	Q2 & Q4
In partnership with Sport Wellington and the Ministry of Education provide the **Healthy Active Learning** programme to schools and early learning services, with a continued emphasis on (a) water-only and (b) low decile schools with higher numbers of Māori and Pacific students. We will report on the number of Early Learning Services, primary, intermediate and secondary schools that have current water-only (including plain milk) policies and healthy food policies. (Core function - health promotion). (EOA) (3DHB)	Q4
Smokefree 2025	
Action(s) (include one action and milestone per row)	**Milestone(s)**
1. Undertake compliance and enforcement activities relating to the Smokefree Environments Act 1990. 2. Work with hapū wāhine and their whānau, through the Hapūtanga Programme to co-design wrap-around stop smoking services that will work for them. 3. Review the Kohanga Reo initiative co-designed to support Kaiako to quit smoking using the concept of shared medical appointments/group work integrated with the local stop smoking service. 4. Refresh the 2019/20 Tapu te Hā the WrDHB Tobacco Control Plan.	1. Q2 & Q4: Number and outcome of compliance and enforcement activities. 2. Q2 & Q3: Hold hui and planning for wrap-around stop smoking services 3. Q3: Finalise the review of kohanga reo initiatives 4. Q1: Update the 2019/20 Tapu te Hā – Tobacco Control Plan into 2021/22
Breast Screening	
Action(s) (include one action and milestone per row)	**Milestone(s)**
Māori and Pacific wāhine prioritised through COVID-19 recovery 1. Regional Screening Services will progress the work started by the 2020 BreastScreen Central Mammography Project for the most effective and efficient way of **increasing access to breast screening services** with a	All data used for monitoring and reporting is provided by the BreastScreen Aotearoa (BSA) data reporting services. Our BreastScreen Central data is fed into the

particular focus on improving access for Māori and Pacific women. The project will look at additional fixed sites and/or a replacement mobile unit. **(EOA)** BreastScreen 'Priority' women (Māori and Pacific) are given first priority for all appointments in the service, including COVID rescheduled appointments. **Eliminate equity gaps** 2. Regional Screening Services will work in partnership with local Māori and Pacific health providers, PHOs, and primary care and community health services, identifying priority women with PHO data matching activity, use of local clinics, and organising education and health promotional events. **(EOA)** **Improve participation for Māori and Pacific women** 3. To support the national (BreastScreen Aotearoa) two-year pathway to achieve the 70% **screening target for Māori and Pacific women**, Regional Screening Services' recruitment and retention (R&R) team will aim to support as many additional Māori and Pacific women as possible who are overdue or unscreened to attend a breast screening clinic. Māori and Pacific women are given first priority when BreastScreen appointments are scheduled for both new enrolments and rescreening. This will be applied to all appointments that are rescheduled due to COVID-19 disruption. R&R team continue to work with individual clients to find appointment days and time that best suit them. When necessary the team will home visit hard to reach overdue and unscreened priority women. Transport to screening appointments and assessment is also provided if needed. R&R will refer priority women to ISP's who have contracts with the NSU or the RSS.	national data base and all reports are generated from this. 1. Q2 & Q4 report on progress 2. Q2 & Q4 report on progress 3. Q2 & Q4 report on progress
Cervical Screening	
Action(s) (include one action and milestone per row)	**Milestone(s)**
Improve Māori and Pacific coverage 1. Regional Screening Services will work in partnership with local Māori and Pacific health providers to attend events where priority populations gather and promote key messages around the importance and benefits of cervical screening. We will provide education and support for women into the screening pathway **(EOA).** **Actions to reduce the equity gap** 2. **Free Screening Clinics** - to reach the National Cervical Screening Programme (NCSP) coverage target of 80 percent and eliminate equity gaps for Māori, Pacific, and Asian women for cervical screening, Regional Screening Services (RSS) will provide four weekend free cervical screening clinics per annum two at Wairarapa Hospital and	1. Q2 & Q4 report on progress 2. Q2 & Q4 report on progress

two in South Wairarapa General Practices. Clinic appointments will be prioritised for Māori, Pacific and Asian women. RSS to report the number of priority women who attend the four cervical screening clinics at WrDHB and South Wairarapa**. (EOA)** 3. **Primary Care -** Regional Screening Services will partner with general practices in the Wairarapa region using PHO data match reports to identify priority group Māori, Pacific, and Asian women who are unscreened and under screened to invite to screening and provide support to services as required. **(EOA)**. **Equitable access to diagnostic and treatment colposcopies** 4. Regional Screening Services will ensure women who did not attend (DNA) diagnostic and treatment colposcopy services are actively followed up and referred to support to Māori, Pacific support to service providers. Support to Service role to be partially funded by RSS subject to MOH funding.	3. Q2 & Q4 report on progress 4. Q2 & Q4 report on progress
Reducing alcohol related harm	
Action(s) (include one action and milestone per row)	**Milestone(s)**
1. RPH continues to develop and improve our local knowledge of how alcohol adversely affects local communities, including using hospital and emergency department data. (3DHB) (RPH: core function – health assessment and surveillance)	Q2 & Q4 report on progress
2. Provide health protection activities relating to the Sale and Supply of Alcohol Act 2012. (3DHB) (RPH: core function – health protection)	Q2 & Q4 report on progress
3. Influence policies related to reducing alcohol related harm, e.g. Councils' local alcohol policies. (3DHB) (RPH: core function – health promotion)	Q2 & Q4 report on progress
4. The RPH Māori and Pacific COVID-19 Response leads will support Māori and Pacific communities to identify and lead COVID-19 recovery projects/plans, including those to reduce alcohol related harm. We will also support communities to have a voice in local alcohol licensing decisions, alcohol and drug policy and legislation development. We engage with Māori and local community leaders to support them to advocate with their communities from their own lived experiences. (EOA) (3DHB) (RPH: core function – health promotion)	Q2 & Q4 report on progress
Sexual and reproductive health	
Action(s) (include one action and milestone per row)	**Milestone(s)**
1. STI rates increased during the time of the COVID-19 lockdown. RPH will assess the ongoing impact of COVID-19 on STI incidence as part of providing information and advice to communities and health providers for sexually transmitted infections (STIs) outbreaks. (RPH: core function – health promotion)	Q2 & Q4 report on progress

2. Lead collaboration with relevant sexual health services and stakeholders to support the sexual health workforce to be able to respond to the sexual health issues identified by Māori and Pacific populations. (EOA) (RPH: core function – health promotion)	Q2 & Q4 report on progress
Cross Sectoral Collaboration including Health in All Policies	
Action(s) (include one action and milestone per row)	**Milestone(s)**
1. Provide equity focused and COVID-19 recovery informed public health input as a member of the Wellington Regional Healthy Housing Group (WRHHG) steering group and working group(s) to implement the 2021 and 2022 WRHHG strategy and action plan. (RPH: core function – Health Promotion). (3DHB)	Q1-4
2. Deliver the Health in All Policies programme (HiAP) providing public health input to local, regional and central government policy processes with significant potential for equity focused health impact. (RPH: core function – Health Promotion). (3DHB)	Q1-4
3. Utilise the Health Equity Assessment Tool (HEAT) in at least one cross sectoral collaborative project (per DHB) to ensure an equity focus (RPH: core function- Health Promotion). (3DHB)	Q1-4
4. Contribute to local Wairarapa Leaders Social Wellbeing Forum through active participation	Q1-4

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

Delivery of Whānau Ora	
Action(s) (include one action and milestone per row)	**Milestone(s)**
1. Work with the whānau ora commissioning agency to understand where the DHB, Iwi and local Māori Health providers could align investment. 2. Build the capability, number and scope of Māori Health Providers and include boutique, emerging providers such as the Māori Women's Welfare League and Te Wahapuahoaho. This gives whānau more and varied options for consistent service support.	1. Q4 At least one hui to discuss the idea of aligning investment in whanau ora. 2. Q1-Q4 offer support, contracts and expertise to a range of Māori Health Providers.
Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025	
Action(s) (include one action and milestone per row)	**Milestone(s)**
WrDHB will develop an implementation plan focused on the six priorities of the Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region being: 1. Pacific child health and wellbeing 2. Pacific young people 3. Pacific adults and ageing well 4. Pacific health and disability workforce 5. Social determinants of health 6. Culturally responsive and integrated system	Q1 -4 Develop the 3DHB Pacific Health and Wellbeing Strategic implementation plan. Q4 Status report on progress.
WrDHB, CCDHB and HVDHB will work together to develop and implement a cultural competency framework to improve cultural responsiveness and increase the capability of the non-Pacific health workforce to respond appropriately to the needs of Pacific people.	Q1-4 Contribute to the 3DHB development of a cultural competency framework.
Care Capacity Demand Management (CCDM)	
Action(s) (include one action and milestone per row)	**Milestone(s)**
Governance – Establish the Inpatient Quality Group as business as usual support group to ward quality initiative development and achievement.	Q1-4
Patient Acuity Data 1. Expand TrendCare use into the Emergency Department and whole of Acute Services 2. Establish patient acuity system for Allied Health	1. Project to be scoped and timelines set during Q1 2. Project to be scoped and timelines set during Q1

Core Data Set – Achieve inclusion of any outstanding core data set measures into regular monitoring and reporting.	Q1-2
Variance Response Management 1. Finalise establishment of paper-based variance response management system as business as usual. 2. Establish project plan for implementation of digital variance response management system support.	1. Q1 2. Planned by 3DHB ICT to begin Q1 a. Establish core data set and variance response management digital requirements – July 21 b. Business process changes agreed for HL7 configuration - July 21 c. Implementation of HL7 messaging between WebPAS and TrendCare – August 21 d. Design approved for core data set and variance response management – August 21 e. Hardware ordered / QLIK build complete – September / October 21 f. Deployment of digital core data set dashboard and variance response management October / November 21
Full Time Equivalent Calculations – Continue business as usual annual FTE calculation process with the inclusion of Midwifery	Q2-3
Health outcomes for disabled people	
Action(s) (include one action and milestone per row)	**Milestone(s)**
1. Implement standardised disability question to collect data and a referral process to ensure reasonable accommodations requested are provided to Māori and Pacific people with disabilities. **(2DHB)**	1. Q2 & Q4 Narrative report
2. Deliver core disability responsive education with the newly completed e-learning programme of three modules that all staff must complete. This programme will ensure that all staff have foundational knowledge about disability; the rights based approach; the importance of attitude and how to make reasonable accommodations.	2. Q1-4 Staff complete new e-learning module
3. Collaborate with the Ministry, DHB staff, community stakeholders and disabled people in each region to develop new Sub Regional Disability Strategy for 2023 - 2028	3. Q4 New Sub Regional Disability Strategy 2023 – 2028

Planned care	
Action(s) (include one action and milestone per row)	**Milestone(s)**
Strategic Priority #1 Understanding health need Develop a framework to assist services to change service delivery model and move settings of care from hospital to community	Q4
Strategic Priority #2: Balancing national consistency and local context Production planning System in place and utilised for planning activity aligned to sub regional DHB models for consistency and sharing.	Q1 – Q4
Strategic Priority #3: Simplifying pathways for service users Continue MSK Non-Surgical Care Pathway outcomes and benefits realisation Establish community based musculoskeletal early intervention service with focus on Māori and Pacific. Increase Virtual Clinic provision to our community by a cumulative 10% for the 2021/22 year (Covid 19 Learning)	 Q1 – Q4 Q4 Q4
Strategic priority 4: Optimising sector capacity and capability Regional Collaboration & Vulnerable Services. Establish and implement Sub Regional Care arrangements for enhanced access and waiting times for Wairarapa patients. Single / shared Service models across other DHBs	Q1 – Q4
Strategic Priority #5: Fit for the future Improve access and provision of critical diagnostics and technology to facilitate future care models. (Hub and Spoke with Sub Region) Virtual Care Clinic Suites operational (COVID ACTION)	 Q1 – Q4
Planned Care Intervention (SS07) 1. Improve Māori DNA rates for access to specialist care through the roll out of changes to ambulatory clinic provision identified in the 20/21 DNA plan. 2. Txt to remind in operation to improve attendance at appointments and procedures.	 Q1 – Q4 Q1

Acute demand

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

Action(s) (include one action and milestone per row) section under development	**Milestone(s)**
1. Continue the falls programme (subject to funding as ACC will cease their funding for some components)	1. Q1 – 4 progress updates
2. New clinical pharmacist service (subject to funding) in place and providing medication review to reduce falls and support long term condition medicines management – with focus on Māori and Pacific populations **(EOA)**	2. Q4
3. Implement the Model of care change in the emergency department to ensure 24/7 SMO senior decision making onsite to ensure senior decision making and avoidance of unnecessary admission or delayed treatment	3. Q2 – Q4
4. Implement revised ambulatory care model in AAU to reduce avoidable admissions and create a dedicated supported clinical environment to expedite rapid transfer of care back into the community and improve ALOS.	4. Q4
5. Continue implementation of Health Care Home model to reduce admissions to ED through GP triage, virtual interventions and year of care plans with a focus on Māori and other vulnerable populations.	5. Q1 – Q4
6. Explore the expansion of the Hospital at Home model pilot to provide escalated clinical care in patients in their home or place of residence.	6. Q4
7. Review the health pathway development localization process to ensure the pathways remain equitable, relevant and useful in the Wairarapa.	7. Q4
8. Actions to improve wait times for patients requiring mental health and addiction services who present to ED include working with MHAIDS to deliver efficient care for these patients in the right location, and ensuring the Te Haika link resource matches demand and presentation trends.	8. Q1 – Q4
9. Work with the DHB Maori Health Directorate to help ensure we provide culturally appropriate care to Māori and their whanau who attend ED. (**EOA**)	9. Q4
10. See also the System Levels Improvement Plan actions including the continuation of the falls program, implementation of a clinical pharmacist service to reduce polypharmacy and focus on Māori populations with long term conditions, and the development of a COPD program for moderate to severe conditions.	10. Q1 – Q4
11. SNOMED codes enable the DHB's raw patient and service data to be coded consistently with a national standard thereby allowing DHB service managers and the Ministry of Health to better understand patient population trends, identify patient needs. With this information we will look to improve patient health pathways for those with long term conditions (with a focus on Māori and Pacific populations) such as diabetes and respiratory conditions to enable such conditions to be better managed in the community. Collated data will be also be used to develop performance dashboards to inform how our services can be streamlined to better meet patient and	11. Q4

community needs and demand. This level of business intelligence supports service design and planning, particularly within primary and community care, to reduce demand on hospital services. **(EOA)**	
Rural health (applies to all DHBs except Capital & Coast and Hutt Valley DHBs)	
Action(s)	**Milestone(s)**
1. Review current investment and outcomes and strengthen the connectivity with supporting services particularly for Māori rural populations 2. Continue Health Care Home programme and support where digital connectivity allows virtual approaches to care.	1. Q4 2. Q1-4

Implementation of the Healthy Ageing Strategy 2016 and Priority Actions 2019-2022	
Action(s) (include one action and milestone per row)	**Milestone(s)**
Pandemic preparedness – Active mentoring to assist ARC providers to implement Advance Treatment plans for long term residents (subject to funding) To enable anticipatory care for frail elderly using HQSC guide, enhance workforce development in difficult conversations, strengthen kaumatua support for Māori in ARC, assist decision making (e.g. relating to transfer to hospital) especially in the event of an outbreak.	1. Q1-2: All ARC facilities have been introduced to ATP simplified tool and concept. 2. Q1-Q4: Establishment of ATP protocol for new ARC admissions for all ARC providers. 3. Q4: 50% ARC providers identified as champions for supporting peers.
Pandemic preparedness – Contribute to and promote national pandemic toolkit for ARC Support a consistent approach locally, regionally and nationally. Ensure alignment with local ARC pandemic plan to inform effective decision making during a pandemic outbreak.	1. Q4: Contribution & feedback linked with Ministry timeframe. Review of local ARC pandemic plan when toolkit confirmed.
Retain & restore the function of older people – Targeted medication management for polypharmacy and optimum osteoporosis management (subject to funding) Reduce the incidence and impact of falls; Hip fracture management and fracture liaison in primary care; Pharmacy inclusion in MDT management of frail elderly; education and mentoring of GP prescribing practice.	1. Q1-2: Provision of dedicated community pharmacist for this function. 2. Q1: Prioritised criteria and action plan developed. 3. Q4: All GP practices linked with community pharmaceutical advice and mentoring. 4. Q4: 50 people from the at-risk groups have benefited from medication reviews.
Retain & restore the function of older people – Reduce social isolation and increase community resilience through community based pet sharing initiative Increase social resilience and community connectedness across generations which will result in kaumatuatanga, meaningful connection for those living with dementia and reduced loneliness (e.g. impact of covid-19) and associated entry to ARC.	1. Q1: Embed parameters, prioritisation, and protocols, to optimise current community connections. 2. Q4: Establish across prioritised Wairarapa communities according to action plan.
Improving dementia services – Promote health professional use of the localised dementia health pathway including implementation of the Mini-ACE assessment tool (e.g. through PHO clinical support & national support systems) Promoting best practice – Implementing the NZ Dementia Action Plan	1. Q1: All GP practices using mini-ACE for general dementia assessment.

	2. Q1-4: Dementia Health Pathway used to guide the interface between primary care and specialised dementia services.
Improving dementia services – Promote option of in-home respite, especially for Māori living with dementia Supporting family carers (Carers' Strategy Action Plan 2019-23); Improving the health and wellbeing of carers, providing meaningful activity and ensuring access to culturally appropriate support services for kuia and koroua living with dementia	1. Q1-4: Service allocation and coordination is flexible and appropriate to meet the support needs of carers. It accommodates in-home respite when appropriate.
Community based support and restorative services – service development for community based rehabilitation aligned with other community based developments in order to maintain highest degree of independence. To assist older people to be functional as long as possible in the way they want to be. Incorporating community stroke rehabilitation, ACC non-acute rehabilitation, implementing HCSS framework, musculo-skeletal programmes and reducing the incidence and impact of falls (subject to funding).	1. Q2: Scoping project and service development plan, completed by Q2 and concurrent with specific developments. 2. Q3: Initial non-operative musculoskeletal management programme commenced. 3. Q1-4: In-home strength & balance for targeted cohort. 4. Q2-1: ACC NAR service agreement. 5. Q4: Establishment of identified (multipurpose) community rehabilitation service.
Health quality & safety (quality improvement)	
Action(s) (include one action and milestone per row)	**Milestone(s)**
1. Develop a sustainable long-term legislative compliance framework that ensures the DHB is able to provide assurance and annual reporting on legislative compliance as is required under the New Zealand Public Health and Disability Act (2003), Crown Entities Act (2004) and Operational Policy Framework.	1. Q1 Develop Policy Q2 Complete internal review and develop Roadmap Q2 Develop Framework
2. Increased focus on Privacy to ensure best practice within the DHB and compliance with new Privacy legislation.	2. Q3 Have in post a new dedicated Privacy Officer role with increased FTE (subject to funding) 3. Q3 Complete and implement Clinical Audit Policy and Procedure

3. Improve audit assurance activity in relation to clinical audit practices to enable measuring of clinical outcomes or a processes against well-defined standards to improve daily care quality.	Q4 Develop central SharePoint repository for all clinical audit activity to be recorded
4. Development and roll out of a Covid Feedback module for staff to identify key areas for improvement and to further enable: • Identification of changes that were made so we can assess the impact of these changes and if they should become permanent. Teams/services will then be able to use this information to integrate into the DHB's operational/annual plans and future performance improvement plans. • Visibility across services to enable collaboration where similar changes/innovations are identified. • Capture of feedback from across the organization to ensure learnings are maximized for future responses.	4. Q1 Review all feedback received for Quality Improvement
Spreading hand hygiene practice 1. Hand hygiene auditing programme will be implemented and reported in the Emergency Department	1. Q1-4 Achieve ≥80% compliance
Improving equity See System Level Measures Improvement Plan, Amenable Mortality section - Tū Ora in partnership with general practices, Māori & Pacific will implement a pro-equity Diabetes medication transition programme.	
Improving Consumer engagement Progress the implementation of the quality and safety marker (QSM) for consumer engagement by: 1. Continuing to support the governance group (or oversight group) of staff and consumers guiding implementation of the marker. 2. Report against this QSM twice-yearly (**Q1 and Q3**) via the online form on the Commission's website using the SURE framework as a guide.	1. Q1 – confirm TOR of governance group. 2. Q1 and Q3 – upload QSM data Q1 – combined review of primary care and adult inpatient survey results using new survey tool.

Te Aho o Te Kahu – Cancer Control Agency	
Action(s) (include one action and milestone per row)	**Milestone(s)**
New Zealanders have a system that delivers consistent and modern cancer care – He pūnaha atawahi 1. Wairarapa DHB will be party to an options paper for the CCDHB and HVDHB board to be developed in the 21/22 financial year to examine options for a 4th LINAC and whether that is delivered via a satellite unit. The new LINAC will service Wairarapa DHB patients.	1. Q1- steering committee appointed to oversee the development of an options paper for the outreach radiation services. Q2 - analysis of HVDHB and Wairarapa DHB population and radiation therapy needs requirements completed. Q3- 4: In 2022 joint CCDHB & HVDHB boards will approve a timeline of when HVDHB & WrDHB will have improved access to radiation therapy by the CCDHB radiation therapy service.
2. Wairarapa DHB will work with Te Aho o Te Kahu to plan and implement the adoption of the cancer-related Health Information Standards Organisation (HISO) standards, to be issued via Data and Digital, Ministry of Health. Our DHB will demonstrate evidence of implementation and compliance of the HISO standards as they are rolled out through timely adoption of the standards where they are relevant to our DHB.	2. Q4
New Zealanders experience equitable cancer outcomes – He taurite ngā huanga 3. Wairarapa DHB will participate in Te Aho o Te Kahu travel and accommodation project that aims to improve cancer patient equity of access and support to cancer services/treatment for local and for inter-district patient flow. Our DHB is committed to implementing the recommendations of this project, particularly those that ensure equity of access for Māori and rural communities who currently experience inequitable access to cancer services.	3. Q1-Q4: Reporting as required by Te Aho o Te Kahu
4. Wairarapa DHB have identified the following actions specifically to address inequalities and access to diagnosis and care for Māori and Pacific patients.	4. a) Q4: Develop Action Plan based on Te Aho o Te Kahu report and recommendations to ensure cancer services that are culturally safe for Māori. b) Q2 and Q4: Report on progress of community initiatives.

5. Consider Te Aho o Te Kahu report and recommendations based on feedback from 3 Māori community hui and agree an action plan. The findings from these huis will also be used to develop the future model for cancer services in the Wairarapa, with a focus on developing services that are culturally safe for Māori.	5. Q1-Q4: evaluate and innovate specifically in programmes of work for tobacco control; alcohol related harm; nutrition and physical activity.
6. Wairarapa DHB will facilitate locally driven community-based initiatives with cancer patients and their whānau to drive service improvements. For example one initiative will focus on building community based cancer co-ordination services in the Wairarapa.	6. Q2 - stocktake complete, gaps understood, tailored approaches recommended
New Zealanders have fewer cancers – He iti iho te mate pukupuku	
7. Continue to increase investment in prevention, specifically programmes of work for tobacco control; alcohol related harm; nutrition and physical activity.	7. Q4 - Number and quality of tailored approaches available.
8. Continue to evaluate and innovate specifically in programmes of work for tobacco control; alcohol related harm; nutrition and physical activity.	8. Q1-Q4: Quarterly report on progress
9. Take a stock take of programmes and improve healthy lifestyle approaches tailored to Māori and Pacific peoples (subject to funding). See also specific sections in this Annual Plan on Breast Screening, Cervical Screening and Bowel Screening.	9. Q1
New Zealanders have better cancer survival, supportive care and end-of-life care- He hiki ake i te o ranga	
10. Wairarapa DHB will continue to implement and report progress against our Bowel Cancer Service Improvement Plan (Bowel Cancer Quality Improvement Plan, 2020; Bowel Cancer Quality Improvement Report, March 2019). Locally, we will continue to work across the community raising the profile and awareness of bowel screening.	10. Q1-Q4: Quarterly report on progress
11. Revise and update our DHB Bowel Cancer Quality Service Improvement Plan following publication of the second national bowel cancer QPI's results in quarter 3 2020-21.	11. Q1-Q4: Quarterly report on progress
12. Develop a DHB Lung Cancer Service Improvement Plan based on the results of the Lung Cancer Quality Improvement Monitoring Report (QPIs 2020) and the impending national Lung Cancer Quality Improvement Plan (2021). • Wairarapa DHB will select the QPIs where our DHB is outside the national average (underperforming) to drive improvements. Lung cancer has been identified as a significant equity issue with incidence rates for Māori being significantly higher than non-Māori and health outcomes for Māori being significantly poorer (due to a combination of factors including late presentation and access barriers to out of region diagnostic	12. Q1-Q4: Quarterly report on progress

and interventional services). As a result of this, the Lung Cancer Service Quality Improvement Plan will incorporate a strong equity focus, identifying how service access and delivery can be improved for Māori specifically. **(EOA)**	
13. Develop a DHB Prostate Cancer Service Improvement Plan based on the results of the impending Prostate Cancer Quality Improvement Monitoring Report (QPIs 2021) and the impending national Prostate Cancer Quality Improvement Plan (2021). • Wairarapa DHB will select the QPIs where our DHB is outside the national average (underperforming) to drive improvements. Prostate cancer rates are higher for Māori than non-Māori and health outcomes for Māori are typically poorer. As a result of this the Prostate Cancer Service Quality Improvement Plan will incorporate a strong equity focus, identifying how service access and delivery can be improved for Māori specifically. **(EOA)**	13. Q1-Q4: Quarterly report on progress
14. Wairarapa DHB will ensure that the 31-day and 62-day cancer treatment wait time measures are met. Our DHB will implement service improvements to improve timely access and demonstrate effective engagement with Māori, Pacific, DHB Consumer Council and other key stakeholders that support local improvement initiatives.	14. Q1-Q4: Quarterly report on progress
15. We will work in partnership with Te Aho o Te Kahu and Ministry of Health to improve the FCT data quality and business rule changes as required.	15. Q1-Q4: Quarterly report on progress
Bowel screening and colonoscopy wait times	
Action(s) (include one action and milestone per row)	**Milestone(s)**
1. Whilst Māori participation is above national target, there remains a gap of 4.2% between Māori and non-Māori participation. A health navigator role is currently being established, and this role will focus on encouraging participation for Māori within Wairarapa, and identifying any local barriers that lead to non-participation which can be minimized to address the current equity gap. **(EOA)** a) Appointment of Health Navigator b) Achieve equity between Māori - Non Māori with participation rate >68.4%.	Q1 Q4
2. Participation in bowel screening at Wairarapa DHB continues to exceed the target of 60%, and is current 68%. A slight drop off has been noted, but nationally for DHBs currently providing bowel screening there has been a drop in participation over the last year. A review of communications, with a goal to **raise** the profile of bowel screening in the Wairarapa is currently underway. This will include (not limited to) regular promotional engagement stories, including participation data for inter-Wairarapa regions, multiple strategically placed	

billboards, images and resources featuring local champions supporting the programme, and regular features in the Health Matters bi-monthly health professionals newsletter. Bowel screening will continue to be promoted on mainstream and community radio, by way of advertising and hosted interviews, and a feature every second month in the Health Highlights health page in the Wairarapa Midweek and the Wairarapa Times Age print publications. a) Review current communications plan and increase promotional activities 3. Maintain delivery to target for Indicators 306 colonoscopy or CTC to be within 45 working days of positive FIT test.	Q1 Q1-4
Health workforce	
Action(s) (include one action and milestone per row)	**Milestone(s)**
1. ***Using our health workforce differently, both locally and regionally, as a result of the learnings from COVID 19*** a.) Planning is underway to implement a regional model for the delivery of identified secondary services. This would result in some clinicians working across regions/DHBs to deliver services where the patient is. b.) Undertaking a project to scope the feasibility of working in partnership with UCOL to co-develop an education/training facility for nurses on the WrDHB campus, providing hands on clinical experience. c.) Pilot of the Gateway Programme for Year 11 and 12 students to gain structured work experience in the Health Sector.	1. a.) Q1 – workforce models and cross DHB employment arrangements to support in place b.) Q1 – results of feasibility work known and plan developed if progressing. c.) Q1 - Pilot commences Q2 – Assess pilot and future Gateways Programmes
2. *Actions planned to engage with unions on* ***initiatives to increase workforce flexibility and mobility*** Develop and implement a flexible work policy and practice that supports wellbeing and workforce mobility.	2. Q2 – Policy and supporting practices developed and implemented Q4 – survey unions and staff on effectiveness of flexibility and wellbeing initiatives. Enhance practices based on feedback.
3. *Key actions* ***to increase the diversity of representation in leadership*** *or decision making roles* a) Enhancing the end to end recruitment process for leadership and decision making roles to ensure targeted recruitment strategies are developed that attract a diverse range of candidates and skills required for specific roles.	3. a) Enhanced recruitment practices including: Q1 - Tools developed i.e. targeted position descriptions, competency framework, advertising and interview guides/templates/strategies, supporting recruiting manager guides. Guides to include info and

	approaches to ensure we are optimizing, attracting and managing Māori and Pacifica candidates well. Q2 – Implementation – including recruiting manager training in tools and techniques. Q4 – increase in diversity stats noticeable, targets set for FY22/23.
b) Development of staff into leadership roles will be managed through our performance and development planning process. Individual development plans will be put in place for potential leaders with targeted training and/or development opportunities.	3. b)Q1 Q4 Ongoing
4. One or two key actions to drive sustained improvement in the number of professionals ***meeting standards of cultural competence and safety****.* a) Implementation of introductory cultural competency training for all staff that increases workforce awareness, capability and understanding to achieve equity.	4. a) Q2. Training in place Q4. All staff completed training
b) We will implement a survey for all staff 6 months after the completion of cultural competence training to assess the effectiveness and application of learnings. This assessment will be used to identify further needs and the appropriate plan developed.	4. b) Q4 Complete survey
5. Key actions to ***support the sustainability and the health and safety/wellbeing including mental wellbeing of our workforce.*** WrDHB have identified workforce wellbeing as a strategic priority for 2021. This will include the development of a wellbeing plan and offering with a strong focus on building resilience, valuing diversity and building a supportive culture.	5. Q1. Wellbeing plan with supporting programme of work in place including: -Tools and training for people leaders to increase their confidence and capability to actively manage the wellbeing of staff -Communications and values driven campaign focused on manaakitanga. Q4 – survey to measure effectiveness and enhance practice based on feedback.
6. Key actions to ***show how the DHB is ensuring work health and safety.*** Health and Safety at work is an integral part of Wairarapa DHB operations. The DHB is committed to improving health and safety across the health workforce.	

• WrDHB has subscribed to the Safe365 Health and Safety Maturity Assessment and Continuous improvement programme and will now focus on prioritising and integrating system improvements and embedding these within the DHB.	6. Q1 Add Safe365 benchmarking into H&S annual work plan to lock in continued monitoring. Q2 Complete Safe365 University on-line training for relevant staff to enable technical expertise on system methodology and software. Q3 Commence key stakeholder engagement on identified priority areas of system and formulate strategies to rectify.
Data and digital enablement	
Action(s) (include one action and milestone per row)	**Milestone(s)**
Supporting COVID-19 recovery Continued support, as required, to enhance our response to COVID – for example enablement of the COVID immunisation register and integration to support national rollout. **(3DHB)**	Alignment with the national rollout programme.
ePrescriptions solution implemented so as to allow outpatient prescriptions to be sent to the pharmacy of choice directly without need for paper forms or face to face contact when telehealth consults were used.	Initial rollout of ePrescriptions during Covid-19 pandemic 2020 with ongoing enhancements through our Community portfolio team. Further enhancements due to be completed by August 2021 with complete integration with MoH ePrescription service.
Delayed initiatives due to COVID-19 3DHB ICT were able to respond to the needs of the DHB with regard to our Covid-19 response without any significant delays to strategic initiatives and other work programmes.	
Most impact on improving outcomes **Implement 3DHB Clinical Portal – a new clinical portal shared by all three DHB's.** Patient safety and care quality improved by:	Q1 – Q4 Q3 20/21 - Business case signoff from MoH/DHB

- 3DHB patient data accessible in one location. - 3DHB patient data accessible in Central Region CP. - Cost reductions for the DHB's due to a shared infrastructure and simplified, supported solutions. - CDR centralisation. - 3DHB improved system resilience, availability and disaster recovery capability.	Q2 21/22 - Wairarapa module live Q2 Q3 21/22 - Hutt Valley module live Q4 21/22 - CCDHB module live
Implement 3DHB Smart eReferrals, intelligent scheduling and appointments platform Consolidate to common e-referrals platform between primary, community and ambulatory care services across 3DHB. Deliver smart referrals connected to health pathways and consider acute, equity and disability context of patient journey.	Q4 21/22 - Deliver ICT foundation capabilities and master data synchronisation End-to-end service enablement process design Implement primary and community referrals
Implement Mobile Electronic Patient Observations Patient safety and care quality improved by: - Reducing errors by removing paper charts and manual calculations - Immediate escalation of concerns based on observations to relevant clinicians - Reduction in effort required to capture observations. - Improved efficiency, as the mobile platform can be extended to other uses, such as drug charting, ordering, task management, results viewing and signoff.	Q1 21/22 - Business case submitted Q2 21/22 - Rollout to pilot teams Q3 21/22 - Rollout to all services
Most important for improving digital inclusion We will co-design healthcare access points and services with community and advocacy groups so that digital services are more widely accessible to all groups	Q2 21/22 - Mobilising our community workforce to ensure the right enablers are available.
Most important for improving equity **Community Networks & Integration of Care** ICT solutions will support implementation of the Community Health Networks by: • partnering with community groups and leaders to link into targeted, trusted sources of information so that patients can find content that makes sense to them, and they know what they need to do to stay healthy • providing a more joined up view of patient care records, care plans and care participants • enabling mobile solutions for the health workforce • providing access to referral and clinical systems.	Initiate primary care and 3DHB working group for shared electronic health record vision and plan Frame capability requirements for supporting community networks, neighbourhoods initiatives Community Nursing & Allied Health Mobility in the Community requirements

The Community Health Networks are focussed on improving equitable access and outcomes. They are designed to deliver coordinated health care closer to the community, address population specific needs, and avoid unnecessary visits to ED or the hospital.	• Q2 - Q4 Creation and maturity of locality based hubs and community networks • Q2 – Q4 Enablement of Mobility tools for community care workforce for • Q4 -Shared Care planning framework and toolkit – dependent in conjunction with shared care records work • Initiation of national child development services operating model. MoH led.

Implementing the New Zealand Health Research Strategy	
Action(s) (include one action and milestone per row)	**Milestone(s)**
1. COVID-19 Recovery Time critical COVID-19 research will be given a high priory for institutional review via an expedited process.	1. Q1-4
2. Implementation of NZ Health Research Strategy Wairarapa DHB commits to working with the Ministry of Health in a programme of work to support the implementation of the NZ Health Research Strategy.	2. Q1-4
3. Work regionally to further develop research & analytics networks • Work with our regional DHB partners and other research partners to create research and analytic networks. • Participate in and support research funded by the HRC in 2020 enhancing New Zealand's Clinical Trials (*Towards a national, equitable and sustainable clinical trial system in Aotearoa New Zealand).* **(EOA)**	3. Q1-4
4. Supporting staff to undertake research a) Develop relevant research policies and procedures for the Wairarapa DHB as required. b) Regular communication of national and international health research funding and training opportunities.	4. Q1-4
5. Produce an Annual Research Summary Update Report	5. Q4

2.5.7 Better population health outcomes supported by primary health care

Primary care	
Action(s) (include one action and milestone per row)	**Milestone(s)**
1. Implement a child health co-ordination service for 0 to 4 year olds with a focus on vulnerable children and in particular Māori and Pacific children. 2. Continue the implementation of the Health Care Home model including access to the patient portal and virtual appointments 3. Implement the National Hauora Coalition program "Equity generation 2040' (early pregnancy assessments) focusing on Māori women once tool is available for implementation	1. Q4 2. Q1 –Q4 3. Q1 – Q4
Pharmacy	
Action(s) (include one action and milestone per row)	**Milestone(s)**
1. Improve medicine information access to improve patient safety and reduce search time. 2. Commission clinical pharmacist service in general practices focusing on polypharmacy and optimum osteoporosis management, and on equity focused conditions. (This action links to the Implementation of the Healthy Ageing Strategy 2016 and Priority Actions 2019-2022.)	1. Q1 - Access to Concerto and Conporto enabled for all pharmacies. Q2 - Undertake pharmacist training on Concerto and Conporto. 2. Q1 - Procurement process completed. Q3 - Objectives, criteria and action plan developed and service started in 3 Practices. Q4 - 150 clinical pharmacist reviews for targeted at- risk group.
Reconfiguration of the National Air Ambulance Service Project – Phase Two	
Action(s) (include one action and milestone per row)	**Milestone(s)**
Support Phase Two of the process and outcomes with a focus on recognition that inter hospital transport involves DHB patients being moved by and under the supervision of DHB clinicians. Reconfiguration of this system must include; 1. The expertise of flight nurses and intensive care doctors who are skilled in assessment, management and co-ordination of the critically ill. 2. Continuity of the clinical expertise involved in the process of coordinating inter hospital transport of critically ill patients.	Q1 – Q4 Status report updates

3. Interoperability and compatibility of aircraft and stretcher systems used by DHB (ICU, NICU and PICU) teams, which is different to those in use in the prehospital domain. 4. Provision of tertiary critical care at the bedside within resource-limited in-patient secondary Hospital facilities.	
Long term conditions	
Action(s) (include one action and milestone per row)	**Milestone(s)**
1. COVID-19 Recovery / Learnings The DHB will work with primary care to implement identified opportunities from COVID-19 to increase the accessibility of primary care services, particularly for our Māori and Pasifika populations. This work will include: • Working with our PHO and Māori providers to ensure COVID-19 vaccine uptake is accessible for Māori, Pasifika and disabled people	1. Q2
2. Nutrition and physical activity The DHB will work with the PHO, RPH and providers to increase awareness and promote healthy nutrition and physical activity to prevent onset and promote the education and management of long-term conditions. This work will include: • PHO review of their self-management programmes • Promote and support Nuku Ora Strategy 2032 • Contract Māori Provider further develop Pae Ora diabetes self-management programme • Increased uptake of Year of Care Plans Activities in LTC section of plan	2. Q4
3. Early risk assessment Strengthen system pathways, particularly for Māori, Pasifika, and South East Asian. This work will include: • More patient-centred opportunities to ensure timely access to screening services • Improving referral pathways for specialist services Identifying and addressing gaps in provider education that will improve patient management	3. Q2 - Q4

4. Management of long term conditions Build on improving Health Care Home model of long-term condition management with a focus on, diabetes, gout and respiratory disease. This work will include: • Multi-disciplinary team meetings in primary care • Develop a co-designed, integrated diabetes model of care • Implement clinical pharmacist role based in primary care prioritising poly-pharmacy, gout, chronic kidney disease, diabetes, heart and respiratory health and hepatitis C pathways • Improving links between primary care and smoking cessation services across the region Further developing opportunistic screening services to complete Cardiovascular Disease Risk Assessment (CVDRA) checks in high risk Māori and Pasifika people	4. Q2 – Q4
5. Hepatitis C The DHB will work with primary care and wider community providers to identify opportunities to improve the health of the DHB population through access to Hepatitis C treatments by; • Prioritising hepatitis C activities throughout the Wairarapa on the 5 key focus areas outlined in the NZ Hepatitis C National Action Plan key focus areas. • Improving access and availability of Hep C point-of-care testing within the community; particular for the vulnerable and at-risk groups • Provision of education sessions for primary care to increase awareness and understanding of Hepatitis C particularly the availability of treatment • Prioritising Hepatitis C in primary care Clinical Pharmacist work plan	5. Q2 – Q4
6. Improving ASH rates (SS05) a) The DHB will identify opportunities to reduce ASH rates in top presenting conditions. This action will have a particular focus on our Māori and Pasifika populations This work will include: • A primary care early intervention respiratory wellness programme, including treatment pathways and self-management with a particular focus on those admitted to hospital in the previous 2 winters • Promotion of Primary Options for Acute Care (POAC) uptake for Māori and Pasifika patients	6. a)Q2 – Q4

b) The DHB will work with primary care to develop a new action model for brief advice to quit smoking. This model will support improved interactions in primary care and place greater emphasis on referral to smoking cessation services. This work will include: • Improving links between primary care and smoking cessation services across the region • Ensuring that the ABC cycle is still routinely initiated with patients in primary care and that every patient is asked about their smoking status in each interaction with the health system, with the message being constantly promoted • Evaluating the smoking targets and developing a plan to increase referrals to smoking cessation services. • Dedicated resource to provide cessation support to Māori women In addition to the above actions, please refer to our 2021/22 System Level Measure Plan, which includes actions to reduce ASH rates for 0 to 4 year olds, with a particular focus on Māori children and Pasifika children. **7. Contributory measures** 1. Reduction in hospital admission rates for patients known to be at higher than normal risk of admission 2. Improved quit smoking rates	6. b)Q2 – Q4

1.6 Financial performance summary

PROSPECTIVE FINANCIAL PERFORMACE FOR THE FOUR YEARS ENDED 30 JUNE 2022, 2023, 2024 AND 2025.

Statement of Comprehensive Income	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
	Audited Actual	Forecast	Plan	Plan	Plan	Plan
	$000	$000	$000	$000	$000	$000
Revenue						
Ministry of Health Revenue	166,285	181,871	193,809	199,765	204,688	209,733
Other Government Revenue	2,531	2,733	2,338	2,370	2,405	2,442
Other Revenue	10,338	12,203	12,849	12,982	13,191	13,402
Interest Revenue	69	62	69	70	71	72
Total Revenue	**179,223**	**196,869**	**209,065**	**215,187**	**220,355**	**225,649**
Expenditure						
Personnel	56,147	50,814	53,718	54,831	55,928	56,907
Outsourced Services	10,519	15,909	10,212	9,680	9,875	10,049
Clinical Supplies	12,591	13,120	13,192	12,890	12,992	13,010
Infrastructure and Non Clinical	10,785	10,584	10,594	10,387	10,457	10,459
Payments to Non-DHB Providers	57,446	61,111	66,140	68,818	70,883	73,187
Inter District Flows	41,404	44,797	53,014	54,286	55,915	57,732
Interest, Capital Charge, Depreciation and Amortisation	8,698	3,988	4,295	4,295	4,305	4,305
Total Expenditure	**197,590**	**200,323**	**211,165**	**215,187**	**220,355**	**225,649**
Surplus/(deficit)	**(18,367)**	**(3,454)**	**(2,100)**	**0**	**0**	**0**
Revaluation of land and buildings	**0**	**0**	**2,100**	**0**	**0**	**0**
Total Comprehensive Income/(Deficit)	**(18,367)**	**(3,454)**	**0**	**0**	**0**	**0**

PROSPECTIVE STATEMENT OF MOVEMENT IN EQUITY FOR THE FOUR YEARS ENDED 30 JUNE 2022, 2023, 2024 AND 2025.

Statement of Movements in Equity	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
	Audited Actual	Forecast	Plan	Plan	Plan	Plan
	$000	$000	$000	$000	$000	$000
Balance at 1 July	35,473	30,103	26,646	28,346	28,346	28,346
Net surplus / (deficit) for the year	(18,367)	(3,454)	(2,100)	0	0	0
Other comprehensive revenue and expense	0	0	0	0	0	0
Increase in revaluation reserve	0	0	2,100	0	0	0
Equity injection from the Crown	13,000	0	1,700	0	0	0
Repayment of equity to the Crown	(3)	(3)	0	0	0	0
Balance at 30 June	**30,103**	**26,646**	**28,346**	**28,346**	**28,346**	**28,346**

PROSPECTIVE SUMMARY OF REVENUE AND EXPENSE BY OUTPUT CLASS FOR THE FOUR YEARS ENDED 30 JUNE 2022, 2023, 2024 AND 2025.

Prospective Summary of Revenue and Expense by Output Class	2019/20 Audited Actual	2020/21 Forecast	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan
	$000	$000	$000	$000	$000	$000
Revenue						
Prevention Services	5,225	5,600	5,938	6,069	6,224	6,385
Early Detection and Management Services	29,335	32,430	32,460	35,397	35,900	36,218
Intensive Assessment and Treatment Services	113,801	126,184	137,387	138,294	141,915	145,807
Rehabilitation and Support Services	30,863	32,655	33,280	35,427	36,316	37,239
Total Revenue	179,224	196,869	209,065	215,187	220,355	225,649
Expenditure						
Prevention Services	5,756	6,092	6,682	6,883	7,058	7,242
Early Detection and Management Services	29,767	32,730	32,846	35,096	36,136	37,292
Intensive Assessment and Treatment Services	133,118	134,470	140,035	140,832	143,869	146,823
Rehabilitation and Support Services	28,950	27,031	31,602	32,376	33,292	34,292
Total Expenditure	197,591	200,323	211,165	215,187	220,355	225,649
Land and buildings revaluation not allocated	-	-	2,100	-	-	-
Consolidated Surplus / (Deficit)	(18,367)	(3,454)	0	0	0	0

PROSPECTIVE STATEMENT OF FINANCIAL POSITION (BALANCE SHEET) FOR THE FOUR YEARS ENDED 30 JUNE 2022, 2023, 2024 AND 2025.

Statement of Financial Position	2019/20 Audited Actual	2020/21 Forecast	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan
	$000	$000	$000	$000	$000	$000
Assets						
Current assets						
Cash & cash equivalents	5,920	4,750	767	1,720	2,603	3,186
Investments	85	83	83	83	83	83
Inventories	1,082	993	1,100	1,100	1,100	1,100
Trade & other receivables	5,922	6,734	5,600	5,400	5,100	5,100
Total current assets	**13,009**	**12,560**	**7,550**	**8,303**	**8,886**	**9,469**
Non-current assets						
Property, plant & equipment	44,976	45,291	50,795	51,148	51,497	51,845
Intangible assets	6,521	6,288	5,748	5,658	5,562	5,467
Total non-current assets	**51,497**	**51,579**	**56,543**	**56,806**	**57,059**	**57,312**
Total assets	**64,506**	**64,139**	**64,093**	**65,109**	**65,945**	**66,781**
Liabilities						
Current liabilites						
Payables, accruals and deferred revenue	15,441	18,132	15,055	15,735	15,735	15,735
Employee entitlements	18,311	18,704	20,035	20,371	21,207	22,043
Total current liabilities	**33,752**	**36,836**	**35,090**	**36,106**	**36,942**	**37,778**
Non-current liabilities						
Employee benefits (non-current)	566	566	566	566	566	566
Trust funds	85	91	91	91	91	91
Total non-current liabilities	**651**	**657**	**657**	**657**	**657**	**657**
Total liabilities	**34,403**	**37,493**	**35,747**	**36,763**	**37,599**	**38,435**
Net assets	**30,103**	**26,646**	**28,346**	**28,346**	**28,346**	**28,346**
Equity						
Crown equity	103,572	103,567	105,267	105,267	105,267	105,267
Revaluation reserve	11,234	11,234	13,334	13,334	13,334	13,334
Retained earnings	(84,703)	(88,155)	(90,255)	(90,255)	(90,255)	(90,255)
Total equity	**30,103**	**26,646**	**28,346**	**28,346**	**28,346**	**28,346**

PROSPECTIVE STATEMENT OF CASH FLOW FOR THE FOUR YEARS ENDED 30 JUNE 2022, 2023, 2024 AND 2025.

Statement of Cashflow	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
	Audited Actual	Forecast	Plan	Plan	Plan	Plan
	$000	$000	$000	$000	$000	$000
Cash flows from operating activities						
Operating receipts:						
Government & crown agency revenue	175,294	191,346	204,062	209,957	215,157	220,082
Other	4,684	5,293	5,364	5,361	5,428	5,495
Interest Received	68	61	69	70	71	72
Payments to suppliers & employees	(180,434)	(194,231)	(207,392)	(210,077)	(215,415)	(220,708)
Capital charge paid	(1,958)	(1,424)	(1,358)	(1,358)	(1,358)	(1,358)
Interest Paid	(9)	0	0	0	0	0
Goods and Services Tax (net)	184	144	(131)	200	200	200
Net cash flows from operating activities	**(2,171)**	**1,189**	**614**	**4,153**	**4,083**	**3,783**
Cash flows from investing activities						
Proceeds from sale of property, plant & equipment	0	60	0	0	0	0
Increase in Investments	0	6	0	0	0	0
Acquisition of property, plant & equipment	(1,687)	(1,789)	(5,688)	(2,150)	(2,150)	(2,150)
Acquisition of intangible assets	(1,291)	(633)	(609)	(1,050)	(1,050)	(1,050)
Net cash flows from investing activities	**(2,978)**	**(2,356)**	**(6,297)**	**(3,200)**	**(3,200)**	**(3,200)**
Cash flows from financing activities						
Equity injected	13,000	0	1,700	0	0	0
Equity Repaid	(3)	(3)	0	0	0	0
Repayments of loans	(139)	0	0	0	0	0
Movement in other Term liabilities	0	0	0	0	0	0
Net increase / (decrease) in cash held	**7,709**	**(1,170)**	**(3,983)**	**953**	**883**	**583**
Cash & cash equivalents at beginning of year	(1,789)	5,920	4,750	767	1,720	2,603
Cash & cash equivalents at end of year	**5,920**	**4,750**	**767**	**1,720**	**2,603**	**3,186**

Notes and Assumptions

General note

The -$2.1m 21/22 budget deficit includes $0.71m Holiday Act costs. Added back for this the 21/22 budget is -$1.49m. Please note that the 20/21 budget deficit was exclusive of Holidays Act costs. And, per the Ministry of Health instructions, we have now included the Holidays Act remediation provisioning in the budget.

Although final remediation payments may occur in 21/22, the 21/22 and out-years cash flow is exclusive of any Holidays Act remediation payments and the DHB would require substantial cash support (up to $10m at this point) to service these payments.

Where known, we have included COVID-19 incremental cost impacts in the plan, offset by the expected, associated, additional funding. Any additional COVID-19 costs impacts will be reported as a variance to budget.

Further to the above, the prospective financial performance, cash flows and equity movements for the years ended 30 June 2022, 2023, 2024 and 2025 represent our assumptions and expectations in light of currently available information only. These projections involve significant, mainly industry-wide, risks, variables and uncertainties that may likely cause actual performance to differ materially from those currently projected.

Key areas of risk and uncertainty, both in timing and value, involve DHB funding, Holiday Act remediation, MECA bargaining, pay equity flow on effects, CCDM recommendations, National managed contract renewals and equity injections, impairment of (in)tangible fixed assets etc.

On a local level, the scale and size of our DHB imposes a high sensitivity to unexpected changes in the type and volume of services provided, staff levels and remuneration, seismic remediation works and the state of our key (non) clinical assets.

Consequently, no guarantee is presented or implied as to the accuracy and achievability of specific forecasts, projections or predictive statements contained herein.

Capital Plan

The capital funding requirements for the Provider Arm will be met from operational cash flow and prioritised with the clinical leaders both within the cost centres and across the Provider Arm. The baseline CAPEX for 2021/22 of $5.8m includes IT/software $1.5m (which covers regional, sub-regional and local projects), Ministry of Health funded infrastructure projects $1.7m, non-clinical Infrastructure/building $1.1m, clinical and other equipment $1.3m.

Debt & Equity

Equity Drawing

Wairarapa DHB does not anticipate requiring any equity funding in 2021/22 with the planned deficit and capital expenditure being funded through available cash on hand and changes to working capital. However, this does not include Holidays Act remediation payments for which the DHB does require additional cash support to service these payments (up to $10m). Wairarapa DHB does anticipate $1.7m equity to fund the Ministry of Health approved $1.7m infrastructure capex projects.

Working Capital

The Board has a working capital facility with the Bank of New Zealand, which is part of the national DHB collective banking arrangement negotiated by NZ Health Partnerships Limited. This facility is limited to one month's provider's revenue, to manage fluctuating cash flow needs for the DHB.

Gearing and Financial Covenants

No gearing or financial covenants are in place.

Asset Revaluation

Wairarapa DHB revalued its land, building as at 30 June 2019. The revaluation was carried out by an independent Registered Valuer (CBRE Limited), which is consistent with the New Zealand Equivalent to International Public Sector Account Standard 17 Property, Plant and Equipment (PBE IPSAS 17).

It is planned to undertake a further valuation at 30 June 2022. It is expected that the buildings will retain their value so the budget for 2021/22 includes an adjustment of depreciation claimed since the last valuation was done.

Strategy for disposing of assets

The DHB regularly reviews its fixed asset register, and undertakes fixed asset audits in order to dispose of assets, which are surplus to requirements. This ensures that the DHB reduces its level of capital to the minimum consistent with the supply of contracted outputs.

Disposal of Land

All land that has legally been declared to be surplus to requirements will be disposed of following the statutory disposal process defined in the Public Works Act 1991, the Health Sectors Act 1993, the New Zealand Public Health and Disabilities Act 2000, the Reserves Act 1977 and the Māori Protection Mechanism Regulations set up to fulfil the Crown's obligations under the Treaty of Waitangi.

SECTION 3: Service Configuration

3.1 Service Coverage

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

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

Wairarapa DHB is not seeking any formal exemptions to the Service Coverage Schedule in 2021/22.

3.2 Service Change

The table below describes all active service changes that have been approved or proposed for implementation in 2021/22.

Wairarapa DHB confirms that it in 2021/22 it will manage its functions in a way that supports the intended direction of the health and disability sector system reforms and the anticipated system change programme.

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Integrated Diabetes Service	Develop a co-designed, integrated model of care for Diabetes services in Wairarapa. The co-design process will include Māori and Pasifika engagement to ensure the service is culturally responsive and delivers equitable outcomes.	• More integration across the primary care team • Consumer empowerment • Safe supply of medicines to the consumer • Improved support for at-risk populations • Improved patient experience • Improved responsiveness to Māori health • Improved health outcomes • Value for money	Local
Radiology Services	During 2021/22 we will be reviewing the provision of MRI services with the view to providing MRI services onsite in Masterton by January 2023.	• Improved health outcomes • Improved clinical sustainability • Address health inequities • Value for money • Improve access to services for our population	Local
Community Pharmacist Services	Review and implement changes to the Long Term Condition service provided by pharmacists, and the commissioning of pharmacist services to aged residential care.	• More integration across the primary care team • Consumer empowerment • Safe supply of medicines to the consumer • Improved support for at-risk populations • More use of pharmacists as first point of contact	Local

School Based Health	Move to single provider (Tu Ora) for all schools and support improvement in available wellbeing services for college pupils.	• Provides clinical governance structure for all college SBH provision • Supports local colleges to share resource to cover SBH if needed • Data sharing and IT systems and consistent across primary care and SBH • Stops the professional isolation of the School Nurse at Wairarapa College in particular • Wairarapa College are now able to employ counsellor / worker to focus on resilience and wellbeing, essential for trauma informed support in school	Local
Access to Local Services	During 2021/22 we will review the range, mix and level of local services provided, and how these services are currently configured in order for us to maintain financial and clinical sustainability, and meet health needs more equitably. This may result in implementation of some changes during 2021/22.	• Improved health outcomes • Improved clinical sustainability • Address health inequities • Value for money • Maintain access to services for our population.	Local
He Ara Oranga	Funding from MoH directly for implementation of recommendations from He Ara Oranga. Initial 6 months starting June 2021 for planning and development, then from early 2022 actual implementation across the sector	• Utilisation of central funding to ensure strategies identified in report are embedded over 2 year period	Local
Acute Care Continuum	A project to develop a new acute respite service commenced in 2019. This may result in commissioning a different range of services than currently funded, with potential review and updating or termination of some existing contracts.	• Integration between providers of acute care services • Improved access and responsive support for at risk service users and family / whānau • Address health inequities • Improved responsiveness to Māori health • Value for money	3DHB - Hutt, Capital & Coast, and Wairarapa
Podiatry Review Implementation	Implement the recommendations of the PHO led Podiatry Review.	• Increased focus on high risk feet • Improved value for money • Consistent and safe practice across the district • Focus on equity of access	Local
Wairarapa Māori Health Inquiry	The recommendations of the Inquiry will be due by Dec 2021 and will have implications across the	• Reduced inequity for Māori in regards to health outcomes	Local

	entire health system locally. Highly likely to require changes to investment, workforce and providership.	• Increased investment and prioritisation of Māori led health service delivery	
Iwi based Cultural Revitalisation	Increase the opportunities for Iwi based activities to increase Hauora Māori.	• A secure cultural identity is linked to better health outcomes for Māori • Iwi Māori also have dedicated resources toward cultural revitalisation.	Local
Grow Māori Health service provision	Continue to work alongside non-traditional service providers to improve the reach into Māori communities.	• Better and more targeted reach into Māori communities • More options on the ground for whānau to utilise and access health and social services	Local
Māori/Crown Service Commissioning	An MOU between Iwi and WrDHB to make joint decisions around commissioning health services across the district.	• Better use of limited resources • Opportunities to target and tailor funding for equity and Māori Health service provision • Increased opportunities for co-design and co-accountability	Local

FTE Reconciliation

The table below shows the movement in budgeted Full Time Equivalent (FTE) employees across the DHB between 2020/21 and 2021/22.

The decrease is mostly due to the transfer of MHAIDS staff (-41 FTE) and ICT staff (-8.3 FTE) to CCDHB who are the employer of these 3DHB services.

The balance are FTE changes related directly to ensuring safe service delivery - of that 3.9 FTE relate to CCDM increased nursing capacity, 4.9 FTE relate to funded programmes of work, 8 FTE relate to a planned establishment of a community team, 2 FTE clinical coordinator and privacy officer, 1FTE general medicine SMO, 1.6 FTE MRT, 0.8 FTE nurse practitioner, 1 FTE CCDM coordinator / respiratory nurse, 0.65FTE Maori / Pacifica Executive lead and cultural advisor.

	2020/21	2021/22	
Full Time Equivalent (FTE)	**Plan**	**Plan**	**Change**
Medical Employees	49	47	-2
Nursing Employees	255	241	-14
Allied Health Employees	81	78	-3
Support Employees	16	16	0
Management and Admin Employees	113	108	-5
Grand Total	**514**	**490**	**-24**

SECTION 4: Stewardship

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

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

4.1 Managing our Business

Regional Public Health (RPH)
Regional Public Health (RPH) is the public health unit for the sub-region (Wairarapa, Hutt Valley, and Capital & Coast DHBs). Organisationally, RPH is part of HVDHB. The three DHBs work in partnership with RPH in their work on health promotion/ improvement, enhancing the effectiveness of prevention activities in other parts of the health system, and regulatory services.

A key focus for 2020/21 is collaboration with RPH, PHOs and other community providers to leverage the investment and coordinate our health promotion activities to deliver collective impact on national and local priorities. Improving equity of outcomes for Māori, Pacific, and people on low incomes is a key focus of this work.

COVID-19 response and recovery: in 2020/21 COVID-19 had a significant impact on the delivery of RPH services as the lead public health agency in a pandemic response. For 21/22 COVID-19 response and recovery planning and implementation will continue to be a focus, working in partnership within health and other sectors. Examples include: implement/maintain capacity and capability for case finding, contact tracing (including national system changes), isolation of cases, quarantine of contacts work; maintain surge capacity; provide surveillance and analysis; implement health promotion strategies to support Māori, Pacific Peoples, disabled, and 'low-income' communities to achieve equitable well-being; and explore/implement new ways of working from based on our learnings.

Organisational performance management
Wairarapa DHB's performance is assessed on both financial and non-financial measures, which are measured and reported at various levels of the organisation, from unit level through to the Hospital Advisory Committee and the Board. These are reported daily, weekly, fortnightly, monthly or quarterly as appropriate.

Funding and financial management
Wairarapa DHB's key financial indicator is how we are tracking against our budget. This is reported through Wairarapa DHB's performance management process to the Executive Leadership Team and the Board. Further information about Wairarapa DHB's planned financial position for 2021/22 and out years is contained in the Financial Performance Summary section of this document in Appendix A: Statement of Performance Expectations.

Investment and asset management
Wairarapa DHB completed their first 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. Work is being done to update the plan manage execution going forward.

Shared service arrangements and ownership interests
Wairarapa DHB has a 16.67% shareholding interest in Central Region's Technical Advisory Services Limited and 0.79% shareholding interest in New Zealand Health Partnerships Ltd. The DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time.

Risk management
Wairarapa DHB has a formal risk management framework and robust reporting system. Risks are recorded on the Wairarapa DHB SharePoint Risk Register and monitored by risk owners, a report is collated and escalated to FRAC and the Board as required. 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
Wairarapa 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.

Health and safety
Health and Safety at work is an integral part of Wairarapa DHB operations. The DHB is committed to improving health and safety across the health workforce.

4.2 Building Capability

4.2.1 Capital and infrastructure development

The main hospital building was built in 2006 as part of the site redevelopment. The building was designed to meet the New AS/NZS1170 Building Standards (NBS) and it had been assumed that the facility would perform in relation to its function as such.
The main hospital facility is rated an Importance Level 4 Building (IL4). In this regards the facility itself is expected to meet 100% NBS and be serviceable after a 1:500 year Earthquake (i.e. operating at normal function within minutes to an hour post event.

As part of the new legislation, requiring Local Territorial Authorities to quantify the seismic compliance ratings of all priority buildings Wairarapa commissioned two separate engineering surveys of the main hospital facility in relation to the primary structure and the contained services of the hospital building. LGE Engineering Ltd and Clendon Burns Park Ltd undertook these reviews respectively.

The reports received by the DHB identified the main hospital building as requiring seismic remediation to meet its service and function requirements as an IL4 building rated overall at 34% NBS. It also identified significant issues specifically in relation to restraint of in-ceiling services rated provisionally at 15%.

The DHB completed, over the 2018/19 and 2019/20 years, restraint remediation for in-ceiling services and undertook remediation to the ambulance bay canopy to address the safety issues identified. In 2019/20 LGE engineering also undertook a detailed assessment of the hospital structure against both the IL4 standard to which the hospital was intended to be designed, and against the building code in force at the time the hospital was constructed. This report, on which a peer review was undertaken by BECA, showed that the hospital, as built, did not comply with the building code and that the defects were not restricted to the already remediated in-ceiling services.

The DHB has initiated legal proceedings against Masterton District Council, who issued the Code Compliance Certificate for the hospital, with a view to using any proceeds from the case to further remediate the hospital structure.

Health Infrastructure Investment Projects
As part of the governments $300m Health Infrastructure investment package announced in 2019/20, Wairarapa DHB expects to receive $1.7m. Of this, $800k is to be used to purchase a new mobile dental van and refurbish another existing mobile van. $900k is planned to be used as part of a reorganisation of hospital ambulatory services and the provision of office space for our Senior Medical Officers. These projects are planned to be completed in the 2021/22 year.

4.2.2 Training and development

High quality training and supervision of interns and RMOs is a strategic priority at Wairarapa DHB. Trainee Intern training (PGY1, PGY2 and RMO) will be offered and supported in 2020/21 as will Community Based Attachments (CBAs) given the DHB's regional setting and our close relationship with Primary Care Providers.

The Wairarapa DHB continues to support the development and placement of students and new graduates within the DHB in conjunction with supporting the wider community where possible. Initiatives include:

Nursing

- MOU in place with UCOL to support nursing student placement
- Employment of nursing students in Healthcare Assistant positions
- Dedicated unit to support new graduate nursing development
- New graduates employed in the community invited to DHB provided study days
- Diversity of new graduate workforce consider as part of new graduate in take

Allied, Scientific and Technical

- Provide placements for Allied, Scientific and Technical students
- Development of graduate program/orientation where applicable (i.e. sterile services and speech language)
- Ongoing Implementation of the Calderdale Framework
- Continued implementation of 3DHB Allied Health Career Framework

General support to encourage working in health is achieved by offering information at local school careers sessions.

Workforce

Building a sustainable workforce is one of the eight key actions identified within WrDHB Strategic Direction for the next 10 years. Our workforce is critical to ensuring we meet the evolving needs of our patients, community and wider health system.

Over the next three to five years WrDHB will focus on the following key capabilities needed to enable this:

- **Workforce** – enhancing and embedding fit for purpose recruitment and talent management tools, practices and capability, including a deliberate focus on developing our Māori workforce.
- **Leadership** – developing strong people and system leadership capabilities, with the ability to effectively lead change.
- **Organisational culture** anchored by our values – that enables the growth of a patient centric, resilient and agile workforce.

Co-operative developments

WrDHB works and collaborates with a number of external organisations and entities on the delivery of programmes and initiatives contributing to the Wairarapa health system. Key co-operative developments for 21/22 include WrDHB's ongoing relationships and/or partnerships with:

- UCOL for the training and placement support of nursing students
- CareerForce and their Gateway programme which provides work experience and exposure to support roles within the Health and Wellbeing sectors
- Kia Ora Hauora – supporting Māori into Health

4.3 Workforce

Listed below are the specific activities that will contribute toward building a sustainable workforce and the key capabilities needed in 21/22:

1. Building a sustainable workforce by:
   - Strengthening our recruitment processes and practices, including developing further pipelines for talent and enhancing the employment brand of Wairarapa DHB
   - Developing robust talent management practices, including strengthening our performance management and professional development practices

   (Refer Section 2 – Health Workforce, Actions 1 and 4)

2. Growing great leaders by:
   - Implementing a WrDHB wide leadership development programme that provides all leaders with a baseline of consistent frameworks and tools that support our values and Strategic Direction.
   - Implementing a fit for purpose leadership framework that develops leaders for their stage of career.

   (Refer Section 2, Health Workforce, Action 3)

3. Embedding our values with a focus on wellbeing by:
   - Integrating our values into everything we do i.e. leadership, performance management, recruitment, how we communicate
   - Developing and implementing a wellbeing plan that supports a resilient and well workforce
   - Implementing a flexible work policy and supporting practices

   (Refer Section 2, Health Workforce, Actions 2 and 5)

The five key areas outlined in 19/20 for Workforce still continue into the 20/21 period. These are:

1. Leadership Development
   a) Leading with Values-providing all leaders with the tools around DHB expectations.
   b) Identifying and implementing relevant leadership programs.
   c) Accelerating capability and skill.
2. Values & Recognition
   a) Embedding our values in everything we do
3. Wellbeing & Safety
   a) Developing a wellbeing focus and program within the organisation.
   b) Ensuring our values and culture support a safe work environment.
4. Culture and Behaviours
   a) Integrating our values into performance frameworks.
   b) Building constructive relationships.
   c) Including the voice of our patients in what we do.
5. Environment and Systems
   a) Making it easier to work at our DHB.
   b) Ensuring a quality start.
   c) Development of the payroll system to support data management and easier processes.

As an organisation we have also now landed on our key Values, these being:

Together we MAKE a difference

MANAAKITANGA **Respect**	We care for each other, showing kindness and empathy in all that we do
AUAHA **Innovation**	We are committed to finding future focused solution and take personal responsibility to be better every day
KOTAHITANGA **Relationships**	Our diversity is our strength, we back each other and work together in partnership
EKE TAUMATA **Equity**	We are committed to doing the right thing by ensuring equity and Hauora are at the heart of everything we do

These values integrate and underpin with the five areas of focus from a Workforce perspective. The challenge we have over the next 12 to 24 months is establishing a health service model that is successful in in attracting people to our DHB and region from a workforce perspective and then retaining them for the long term. As a DHB we need to be engaging with our regional peers and local businesses to be able to offer opportunities not only based in the DHB setting but also the wider local health sector and with those outside the health sector.

The DHB is continuing its journey to challenge how we do things as an organisation and support each other in the work environment. For transformation to occur everyone within the organisation needs to be engaged and invested in the work that is occurring. A key component of this is ensuring we focus on the diversity of our workforce and continue to build strong linkages with the work that is occurring via the Kia Ora Hauora Programme.

4.4 Information technology

Information technology and communications systems

Over the next financial year and beyond, 3DHB Data and Digital intend to continue its work in delivering high quality, fit for purpose digital tools to the DHBs and the wider health community.

As described in last year's annual plan, 3DHB Data and Digital have developed a new digital strategy, consisting of five major themes that inform our operating model for a modern data and digital business unit.

3DHB Data and Digital have a responsibility to support the DHB in delivering on its strategic goals as well as the expectations of the Minister of Health and the Ministry.

Whilst the DHB are primarily responsible for health outcomes within the greater Wellington region, we have responsibilities as the provider of tertiary services to lower North Island and upper South Island DHB as well as to our public health partners and other primary health providers and to the wider nation.

We work with our regional partners and at a national level to ensure that we leverage good thinking and existing solutions to reduce the national complexity and variety of Heath ICT solutions.

This is done by attending National CIO's meetings, meeting monthly with the Ministry of Health on the progress of our plans, and inclusion of regional participants in our architecture governance board where we ensure sound architectural decisions and consistency of solutions across the region.

A critical success factor will be the co-development of national health data interoperability standards. These standards will enable sharing of information across all DHBs thus achieving a virtual national health record.

The table below identifies which aspects of our digital strategy and work programmes aid the realisation of the DHBs strategic priorities and the expectations of the Crown.

Ministerial Expectations	DHB Strategic Priority	Data and Digital Strategic Theme
Giving practical effect to the Māori health action plan	Intensify service delivery for those who are vulnerable to reduce inequalities	Theme 4: Equity of access and health outcomes, especially for Māori, Pacific peoples and people with disabilities
Improving sustainability	Organise technology and interdisciplinary teams in homes, communities and hospital to ensure efficient use of resources Implement models of care that intervene earlier in lower cost settings	Theme 5: Empowering our workforce to deliver high quality, efficient care
Improving child wellbeing	Work in communities to improve health and wellbeing and prevent or delay the onset of illness	Theme 1: Health Options in our Communities
Improving mental health wellbeing	MHAIDS Service Improvement	Theme 1: Health Options in our Communities Theme 2: Empowering people as partners in their care
Improving wellbeing through prevention	Work in communities to improve health and wellbeing and prevent or delay the onset of illness	Theme 1: Health Options in our Communities Theme 2: Empowering people as partners in their care Theme 3L Seamless collaboration across our greater Wellington sub-region and wider health ecosystem
Better population outcomes supported by a strong and equitable public health and disability system	Intensify service delivery for those who are vulnerable to reduce inequalities	Theme 3: Seamless collaboration across our greater Wellington sub-region and wider health ecosystem
Better population health and outcomes supported by primary care	Work in communities to improve health and wellbeing and prevent or delay the onset of illness	Theme 2: Empowering people as partners in their care

3DHB Data and Digital continue to upgrade and update our legacy technology as we shift towards enabling better health care for our region. This means improving the resiliency of our supporting infrastructure in the advent of a disaster, shifting away obsolete voice technology towards unified communications, addressing gaps in cyber security to protect our systems and information as well as increasing awareness of cyber security risks.

We continue to progress our programme of consolidation of disparate bespoke solutions across the Wellington regional DHBs. Key initiatives such patient administration systems (WebPAS) consolidation which will enable centralised and consistent patient management. We are also consolidating the clinical portals (Concerto) that will enable better patient care and cost efficiencies.

There has to be increased focus on the corporate systems and the tools needed to run an effective health service. We are working with the corporate functions across the three DHBs to standardise the tools and systems.

3DHB Data and Digital has selected its four critical initiatives for inclusion into the 2021/22 annual plan. These initiatives are focused on achieving stability of existing critical clinical and corporate systems, bringing

significant improvements to operational efficiency, improving patient care, transforming services to be fully digital, and Ministry / Minister Directives.

There are other supporting initiatives in our capital plans across the three DHBs we support which are not included here. We have not included our BAU support activity which underpins existing health services provided by the three DHB's.

In addition 3DHB Data and Digital are actively supporting the DHBs with regard to their Covid-19 response and improving systems to support any further community outbreaks and potential lockdowns. The Digital Workplace programme is particularly important in this area as this will further our workforce to work remotely.

What this plan does not allow for is the significant increase of ICT resources to support a modern health service and the change programme required to achieve the aspirations of the Minister and Ministry of Health.

Key Activities for 2021/22

3DHB Data and Digital, in conjunction with the Digital & Data Intelligence Governance Group have identified two main programmes of work which deliver on our digital strategy. These programmes of work both improve the stability and resiliency of our existing clinical and corporate systems and bring significant improvements to operation efficiency, improve patient care and move services towards being fully digital.

These programmes of work, support our need to support our regional and national partners in health care, though ensuring interoperability, data sharing and digital means of accessing the services our DHB's provide.

Underpinning all of this work are changes to our delivery model, improvements to the way we procure, deliver and support the services we provide through a combination of partnering with specialists and outsourcing low level operations so our staff can focus on delivering high quality systems.

The programmes of work are described below:

Clinical Workspace Programme

The Clinical Workspace programme aims to deliver on five primary projects which intend to modernise and mobilise systems within the hospital system and enable our community providers.

These projects are as follows:

3DHB Clinical Portal – a new clinical portal shared by all three DHBs. The value to the business and to our communities by ensuring patient data is accessible in one location and able to be accessed through the central region clinical portal, supported by increased resilience, availability and disaster recovery.

3DHB Éclair – consolidating 3DHB laboratory ordering, processing and sign-off, which provides value through laboratory data accessible in one location via the 3DHB Clinical Portal and available to the central region. Reduced costs for the DHB through shared infrastructure and increased resilience.

ePrescribing for Outpatients an electronic prescribing tool whose value includes, patient safety and care quality improvement and more convenience for patients when collecting prescriptions combined. The tool also ensures our compliance with the Medicines Act and is integrated into our 3DHB Clinical Portal.

3DHB Regional Radiology Information System replacing our existing aging and out of support radiology information system which is currently posing significant risk and adds additional value through shared infrastructure and simplified, supported solutions and the ability to outsource clinical investigations and/or reporting between both DHB's and external partners.

Mobile Clinical Platform (MEPO), a new mobile platform, initially for the purposes of electronic observations, early warning scores, nursing assessments and clinical photography – but with the scope to replace other manual and paper based systems though a mobile phone interface. Expected to deliver new value to the DHB's though clinical efficiencies, reduction in errors seen with manual paper charts and provides extensibility to other functions such as ordering, results viewing and signoff, electronic drug charting and administration.

3DHB eReferrals for Primary, Community and Ambulatory Care provides a smart eReferrals, intelligent scheduling and appointment platform, this provides for patient safety and care quality improvements, shared infrastructure and simplified, supported solutions, integration into the 3DHB Clinical Portal as a single source of digital information.

Digital Workplace Programme

The Clinical Workspace programme has four focus areas to transform the digital environment within the organisation. Focussing specifically within the non-clinical space, the projects aims are to deliver a modern digital desktop and devices, with robust information management practices together with modern collaboration and communication tools supported with strong change management and training.

Modern Devices, Desktops and Office

Delivers devices to staff which meet their requirements with regard to form factor and capability. Implements managed, modern Windows 10 environment with O365 including Teams, SharePoint and OneDrive. Allows for access to the same IT resources across multiple device types, enhanced user experiences with information easy to find and provides for flexible working options creating better outcomes for pandemic response, staff mobility, morale and operational efficiency.

Digital Foundations

Delivers the foundational infrastructure and improved policy and system configuration to support the rollout of the new modern way of working through new remote access solutions to support seamless end user experience whether working in the office or remotely, improved on campus Wi-Fi to support predominantly mobile workforce with high degree of security and ensuring that the right individuals have the appropriate access to technology resources together with improved protection of our data assets and our Identities from malicious actors.

Unified Communications

Replaces legacy PBX systems with cloud based contact centre platform, new IP based telephony end points for critical areas and MS Teams based Telephony (chat, calling, and conferencing) for individual users by de-risking the DHB's communications systems failure by replacing aged telephony systems (PBXs), improving availability and functionality of critical communication services and enhances organisational resilience and ability to respond to emergency scenarios (e.g. pandemic/earthquake) with capability to support fully mobile workforce.

Information Management

Implements good Information Management practice ensuring data is correctly categorised, retained and easily searchable where, staff are able to access and locate the right information they need and when they need it. Makes the data easily searchable and accessible to relevant staff and solution that meets our obligations under the Public Records act. Reduces the number of duplicated tools which will reduce costs to maintain, update and support and increases the ability to utilise cross-functional and cross sector teams to address health system challenges.

Resilient Systems

To ensure that DHB systems continue to function with minimal downtime and that data on these systems is can be restored in the event of data loss 3DHB data and digital have a number of projects currently underway and planned for the next financial year. These projects include:

- Improving resilience of clinical and corporate systems and staff productivity through replacement and increasing the availability of PCs, Tablets, Laptops, Terminals, & Screens.
- Improve information security through implementation of tools such as threat detection and auditing, this includes all security systems with an ICT component, improving resilience and performance of clinical and corporate systems through replacement of aged ICT servers and a planned migration of DHB systems as a service offerings.

Additionally we will maintain stable, secure systems by ensuring our aged network equipment is replaced.

We are in the process of updating our backup and recovery system so ensure that our data is safe and can be easily retrieved in a reliable and cost effective manner.

Lastly, we have a programme for the continuous upgrading of clinical and corporate systems ensuring these systems are up to date and in support.

Regional/National Systems

3DHB ICT continue to contribute to regional and national systems, in particular we to support the regional clinical portal via data sharing, regional WebPAS and Regional Radiology Information System (RRIS) work through TAS.

As stated above, within the Clinical Workspace programme we will be delivering the RRIS platform into the three Wellington regional DHBs over the course of the next year.

The DHB will be supporting and aligning our technology decisions to support national programmes, including the National Health Informatics Platform (NHIP_HIRA) as well as the NHI and HCP systems through the adoption of Application Programming Interface (API's) and the use of interoperability standards such as FHIR (Fast Healthcare Interoperability Resources).

Support and Maintenance

Capabilities within our support and maintenance team will be enhanced through partnering with suppliers and vendors. Alternative models of delivery are being examined, which includes "as a service" models for device management, networks and other services.

As part of the 3DHB Data and Digital restructure we have entered in to a service level agreement for the provision of services to Hutt Valley and Wairarapa DHB so as to ensure their critical systems are kept operational and in support at the levels they expect.

SECTION 5: Performance Measures

5.1 2021/22 Performance Measures

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

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

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

Performance measure		Expectation		
CW01	Children caries free at 5 years of age	Year 1	68 %	
		Year 2	68 %	
CW02	Oral health: Mean DMFT score at school year 8	Year 1	<0.51	
		Year 2	<0.51	
CW03	Improving the number of children enrolled and accessing the Community Oral health service	Children (0-4) enrolled (≥ 95 percent of pre-school children (aged 0-4 years of age) will be enrolled in the COHS)	Year 1	≥ 95%
			Year 2	≥ 95%
		Children (0-12) not examined according to planned recall (≤ 10 percent of pre-school and primary school children enrolled with the COHS will be overdue for their scheduled examinations with the COHS.)	Year 1	≤ 10%
			Year 2	≤ 10%
CW04	Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	Year 1	≥ 85%	
		Year 2	≥ 85%	
CW05	Immunisation coverage at eight months of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	95% of eight-month-olds olds fully immunised.		
		95% of five-year-olds have completed all age-appropriate immunisations due between birth and five year of age.		
		75% of girls and boys fully immunised – HPV vaccine.		
		75% of 65+ year olds immunised – flu vaccine.		
CW06	Child Health (Breastfeeding)	70% of infants are exclusively or fully breastfed at three months.		
CW07	Newborn enrolment with General Practice	The DHB has reached the "Total population" target for children enrolled with a general practice by 6 weeks of age (55%) and by 3 months of age (85%) and has delivered all the actions and milestones identified for the period in its annual plan and has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group, for both targets.		

CW08	Increased immunisation at two years	95% of two-year-olds have completed all age-appropriate immunisations due between birth and age two years.		
CW09	Better help for smokers to quit (maternity)	90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.		
CW10	Raising healthy kids	95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.		
CW12	Youth mental health initiatives	Focus area 1 (Youth SLAT): Provide reports as required		
		Focus area 2 (School Based Health Services): Provide reports as required		
		Focus area 3: (Youth Primary Mental Health services) refer MH04		
MH01	Improving the health status of people with severe mental illness through improved access	Age (0-19)	Māori	6.00%
			Other	4.06%
			Total	5.05%
		Age (20-64)	Māori	12.00%
			Other	5.50%
			Total	6.65%
		Age (65+)	Māori	4.20%
			Other	2.25%
			Total	2.36%
MH02	Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan.		
		95% of audited files meet accepted good practice.		
MH03	Shorter waits for mental health services for under 25-year olds	Provide reports as specified		
MH04	Rising to the Challenge: The Mental Health and Addiction Service Development Plan	Provide reports as specified		
MH05	Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.		
MH06	Output delivery against plan	Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.		
MH07	Improving the health status of people with severe mental illness through improved acute inpatient post discharge community care	Provide reports as specified		

PV01	Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall.		
PV02	Improving cervical screening coverage	80% coverage for all ethnic groups and overall.		
SS01	Faster cancer treatment – 31 day indicator	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.		
SS03	Ensuring delivery of Service Coverage	Provide reports as specified		
SS04	Delivery of actions to improve Wrap Around Services for Older People	Provide reports as specified		
SS05	Ambulatory sensitive hospitalisations (ASH adult)	2,806 per 100,000		
SS06	Better help for smokers to quit in public hospitals (previous health target)	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.		Only applies to specified DHBs
SS07	Planned Care Measures	Planned Care Measure 1:		TBC
		Planned Care Interventions		
		Planned Care Measure 2:	ESPI 1	100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less)
		Elective Service Patient Flow Indicators	ESPI 2	0% – no patients are waiting over four months for FSA
			ESPI 3	0% - zero patients in Active Review with a priority score above the actual Treatment Threshold (aTT)
			ESPI 5	0% - zero patients are waiting over 120 days for treatment
			ESPI 8	100% - all patients were prioritised using an approved national or nationally recognised

				prioritisation tool
		Planned Care Measure 3: *Diagnostics waiting times*	Coronary Angiography	95% of patients with accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)
			Computed Tomography (CT)	95% of patients with accepted referrals for CT scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).
			Magnetic Resonance Imaging (MRI)	90% of patients with accepted referrals for MRI scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).
		Planned Care Measure 4: *Ophthalmology Follow-up Waiting Times*	No patient will wait more than or equal to 50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service.	
		Planned Care Measure 5: *Cardiac Urgency Waiting Times*	N/A for Wairarapa DHB. All patients (both acute and elective) will receive their cardiac surgery within the urgency timeframe based on their clinical urgency.	
		Planned Care Measure 6: *Acute Readmissions*	The proportion of patients who were acutely re-admitted post discharge improves from base levels.	10.5%
		Planned Care Measure 7:	Note: There will not be a Target Rate identified for this measure. It will be	

		Did Not Attend Rates (DNA) for First Specialist Assessment (FSA) by Ethnicity (Developmental)	developmental for establishing baseline rates in the 2020/21 year.	
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (causing duplication)	>1.5% and <=6%
			Recording of non-specific ethnicity in new NHI registration	>0.5% and < or equal to 2%
			Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% and < or equal to 2%
			Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and < or equal to 85%
			Invalid NHI data updates	Still to be confirmed
		Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC and NMDS for FSA and planned inpatient procedures.	Greater than or equal to 90% and less than 95%
			National Collections completeness	Greater than or equal to 94.5% and less than 97.5%
			Assessment of data reported to the NMDS	Greater than or equal to 85% and less than 95%
		Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)		Provide reports as specified
SS10	Shorter stays in Emergency Departments	95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.		
SS11	Faster Cancer Treatment (62 days)	90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.		
SS12	Engagement and obligations as a Treaty partner	Reports provided and obligations met as specified		
SS13	Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	Focus Area 1: Long term conditions	Report on actions, milestones and measures to:	
			Support people with LTC to self-manage and build health literacy.	

		Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care*.
			Ascertainment: target 95-105% and no inequity
			HbA1c<64mmols: target 60% and no inequity
			No HbA1c result: target 7-8% and no inequity
		Focus Area 3: Cardiovascular health	Provide reports as specified
		Focus Area 4: Acute heart service	**Indicator 1: Door to cath** - Door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram.
			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.
			Indicator 3: ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (i.e. have had an echocardiogram or LVgram).
			Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator in the absence of a documented contraindication/intolerance ≥85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge - Aspirin*, a 2nd anti-platelet agent*, and an statin (3 classes) - ACEI/ARB if any of the following – LVEF ,50%, DM, HT, in-hospital HF (Killip Class II to IV) (4 classes), - Beta-blocker if LVEF<40% (5-classes). * An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.
			Indicator 5: Device registry completion ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS-QI Device PPM forms completed within 2 months of the procedure.
			Indicator 6: Device registry completion- ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device PPM (Indicator 5A) and ICD (Indicator 5B) forms within 2 months of the procedure.

		Focus Area 5: Stroke services Provide confirmation report according to the template provided	**Indicator 1** ASU: 80% of acute stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital
			Indicator 2 Reperfusion Thrombolysis /Stroke Clot Retrieval: 12% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile, (Service provision 24/7)
			Indicator 3: In-patient rehabilitation: 80% patients admitted with acute stroke are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission
			Indicator 4: Community rehabilitation: 60% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.
SS15	Improving waiting times for Colonoscopy	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less 100% within 30 days or less.	
		70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less.	
		70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less.	
		95% of people who returned a positive FIT have a first offered diagnostic date that is within 45 working days or less of their FIT result being recorded in the NBSP IT system.	
SS17	Delivery of Whānau ora	Appropriate progress identified in all areas of the measure deliverable.	
PH01	Delivery of actions to improve SLMs	Provide reports as specified	
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers	All PHOs in the region have implemented, trained staff and audited the quality of ethnicity data using EDAT within the past three-year period and the current results from Stage 3 EDAT show a level of match in ethnicity data of greater than 90 percent.	
PH03	Access to Care (PHO Enrolments)	The DHB has an enrolled Māori population of 95 percent or above	
PH04	Primary health care: Better help for smokers to quit (primary care)	90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	
Annual plan actions – status update reports		Provide reports as specified	

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

E94

Wairarapa District Health Board

Statement of Performance Expectations 2021/22

Presented to the House of Representatives pursuant to section 149(L) of the Crown Entities Act 2004.

2021/22 Statement of Performance Expectations including Financial Performance

This Statement of Performance Expectations (SPE) is a requirement of the Crown Entities Act 2013 and serves three purposes:

1. To allow the responsible Minister to participate in setting the annual performance expectations of the Wairarapa DHB
2. To provide parliament with information on these expectations, and
3. To provide a base against which actual performance can be assessed. The actual results of service performance against what was forecast here will be published in our 2021/22 Annual Report.

Board Statement

In signing this statement, we acknowledge that we are responsible for the information contained in the Statement of Performance Expectations (SPE) for the Wairarapa District Health Board.

This information has been prepared in accordance with the requirements of the Crown Entities Act 2004. The SPE sets out our performance expectations for the period from 1 July 2021 to 30 June 2022.

Signed on behalf of the Board

Sir Paul Collins
Board Chair

Date: 25 June 2021

Dr Tony Becker
Deputy Chair

Date: 25 June 2021

Output class measures

Four Output Classes are used by (all) DHBs to reflect the nature of services provided. These are as follows:

1. **Prevention services:** publicly funded services that protect and promote health in the whole population.
2. **Early detection and management:** services delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings including general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.
3. **Intensive assessment and treatment:** generally hospital services including Emergency Departments, ambulatory services (outpatients, district nursing and day procedures) and inpatient services (acute and planned care).
4. **Rehabilitation and support:** services delivered following a 'needs assessment' process and co-ordination input by NASC Services including palliative care, home-based support and residential care services.

The aim of selecting output measures within each class for inclusion in the SPE is to ensure that the SPE meaningfully supports the key strategic priorities of the Wairarapa DHB's planned activities as outlined in the earlier Sections of this Annual Plan, and provides representative information about the vast scope of business as usual services we provide in support of our strategic goals.

In identifying appropriate output measures[2] within each output class we have included, in addition to volume measures, a mix of measures that help us evaluate different aspects of our performance. These measures indicate performance against service coverage (encompassing health equity) quality, volume (quantity) and timeliness. The intervention logic is depicted in Figure 1.

Some performance measures are demand-based and are included to provide a picture of the services funded and/or provided by the Wairarapa DHB. For such measures, there are no assumptions about whether an increase or decrease is desirable. As such, the "target" represents an estimation of the service delivery for 2021/22 based on historical and population trends.

The following tables provide baselines, forecasts and targets for each output area.

Reference key			
HT	(National) Health Target*	C	Coverage
SLM	System Level Measure*	V	Volume (quantity) measure
PP	Policy priority measure*	Q	Quality measure
SI	System Integration measure*	T	Timeliness measure
OP	Output measure*		
OS	Ownership measure*		*These measures are part of the National non-financial performance monitoring framework.
DV	Development measure*		
WPI	Wairarapa DHB performance indicator		
3DHB[3]	3DHB performance indicator (Capital & Coast DHB, Hutt Valley DHB, Wairarapa DHB)		

[2] Some performance measures show health indicators by locality, i.e. the people who live in the Wairarapa DHB's catchment, while other measures show performance of the services provided by Wairarapa DHB regardless of the service user's home district.

[3] Some measures show combined data for all 3 DHBs; Wairarapa, Hutt Valley and Capital & Coast, most often where services are provided on a sub-regional basis and data is not disaggregated by DHB. These measures are indicated in the tables as (3DHB).

Figure 1 – Intervention logic map for Wairarapa DHB SPE Output classes.

National	**NZ Health System intended outcomes:** **New Zealanders live longer, healthier and more independent lives.**			
Central Region Triple Aim	In the Central Region we aim to achieve: • Improved health & equity for all populations • Improved quality, safety & experience of care • Best value for public health system resources			
DHB vision	**Better health for all**			
System level health outcome measures	**For the Wairarapa success will mean:** • Improved health equity - reduced outcome disparity in system level measures • Reduction in Ambulatory sensitive hospital (ASH) admissions 0-4 yr olds and age 45-64 • Reduction in amenable mortality rates • Reduction in Acute Hospital bed days per capita • Improved scores across domains of the patient experience survey • Increase in number of babies in smoke-free homes at 6 weeks • Improved youth health – reduced hospitalisations for self-harm and increased chlamydia testing			
Impacts How we measure our progress.	• Increased and more equitable number of babies who live in smoke-free households. • More babies breastfed. • More adults and pregnant women offered help to quit smoking. • High proportion 8-month old immunised equitably across ethnicities. • Improved and more equitable oral health for children. • More women screened for breast and cervical cancers equitably across ethnicities.	• More adults referred to Green Prescription program. • Increased and more equitable number of patients enrolled in PHOs. • More people assessed for CVD risk equitably across ethnicities. • Improved access to mental health and addiction services. • Reduced Rheumatic Fever (first) hospitalisation rates. • More patients attend planned appointments equitably across ethnicities.	• Shorter stays in our Emergency Department. • Shorter and equitable waiting time for cancer diagnosis and treatment. • Timely access to planned elective services. • Proportion of older people receiving long term support that are comprehensively clinically assessed (inter RAI). • Number of people registered with Disability Alert.	
DHB intended outcomes	• Environmental and disease hazards minimized • Lifestyle factors affecting health well managed • Children have a healthy start in life • Long term conditions well managed • Improved health, wellbeing & independence of our older people		• Responsive services for people with disabilities • People receive high quality hospital and specialist health services when needed • People receive high quality mental health services when needed • Reduced health disparities	
Outputs Services provided	**Prevention** • Health protection & regulatory services • Health promotion & education • Pop-In health screening • Immunisation • Smoking cessation	**Early Detection & Management** • Primary health care • Oral health • Community care • Pharmacy services • Diagnostics	**Intensive Assessment & Treatment** • Mental Health & Addictions services • Elective and acute medical and surgical services • Cancer services • Maternity	**Rehabilitation & support** • Disability services • Health of older people • Age-related residential care • Needs assessment • Home based care • Palliative care
Inputs	People & knowledge	Collaborative partnerships	Quality systems & processes	Technology	Facilities	Funding	Risk management

Output class 1: Prevention Services

Prevention services

- Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.
- Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing.
- Preventative services 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; and, population health protection services such as immunisation and screening services.
- On a continuum of care these services are public wide preventative services.

Outputs measured by	Note		Target/Est. 2021/22	Baseline	Baseline data date
Health promotion and education					
Number of adult referrals to the Green Prescription program.	V	WPI	≥ 250	243	19/20 Q4
Smoking cessation					
Percentage of PHO enrolled patients who smoke and have been offered help to quit smoking by a health care practitioner in last 15 months.	C	PH04	≥90%	87%	2020/21 Q1
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or LMC being offered brief advice and support to quit smoking.	Q	CW09	≥90%	100%	2020/21 Q1
Babies living in Smokefree Homes at 6 weeks post-natal	Q	WPI	Total ≥70% Māori ≥50% Pacific ≥50%	Total 59% Māori 40% Pacific 64%	Average of Q2 & Q4 2019 and 2020
Immunisation					
Percentage of 8-month olds fully vaccinated	C	W08	≥95%	Total 89.9% Māori 89.5% Pacific 85.7% Other 90.0%	2020/21 Q2
Percentage of 5-year olds fully immunised	C	CW05	≥95%	Total 93.5% Māori 96.0 % Pacific 100% Other 89.4%	2020/21 Q2
Percentage of year 7 children provided Boostrix vaccination in Wairarapa district.	C	WPI	≥95%	Total 92% Māori 94% Pacific 113% Other 90%	2019/20 Q4
Percentage of girls and boys fully immunised – HPV vaccine.	C	CW05	≥75%	Total 66% Māori 67% Pacific 76% Other 66%	2019/20 Q4
Percentage of people aged 65+yrs who have completed their annual influenza immunisation.	C	CW05	≥75%	Total 77% Māori 63% Other 78%	2020/21 Q1
Breastfeeding					

Outputs measured by	Note		Target/Est. 2021/22	Baseline	Baseline data date
Percentage of infants fully or exclusively breastfed at 3-months.[4]	Q	CW06	≥70%	Total 59% Maori 44% Pacific 67%	Q3 20/21
Population based screening services					
Percentage of obese children identified in the Before School Check (B4SC) programme offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.	C	CW10	≥95%	Other 92% Māori 100%	2020/21 Q2
Percentage of eligible women (25-69 years) having cervical screening in last 3 years.	C	PV02	>80%	Total 70% Māori 70% Pacific 63% Other 70%	2020/21 Q1
Percentage of eligible women (50-69 years) having breast screening in the last 2 years.	C	PV01	>70%	Total 69% Māori 65% Pacific 64% Other 69%	2020/21 Q1

[4] This measure is based on all WCTO providers (not just Plunket).

Output class 2: Early detection and management

Early detection and management

1. 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. Include general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.
2. These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.
3. On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

Outputs measured by	Note		Target/Est. 2021/22	Baseline	Baseline data date
Primary Care services / Long term conditions management					
Newborn enrolment with General Practice	C	CW07[5]	≥85%	Total 92.9% Māori 74.0% Pacific NA Other 105%	Dec 2020
Percentage of DHB-domiciled population enrolled in a PHO.	C	WPI	All ethnicities 100%	Total 97% Maori 93% Pacific 96% Other 98%	Jan-21
ASH Rates (avoidable hospitalisations) for 0-4 years (rate per 100,000)	Q	WPI	Total ≤ 4,000 Māori ≤ 4,000 Pacific NA Other ≤4,000	Total 4,323 Māori 4,574, Pacific NA Other 4,208	12 months to Sep 2020
ASH Rates (avoidable hospitalisations) for 45-64 years	Q	SS05 (WPI)	Total ≤ 3,000 Māori ≤ 5,000 Pacific NA Other ≤2,500	Total 3,203 Māori 5,548 Pacific NA Other 2,883	12 months to Sep 2020
Percentage of DHB-domiciled population (15-74 yrs) enrolled in a PHO with well managed diabetes (HbA1c ≤ 64 mmol/mol)	C	SS13 FA2	≥60%	Total 59% Māori 53% Pacific 58% Other 61%	2020/21 Q2
Oral health					
Children Carries Free at 5 years of age	Q	CW01 (WPI)	Total ≥68%	Total 67% Māori 41% Pacific 45% Other 77%	2020/21 Q3
Mean DMFT (Decayed, Missing, and Filled Teeth) score at school year 8. (This is the average number of decayed, missing or filled teeth per person at school yr 8)	Q	CW02 (WPI)	Total <0.51	Total 0.54 Māori 0.99 Pacific 0.08 Other 0.37	2020/21 Q3
Percentage of children under 5 years enrolled in DHB-funded dental services.	C	CW03	≥95%	Total 92% Māori 83% Pacific 81% Other 98%	2020/21 Q3

[5] Also a Well Child/Tamariki Ora Quality Improvement Framework Indicator (number 11) - with a national target of ≥90%.

Output class 3: Intensive assessment and treatment

Intensive Assessment and Treatment services

- 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 specialized 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 focussed on individuals.

Outputs measured by	Note		Target/Est. 2021/22	Baseline	Baseline data date
Mental Health and Addiction services					
Percentage of patients referred to non-urgent mental health services & seen within 8 weeks.	T	MH03	≥95%	87.7%	2020/21 Q2
Percentage of patients referred to non-urgent Addiction services & seen within 8 weeks.	T	MH03	≥95%	98.4%	2020/21 Q2
Percentage of clients with transition (discharge) plan	C	MH02	≥95%	50%	2020/21 Q2
Percentage of people discharged from an acute mental health inpatient service that were seen by the mental health community team in the 7 days following discharge.	Q	WPI	≥90% (Nat'l ≥90%)	78.1%	2020/21 Q3
Elective and Acute (Emergency Dept.) inpatient/outpatient					
Number of surgical elective discharges.	V	SS07 (PCM1)	≥3,404	2,276	2020/21 Q2
Percentage of patients admitted, discharged or transferred from ED within 6 hours.	T	SS10	≥95%	91.3%	2020/21 Q2
Standardised inpatient average length of stay ALOS (Acute).	T	WPI	≤2.35	2.66	2020/21 Q2
Standardised inpatient average length of stay ALOS (Elective).	T	WPI	≤1.45	1.47	2020/21 Q2
Standardised Acute Readmissions	Q	SS07 (PCM6)	Total ≤10.5%	Total 10.9% Māori 10.2%	2020/21 Q2
Rate of inpatient falls causing harm per 1,000 bed days.	Q	WPI	≤0.15	0.19	2020/21 Q3
Rate of hospital acquired pressure injuries per 1,000 bed days.	Q	WPI	≤0.15	0.17	2020/21 Q3
Rate of identified medication errors causing harm per 1,000 bed days.	Q	WPI	≤0.05	0.08	2020/21 Q3
Weighted average score in Patient Experience Survey	Q	WPI	≥8.5	Comms: 8.4 Co-ord: 8.3 P/ship: 8.3 Physical and emotional needs: 8.4	2019/20 Q2
Percentage Did Not Attend (DNA) appointments for outpatient First Specialist assessments.	Q	WPI	≤8%	8.2%	2019/20

Outputs measured by	Note		Target/Est. 2021/22	Baseline	Baseline data date
Percentage DNA appointment for follow-up Specialist appointments.	Q	WPI	≤6%	6.5%	2019/20
Cancer services					
Percentage of patients receiving their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	T	SS01	≥85%	93%	2020/21 Q2
Percentage of patients with a high suspicion of cancer and a need to be seen within 2 weeks that received their first cancer treatment (or other management) within 62 days of being referred.	T	SS11	≥90%	93%	2020/21 Q2

Output class 4: Rehabilitation and Support

Rehabilitation and Support services

- Rehabilitation and support services are delivered following a 'needs assessment' process and co-ordination input by 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

The second implementation phase of the Ageing Well Strategy (2016), covering 2019 - 2022, prioritises achieving greater equity, measuring and monitoring progress. One of the priority actions is the "the development of an outcomes and measurement framework for this purpose". Readmissions and length of stay are two system measures which appear will be included in this monitoring framework.

Outputs measured by	Note		Target/Est 2021/22	Baseline	Baseline data date
% People > 75 living in their own home	C	SS04 (WPI)	≥92%	92%	2020/21 Q2
Standardised acute readmission rate for people >75 years of age	C	SS04 (WPI)	Total ≤12%	Total 12.6%	2020/21 Q2
			Māori ≤12%	Māori 11%	2020/21 Q2
Rate of hip (neck of femur) fractures due to an out of hospital fall per 1,000 people >50 years of age	C	WPI	Total ≤0.7500	0.7483	2020/21 Q2
% people who have received a LTCF residing in ARC or Residential Facilities within timeframes	Q	SS04 (WPI)	≥95%	96%	2020/21 Q2
% of residential care providers being awarded 3-year (or more) certification in the planned year	Q	WPI	100%	100%	2020/21 Q2

Financial performance summary

PROSPECTIVE FINANCIAL PERFORMACE FOR THE FOUR YEARS ENDED 30 JUNE 2022, 2023, 2024 AND 2025.

Statement of Comprehensive Income	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
	Audited Actual	Forecast	Plan	Plan	Plan	Plan
	$000	$000	$000	$000	$000	$000
Revenue						
Ministry of Health Revenue	166,285	181,871	193,809	199,765	204,688	209,733
Other Government Revenue	2,531	2,733	2,338	2,370	2,405	2,442
Other Revenue	10,338	12,203	12,849	12,982	13,191	13,402
Interest Revenue	69	62	69	70	71	72
Total Revenue	**179,223**	**196,869**	**209,065**	**215,187**	**220,355**	**225,649**
Expenditure						
Personnel	56,147	50,814	53,718	54,831	55,928	56,907
Outsourced Services	10,519	15,909	10,212	9,680	9,875	10,049
Clinical Supplies	12,591	13,120	13,192	12,890	12,992	13,010
Infrastructure and Non Clinical	10,785	10,584	10,594	10,387	10,457	10,459
Payments to Non-DHB Providers	57,446	61,111	66,140	68,818	70,883	73,187
Inter District Flows	41,404	44,797	53,014	54,286	55,915	57,732
Interest, Capital Charge, Depreciation and Amortisation	8,698	3,988	4,295	4,295	4,305	4,305
Total Expenditure	**197,590**	**200,323**	**211,165**	**215,187**	**220,355**	**225,649**
Surplus/(deficit)	**(18,367)**	**(3,454)**	**(2,100)**	**0**	**0**	**0**
Revaluation of land and buildings	**0**	**0**	**2,100**	**0**	**0**	**0**
Total Comprehensive Income/(Deficit)	**(18,367)**	**(3,454)**	**0**	**0**	**0**	**0**

PROSPECTIVE STATEMENT OF MOVEMENT IN EQUITY FOR THE FOUR YEARS ENDED 30 JUNE 2022, 2023, 2024 AND 2025.

Statement of Movements in Equity	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
	Audited Actual	Forecast	Plan	Plan	Plan	Plan
	$000	$000	$000	$000	$000	$000
Balance at 1 July	35,473	30,103	26,646	28,346	28,346	28,346
Net surplus / (deficit) for the year	(18,367)	(3,454)	(2,100)	0	0	0
Other comprehensive revenue and expense	0	0	0	0	0	0
Increase in revaluation reserve	0	0	2,100	0	0	0
Equity injection from the Crown	13,000	0	1,700	0	0	0
Repayment of equity to the Crown	(3)	(3)	0	0	0	0
Balance at 30 June	**30,103**	**26,646**	**28,346**	**28,346**	**28,346**	**28,346**

PROSPECTIVE SUMMARY OF REVENUE AND EXPENSE BY OUTPUT CLASS FOR THE FOUR YEARS ENDED 30 JUNE 2022, 2023, 2024 AND 2025.

Prospective Summary of Revenue and Expense by Output Class	2019/20 Audited Actual	2020/21 Forecast	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan
	$000	$000	$000	$000	$000	$000
Revenue						
Prevention Services	5,225	5,600	5,938	6,069	6,224	6,385
Early Detection and Management Services	29,335	32,430	32,460	35,397	35,900	36,218
Intensive Assessment and Treatment Services	113,801	126,184	137,387	138,294	141,915	145,807
Rehabilitation and Support Services	30,863	32,655	33,280	35,427	36,316	37,239
Total Revenue	179,224	196,869	209,065	215,187	220,355	225,649
Expenditure						
Prevention Services	5,756	6,092	6,682	6,883	7,058	7,242
Early Detection and Management Services	29,767	32,730	32,846	35,096	36,136	37,292
Intensive Assessment and Treatment Services	133,118	134,470	140,035	140,832	143,869	146,823
Rehabilitation and Support Services	28,950	27,031	31,602	32,376	33,292	34,292
Total Expenditure	197,591	200,323	211,165	215,187	220,355	225,649
Land and buildings revaluation not allocated	-	-	2,100	-	-	-
Consolidated Surplus / (Deficit)	(18,367)	(3,454)	0	0	0	0

PROSPECTIVE STATEMENT OF FINANCIAL POSITION (BALANCE SHEET) FOR THE FOUR YEARS ENDED 30 JUNE 2022, 2023, 2024 AND 2025.

Statement of Financial Position	2019/20 Audited Actual	2020/21 Forecast	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan
	$000	$000	$000	$000	$000	$000
Assets						
Current assets						
Cash & cash equivalents	5,920	4,750	767	1,720	2,603	3,186
Investments	85	83	83	83	83	83
Inventories	1,082	993	1,100	1,100	1,100	1,100
Trade & other receivables	5,922	6,734	5,600	5,400	5,100	5,100
Total current assets	**13,009**	**12,560**	**7,550**	**8,303**	**8,886**	**9,469**
Non-current assets						
Property, plant & equipment	44,976	45,291	50,795	51,148	51,497	51,845
Intangible assets	6,521	6,288	5,748	5,658	5,562	5,467
Total non-current assets	**51,497**	**51,579**	**56,543**	**56,806**	**57,059**	**57,312**
Total assets	**64,506**	**64,139**	**64,093**	**65,109**	**65,945**	**66,781**
Liabilities						
Current liabilites						
Payables, accruals and deferred revenue	15,441	18,132	15,055	15,735	15,735	15,735
Employee entitlements	18,311	18,704	20,035	20,371	21,207	22,043
Total current liabilities	**33,752**	**36,836**	**35,090**	**36,106**	**36,942**	**37,778**
Non-current liabilities						
Employee benefits (non-current)	566	566	566	566	566	566
Trust funds	85	91	91	91	91	91
Total non-current liabilities	**651**	**657**	**657**	**657**	**657**	**657**
Total liabilities	**34,403**	**37,493**	**35,747**	**36,763**	**37,599**	**38,435**
Net assets	**30,103**	**26,646**	**28,346**	**28,346**	**28,346**	**28,346**
Equity						
Crown equity	103,572	103,567	105,267	105,267	105,267	105,267
Revaluation reserve	11,234	11,234	13,334	13,334	13,334	13,334
Retained earnings	(84,703)	(88,155)	(90,255)	(90,255)	(90,255)	(90,255)
Total equity	**30,103**	**26,646**	**28,346**	**28,346**	**28,346**	**28,346**

Statement of Cashflow	2019/20 Audited Actual	2020/21 Forecast	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan
	$000	$000	$000	$000	$000	$000
Cash flows from operating activities						
Operating receipts:						
Government & crown agency revenue	175,294	191,346	204,062	209,957	215,157	220,082
Other	4,684	5,293	5,364	5,361	5,428	5,495
Interest Received	68	61	69	70	71	72
Payments to suppliers & employees	(180,434)	(194,231)	(207,392)	(210,077)	(215,415)	(220,708)
Capital charge paid	(1,958)	(1,424)	(1,358)	(1,358)	(1,358)	(1,358)
Interest Paid	(9)	0	0	0	0	0
Goods and Services Tax (net)	184	144	(131)	200	200	200
Net cash flows from operating activities	**(2,171)**	**1,189**	**614**	**4,153**	**4,083**	**3,783**
Cash flows from investing activities						
Proceeds from sale of property, plant & equipment	0	60	0	0	0	0
Increase in Investments	0	6	0	0	0	0
Acquisition of property, plant & equipment	(1,687)	(1,789)	(5,688)	(2,150)	(2,150)	(2,150)
Acquisition of intangible assets	(1,291)	(633)	(609)	(1,050)	(1,050)	(1,050)
Net cash flows from investing activities	**(2,978)**	**(2,356)**	**(6,297)**	**(3,200)**	**(3,200)**	**(3,200)**
Cash flows from financing activities						
Equity injected	13,000	0	1,700	0	0	0
Equity Repaid	(3)	(3)	0	0	0	0
Repayments of loans	(139)	0	0	0	0	0
Movement in other Term liabilities	0	0	0	0	0	0
Net increase / (decrease) in cash held	**7,709**	**(1,170)**	**(3,983)**	**953**	**883**	**583**
Cash & cash equivalents at beginning of year	(1,789)	5,920	4,750	767	1,720	2,603
Cash & cash equivalents at end of year	**5,920**	**4,750**	**767**	**1,720**	**2,603**	**3,186**

Notes and Assumptions

General note

The -$2.1m 21/22 budget deficit includes $0.71m Holiday Act costs. Added back for this the 21/22 budget is -$1.49m. Please note that the 20/21 budget deficit was exclusive of Holidays Act costs. And, per the Ministry of Health instructions, we have now included the Holidays Act remediation provisioning in the budget.

Although final remediation payments may occur in 21/22, the 21/22 and out-years cash flow is exclusive of any Holidays Act remediation payments and the DHB would require substantial cash support (up to $10m at this point) to service these payments.

Where known, we have included COVID-19 incremental cost impacts in the plan, offset by the expected, associated, additional funding. Any additional COVID-19 costs impacts will be reported as a variance to budget.

Further to the above, the prospective financial performance, cash flows and equity movements for the years ended 30 June 2022, 2023, 2024 and 2025 represent our assumptions and expectations in light of currently available information only. These projections involve significant, mainly industry-wide, risks, variables and uncertainties that may likely cause actual performance to differ materially from those currently projected.

Key areas of risk and uncertainty, both in timing and value, involve DHB funding, Holiday Act remediation, MECA bargaining, pay equity flow on effects, CCDM recommendations, National managed contract renewals and equity injections, impairment of (in)tangible fixed assets etc.

On a local level, the scale and size of our DHB imposes a high sensitivity to unexpected changes in the type and volume of services provided, staff levels and remuneration, seismic remediation works and the state of our key (non) clinical assets.

Consequently, no guarantee is presented or implied as to the accuracy and achievability of specific forecasts, projections or predictive statements contained herein.

Capital Plan

The capital funding requirements for the Provider Arm will be met from operational cash flow and prioritised with the clinical leaders both within the cost centres and across the Provider Arm. The baseline CAPEX for 2021/22 of $5.8m includes IT/software $1.5m (which covers regional, sub-regional and local projects), Ministry of Health funded infrastructure projects $1.7m, non-clinical Infrastructure/building $1.1m, clinical and other equipment $1.3m.

Debt & Equity

Equity Drawing

Wairarapa DHB does not anticipate requiring any equity funding in 2021/22 with the planned deficit and capital expenditure being funded through available cash on hand and changes to working capital. However, this does not include Holidays Act remediation payments for which the DHB does require additional cash support to service these payments (up to $10m). Wairarapa DHB does anticipate $1.7m equity to fund the Ministry of Health approved $1.7m infrastructure capex projects.

Working Capital

The Board has a working capital facility with the Bank of New Zealand, which is part of the national DHB collective banking arrangement negotiated by NZ Health Partnerships Limited. This facility is limited to one month's provider's revenue, to manage fluctuating cash flow needs for the DHB.

Gearing and Financial Covenants

No gearing or financial covenants are in place.

Asset Revaluation

Wairarapa DHB revalued its land, building as at 30 June 2019. The revaluation was carried out by an independent Registered Valuer (CBRE Limited), which is consistent with the New Zealand Equivalent to International Public Sector Account Standard 17 Property, Plant and Equipment (PBE IPSAS 17).

It is planned to undertake a further valuation at 30 June 2022. It is expected that the buildings will retain their value so the budget for 2021/22 includes an adjustment of depreciation claimed since the last valuation was done.

Strategy for disposing of assets

The DHB regularly reviews its fixed asset register, and undertakes fixed asset audits in order to dispose of assets, which are surplus to requirements. This ensures that the DHB reduces its level of capital to the minimum consistent with the supply of contracted outputs.

Disposal of Land

All land that has legally been declared to be surplus to requirements will be disposed of following the statutory disposal process defined in the Public Works Act 1991, the Health Sectors Act 1993, the New Zealand Public Health and Disabilities Act 2000, the Reserves Act 1977 and the Māori Protection Mechanism Regulations set up to fulfil the Crown's obligations under the Treaty of Waitangi.

Wairarapa DHB
System Level Measures Improvement Plan
2021/2022

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

Regional Public Health
HAUORA Ā IWI KI TE ŪPOKO O TE IKA A MĀUI
Better health for the greater Wellington region

Tū Ora
COMPASS HEALTH

WHAIORA
In pursuit of wellness

Signatories

The members of Tihei Wairarapa - the Wairarapa Alliance Leadership Team

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Chair
Tihei Wairarapa

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Wairarapa District Health Board

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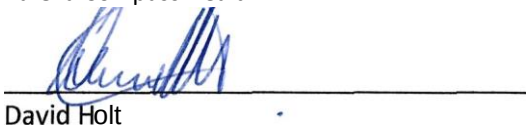

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Wairarapa District Health Board

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Wairarapa DHB SLM Plan Development 2021/22

Collaborative Development

The development of the SLM Improvement Plan specifically has been led by a collaborative SLM Development Group comprising Executives and Clinical Leads in the PHO and DHB.
Other Groups that have been engaged with and/or provided with progress updates:

- Community and Public Health Advisory Group
- Tū Ora Compass Health Clinical Quality Management Committee
- Tū Ora Compass Health Board
- Wairarapa DHB Executive Leadership Team

Links with Strategic Priorities

Strategic Objectives

The SLM development team agreed that the milestones for the SLMs should consider and align with strategic priorities across the sector, should focus on reducing inequity, and should be attainable while supporting the current performance of Wairarapa DHB. Our strategic priorities for the 2021/22 plan are based on our new direction, they are about changing our mind-set and looking at what is important to the communities we serve and making the best decisions for us and our children after us.

The SLM milestones are also aligned with the National Health Strategy, and DHB performance measures as reflected in the DHBs 2021/22 Annual and Strategic Plans.

Strategic Objectives

There are eight broad activity areas identified in WrDHB Strategic Direction (2020-2030 –HAUORA MŌ TĀTOU). It is acknowledged that change is needed in order to shift to a responsive, effective health system that achieves equitable outcomes for all people in our communities.

Activity Areas include:

1. Integrated health and social services
2. Strengthening Primary Care
3. Excellence in Older persons Services
4. Improving access to health and disability services
5. Close connections between primary and secondary care
6. Creating a fit for purpose hospital
7. Building a sustainable workforce
8. Tamariki-Mokopuna (our children and young people are our future)

Equity as a focus area

The disparities experienced by some parts of our community are unacceptable, Māori and Pacific peoples consistently suffer greater disadvantage yet have limited access to the services they need. Our fresh focus on equity seeks to address some of these barriers to health care, we are at the early stages of designing new ways of working in and with communities. We are also getting a much clearer picture of where the efficiency gains are within our current system and working on how we disentangle resources to re-invest in equity.

The cornerstone principles that will support effective change include consideration of the Treaty of Waitangi relationship, Equity, Change Readiness and a sustainable workforce.

2021/22 System Level Measures

From 1 July 2020 the System Level Measures remain:

- Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds
- Acute hospital bed days per capita
- Patient experience of care
- Amenable mortality rates under 75 years
- Youth access to and utilisation of youth-appropriate health services
- Proportion of babies who live in a smoke-free household at six weeks postnatal

In 2021/22, 25% of PHO incentive pool funding will be paid on Quarter 4 achievement of the following three SLM improvement milestones and two primary care targets (to be confirmed):

- Acute hospital bed days per capita
- ASH rates for 0-4 year olds
- Patient experience of care
- Primary Care Target: Better help for smokers to quit
- Primary Care Target: Increased immunisation for eight month olds.

The 25% incentive funding is equally weighted across all five incentivised measures.

The context of our 2021/22 Plan

Our 2020/21 plan and actions supported the foundation for future service development. The Alliance Leadership Team was renewed and local Service Level Alliances established to provide an operational framework to effectively monitor and evaluate our performance, and agree priorities and service improvement actions.

We also recognised the need to modernise and free-up capacity in primary care to improve the management of patients in the community. The implementation and embedding of the Health Care Home Model (HCH) across all seven Wairarapa practices is a major commitment for the PHO and practices. Alongside this, management and resurgence planning for Covid-19 across the sector is a major and ongoing priority since late 2019-2021.

The implementation of Health Care Homes and Hospital at Home Team, alongside Whakapuāwai improvement work across the Provider Arm, have provided platforms for both planned Long Term Conditions and urgent care developments. Covid-19 necessitated a change in face to face health access for the Wairarapa population and initiation of pandemic plans in all health sectors in case of resurgence and future lockdowns. This event has required the whole sector to review patient/client management and access and to consider the most vulnerable populations. Health and associated support systems have needed to work collaboratively across sectors to optimise patient outcomes and protect the health of our most vulnerable groups within our community. Lessons learnt from Covid-19 that improve service integration and inter-sectorial collaboration resulting in improved health outcomes for these groups, have been integrated into new SLM actions for 2021-22.

Wairarapa DHB 2021/22 Annual and SLM Plan have a focus on equity priorities which are intended to narrow the health outcome gaps between Māori and other ethnic groups and if achieved, will demonstrably improve Māori health status. In 2021/22 we continue to work with a wider range of providers to achieve better synergy with the community and especially Whānau Māori, Pacifica and vulnerable whānau. All contributory measures will be monitored by Māori, Pacific and other populations. Where this data is not currently collected, the Wairarapa DHB will ensure that steps are put in place to start collecting this data by ethnicity.

The Wairarapa area has experienced higher than expected population growth in recent years and we have seen persistent inequities in health outcomes for Māori, and other groups whose needs are not being met. At the same time, local workforce and facility problems have been identified. The population of Wairarapa is rapidly changing. Wairarapa has an estimated population of 47,600 people as at June 2019. The Wairarapa population has grown by around 10 percent since 2013. Growth for Māori and older people (65+ years) was higher. According to general practice registers, around 32 percent of enrolled people are likely to have high need for health services, on the basis of standard Ministry of Health criteria. Seventeen percent of the total population are Māori and 2 percent Pacific peoples. The Māori and Pacific populations are youthful compared to the non-Māori, non- Pacific population. Life expectancy is increasing for all ethnicities including Maori and Pacific.

The current level of service volume is unsustainable. The consequences of population change will be an increased need for services. If existing rates of service delivery are extrapolated to projected populations and increased need of an ageing population as well as a population that is growing overall. Hospital volume growth and the demand for specialist services (especially for Maori) will increase significantly in the coming decades.

These changes have increased the disparity between population sub-groups, with significant proportions of our population, particularly in Masterton, living in relative deprivation. In both the hospital and primary care there has been significant growth in acute demand. Primary Health Care (PHC) continues to have workforce challenges including GP recruitment and skill mix, this is an ongoing focus.

In this context it has been crucial that we continue to progress our current work programme.

- Implementation of a WrDHB strategic direction (Hauora Mō Tātou), Health System Services Plan, Wellbeing Plan (under development), Māori Health Plan (underdevelopment) and Pacific health plan;
- Implementation of the Health Care Home model across all Wairarapa practices
- Revision of the youth health strategy and implementation of the recommendations from the youth health service review.
- Continued implementation of an integrated palliative care service
- Continued implementation of the falls prevention programme
- Participation in the ongoing development of Health Pathways and a new smart e-referral system

Table 1 below summarises the headline actions that have been agreed as priorities for the 2021/22 year, and the intervention logic behind them.

Our 2021/22 Priority Projects

Table 1: Our priority projects and the milestones they will impact on

	ASH 0-4	Acute bed days	Patient Experience	Amenable mortality	Youth access to service	Babies in smoke free households
The Alliance Leadership Team (ALT) will continue to be responsible for the development and implementation of the system level measures and will be accountable to the Board for the SLM Programme of work.	✓	✓	✓	✓	✓	✓
The Health Care Home (HCH) model has been implemented in all seven Wairarapa practices. In 2021/22 there will be a focus on embedding the new model to achieve: • Improvements in patient experience of healthcare • Equity initiatives that demonstrate improvement in a quality indicator • Improved satisfaction and sustainability of the workforce, including expanding MDT to include clinical pharmacist. • Improved quality of care through improved access and a focus on prevention and early intervention • A reduction in the downstream impacts on the broader health system such as hospitalisation, emergency presentations and amenable mortality. • Inclusion of COVID response insights; embed pandemic planning with virtual consults to improve access and timeliness to care.	✓	✓	✓	✓		
The ALT will monitor LTC quality indicators, and identify opportunities to work collaboratively to improve outcomes. This activity will include reviewing: • the SLM contributory measures, • the Atlas of Healthcare Variation data • Health Roundtable data and • the Tū Ora Compass Health quality indicator data, System improvements to improve population health outcomes will be prioritised by equity. The ALT will use the Wairarapa 'palliative care model' as a model for improvement for long term conditions services. MDT activity in this space will focus on diabetes and cardiac conditions. The ALT will have primary responsibility for the implementation of the acute bed days and amenable mortality measure improvement plans.	✓	✓	✓	✓		✓

	ASH 0-4	Acute bed days	Patient Experience	Amenable mortality	Youth access to service	Babies in smoke free households
A Service Level Alliance will identify and monitor system improvement in child and youth health services. The SLA will monitor quality indicators including: • the WCTO quality framework • the SLM contributory measures, and • the Tū Ora Compass youth health quality indicator data and will make recommendations to the ALT on system improvements to improve child and youth health outcomes including increasing equity. The SLA will continue to focus on respiratory health for Māori under 5s, developing culturally appropriate antenatal and postnatal options for Māori, reconfiguring services to provide more support for high needs families and improving access to youth health services (in particular mental health support). The SLA continues to have primary responsibility for the implementation of the ASH 0-4, babies in smoke-free households and youth measure improvement plans. The SLA will also focus specifically on the development of youth services including the Youth clinic, services in South Wairarapa and school-based services.	✓		✓	✓	✓	✓
The Alliance believes there are opportunities to improve the patient experience of the health system as a whole by sharing NZ health survey results and quality improvement initiatives. We will continue to conduct quarterly reviews of survey results and commit to an integrated quality improvement approach.			✓			

The Wairarapa DHB/Tihei Wairarapa agreed Improvement Milestones for 2021/22 are:

System Level Measure	Key Improvement Milestones	Date	2020/21 Target and latest results	2021/22 Improvement Milestone
ASH rates for 0-4 year olds	Wairarapa Māori 0-4 years non-standardised ASH rate per 100,000	End of Q4	Reduce non-standardised Māori 0-4 years ASH rate from 8,136 to <8,000 per 100,000 population Target - Māori 0-4yrs <8,000 Baseline: 5yrs to end of December 2019 Māori 0-4yrs = 4,409 Other 0-4yrs = 5,054	Reduce non-standardised Māori 0-4 years ASH rate per 100,000 population From 4,409 to <4,200 by Dec 2022
Acute bed days per capita	Wairarapa acute bed day rate per 1,000	End ofQ4	Reduce standardised Māori acute bed days for DHB of domicile by 5% from 491 to 466 per 1,000 population Baseline: year to Sep 2020 Maori rate: 454 per 1,000 population	Reduce standardised Māori acute bed days for DHB of Domicile by 5% from 454 to 431 per 1,000 population
Patient Experience Survey	Wairarapa Primary Care And Hospital services will focus on specific questions from previous survey results to inform improvement activities in 2021-22.	End of Q4	**Primary Care:** Improvement milestone for 2021/22 We have 100% of practices transitioned and participating in the new PES. There are a number of plans developed with patients, including Year of Care (YOC) plans. 80% of people with (YOC) plans have completed a 'Partners in Health' Scale. Improvement milestone to July 2022 is 25% of Clients activated in the healthcare portal. Dec 2020 = 18.9%. Improvement milestone is ≤2 days for the time to third next available appointment (TNAA) 2021-22. Dec 2020 – average across all practices is 4 days. **Inpatient:** Improvement milestone 2021/22 To improve the results of the selected questions in the Q4 PES by 1-2% by July 2022 **Inpatient cont…:** 2021/22	**Primary Care:** To improve the results of the following two questions by 1-2% by July 2022. ***Q35."In the last 12 months, was there ever a time when you wanted health care from a GP or nurse, but you couldn't get it? "*** ***Q39. "Did the GP or nurse involve you as much as you wanted to be in making decisions about your treatment and care?"***80% of people with Year of Care (YOC) plan have completed Partners in HealthScale. **Inpatient:** To improve the results of the four following questions by 1-2% by July 2022. ***Q6."Were you involved as much as you wanted to be in making decisions about your treatment and care?"*** ***Q16."Did hospital staff include your family/whanau or someone close to you in discussions about the care you received during your stay?"*** ***Q22. "Did you have enough information about how to manage your condition or recovery after you left hospital?"*** ***Q24. "Were you told the possible side-effects of the medicine (or prescription***

			To improve the results of the selected questions in the Q4 PES by 1-2% by July 2022	***for medicine) you left the hospital with, ina way you could understand?"***
Amenable mortality rates	Wairarapa total 0-74 standardised AM rate per 100,000	End of Q4	Reduce 0-74 year age standardised AM rate for Māori from 188 to at or below 165 per 100,000 (5 year average) Baseline: 2012-2016 - 5 year average Māori = 188.0 Total = 94.7	Reduce 0-74 year age standardised AM rate for Māori from 188 to at or below 165 per 100,000 (5 year average)
Youth access to and utilisation of youth-appropriate health services	**Access to preventative services:** Increase Māori and Pacific adolescent dental coverage **Intentional self-harm hospitalization's** (including short-stay hospital admissions through ED) for 15 - 19 year olds	End of Q4	**Access to preventative services:** Increase Māori and Pacific oral health utilisation to 55% by 30 June 2021 Baseline: June 2019 Māori = 49% Pacific = 56% **Mental Health and Wellbeing:** Decrease intentional self-harm ED presentations / hospitalizations of Māori 10-24 year olds to a rate of 60 (per 10,000 population) Age standardized Baseline: Year to Sept 2020 (per 10,000 population) Māori rate = 90.8 Other rate = 49.4	**Access to preventative services:** Increase Māori and Pacific adolescent oral health utilisation to 60 % by 30 June 2022 **Mental Health and Wellbeing**: Decrease intentional self-harm ED presentations / hospitalisations of Māori 10-24 year olds to a rate of 60 per 10,000 population (standardised)
Babies in smoke-free households	Percentage of babies that are six weeks old, who live in a household with no smoker present	End of Q4	Increase the % of all babies living in smoke-free homes to 60% and Māori babies to 50% by 30 June 2021. Baseline: June 2020 Total babies = 54.1% Māori babies = 36.3%	Increase the % of Maori babies living in smoke-free homes to 50% by 30 June 2022.

Ambulatory Sensitive Hospitalisations 0-4yo

As a Wairarapa DHB system we want all our children to have a healthy start in life. One of the DHBs strategic goals is to improve child health and child health services in the Wairarapa Region. Our system will support all families to maximise their child's health and potential. In 2020/21 WrDHB, we achieved our 2020-21 goal of reducing the Māori ASH rates (non-standardised) for 0 – 4 year olds to under 8,000 per 100,000. Maori ASH rates for 0-4yrs reduced to 4,737 and other at 4,850. We aim for a further reduction from Dec 2020 Maori ASH rates from 4,737 to under <4,200 per 100,000.

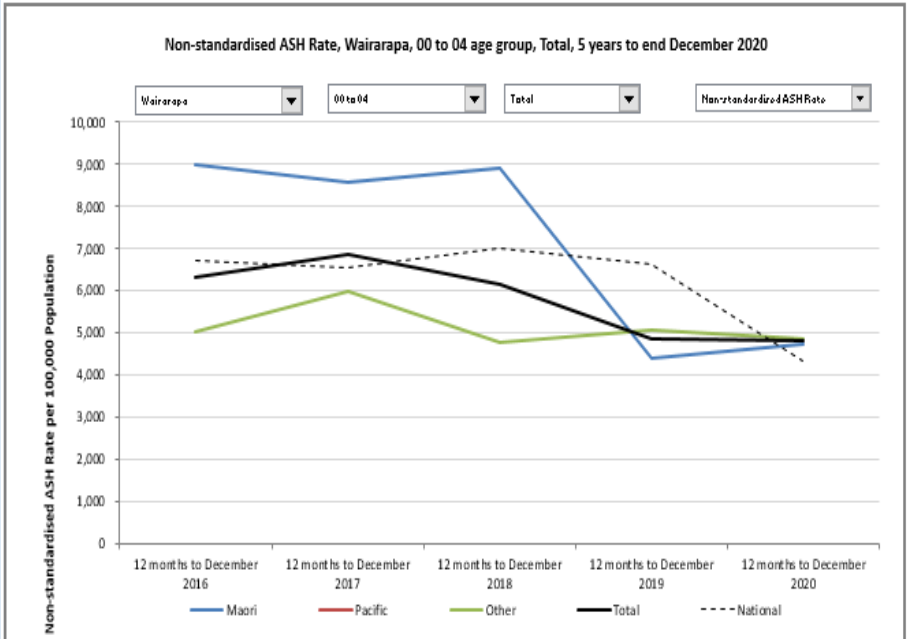
SI 1: Ambulatory Sensitive Hospitalisations (ASH)

ASH Top 10 Conditions over last 6 years to 30 September 2020 (split by Maori and Other) - Actual admissions

Condition	12 months to December 2014		12 months to December 2015		12 months to December 2016		12 months to December 2017		12 months to December 2018		12 months to September 2019		12 months to September 2020	
	Maori	Other	Maori	Other	Maori	Other	Maori	Other	Maori	Other	Maori	Other	Maori	Other
Upper and ENT respiratory infections	16	19	18	40	21	31	15	36	25	25	10	14	10	12
Gastroenteritis/dehydration	16	22	3	16	10	14	7	26	15	14	8	14	7	18
Asthma	17	16	24	20	17	15	16	9	12	16	9	18	4	3
Dental conditions	11	19	16	13	13	12	13	10	8	8	3	8	16	26
Lower respiratory infections	3	2	3	2	3	6	3	6	8	5	2	5	0	1
Pneumonia	5	6	6	4	3	6	12	9	4	6	5	6	0	3
Cellulitis	7	5	12	5	2	4	6	5	4	3	2	4	2	3
GORD	1	1	0	0	0	2	1	0	1	6	0	0	1	1
Dermatitis and eczema	6	4	4	1	7	1	1	2	4	1	3	3	1	3
Constipation	0	3	1	2	3	2	3	3	1	2	3	4	2	7
TOTAL	82	97	87	103	79	93	77	106	82	86	45	76	43	77
TOTAL POPULATION 0-4 Year Olds	810	1930	840	1860	840	1830	860	1775	880	1755	890	1715	950	1830
% of Total Population 0-4 Year Olds	10%	5%	10%	6%	9%	5%	9%	6%	9%	5%	5%	4%	5%	4%

Inequity for Māori children has reduced over the past year. Comparative data is not available for Pacific children due to the small population, but we intend to monitor hospitalization's for Pacific children at an individual level. Dental conditions, Gastroenteritis / dehydration,
Upper and ENT respiratory infections and Asthma are the three largest drivers of admissions, especially for Māori children.

SI 1: Ambulatory Sensitive Hospitalisations (ASH)



DHB	Ethnic Group	12 months to December 2016	12 months to December 2017	12 months to December 2018	12 months to December 2019	12 months to December 2020
Wairarapa	Maori	8,977	8,556	8,913	4,409	4,737
Wairarapa	Pacific	.	.	.	.	.
Wairarapa	Other	5,041	5,989	4,783	5,054	4,850
Wairarapa	Total	6,312	6,854	6,159	4,838	4,811
National	Total	6,697	6,564	7,010	6,628	4,315

The number of ASH events has seen a drop over time, especially for Maori (per graph above). This has been maintained over the last 12 months and is consistent with National rates, Covid lockdowns may have contributed to this.

Milestone	Actions	Contributory Measures All contributory measures will be monitored by Māori, Pacific & Other Population where data allows
Reduce non-standardised Māori 0-4 years ASH rate per 100,000 population From 4,409 to <4,200 by Dec 2022	Embed enhanced Whānau Ora services for families of children identified through LMC/WCTO needs assessments, those booked for dental treatment on the surgical bus and those with repeat respiratory presentations at primary and /or secondary care.	• % preschool children enrolled with oral health service by ethnicity and level of treatment. • Hospital admissions for children under 5 years with dental or respiratory issues as a primary diagnosis by ethnicity
	Form a Wairarapa based child health coordination service (DHB, PHO, and MWWL) for 0-4 year olds, particularly for vulnerable children.	• Number of children supported by this service by ethnicity and decile • % of newborn enrolled with a GP by 1 year of age • % of babies who have received and have NOT received all core (well child Tamariki ora) WCTO contacts in first year of life
	Embed the enhanced model of care that increases the number of children proactively having fluoride applied biannually by the dental service. Prioritising high needs children	• Number of children who have had fluoride application • 5yr old DMF • Yr 8 DMF - measures
	Provide practices with lists of children who are potentially eligible for fluvax and continue the auto-referral process to outreach for Māori and Pacific.	• Fluvax 6 months to 4 years (Māori, Pacific and other)
	Maintain the pathways for children with repeat childhood respiratory presentations.	• Number of children supported by the child health co-ordination service by ethnicity and decile • 0-4 ASH Rate with a primary diagnosis of respiratory disease (Māori and other) • Number of referrals to the Ha Ngawari program (All practices) • Rate of prescription and dispensing of asthma related medicine to under 4 year olds by ethnicity
	Implement the National Hauora Coalition program 'Equity generation 2040' (early pregnancy assessments)	• The number of early pregnancy assessments completed for Māori pregnant women.

Patient Experience of Care

The Wairarapa health system encourages patients to provide feedback about their experience of care through our complaints and compliments process and by participating in the Adult Inpatient and Primary Care Patient Experience Surveys (PES). One of our priorities is to monitor results and feedback, and use them to inform and measure the impact of initiatives that are designed to improve outcomes and patient experience.

A new provider (IPSOS) has revamped both the PHC and Adult Inpatient National Patient Experience Surveys (PES), available from October 2020. We aim to have 100% of PHC practices transition and participating in the new PES. Parallel to this, the management of Covid-19 since early 2020-21 saw a significant changes in the way patients accessed PHC services during lockdown. There was a major shift to remote and virtual access during this time, this shift in patient management and service provision has needed to be consciously built into practice resurgence plans.

A patient centered approach to care requires a shift in focus from participation and response rates to using the Survey feedback to create meaningful actions that support changes called for by the users of our service. In order to do this we will look more closely at our selected questions and also to consider what changes in service provision to keep and build on from learnings gained during our pandemic response. This approach is patient centered and truly responds to feedback in a meaningful way for the users of our service.

Primary Health Care

Wairarapa Primary Care will focus on 2 key areas in 2021-22 for improvement purposes. The key areas of focus will be on feedback from questions related to access and partnership. In order to investigate observations made during Covid-19 and embed or develop positive changes to services made during this time.

PES Questions for focus in 2021-22 are:

Q35. "In the last 12 months, was there ever a time when you wanted health care from a GP or nurse, but you couldn't get it? "

and

Q39. "Did the GP or nurse involve you as much as you wanted to be in making decisions about your treatment and care?"

The Primary Care PES data will provide improvement opportunities for practices implementing the Health Care Home model for the 2021-22 year.

Adult Inpatient

PES Questions for focus in 2021-22 are:

Q6: Partnership Domain: ***"Were you involved as much as you wanted to be in making decisions about your treatment and care?"***

Q16: Partnership Domain: ***"Did hospital staff include your family/whanau or someone close to you in discussions about the care you received during your stay?"***

Q22: Coordination Domain: ***"Did you have enough information about how to manage your condition or recovery after you left hospital?"***

Q24: Communication Domain: ***"Were you told the possible side-effects of the medicine (or prescription for medicine) you left the hospital with, in a way you could understand?"***

The survey results will inform improvement activities for 2021-22. The revamped survey has a focus on equity and includes the ability for respondents to answer the survey in te reo Māori. Māori data review options for DHBs have been added to help identify high performing and areas for improvement with Māori patients. An important equity focus will be to achieve a representational sample of this cohort in order to use this data to create meaningful actions called for by the users in this cohort.

Primary Health Care: Baseline Results Nov 2020 - Feb 2021:

	Adult **PHC** Survey – November 2020	Baseline Results Wairarapa PHC	Baseline Results Wairarapa PHC	Baseline Results
Question Number	Question	% Overall n= participant numbers	% Maori n= participant numbers	% National Total n= participant numbers
Q35.	***"In the last 12 months, was there ever a time when you wanted health care from a GP or nurse, but you couldn't get it? "***	80.3% n= 157	75% n=24	80.3% n=20,559
Question Number	Question	% yes definitely Overall	% yes definitely Maori	% yes definitely National Total
Q39.	***"Did the GP or nurse involve you as much as you wanted to be in making decisions about your treatment and care?"***	84.9% n=152	87.0% n=23	88.2% n=18,896

	Adult **Inpatient** Survey - 19th Oct to 15th Nov 2020	Baseline Results Wairarapa DHB	Baseline Results Wairarapa DHB	Baseline Results
Question Number	Question	% Overall Yes, always	% Maori n=participant numbers	% Yes, always National Total
Q6.	***"Were you involved as much as you wanted to be in making decisions about your treatment and care?"***	87.9% n=58	100% n= 5	79.4%
Q16.	***"Did hospital staff include your family/whanau or someone close to you in discussions about the care you received during your stay?"***	87.8% n=49	100% n=5	77.2%
Q22	***"Did you have enough information about how to manage your condition or recovery after you left hospital?"***	75.0% n=40	100% n=6	61.5%
Q24.	***"Were you told the possible side-effects of the medicine (or prescription for medicine) you left the hospital with, in a way you could understand?"***	68.4% n=57	0% n=0 Feb 100% n=5	69.5%

Milestone	Actions	Contributory Measures All contributory measures will be monitored by Māori, Pacific & Other Population where data allows
Primary Care Milestone: A 1-2% increase by July 2022, in people answering "no" to the question: ***"In the last 12 months, was there ever a time when you wanted health care from a GP or nurse, but you couldn't get it? "*** A 1-2% increase by July 2022, in people answering yes definitely to the question: ***"Did the GP or nurse involve you as much as you wanted to be in making decisions about your treatment and care?"*** 80% of people with Year of Care (YOC) plan have completed Partners in Health Scale.	All 7 practices will transition and participate in the new PES. All Individual GP Practice in the HCH program actively participate in the Health Care Home Maturity Matrix – Urgent and Unplanned Care monitoring system. **Follow-up**: People with YoC plan have completed Partners in Health Scale annually (This scale gathers information on how the patient feels they are doing regarding self-management), YoC plan is adjusted accordingly. **Access:** PHO will review feedback from questions linked to Access and Partnership to identify opportunities for service improvement 2021-22. Strengthen and progress the Health Care Home (HCH) Business model in Wairarapa GP practices. This model supports improved patient access to PHC services through encouraging patient enrollment in the health portal, timely information provision, GP/Clinical triaging with phone and/or video consult options. This model includes systems to manage Socio-economic and cultural issues that are barriers to access to care.	• Percentage of people with a YoC plan that have completed the 'Partners in Health' Scale annually. • Number of practices who are actively participating in the HCH Maturity Matrix • YoC plans adjusted as necessary after feedback (qualitative Narrative) • Percentage of people with email recorded in the PMS • The time to third next available appointment (TNAA)
Adult Inpatient Milestone: **Q6. Improvement Milestone:** A 1-2% improvement by July 2022, in people answering "yes always" to the question: ***Q6."Were you involved as much as you wanted to be in making decisions about your treatment and care?"*** **Q16. Improvement Milestone:** A 1-2% improvement by July 2022 in	• To promote the use of the Health Navigator tool for staff and patients in the inpatient setting to support health literacy and pre-discharge discussion for medication management and self-management post discharge. This tool is already in use in the PHC sector and familiar to patients. Promotion of the same evidence based health promotion and patient self-management tools between sectors enables inter-sectorial continuity with information tools. Quality Team to work with the Māori Health team to develop and action the most suitable approaches and models of engagement with Māori and family/whānau in discussion, co-design of care plans and PES participation. To continue to embed the WrDHB organisational values, which include recognising the impact of communication on patient experience. E.g. Sharing	• Increase in number of health navigator hits generated from WrDHB • Improvement in PES Participation rates, esp. for Māori • To see improvements in the Patient Experience Survey scores for the identified questions linked to communication, partnership and coordination in 2021-22.

people answering "yes definitely" to the question: ***Q16. "Did hospital staff include your family/whanau or someone close to you in discussions about the care you received during your stay?"*** **Q22. Improvement Milestone**: A 1-2% improvement by July 2022 in people answering "yes definitely" to the question: ***Q22. "Did you have enough information about how to manage your condition or recovery after you left hospital?"*** ***Q24* Improvement Milestone:** A 1-2% improvement by July 2022, in the patients answering "yes definitely" to the question: ***Q24. "Were you told the possible side-effects of the medicine (or prescription for medicine) you left the hospital with, in a way you could understand?"***	patient stories via staff communication systems and qualitative presentations to the Board. To improve patient participation (esp Maori) in the Adult inpatient Survey by: • Pairing email and sms invites. • Monitoring the collection of valid email and SMS contacts by ethnicity and include proactive steps to improve the collection of patient contact details • Monitoring Maori data in the survey provider snapshot screen to compare results of Maori respondents with total results and identify high performing and areas for improvement with Maori patients. Review percent of invitations sent each quarter by ethnicity to ensure a representative sample • Offering all inpatients who identify as Maori a visit by a Maori Health Team member. The Maori Health team have been updated and use the most suitable approaches to discuss and promote completion of the National Survey, especially to the Maori patient cohort. • Ensuring WrDHB National survey promotional material is replaced with new material available in both Maori and English. • Survey information is displayed where patients are likely to see it during survey weeks and Survey promotional flyers are included on patient meal trays.	

Acute Bed Days

Better health for all is the WrDHB vision. We want our population to be well in the community and to receive appropriate care when they are not well. Our aim is to maintain acute bed days (standardised by DHB of Domicile) under 300 per 1,000, in 2021/22. A short-term goal for 21/22 is to better manage long term conditions, particularly respiratory conditions and diabetes in primary care. Also for general practices, through the Health Care Home model of care which all 7 practices have adopted, to use stratification tools to identify populations at risk of admission and implement year of care planning.

Over all, the Wairarapa standardised rate of acute bed days has continued to decrease with the latest results the lowest yet. Our rate has consistently been below the national average for the past three years

Stroke and other cerebrovascular disorders, respiratory infections/inflammations and fractures especially (in the elderly) and cellulitis for Māori, are the largest drivers of acute bed day usage.

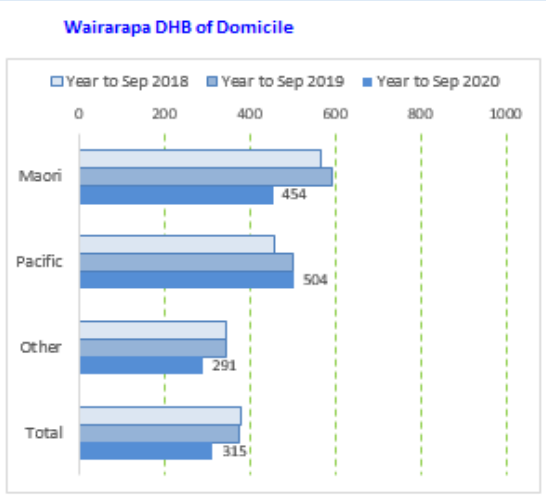
Māori rates have improved with a drop from 491 to 454 per 1,000 from September 2018 to September 2020.

DHB Comparison - Standardised Acute Bed Days per Capita Rates

Using Standard Population: Census 2013 Usual Resident Population

DHB of Domicile	ed Popn Year to Sep 2020	Acute Stays Year to Sep 2020	Bed Days Year to Sep 2020	Bed Days per 1,000 Popn Year to Sep 2018	Year to Sep 2019	Year to Sep 2020	(Year to Sep 2020
Auckland	483,710	58,242	181,214	445.4	458.6	401.1	4
Bay of Plenty	256,210	33,775	109,843	400.0	413.3	358.5	12
Canterbury	572,725	55,807	212,877	396.3	393.0	343.4	14
Capital and Coast	318,355	33,672	92,235	338.8	336.2	290.9	19
Counties Manukau	571,790	61,875	217,213	430.4	475.6	425.6	3
Hawke's Bay	175,015	24,488	76,873	430.1	416.5	379.7	9
Hutt	155,820	19,196	52,333	349.3	367.0	325.2	16
Lakes	115,515	14,258	46,173	415.0	443.7	383.2	7
Midcentral	184,310	21,393	71,729	399.5	410.0	331.7	15
Nelson Marlborough	158,165	17,430	47,133	249.7	267.8	240.8	20
Northland	191,190	24,925	81,305	405.2	419.8	366.6	11
South Canterbury	61,555	8,192	23,842	430.8	456.6	383.0	8
Southern	342,335	35,644	117,734	373.4	366.4	309.6	18
Tairawhiti	43,558	6,471	23,333	468.7	482.6	458.0	1
Taranaki	123,693	18,027	55,402	466.2	447.7	393.8	6
Waikato	431,205	54,673	203,063	483.3	496.0	436.6	2
Wairarapa	48,083	5,433	18,388	378.8	374.0	314.6	17
Waitemata	621,450	72,293	250,009	446.5	441.5	397.2	5
West Coast	32,610	3,768	14,883	436.1	390.9	369.6	10
Whanganui	68,040	11,116	27,725	403.3	375.4	344.4	13
National	######	580,636	1,931,337	415.7	417.4	365.5	

Wairarapa DHB of Domicile – Ethnic Group Comparison –Standardised Acute Bed Days per Capita Rates year to Sept 2018-20



Milestone	Actions	Contributory Measures All contributory measures will be monitored by Māori, Pacific & Other Population where data allows
Reduce standardised Māori acute bed days for DHB of Domicile by 5% from 454 to 431 per 1,000 population	Continue the falls programme and specifically embed the Fragility Fracture Protocol for targeted management of bone health	• Number of people 55+ years with low impact fragility fractures who have been referred to their GP service for bone health and falls risk assessment
	Implement 'Health Point' locally for mapping access to Health and Social Services	• Monitor an increase in access and establish a baseline
	To implement community pharmacy reviews in PHC for identified priority groups (e.g. polypharmacy, Maori with long term conditions, people who have had a fragility fracture). Pharmacists advising best prescribing practice (e.g. osteoporosis medication management) to support reduction in admissions related to polypharmacy, falls injury and long term conditions.	• An accumulative increase (target yet to be decided) in numbers reviewed in PHC • Number of patients with acute medical presentations supported in PHC who would otherwise have been admitted to hospital – Decreased LOS and Bed Day Savings for identified DRGs.
	Continue to embed the Health Care Home model across the seven general practices	• All practices showing progress in model maturity using the HCH maturity matrix • Number of people with Year of Care Plan compare to HCH goal for the 12 months

	Develop the Community Service Integration component of Health Care Home for patients identified as being at risk of hospitalisation	
	Develop and implement a COPD programme to support consistency and continuity of care in primary care with a particular focus on Māori	• COPD hospital admission rate by ethnicity over time • Trend of COPD diagnosis by ethnicity
	Pandemic Preparedness – ARC • Contribute to and promote the national pandemic toolkit for polypharmacy • Mentor and assist ARC providers to implement advanced treatment plans for long term residents	• All ARC facilities have been introduced to the ATP simplified tool and concept Q1 • ATP protocol for new ARC admissions for all ARC providers Q1-4 • Review of local ARC pandemic plan when toolkit confirmed Q4

Amenable Mortality

We want to have an effective WrDHB health system, for individuals and the population as a whole. Wairarapa DHB aims to maintain its 5 year average amenable mortality rate at less than 105 per 100,000. Our focus in 2021/22 and beyond continues to be on reducing the Māori amenable mortality rate. Suicide continues to have a large relative impact on the rate at WrDHB. We are continuing to develop an improved understanding (including by age and ethnicity), so effective solutions can be developed and implemented in future years.

Wairarapa DHBs amenable deaths for 0-74 year olds between 2000 and 2016 has continued to drop steadily year on year from 155.9 in 2000 to 94.7 in 2016.

Inequities remain with the Māori population continuing to have the highest AM rates (188 per 100,000 compared to non-Māori 85.0).

At Wairarapa DHB between 2010 and 2016, the most prevalent condition for AM was coronary disease (especially for Maori), followed by suicide, rectal cancer, COPD and female breast cancer.

Amenable mortality, ages 0-74, 2012-2016
Calculated using 2014 population data
With 99% confidence intervals

	Maori				non-Maori, non-Pacific				Total			
DHB of domicile	Deaths	Rate	LCB	UCB	Deaths	Rate	LCB	UCB	Deaths	Rate	LCB	UCB
Northland	632	231.4	207.7	255.1	832	85.4	77.8	93.0	1484	121.7	113.5	129.8
Waitemata	323	147.5	126.4	168.6	1854	58.0	54.5	61.4	2415	67.5	63.9	71.0
Auckland	297	176.9	150.5	203.3	1342	59.4	55.2	63.6	2055	76.9	72.6	81.3
Counties Manukau	707	220.4	199.0	241.7	1430	66.2	61.7	70.7	3040	102.7	97.9	107.5
Waikato	791	214.9	195.2	234.5	1716	82.1	77.0	87.2	2600	104.2	98.9	109.4
Lakes	393	241.7	210.3	273.1	442	86.1	75.5	96.6	852	123.4	112.5	134.3
Bay of Plenty	559	217.4	193.7	241.1	984	77.3	70.9	83.6	1577	104.8	98.0	111.6
Tairawhiti	264	233.1	196.1	270.0	160	86.7	69.0	104.3	434	139.6	122.4	156.9
Hawkes Bay	358	203.5	175.8	231.2	744	80.3	72.7	87.9	1149	103.7	95.8	111.5
Taranaki	163	185.8	148.3	223.3	596	85.7	76.6	94.7	775	97.6	88.6	106.6
Midcentral	262	192.0	161.5	222.6	943	91.9	84.2	99.6	1240	106.6	98.8	114.4
Whanganui	168	225.0	180.3	269.7	386	107.0	93.0	121.1	562	125.4	111.7	139.0
Capital & Coast	193	147.0	119.7	174.2	988	62.0	56.9	67.1	1357	74.3	69.1	79.5
Hutt Valley	169	174.8	140.2	209.4	638	80.6	72.4	88.8	884	94.3	86.1	102.4
Wairarapa	59	188.0	124.9	251.0	252	85.0	71.3	98.8	315	94.7	81.0	108.4
Nelson Marlborough	78	123.0	87.1	158.8	781	73.7	66.9	80.5	874	77.4	70.6	84.1
West Coast	30	181.4	96.1	266.7	232	108.0	89.7	126.3	269	117.2	98.8	135.6
Canterbury	298	160.4	136.5	184.4	2503	77.1	73.2	81.1	2886	83.7	79.6	87.7
South Canterbury	23	...	...	...	380	94.1	81.7	106.5	408	94.7	82.6	106.8
Southern	192	158.9	129.4	188.5	1729	86.1	80.8	91.4	1953	91.0	85.7	96.3
Overseas and undefined	13	...	...	...	249	...	...	...	315	...	...	...
Total New Zealand	5972	197.4	...	...	19181	75.1	...	...	27444	92.6	...	...

Rates per 100,000 age standardised to WHO world standard population
Rates are suppressed where there are less than 30 deaths

Milestone	Actions	Contributory Measures All contributory measures will be monitored by Māori, Pacific & Other Population where data allows
Reduce 0-74 years age standardised AM rate for Māori to at or below 165 per 100,000 (5 year average)	Continue to influence policy to improve healthy lifestyles through submissions to local councils and relevant national bodies e.g. supporting RPH submissions by co-signing or co-presenting	• Numbers of submissions
	Tū Ora in partnership with general practices, Māori, Pacific will implement a pro-equity Diabetes medication transition programme.	• Patients with CVD risk >15% who have been seen for annual review • Māori and Pacific patient with T2DM and HbA1c >53mmol/L who have been seen for empagliflozin consult
	Implement Access and Choice Wellbeing Support Initiative	• Number of patient encounters per Health Improvement Practitioner/ Coach by ethnicity, describing need and outcome for each encounter • Number of return patient encounters per Health Improvement Practitioner/ Coach by ethnicity, describing need and outcome for each encounter
	Develop new and innovative ways to support Whānau Māori to quit smoking. Facilitate smoking referrals from non-traditional locations i.e. Marae, Kapa Haka, Kohanga and in partnership with groups and communities	• Smoking quit rates for Māori & Pacific • Smoking Brief Advice in hospital by ethnicity • Number of current smoke-free projects conducted within the • Māori community with narrative/reports that outline the process and relationships

	(PHO/DHB/RPH/Māori/Pacific) to implement a holistic approach to becoming smoke free which includes breastfeeding, nutrition, physical activity, whanau ora navigation	
	Report on progress with the Pacific Navigation role and look for opportunities to grow Pacific Health service provision in Wairarapa over the next 2 years	• Māori and PI breast screening rates • Māori and PI cervical screening rates • Pacific health narrative/reports demonstrate engagement with Pacific individuals and whānau or identify gaps. • Brief or proof of concept developed looking into growing the Pacific Health resource and providership in Wairarapa

Youth access to and utilisation of youth appropriate health services

As a Wairarapa DHB system we want all our youth to have access to, and to utilise, appropriate services that meet their age-specific health needs. One of the DHBs priorities is to engage young people with health services where they are comfortable and receive youth friendly health care. 2020/21 has already seen some activity in the primary Mental Health (MH) integration space, as well as further growth of strategies to engage youth in the planning and maintenance of services locally. The remainder of the year will be formalising these into our business as usual and finalising our DHB Youth Strategy 2020-25.

Self-Harm

Youth access to the 'right' support and intervention and a positive experience in the relationship with health staff is key following a self-harm event or suicide attempt. A constructive helpful engagement can be key to positive longer term outcomes and the relationship formed with health service in ED are at the forefront of this relationship. With higher than national average rates of treatment for self-harm within the Wairarapa, particularly amongst Māori youth, our strategy needs to include focussed development of services in this area.

Youth Oral Health

Between 2010 and 2017 adolescent oral health utilisation dropped from 82% to 64%.
Rates of engagement with Maori and Pacific adolescents at 53/54% are considerably lower than the 83/84% being achieved with Asian and Other ethnicities.

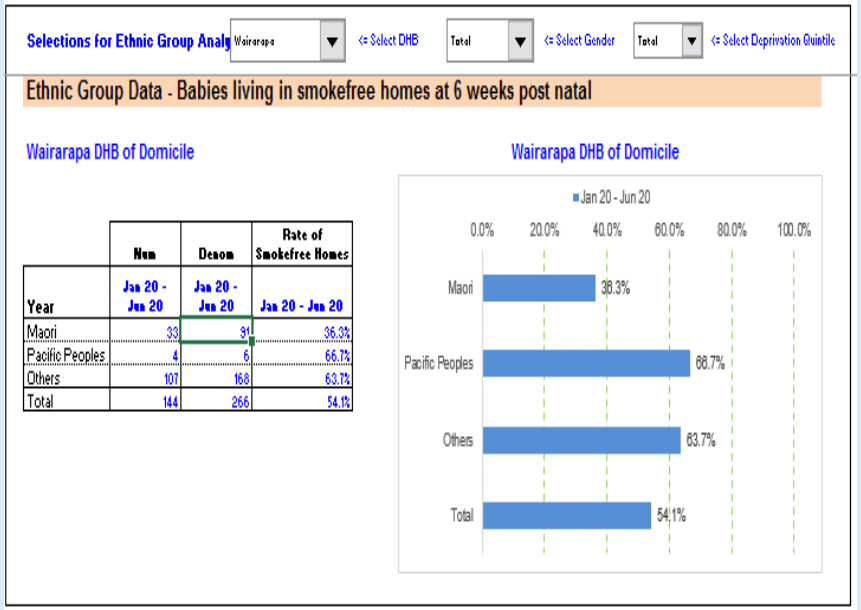
Milestone	Actions	Contributory Measures All contributory measures will be monitored by Māori, Pacific & Other Population where data allows
Access to preventative services:	• Finalise DHB Youth Strategy 2020-25 with key stakeholders • Key stakeholders identified and group TOR formulated. • Review youth service 2019 and DHB Youth Strategy recommendations for implementation and development of Youth Service and Strategy are finalised and implemented has begun by Qtr 4.	• Quarter 4. Report back on implementation progress
	• To deliver care within an integrated Wairarapa Youth Health Service. The Youth hub model of service is developed as part of the Youth Advisory group activity. • Engagement with other agencies to deliver services from Youth Hub • Consumer feedback is captured and utilized to develop focused outcomes. • Service development outcomes can be linked to customer survey feedback and satisfaction improvements by	• Rates of utilization are measured and show a 10% increase from baseline (Baseline to be established). • Review Customer satisfaction and Service Improvements Q2 & Q4.

Access to preventative services cont… Increase Māori (49%) and Pacific (56%) adolescent oral health utilisation to 60% by 30th June 2022 Mental Health and Wellbeing: Decrease intentional self-harm ED presentations / hospitalizations of Māori 10-24 year olds to a rate of 60 per 10,000 population (standardized)	Enhance youth primary mental health services across youth settings, including school based services and the youth clinic: • Investigate options in South Wairarapa for enhanced service development • Strengthen and improve responses of the Emergency Department and links with other agencies • Initiate Mental Health and Addictions Crisis support role within ED, including engagement with primary care for improved outcomes including follow up service post discharge	• Intentional self-harm presentations 10-14 and 15-19 years (Māori /Other) • Number of referrals to youth mental health programmes (Māori /Pacific/Other) • Primary health integration youth services have been initiated – numbers of referrals and active engagement data and referrals on to MH&A services Staff report increased confidence.
	Further develop the Youth Oral Health Coordination function to include protocols for information sharing between dentists and youth health providers. In collaboration with the Wairarapa Youth Health Service and the Youth Health Advisory Group develop a youth-led approach to oral health promotion.	• Year 9 transfers to community based dentists (Māori /Pacific /Other) • DNA rates

Babies in smoke-free households

As a Wairarapa DHB system we want all our children to have a healthy start in life. Babies and children who have a smoke-free home have better outcomes. One of our priorities is to reduce the rate of infant exposure to cigarette smoke. Maternal smoking is associated with a range of poor child health outcomes such as sudden unexpected death in infancy (SUDI) and low birth weight. This measure seeks to go beyond maternal smoking, focusing on the home and family/whānau environment. In addition to the benefits to babies of no smoke exposure, other members of the population would benefit from a change in the households' smoking behavior. There is also potential for positive impact at a broader system level, due to the integrated approach required between maternity, community and primary care services.

As at June 2020, 36.3% of Māori babies and 54.1% of all babies were recorded as living in smoke-free homes in the Wairarapa. This is a drop since June 2019.



Year	Num Jan 20 - Jun 20	Denom Jan 20 - Jun 20	Rate of Smokefree Homes Jan 20 - Jun 20
Maori	33	91	36.3%
Pacific Peoples	4	6	66.7%
Others	107	168	63.7%
Total	144	266	54.1%

Milestone	Actions	Contributory Measures All contributory measures will be monitored by Māori, Pacific & Other Population where data allows
Increase the % of Maori babies living in smoke-free homes to 50% by 30 June 2022.	First 1,000 Days Professional education day for clinicians with contact with Māori whānau with focus on motivational interviewing.	• Number of clinicians attending First 1,000 Days Professional education day
	Implement 'Hapūtanga' programme	• Programme referrals, enrolments, and quit rates • Pregnant women who identify as smokers upon registration with an LMC by ethnicity
	Contract local Māori heath provider to deliver wahakura [traditional Māori sleeping devices] and traditional baby rearing training to whānau	• Number wahakura and sleeping devices distributed • Number of whānau attending antenatal programme and attempting or completing wahakura weaving by ethnicity
	Refresh and Implement the DHB's 'Tapu te Hā' [*Tobacco Control Plan 2020/21*] including implementing processes for increasing referrals to cessation support services from LMCs and WCTO providers	• % and number of mothers smoke free at first core contact by ethnicity • PHO rate of babies in households with smokers by ethnicity • % and number of Mothers smokefree via LMC data collection by ethnicity
	Review the Kainga Ora Project refresh the approach in order to target vulnerable whānau with home assessment and remedies packages for creating a healthy home.	• Programme referrals, enrolments, and quit rates by ethnicity