Southern District Health Board
Piki Te Ora

Southern DHB Annual Plan 2018/19

E90

Incorporating the Statement of Performance Expectations (SPE)

OUR VALUES

Kind Manaakitanga

Looking after our people : we respect and support each other. Our hospitality and kindness foster better care.

Open Pono

Being sincere: we listen, hear and communicate openly and honestly and with consideration for others. Treat people how they would like to be treated.

Positive Whaiwhakaaro

Best action: we are thoughtful, bring a positiive attitude and are always looking to do things better.

Community Whanaungatanga

As family: we are genuine, nurture and maintain relationships to promote and build on all the strengths in our community.

OUR VISION

Better health, better lives, whānau ora

OUR MISSION

We work in partnership with people and communities to achieve their optimum health and wellbeing. We seek excellence through a culture of learning, inquiry, service and caring.

ANNUAL PLAN DATED XXXX

(Issued under Section 39 of the New Zealand Public Health and Disability Act 2000)

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FOREWORD FROM THE COMMISSIONER AND CHIEF EXECUTIVE

The Southern district is a vast and demanding landscape where, over generations, numerous health care structures have been established to enable us to take care of one another. These are wide and varied, from GP and nurse-led practices, to rural hospitals, iwi providers, NGOs, as well as the secondary and tertiary hospitals in Invercargill and Dunedin.

The challenge we share is to ensure that all of these efforts combine in the best possible way to provide the care our communities need, in the right place, at the right time.

This vision, to develop an equitable and coherent system of care across the Southern district, has been long been articulated, and is fundamental to our Southern Strategic Health Plan adopted in 2015. Numerous efforts have been made in pursuit of this in recent years, from the roll-out of shared electronic records, so all clinicians can access the same critical information when providing care to a patient, to specific models of care for conditions.

We have made some good progress in areas including virtual telehealth, reducing need for patients to travel for specialist appointments, and the integration of the Community Health Council, working to ensure the patient perspective is central to everything we do.

What has been lacking, however, is a comprehensive, agreed roadmap that would take us from our current state, to a truly integrated health system that sets us up for the future. In the past year, we added an important piece to this puzzle with the development of the Primary and Community Care Strategy and Action Plan.

Developed through extensive research and consultation with the community, and based on core principles, the Strategy envisages a health system that is more coordinated, accessible and delivered closer to home where possible. It spells out the practical steps required to achieve this, from encouraging general practices to offer more flexibility in providing care through the Health Care Home (HCH) model, to better enabling the community to access services and information online. It challenges us to look at how more specialist services can be delivered in a community setting, and achieve more through health care professionals working at the top of their scope. Some aspects of this are around sensible new initiatives, while elsewhere we have the opportunity to reset our understandings of how care is provided across the district.

Importantly, it calls upon all providers of health services in our district to present our services in a way that makes it easier for our communities to navigate. Building a stronger shared identity as members of the Southern health system reinforces our shared purpose, commitment to working together, and that we deliver care in a seamless and integrated way.

This 2018/19 Annual Plan centres on taking steps towards implementing this Strategy and Action Plan. In doing so, we welcome the additional support for primary care in the recent budget, supporting those at risk to seek care early, and in the right place.

We will also continue to build on the wider priorities of recent years, to ensure a transformed health system is built on a solid foundation.

These include developing a whole-of-system culture based on shared values, collaboration and innovation. We continue to invest in organisational capability and leadership, business and IT systems, quality improvement processes and communications with our communities. Implementation of our workforce and digital strategies are key areas of focus for the coming year, as are clinical service design projects. These are aimed at improving the flow of patients through our hospitals and wider health system, including improving access and reducing waiting times for acute and elective procedures.

We are also committed to improving our services in the fast-growing Queenstown-Lakes area, through the building work to develop the emergency, diagnostics and transfer capabilities at the hospital, and better supporting those living with long-term conditions in the district.

Our progress in reshaping our health system is receiving significant impetus through the planning for the new Dunedin Hospital. Achieving project milestones, in particular the Detailed Business Case and Implementation Business Case, will be a key focus in 2018/19.

As well as designing patient-centred, technology-enabled environments for our future patients and staff, the work demands that we look beyond our physical hospital walls, and consider how health care will be delivered in decades to come.

By asking questions around which services should be provided in a hospital setting at all, this project complements the goals for primary and community care.

We therefore have a unique opportunity to work on key pillars of our health system in tandem. Having a vision of the future, and putting in place the immediate steps to get there, means we can begin to enjoy the benefits of a redesigned health system long before the opening of the new hospital.

In all this work, we value our partnerships with the rural hospital trusts, primary and community care providers across the district, and iwi and education partners. By working together, and drawing upon the exceptional capability of our 4,500 staff and partners in the community, we are committed to delivering the health system the people of our district have asked us for.

Chris Fleming	Kathy Grant
Chief Executive	Commissioner
Southern DHB	Southern DHB

EQUITABLE OUTCOMES FOR CARE

E ngā iwi, e ngā rangatira, e ngā tangata o te Tai Tonga, tēnā koutou katoa

The 2018/19 Annual Plan has a strong focus on achieving equitable health outcomes for all population groups residing within the Southern district. Good health is a universal human aspiration and a basic human necessity to live well. Whilst good gains have been made, further actions and targeted work is required to ensure inequities are reduced and optimal care is achieved. Equitable care does not mean treating every patient exactly the same, rather it ensures best outcomes for all patients regardless of their background or circumstances.

Strengthening health equity is going beyond contemporary concentration on the immediate causes of the disease. In fact, it is removing barriers to health care and bias that contribute to poor health outcomes. Activity is aimed at reducing health equity gaps, for either Māori, Pacifica, high deprivation or vulnerable populations, was well as ensuring equal access for rural populations. Much of our population reside in rural areas that are widely dispersed across our district. We all have a responsibility to address the disparities and inequities within our communities.

The Ministry of Health (MoH) are requiring specific actions to achieve health equity, and each government health priority requires an *Equitable Outcomes Action* (EOA). Each EOA is clearly defined within the AP; at least one equity activity will address the disparities between Māori and non-Māori. Affirmative actions that will create fairness across the 'whole' Southern health system will make the biggest difference. Additional actions also include our response to Refugee health needs, in the additional context that Southern DHB now has the largest annual resettlement volumes of all DHBs.

The 2018/19 Annual Plan will measure data that is captured as Māori and non-Māori whenever possible. This allows ongoing monitoring of achievements and opportunities for improvements to ensure that there is a continued focus on achieving equitable health outcomes. To reduce inequities it is important to improve quality and performance and increase access to health care across the whole health system.

Implementation of the 2018/19 Annual Plan will require an integrated and collaborative approach across the Southern health system. Collectively, we will accelerate Māori health gains by ensuring the health needs of patients, whānau and our communities are met so that our people can engage effectively in society.

Nā tō rourou, nā taku rourou ka ora ai te iwi

With your food basket and my food basket the people will thrive

Signature Page

This Annual Plan is signed and approved by the Minister of Health, Minister of Finance, the Commissioner and Chief Executive of the Southern DHB, as required under section 39(3) of the New Zealand Public Health and Disability Act 2000.

Kathy Grant

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Kathy Grant
Commissioner
Southern District Health Board
Date: ...12.. / ...02... / 2019

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Chris Fleming
Chief Executive
Southern District Health Board
Date: ...12.. / ...02... / 2019

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Hon. Dr David Clark
Minister of Health
Date: ..13.. / ..2.. / 2019

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Hon. Grant Robertson
Minister of Finance
Date: ..24.. / ..2.. / 2019

MINISTER'S LETTER OF APPROVAL

Hon Dr David Clark

MP for Dunedin North
Minister of Health
Associate Minister of Finance

27 FEB 2019

Mrs Kathy Grant
Commissioner
Southern District Health Board
kathy.grant@thegrants.nz

E-MAILED

Dear Kathy

Southern District Health Board 2018/19 Annual Plan

This letter is to advise you I have approved and signed Southern District Health Board's (DHB) 2018/19 Annual Plan for one year together with the Minister of Finance.

I have been clear that my expectation for the total DHB sector financial position was that it was an improvement on 2017/18. I am concerned that this expectation is unlikely to be met. I have previously emphasised to you that it is important DHBs are doing all they can individually and collectively – both regionally and nationally to live within the funding provided. I note your DHB has planned significant deficits in 2018/19 and in the coming years. I encourage your Board to consider appropriate activities to ensure that you reduce the projected deficits in the coming years.

With the hospital redevelopment work underway, it is important that your DHB reaches a sustainable financial operational position as soon as possible. I understand that you are developing a financial recovery plan, and look forward to successful achievement of this plan. This will require a concerted effort and I trust that you will continue to work with the Ministry of Health to evaluate and improve your financial performance.

Your Production Plan is still to be confirmed, and you will work with the Ministry to resolve this.

I am aware you are planning a number of service reviews in the 2018/19 year. My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

It is really important that the health sector continues to deliver timely and effective services so that we can provide high quality and equitable outcomes for New Zealanders. I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2018/19 Annual Plan. I look forward to seeing your achievements.

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

Yours sincerely

Hon Dr David Clark
Minister of Health

cc: Mr Chris Fleming, Chief Executive, Southern District Health Board, chris.fleming@southerndhb.govt.nz

1 OVERVIEW OF STRATEGIC PRIORITIES

1.1 STRATEGIC INTENTIONS AND PRIORITIES

Strategic Context

This Annual Plan for 2018/19 articulates Southern DHB's (SDHB) commitment to meeting the expectations of the Minister of Health. The Plan will deliver against national and regional priorities and illustrate our continued commitment to the goals of supporting everyone across our district to live well and access the right care when they need it. We will work as part of a wider Southern health system to deliver high quality, patient-centred and equitable health services to our diverse communities.

National Direction

The long-term vision for New Zealand's health service is articulated through the New Zealand Health Strategy. The overarching intent is to support all New Zealanders to 'live well, stay well, and get well'. [1]

The Strategy identifies five key themes to give the health sector a focus for change:

- People powered
- Closer to home
- High value and performance
- One team
- Smart system

Figure 1:
Five strategic themes of the Strategy

Southern DHB's direction is further guided by a range of population or condition-specific strategies. These include: *He Korowai Oranga*[2], *Ala Mo'ui*: Pathways to Pacific Health and Wellbeing[3], *Healthy Ageing Strategy*[4], *Rising to the Challenge*: Mental Health & Addiction Service Development Plan[5], *Disability Strategy*[6] and the UN Convention on the Rights of Persons with Disabilities.

The Ministry of Health's letter of expectations signals annual expectations and priorities for DHBs. The Government has signalled an increased priority for primary care, mental health, public delivery of health services and a strong focus on improving equity in health outcomes.

Southern DHB aligns health and disability services with *He Korowai Oranga*, the New Zealand Māori Health Strategy and is committed to a special relationship between Iwi and the Crown under the Treaty of Waitangi. A *Principles of Relationship*[7] - *Te Hauroa o Murihiku me Araiteuru* is in place between Murihiku and Araiteuru Rūnaka and the Southern DHB. The purpose of *Te Hauora o Murihiku me Araiteuru* is to improve Māori health and wellbeing outcomes in the Southern district.

DHBs are expected to work closely with and support their local public health units and health promotion providers; continue to focus on capital planning; support regional delivery of services where appropriate; be bold with workforce change and increase collaboration.

DHBs are also expected to increase the rate of organ donations; improve the health and wellbeing of infants, children and youth; improve equity and reduce the burden of long term conditions, particularly diabetes; and address climate change. This Annual Plan outlines how the Southern DHB will meet those expectations in 2018/19.

[1] Minister of Health. 2016. New Zealand Health Strategy. Wellington: Ministry of Health www.moh.health.nz
[2] Ministry of Health – *He Korowai Oranga* – Māori Health Strategy (2013/14) http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga
[3] Ministry of Health - 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing (2014–18) http://www.health.govt.nz/publication/ala-moui-pathways-pacific-health-and-wellbeing-2014-2018
[4] Ministry of Health – Healthy Ageing Strategy (2016) http://www.health.govt.nz/publication/healthy-ageing-strategy
[5] Ministry of Health – Rising to the Challenge (2012-17) http://www.health.govt.nz/our-work/mental-health-and-addictions/rising-challenge
[6] Office of Disability Issues – Disability Strategy (2016-26) http://www.odi.govt.nz/nz-disability-strategy/
[7] Principles of Relationship – Te Hauroa o Murihiku me Araiteuru http://www.southerndhb.govt.nz/files/15686_2015051993319-1431984799.pdf

Regional Direction

There are five DHBs in the South Island (Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern) and together we provide services for over one million people, almost a quarter (23.2%) of the total New Zealand population. While each DHB is individually responsible for the provision of services to its own population, we work regionally through the South Island Alliance to better address our shared challenges and technology and demographics. Our jointly-developed South Island Regional Health Services Plan outlines the agreed regional activity 2016-2019. The Regional vision is a sustainable South Island health system, focused on keeping people well and providing equitable and timely access to safe, effective, high-quality services as close to people's homes as possible. Southern DHB has made a strong regional commitment and staff take the clinical or executive lead in a number of priority areas such as mental health and addiction services, IT, and public health.

Southern DHB Direction

In agreeing local priorities with the Ministry of Health for 2018/19, four focus areas were signalled. These areas align with the national direction and the strategic themes identified by our Commissioners. Action in support of these local priorities are highlighted in the next section of the plan.

1. Facilities and the Dunedin Rebuild Transition Programme: This focuses on work required to ensure safety and sustainability of services for the next 10 years until the opening of the new hospital. This includes maintenance, creating physical capacity with alterations and capacity through outsourcing elective volumes and day case procedures. A key part of this activity will be the development of an Ambulatory services centre, which will open in advance of the new Dunedin Hospital, and will focus on delivering day surgery and outpatient clinics, as well as other secondary services that are not required to be delivered from the Acute services block. This is a critical first step in moving to new strategic models of care which includes altering behaviours across clinician groups as well as patients to think and use both acute hospital, community and primary care services differently.
2. Valuing Patient Time: This is a critical programme which SDHB will be partnering with Francis Health to deliver. The approach is based on the principles of Agile, so that high staff engagement translates to swift change with a balanced approach to traditional project management processes. Critical to this work will be the mentoring, support and engagement of clinicians, to lead a transformational change process in patient care, resulting in initiatives across primary & community and acute hospital based on shaping or reducing demand, matching capacity and demand, and redesigning the system.
3. Primary and community services, investing in change: Developed in partnership with WellSouth PHO, the Primary and Community Strategy has been developed as a framework for primary, community and secondary areas that also acts as an enabler for the delivery system to be reframed. It forms the first of the two key planks to create system change alongside Valuing patients Time. We have now articulated at a conceptual level a change programme focussed on redesigning services across the Southern health system to achieve our commitment to integrated, patient focussed care and many of these initiatives are already underway.
4. Which services go where, both at a district and regional level: A critical part of the planning for the new Dunedin hospital is the appropriate planning for what can be provided in the regions, and what is required to enable this. The Southern DHB is undertaking upgrade work to Lakes Hospital to ensure that services can be delivered for the next 7-8 years whilst further work is undertaken to look at the needs of the broader Lakes/Dunstan area, taking into consideration the projected population growth and where services are best placed. This includes an examination of primary maternity needs; the DHB will consider long term positioning of primary birthing units across the district given the change in population.

Given the strong foundation of organisational and culture change that has been laid down in recent years, the DHB is well placed to continue in 2018/19 on this journey of change. In the past year we undertook a restructure to better align our key roles and responsibilities to the transformational changes envisioned, and this has clearly enabled a sharpened focus on integration with primary care, improved clinical quality and safety and more strategic investments in effective infrastructure such as IT. The organisational restructure has been implemented and all new roles have been filled. A platform has therefore been articulated which outlines the pathway we will take to organisational stability and an eventual breakeven position.

The development of the Primary and Community Care Strategy and Action Plan in the preceding year has provided a much needed roadmap for not only Primary Care but also the broader system and 2018/19 will see a significant emphasis supported by sizable investment on the realisation of the year one goals outlined in the plan. These include the development of the first tranche of Healthcare Homes alongside the establishment of a network of Healthcare Hubs, which collectively will provide the relevant

infrastructure to begin integrating key services across traditional domains of primary and secondary care. The HCH model reinforces the role of the general practice as the main provider of primary care and enhances capacity and capability through new roles, skills and ways of working[8]. HCHs will be rolled out across the district in accordance with national model of care requirements which will see traditional general practices transition into modern, fit for purpose business units which are characterised by being:

- The key source of holistic care for patients
- Embracing of risk stratification to target workforce time and effort to people with higher need
- Expanded primary care team though introduction of new workforce roles
- Made up of higher skills within scopes of practice, and delegation of clinical and non-clinical functions within the team
- Engaged in the education of undergraduate and postgraduate students, as well as participation in primary care research networks
- Able to provide urgent and extended consultations
- Able to employ virtual health approaches to enhance access
- Able to employ system-generated contacts to support proactive practice engagement with consumers
- Able to utilise evidence-based care pathways
- Actively involved in care planning and delivery with DHB and NGO services as part of locality networks
- Actively engaged in the education of undergraduate and post graduate students, as well as participation in primary care research networks
- Able to move to hub and spoke models through the development of large Community Care Hubs networked with other locality providers

Shift services into the community where appropriate

As part of the Primary and Community Care Action Plan, the DHB is in discussions with WellSouth on the development of the community hubs, in terms of the number, location and the range of services that will be provided from them. This work will link in with the further work underway over June and July 2018 on revising the schedule of accommodation with regard to services that could be shifted from the hospital to the community in conjunction with the plans for the Dunedin rebuild and the capital development to see additional capacity available for emergency care at Queenstown Lakes District Hospital.

The community care hub models will provide expanded HCH services, to include colocation of community health services, both mobile and in-clinic services (for example rehabilitation), hospital specialist care, on-site pharmacy and diagnostics, enhanced urgent care and minor procedures.

The DHB has identified a range of services that could appropriately be repurposed to operate from an ambulatory care centre, but before this can be ultimately confirmed important current conversations need to be concluded to ensure that the opportunity for integrated care responses delivered out of Community Health Hubs are maximised and leveraged. To support the discussion, a closer examination of current patient pathways through the inpatient journey are being undertaken, firstly to ensure that as an organisation we truly are valuing patient time, but also to ensure that we are committed to shifting as much activity to the community to be delivered in a primary/secondary partnership model as is clinically appropriate. In turn, opportunities to execute a more generalist medical workforce, to employ the Calderdale Framework for Allied Health, are also being explored.

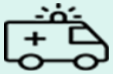
Alliance South

Alliance South, the Southern health system primary care alliance, is being recommissioned with the first meeting being held early in July 2018. The main body of work for the new Alliance will be to provide governance for the implementation of the Primary and Community Care Strategy while also monitoring progress with the suite of System Level Measures (SLMs). An Independent Chairperson has been appointed by the chief executives of the Southern DHB and WellSouth Primary Health Network. New terms of reference are being finalised prior to the appointment of the new Alliance Leadership Team.

[8] Draft Southern Primary and Community Care Action Plan, (2018) SDHB and WellSouth Primary Health Network

Our Health and Wellbeing

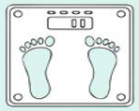
People living in the Southern district have relatively good health status[12] compared with the rest of New Zealand. However, there are a number of areas still requiring improvement to reduce inequalities.



Emergency Department attendances for Southern residents have been rising faster than population growth, suggesting potential barriers in accessing primary care.

Smoking rates are decreasing, but remain nearly twice as high for Māori as for non-Māori.

Our rates of chronic disease (diabetes, cardiovascular disease, stroke, cancer, asthma and chronic obstructive respiratory disease) are similar to national rates.



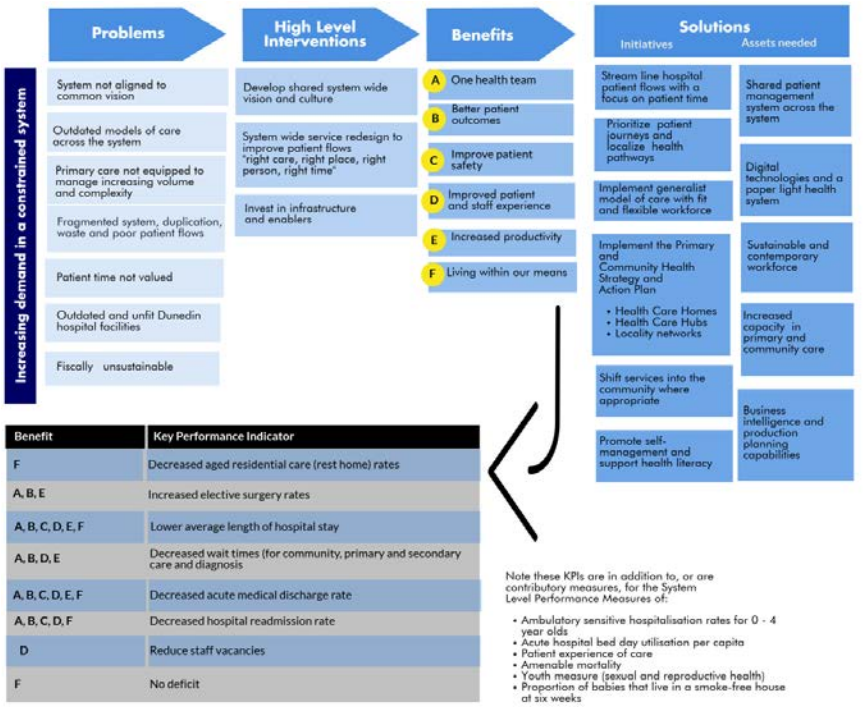
Our adult non-Māori population are more likely to be overweight than the Māori population. However, Māori children were twice as likely, and Pacific children three times more likely to be overweight.

System wide service redesign to value our patients' time and streamline the patient journey

Southern DHB is committed to a quality and patient-focused health system while achieving clinical and financial sustainability. Health systems are complex and this requires an approach that addresses not only services and performance but how we engage with our people and the way we work together.

Other initiatives will need to be fully scoped, approved and planned but these include a range of activity to ensure that we are able to deliver on the national, regional and local priorities as described in more detail within the plan. As a priority, we will look to an overarching programme of patient flow and service redesign that will provide a robust level of assurance to our community that we do in fact value patients' time and are working in a way that gives confidence to our governance team that we are efficient, effective and that models of care are ready to transition into a fit for purpose Dunedin Hospital in 7 years.

Figure 1: Intervention Map



Population Performance

Public health is the part of our health system that works to keep our people well. The public health goal is to improve, promote and protect the health and wellbeing of populations and to reduce inequities. Key strategies are:

1. Information: sharing evidence about our people's health and wellbeing (and how to improve it)
2. Capacity-building: helping agencies to work together for health
3. Health promotion: working with communities to make healthy choices easier
4. Health protection: organising to protect people's health, including via use of legislation
5. Supporting preventive care: supporting our health system to provide preventive care to everyone who needs it (for example immunisation, stop smoking)

The principles of public health work are: focusing on the health of **communities** rather than individuals; influencing **health determinants**; prioritising improvements in **Māori health**; reducing **health disparities**; basing practice on the best available **evidence**; building effective **partnerships** across the health sector and other sectors; and remaining **responsive** to new and emerging health threats.

Public health takes a life course perspective, noting that action to meet our goal must begin before birth and continue over the life span**.** Southern DHB is committed to exploring life course approaches as a way of understanding our population performance challenges. The most significant actions Southern DHB expects to deliver in the 2018/19 year to address local population challenges are identified in the table below:

Life course group	One significant action that is to be delivered in 2018/19
Pregnancy	Implementation of the Primary Maternity System of Care (refer Section 3.1: Service Change)
Early years and childhood	Improve co-ordination across maternal and infant health (refer Section 2: Child Wellbeing)
Adolescence and young adulthood	Development of a Youth Health Strategy (refer Section 2: Child Wellbeing)
Adulthood	Roll out of CLIC (refer Section 2: CVD and Diabetes Risk Assessment)
Older people	Home Team (refer Section 2: Healthy Ageing)

At a Glance ***Southern Population***

We are the DHB in New Zealand with the largest geographical area.

Approximately 329,890 people live in the Southern district. Approximately 40% live in rural areas that are widely dispersed across the district. The other 60% of the population live in the two main centres of Dunedin and Invercargill.

Ethnically the Southern district is predominantly European, at 80.6%, 10.1% are Māori, 7.3% Asian and 2.0% Pacific.

Our population is slightly older when compared to the national

2 DELIVERING ON PRIORITIES

2.1 GOVERNMENT PLANNING PRIORITIES

Overarching Government priorities were presented in the previous Minister's Letter of Expectations which was sent to the Southern DHB Commissioner in May 2018. DHBs are expected to consider and include actions in their Annual Plans that will help them to achieve health equity for all of their populations, including Māori. Guidance was received from the Ministry around each priority area. Equity actions are identified within this Annual Plan with the abbreviation "EOA**"** *for "Equitable Outcomes Action*" immediately following any action that is specifically designed to help reduce health equity gaps.

Government Planning Priority		Link to NZ Health Strategy	Southern DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Child Health	Child Wellbeing	Value and High Performance hāinga hua me te tika o ngā mahi	1. The Well Child Tamariki Ora (WCTO) Quality Improvement Framework (QIF) Steering Group will work together to plan for increased coverage and service delivery, information sharing and to assist local programme development (EOA)	▪ WCTO QIF Steering Group will meet quarterly throughout 2018/19 ▪ Review WCTO QIF work plan annually	PP27: Supporting child well being Increased enrolment in WCTO services Increased completion of WCTO contacts SI: 18 Improving newborn enrolment in general practice PP37: Improving breast feeding rates Number of wahakura and pepi pods distributed across the district
			2. Host a district wide breastfeeding Hui with key stakeholders to agree strategies to increase breast feeding support across the Southern district. This will build on the 2018 South Island Alliance Stocktake of Breast Feeding and the Maternity Quality and Safety Māori breast feeding Hui (EOA)	▪ Hold Breast Feeding hui Q2 ▪ Consider and implement recommendations following hui Q4	
			3. Draw together Māori and Pacific Well Child Tamariki Ora providers and others to enhance safe sleep programmes to: ▪ Increase awareness of SUDI ▪ Increase understanding of how to safely sleep babies ▪ Provide access to wahakura by establishing weaving programmes and process to distribute wahakura to those who do not wish to weave them (EOA)	▪ Community consultation is held in Dunedin and Invercargill Q1 ▪ Safe sleep programme is developed, contracts are in place with providers and weaving with interested whanau begins Q3 ▪ Wahakura are available across the Southern District Q3	
			4. To improve responsiveness to Sudden Unexplained Death in Infants (SUDI), we will: ▪ Review (2017/2018) work plan ▪ Establish and operationalise 2018/2020 SUDI work plan for the MoH by consultation with key stakeholders across the Southern district (EOA)	▪ Southern district SUDI work plan is submitted to the MoH following engagement with key stakeholders Q1 ▪ Education hui on SUDI for key stakeholders is held across the Southern district Q2	
			5. SDHB Pregnancy and Parenting Services will pilot with Plunket to deliver individual pregnancy and parenting packages of care for women and whanau who find it difficult to participate in a traditional course environment, in particular Māori and Pacific families or those with mental health illness (EOA)	▪ Contract variation in place with Plunket Q1 ▪ Plunket deliver individual packages of care Q1-4	

			6. Produce a Youth Health and Wellbeing Strategy that articulates the vision for collaboratively improving health outcomes for young people so that they flourish. Specifically we will: ▪ Produce a Southern Youth Health and Wellbeing Strategy ▪ Produce a supporting action plan that clearly defines and prioritises actions required to implement the strategic vision	▪ Southern Youth Health and Wellbeing Strategy and action plan is produced by Q4	
			7. Work with I-Moko and Ministry of Education to roll out the I-Moko healthcare programme in lower decile areas of the Southern district. The programme assesses common ailments, which can be identified, triaged and treated from within either an early childhood centre (ECC), kōhanga reo or a primary school setting. I-Moko is to connect back to the child's primary care practice for those children assessed (EOA) ▪ Southern DHB to work with MoE to identify up to six Early Childhood Centres (ECC), kōhanga reo or primary schools to roll out I-Moko in the Southern district ▪ Identified member in each ECC, kōhanga or school is trained to deliver I-Moko ▪ Up to six childhood centres, kōhanga reo or primary schools agree to participate in I-Moko; work through processes to launch the programme within their organisations and with families	▪ Identification of up to six ECC, kōhanga reo or primary schools to roll out I-Moko in the Southern district Q1 ▪ Launch of I-Moko with up to six participating organisations and families Q3 ▪ Increase in Māori enrolment in primary care within the Southern district by Q4	Number of consents given within each participating ECC, kōhanga or school as a percentage of children enrolled in centre Number of referrals of children for consultations recorded by learning centre/domicile, ethnicity Māori enrolment in primary care within the Southern district

Government Planning Priority		Link to NZ Health Strategy	Southern DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	**Milestones**	
Child Health	**Maternal Mental Health Services**	**Closer to Home Ka aro mai ki te kāinga**	1. Review service provision for maternal mental health as part of ensuring best start in life	▪ Co-design process to explore child and youth and maternal mental health is established Q4	PP7: Improving the health status of people with severe mental illness through improved access PP8: Shorter waits for non-urgent mental health and addictions services for 0-19 year olds PP44: Maternal mental health
			2. Explore options for closer working with primary care and midwifery services for early identification and intervention	▪ Model of care review for maternal mental health 2018-2019 is completed by Q4	
			3. Explore options for a connected up mother and baby mental health model of care, including primary and secondary across the district: ▪ Review current provision (2019) and review other similar reports ▪ Consider alternative models of care	▪ Review is completed and report generated by Q4	
			4. Identify the number of women, including Māori women, accessing primary maternal mental health services funded through DHB contracts ▪ Identifying the number of Māori women will contribute to understanding gaps in services and support service changes to ensure best start in life (EOA)	▪ Report is submitted on the number of women (including Māori women) accessing DHB funded primary maternal mental health services Q4	
Child Health	**Supporting Health in Schools**	**Closer to Home Ka aro mai ki te kāinga**	1. Continue to work with the Ministry of Education (MoE) on the roll out of Communities of Learning (EOA) ▪ Support Public Health Nurses to engage in processes within identified areas (Milton, Gore and Maniototo) ▪ Identify number of Māori children who require additional support with transition to school	▪ Communities of Learning are established in the 3 pilot sites by end of Q4 ▪ Report on number of children starting in the 3 pilot sites during the school year Q4 ▪ Report on number of Māori children who require additional support with transition to school Q4 ▪ Report on type of support/intervention provided Q4	PP39: Supporting Health in Schools - Number of non-critical reports of concern received by Oranga Tamaraki -Number of renotifications
			2. Continue to work with MoE and Oranga Tamariki, to address systemic barriers ▪ Provide necessary information to schools to support education of children with identified health needs	▪ Processes in place to support implementation of information sharing from B4 Schools Check (B4SC) and Gateway Health Assessments Q4	
			3. Partner with Oranga Tamariki and NGOs on the Urban Dunedin Initiative with intent to improve the health outcomes for Māori (EOA) ▪ Develop a pathway for non-critical reports of concern received by Oranga Tamariki Urban Dunedin site ▪ Monitor number of renotifications	▪ Completion of the Urban Initiative by the end of Q1	

			4. Identify actions currently underway to support health in schools	▪ Report of actions underway to support health in schools Q2	
Child Health	**School Based Health Services (SBHS)**	**Closer to Home Ka aro mai ki te kāinga**	1. Work to improve equitable access to School Based Health Services (SBHS) to improve health outcomes for youth across the District (EOA) ▪ Complete a stocktake of health services in public secondary schools in the DHB catchment ▪ Use equity tools to assess and identify disparities ▪ Engage established youth and student advisory groups in process ▪ Develop an implementation plan which outlines activities for improved equitable access and outcomes, as well as timeframes for how SBHS would be expanded to all public secondary schools in the DHB catchment	▪ Stocktake report completed by end of Q2 ▪ Implementation plan developed by end of Q4	PP25: Youth mental health initiatives Number of nurses completing training by then end of Q4: - Youth Health training programme -eCALD Cultural competence training - Diversity training
			2. Continue to develop the youth health training programme, to ensure youth friendly service provision (EOA) ▪ Support workforce development priorities: primary mental health, sexual health and diversity	▪ Youth health training programme developed and implemented by Q4	
			3. Work with WellSouth and Family Planning to improve access to sexual and reproductive health services across Southern (EOA) ▪ Finalise and implement Southern Sexual and Reproductive Health Strategy ▪ Identify service redesign, using equity tools to assess and identify disparities in current service provision ▪ Identify actions for specific groups with higher needs or who are less likely to use other health and social services	▪ Southern Sexual and Reproductive Health Strategy finalised by end Q1 ▪ Implementation plan developed by Q3	
Child Health	**Immunisation**	**One Team Kotahi te tima**	1. Continue Immunisation target work to ensure services are 'Reaching Every Child' on time every time (EOA) ▪ Readjust service delivery models to align with community needs and to support One Team Approach - Realign services to support families in a more integrated way, i.e. wraparound service - Focus on vulnerable families (including Māori) , e.g. those not currently engaged with GPs, to improve equity of care - Share administration between child health services such as dental services, immunisation, B4 School Check and Public Health Nursing to identify and follow up children missing out on services ▪ Undertake work to understand the volatility of Māori coverage rates ▪ Undertake a review of declines, delays and DNAs (did not attend)	▪ Increase in coverage rates of Māori children at 6 months of age ▪ More consistent coverage rates for Māori children is achieved by end of Q4, across all milestones ages ▪ NIR data merge completed by end of Q2 ▪ Report on outcome of review of declines, delays and DNAs by Q2	PP21: Immunisation coverage Every child has an identified GP and Well Child Tamariki Ora Provider by 3 months of age Number of PHNs/B4SC nurses able to provide opportunistic vaccinations across the district Coverage of vaccination in pregnancy
			2. Continue to work with the Ministry of Health (MoH), Immunisation Advisory Centre (IMAC) and WellSouth on the feasibility of an 'Online Catch Up Calculator' (EOA)	▪ Feasibility report produced by end of Q2 ▪ Implementation plan completed and signed off by end of Q4 (subject to outcome of feasibility study)	

			3. Increase number of workforce providing opportunistic vaccinations (EOA) ▪ Change DHB vaccinator training update and authorisation criteria from age specific to site specific ▪ Explore the feasibility of combining the Vaccine Preventable Disease (VPD), Human Papillomavirus (HPV) and Influenza steering groups, to adopt and lead the One team approach	▪ Change DHB vaccinator authorisation criteria from age specific to site specific Q3 ▪ Report on Feasibility of combining the VPD, HPV and Influenza steering groups Q2	
			4. Promote the benefits of vaccination in pregnancy ▪ Work with Midwifery sector on identifying education needs and roll out promotion of key National messages ▪ Work with WellSouth to deliver opportunistic vaccinations through Outreach services	▪ Denominator and numerator identified Q1 ▪ Increased coverage of vaccination in pregnancy Q2-Q4	
Child Health	**Responding to Childhood Obesity**	**Closer to Home Ka aro mai ki te kāinga**	1. Continue to achieve health measure for Raising Healthy Kids ▪ Review and monitor Ministry of Health monthly report and quality report templates for target volumes inclusive of priority population targets including high deprivation Māori and Pacific ▪ Continually make quality improvements to the B4 School Checks Healthy Kids Clinical Pathways and action service model of care to achieve targets in all population groups ▪ Maintain focus on removing barriers to access to B4 School Checks for priority population groups (including Māori), e.g. clinic appointments out of hours, home visits, Te Reo speaking nurse, Whanau Ora services (EOA) ▪ Continue to monitor and reduce decline rate for healthy weight referrals	▪ B4 School Check 95% target for raising healthy kids including high deprivation, Māori and Pacific achieved by end Q4 ▪ Report on outcomes of quality improvements to Healthy Kids Clinical Pathway at end of each quarter ▪ 80% of Children identified in B4 School Check with a height and weight ≥ 98 centile are referred by Q4	
			2. Workforce development and education ▪ Continue with a whole of life approach to healthy kids through regular education and training on healthy lifestyles conversational interventions and resources	▪ All Southern DHB B4 School Check trained nurses have completed training in healthy weight interventions for children by Q4	
			3. Continue to promote key health messaging and brief healthy weight interventions to parents and child health sector ▪ Engage and liaise with parents through Early childhood sector and Well Child services on Healthy Weight key messages and brief interventions	▪ Report on sector engagement Q1-Q4 ▪ Report on B4 School Check parent feedback Survey Q1-Q4	

Government Planning Priority		Link to NZ Health Strategy	Southern DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Mental health	**Population Mental Health**	**One Team Kotahi te tima**	1. Work across the Southern district to enable more people with mental illness, mental health problems and addiction issues to experience better physical health (EOA): ▪ Include as outcome in refreshed Raise Hope – Hāpai Tūmanako mental health and addiction strategic plan ▪ Increase primary health participation in Southern Mental Health and Addiction Network and support development of health pathways ▪ Establish operational links with stop smoking campaigns/services ▪ Prioritise management of long term conditions with GPs through CLIC programme (refer Primary Care) ▪ Phase 1 Primary and Community Care Action Plan has aspects to integrate mental health and addiction services into Primary Care ▪ Provide accessible activity focused services (day activity) ▪ Establish links and pathways with government agencies for access to health housing ▪ Promote and support use of low cost primary practices especially for Māori to reduce over-representation in inpatient services (EOA)	▪ Operational links established with smoking campaigns/service links Q2 ▪ Number of consumers registered with and accessing PHO increased by Q4 ▪ Mental health pathways developed and implemented for primary care to support appropriate onward referral and service access for treatment and support Q3 ▪ Pathway established for access to healthy housing Q4 ▪ Report on progress for the promotion and support of low cost primary practices in Q2 and Q4, highlighting number of Māori enrolled	Number of consumers registered with and accessing PHO PP7: Improving the health status of people with severe mental illness through improved access PP26: The Mental Health & Addiction Service Development Plan PP31: Better Help for Smokers to quit in public hospitals PP36: Reduce the rate of Māori under the Mental Health Act: section 29 Community Treatment Orders Number of staff and community members participating in the Govt inquiry
			2. Enable whānau to better support and care for each other ▪ Undertake pilot re access to psychological therapies, including evaluation and plan for full roll out ▪ Establish pathways for appropriate access to Māori healing (EOA) ▪ Work with Oranga Tamariki to provide support for relationships and attachments ▪ Deliver three Single Session Family Consultation Workshops Supporting Parents (Healthy Children) ▪ Work to improve connections to community resources – including existing social networks through networks such as hapu, faith-based, Lesbian, Gay, Bisexual, Trans, Intersex (Takatapui) EOA	▪ Psychological therapy pilot is undertaken by end of Q2 ▪ Evaluation of pilot is completed by end of Q3 ▪ Plan for full roll out is completed by Q4 ▪ Three Supporting Parents sessions are delivered Q1 ▪ Report on number accessing Māori healing by Q4	
			3. Facilitate the participation of staff and community members in the Government inquiry into mental health and addiction ▪ Promote and publicise public forums ▪ Provide space for NGO and community group presentations to panel ▪ Hold staff specific meetings ▪ Participate as requested by the Inquiry Panel	▪ Promotion and publicity is undertaken to facilitate public participation Q1-Q4 ▪ Specific meetings are held for staff Q1-Q4 ▪ Panels include NGOs and community groups Q1-Q4	

Mental Health	**Mental Health and Addiction Improvement Activities**	**One Team Kotahi te tima**	1. Engage with the HQSC co-design process for reducing use of seclusion, follow up after discharge (transition) and advanced directives work ▪ Participate in National HQSC projects ▪ Meet timelines of the National HQSC projects ▪ Undertake analysis for seclusion project ▪ Recruit project team members (inter disciplinary, NGOs) ▪ Support programme roll out through co-design workshops	▪ Completion of National HQSC projects Q1-3 ▪ Analysis and gaps analysis for seclusion project Q1-3 ▪ Recruitment of project team members Q1 ▪ Co-design workshops support programme roll out Q3	PP7: Improving the health status of people with severe mental illness through improved access PP36: Reduce the rate of Māori under the Mental Health Act: section 29 Community Treatment Orders Number of consumers registered with and accessing PHO Number of Marama RTF collections Number of co-design sessions Number of listening sessions
			2. Enable more people with mental illness, mental health problems and addiction issues to experience better physical health (Refer to Population Mental Health Action number 1 (EOA) ▪ Link to Southern Primary and Community Care Strategy and integrate mental health into community hubs ▪ There are anticipated benefits for Māori with integrated health care, including hinengaro, wairua and tinana		
			3. Learn from adverse events & consumer experience ▪ Co-design consumer reference groups support improvement programmes of work ▪ Hold six listening (focus) groups for consumers and families	▪ Implement Marama real time feedback (RTF) by Q2 ▪ Hold six focus groups for consumers and families Q1-Q4	
Mental Health	**Addictions**	**Value and High Performance Te whāinga hua me te tika o ngā mahi**	1. Evaluate the repatriation of regional addiction services to ensure they meet local needs including: (EOA) ▪ Sufficient levels of culturally appropriate services for Māori and Pacifica, especially community options ▪ Sufficient levels of rural and remote access to AOD (alcohol and other drug) services	▪ Engage with South Island (SI) Regional Services Q1 ▪ Co-design processes organised to gather data on need, including gaps for Māori Q4 ▪ Progress report in Q2 and Q4	PP6: Improving the health status of people with severe mental health through improved access
			2. Co-design mental health and addiction system and identify opportunities for integrated working with greater consumer and whanau centric support and services (physical health, addiction, mental health: ▪ Increase assessments undertaken in mental health for addiction issues ▪ Addiction services undertake treatment work for mental health issues ▪ Refresh Specialist Services for Co-Existing Problems systems	▪ Report on progress Q4 re number of assessments completed, treatment work undertaken for mental health issues and Specialist Services work undertaken	

Government Planning Priority		Link to NZ Health Strategy	Southern DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	**Milestones**	
Primary Health Care	**Pharmacy Action Plan**	One Team Kotahi te tima	1. When finalised, make the new Integrated Community Pharmacy Services Agreement (ICPSA) contract available for local community pharmacists from 1st October 2018	▪ Implement the ICPSA contract from Q2 ▪ Community pharmacists sign the new ICPSA Q2	Number of community pharmacists signing the new ICPSA Percentage of community pharmacists using the pharmacist portal Number of Māori using WellSouth clinical pharmacist services
			2. Develop local services in consultation with community pharmacists (Aligned to the Community Pharmacy Action Plan and the Primary & Community Care Action Plan)	▪ Community pharmacist consultation group established Q2 ▪ Service development with community Pharmacy through ICPSA (schedule 3) Q4	
			3. Integrate community pharmacists into GP practices and the wider health team. (WellSouth to develop) ▪ Roll out of pharmacy portal Q2	▪ 80% of community pharmacists are using the pharmacist portal by Q4	
			4. Continue to target high need populations including Māori in service delivery through WellSouth clinical pharmacist services (EOA)	▪ Increased Māori utilisation of WellSouth clinical pharmacist services by Q4	
Primary Health Care	**CVD and diabetes risk assessment**	One Team Kotahi te tima	1. Roll out of Consumer Led Integrated Care (CLIC) programme of activity. This includes risk stratification for CVD and Diabetes patients (Aligned to the Primary and Community Care Strategy). Stratification will ensure that service delivery is aligned to patient need.	▪ 100% of GP practices are enrolled to use CLIC by Q4	Number of practices using CLIC Number of patients using portal PP20: Improved management for LTC Focus area 2: Diabetes services Focus area 3: Cardiovascular heath Number of Māori using CVD and diabetes management services through WellSouth
			2. Implement quality improvements in diabetes care ▪ Integrate Diabetes Annual Review into CLIC programme (it will become part of LTC programme) ▪ Stratify level 2-3 diabetic patients, enabling care plans to be developed within 12 months ▪ Integrate Type II diabetics programme of insulin initiation support into the CLIC LTC management of diabetes	▪ 100% of patients with diabetes registered in CLIC have an LTC diabetes care plan within 12 months of enrolment (includes stratification of level 2-3 diabetic patients)	
			3. Promote the use of WellSouth Portal to capture CVD and Diabetes data accurately ▪ Increase patient portal usage, using the WellSouth practice support network and through education	▪ WellSouth promote portal uptake and achieve 15% target Q4	
			4. Continue with WellSouth Long Term Conditions (LTC) programme of support for GP practices Cardiovascular Disease (CVD) and Diabetes patients ▪ Develop the one team strategy for Multidisciplinary Team (MDT) primary care support (Aligned to the Primary and Community Care Action Plan) ▪ MDT involvement is subject to risk stratification embedded in CLIC; this will ensure appropriate levels of care	▪ 100% of GP practices are utilising CLIC by Q3	

			5. Increase uptake of Incentive programme for CVD and Diabetes risk assessment (SLM amenable mortality), targeting Māori and high needs populations with incentive (EOA). The incentive programme will support equity of access for those who cannot afford a GP consultation fee.	▪ Uptake of the incentive programme has increased by Q4 ▪ Māori usage of CVD and diabetes assessment and management services has increased by Q4	
Primary Health Care	**Access**	**Closer to Home Ka aro mai ki te kāinga**	1. Implement the HCH model of care with telephone triage occurring in all HCHs- (Aligned to the Primary and Community Care Action Plan)	▪ Tranche 1a practices (Q1) and 1b practices (Q4) start using GP telephone triage	Use of telephone triage by GPs Portal usage by patients Portal GP enrolment and use Number of GP practices in HCH programme Percent of children age 14 and under with zero fees access to: GP within 30 min travel time After-hours care within 60 min travel time Number of patients through winter clinics Number of Māori enrolled in General Practices WellSouth ABC target (90%)
			2. WellSouth to work with GP practices to increase uptake of patient portals (current patient registration is 5.9%) and GP portal enrolment (currently 37%) (Aligned to the Primary and Community Care Action Plan)	▪ Portal usage by patients reaches 15% by Q4 ▪ Portal GP enrolment to 42% Q2 and 50% Q4	
			3. Increase access for Māori populations through education programmes, outreach teams and utilisation of the voucher incentive programme for Māori. Increase enrolment into GP practices and pharmacy medication usage through WellSouth outreach teams and education (EOA)	▪ Increased enrolment of Māori into GP practice by Q4	
			4. Deliver on optimisation of primary and urgent care services in Invercargill. (aligned to the Primary and Community Care Action Plan): ▪ Promote utilisation of primary care to reduce presentations to ED ▪ Reinforce pathway of care between primary care and Invercargill ED ▪ WellSouth to develop and implement after hours model of care in Invercargill ▪ Publish information on DHB websites re GPs providing zero fee daytime access and zero fee urgent after hours ▪ Review of winter performance (operation between 1 June and 31 August 2018)	▪ Implement recommended pathway of care between Primary Care and Invercargill ED Q2 ▪ Review demand and capacity to address gaps and opportunities Q4 ▪ Create an approved business plan for afterhours care in Invercargill Q2 ▪ Model of after afters care implemented in Invercargill by Q4 ▪ Winter clinic operation reviewed by Q2	
			5. Southern DHB to support WellSouth to implement the Government's announcement to increase accessibility to funded GP visits for CSC (Community Service Card) card holders and others who meet expanded eligibility criteria.		
			6. Undertake activities that continue to support delivery of smoking ABC in primary care ▪ Develop 2018/19 Tobacco Control Plan ▪ Contract with Southern Stop Smoking Service (SSS) for incentive voucher scheme to increase uptake of vouchers by priority populations. Voucher providers are required to facilitate support from whanau/hapu, kuia/kaumatua, Māori staff and others as appropriate, for Māori accessing the service (EOA) ▪ WellSouth GP champion to continue to work with practices providing ABC	▪ Tobacco control plan developed by Q2 ▪ SSS voucher scheme in place by Q3 ▪ WellSouth achieves 90% target Q1-Q4	

Primary Health Care	**Integration**	**Closer to Home** **Ka aro mai ki te kāinga**	1. Implement integration through the Primary and Community Care Strategy ▪ Support newly appointed independent chairperson to establish the Alliance Leadership Team inclusive of a wide range of community providers	▪ Establish Alliance Leadership Team Q1 See SLM Implementation Plan	PP22: Delivery of actions to improve system integration including SLMs
			2. Initiate the agreed SLM integration plan focusing on 0-4 ASH and smoke free homes for babies with a focus on high needs Māori populations (EOA) (aligned to the Primary and Community Care Action Plan and Government Planning Priorities)	▪ SLM leadership group initiated Q1 See SLM Activity	
			3. Agree on the data sharing framework between SDHB and WellSouth	▪ Data sharing framework completed Q2	
			4. Implement the HCH model of care with a focus on the workforce working at their top of scope (aligned to the Primary and Community Care Action Plan)	▪ Tranche 1a (Q1) and 1b (Q4) start the programme	
			5. Develop the 'Home Team' strategy for LTC and Acute demand management (aligned to the Primary and Community Care Action Plan)	▪ Establish' 'home team' Q4	
			6. Initiate Locality Networks to analyse and prioritise health needs for each network ▪ Undertake a stocktake to ensure best use of existing services and the entire workforce	▪ Undertake stocktake and establish locality networks Q4	
			7. WellSouth to increase utilisation of electronic Newborn Enrolment form in order to increase the number of babies who are enrolled with a GP practice by 6 weeks (EOA) - included in the joint SLM implementation plan	▪ Ongoing action to increase utilisation of electronic Newborn Enrolment from Q1-Q4	SI: 18 Improving newborn enrolment in General Practice
Primary Health Care	**System Level Measures**	**Value and High Performance** Te whāinga	1. See Attached SLM implementation plan		SI1, SI7, SII8, SI9, SI12, SI13

Government PlanningPriority		Link to NZ Health Strategy	Southern DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	**Milestones**	
System Settings	**Healthy Ageing**	**Closer to Home Ka aro mai ki te kāinga**	1. Continue to work with ACC, the Health Quality and Safety Commission (HQSC) and the MoH to promote and increase enrolment in our integrated falls and fracture prevention services as reflected in the associated "Live Stronger for Longer" Outcome Framework and Healthy Ageing Strategy ▪ Deliver an education programme that continues focus on primary care providers but also meets the training and support needs of other health care professionals such as contracted home based providers, Age Related Residential Care (ARRC) and community group providers	▪ Establish the non-urgent falls prevention referral pathway and single point of contact Q4 ▪ Deliver an education programme Q4 ▪ Roll out the In Home Strength and Balance Programme across the district Q4	Number of non-urgent falls assessments completed in primary care Number of fall injuries (ACC) Number of serious harm falls (ACC) Number of ARRC admissions Number and rate of people who remained at home or returned home Number and rate of Māori who remained at home or returned home PP23: Implementing the Healthy Ageing Strategy
			2. Participate in the DHB and Ministry led development of Future Models of Care for home and community support services		
			3. Continue the "Home as my first choice" campaign aimed at conversations to prevent unnecessary hospital admissions and support people to remain in their own environments for as long as possible ▪ Expand "Home as my first choice" resources to include comprehensive information on dementia Q2 ▪ Set-up regular "Home as my first choice" presentations to in-service education in teams/areas Q2 ▪ Set-up regular "Home as my first choice" presentations to service providers and the wider community Q4	▪ "Home as my first choice" resources expanded to include comprehensive information on dementia Q2 ▪ Regular "Home as my first choice" presentations to in-service education in teams/areas Q2 ▪ Regular "Home as my first choice" presentations to service providers and the wider community Q4	
			4. Establish "Home Team" in Dunedin and Invercargill which includes rapid response and supported discharge to reduce rates of admission or readmission to hospital for the more vulnerable people in the population (EOA)	▪ Commence implementation including recruitment Q1 ▪ Establish KPI framework Q2, including ethnicity data collection ▪ Review Home Team functionality and activity and commence PDSA cycles where appropriate Q3	
			5. Work alongside ARRC facilities who have higher rates of ED attendances with quality improvement plans	▪ Review data and meet with facilities to establish issues Q1 ▪ Meet quarterly on progress Q1-Q2	ED presentations from ARRC
			6. Support Hospice and ARRC facilities in the implementation of Te Ara Whakapiri: Principles and guidance for the last days of life	▪ Implement Te Ara Whakapiri (TAW) in all ARRC facilities by Q4	Number of ARRC facilities implementing TAW

System Settings	**Disability Support Services**	**One Team Kotahi te tima**	1. Develop an SDHB Disability Strategy and associated Actions and Communication Plan to raise awareness of disability for staff and communities and investigate different methods of communicating with members of the public which provides information on what might be important to consider when interacting with a person with a disability	▪ Continue developing Patient Stories on people with disabilities for staff learning Q2-Q3 ▪ Promote stories Q3-4 ▪ Finalise strategy Q4 ▪ Agree implementation strategy Q4	SI14: Disability support services Number and percent of staff completing e-training
			2. Staff workforce development – Develop a disability awareness programme for staff via e-Learning for front line staff and clinicians i.e. increase awareness through the use of eLearning, toolkits and staff training on identification of Disability Support Needs and the impact on recovery from acute medical conditions (EOA), to include cultural competency component	▪ CHC member raise awareness with administration staff at symposium Q1-Q4 ▪ Incorporate disability awareness into staff training Q4 ▪ Create e-Learning module Q4	
			3. Report and follow-up where gaps occur with staff who do disability awareness workforce training, to include analysis of cultural competency in relation to disability awareness (EOA)	▪ Report on % of staff who completed training by end of Q4 ▪ Follow up with staff how have not completed the training Q4 ▪ Report on gaps in cultural competency as demonstrated in e-learning Q4	
System Settings	**Cancer Services**	**Value and High Performance hāinga hua me te tika o ngā mahi**	1. Faster Cancer Treatment (FCT)- Enable equity of access to timely diagnosis & treatment for all patients on the FCT pathway (EOA): ▪ Undertake system/service improvements to deliver the FCT target including systematic approach to monitoring and acting on 62 day pathway breaches ▪ Support clinical staff to gain visibility of cancer patients on both 62-day and 31-day FCT pathways ▪ Enhance cultural pathways through the FCT journey (EOA) ▪ Accurate collection and reporting of ethnicity data for FCT to assist in the development of an electronic flag to the SDHB Māori Health Units for patients that are newly diagnosed that identify as Māori	▪ Undertake work with SCN on implementation of FCT indicator on patient's records Q4 ▪ Implement service improvement initiatives Q1-Q4 ▪ Develop an electronic flag to the SDHB Māori Health Units for patients that are newly diagnosed that identify as Māori Q2	PP30: Faster Cancer Treatment (31 day indicator and 62 day target) % of Māori achieving the FCT target
			2. Cancer Pathways ▪ Undertake quality improvement initiatives that align with national cancer strategies to achieve health gain for Māori & equitable and timely access to cancer services (EOA) ▪ Work with the MoH, Southern Cancer Network (SCN) & Radiation Oncology Work Group (ROWG) to investigate & reduce unwanted variation in radiation oncology treatment as set out in the Radiation Oncology National Plan 2017-2021 ▪ Collaborate with the SDHB Māori Health Units to ensure equitable access for Māori and enhance the cultural competency of the health workforce ▪ DHB to engage in bowel screening implementation	▪ Implement service & quality improvement initiatives Q1-Q4 ▪ Implement the Improving the Cancer Pathway for Māori Plan Q1-Q4 ▪ Liaison with the SDHB Māori Health Units to ensure equitable access for Māori and enhance the cultural competency of the health workforce Q1-Q4 ▪ Monitor and navigate Māori newly diagnosed with cancer Q1-Q4.	Bowel Screening Programme KPIs Number of Māori newly diagnosed with cancer Number of Māori referred to Māori cancer support services within the community % of SDHB cancer services staff participating in cultural competency training

				▪ Implement strategies to reduce variation and maximise use of the available capacity for early stage breast cancer Q1-Q4 ▪ Implement national bowel screening programme including services to support the delivery of additional cancer cases Q1-4	
			3. Cancer Information Strategy ▪ Participate in SI alignment of digital systems to collect and report consistent, accessible and accurate cancer data ▪ Work with SCN to develop a plan to support and implement the NZ Cancer Health Information Strategy across the South Island (waiting on MoH guidelines)	▪ Further develop and report into South Island Multidisciplinary Meeting (MDM) system (SIMMS) Q1-Q4 ▪ Local reporting into Radiation Oncology Minimum Dataset (ROMDS) Q1-Q4 ▪ Input into SI Cancer Dashboard being developed by SCN	PP30: Faster Cancer Treatment (31 day indicator and 62 day target ROMDS Reporting SIMMS reporting
			4. Survivorship ▪ Work with SCN to explore an end of treatment regional service initiative to improve quality of life for people who have recently completed cancer treatment, such as end of treatment meetings or clinic offered; development of follow-up care plans for both secondary and primary health care; referrals to appropriate service providers for self-care supports such as nutrition, physical therapy and psychosocial support ▪ Assist SCN in the development of a pilot initiative to address needs of people who have recently completed cancer treatment that aligns to developing survivorship guidance	▪ Develop and complete pilot project by Q4	
			5. Participate in SI Cancer Service Reducing Inequities Equitable Access & Outcomes Cancer Services ▪ Work with SCN to explore evidence based equity tools/processes to identify disparities for Māori & vulnerable population groups, the causes of disparities and the impacts (intended and unintended) of initiatives (EOA) ▪ Participate in an SCN pilot as required and implement equity assessment framework that aligns with national and regional guidance ▪ Utilise the findings from the 2017/18 Routes to Diagnosis FCT project to target improved access to detection, diagnosis and treatment for high needs and high risk patient groups (EOA)	▪ Confirm high needs/high risk populations Q1-Q4 ▪ Confirm service improvement initiatives Q2-Q4 ▪ Participate in an SCN pilot as required and implement equity assessment framework that aligns with national and regional guidance Q4 ▪ Use findings from the 2017/18 Routes to Diagnosis FCT project to target improved access to detection, diagnosis and treatment for high needs and high risk patient groups Q1-Q4	

			6. Apply and integrate the prostate cancer decision support tool ▪ WellSouth to provide (Continuing Medical Education) CME for GPs to support tool as business as usual ▪ Integrate prostate cancer decision support tool into Health Pathways. Review Health Pathways to ensure links to the tool are included and content is aligned ▪ Provide CME re prostate cancer decision support tool to urologists and oncologists	▪ Integrate prostate cancer decision support tool into Health Pathways by Q4 ▪ WellSouth to provide CME for GPs to support tool as business as usual by Q4 ▪ Provide CME re prostate cancer decision support tool delivered to urologists and oncologists by Q4	
			7. Implement the *Cancer Pathway for Māori* P*lan* ▪ Enhance cultural pathways through the development of an electronic flag to the SDHB Māori Health Units for the patients that are newly diagnosed that identify as Māori (EOA) ▪ Build cultural competency within cancer services ▪ Enhance knowledge and health literacy within Māori whānau and communities through facilitating two Kia Ora e te Iwi training workshops (cancer education and support programme for Māori) within the community (EOA)	▪ Monitor and navigate Māori newly diagnosed with cancer Q1-Q4 ▪ SDHB cultural competency training includes the MoH Health Literacy Framework and incorporates components of Kia Ora e te Iwi Q4 ▪ SDHB to provide support to the delivery of the Kia Ora e te Iwi programme in the community Q3	Number of Māori newly diagnosed with cancer - % of Māori referred to Māori Cancer support services within the community -% of Māori achieving the FCT target % of SDHB staff within cancer services participating in cultural competency training Number of Māori participating within the Kia Ora e te Iwi training workshops
			8. DHB to engage in bowel screening implementation to include focus on enhancing participation rates for Māori and Pacifica (EOA) ▪ WellSouth to support Māori and Pacifica providers to promote awareness of the programme and its benefits among Māori and Pacifica whānau and encourage whānau to participate ▪ SDHB programme team to work with respected champions within the Māori community to promote the programme and the advantages of early detection ▪ SDHB to deliver a campaign with the working title "Lives Touched, Lives Saved" to communicate the importance of the screening programme as a way of supporting the longevity of health for an individual as part of their wider family and whānau health ▪ Follow up with Māori and Pacifica participants who fail to return kits after 6 weeks; WellSouth's outreach team to provide further follow up after a further 4 weeks	▪ Develop and deliver SDHB 'Lives Touched, Lives Saved' campaign Q2-Q4 ▪ Monitor and evaluate active follow up by SDHB and WellSouth in relation to Māori and Pacifica participants who fail to return kits Q1-Q4	Bowel Screening Programme & KPIs, including Māori participation rates % of Māori and Pacifica actively followed up Number of people engaged in campaign

System Settings	**Climate Change**	**Value and High Performance hāinga hua me te tika o ngā mahi**	1. Develop DHB Environmental Sustainability Strategy to guide longer term actions, planning and carbon footprint reduction	▪ Develop strategy and implement and finalise plan by end of Q2	PP40: Responding to climate change
			2. Undertake stocktake of activity/actions being delivered and planned that are expected to positively mitigate or adapt to the effects of climate change	▪ Stocktake complete by December 2018	
			3. Assess and benchmark the carbon footprint of SDHB to act as a baseline for measurement of future emission reductions	▪ Complete baseline carbon footprint report Q4 ▪ Source third party verification of results by Q4	
System Settings	**Waste Disposal**	**Value and High Performance hāinga hua me te tika o ngā mahi**	1. Ensure that all community pharmacies are aware of the disposal service for waste product through a community pharmacist consultation group and promotion/education around waste disposal	▪ Establish community pharmacist consultation group Q2 ▪ Promote/educate around waste disposal Q3 ▪ Community pharmacists sign the new ICPSA Q1	PP41: Waste disposal Number of pharmacies participating in education Number of pharmacists signing new ICPSA Completion of waste disposal stocktake
			2. Complete stocktake to identify activity/actions to support the environmental disposal of hospital and community waste products (including cytotoxic waste)	▪ Complete and report stock take of waste disposal Q2	
System Settings	**Improving quality**	**Value and High Performance hāinga hua me te tika o ngā mahi**	1. Improve access and equity in outcomes for asthma patients in the community, including Māori (aligned to the Primary and Community Care Action Plan.) ▪ Establishment of SLM governance group out of the Alliance, focus on 0-4 ASH and smoke free homes for babies. ▪ Formation of Locality Networks as part of the Primary and Community Strategy, prioritising Asthma as an initial review of service ▪ Increase incentive programme uptake for smoke free mums. Focus population of Māori Mums, through Southern DHB smoking cessation incentive programme (EOA)	▪ Alliance SLM governance group completes review of SLM 0-4 ASH and babies living in a smoke free home. Q4 ▪ All localities have a working locality network group by Q4 ▪ 100% utilisation of funding for smoke free Mums Q4	SI17: Improving quality Completion of review Number of localities with a working locality network Percentage of utilisation of funding for Smokefree Mums for Māori
			2. Improve patient experience as measured by the Health Quality and Safety Commission's national inpatient experience survey question: "Did the hospital staff include your family/whānau or someone close to you in discussions about your care?" In the last survey 42% of respondents from SDHB answered Always, as compared to a national average of 58%. ▪ Integrate action to improve this measure into the Releasing Time to Care Ward Round Module, My Care Plan and Bedside handover across Dunedin and Southland sites ▪ The quality improvement project on Reducing Emergency Admissions within 28 days of Discharge will expect family/whanau to be involved in discussions with high risk families, as appropriate. ▪ Improve engagement with families/whanau to reduce the percentage of Māori emergency readmissions within 28 days (awaiting current data for baseline)	▪ Improve the percentage of patients answering *Always* by 10% by Q4 ▪ Reduction in emergency readmissions within 28 days for Māori by Q4	Health Quality and Safety Commission's quarterly national inpatient survey Percentage of emergency readmissions within 28 days

System Settings	**Strengthen Public Delivery of Health Services**	**Value and High Performance hāinga hua me te tika o ngā mahi**	1. Lakes Hospital (Queenstown) refurbishment programme ▪ Commission a CT machine to be operational in Q4 of 2018/19 to reduce the need for patients to travel to other sites such as Dunstan and Invercargill for CT examination	▪ Commission CT machine to be operational in Lakes Hospital (in Queenstown) Q4	SI16: Strengthening Public Delivery of Health Services
			2. Expand the number of telehealth clinics as enabling steps (both technology and funding) are put in place (EOA)	▪ Expand the number of telehealth clinics Q4	
			3. Develop the HCH model to increase the integration of providers and develop holistic care service networks	▪ HCH established in Tranche 1 Q1	
			4. Advance specialist models of care and pathways between primary, community and secondary: ▪ Refocus the integrated rapid response and enablement team, with a focus on the frail elderly	▪ Commence work to refocus in Q1, further develop Q4	
System Settings	**Access to Elective Services**	**Value and High Performance hāinga hua me te tika o ngā mahi**	1. An improved production planning process has highlighted constraints to increasing the number of Elective discharges. The below actions will assist in increasing the number of Elective discharges. ▪ Increase the number of surgical inpatient beds at Dunedin Hospital ▪ Leasing of external operating facilities for outplacing and outsourcing of surgery ▪ Increase the level of throughput immediately before key holiday periods of Christmas and Easter ▪ Acuity Index Tool rolled out to general surgery service and orthopaedic surgery service for booking patients from the waitlist	▪ Additional four beds opened at Dunedin Hospital by Q1 ▪ Agreement with external providers by Q2 ▪ Increased throughput (compared to the same period for FY 17/18) to be recorded in Q3 for the Christmas/New Year period and Q4 for the Easter period ▪ Acuity Index tool to be implemented by Q4	Number of Elective Discharges SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Elective Services Patient Flow Indicator
			2. Complete detailed analysis for ENT, Paediatric Surgery and Plastic surgery to better understand apparent variation in levels of Elective surgery between Māori and Non- Māori (EOA)	▪ Analysis to be complete by Q2	
System Settings	**Shorter Stays in emergency Department**	Value and High Performance hāinga hua me te tika o ngā mahi	1. ED Performance Improvement Steering Group established to provide guidance, leadership and coordination of current and new initiatives to improve Dunedin ED Shorter Waiting times Target	▪ Establish project group and develop work plan Q1	
			2. Invest in Allied Health in ED Southern DHB to support patients to remain at home or, if an ED presentation or hospital admission is necessary, to return home as soon as possible ▪ Evaluate impact of additional allied health workforce Q2	▪ Invest in Allied Health in ED in Q1 ▪ Evaluate impact of additional allied health workforce Q2	
			3. Extend Winter Advertising Campaign	▪ Extend winter beds campaign through Q1	
			4. Provision of eight additional winter beds in Dunedin hospital to support Shorter Stays in ED ▪ Additional Winter beds extended through Q1 (beyond the Winter period)	▪ Additional winter beds provided Q1	

			5. Review feasibility for extended scope of practices for experienced ED nurses	▪ Complete feasibility report Q3	
			6. Reduction in siloed thinking and move to generalist approach with aim to change model of care at Dunedin hospital ▪ Commence work/discussions having all adult medical admissions admitted to the General Medicine service ▪ Complete review of generalist approach	▪ Complete review Q4	
			7. Work with mental health services to ensure the ED is responsive to the needs of those suffering acute or chronic mental health conditions (EOA)	▪ Complete review Q4	
Fiscal Responsibility		**Value and High Performance Te whāinga hua me te tika o ngā mahi**	Commit to managing Southern DHB finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results	▪ Monthly review of finances Q1-4	Agreed financial templates

Government Planning Priority	Link to NZ Health Strategy	Southern DHB Key Response Actions to Deliver Improved Performance		Measures
		Activity	**Milestones**	
Delivery of Regional Service Plan	One Team Kotahi te tima	DHBs are asked to identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan. In particular, for Elective Services, DHBs are asked to identify local actions to support planned Elective activity in the regional service plan across Workforce, Clinical Leadership, Quality and Pathways. There is a strong focus on regional collaboration in 2018/19 for Orthopaedics, Ophthalmology, Vascular and Breast Reconstruction.		SI2
		1. Work is anticipated in 2018/19 relating to improving access, and consistency of access, to plastics and reconstructive services, including breast reconstruction ▪ SDHB to engage with the national service improvement programme as actions are developed and support regional implementation as required	▪ Report actions undertaken Q2 and Q4	
		2. Collaborate to achieve consistent ophthalmology pathways for Age-Related Macular Degeneration and Glaucoma across South Island DHBs, reducing variations in patterns of care and improving health equity	▪ Report actions undertaken Q2 and Q4	
		3. Review current orthopaedic workforce resources, including subspecialty capability, future requirements to meet demand, gap analysis	▪ Review undertaken Q1	

2.2 FINANCIAL PERFORMANCE SUMMARY

(Refer to the Financial Performance on page 48 for further detail)

2.2.1 PROSPECTIVE STATEMENT OF FINANCIAL PERFORMANCE

Table 1: Comprehensive Income for 30 JUNE 2019, 2020, 2021 and 2022

DHB Consolidated Statement of Prospective Financial Performance	2016/17 Actual $' 000	2017/18 Actual $' 000	2018/19 Budget $' 000	2019/20 Projection $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000
Revenue						
PBF Funding Package	823,201	852,077	883,906	916,725	950,799	986,182
Inter District Revenue	21,894	21,778	22,377	23,207	24,071	24,968
Funder Side Contracts	42,960	57,645	59,587	57,310	59,440	61,652
Provider Misc Revenues	46,220	48,487	48,012	49,238	50,528	51,888
Total Revenues	934,275	979,987	1,013,882	1,046,481	1,084,839	1,124,689
less Personnel Expenses						
Medical Personnel	(122,538)	(125,880)	(131,858)	(124,681)	(128,058)	(132,502)
Nursing Personnel	(137,529)	(142,782)	(145,389)	(156,492)	(159,331)	(163,812)
Allied Health Personnel	(50,376)	(50,560)	(53,957)	(53,070)	(54,890)	(57,048)
Support Services Personnel	(5,833)	(5,696)	(6,294)	(6,305)	(6,393)	(6,535)
Management/Admin Personnel	(45,695)	(44,711)	(49,156)	(51,099)	(51,694)	(52,719)
Personnel Costs Total	(361,973)	(369,628)	(386,655)	(391,647)	(400,367)	(412,616)
less Non Personnel Expenditure						
Outsourced Services Expenses	(42,785)	(45,237)	(42,404)	(41,100)	(42,160)	(43,552)
Clinical Supplies Expenses	(89,109)	(93,481)	(94,386)	(93,792)	(96,690)	(97,892)
Infrastructure & Non Clinical Supplies Expenses	(69,754)	(73,463)	(79,430)	(87,753)	(94,262)	(97,329)
Total Non-Personnel Expenditure	(201,649)	(212,180)	(216,220)	(222,645)	(233,113)	(238,773)
less Provider Payments						
Personal Health Expenses	(242,673)	(249,643)	(255,620)	(265,980)	(273,533)	(283,521)
Mental Health Expenses	(24,412)	(24,673)	(25,434)	(26,379)	(27,359)	(28,377)
Disability Support Expenses	(123,762)	(143,740)	(150,384)	(152,540)	(158,210)	(164,098)
Public Health Expenses	(702)	(601)	(729)	(756)	(784)	(813)
Maori Health Expenses	(975)	(900)	(1,230)	(1,276)	(1,323)	(1,373)
Total Provider Payments	(392,524)	(419,557)	(433,397)	(446,930)	(461,210)	(478,182)
Total Expenses	(956,145)	(1,001,366)	(1,036,272)	(1,061,221)	(1,094,689)	(1,129,572)
Net Surplus / (Deficit)	**(21,870)**	**(21,378)**	**(22,390)**	**(14,740)**	**(9,851)**	**(4,883)**

2.2.2 PROSPECTIVE PERFORMANCE BY OUTPUT CLASS

Table 2: Prospective Performance by Output Class for the four years ended 30 June 2019, 2020, 2021 AND 2022

Revenue & Expenditure by Output Class	2016/17 Actual $' 000	2017/18 Actual $' 000	2018/19 Budget $' 000	2019/20 Projection $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000
Prevention Services						
Revenue	8,144	4,834	4,995	5,164	5,339	5,521
Expenditure	(8,144)	(4,834)	(4,995)	(5,164)	(5,339)	(5,521)
Net Result	0	0	0	0	0	0
Early Detection and Management Services						
Revenue	180,267	186,855	194,170	206,382	214,821	225,710
Expenditure	(187,843)	(194,261)	(201,926)	(211,488)	(218,233)	(227,401)
Net Result	(7,576)	(7,406)	(7,756)	(5,106)	(3,412)	(1,691)
Intensive Assessment and Treatment						
Revenue	628,954	650,843	670,828	685,718	707,727	728,519
Expenditure	(634,448)	(656,214)	(676,453)	(689,421)	(710,202)	(729,746)
Net Result	(5,494)	(5,371)	(5,625)	(3,703)	(2,475)	(1,227)
Rehabilitation and Support						
Revenue	116,910	137,456	143,889	149,217	156,951	164,938
Expenditure	(125,710)	(146,058)	(152,898)	(155,148)	(160,915)	(166,903)
Net Result	(8,800)	(8,602)	(9,009)	(5,931)	(3,964)	(1,965)
Share of Loss in associates	0	0	0	0	0	0
Total Revenue per DHB Consolidated Financials	934,275	979,987	1,013,882	1,046,482	1,084,839	1,124,688
Total Expenditure per DHB Consolidated Financials	(956,145)	(1,001,366)	(1,036,272)	(1,061,222)	(1,094,689)	(1,129,571)
Net Surplus / (Deficit)	**(21,870)**	**(21,378)**	**(22,390)**	**(14,740)**	**(9,851)**	**(4,883)**

3 SERVICE CONFIGURATION

3.1 SERVICE COVERAGE

All DHBs are required to deliver a minimum level of services, as defined in *The Service Coverage Schedule*. This is incorporated as part of the Crown Funding Agreement under section 10 of the New Zealand Public Health and Disability Act 2000. This 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. Southern 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.
Southern DHB is not seeking any formal exemptions to the Service Coverage Schedule in 2018/19.

3.2 SERVICE CHANGE

The table below describes all service reviews and service changes that have been approved or proposed for implementation in 2018/19.

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Health of Older Persons	Tiered approach to management of older people and those with multiple co- morbidities. Patients stratified according to complexity, with service clusters wrapped around communities. Case management for those with most complex needs; enhanced multidisciplinary primary care teams; rapid response to prevent hospital admission; early supported discharge from hospital; specialist community rehabilitation; and population health services	Person-centred, Level of care proportional to health need, Improved equity of access, Improved service integration, Value for money	Local

Table continued

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Primary Maternity Services	Explore how Southern DHB might better configure clinically sustainable maternity services for our rural communities	Improved access, Improved service integration	Local
Community Pharmacy	Develop pharmacist services contract from 1 October 2018	Person-centred, Improved service integration, Value for money	National Local
Mental Health	Day Activity and Vocational Services Mental Health Needs Assessment Service co-ordination Community Based Rehabilitation	Person-centred, Care closer to home, Improved equity of access, Value for money, Improved service integration	Local

4 STEWARDSHIP

As part of our stewardship role, Southern DHB are committed to supporting and working in partnership with Public Health South in their work on health promotion/improvement services, delivering services that enhance the effectiveness of prevention activities in other parts of the health system and in undertaking regulatory functions. This is further described in Population Performance (Section 1).

4.1 MANAGING OUR BUSINESS

4.1.1 ORGANISATIONAL PERFORMANCE MANAGEMENT

Southern DHB's performance is assessed on both financial and non-financial measures, which are measured and reported at governance and executive levels of the organisation. These are reported daily, weekly, fortnightly or monthly as appropriate.

4.1.2 FUNDING AND FINANCIAL MANAGEMENT

Southern DHB's key financial performance is reported through the Finance Audit and Risk Committee (FARC) and Commissioner team every month. Further information about Southern DHB's planned financial position for 2018/19 and out years is contained in the Financial Performance Summary section of this document on page 29, and the Statement of Performance Expectations on page 40.

4.1.3 INVESTMENT AND ASSET MANAGEMENT

The Treasury is committed to robust and transparent stewardship of public funds. Owning the right assets, managing them well, funding them sustainably and managing risks to the Crown balance sheet are all critical to public services being cost effective and high quality.

The Investor Confidence Rating (ICR) three yearly assessment is Treasury's process to assess the performance of investment-intensive agencies in managing investments and assets that are critical to the delivery of NZ Government services. The ICR provides an indication of the level of confidence that investors (such as Cabinet and Ministers) can have in an agency's ability to realise a promised investment result if funding was committed. The assessment of Southern DHB was undertaken in November and December 2017, results are expected to be submitted to Cabinet in August 2018 and published on the Treasury website by December 2018.

4.1.4 SHARED SERVICE ARRANGEMENTS AND OWNERSHIP INTERESTS

Southern DHB does not hold any controlling interests in a subsidiary company. The DHB does not intend to acquire shares or interest in other companies, trusts or partnerships at this time.

4.1.5 RISK MANAGEMENT

Southern DHB has a formal risk management and reporting system, which entails monthly reporting to the Executive Leadership Team and FARC. 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).

4.1.6 QUALITY ASSURANCE AND IMPROVEMENT

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

4.2 BUILDING CAPABILITY

This section provides an outline of the arrangements and systems that Southern DHB has in place to manage our core functions and to deliver planned services. Greater detail is included in Southern DHB's three-yearly Statement of Intent, which was last produced for the 2016/17 year and is available on our website at www.southerndhb.govt.nz

4.2.1 WORKFORCE

Below is a short summary of Southern DHB's organisational culture, leadership and workforce development initiatives. Further detail about the South Island regional approach to workforce is contained in the 2018/19 South Island Services Regional Plan.

Southern DHB launched the 'Southern Future – It's up to Us' programme in December 2015. This programme was introduced as a system-wide transformation project to build a stronger internal culture at Southern DHB. Through our listening sessions with staff, leaders and providers a set of values was adopted to guide our behaviours and decision-making, and focus areas to help improve our staff experience have been defined in our '7+7 improvement priorities'. Southern DHB has established a Southern Future working group and a new Community Health Council (CHC) to monitor and drive these engagement initiatives. Part of this work has been the development and implementation of the 'Speak Up' programme and speak up representatives which focuses on which focuses on building a positive culture and professional behaviours. We measure our progress via staff engagement surveys and via further listening sessions with the community. Surveys are carried out and are aligned to the priority focus areas to improve the patient and staff experience.

Prompted by the new Dunedin Hospital development, we have developed a new Southern health workforce strategy and action plan in order to modernise and future proof our ability to meet the needs of both staff and patients alike.

These strategic goals and actions fit into the categories of service redesign, valuing staff, building the Māori workforce, and patient empowerment.

- Interprofessional care/Integrated agency care – Deliver services where care is provided by right person (not a specific profession)
- People planning – Work with our people to proactively manage recruitment and retention to fit the workforce plan and future need
- Making changes stick/accountability – Engage workforce in decision making that results in efficient and effective organisational processes
- Leadership and change – Foster leadership that drives forward transformation of Southern Health and excites and empowers staff in the services that we will provide
- Our staff as assets – Be a health system that recognises that staff are its biggest asset (it is through staff that we will serve the customer)
- Customer focus – Grow a workforce that empowers patients to take charge of their own care

SAFE STAFFING AND CARE CAPACITY DEMAND MANAGEMENT (CCDM)

Southern DHB is committed to safe staffing and healthy workplaces and this means ensuring we have the right number of staff, appropriately skilled, in the right place at the right time. Getting the balance right between patient demand and staff capacity means DHBs can improve the quality of care for patients, the staff working environment, and organisational efficiency. Southern DHB has obligations under the Safe Staffing and CCDM Effective Implementation Accord to fully roll out CCDM by 2021 using a validated patient acuity tool. Although Southern DHB has been progressing the roll out of CCDM for some time, an accelerated programme and implementation plan will now be agreed between the DHB's CCDM Council and the Safe Staffing Healthy Workplaces Governance Group. This will be published and reported on in accordance with the signed Accord.

4.2.2 CAPITAL AND INFRASTRUCTURE DEVELOPMENT

INTERIM WORKS

Work continues on the short-term redevelopment at Dunedin Hospital for the Intensive Care Unit and High Dependency Unit. This will have a significant impact for services for some months as the various stages of construction progress. The services will be involved in planning the management of impacts as we continue through this process.

DUNEDIN HOSPITAL TRANSITION PROGRAMME

The condition of some major assets on the Dunedin hospital campus is beyond remediation and the infrastructure is frail. The poor condition of these assets was a major driver in the decision to build a new hospital.

Maintaining these assets and infrastructure is critical, and in addition there is an urgent need to address capacity issues in ED, Theatre, Day Surgery and Outpatient areas and bed capacity to support theatre. Options to address these issues have been developed and will continue to be explored.

DUNEDIN HOSPITAL REBUILD

Southern DHB is working with the Ministry of Health and Southern Partnership Group on the redevelopment of Dunedin Hospital to ensure it is fit for purpose and meets the current and future needs of our communities.

The Detailed Business Case (DBC) is expected to be submitted to the Ministry of Health and Treasury in July 2018. This will be followed by the Implementation Business Case in March 2019. The construction of the new Dunedin Hospital is expected to commence in mid-2020.

User group involvement in the DBC enables stakeholder input in planning for future models of care as well as for physical spaces and will identify enhancements or changes to service delivery which can be implemented irrespective of building changes. Information gathered will also inform development of strategic models of care and change management strategy.

LAKES DISTRICT HOSPITAL

Southern DHB has committed to developing Lakes District Hospital to a contemporary standard and ensuring the hospital meets the community's needs over the coming years. The preliminary concept design for the first stage of the refurbishment is underway and will focus on developing options for a reconfiguration of the emergency department, diagnostic capacity including exploring options for a CT scanner and ultrasound services, specialist audio-visual suite to enable telemedicine and refurbishment of other areas as required.

4.2.3 INFORMATION TECHNOLOGY AND COMMUNICATIONS SYSTEMS

Digital technologies are rapidly changing the way that people manage their health and wellbeing and transforming the nature of healthcare delivery. Southern DHB have developed, in partnership with the MOH, a new Southern Health System Digital Strategy and action plan. Priority is given to aligning our action plan to the national and regional initiatives where applicable. A new IT governance group, with members from across the regional health system has been established to monitor and support the implementation of this strategy.

4.2.4 COOPERATIVE DEVELOPMENTS

Southern DHB works and collaborates with a number of external organisations and entities, including:

- Southern DHB is a member of the South Island Alliance Programme Office (SIAPO) which is a partnership between the five South Island DHBs, and works to deliver shared services collaboratively, under an Alliance framework as detailed in the South Island Health Services Plan (SIHSP).
- Alliance South is a partnership between Southern DHB and WellSouth PHN, and is aimed at improving integration and patient focus of health services, by considering the system as a whole, and by collaborating with clinicians and communities. WellSouth PHN is a Primary Health Organisation (PHO) which is the DHB's primary care partner and has an important role to plan, coordinate and fund primary health care.
- Our relationship with the tangata whenua of our district is expressed through our Iwi Governance Committee and our formalised signed collective agreement between Southern DHB and Murihiku and Araiteuru Rūnaka - *Principles of Relationship agreement (2011).*
- New Zealand Health Partnerships Limited (HPL) has the broad aim to enable DHBs to collectively maximise shared service opportunities for the benefit of the sector, and Southern DHB is committed to supporting HPL's work and the local implementation of business cases.
- Southern DHB and the University of Otago have a long history of co-operation and collaboration. Southern DHB and the Dunedin School of Medicine combine in employing staff to achieve the high standard of teaching and research
- Southern DHB has enjoyed long-standing relationships with the other local tertiary providers, Otago Polytechnic and Southern Institute of Technology (SIT), which provide training to nursing, midwifery and allied health staff. We are working to strengthen these relationships through shared training initiatives and exploring emerging career pathways.
- Southern DHB continues to work across multiple agencies and sectors including the Ministries of Social Development, Education, Police, and local and regional Councils in service of our shared commitment to building healthier and safer communities.
- Southern DHB engages in regular forums with the larger unions such as NZ Nursing Organisation, Association of Salaried Medical Specialists & PSA which provides an opportunity to build relationships and a deeper understanding of issues or challenges facing both parties.

4.3 WORKFORCE

4.3.1 HEALTHY AGEING WORKFORCE

Southern DHB will work to identify the workforces working with older people and their family/whanau/informal carers and to develop a workforce plan to ensure that those working with older people have the training and support they require to deliver high-quality, person-centred care.

This workforce plan will include strategies to support specialist workforce delivery of education and training for non-specialist workforces. The plan will identify and prioritise vulnerable workforces in planning, including allied health, kaiāwhina and carer and support worker workforces. This plan will include working as 'one team' with our healthcare partners in attracting, retaining and making the best use of the skills in the health workforce to meet the needs of an older population, whilst ensuring the workforce appropriately reflects our growing ethnic diversity, reflecting guidance and actions outlined in the Healthy Ageing Strategy.

4.3.2 HEALTH LITERACY

In line with the New Zealand Health Strategy, the DHB recognises that strong health literacy leads to better health outcomes and more effective use of resources. 'Support consumers and whānau to self-care' is a priority for the DHB and expressed as a stream of work in the DHB's Primary and Community Action Plan. The DHB has a road map of actions centred on the following core components:

- A targeted focus on public education about the core role of primary care, including when, how and where to access services for urgent needs
- Consumer portal access will be expanded and enhanced
- Peer support approaches (for example consumer networks for mental health issues and addictions) will be explored and progressed
- Adopt a Health in All Policies (HiAP) approach working across sectors to address the major risk factors that contribute to inequities, avoidable acute demand and amendable mortality
- Developing the health literacy competencies of the health workforce, particularly in regards to working with Māori

4.4 INFORMATION TECHNOLOGY

The ultimate goal of the Digital Strategy is to create an ecosystem of innovative development teams that can utilise the platform and its open standards to deliver an evolving experience across the health system. All the while, maintaining the security and

integrity of an individual's health information. Specific strategic goals within the plan are outlined in the table following.

Goal	Activities	Milestones and measures
Digital services	Expand and enhance consumer portal access to provide consumers with access to all of their health information and care team	Capex underway. Detailed plan provided by WellSouth by Q4
	Establish a shared health and business intelligence function to guide district-wide and specific service or population analysis	Defining scope of information required to be shared with Primary Care by Q3
Digital Platform	Adopt MoH Architecture Standards	Standards (to be provided by MoH)
	Identify IT drivers from a new service redesign process	Output from service redesign by Q3
	Create Application portfolio (remove, replace or modernise for the future)	Application portfolio created by Q2
	Application roadmap for digital transformation	Creation of application roadmap for digital transformation by Q3
Digital Ecosystem	Execute change defined by new architecture standards	Standards to be provided by MoH
	Identity and access management	Currently reviewing
	Data and privacy architecture	Continuous discovery and improvement
	Integration and applications architecture	Continuous discovery and improvement
Implementation of SI PICS	Implementation of SI PICS (Patient Information Care System)	Southern business case completed Q2 FY18/19 Implementation of SI PICS in Southern DHB subject to planning with regional team, migration expected FY20/21
Implementation of e-Triage (ERMS III)	Dermatology will be the pilot group in Southern with the rollout planned for Q2 FY18/19	Delivery of actions to roll out of e-Triage (ERMS III) in dermatology by Q2
Other areas within strategy and action plan	Ensuring that Southern is nationally/regionally aligned and where applicable leveraging investments	Southern is actively engaged on a Regional basis and Nationally where appropriate to ensure alignment and value is achieved
	Improving digital capabilities within Southern (Southern Heath System Workforce Strategy and Action Plan	Continuous discovery and improvement
	Application portfolio management via a new Change Delivery Framework and projects office	This has been in place since Q3 17_18
	Proactive engagement with the ministry as we co-designed the strategy and work in partnership to implement our aspirations	Southern Digital Strategy is aligned to the Ministry Digital Strategy that will be updated as necessary. We have hosted MoH for workshops specifically relating to the strategy.
	Implementation of the national bowel screening programme	SDHB has implemented and is live with this programme
	Further deployment of telehealth, integrated care and working	Southern's Telehealth platform introduced Q4 17_18
	Development of a new digital hospital via the new build within Dunedin	Ongoing

5 PERFORMANCE MEASURES

5.1 2018/19 PERFORMANCE MEASURES

The DHB non-financial monitoring framework aims to provide a rounded view of performance in key areas using a range of performance markers. The measures are intended to cover a specific set of markers of DHB performance in key areas, rather than all health services or DHB activity. Four dimensions are identified reflecting DHB functions as owners, funders and providers of health and disability services. The four identified dimensions of DHB performance cover:

- achieving Government's priority goals/objectives and targets or 'Policy Priorities'
- meeting service coverage requirements and supporting sector inter-connectedness or 'System Integration'
- providing quality services efficiently or 'Ownership'
- purchasing the right mix and level of services within acceptable financial performance or 'Outputs'

Each performance measure has a nomenclature to assist with classification as follows:

Code	Dimension
PP	Policy Priorities
SI	System Integration
OP	Outputs
OS	Ownership
DV	Developmental – Establishment of baseline (no target/performance expectation is set)

Inclusion of 'SLM' in the measure title indicates a measure that is part of the 'System Level Measures' identified for 2018/19.

Performance Measure	Performance Expectation / Target			
HS: Supporting delivery of the New Zealand Health Strategy	Quarterly highlight report against the Strategy themes			
PP6: Improving the health status of people with severe mental illness through improved access	Percentage of the population accessing specialist mental health services	0 - 19 years	Total	3.75%
			Māori	
			Other	
		20 - 64 years	Total	3.75%
			Māori	
			Other	
		65+ years	Total	1%
			Māori	
			Other	
PP7: 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			
	Report on activities in the Annual Plan			
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	Percentage of young people (0-19) referred for non-urgent mental health services seen within 3 weeks and within 8 weeks		≤ 3 weeks	80%
			≤ 8 weeks	95%
			Report on activities in the Annual Plan	
PP10: Oral Health - Mean DMFT score at Year 8	DMFT score at Year 8		2018	0.75
			2019	0.75
PP11: Children caries-free at five years of age	Children caries-free at 5 years of age		2018	69%
			2019	69%
PP12: Utilisation of DHB-funded dental services by adolescents	School Year 9 up to and including age 17 years		2019	85%
			2019	85%

PP13: Improving the number of children enrolled in DHB funded dental services	Percentage of 0-4 years enrolled	2018	95%
		2019	95%
	Percentage of children (0-12 years) not examined based on recall	2018	<10%
		2019	<10%
PP20: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)			
Focus Area 1: Long term conditions	Report on activities in the Annual Plan.		
Focus Area 2: Diabetes services	Implement actions from Living Well with Diabetes.		
	Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1C indicator		
Focus Area 3: Cardiovascular health	**Indicator 1**: Percentage of the eligible population will have had their cardiovascular risk assessed in the last 5 years		90%
	Indicator 2. Percentage of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the past 5 years		90%
Focus Area 4: Acute heart service	Percentage of high-risk patients receive an angiogram within 3 days of admission		>70%
	Percentage of patients presenting with ACS who undergo coronary angiography who have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days		>95%
	Percentage of patients presenting with ACS who undergo coronary angiography who have completion of ANZACS QI ACS and Cath/PCI registry data collection within 3 months		>99%
	Percentage of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF		≥85%
	Composite Post ACS Secondary Prevention Medication Indicator – in the absence of a documented contraindication/intolerance all ACS patients who undergo coronary angiogram should be prescribed, at discharge, aspirin, a second anti-platelet agent, statin, and an ACEI/ARB (4-classes), and those with LVEF<40% should also be on a beta-blocker (5 classes)		>85%
Focus Area 5: Stroke services	Percentage of potentially eligible stroke patient's thrombolysed 24/7		≥10%
	Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway		80%
	Percentage of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission		80%
	Percentage of patients referred for community rehabilitation who are seen face to face by a member of the community rehabilitation team i.e. RN/PT/OT/SLT/SW/Dr/Psychologist within 7 calendar days of hospital discharge		60%
PP21: Immunisation coverage	Percentage of 2 year olds fully immunised	Total	≥95%
		Māori	
	Percentage of 5 year olds fully immunised	Total	≥95%
		Māori	
	Percentage of girls fully immunised – HPV vaccine	Total	≥75%
		Māori	
	Percentage of 65+ year olds immunised – flu vaccine	Total	≥75%
		Māori	
	Report on activities in the Annual Plan		
PP22: Delivery of actions to improve system integration including SLMs	Report on activities in the Annual Plan		

PP23: Implementing the Healthy Ageing Strategy	Report on activities in the Annual Plan.		
	Conversion rate of Contact Assessment (CA) to Home Care Assessment where CA scores are 4-6 for assessment urgency	Baseline to be established	
PP25: Prime Minister's youth mental health project	***Initiative 1:*** Report on implementation of school-based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement *Youth Health Care in Secondary Schools: A framework for continuous quality improvement* in each school (or group of schools) with SBHS		
	Initiative 3: Youth Primary Mental Health. As reported through PP26 (see below)		
	Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population		
PP26: The Mental Health & Addiction Service Development Plan	Provide reports as specified for the focus areas of Primary Mental Health, District Suicide Prevention and Postvention, improving Crisis Response services, improving outcomes for children, and improving employment and physical health needs of people with low prevalence conditions		
PP27: Supporting Child Well-being	Report on activities in the Annual Plan		
PP28: Reducing Rheumatic fever	Reducing the Incidence of First Episode Rheumatic Fever	Provide progress report against rheumatic fever prevention plan	
		Provide report on lessons learned and actions taken following reviews	
		Target of ≤0.2 per 100,000 for South Island DHBs	
PP29: Improving waiting times for diagnostic services	Coronary angiography	Percentage of accepted referrals for elective coronary angiography will receive procedure within 3 months (90 days)	95%
	CT Scans	Percentage of accepted referrals for CT scan will receive scan within 6 weeks (42 days)	95%
	MRI Scan	Percentage of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days)	90%
PP29: Improving waiting times for diagnostic services	Diagnostic Colonoscopy (urgent)	Percentage of people accepted for an urgent diagnostic colonoscopy will receive procedure within 2 weeks (14 calendar days, inclusive), 100% within 30 days	90%
	Diagnostic Colonoscopy (non-urgent)	Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 days), 100% within 90 days	70%
	Surveillance Colonoscopy	Percentage of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date. 100% within 120 days	70%
PP30: Faster cancer treatment	Patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat		85%
	Report on activities in the Annual Plan		
PP31: better help for smokers to quit in public hospitals	Hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking		95%
PP32: Improving the quality of ethnicity data collection in PHO and NHI registers	Report on progress with implementation and maintenance of Ethnicity Data Audit Toolkit (EDAT)		
PP33: Improving Māori enrolment in PHOs	Meet and/or maintain the national average enrolment rate		90%

PP36: 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)	≥10% by end of reporting year	
PP37: Improving breastfeeding rates	Percentage of infants exclusively or fully breastfed at three months	70%	
PP39: Supporting Health in Schools	Report on activities in the Annual Plan		
PP40: Responding to climate change	Report on activities in the Annual Plan		
PP41: Waste disposal	Report on activities in the Annual Plan		
PP43: Population mental health	Report on activities in the Annual Plan		
PP44: Maternal mental health	Report on activities in the Annual Plan		
PP45: Elective surgical discharges	13,502 publicly funded, casemix included, elective and arranged discharges for people living with the Southern district		
SI1: Ambulatory sensitive hospitalisations	Age 0-4 years	Refer to SLM Improvement Plan	
	Age 46-65 years	Maori	4,458
		Total	2,968
SI2: Delivery of Regional Plans	Provision of a progress report on behalf of the region agreed by all DHBs within that region		
SI3: Ensuring delivery of Service Coverage	Report progress towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage (as identified by the DHB or by the Ministry)		
SI4:Standardised Intervention Rates (SIRs)	Major joint replacement	21/10,000	
	Cataract Procedures	27/10,000	
	Cardiac Surgery	6.5/10,000	
	Percutaneous revascularization	12.5/10,000	
	Coronary Angiography Services	34.7/10,000	
SI5: Delivery of Whānau Ora	Provide reports as specified about engagement with Commissioning Agencies and for the focus areas of mental health, asthma, oral health, obesity, and tobacco		
SI7: SLM total acute hospital bed days per capita	As specified in the jointly agreed (by district alliances) SLM Improvement Plan		
SI8: SLM patient experience of care	As specified in the jointly agreed (by district alliances) SLM Improvement Plan		
SI9: SLM amenable mortality	As specified in the jointly agreed (by district alliances) SLM Improvement Plan		
SI10: Improving cervical screening coverage	Percentage coverage for all ethnic groups and overall	80%	
SI11: Improving breast screening rates	Percentage coverage for all ethnic groups and overall	70%	
SI12: SLM youth access to and utilisation of youth appropriate health services	See System Level Measure Improvement Plan		
SI13: SLM number of babies who live in a smoke-free household at six weeks postnatal	See System Level Measure Improvement Plan		
SI14: Disability support services	Report on activities in the Annual Plan		
SI15: Addressing local population changes by life course	Report on activities in the Annual Plan		
SI16: Strengthening Public Delivery of Health Services	Report on activities in the Annual Plan		
SI17: Improving quality	Report on activities in the Annual Plan		
SI18: Improving newborn enrolment in General Practice	Percentage of newborns enrolled in General Practice by 6 weeks of age	55%	
	Percentage of newborns enrolled in General Practice by 3 months of age	85%	
	Report on activities in the Annual Plan		

OS3: Inpatient Average Length of Stay (LOS)	Elective LOS (Surgical Inpatient)	1.45 days
	Acute LOS (Inpatient)	2.3 days
OS8: Reducing Acute Re-admissions to Hospital	11.9%	
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections		
Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (causing duplication)	Group A >2% and <= 4%
	Recording of non-specific ethnicity in new NHI registrations	>0.5% and <= 2%
	Update of specific ethnicity value in existing NHI record with non-specific value	>0.5% and <= 2%
	Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and <= 85%
	Invalid NHI data updates	TBA
Focus Area 2: Improving the quality of data submitted to National Collections	NBRS collection has accurate dates and links to National Non-admitted Patient Collection (NNPAC) and the National Minimum Data Set (NMDS)	>= 97% and <99.5%
	National Collections File load Success	>= 98% and <99.5%
	Assessment of data reported to NMDS	>= 75%
	Timeliness of NNPAC data	>= 95% and <98%
Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)	Provide reports as specified about data quality audits.	

Output 1: Mental Health 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

6 APPENDICES

6.1 STATEMENT OF PERFORMANCE EXPECTATIONS

This Statement of Performance Expectations sets out the four Output Classes that the Southern DHB will deliver in the 2018/19 financial year.

Key Facts about Southern DHB

Crown Entity (established under *New Zealand Public Health & Disability Act 2000*)

Purpose:

- Improve, promote and protect the health of our population
- Promote the integration of health services across primary and secondary care services
- Seek the optimal arrangement for the most effective and efficient delivery of health services in order to meet local, regional and national needs
- Reduce health disparities by improving health outcome for Māori and other population groups
- Manage national strategies and implementation plans
- Develop and implement strategies for the specific health needs of the local population

Vision: *Better Health, Better Lives, Whānau Ora*

Values:

Kind- Manaakitanga
Open –Pono
Positive – Whaiwhakaaro
Community - Whanaungatanga

Governance: DHB Commissioner: Mrs Kathy Grant
Deputy Commissioners: Mr Graham Crombie
Mr Richard Thomson

Population: Approximately 324, 090 people live within Southern DHB boundaries.

Staff: Southern DHB employs over 4,500 people.

Southern DHB's Statement of Intent (SOI)[9] provides the basis for our Statement of Performance Expectations (SPE), outlining the strategic directions for the DHB for the next four years, and defining the performance framework and outcomes that we are aiming to achieve.

HOW WILL WE DEMONSTRATE SUCCESS?

The SPE presents a view of the range and performance of services provided for our population across the continuum of care.

As a DHB we aim to make positive changes in the health status of our population over the medium to longer term. As the major funder and provider of health and disability services in the Southern district, the decisions we make about the services to be delivered have a significant impact on our population.

If coordinated and planned well, these will improve the efficiency and effectiveness of the whole Southern health system.

There are two series of measures that we use to evaluate our performance: outcome and impact measures which show the effectiveness over the medium to longer term (3-5 years); and output measures which show performance against planned outputs (what services we have funded and provided in the past year).

On an annual basis, we evaluate our performance by providing a forecast of the services we plan to deliver in the coming year and the standards we expect to meet. We then report actual performance against this forecast in our end-of-year Annual Report[10].

[9]Southern DHB's Statement of Intent (SOI) is available on the DHB's website http://www.southerndhb.govt.nz
[10]The Annual Report is tabled in Parliament and will be available on the DHB's website.

CHOOSING MEASURES OF PERFORMANCE

To make all this happen we have to balance our investment so we can deliver services now and into the future. In 2018/19, the Southern DHB plans to spend approximately $989 million in delivering the following four Outputs funded through Vote Health:

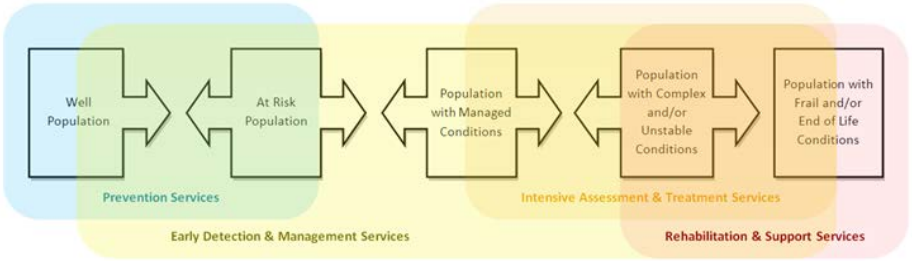
Output 1: Prevention Services;

Output 2: Early Detection and Management Services;

Output 3: Intensive Assessment & Treatment Services; and

Output 4: Rehabilitation & Support Services.

Figure 1: Scope of DHB operations - output classes against the continuum of care



Identifying a set of appropriate measures for each output class can be difficult. We cannot simply measure 'volumes' of service delivered. The number of services delivered or the number of people who receive a service is often less important than whether 'the right person' or 'enough' of the right people received the service, and whether the service was delivered 'at the right time'. In order to best demonstrate this, we have chosen to present our statement of performance expectations using a mix of measures of Timeliness (T), Volume (V), Coverage (C) and Quality (Q).

Wherever possible, past years' baseline and national results are included to give context in terms of what we are trying to achieve and to support evaluation of our performance over time. Services have also been grouped into one of the four 'output classes' that are a logical fit with the continuum care and are applicable to all DHBs.

SETTING STANDARDS

In setting performance targets, we have considered the changing demographics of our population, increasing demand for health services and the assumption that funding growth will be limited. Targets tend to reflect the objective of maintaining performance levels against increasing demand growth but reducing waiting times and delays in treatment to demonstrate increased productivity and capacity. Targets that demonstrate growth in service activity or the establishment of new services tend to be based in primary and community settings (closer to people's own homes) and are set against programmes that will support people to stay well and reduce demand for hospital and residential care. Our targets also reflect our commitment to reducing inequities between population groups, and hence some measures appropriately reflect a specific focus on high need groups. Measures that relate to new services have no baseline data.

WHERE DOES THE MONEY GO?

Table 3 (page 42) presents a summary of the budgeted financial expectations for 2018/19, by output class.

Table 4: Revenue and expenditure by Output Class (page 42) presents a summary of budgeted financial expectations through until 2021/22. Over time, we anticipate it will be possible to use this framework to demonstrate changes in the allocation of resources and funding from one end of the continuum of care to the other. The output measures chosen cover the activities with the potential to make the greatest contribution to the wellbeing of our population in the shorter term, and to the health outcomes we are seeking over the longer term. They also cover areas where we are developing new services and expect to see a change in activity levels or settings in the coming year and therefore reflect a picture of activity across the Southern health system.

Table 3: Revenue and expenditure by Output Class 2018/19

REVENUE	Total $'000
Prevention	4,995
Early Detection and Management	194,170
Intensive Assessment & Treatment	670,828
Rehabilitation & Support	143,889
Total Revenue	**1,013,882**

EXPENDITURE	Total $'000
Prevention	4,995
Early Detection and Management	201,926
Intensive Assessment & Treatment	676,453
Rehabilitation & Support	152,898
Total Expenditure	**1,036,272**
Net Surplus / (Deficit) – $' 000	**(22,390)**

Table 4: Revenue and expenditure by Output Class 2018/19 – 2021/22

Revenue & Expenditure by Output Class	2016/17 Actual $' 000	2017/18 Actual $' 000	2018/19 Budget $' 000	2019/20 Projection $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000
Prevention Services						
Revenue	8,144	4,834	4,995	5,164	5,339	5,521
Expenditure	(8,144)	(4,834)	(4,995)	(5,164)	(5,339)	(5,521)
Net Result	0	0	0	0	0	0
Early Detection and Management Services						
Revenue	180,267	186,855	194,170	206,382	214,821	225,710
Expenditure	(187,843)	(194,261)	(201,926)	(211,488)	(218,233)	(227,401)
Net Result	(7,576)	(7,406)	(7,756)	(5,106)	(3,412)	(1,691)
Intensive Assessment and Treatment						
Revenue	628,954	650,843	670,828	685,718	707,727	728,519
Expenditure	(634,448)	(656,214)	(676,453)	(689,421)	(710,202)	(729,746)
Net Result	(5,494)	(5,371)	(5,625)	(3,703)	(2,475)	(1,227)
Rehabilitation and Support						
Revenue	116,910	137,456	143,889	149,217	156,951	164,938
Expenditure	(125,710)	(146,058)	(152,898)	(155,148)	(160,915)	(166,903)
Net Result	(8,800)	(8,602)	(9,009)	(5,931)	(3,964)	(1,965)
Share of Loss in associates	0	0	0	0	0	0
Total Revenue per DHB Consolidated Financials	934,275	979,987	1,013,882	1,046,482	1,084,839	1,124,688
Total Expenditure per DHB Consolidated Financials	(956,145)	(1,001,366)	(1,036,272)	(1,061,222)	(1,094,689)	(1,129,571)
Net Surplus / (Deficit)	**(21,870)**	**(21,378)**	**(22,390)**	**(14,740)**	**(9,851)**	**(4,883)**

NOTE:

Rather than repeating footnotes, the following symbols have been used in the performance tables:

E Some services are demand driven and it is not appropriate to set targets: instead estimated volumes are provided to give context as to the use of resource across our system.

Δ Performance data provided by external parties can be affected by a delay in invoicing and results are subject to change.

❖ Performance data for some programmes relate to the calendar rather than financial year.

† National Health Targets are set for DHBs to achieve by the final quarter of the year. Performance data therefore refers to the fourth quarter result for any given year.

☩ System Level Measure

6.1.1 PREVENTION SERVICES

'Preventative' health services promote and protect the health of the whole population or identifiable sub-populations, and influence individual behaviours by targeting population-wide physical and social environments to influence and support people to make healthier choices.

Preventative services include health promotion and education programmes which promote healthy choices and work to create environments where we live, learn, work and play to support wellness; statutory mandated health protection services to protect the public from environmental risks and communicable diseases; and population health prevention services such as immunisation and screening services that support early intervention and good health.

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes, cancer, cardiovascular disease and respiratory disease, which account for a significant number of presentations in primary care and admissions to hospital and specialist services. These diseases are largely preventable.

By improving environments and raising awareness, preventative services support people to make healthier choices – reducing major risk factors that contribute to long-term conditions and delaying or reducing the impact of these conditions. High-needs and at-risk population groups are also more likely to engage in risky behaviours and to live in environments less conducive to making healthier choices.

Prevention services are our best opportunity to target improvements in the health of high-needs populations and to reduce inequalities in health status and health outcomes.

HOW WE WILL MEASURE PERFORMANCE OF OUR PREVENTION SERVICES

Output Class: Prevention Services

Sub Output Class	Measure	Notes		Actual 2016/17	Target 2017/18	Target 2018/19
Immunisation Services These services reduce the transmission and impact of vaccine-preventable diseases. The DHB works with primary care & allied health professionals to improve the provision of immunisations both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service.	Percentage of children fully immunised at age 8 months	C†	Total	94%	95%	>95%
			Māori	94%		
	Percentage of children fully immunised at age 2 years	C	Total	95%	95%	>95%
			Māori	96%		
	Percentage of eligible girls fully immunised with HPV vaccine	C	Total	68%	75%	>75%
			Māori	72%		
	Percentage of people (≥ 65 years) having received a flu vaccination	C	Total	-	75%	>75%
			Māori	-		
Health Promotion & Education Services These services inform people about risks and support them to be healthy. Success begins with awareness and engagement, reinforced by programmes and legislation that support people to maintain wellness and make healthier choices.	Percentage of enrolled patients who smoke and are seen by a health practitioner in primary care and offered brief advice and support to quit smoking	C†	Total	85%	90%	>90%
			Māori	89%		
	Infants exclusively or fully breastfeeding at 3 months	Q Δ	Total	58%	60%	>60%
			Māori	50%		
Population Based Screening These services help to identify people at risk of illness and pick up conditions earlier. The DHB's role is to encourage uptake, as indicated by high coverage rates.	Percentage of 4 year old children receiving a B4 School Check	C	Total	87%	90%	>90%
			Quintile 5	74%		
	Percentage of obese children identified in the B4 School Check programme offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions	Q †	Total	87%	95%	>95%
	Percentage of eligible women (50-69 years) having a breast cancer screen in the last 2 years	C	Total	75%	70%	>70%
			Māori	67%		
	Percentage of eligible women (25-69 years) having a cervical cancer screen in the last 3 years	C	Total	78%	80%	>80%
			Māori	63%		

6.1.2 EARLY DETECTION AND MANAGEMENT

Early detection and management services maintain, improve and restore people's health by ensuring that people at risk or with disease onset are recognised early, their need is identified, long-term conditions are managed more effectively and services are coordinated.

Providers of these services include general practice, community and Māori and Pacific health services, pharmacy, diagnostic imaging, laboratory services, child and youth oral health services.

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

New Zealand is experiencing an increasing prevalence of long-term conditions, so called because once diagnosed people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others, and prevalence also increases with age.

By promoting regular engagement with health and disability services, we support people to maintain good health through earlier diagnosis and treatment, intervene in less invasive and more cost-effective ways with better long-term outcomes.

Our vision to better integrate services presents a unique opportunity to reduce inefficiencies across the health system and provide access to a wider range of publicly funded services closer to home. Providing flexible and responsive services in the community, without the need for a hospital appointment, better supports people to stay well and manage their condition.

HOW WE WILL MEASURE PERFORMANCE OF OUR EARLY DETECTION AND MANAGEMENT SERVICES

Output Class: Early Detection and Management

Sub Output Class	Measure	Notes		Actual 2016/17	Target 2017/18	Target 2018/19
Oral Health These services are provided by registered oral health professionals to help people maintain healthy teeth and gums. High enrolment indicates engagement, while timely examination & treatment indicates a well-functioning, efficient service.	Percentage of eligible preschoolers enrolled in community oral health services	C ❖	Total	81%	95%	>95%
			Māori	65%		
	Percentage of children caries-free at five years of age	Q ❖	Total	69%	70%	>70%
			Māori	58%		
Primary Health Care Services These services are offered in local community settings by general practice teams and other primary health care professionals, aimed at improving, maintaining or restoring people's health. High levels of enrolment or uptake of services are indicative of engagement, accessibility & responsiveness of primary care services.	Avoidable Hospital Admissions[11] rates for children (0-4 years)	Q ✞	Total	5,450	<5,190	<5,370
			Māori	5,437	<5,190	<5,370
	Number of people receiving a brief intervention from the primary mental health service	V	Total	7,418	6,000	>6,000
	Percentage of the eligible population who have had a CVD Risk Assessment[12] in the last 5 years	C	Total	86%	90%	>90%
			Māori	82%		
	Percentage of the population identified with diabetes having good or acceptable glycaemic control[13]	C	Total	37%	79%	>58%
			Māori	36%		
Community Referred Testing & Diagnostics These are services which a health professional may use to help diagnose a health condition, or as part of treatment. While services are largely demand driven; faster & more direct access aids clinical decision-making, improves referral processes & reduces the wait for treatment.	Percentage of accepted referrals for Computed Tomography (CT) scans receiving procedure within 42 days	T	Total	74%	95%	>85%
	Percentage of accepted referrals for Magnetic Resonance Imaging (MRI) scans receiving procedure within 42 days	T	Total	48%	85%	>67%
	Percentage of patients to 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 2 weeks	T †	Total	79%	90%	>90%

[11] Avoidable Hospital Admissions are admissions to hospital seen as preventable through appropriate early intervention and therefore provide an indication of access to and effectiveness of primary care, the interface between primary and secondary services. The measure is a national DHB performance indicator (SI1), and is defined as the standardised rate per 100,000. The definition for this measure is being revised nationally and was not available at the time of printing – targets will be confirmed once the definition is set.

[12] This refers to CVD risk assessments undertaken in primary care in line with the national 'More heart and diabetes checks' Health Target is for those who are aged 45-79 years.

[13] An annual HbA1c test of patient's blood glucose levels is seen as a good means of assessing the management of their condition - HbA1c <64mmol/mol reflects an acceptable blood glucose level.

6.1.3 INTENSIVE ASSESSMENT AND TREATMENT

Intensive assessment and treatment services are usually complex services provided by specialists and other health professionals working closely together. These services are therefore usually (but not always) provided in hospital settings, which enable the co-location of clinical expertise and specialist equipment.

A proportion of these services are in response to an acute event and others are planned where access is determined by clinical triage, capacity, treatment thresholds and national service coverage agreements. Services include: Ambulatory services, Inpatient services and Emergency Department services. There are expectations for the delivery of increased elective surgical volumes, a reduction in waiting times for treatments, and increased clinical leadership around improving service delivery and safety to improve the quality and efficiency of care being delivered.

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

Equitable, timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention or through corrective action. Responsive services and timely treatment support improvements across the whole system and give people confidence that complex intervention is available when needed. People are then able to establish more stable lives, resulting in improved public confidence in the health system.

As an owner of these services, Southern DHB is also committed to providing high quality services. Quality improvement in service delivery, systems and processes will improve patient safety, reduce the number of events causing injury or harm and improve health outcomes.

HOW WE WILL MEASURE PERFORMANCE OF OUR INTENSIVE ASSESSMENT AND TREATMENT SERVICES

Output Class: Intensive Assessment and Treatment

Sub Output Class	Measure	Notes		Actual 2016/17	Target 2017/18	Target 2018/19
Specialist Mental Health These are services for those most severely affected by mental illness or addictions. They include assessment, diagnosis, treatment, rehabilitation and crisis response when needed. Utilisation and wait times are monitored to ensure service levels are maintained and to demonstrate responsiveness to need.	Percentage of young people (0-19 years) accessing specialist mental health services	C Δ	Total	3.85%	3.75%	>3.75%
			Māori	3.96%		
	Percentage of adults (20-64 years) accessing specialist mental health services	C Δ	Total	3.60%	3.75%	>3.75%
			Māori	6.93%	5.22%	>5.22%
	Percentage of people who have a transition (discharge) plan	Q	Total	85%	95%	>95%
	Percentage of people (0-19 years) referred for non-urgent mental health or addiction DHB Provider services who access services in a timely manner	T	< 3 weeks	74%	80%	>80%
			< 8 weeks	88%	95%	>95%
Acute Services These are services for illnesses that may have a quick onset, are often of short duration and progress rapidly, for which the need for care is urgent. Hospital-based services include EDs, short-stay acute assessments and intensive care services.	People are assessed, treated or discharged from ED in under 6 hours	T†	Total	90%	95%	>95%
	Number of people presenting at ED	V	Total	80,903	< 80,000	< 80,000
Elective Services (Inpatient & Outpatient) These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. They include elective surgery, but also nonsurgical interventions (such as coronary angioplasty) and specialist assessments (either first assessments, follow-ups or preadmission assessments).	Number of elective surgical service discharges [14]	V†	Total	12,756	13,190	13,502
	Percentage of elective and arranged surgery undertaken on a day case basis[15]	Q	Total	N/A	60%	>60%
	Percentage of people receiving their elective and arranged surgery on day of admission	Q	Total	N/A	95%	>95%
	Number of elective surgical services (CWDs) delivered (elective initiative)	V	Total	15,197	16,090	18,311

[14] This measure is a national performance measures (the electives health target). The measure was redefined in 2015/16 and now includes inpatient surgical discharges, regardless of whether the discharge is from a surgical or non-surgical speciality and both 'elective' and 'arranged' admissions. Previous year's baselines were provided by the Ministry of Health.

[15] When elective surgery is delivered as a day case or on the day of admission, it makes surgery less disruptive for patients, who can spend the night before in their own home and it frees up hospital resources.

Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services. Appropriate and quality service provision will reduce readmission rates and better support people to recover from complex illness and/or maximise their quality of life.

Output Class: Intensive Assessment and Treatment						
Sub Output Class	Measure	Notes		Actual 2016/17	Target 2017/18	Target 2018/19
Maternity Services These services are provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Services are provided by a range of health professionals, including midwives, GPs and obstetricians. Utilisation is monitored to ensure service levels are maintained and to demonstrate responsiveness to need.	Number of maternity deliveries in Southern DHB facilities[16]	V E	Total	3,420	<3,277	3,400
			Māori	559	>542	560
	Percentage of pregnant women registered with a Lead Maternity Carer in the first trimester	Q	Total	TBC	80%	>80%
Assessment Treatment & Rehabilitation (AT&R) These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered in specialist inpatient units and outpatient clinics. An increase in the rate of people discharged home with support, rather than to residential care or hospital environments (where appropriate) reflects the responsiveness of services.	Average length of stay (days) for inpatient AT&R services	T	<65 years	27.1	28.3	<28.3
			≥65 years	17.0	18.5	<18.5
	Patients have improved physical functionality on discharge	Q ❖	<65 years	25.2	24.2	>24.2
			≥65 years	18.8	16.9	>16.9

[16] Some services are demand driven and it is not appropriate to set targets, instead estimated volumes are provided to give context as to the use of resource across our system.

6.1.4 REHABILITATION & SUPPORT

Rehabilitation and support services provide people with the assistance they need to maintain or regain maximum functional independence, either temporarily while they recover from illness or disability, or over the rest of their lives.

These services are delivered after a clinical 'needs assessment' process coordinated by Needs Assessment and Service Coordination (NASC) services and include: domestic support, personal care, community nursing, respite and residential care. Services are mostly for older people, mental health clients and people with complex conditions.

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

Services that support people to manage their needs and live well, safely and independently in their own homes are considered to provide a much higher quality of life, as a result of people staying active and positively connected to their communities. This is evident by less dependence on hospital and residential services and a reduction in acute illness, crisis or deterioration leading to acute admission or re-admission into hospital services. Even when returning to full health is not possible, timely access to responsive support services enables people to maximise function and independence.

In preventing deterioration and acute illness or crisis, these services have a major impact on the sustainability of hospital and specialist services and on the wider health system in general by reducing acute demand, unnecessary ED presentation and the need for more complex intervention.

Support services also include palliative care services for people who have end-stage conditions. It is important that they and their families are appropriately supported, so that the person is able to live comfortably, have their needs met in a holistic and respectful way and die without undue pain and suffering.

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HOW WE WILL MEASURE PERFORMANCE OF OUR REHABILITATION AND SUPPORT SERVICES

Output Class: Rehabilitation and Support					
Sub Output Class	Measure	Notes	Actual 2016/17	Target 2017/18	Target 2018/19
Needs Assessment & Services Coordination Services These are services that determine a person's eligibility and need for publicly funded support services and then assist the person to determine the best mix of supports based on their strengths, resources and goals.	Percentage of aged care residents who have had an InterRAI[17] assessment within 6 months admission	Q Δ	100%	90%	>95%
	Percentage of people ≥65 years receiving long-term home support who have a Comprehensive Clinical Assessment & an Individual Care Plan	Q	99%	95%	>95%
Home and Community Support Services (HCSS) These are services designed to support people to continue living in their own homes and to restore functional independence. An increase in the number of people being supported is indicative of the capacity in the system, and success is measured against delayed entry into residential or hospital services with more people supported to live longer in their own homes.	Total number of eligible people aged over 65 years supported by home and community support services	E	4,287	4,200	4,400
	Percentage of clients receiving home support who are classified as complex	Q Δ	52%	55%	>55%
	Percentage of HCSS support workers who have completed at least Level 2 in the National Certificate in Community Support Services (or equivalent)	Q Δ	80%	80%	>80%
Rehabilitation These services restore or maximise people's health or functional ability following a health-related event. They include mental health community support, physical or occupational therapy, treatment of pain or inflammation and retraining to compensate for lost functions.	Number of people assessed by the GP (primary care provider) for fracture risk using the portal	Q Δ	170	100	300
Age Related Residential Care These services are provided to meet the needs of a person who has been assessed as requiring long-term residential care in a hospital or rest-home indefinitely.	Number of Rest Home Bed Days per capita of the population aged over 65 years	V	6.94	7.5	<7.0

[17] InterRAI is an evidence-based geriatric assessment tool the use of which ensures assessments are high quality and consistent and that people receive equitable access to support and care.

6.1 FINANCIAL PERFORMANCE

6.1.1 FORECAST FINANCIAL STATEMENTS

The projected DHB deficit for 2018/19 is $20.1 million. The projected deficits in the three out-years progressively track downwards with a deficit of $4.9 million planned in 2021/22.

The Commissioner team is embedded into Southern DHB and consults with the community, health service providers and staff. The Commissioners actively support the improvement in culture at Southern DHB and encourage staff to identify and implement changes to processes to achieve efficiencies.

It has been highlighted over the past few years that the DHB must invest in services and facilities to continue to meet the health demands from the population groups it serves. The investment in bringing to life the Primary & Community Strategy is a key component of the fundamental shift in service delivery for Southern DHB.

Table 5: DHB Consolidated Prospective Net Results

DHB Consolidated Prospective Net Results	2016/17 Actual $' 000	2017/18 Actual $' 000	2018/19 Budget $' 000	2019/20 Projection $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000
Governance	1,616	576	681	(272)	(156)	(101)
Funds	(2,412)	(7,858)	6,090	5,448	7,983	8,471
Provider	(21,075)	(14,096)	(29,160)	(19,917)	(17,677)	(13,253)
Net Surplus / (Deficit)	**(21,870)**	**(21,378)**	**(22,390)**	**(14,740)**	**(9,851)**	**(4,883)**

The focus is on valuing patient time as a key driver for change in the DHB. By rethinking the models of care, investing and coordinating the process change across the DHB to drive the pace of change required to take the DHB forward. The budget for 2018/19 reflects the investments on the pathway to a sustainable future across all areas of the DHB.

KEY ASSUMPTIONS

Key assumptions include:

- Successful delivery of the programme of change through service alignment initiatives.
- The improvement of information delivery primarily due to investment in IT systems.
- Achieving elective surgery targets to ensure receipt of the associated revenue.
- Managing personnel cost growth and the impacts from national collective agreements and workforce retention / recruitment issues.
- Managing service growth demand and Full Time Equivalent (FTE) staff growth within the context of the limited increase in demographic funding.
- Continuing the focus on management of expenditure through regional alignment, national procurement and shared services activity.
- Effective capital expenditure to enhance service delivery and continue on the pathway to robust Asset Management Plan.
- Managing the working capital and cash position to minimise the cost of capital.

SIGNIFICANT ASSUMPTIONS

The DHBs key assumptions relating to the 2018/19 budgeted financial statements are listed below:

- The 2018/19 budget includes the impact of the one off payment and 2% increase for the NZNO settlement recognised at 30 June 2018. Any settlement higher than this is assumed to be offset by an increase in revenue from MoH.
- Funding is based on the Government Allocations under Population Based Funding (PBF). Southern DHB's share of the pool is projected to decrease marginally year on year as shown below.

Table 6: Southern DHB PBF projections

DHB	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Southern	6.81%	6.76%	6.75%	6.72%	6.66%	6.63%

- Despite the decreasing share of PBF revenue, Government allocated revenue is forecast to increase by 2.9% both in 2018/19 and the out years.
- The investments include outsourcing to meet capacity constraints, implementing the primary & community strategy action plan, increasing ICU capacity, progressively reducing the vacancy factor, resourcing for growth in Lakes region and implementing change management processes with the focus on valuing patient time.
- Demographic driven service growth continues to be projected as follows;

Table 7: Southern DHB demographic driven service growth

DHB	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Southern	2.10%	1.85%	1.80%	1.75%	1.65%	1.62%

- Incremental savings and efficiency targets have been built into baseline budgets. The detail programmes that contribute to the savings in the out years are still being defined.
- Costs associated with the activities of New Zealand Health Partnership Ltd (NZHPL) have been factored in together with the significant benefits proposed to be delivered from procurement.
- Elective targets have been increased by 229 discharges over levels planned in 2017/18 with associated additional revenue.
- Acute demand continues to increase, however the DHB plans to meet the elective targets set.

6.1.2 CAPITAL EXPENDITURE AND CAPITAL FUNDING

Southern DHB faces on-going difficulties in funding capital expenditure. Capital Expenditure is shown in Table 8.

Table 8: Planned Capital Expenditure

Planned Capital Expenditure	2016/17 Actual $' 000	2017/18 Actual $' 000	2018/19 Budget $' 000	2019/20 Projection $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000
Clinical Capital	(2,420)	(11,228)	(28,999)	(11,569)	(11,120)	(6,854)
Building Capital	(9,349)	(1,507)	(19,737)	(83,496)	(18,850)	(5,950)
Dunedin Master Site Redevelopment	(4,624)	(12,118)	(15,117)	(244)	0	0
Local Informatiom System requirement	(904)	(2,563)	(13,477)	(23,240)	(13,397)	(12,919)
Total capital expenditure budget	**(17,297)**	**(27,415)**	**(77,330)**	**(198,549)**	**(43,367)**	**(25,722)**

The capital investment needs are spread across the DHB with services (demographics), technology, productivity, and quality requirements all driving demand for capital expenditure. The development and refinement of the Asset Management Plan currently in progress is critical for effective assessment of expenditure especially for the Interim Works Programme on the Dunedin Hospital site.

INTERIM WORKS PROGRAMME

During 2019 the ICU redevelopment will be completed and is expected to be fully operational at the commencement of the 2019/2020 year. There are ongoing deferred maintenance projects required to sustain the operational capability of Dunedin Hospital through to the new Dunedin Hospital.

LAKES HOSPITAL REDEVELOPMENT

Equity injections will be sought to fund the Lakes Redevelopment Project that has a budget of $9.8m in 2018/19.

BASELINE CLINICAL CAPITAL

Capital investment includes a commitment from the Commissioners for capital to assist Southern DHB meet its clinical goals with $2.0m allocated to the 2018/19 year.

A Contingency fund is included within the baseline investment level to ensure the Southern DHB has the ability to meet expenditure that has arisen through items such as unexpected failures and changes in legislation.

CAPITAL FINANCING AND DEBT FACILITIES

Financing for capital expenditure and the cash requirements for the DHB are shown in Table 9. The key component of financing highlighted is as follows;

- Deficit support, which will be a requirement until 2020/21 when the DHB is in a better position. After this the level of deficit support will be dependent on maintaining this position, particularly when undergoing a significant rebuild that will attract a capital charge on the funding.

Table 9: Planned Capital Financing

Planned Capital Financing	2016/17 Actual $' 000	2017/18 Actual $' 000	2018/19 Budget $' 000	2019/20 Projection $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000
Deficit Support	(20,000)	(15,000)	(40,300)	(30,966)	(20,857)	0
Equity for conversion of Crown Loans	0	(97,400)	0	0	0	0
Equity for Capital Projects	(97,400)	91,694	(23,694)	(80,000)	0	0
NZHPL Investment (Capital component)	0	0	0	0	0	0
Equity repaid	(707)	(707)	(707)	(707)	(707)	(707)
Cash Balance	(22,840)	(30,377)	(36,178)	(27,749)	(27,838)	(18,590)

The DHB has the following financing arrangements in place:

Table 10: DHB Financing Arrangements

Facility / Lender	Facility $'000	Amount Drawn	Due Date	Rate
Crown Debt	1,670	1,670	Qrtly Instalment	0.00%
EECA Loans	166	166	Qrtly Instalment	0.00%
Finance Leases	1,830	1,830	Mthly & Qtrly Instalment	3.76%-8.56%
	3,666	3,666		

ASSET VALUATIONS AND DISPOSALS

Land and buildings are revalued to fair value as determined by an independent registered valuer. The revaluation is undertaken with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. This determination is made each year. The last revaluation was undertaken as at 30 June 2014.

Buildings with known asbestos issues were impaired by $20 million as at 30 June 2017 in accordance with PBE IPSAS 21 – Impairment of Non-Cash Generating Assets. This resulted in a decrease in the carrying cost of the assets as well as a corresponding reduction in the revaluation reserve. As remedial work is undertaken on the buildings, the DHB increases the carrying cost of the asset by the value of the remediation work.

Future valuations of Land and Buildings will be adjusted to include the essential capital maintenance at the Dunedin Hospital site to ensure the buildings are maintained to a minimum standard until the new Dunedin Hospital is operational.

The DHB will ensure that disposal of land or buildings transferred to, or vested in it pursuant to the Health Sector (Transfers) Act (1993) will be subject to approval by Cabinet. The DHB will ensure that the relevant protection mechanisms that address the Crown's obligations under the Treaty of Waitangi and any processes relating to the Crown's good governance obligations in relation to Māori sites of significance and that the requirements of section 40 of the Public Works Act and Ngai Tahu Settlements Act are addressed. Any such disposals are planned in accordance with s42(2) of the NZPHD Act 2000.

VALUATION OF LAND AND BUILDINGS AT 30 JUNE 2018

Tony Chapman of Colliers Otago undertook a valuation of the Southern DHB land and buildings portfolio at 30 June 2018. As a result a revaluation of $34,570,000 was made to land and buildings at 30 June 2018 based on the existing useful lives. The Minister of Health has announced an intention to build a new Dunedin Public Hospital and the Ministry of Health has commenced work on the project. However, at 30 June 2018 the master site plan for the new Dunedin Public Hospital had not been developed. Therefore, the Southern DHB finance team have been unable to assess the remaining useful life of the existing Dunedin Public Hospital or the potential for repurposing and/or sale of the land and buildings. For this reason the depreciation charge in the 2019 Annual Plan was calculated using the building base before the revaluation. As such the budget deprecation charge is understated by $2,245,197 arising from the revaluation of buildings at 30 June 2018 and there is no way to mitigate the impact on the 2019 financial performance. In addition, once the master site plan is available there is potential for the depreciation charge to further increase to reflect the reassessment of the remaining useful life of the existing buildings used by Dunedin Public Hospital.

6.1.3 PROSPECTIVE FINANCIAL STATEMENTS

In accordance with the new Accounting Standards Frameworkthe District Health Board is classified as a Tier 1 Public Sector Public Benefit Entity (PBE).

Table 11: DHB Consolidated Statement of Prospective Financial Performance

DHB Consolidated Statement of Prospective Financial Performance	2016/17 Actual $' 000	2017/18 Actual $' 000	2018/19 Budget $' 000	2019/20 Projection $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000
Revenue						
PBF Funding Package	823,201	852,077	883,906	916,725	950,799	986,182
Inter District Revenue	21,894	21,778	22,377	23,207	24,071	24,968
Funder Side Contracts	42,960	57,645	59,587	57,310	59,440	61,652
Provider Misc Revenues	46,220	48,487	48,012	49,238	50,528	51,888
Total Revenues	934,275	979,987	1,013,882	1,046,481	1,084,839	1,124,689
less Personnel Expenses						
Medical Personnel	(122,538)	(125,880)	(131,858)	(124,681)	(128,058)	(132,502)
Nursing Personnel	(137,529)	(142,782)	(145,389)	(156,492)	(159,331)	(163,812)
Allied Health Personnel	(50,376)	(50,560)	(53,957)	(53,070)	(54,890)	(57,048)
Support Services Personnel	(5,833)	(5,696)	(6,294)	(6,305)	(6,393)	(6,535)
Management/Admin Personnel	(45,695)	(44,711)	(49,156)	(51,099)	(51,694)	(52,719)
Personnel Costs Total	(361,973)	(369,628)	(386,655)	(391,647)	(400,367)	(412,616)
less Non Personnel Expenditure						
Outsourced Services Expenses	(42,785)	(45,237)	(42,404)	(41,100)	(42,160)	(43,552)
Clinical Supplies Expenses	(89,109)	(93,481)	(94,386)	(93,792)	(96,690)	(97,892)
Infrastructure & Non Clinical Supplies Expenses	(69,754)	(73,463)	(79,430)	(87,753)	(94,262)	(97,329)
Total Non-Personnel Expenditure	(201,649)	(212,180)	(216,220)	(222,645)	(233,113)	(238,773)
less Provider Payments						
Personal Health Expenses	(242,673)	(249,643)	(255,620)	(265,980)	(273,533)	(283,521)
Mental Health Expenses	(24,412)	(24,673)	(25,434)	(26,379)	(27,359)	(28,377)
Disability Support Expenses	(123,762)	(143,740)	(150,384)	(152,540)	(158,210)	(164,098)
Public Health Expenses	(702)	(601)	(729)	(756)	(784)	(813)
Maori Health Expenses	(975)	(900)	(1,230)	(1,276)	(1,323)	(1,373)
Total Provider Payments	(392,524)	(419,557)	(433,397)	(446,930)	(461,210)	(478,182)
Total Expenses	(956,145)	(1,001,366)	(1,036,272)	(1,061,221)	(1,094,689)	(1,129,572)
Net Surplus / (Deficit)	**(21,870)**	**(21,378)**	**(22,390)**	**(14,740)**	**(9,851)**	**(4,883)**
Supplemental Information						
Depreciation Charges	(21,396)	(21,590)	(26,570)	(28,012)	(32,116)	(34,240)
Interest Costs	(2,471)	(10)	0	0	0	0
Capital Charge	(5,042)	(9,120)	(9,850)	(14,208)	(18,701)	(18,970)
Total IDCC Costs	(28,909)	(30,720)	(36,419)	(42,220)	(50,817)	(53,211)
Medical FTE	528	546	579	526	534	542
Nursing FTE	1,663	1,687	1,716	1,785	1,799	1,816
Allied FTE	668	668	687	684	693	701
Support FTE	102	101	103	103	103	103
Management/Admin FTE	675	675	702	714	715	717
Total FTE	3,636	3,676	3,788	3,812	3,845	3,879

Table 12: DHB Consolidated Prospective Balance Sheet

DHB Consolidated Prospective Balance Sheet	2016/17 Actual $' 000	2017/18 Actual $' 000	2018/19 Budget $' 000	2019/20 Projection $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000
Current Assets:						
Cash & Bank Accounts	8	8	8	8	8	8
Prepayments	6,113	3,258	3,258	3,317	3,380	3,447
Inventory	4,922	5,032	5,032	5,122	5,220	5,324
Accounts Receivable	36,219	40,473	40,473	41,201	41,984	42,824
Assets held for resale	0					
Total Current Assets	47,262	48,771	48,771	49,648	50,592	51,604
Current Liabilities:						
Bank overdraft and current debt	(1,530)	(1,631)	(1,226)	(1,226)	(1,226)	(1,226)
Creditors provisions and payables	(147,048)	(156,800)	(166,443)	(161,493)	(162,552)	(159,742)
Total Current Liabilities	(148,577)	(158,431)	(167,669)	(162,718)	(163,777)	(160,967)
Net Working Capital	(101,315)	(109,660)	(118,898)	(113,070)	(113,186)	(109,364)
Non Current Assets:						
Land , Buildings, Plant and Equipment	278,032	318,380	369,139	459,677	470,928	462,409
Long Term Investments	4,469	4,469	4,469	4,469	4,469	4,469
Total Non Current Assets	282,501	322,849	373,608	464,146	475,397	466,878
Non Current Liabilities:						
Long Term Debt	(3,643)	(2,455)	(2,455)	(2,455)	(2,455)	(2,455)
Other Liabilities	(18,149)	(18,149)	(18,774)	(19,622)	(20,458)	(21,352)
Net Equity	**159,394**	**192,585**	**233,480**	**328,999**	**339,298**	**333,708**

Table 13: DHB Consolidated Statement of Prospective Changes in Equity

DHB Consolidated Statement of Prospective Changes in Equity	2016/17 Actual $' 000	2017/18 Actual $' 000	2018/19 Budget $' 000	2019/20 Projection $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000
Total Equity at beginning of period	84,662	159,394	192,585	233,481	328,999	339,298
Net Result for the period - Governance	1,616	576	681	(272)	(156)	(101)
Net Result for the period - Funds	(2,412)	(7,858)	6,090	5,448	7,983	8,471
Net Result for the period - Provider	(21,075)	(14,096)	(29,160)	(19,917)	(17,677)	(13,253)
Revaluation of Fixed Assets	(20,090)	34,570	0	0	0	0
Other movement	0	0	0	0	0	0
Equity Repaid (Revaluation funding)	(707)	(707)	(707)	(707)	(707)	(707)
Equity Injections for Capital	97,400	5,706	23,694	80,000	0	0
Equity Injections for Deficit	20,000	15,000	40,300	30,966	20,857	0
Total Equity at end of Period	**159,394**	**192,585**	**233,481**	**328,999**	**339,298**	**333,708**

Table 14: DHB Consolidated Statement of Prospective Cash Flows

DHB Consolidated Statement of Prospective Cash Flows	2016/17 Actual $' 000	2017/18 Actual $' 000	2018/19 Budget $' 000	2019/20 Projection $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000
Operating Cashflows						
Cash inflows from operating activities	931,178	971,515	1,005,252	1,045,570	1,083,869	1,123,658
Cash outflows from operating activities	(935,902)	(970,585)	(997,184)	(1,029,037)	(1,060,930)	(1,088,175)
Net cash inflows(outflows) from operating activities	(4,724)	929	8,068	16,533	22,939	35,483
Investing Cashflows						
Cash inflows from investing activities	295	319	183	187	190	194
Cash outflows from investing activities	(23,061)	(27,409)	(77,329)	(118,549)	(43,367)	(25,722)
Net cash flows from investing activities	(22,766)	(27,090)	(77,146)	(118,363)	(43,177)	(25,528)
Financing Cashflows						
Cash inflows from financing activities	20,000	20,706	63,994	110,966	20,857	0
Cash outflows from financing activities	(5,498)	(2,082)	(717)	(707)	(707)	(707)
Net cashflows from financing activities	14,502	18,624	63,277	110,258	20,150	(707)
Net increase/(decrease) in cash held	(12,989)	(7,537)	(5,801)	8,429	(88)	9,248
Add opening balance	(9,850)	(22,840)	(30,377)	(36,178)	(27,749)	(27,838)
Closing cash balance	**(22,840)**	**(30,377)**	**(36,178)**	**(27,749)**	**(27,838)**	**(18,590)**

6.2 STATEMENT OF ACCOUNTING POLICIES

6.2.1 REPORTING ENTITY

Southern District Health Board (DHB) is a Health Board established by the New Zealand Public Health and Disabilities Act 2000. Southern DHB is a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand.

Southern DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 2013, the Public Finance Act 1989 and the Crown Entities Act 2004.

Southern DHB designated itself as a public benefit entity (PBE) for financial reporting purposes.

Southern DHB's activities involve delivering health and disability services and mental health services in a variety of ways to the community.

6.2.2 BASIS OF PREPARATION

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

STATEMENT OF COMPLIANCE

The financial statements of the DHB have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004, which include the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP).

The financial statements comply with Public Sector PBE accounting standards including PBE FRS 42.

The financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

GOING CONCERN

The Southern DHB's Commissioner has received a letter of support from the Ministers of Health and Finance in the New Zealand Government. The Ministers' acknowledge that equity support may be required and the Crown will provide such support should it be necessary. The letter of support is fundamental to the going concern assumption underlying the preparation of the financial statements as the 2018/19 Annual Plan has yet to receive approval from the Ministry of Health.

FUNCTIONAL AND PRESENTATION CURRENCY

The financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand dollars ($000).

MEASUREMENT BASE

The assets and liabilities of the Otago and Southland DHBs were transferred to the Southern DHB at their carrying values which represent their fair values as at 30 April 2010. This was deemed to be the appropriate value as the Southern District Health Board continues to deliver the services of the Otago and Southland District Health Boards with no significant curtailment or restructure of activities. The value on recognition of those assets and liabilities has been treated as capital contribution from the Crown.

The financial statements have been prepared on a historical cost basis except;

- where modified by the revaluation of land and buildings
- non-current assets that are held for sale are stated at the lower of carrying amount and fair value less cost to sell
- inventories are stated at the lower of cost and net realisable value.

STANDARDS, AMENDMENTS, AND INTERPRETATIONS ISSUED THAT ARE NOT YET EFFECTIVE AND HAVE NOT YET BEEN EARLY ADOPTED

In 2017, the External Reporting Board issued the following amendments for future adoption:

- PBE IPSAS 39, Employee benefits. This amendment is effective for annual financial statements beginning on or after 1 January 2019.
- PBE IPSAS 9 Reclassification and measurement of financial assets that replaces most of the requirements of PBE ISAS 29. This becomes mandatory for annual periods beginning on or after 1 January 2021 and looks to improve and simplify the approach for classification and measurement of financial assets.

Southern DHB expects there will be no effect in applying these amendments.

STANDARDS, AMENDMENTS, AND INTERPRETATIONS ISSUED THAT ARE NOT YET EFFECTIVE AND HAVE BEEN EARLY ADOPTED

PBE IPSAS 21 Impairment of Non-Cash-Generating Assets - Amendment.

Previously there was some uncertainty about the requirements relating to the recognition of an impairment loss when an item of revalued property, plant and equipment was damaged or no longer available for use. The issue was whether the entire class of assets

needed to be revalued when an impairment loss on damaged/unusable property, plant and equipment was recognised.

This standard removes the uncertainty by including revalued property, plant and equipment and revalued intangible assets in the scope of the impairment standards.

SDHB is an early adopter of this policy, impairing those buildings that have quantifiable asbestos issues impacting their usability.

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

The preparation of financial statements in conformity with International Public Sector Accounting Standards (IPSAS) requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, revenue and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances. The results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an on-going basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Major areas of estimate uncertainty that have a significant impact on the amounts recognised in the financial statements are;

- Impairment due to reduction of service potential caused by asbestos,
- Fixed assets revaluations, and
- Employee entitlements.

6.2.3 SIGNIFICANT ACCOUNTING POLICIES

REVENUE

Revenue is measured at the fair value of consideration received or receivable.

MOH REVENUE

The DHB is primarily funded through revenue received from the Ministry of Health. This funding is restricted in its use for the purpose of the DHB meeting the objectives specified in its founding legislation and the scope of the relevant appropriations of the funder.

Revenue from the Ministry of Health is recognised as revenue at the point of entitlement if there are conditions attached in the funding.

The fair value of revenue from the Ministry of Health has been determined to be equivalent to the amounts due in the funding arrangements.

ACC CONTRACT REVENUE

ACC contract revenue is recognised as revenue when eligible services are provided and any contract conditions have been fulfilled.

REVENUE FROM OTHER DHBS

Inter-district patient inflow revenue occurs when a patient treated within the Southern DHB region is domiciled outside of Southern. The Ministry of Health credits Southern DHB with a monthly amount based on estimated patient treatment for non-Southern residents within Southern. An annual wash-up occurs at year end to reflect the actual number of non-Southern patients treated at Southern DHB.

INTEREST INCOME

Interest income is recognised using the effective interest method.

RENTAL INCOME

Lease income under an operating lease is recognised as revenue on a straight-line basis over the lease term.

PROVISION OF SERVICES

Revenue derived through the provision of services to third parties is recognised in proportion to the stage of completion at the balance date, based on the actual service provided as a percentage of the total services to be provided.

DONATIONS AND BEQUESTS

Donations and bequests to the DHB are recognised as revenue when control over the asset is obtained. Those donations and bequests for specific purposes are transferred from accumulated surpluses / (deficits) to the trust funds component of equity. When expenditure is subsequently incurred in respect of these funds, it is recognised in the surplus or deficit and an equivalent amount is transferred from the trust component of equity to accumulated surpluses / deficits.

REVENUE FROM GRANTS

Revenue from grants includes grants given by other charitable organisations, government organisations or their affiliates. Revenue from grants is recognised when the funds transferred meet the definition of an asset as well as the recognition criteria of an asset. Grants are recognised when they become receivable unless there is an obligation in substance to return the funds if conditions of the grant are not met. If there is such an

obligation, the grants are initially recorded as revenue received in advance and recognised as revenue when conditions of the grant are satisfied.

RESEARCH REVENUE

Research costs are recognised in the Statement of Comprehensive Revenue and Expense as incurred. Revenue received in respect of research projects is recognised in the Statement of Comprehensive Revenue and Expense in the same period as the related expenditure.

Where requirements for Research revenue have not yet been met, funds are recorded as revenue in advance. The DHB receives revenue from organisations for scientific research projects, under PBE IPSAS 9 funds are recognised as revenue when the conditions of the contracts have been met. A liability reflects funds that are subject to conditions that, if unfulfilled, are repayable until the condition is fulfilled.

LEASES

Finance Leases

A finance lease is a lease that transfers to the lessees substantially all risks and rewards incidental to ownership of the asset, whether or not title is eventually transferred.

At the start of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments.

Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.

The amount recognised as an asset is depreciated over its useful life. If there is no reasonable certainty as to whether the DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

Operating Leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of the asset.

Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit as a reduction of rental expense over the lease term.

FOREIGN CURRENCY TRANSACTIONS

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction.

CASH AND CASH EQUIVALENTS

Cash and cash equivalents comprises cash balances, call deposits and deposits with a maturity of no more than three months from the date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of Southern DHB's cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows.

TRADE AND OTHER RECEIVABLES

Trade and other receivables are recorded at face value less any provisions for uncollectability and impairment.

A receivable is considered impaired when there is evidence that the DHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

INVESTMENTS

Bank Deposits

Investments in bank term deposits are initially measured at the amount invested.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest rate method, less any provisions for impairment. A bank deposit is impaired when there is objective evidence that the Southern DHB will not be able to collect amounts due according to the original terms of the deposit.

INVENTORIES

Inventories are stated at the lower of cost, on a first in first out basis and net realisable value. Net realisable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses.

INVENTORIES HELD FOR DISTRIBUTION

Inventories held for distribution are stated at the lower of cost and current replacement cost.

NON-CURRENT ASSETS HELD FOR SALE

Non-current assets held for sale are measured at the lower of their carrying amount and fair value less cost to sell.

Any increases in fair value (less cost to sell) are recognised up to the level of any impairment losses previously recognised.

Impairment losses are recognised in the surplus and deficit.

Non-current assets held for sale are not depreciated or amortised while held for sale.

PROPERTY, PLANT AND EQUIPMENT

The major classes of property, plant and equipment are as follows:

- land
- buildings
- plant and equipment
- motor vehicles.

Land is measured at fair value, buildings are measured at fair value less accumulated depreciation and impairment losses. All other assets are measured at cost less accumulated depreciation and impairment losses.

The DHB capitalises all fixed assets or groups of fixed assets costing greater than or equal to $2,000

The cost of self-constructed assets includes the cost of materials, direct labour, the initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located and an appropriate proportion of direct overheads.

REVALUATIONS

Land and buildings are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in other comprehensive revenue. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in other comprehensive revenue.

Additions to property, plant and equipment between valuations are recorded at cost.

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

DISPOSAL OF PROPERTY, PLANT AND EQUIPMENT

Where an item of plant and equipment is disposed of, the gain or loss recognised in the surplus (deficit) is calculated as the difference between the net sales price and the carrying amount of the asset.

Any balance attributable to the disposed asset in the asset revaluation reserve is transferred to accumulated surpluses (deficits).

ADDITIONS

The cost of an item of property, plant and equipment is recognised as an asset if it is probable that future economic benefits or service potential associated with the item will flow to Southern DHB and the cost of the item can be reliably measured.

Capital work in progress is recognised at cost less impairment.

In most instances, an item of property, plant, and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at fair value as at the date of acquisition.

SUBSEQUENT COSTS

Costs incurred subsequent to initial acquisitions are capitalised only when it is probable that the service potential associated with the item will flow to the Southern DHB and the cost of the item can be reliably measured. All other costs are recognised in the surplus and deficit as an expense as incurred.

DEPRECIATION

Depreciation is provided on a straight line basis on all fixed assets other than land, at rates which will write off the cost (or revaluation) of the assets to their estimated residual values over their useful lives.

The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

Buildings	1 to 79 years	1.25-6.67%
Plant and Equipment	3 to 40 years	6.67-33%
Motor Vehicles	5 to 12 years	20%

Capital work in progress is not depreciated. The total cost of a project is transferred to freehold buildings and/or plant and equipment on completion and then depreciated.

The residual value of assets is reassessed annually, and adjusted if applicable, at each financial year-end.

INTANGIBLE ASSETS

Intangible assets that are acquired by Southern DHB are stated at cost less accumulated amortisation (assets with finite useful lives) and impairment losses.

Acquired computer software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overhead costs.

The National Oracle System Project (NOS) (previously part of the Finance, Procurement and Supply Chain programme) rights represent the DHB's right to access, under a service level agreement, shared NOS services provided using assets funded by the DHBs.

NZ Health Partnerships Limited (NZHPL) was established on 1 July 2015 taking on the assets and liabilities of Health Benefits Limited (HBL). HBL was an agency set up by the Ministry of Health to provide shared services for District Health Boards. The investment was made to fund the establishment of a shared service arrangement to support the delivery of the National Oracle System Project.

The rights are considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by HBL through the on-charging of depreciation on the NOS assets to the DHBs will be used to, and is sufficient to, maintain the NOS assets standard of performance or service potential indefinitely.

As the rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

AMORTISATION

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life.

Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

The estimated useful lives are as follows:

Type of asset	Estimated life	Amortisation rate
Software	3 to 10 years	10-33%

IMPAIRMENT

Property, plant and equipment and intangible assets that have a finite useful life are reviewed for indicators of impairment at each balance date and whenever events or changes in circumstances indicate that the carrying amount might not be recoverable. If any such indications exist, the recoverable amount of the asset is estimated. The recoverable amount is the higher of an asset's fair value less cost to sell and value in use. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount.

Value in use is determined using an approach based on either a depreciated replacement approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of the information

If an asset's carrying amount exceeds its recoverable amount, the assets are impaired and the carrying amount is written down to the recoverable amount. For revalued assets, the impairment loss is recognised in other comprehensive revenue and expenses to the extent that the impairment loss does not exceed the amount in the revaluation reserve in equity for that class of asset. Where that result is a debit in the revaluation reserve, the balance is recognised in the surplus or deficit.

For assets not carried at a revalued amount, the total impairment loss is recognised in the surplus and deficit.

The reversal of an impairment loss on a revalued asset is credited to other comprehensive revenue and expenses and increases the asset revaluation reserve for that class of assets. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus and deficit.

TRADE AND OTHER PAYABLES

Trade and other payables are generally settled within 30 days and are recorded at face value.

BORROWINGS

Interest-bearing and interest-free borrowings are recognised initially at fair value less transaction costs. After initial recognition, borrowings are stated at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless the DHB has an unconditional right to defer settlement of the liability for at least 12 months after the balance date.

EMPLOYEE BENEFITS

EMPLOYEE ENTITLEMENTS

Short-term Employee Entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay. These include salaries and wages accrued up to balance date, annual leave earned to but not yet taken at balance date, continuing medical education leave, sick leave, sabbatical leave, long service leave and retirement gratuities.

Southern DHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates.

Long-term Entitlements

Employee benefits that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as long service leave and retirement gratuities, have been calculated on an actuarial basis by AON New Zealand Ltd using accepted accounting principles. The calculations are based on the:

- likely future entitlements accruing to staff based on years of service; years to entitlement; and
- the likelihood that staff will reach the point of entitlement and contractual entitlement information; and
- the present value of the estimated future cash flows.

Presentation of Employee Entitlements

Sick Leave, continuing medical education leave, annual leave and vested long service and sabbatical leave are classified as a current liability. Non-vested long service leave, sabbatical leave, retirement gratuities, sick leave and continuing medical education leave expected to be settled within 12 months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

SUPERANNUATION SCHEMES

Defined Contribution Plans

Obligations for contributions to defined contribution plans are recognised as an expense in the statement of comprehensive revenue and expenditure as incurred.

PROVISIONS

A provision is recognised for future expenditure of uncertain amount or timing when Southern DHB has a present obligation (either legal or constructive) as a result of a past event, it is probable that an outflow of future economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

RESTRUCTURING

A provision for restructuring is recognised when Southern DHB has approved a detailed and formal restructuring plan, and the restructuring has either commenced or has been announced publicly. Future operating costs are not provided for.

ONEROUS CONTRACTS

A provision for onerous contracts is recognised when the expected benefits to be derived by Southern DHB from a contract are lower than the unavoidable cost of meeting its obligations under the contract.

ACC PARTNERSHIP PROGRAMME

Southern DHB belongs to the ACC Partnership Programme whereby Southern DHB accepts the management and financial responsibility of work related illnesses and accidents of employees. Under the ACC Partnership Programme Southern DHB is effectively providing accident insurance to employees and this is accounted for as an insurance contract. The value of this liability represents the expected future payments in relation to accidents and illnesses occurring up to the balance sheet date for which Southern DHB has responsibility under the terms of the Partnership Programme.

The liability for claims reported prior to balance date has been determined by assuming that the future experience for each current claim is consistent with historical claim information since the commencement of the programme. The liability for injuries or illnesses that have occurred up to balance date, but not yet reported or not enough reported, has been determined by reference to historical information of the time it takes to report injury or illness.

The value of the liability is measured at the present value of the future payments for which Southern DHB has responsibility using a risk free discount rate. The value of the liability includes a risk margin that represents the inherent uncertainty of the present value of the expected future payments.

INCOME TAX

Southern DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CW38 of the Income Tax Act 2007.

BUDGET FIGURES

The budget figures are derived from the statement of intent as approved by the Commissioner at the beginning of the financial year. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the Commissioner in preparing these financial statements. They comply with PBE IPSAS and other applicable Financial Reporting Standards as appropriate for public benefit entities.

GOODS AND SERVICES TAX

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is not recoverable as an input tax, it is recognised as part of the related asset or expense.

CUSTODIAL/TRUST AND BEQUEST FUNDS

Donations and bequests to Southern DHB are recognised as revenue when control over assets is obtained. A liability, rather than revenue, is recognised where fulfilment of any restrictions attached to those assets is not probable. Those donations and bequests with restrictive conditions are appropriated from retained earnings to the trust funds component of equity. When expenditure is subsequently incurred in respect of these funds it is recognised in the statement of comprehensive revenue and expenditure and an equivalent amount is transferred from the trust funds component of equity to retained earnings.

FINANCIAL INSTRUMENTS

Southern DHB is party to financial instruments as part of its normal operations. Financial instruments are contracts which give rise to assets and liabilities or equity instruments in another equity. These financial instruments include bank accounts, short-term deposits, investments, interest rate swaps, debtors, creditors and loans. All financial instruments are recognised in the balance sheet and all revenues and expenses in relation to financial instruments are recognised in the statement of comprehensive revenue and expenditure. Except for those items covered by a separate accounting policy, all financial instruments are shown at their estimated fair value.

COST OF SERVICE STATEMENTS

The cost of service statements, as reported in the statement of objectives and service performance, reports the net cost of services for the outputs of Southern DHB and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.

COST ALLOCATION

Southern DHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.

COST ALLOCATION POLICY

Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity/usage information.

CRITERIA FOR DIRECT AND INDIRECT COSTS

"Direct costs" are those costs directly attributable to an output class. "Indirect costs" are those costs which cannot be identified in an economically feasible manner with a specific output class. Indirect Costs are therefore charged to output classes in accordance with prescribed Hospital Costing Standards based upon cost drivers and related activity/usage information.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

COMPARATIVE DATA

Comparatives have been reclassified as appropriate to ensure consistency of presentation with the current year.

6.3 SYSTEM LEVEL MEASURES IMPROVEMENT PLAN

AllianceSouth
Better health together

WellSouth
Primary Health Network
Hauora Matua Ki Te Tonga

Southern District Health Board
Pāki Te Ora

System Level Measures Improvement Plan
2018/19

Table of Contents

1 Introduction & Background

System Level Measures (SLMs) are high level aspirational goals for the health system that align with the five strategic themes in the New Zealand Health Strategy and other national strategic priorities, such as Health Targets. They are focussed on improving health outcomes for vulnerable populations including children and youth. System Level Measures have evolved from the primary care focused Integrated Performance Incentive Framework (IPIF), which aimed to shift health performance measurement away from outputs to outcomes.

District Health Boards (DHBs), Primary Health Organisations (PHOs) and District Alliances are expected to drive the development and implementation of a System Level Measures. In order to achieve this, Southern DHB, WellSouth Primary Health Network and Alliance South have developed the System Level Measures Improvement Plan, which includes a range of meaningful Contributory measures, which in turn are underpinned by local clinically led quality improvement initiatives. Planning for and reporting of System Level Measures therefore requires DHB's, PHOs and Alliances to work with providers across the spectrum of care to determine how they will improve the well-being of their local population.

System Level Measures have nationally consistent definitions and performance must be reported to the Ministry of Health. Contributory measures have nationally consistent definitions and data sets, but are selected locally and do not need to be reported to the Ministry of Health. District Alliances may agree to use a local indicator based on local data. This is considered a local continuous quality improvement activity and will not be used for benchmarking performance.

This System Level Measures Improvement Plan for 2018/19 therefore sets out agreed milestones for each of the following SLMs:

• Ambulatory sensitive hospitalisations per 100,000 for 0-4 years olds	"Keeping Children Out of Hospital"
• Acute hospital bed day utilisation per capita	"Using Health Resources Effectively"
• Patient Experience of Care	"Person Centred Care"
• Amenable Mortality	"Prevention and Early Detection"
• Youth Measure	"Youth are Healthy, Safe and Supported"
• Proportion of babies who live in a smoke-free household at six weeks post-natal	"A Healthy Start"

The Southern District has determined all Contributory Measures, end of year Goals, and Activities through a review of each System Level Measure. The Chair of Alliance South has been appointed in the 2017-18 year and will establish the Alliance Leadership Team. Alliance South will then facilitate SLM's development and implementation. Each contributory measure and action related to that measure will be reviewed again as a starting point in 2018-19. To ensure that the SLM process is meaningful and well integrated across Primary, Secondary and Tertiary care, planning within the Southern District health system will focus primarily on two measures, 0-4 ASH and Babies living in smoke free households.

In selecting SLM's and Contributory Measures, Actions and end of year Goals, the review process has looked to ensure that each measure is Meaningful (aligns to the SLM and is contextual to local need), Measurable (data is available and of sufficient quality) and Representative (representative of the range of local needs). SLM's will also need to be aligned to the Primary and Community Care Strategy and with Government Planning Priority's for Improving Quality of Asthma.

Alliance South, Southern DHB and WellSouth are committed to the improving the health of the people in Otago and Southland. The System Level Measures, their Contributory Measures and the Activities are central to delivering this.

2 System Level Measures – Overview

Ambulatory Sensitive Hospitalisations	Acute Hospital Bed Days per Capita	Patient Experience of Care	Amenable Mortality	Youth System Level Measure	Proportion of babies who live in a smoke-free household at six weeks
Hospital admissions for children 0-5 years with a primary diagnosis of asthma or upper/ENT respiratory infection	Inpatient Average Length of Stay (ALOS) for acute admissions	Hospitalised patients completing an adult in-patient survey	Primary Health Organisation (PHO) enrolled women aged 25 to 69 years who have received a cervical smear in the past 3 years	Chlamydia Testing Coverage for 15-24 year olds - % of age group tested in one year	Babies whose families/whanau referred from their Lead Maternity Carer to a Well Child Tamariki Ora provider
Pre-school children enrolled in publicly funded child oral health services	Acute readmissions to hospital		Faster Cancer treatment		Four year old children living in a smokefree home

2.1 *Ambulatory Sensitive Hospitalisations (ASH): 0-4 year old children* *"Keeping children out of hospital"*

Where are we now? **Ambulatory Sensitive Hospitalisations Summary**

Ambulatory sensitive hospitalisation (ASH) rates for 0-4 year olds in Southern DHB have been gradually decreasing since 2013, with a total and Māori rate below the national average. Southern DHB has the 5th lowest ASH rates for total population and 6th lowest ASH rates for Māori in New Zealand.

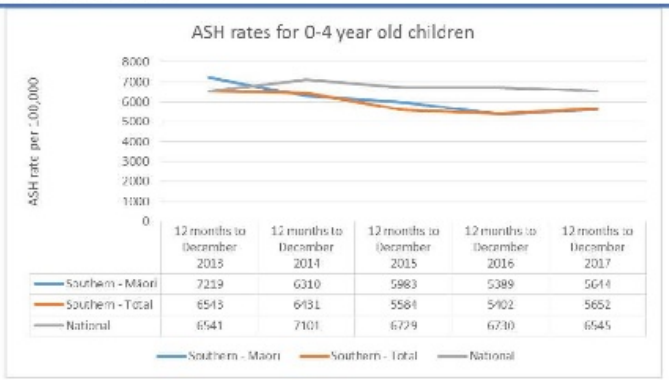
The most prevalent clinical conditions that contribute to Southern DHB's ASH rate include respiratory conditions (infections and asthma), gastroenteritis and dental conditions. Eight of Southern DHB's top ten ASH presentations are below the national average, with the exception of upper and ENT respiratory infections and gastro-oesophageal reflux disease (GORD).

Measure description:

Standardised Rate per 100,000 as per non-financial quarterly measure

Baseline Data

Five year trend to December 2017



Key Contributing Conditions				
Top Ash Conditions for 12 months to December 2017	ASH rate per 100,000			
	Other	Maori	Total	National
Upper and ENT respiratory infections	1822	1699	1798	1577
Dental conditions	948	1123	982	890
Gastroenteritis/dehydration	955	712	907	1067
Asthma	567	1041	660	1192
Lower respiratory infections	280	384	301	404
Cellulitis	267	219	258	472
Constipation	274	27	225	139
Pneumonia	174	137	166	580
Dermatitis and eczema	147	164	150	139
GORD	160	82	145	63

Note that the reporting period for this measure has changed from the year ending September to the year ending December

Where do we want to be?

Long term goal: To reduce and maintain ASH rate to fewer than 4,100 people per 100,000 population aged 0-4 years by 30 June 2022

Target for 2018/19: <5,370 per 100,000

Rationale: Aiming for a 5% annual reduction, with a view to achieving a 25% reduction.

How will we get there? (Contributory Measures)

Over the next five years, Southern DHB and WellSouth PHN will work progressively to achieving the long term goal through the development and implementation of key actions to reduce hospital admissions for children, putting strategies in place to better manage children with a primary diagnosis of asthma or upper/ENT infection in the community, ensuring more pre-school children are enrolled in publicly funded child oral health services.

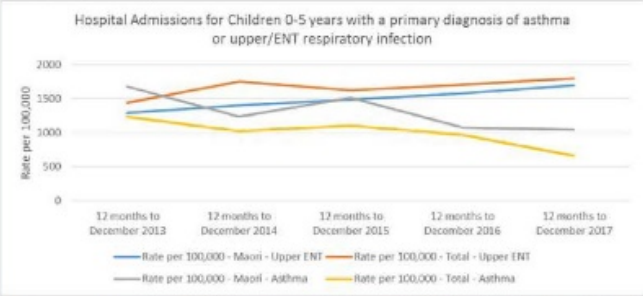
2.1.1 Hospital admissions for children 0-5 years with a primary diagnosis of asthma or upper/ENT respiratory infection

Measure description: Standardised rate per 100,000 as per non-financial quarterly measure – system integration 1

Baseline Data:

Hospital admissions for children aged up to five years with a primary diagnosis of Asthma or Upper and ENT respiratory infections	12 months to December 2013	12 months to December 2014	12 months to December 2015	12 months to December 2016	12 months to December 2017
	2673	2783	2728	2674	2458

2018/19 goal: <2,335



Activities that will enable us to achieve the goal

- Develop a training program for general practices on respiratory management of asthma, with a particular sub-focus on children aged 0-4 who present to ED more than twice a year ***(WellSouth PHN)***
- Complete the implementation of relevant Health Pathways ***(Medical, Women's and Children's Health)***
- Established group will continue to work towards reduced Invercargill ED presentations ***(WellSouth PHN)***
- WellSouth to work with GP's to build increased capacity for sustainable after-hours services, aligned to the primary and Community Care Strategy ***(WellSouth PHN)***

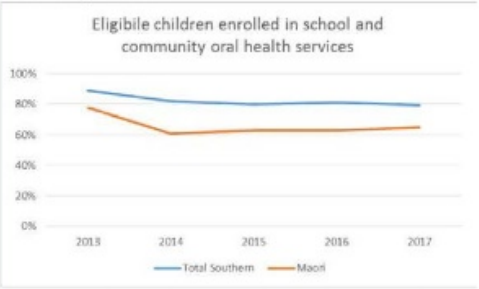
2.1.2 Pre-school children enrolled in publicly funded child oral health services

Measure description: Data sourced from Well Child Tamariki Ora quality improvement framework

Baseline Data

Eligible children enrolled in school and community oral health services	2013	2014	2015	2016	2017
	89%	82%	80%	81%	79%

2018/19 goal: 90%



Activities that will enable us to achieve the goal

- Establish a data matching platform to identify 0-4 year olds not enrolled in oral health services. For those not enrolled, contact will be made with families to encourage enrolment ***(Community Oral Health)***
- The newly established oral health online enrolment process will be promoted to encourage families to engage with the service ***(Community Oral Health)***
- Support increase usage for LMC/Midwives around new processes to ensure timely handovers to WCTO providers within 28 days ***(Medical, Women's and Children's Health)***

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2.2 *Acute Hospital Bed Days per Capita*

"Using Health Resources Effectively"

Where are we now? **Acute Hospital Bed Days per Capita Summary**

Southern DHB's acute hospital bed days rate for Total population has reduced steadily since 2013. Our Māori population generally has a higher bed days rate and has lifted in the 2017 year. Acute hospital bed days rates are highly correlated with age, with the exception of 0-4 years olds, and Southern DHB historically performs better than the national average showing sustained reduction in rates in the older age groups however this is not the case in 2017.

The most prevalent clinical conditions that contribute to Southern DHB's Acute Hospital Bed Days per Capita rate are stroke and other cerebrovascular disorders, hip and femur fractures and respiratory infections/inflammations. The rate for these three conditions has reduced since 2014 with a lift for some in 2017.

Measure description

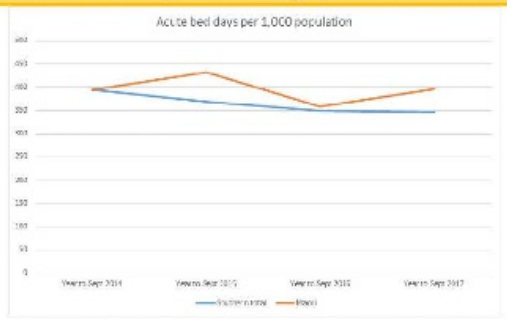
The measure is the rate calculated by dividing acute hospital bed days by the number of people in the New Zealand (NZ) resident population. The acute bed days per capita rates are presented using the number of bed days for acute hospital stays per 1000 population domiciled within a District Health Board (DHB) with age standardisation.

The measure is calculated quarterly with a rolling 12-month data period. Acute hospital bed days are calculated by adding up the length of stays in days for patients presented to a NZ hospital acutely that are publicly funded.

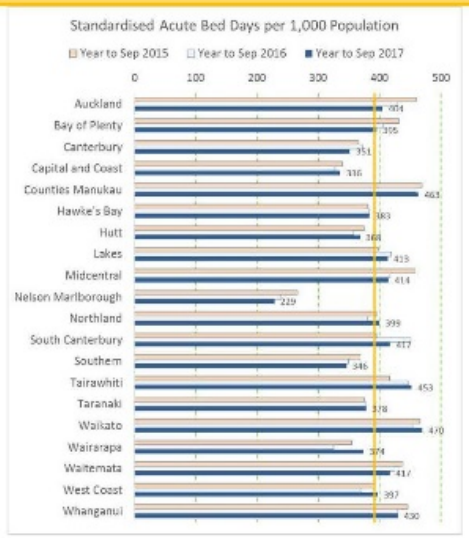
A stay is counted if the first event in that stay is classified as an acute inpatient event.

The acute bed days per capita measure can be age standardised at domicile DHB level.

Baseline Data – 5 year trend to September 2017 [graph and table have been updated]



Acute Bed Days per 1,000 Population					
	Year to September 2013	Year to September 2014	Year to September 2015	Year to September 2016	Year to September 2017
Southern	N/A	395	368.3	349.2	346.1
Maori	N/A	394.9	431.9	358.1	395.3



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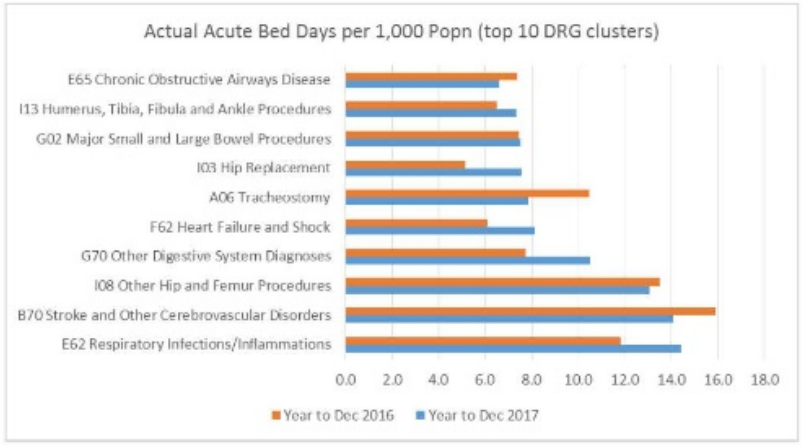
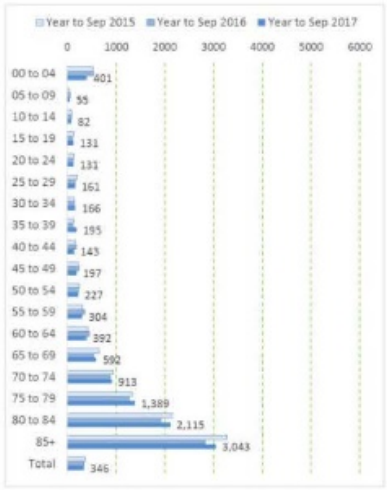
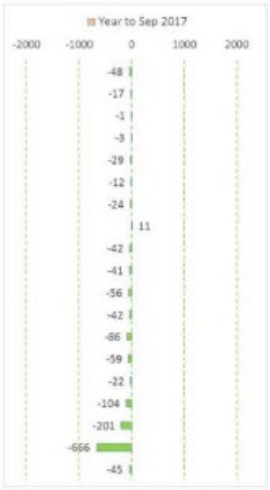
Key contributing clinical conditions



Southern DHB of Domcile



Difference between DHB and NZ rates



Where do we want to be?

Long term goal: Reduce and maintain Acute Hospital Bed Days per Capita rate to fewer than 300 days per 1,000 population by 30 June 2024, with equity of outcome for Māori.

Target for 2018/19: Less than 347 Acute Hospital Bed Days per Capita

Rationale: Southern DHB has modelled a 15% decrease in forecast discharges and 16% decrease in forecast ALOS over 7-10 years for general medicine as part of changes to models of care through a new hospital rebuild.

How will we get there? (Contributory Measures)

Over the next five years, Southern DHB and WellSouth PHN will work progressively to achieving the long term goal through the development and implementation of key actions to steadily reduce inpatient average length of stay, acute re-admissions rates. Southern DHB and WellSouth PHO will continue to explore all options to ensure that we achieve equity of outcome for all priority groups.

Consideration will be given to:

- Factors that have resulted in an increase in acute bed days for Maori in 2016-17 period.
- While ALOS is below national levels, the SDHB acute readmission rate is higher.

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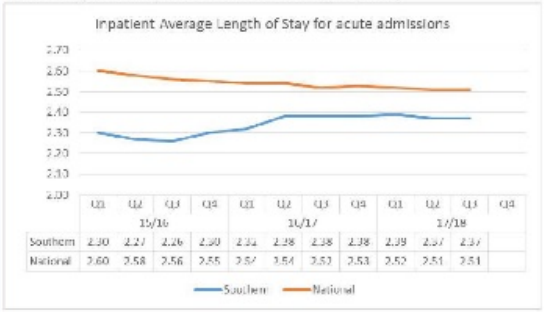
2.2.1 Inpatient Average Length of Stay (ALOS) for acute admissions [graph updated]

Measure description: Non-Financial Quarterly Reporting – Ownership measure

Baseline Data

2018/19 goal: Stay below the MOH target (2.35)



Activities that will enable us to achieve the goal

- Continue roll out of Enhanced Recovery After Surgery ***(Surgical)***
- Work toward a single AT&R service across two sites ***(Strategy, Primary & Community)***
- MDT (medical, nursing, allied) in-reach model for patients who would achieve better outcomes with AT&R input ***(Strategy, Primary & Community)***
- Purchase of continuing care, transition, hospital and rest home beds in community as needed ***(Medical)***

2.2.2 Acute readmissions to hospital

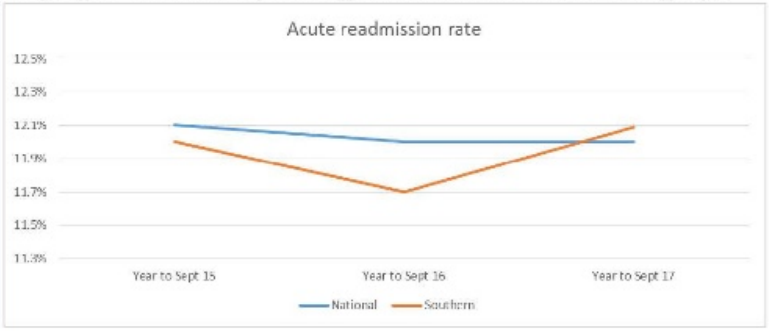
Measure description: Non-Financial Quarterly Reporting – Ownership measure 8

Baseline Data

Acute readmissions to hospital

	Year to Sept 15	Year to Sept 16	Year to Sept 17
National	12.1%	12.0%	12.0%
Southern	12.0%	11.7%	12.1%

2018/19 goal: * MOH currently reviewing definition of this measure and setting target



Activities that will enable us to achieve the goal

- Introduction of CLIC (client lead integrated care) and acute care planning programmes to improve management of Long Term Conditions, aligned to the Primary and Community Care Strategy and development of HCH's ***(WellSouth PHN)***
- Clinical pharmacists to focus on polypharmacy and targeted conditions ***(WellSouth PHN)***
- MDT (medical, nursing, allied) in reach model for patients who would achieve better outcomes with AT&R input ***(Strategy, Primary & Community)***
- Project to ensure that all patients have a finalised accurate discharge summary on discharge ***(Medical)***
- Development of condition specific rehabilitation programs (Cardiac and Pulmonary) as part of the implementation of the Acute Demand Management Service programme ***(Alliance)***
- Falls Prevention and Fracture Liaison service providing education on falls-prevention and notifying general practices when patients present with a fragility fracture ***(WellSouth PHN)***

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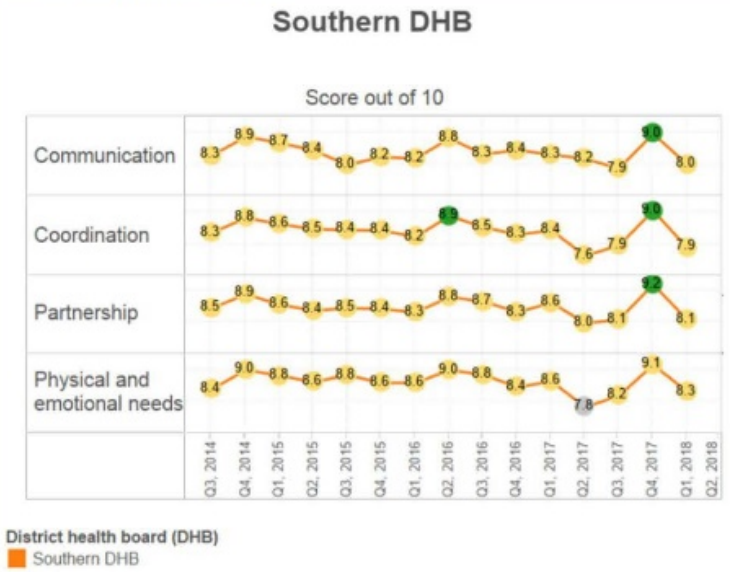
2.3 *Patient Experience of Care*

"Person Centred Care"

Where are we now?	**Patient Experience Summary**
The results of the adult inpatient experience survey with scores typically in line with or above the New Zealand average. The primary care patient experience survey has been taken up by all but 9 General Practices in Southern DHB as part of practice accreditation activity. However, the results of these surveys are currently unknown as related data is linked to the roll out of the National Enrollment Service (NES).	
Measure description	
As per HQSC – patient experience reporting	
Baseline Data [GRAPH UPDATED]	**Activities that will enable us to achieve the goal**



Primary Care Patient Experience Survey

Data for the Primary Care Patient Experience Survey is not currently available as it is still being established.

Contingent on rollout of National Enrolment Service (NES) as modules for each of the Primary Care Management Systems (PMS) are developed and diseminated by the Ministry of Health.

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Where do we want to be?

Long term goal: Consistently scoring at least 9/10 for each domain in the adult inpatient experience survey by 30 June 2022

Target for 2018/19: A survey return rate of 30% (130) per quarter that provides a consistent score of 8.6 or more on all four key domains of the adult inpatient experience survey.

Rationale: Whilst currently better than the national average, Southern DHB's low sample size means there is significant variation in each of the domains. Our goal is to smooth this variation firstly through larger sampling and secondly, and more importantly, by delivering better care.

How will we get there? (Contributory Measures)

Over the next five years, Southern DHB will work to increase the use and uptake of the inpatient experience of care survey. Focus for improvement will be on the lowest scoring areas in the previous year, aligning to government planning priorities.

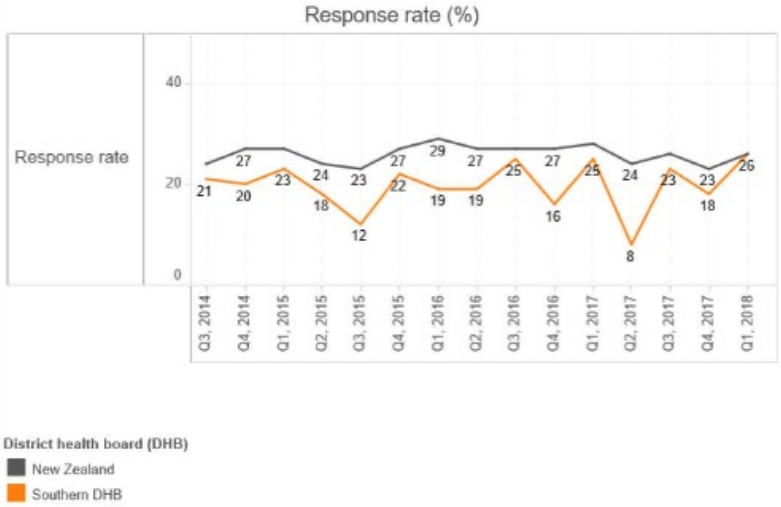
2.3.1 Hospitalised patients completing an adult in-patient survey

Measure description: As per HQSC patient experience reporting.

Baseline Data [GRAPH UPDATED]

2018/19 goal: Response rate of 30%, aiming to receive 130 completed surveys per quarter.

Rationale: Recommendation from HQSC to achieve 95% confidence intervals



Activities that will enable us to achieve the goal

- Ensure that 400 contacts per quarter are made available to the Survey Provider ***(Quality & Safety)***
- Improve accuracy of cell phone and email addresses of all patients admitted for care ***(Quality & Safety)***
- Identify actions to increase the return rate with the Survey Provider ***(Quality & Safety)***

2.4 *Amenable Mortality*

"Prevention and Early Detection"

Where are we now? **Amenable Mortality Summary**

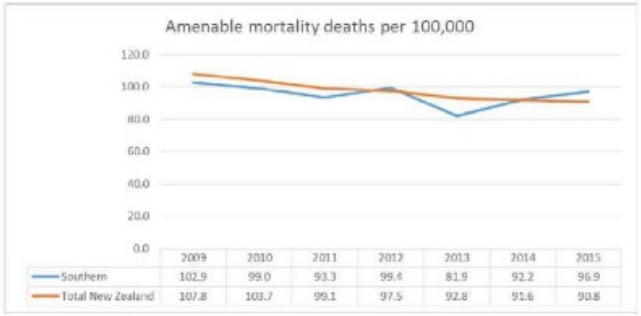
Total amenable mortality rates have been declining in Southern DHB. The data is still presented by the Ministry of Health individually for Otago and Southland rather than a single Southern DHB view, and it is not possible to combine the data without a clear numerator and denominator. It is noted that Southland has a slightly higher amenable mortality rate than Otago.

Disparities between Māori and non- Māori amendable mortality rates persist, with Māori rates 46% higher than non- Māori.
Coronary disease is the single largest cause of amenable mortality, followed by COPD, suicide, cerebrovascular disease and female breast cancer.

Measure description

Age standardised rate per 100,000, calculated by MOH using estimated resident population at June 2016.

Baseline Data – 5 year trend to June 2016 [graph and tables updated]



	2009	2010	2011	2012	2013	2014	2015
Southern	102.9	99.0	93.3	99.4	81.9	92.2	96.9
Total New Zealand	107.8	103.7	99.1	97.5	92.8	91.6	90.8

Southern - Amenable mortality deaths, 0-74 year olds, 2011-2015	
Coronary disease	501
COPD	231
Suicide	191
Cerebrovascular diseases	177
Female breast cancer	151

	Māori		Pacific		non-Māori, non-Pacific		Total	
DHB of domicile	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate
Southern	175	151.5	34	159.7	1765	89.1	1974	93.4
Total New Zealand	5891	201.7	2298	189.9	19312	77.3	27501	94.8

Where do we want to be?

Long term goal: Reduce and maintain amenable mortality rates to fewer than 46 people per 100,000 population by 30th June 2022, with equity of outcome for Māori.
Target for 2018/19: Otago: 60 deaths per 100,000. Southland: 74 deaths per 100,000.
Rationale: Saving Lives Amenable Mortality in New Zealand, 1996-2006, states that "...a one-third reduction from the current level of amenable mortality represents a feasible target."

How will we get there? (Contributory Measures)

Over the next five years, Southern DHB and WellSouth PHN will work progressively to reduce mortality rates. This will be achieved by increased uptake of screening services and ensuring faster cancer treatment.

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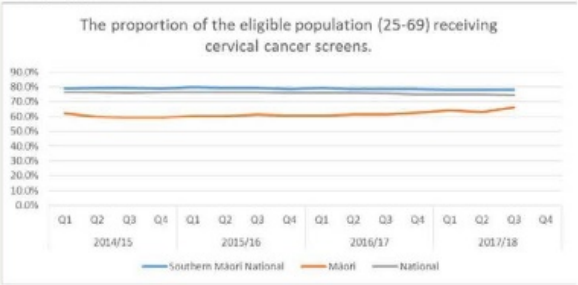
2.4.1 Primary Health Organisation (PHO) enrolled women aged 25 to 69 years who have received a cervical smear in the past 3 years [updated graph and table]

Measure description: Measured on Rolling three year basis, information provided by National Screening Unit

Baseline Data

Primary Health Organisation (PHO) enrolled women aged 25 to 69 years who have received a cervical smear in the past three years	13/14	14/15	15/16	16/17
	79.4%	78.8%	78.7%	78.4%

2018/19 goal: >80%



Activities that will enable us to achieve the goals

- Continue to develop Health Cloud reporter to provide real time reporting against priority KPIs for all general practices, aligned to the Primary and Community Care Strategy ***(WellSouth PHN)***
- Undertake a cervical screening data matching process between different services to ensure that all eligible women are tracked through the system ***(WellSouth PHN)***
- Priority population women receive fully funded smear visits ***(WellSouth PHN)***
- Increase screening rates for priority populations by employing a Kaiawhina and screening coordinator, as well as the development of peer support networks ***(Screening Services)***

2.4.3 Faster Cancer treatment [updated graph]

Measure description: Patients who receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks to receive their first cancer treatment

Baseline Data

2018/19 goal: 90%

Activities that will enable us to achieve the goals

- Funded GPSI skin lesion clinics for assessment and surgical removal supported by POAC (primary options for acute care) ***(WellSouth PHN)***
- Funded GPSI pipelle endometrial biopsies service enabling faster assessment and referral on for treatment and removal, supported by POAC (primary options for acute care) ***(WellSouth PHN)***
- Implement mobile colposcopy service, with special reference for high risk women ***(Medical)***
- Introduction of CLIC and acute care planning programmes to improve management of Long Term Conditions, in alignment with the Primary and Community Care Strategy ***(WellSouth PHN)***

2.5 *Youth System Level Measure*

"Youth are healthy, safe and supported"

Where are we now? Youth System Level Measure Summary

We have selected the Domain "Sexual and Reproductive Health" because of the availability of data with which to prioritise contributory measures and actions.

Outcome: "Young people manage their sexual and reproductive health safely and receive youth friendly care"

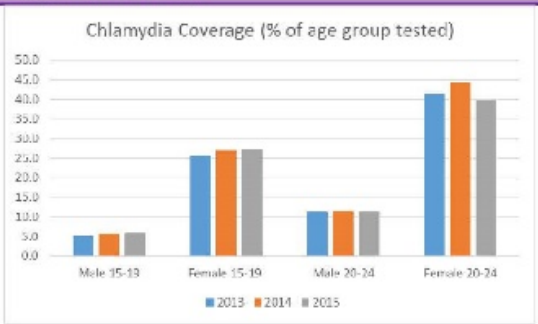
Chlamydia is the most commonly reported STI in New Zealand. It is most commonly diagnosed in females 15-19 years and in males 20-24 years. There is significant variation in rates and testing between males and females and between Māori, Pacific and non-Māori. Number of chlamydia infections can be considered a proxy for the burden of a range of sexually transmitted diseases through failure to use condoms or access treatment.

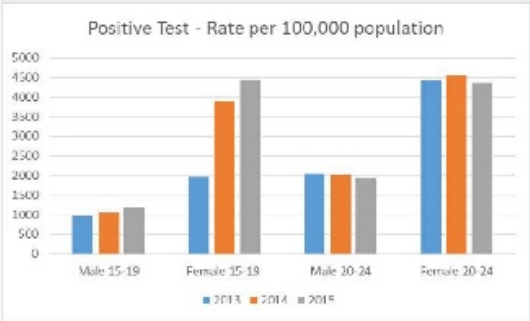
Measure description

Chlamydia Testing Coverage for 15-24 year olds - % of age group tested in one year

Numerator Number of youth who are domiciled in the DHB district who have been tested for chlamydia in the last 12 months **Denominator** Number of youth who are domiciled in the DHB district (15-24) Source: MoH provides annually

Baseline Data – 3 year trend to 2015





Positive tests for Chlamydia have risen significantly since 2013 in the 15-19yo cohort in Southern. Males have proportionally higher positive rates than females. The true rate is also masked by the modestly low testing coverage rate in females and severely low testing coverage rates in males.

Age group	Males – Positive tests		Females – Positive tests	
	Number	*Rate*	*Number*	*Rate*
15-19	134	17%	498	11%
20-24	252	13%	558	8%

Activities:

- Look to obtain more recent data from Southern Community Laboratories using the COAG and/or ESR and see if it can be broken down by age group, geography and general practice ***(Strategy, Primary & Community, WellSouth PHN)***
- ***Southern District Sexual Health Group*** to continue its work in the following domains:
  - Health promotion
  - Self-management
  - Community services
  - Specialist health services
  - Improving quality of data, particularly from a district-wide perspective
- Investigate option of developing a business case for ALT/ELT to increase testing coverage rates in Southern ***(Southern District Sexual Health Group)***

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Where do we want to be?	
Long term goal:	30% of 15-24 year olds are tested. Young men to account for 50% of all tests done. Positive rates to decline to <10%.
Target for 2018/19:	Increase coverage for males to 10%
Rationale:	International modelling suggests that testing coverage needs to be between 30-40% to begin to reduce prevalence of infection.

How will we get there? (Contributory Measures)
Over the next five years, Southern DHB and WellSouth PHN will look to progressively improve sexual health in youth. This will be achieved by increasing screening rates, improving access to services and appropriately trained staff.

2.6 *Proportion of babies who live in a smoke-free household at six weeks* *"A healthy start"*

Where are we now?	**Proportion of babies who live in a smoke-free household at six weeks**
This measure is important because it aims to reduce the rate of infant exposure to cigarette smoke by focussing attention beyond maternal smoking to the home and family/whānau environment and will encourage an integrated approach between maternity, community and primary care. The term smokefree household is one where no person ordinarily resident in the household, is a current smoker (regardless of whether they smoke outside or in the garage or car etc.)	
Measure description	
Numerator: Number of new babies with No recorded for 'Is there anyone in the house who is a tobacco smoker?' for their WCTO first core contact (up to 56 days of age) Denominator: Number of new babies with Yes or No recorded for 'Is there anyone in the house who is a tobacco smoker?' for their WCTO 1st Core Contact (up to 56 days of age)	
Baseline Data – 5 year trend to June 2016	
1. Proportion of babies who live in a smoke-free household at six weeks: 91.8% 2. Percentage of households with smoking status checked and recorded: 24%	**Activities:** ○ In the 2018/19 year Southern DHB will work with the four locally contracted WellChild Tamariki Ora providers to improve data collection systems so there is a mandatory question on Smokefree status that is asked at the WCTO core 1 visit and that the answer is consistently recorded. The focus is on improving the consistency, and therefore quality, of the data for this measure.
Where do we want to be?	
Long term goal:	95% of babies live in a smoke-free household at six weeks
Target for 2018/19:	Increase the percentage of households having the smoking status checked and accurately recorded to 80%
Rationale:	A reasonable number of households are required to have smoking status recorded to provide meaningful results on the number of babies impacted by smoking.
How will we get there? (Contributory Measures)	
Over the next five years, Southern DHB will look to ensure that all children have a healthy start to life. This will be achieved by ensuring babies are engaged with Well Child Tamariki Ora providers and are living in smokefree homes and environments.	
2.6.1	**Babies whose families/whanau referred from their Lead Maternity Carer to a Well Child Tamariki Ora provider**
Measure description: Well Child Tamariki Ora (WCTO) Quality Improvement Framework (Quality Indicator 2)	
Baseline Data	**Activities that will enable us to achieve the goals**
2018/19 goal: 95%	○ Increase utilisation of Oranga Pepi New-born Enrolment form (first presented to women in the 3rd trimester) by LMCs in order to ensure women and whanau are aware of the five new-born services babies are entitled to. This will increase health literacy of pregnant women and support more timely enrolment in services such as WellChild Tamariki Ora, immunisation, general practice, oral health and hearing screening. (EoA) ***(Strategy, Primary & Community)*** ○ New-born enrolment form is completed by new mother prior to leaving the birthing facility to ensure more timely decision making on which WCTO service to enrol in and which GP baby is to be registered with. This will increase the

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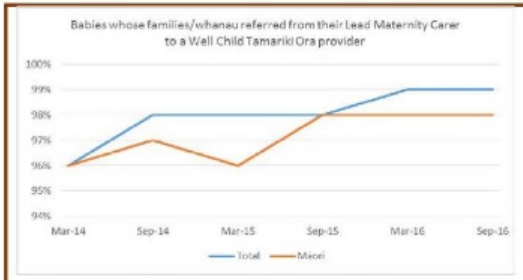
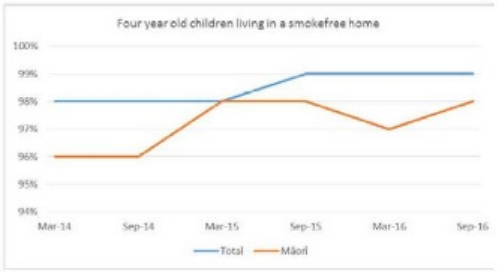


number of babies who are enrolled with a GP practice by 6 weeks, and increase the number of babies who have received their first core contact with their WCTO provider on-time. (EoA) ***(Strategy, Primary & Community)***

2.6.2 Four year old children living in a smokefree home

Measure description: Percentage or number of four year old children living in a smokefree home – Well Child Tamariki Ora (WCTO) Quality Improvement Framework (Quality Indicator 20)

Baseline Data	Activities that will enable us to achieve the goals
2018/19 goal: 99% (Total & Māori) 	○ Increase the number of pregnant women who accept a referral to the stop smoking service and then progress to setting a quit date. (EoA) ***(Strategy, Primary & Community)*** ○ Continue the Quality in Early Pregnancy Project to improve screening and offering of stop smoking services to pregnant women in early pregnancy (EoA) ***(Strategy, Primary & Community)*** ○ Promote the use of Stop Smoking Incentivised Programmes for pregnant women. (EoA) ***(Strategy, Primary & Community)*** ○ Introduce Stop Smoking Incentivised Programmes for families of children admitted to hospital with a primary diagnosis of asthma / respiratory infection. (EoA) ***(Strategy, Primary & Community)***

3 Signatories:

Chris Fleming
CEO Southern DHB

Ian Macara
CEO WellSouth PHN

Dr Carol Atmore
Chair of Alliance South