Southern DHB Annual Plan 2019/2020

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

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

Southern District Health Board
Piki Te Ora

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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

(Issued under Section 38 of the New Zealand Public Health and Disability Act 2000)

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Foreword from the Commissioner and Chief Executive

The Southern district covers the largest geographic area of all DHBs, across which, 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. This was reinforced by Southern Future, an extensive community and staff engagement programme in 2016 that articulated their expectations of a health care system. They asked us to ensure care was better coordinated across providers, with less wasted time and delivered closer to home; that communication made sense and was respectful; that they would have a calm, compassionate and dignified experience and that health services are high quality and equitable.

Over the past years, our focus has been on developing a comprehensive roadmap that would take us from our current state to a truly integrated, equitable health system that sets us up for the future, contributes to the vision of a strong public health sector and aligns with national health priorities. For Southern DHB this includes:

- **Creating an environment for good health** – building an environment and society that supports health and well-being
- **Primary and Community Care Strategy and Action Plan** – creating a health system that is more equitable, coordinated, accessible and delivered closer to home where possible.
- **Valuing Patients' Time** – focusing on patient flow through our hospital system to remove steps that add time with no value to our patients.
- **Enabling people and systems –** so that people have the skills, support and systems to deliver the care our communities have asked for. This is underpinned by digital and workforce strategies.
- **Facilities for the future –** Including ongoing planning for the new Dunedin Hospital, continuing redevelopment work at Lakes District Hospital, and progressing Community Health Hubs to accommodate and adapt to new models of care.

This 2019/20 Annual Plan centres on taking steps towards implementing these priority areas. These consolidate and 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.

They also see dedicated focus on creating sustainable pathways in key identified areas, to ensure we are optimising new opportunities and making the most effective use of our resources. Five critical programmes of improvement have been commenced in the 2018/19 year and are expected to bear significant results in the next one to two years, and a further tranche are being refined for inclusion in the 2019/20 year, which will provide longer term opportunities.

Collectively, these efforts enable no less than an overarching reshaping of the health care system for our district. Indeed, by addressing both primary and secondary care infrastructure in tandem, we have a unique opportunity to ensure our whole health system is designed to meet the needs of our community, and set us up for the future, with positioning for anticipated growth across Southern DHB localities.

This 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 WellSouth Primary Health Network, 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 4,600 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

He Mihi

Tērā ia te pure rangi
Haehae ana kei Hananui
Aro-paki mai ki te Rua-o-te-Moko
Aro atu rā ki te Puna Hauaitu
Tārere Waitaki ki te Umu o Te Rakitauneke
Rere atu ra te Tai o Araiteuru
Ki te Rae o Tupa
Ki Tarahaukapiti ē.

Kei reira ra te waka o Tākitimu e takoto ana
Ko tēnei uri o Aotea, o Ngatokimatawhaorua
E mihi atu nei.

E ngā mate huhua kua ninihi rā ki Tua-o-Paerau
Haere ake koutou ki te Huinga o ngā Mano
Ki te Okiokinga o ngā Tūpuna
Waiho koutou ki te Ao Wairua
Hoki mai ki a tātou anō.

Tēnā rā koutou katoa e te iwi ē
Ngāi Tahu, Ngāti Māmoe, Waitaha
Tēnā koutou nōhou te mana o te whenua
Tēnā hoki tātou ngā heke o ngā waka Māori e maha
E noho pīwawa nei ki tēnei takiwā
Tahuri mai ki tēnei waha e mea ake nei
Me whai tātou i te oranga tonutanga o te tangata.

Translation

Light breaks upon the peak of Hananui (Mount Anglem, Rakiura)
Turn then to Orepuke and Fiordland
Then to the Inland Lakes
Waitaki flows to the Oven of Te Rakitauneke (Mouth of the Waitaki)
Flowing down the Eastern coast
To the Otago Heads
And back to Western Dome (in Central Southland).

There lies the canoe Tākitimu
Whilst this descendant of Aotea and Ngatokimatawhaorua
Sends greetings.

To the many dead passed on to Paerau
Go to the gathering place of the multitudes
To the resting place of ancestors
To you consigned to the Spirit World
We return to our world.

Greetings Ngāi Tahu, Ngāti Māmoe, Waitaha
You who maintain the mana of the land
And also to us who are the descendants of all the ancestral canoes
Now living scattered about this region
Turn your ears and listen to my important thoughts
We must pursue that which delivers those most lifegiving outcomes for us all.

Greetings all

Equity of Health Care for Māori

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage, require different approaches and resources to get equitable health outcomes. Achieving equity is not a series of discrete deliverables and milestones, instead it is recognising and taking opportunities to embed equity within the operation of the health and disability system at all levels. The Southern DHB holds the view that these differences are not random and exist because of multiple reasons. Achieving equity for Māori must be a priority, as the health gaps across the life-course are more significant.

The right to the highest attainable standard of health, implies a clear set of legal obligations to ensure appropriate conditions for the enjoyment of health for all people without discrimination. Equity in health is based on the WHO definition, the absence of avoidable or remediable difference among groups of people. The concept acknowledges that these differences in health status are unfair and unjust, but are also the result of differential access to the resources necessary for people to lead healthy lives.

The SDHB 2019/20 Annual Plan has a focus on working towards achieving equitable health outcomes for its population across the Southern health system. Our System Level Measures Improvement Plan will focus on Māori: ambulatory sensitive (avoidable) hospital admissions 0-4 and 45-64 years; acute admissions and readmissions to hospital; amenable mortality; acute bed days; and self-harm hospitalisation admissions. We will also focus on cervical screening 25-69, cancer treatment services and child respiratory inpatient admissions. This will include the development of robust data sets, the establishment of a clinical Māori strategy group, and a work plan that targets activities to reduce disparity. This will include the realignment of our Māori secondary health services across both the general hospitals and mental health services, stronger linkages with WellSouth Primary Health Network and our Kaupapa Māori health providers. Strengthening Māori workforce is critical as we move forward and our equity plan will include the development of a Māori workforce strategy. This work will be developed with oversight of the Iwi Governance Group and the Alliance Leadership Team.

Activity needs to aim at reducing health equity gaps, not only for Māori, but for Pacifica and other high needs 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. As our ethnicity data improves we will work towards placing the spotlight on these groups and alight actions appropriate over time.

In New Zealand, disparities between Māori and non-Māori are the most consistent and compelling inequities in health. The Treaty of Waitangi was signed to protect the interests of Māori and it is not in the interest of Māori to be disadvantaged in any measure of health, social or economic wellbeing. Effective, responsive, patient-centred services, supported by targeted interventions, will be required to achieve health equity.

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 38(3) of the New Zealand Public Health and Disability Act 2000.

Kathy Grant

Kathy Grant
Commissioner
Southern District Health Board
Date: 4 December 2019

Chris Fleming
Chief Executive
Southern District Health Board
Date: 4 December 2019

Hon. Dr David Clark
Minister of Health
Date: 17/12/19

Hon. Grant Robertson
Minister of Finance
Date: 18/12/19

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

19 DEC 2019

Mr David Cull
Chair
Southern District Health Board
daveccull@gmail.com

Dear David

Southern District Health Board 2019/20 Annual Plan

This letter is to advise you I have approved and signed Southern District Health Board's (DHB's) 2019/20 Annual Plan for one year together with the Minister of Finance, as submitted by the previous DHB governance.

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

The Annual Plan indicates an improving out-years position. However, I have asked the Ministry to request detail on the development of your savings plans for out-years as part of your 2019/20 quarter two report. I expect this report will include a granular and phased focus on cost containment, productivity and efficiency, quality, safety and Māori health and equity.

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

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

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

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approval of any capital business cases that have not been approved through the normal process.

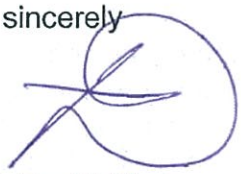
It is really important that the health sector continues to deliver timely and effective services so that we can provide high quality and equitable outcomes for New Zealanders that will deliver on our Government's Wellbeing priorities.

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

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

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

Yours sincerely



Hon Dr David Clark
Minister of Health

Hon Grant Robertson
Minister of Finance

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 2019/20 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.

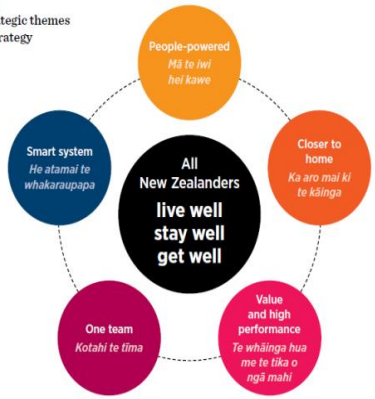
National Direction

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 Minister's letter of expectations signals annual expectations and priorities for DHBs. The Government has signalled an increased priority for bowel screening, planned care, disability, rural health, primary care, mental health and addiction care, child wellbeing, Smokefree 2025 goal, non-communicable disease, public health and the environment, maternity care and midwifery 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 and is currently being revised 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; demonstrate leadership in the collaboration between and integration of health and social services, especially housing; continue to co-design and deliver initiatives to achieve progress on System Level Measures with Primary Health Organisations (PHOs) and other key stakeholders; establish clear processes to ensure appropriate skill mix and FTE growth that supports changes in models of care and use the full range of the available workforce and settings and to support workforce training opportunities; and to live within their means.

DHBs are also expected to contribute to the Government's priority outcome of environmental sustainability, support healthy eating and health weight and support changes to drinking water regulations. This Annual Plan outlines how the Southern DHB will meet those expectations in 2019/20.

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[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/Māori-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 Health Services Plan outlines the agreed regional activity 2017-2020. 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 child health services and mental health and addiction services.

Southern DHB Direction

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. These inter-related areas build on local priorities agreed with the Ministry in 2018/19 and align with the national direction and the strategic themes identified by our Commissioners; these will continue in 2019/20.

1. **Positioning public health services for the future.** 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:

    - Information: sharing evidence about our people's health and wellbeing (and how to improve it)
    - Capacity-building: helping agencies to work together for health
    - Health promotion: working with communities to make healthy choices easier
    - Health protection: organising to protect people's health, including via use of legislation
    - 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.

2. **Primary and community services, investing in change:** Developed in partnership with WellSouth PHO, the Primary and Community Care Strategy has been developed as a framework for primary, community and secondary areas and 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 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, including Health Care Homes (HCH) and planning for Community Health Hubs.

    The development of the Primary and Community Care Strategy and Action Plan has provided a much needed roadmap not only for Primary Care but also the broader system and 2018/19 saw 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 Health Care Homes alongside the establishment of a network of Community Health 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 are being 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. Sixteen General Practices were designated as Southern Health Care Home Practices in 2018/19 and a further five practices will begin the programme in mid-2019. All practices in the district are eligible to apply to

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

become a Health Care Home. The full process of implementing changes and becoming a Health Care Home can take up to three years, depending on how ready a practice is to implement change.

3. **Valuing Patients' Time** is a critical programme which Southern DHB is 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 and community and acute hospital based on shaping or reducing demand, matching capacity and demand, and redesigning the system. The pace of Valuing Patient Time will be enhanced and accelerated in 2019/20 by improving workflow, outcomes, work place, patient experience, and by saving resources. These initiatives will benefit all patients but particularly those living in rural areas.

4. **Enabling people and systems.** We continue to strengthen the foundations of our organisation through a focus on our workforce, and on the underlying infrastructure and business processes that support the health system.

   Within this, and in addition to the transformation that is required to support a new delivery system, we are also focusing on creating new and sustainable pathways in specific areas. Four specific critical areas for improvement have been identified as opportunities to optimise new opportunities, maximise efficiencies and help return the system to financial good health. These areas are:

   - Efficient Utilisation of Pharmaceuticals
   - SMO Remuneration Review Programme
   - Maximisation of Procurement Opportunities
   - Optimisation of the Nursing Workforce

   This year will see the beginning of the roll out of the Workforce and Digital Strategy, that anticipates the requirements of the new Dunedin Hospital and reconfigured health system of the future.

5. **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 procedures 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.

At a Glance ***Southern Population***

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

Approximately 336,000 people live in the Southern district. Approximately 45% live in rural areas that are widely dispersed across the district. The other 55% of the population live in the two main centres of Dunedin and Invercargill.

Ethnically the Southern district is predominantly European, at 79.8%. 10.1% are Māori, 8.0% Asian and 2.1% Pacific.

Our population is slightly older (17.3% aged >65) compared to the national average, with 15.7% aged >65.

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 across the district , and what is required to enable this. Southern DHB is undertaking upgrade work to Lakes Hospital to ensure that services can be delivered for the next seven to eight 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. In 2019/20 a detailed co-design will be undertaken in respect of the future service model of primary maternity services in the Queenstown/Central Lakes locality. This will be overseen by the Central Lakes Locality Network, and will, among other things, definitively decide on the preferred location of a primary birthing unit or units across the Central Lakes part of the district.

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 Health Hubs, in terms of the number, location and the range of services that will be provided from them. This work links in with the further work underway 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.

The Community Health 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 and to employ the Calderdale Framework for Allied Health, are also being explored.

Working with communities to shape our health system

This journey of transformation requires advice, input and support from across the health system and wider community. Its success will be defined by the extent to which it meets the needs of our people, and delivers on the priorities they told us were important. To support this, the following bodies have been established or reshaped in the past year, and continuing to support their work, and draw upon their insights, remain a critical priority for building the Southern health system we need.

Alliance South

Alliance South, the Southern health system primary care alliance, was recommissioned in July 2018. The main body of work for the new Alliance is 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).

Community Health Council

The Community Health Council (CHC) is an advisory council for the Southern District Health Board (DHB) and WellSouth Primary Health Network (hospital and community health services including GPs) and has enabled a stronger patient and whānau voice to be heard across the Southern district. The CHC was established in February 2017 and includes community representatives from across the Southern district. For the 2019/20 year the CHC will continue to progress a programme of work to engage communities, whānau and patients in decision-making across the health system. As of January 2019, the CHC has 34 CHC advisors involved in 22 projects across our health system, and there is a growing number of people who have expressed an interest in becoming CHC advisors. There will be a focus on obtaining feedback from the CHC advisors and staff, already engaged in projects, in relation to what has worked and what needs to be focussed on in order to make future improvements to this process. The CHC plan to host a symposium to bring together staff and CHC advisors to share experiences over the last year.

The CHC will also be involved with providing recommendations to improving the feedback process at Southern DHB. Another key challenge this year will be to provide updated communication to our communities and staff about the role and purpose of the CHC and activities that are occurring.

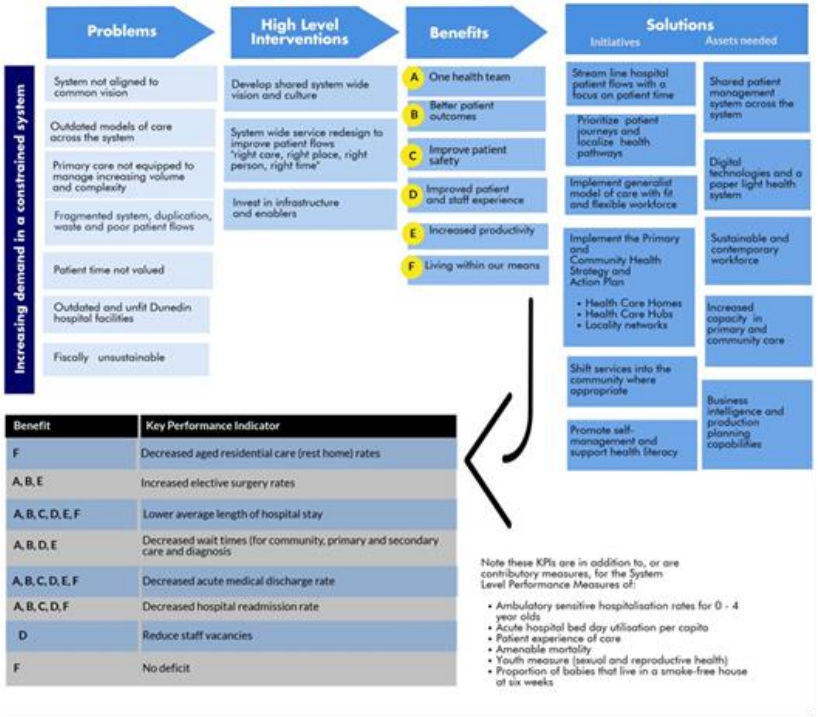
Clinical Council

The Southern Clinical Council (CC) is the principal clinical governance, leadership and multi-disciplinary advisory group for the Southern DHB. The purpose of the Clinical Council is to give balanced, clinically-informed advice to the Commissioners/Board and the Executive Leadership Team as to clinical governance at Southern DHB.

For the 2019/20 year the CC will focus on aligning more with the HQSC Clinical Governance Framework. The newly formed Mortality Review Committee and Clinical Practice Committee will both report through to the Council.

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 2019/20 on this journey of change. A platform has been established which outlines the pathway we will take to organisational stability and an eventual breakeven position.

Figure 2: Intervention Map



Our Health and Wellbeing

People living in the Southern district have relatively good health status 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.

16.9% of our adult population are current smokers, with smoking rates for Māori (33.5%) populations significantly higher.

12.4% of our adult population were told by a doctor that they had asthma and were taking regular treatments for asthma. Rates were significantly higher for Māori (21%).

30.6% of our adult population are classified as obese and rates amongst our Māori (43.2%) and Pacific (70.2%) are signifantly higher.

Source for smoking asthma and obesity data: Regional Results 2014-2017: New Zealand Health Survey

2. SYSTEM OUTCOMES

People are healthier and enabled to take greater responsibility for their own health

WHY IS THIS A PRIORITY?

New Zealand is experiencing a growing prevalence of long-term conditions. Cancers, heart disease, musculoskeletal conditions, respiratory disease, diabetes and mental illness are major drivers of poor health and premature mortality and account for significant pressure on our health services. The likelihood of developing a long-term condition increases with age and as our population ages the demand for health services will continue to grow. The World Health Organisation (WHO) estimates that long-term conditions make up 87.3% of all health loss in New Zealand up from 82.5% in 1990.

Tobacco smoking, inactivity, poor nutrition and hazardous drinking and substance abuse are major risk factors for a number of the most common long-term conditions. These are modifiable risk factors and can be reduced through supportive environments and improved awareness, which enable people to take personal responsibility for health and wellbeing. Public health, promotion and education services, by supporting people to make healthier lifestyle choices, will improve health outcomes for our population. Because these major risk factors also have strong socio-economic gradients, a change in behaviours will contribute to reducing inequities in health outcomes between population groups.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

A REDUCTION IN SMOKING RATES

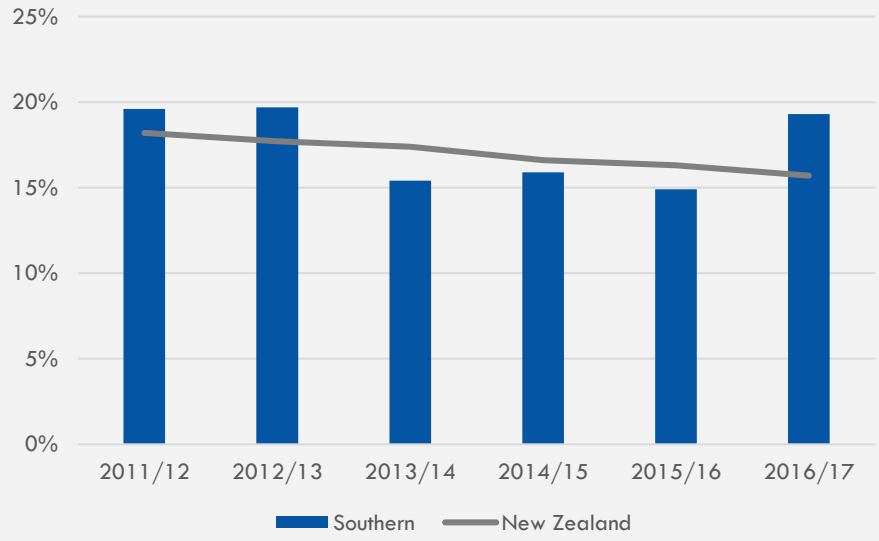
Smoking and exposure to second-hand smoke causes an estimated 4,627 premature deaths in New Zealand every year. Tobacco smoking is a major risk factor for many preventable illnesses and long-term conditions, including cancer, respiratory disease, heart disease and stroke.

In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, meaning less money for necessities such as nutrition, education and health.

Supporting people to say 'no' to smoking is our foremost opportunity to improve health outcomes and to reduce inequalities in health status between population groups.

Data Source: Ministry of Health NZ Health Survey [9]

Measure: Proportion of the population (15+) who smoke



[9] The New Zealand Health Survey is commissioned by the Ministry of Health and collects information about the health and wellbeing of New Zealanders, the services they use and key factors that affect their health. Every year about 14,000 households take part in the survey with total population results presented annually and ethnicity breakdowns over combined time periods (due to small population numbers).

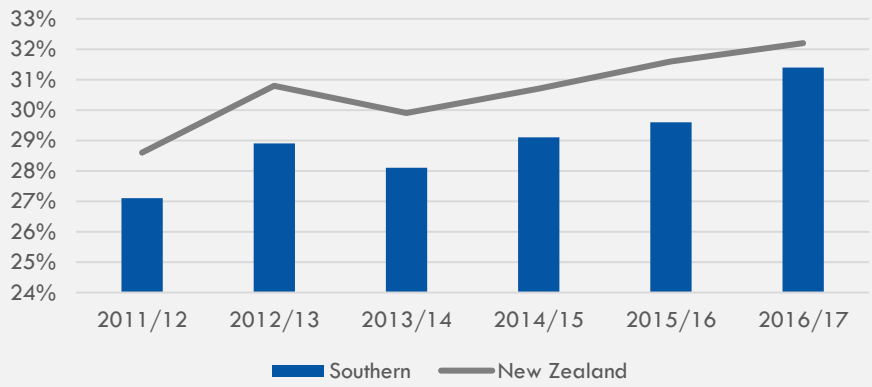
A REDUCTION IN OBESITY RATES

There has been a steady rise in obesity rates in New Zealand across all ages, genders and ethnicities. Obesity is set to overtake tobacco as the leading risk to health and the most recent NZ Health Survey found 32% of all adults and 12% of children were obese.

Supporting people to achieve a healthier body weight is fundamental to improving people's wellbeing and to preventing poor health and disability at all ages.

Data Source: Ministry of Health NZ Health Survey [10]

Measure: Proportion of the population (15+) who have obesity



IMPACT MEASURES - CONTRIBUTING TOWARDS OUR STRATEGIC OBJECTIVES

FEWER AVOIDABLE HOSPITAL ADMISSIONS

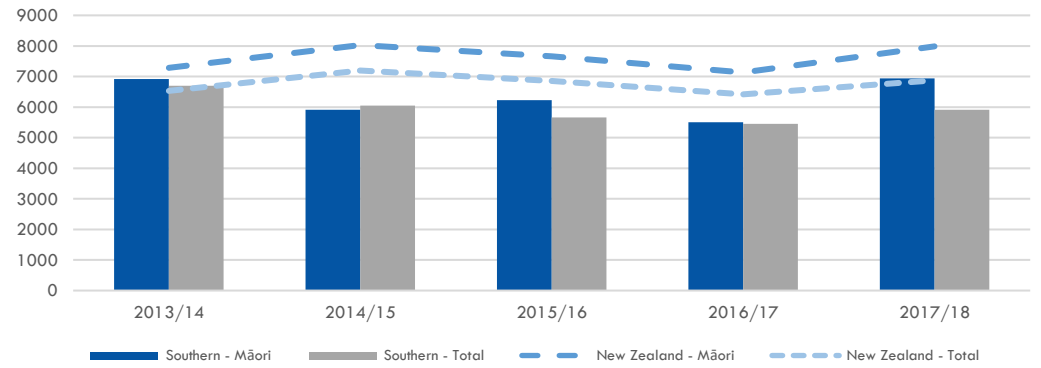
A number of admissions to hospital are for conditions which are seen as preventable through lifestyle change, a reduction in risk factors and earlier intervention by primary and community services.

Ensuring children have the best start to life is a crucial component in the long-term health and wellbeing of our population and keeping children out of hospital is a priority. A reduction in preventable admissions will also free up hospital and specialist resources and reduce pressure on our health system.

This measure is seen as an indicator of the accessibility and effectiveness of health care and a marker of increased integration between health and social services and a reduction in the burden of disease for young children.

Data Source: Ministry of Health DHB Performance Reporting [11]

Measure: Rate of ambulatory sensitive hospital admission for children (0-4)	Base	Target			
	17/18	19/20	20/21	21/22	22/23
	5,912	<5,678	<5,678	<5,678	<5,678



[10] The NZ Health Survey defines 'Obese' as having a Body Mass Index (BMI) of >30 or >32 for Māori and Pacific people. Rates are available by ethnicity over the combined period 2014-2017 – 35.2% of the total population were obese, compared to 55.5% of the Māori population.

[11] This measure is a national DHB performance indicator (SI1) and refers to hospitalisations for conditions considered preventable including: asthma, vaccine-preventable diseases, dental conditions and gastroenteritis. The DHB's aim is to maintain performance below the national rate (reflecting fewer people presenting to hospital) and reduce equity gaps between populations. The measure is a non-standardised rate per 100,000 people and results differ to those previously presented, reflecting updated national data provided by the Ministry to June 2018.

CHILDREN HAVE IMPROVED ORAL HEALTH

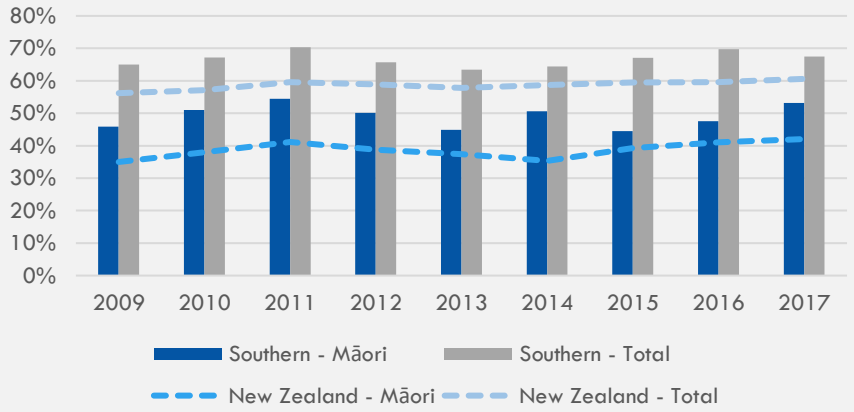
Poor oral health is a marker for a range of poor health outcomes in childhood and later in life. There is a direct link between good nutrition and good oral health, and good nutrition is also an important factors in supporting a healthy weight and reducing obesity.

Improvements in the proportion of children caries-free at age five is seen as a proxy indicator of the effectiveness of mainstream services in reaching those most at risk. It is also an indicator of improved nutrition and wellbeing.

Data Source: School & Community Oral Health Services and Statistics NZ Population Projections [12]

Measure: children caries-free at age five

Base	Target			
2018	2019	2020	2021	2022
67%	>70%	>70%	>70%	>70%



FEWER YOUNG PEOPLE TAKE UP SMOKING

The highest prevalence of smoking is amongst younger people, and preventing young people from taking up smoking is a key contributor to reducing smoking rates across our total population.

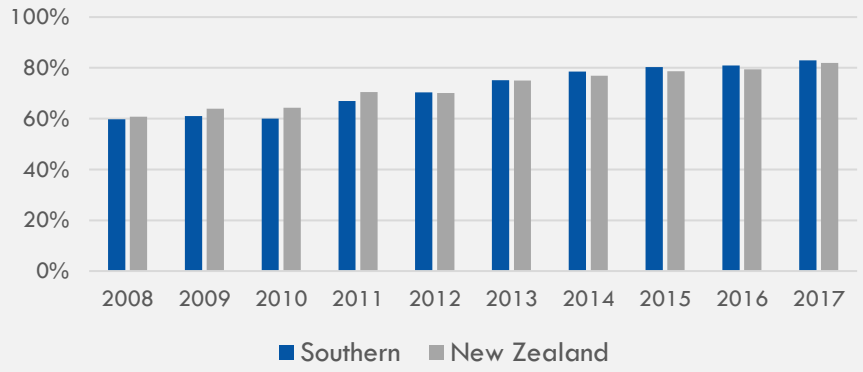
Because Māori and Pacific people have higher smoking rates, reducing the uptake amongst Māori and Pacific youth provides a significant opportunity to improve long-term health outcomes for these population groups and reduce inequalities.

A reduction in the uptake of smoking by young people is seen as a proxy indicator of the success of our health promotion activity and a change in the social and environmental factors that support healthier lifestyles.

Data Source: National ASH Year 10 Survey [13]

Measure: 'never smokers' amongst Year 10 students

Base	Target			
2018	2019	2020	2021	2022
82.6%	>82.6%	>82.6%	>82.6%	>82.6%



[12] This measure is a national DHB performance indicator (PP11) and is reported annually for the school year.

[13] The ASH Survey is an annual survey of around 30,000 Year 10 students across New Zealand. Run by Action on Smoking & Health, the survey has been used to monitor student smoking since 1999 and provides valuable insights into tobacco use trends amongst young people. For more detail see www.ash.org.nz.

People stay well, in their own homes and communities

WHY IS THIS A PRIORITY?

When people are supported to stay well, and can access the care they need closer to home, in the community, they are less likely to experience acute illness or the kind of complications that might lead to a hospital admission, residential care or premature mortality (death). This is not only better in terms of people's health outcomes and quality of life, but it reduces the pressure on our hospitals and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of premature death from heart disease, cancer and stroke. They also achieve these health outcomes at a lower cost than countries with systems that focus more heavily on a specialist or hospital level response.

Health services also play an important role in supporting people to regain functionality after illness and supporting people to remain independent for longer. Even where returning to full health is not possible, access to responsive, needs-based rehabilitation, pain management and palliative care services can help to improve the quality of people's lives.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

A REDUCTION IN ACUTE HOSPITAL ADMISSIONS

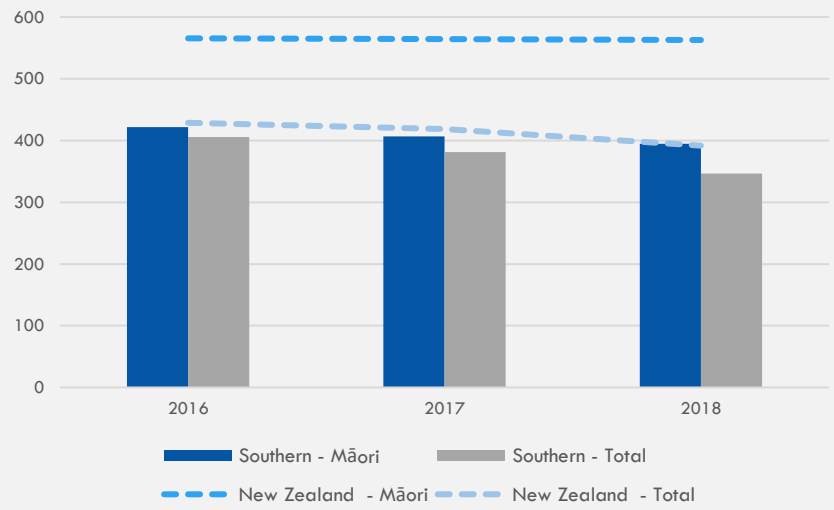
Acute (unplanned) hospital admissions account for almost two thirds of hospital admissions in New Zealand.

Acute hospital bed-days are used as a proxy indicator of improved long-term conditions management and access to timely and appropriate treatments that reduce crisis and deterioration. The measure also reflects the quality and effectiveness of discharge planning.

Reducing acute hospital admissions and the length of time people spend in our hospitals has a positive effect on people's health. It also enables more efficient use of specialist resources that would otherwise be captured responding to demands for urgent care, allowing the DHB to provide more planned care.

Data Source: National Minimum Data Set[14]

Measure: rate of acute hospital bed-days (age standardised, per 1000 people)



[14] Data is provided by the Ministry of Health via the national minimum data set. This is a newly introduced measure with only a three year time period currently available for comparison, a longer-term view will build over time.

MORE PEOPLE LIVING LONGER IN THEIR OWN HOME

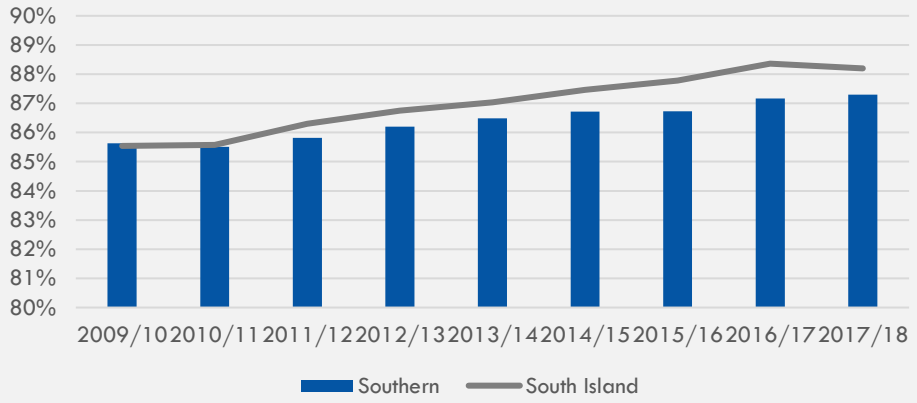
While living in residential care is appropriate for a small proportion of our population, studies have shown a higher level of satisfaction and better long-term outcomes when people remain in their own homes and are positively connected to their local communities.

Living in residential care is also a more expensive option and resources could be better spent providing home-based support and packages of care to help people stay well in their own homes.

An increase in the proportion of older people living in their own homes is seen as a proxy indicator of how well the health system is enabling people's wishes to remain in their own homes, managing age-related and long-term conditions and responding to the needs of our older population groups.

Data Source: SIAPO Client Claims Payment System

Measure: proportion of the population (75+) living in their own home



IMPACT MEASURES - CONTRIBUTING TOWARDS OUR STRATEGIC OBJECTIVES

PEOPLE'S CONDITIONS ARE DIAGNOSED EARLIER

People want certainty regarding access to health services when they need it, without long waits for diagnosis or treatment.

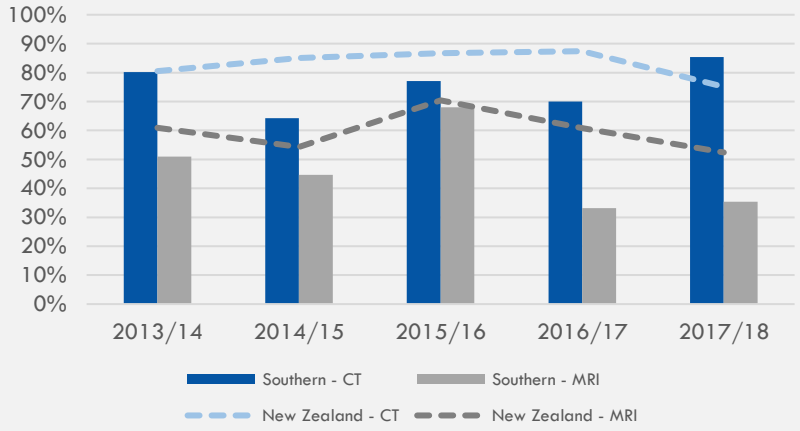
Timely access to diagnostics, by improving clinical decision-making, enables earlier and more appropriate intervention and treatment. This contributes to both improved quality of care and improved health outcomes.

Wait times for diagnostics therefore can be seen as a proxy indicator of the responsiveness of our health system and our ability to match capacity with demand, particularly when we are seeking to minimise wait times and operating within a constrained environment.

Data Source: DHB Patient Management System[15]

Measure: people receiving non-urgent MRI or CT scan within six weeks

Base	Target			
17/18	19/20	20/21	21/22	22/23
MRI 32%	>67%	>75%	>90%	>90%
CT 81%	>85%	>95%	>95%	>95%



[15] These measures are national DHB performance indicator (PP29) Standards are set nationally and in line with national expectations and reporting, the results presented refer to the final month of each year (June).

FEWER AVOIDABLE HOSPITAL ADMISSIONS

An increasing number of admissions to hospital are for conditions which are seen as preventable through lifestyle change, risk factor reduction, earlier intervention and the effective management of long-term conditions.

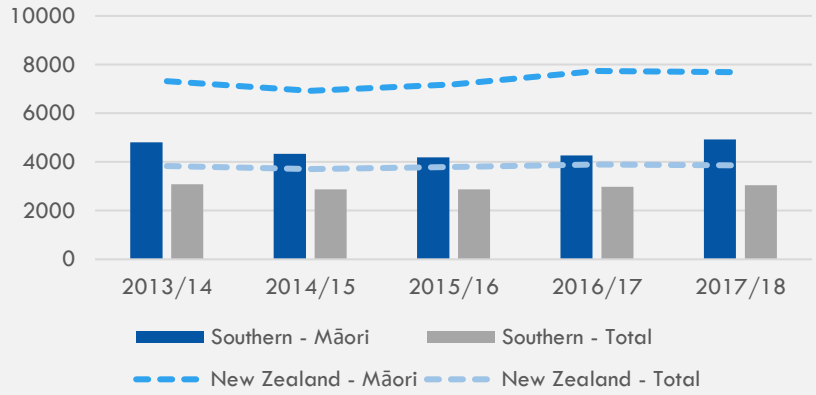
With the right approach, people can live healthier lives and avoid the deterioration of their condition that leads to acute illness or hospital admission. A reduction in avoidable admissions will also reduce pressure on hospital and specialist service resources.

A key factor in reducing avoidable hospital admissions is improved coordination between primary and secondary services. As such, this measure is seen as an indicator of the accessibility and effectiveness of primary care and a marker of a more integrated health system.

Data Source: Ministry of Health Performance Reporting [16]

Measure: Rate of ambulatory sensitive hospital admission for adults (45-64)

Base	Target			
17/18	19/20	20/21	21/22	22/23
3,047	2,865	2,865	2,865	2,865



FEWER FALLS-RELATED HOSPITAL ADMISSIONS

Compared to older people who do not fall, those who fall experience prolonged hospital stays, loss of confidence and independence and an increased risk of institutional care.

With an ageing population, our focus on reducing harm from falls will help people to stay well and independent and reduce the demand for hospital and residential services.

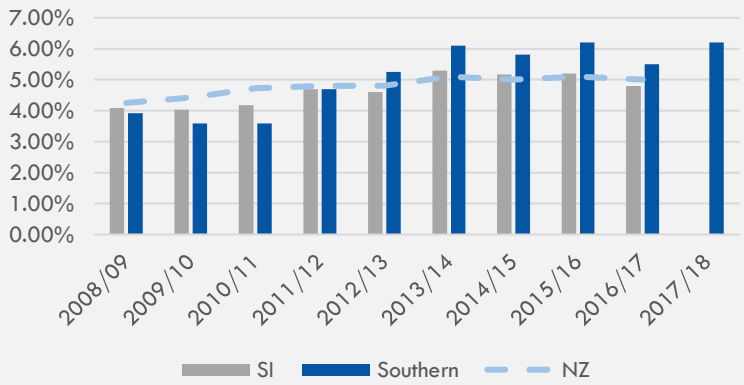
Solutions to preventing falls include appropriate medications use, improved physical activity and nutrition, access to restorative support and rehabilitation and a reduction in personal and environmental hazards.

This measure is seen as an indicator of the responsiveness of our system to the needs of our older population, as well as a measure of the quality of the services being provided.

Data Source: National Minimum Data Set[17]

Measure: population (75+) admitted to hospital as a result of a fall

Base	Target			
17/18	19/20	20/21	21/22	22/23
6.2%	<5.0%	<5.0%	<5.0%	<5.0%



[16] This measure is a national DHB performance indicator (SI1) and refers to hospitalisations for conditions considered preventable including: asthma, vaccine-preventable diseases, dental conditions and gastroenteritis. The aim is to maintain performance below the national rate (reflecting fewer people presenting to hospital) and reduce equity gaps between populations. The measure is a standardised rate per 100,000 people and results differ to those previously presented, reflecting updated national data provided by the Ministry to June 2018.

People with complex illness have improved health outcomes

WHY IS THIS A PRIORITY?

For people who do need a higher level of intervention, timely access to high quality specialist care and treatment is crucial in delivering a positive outcome, supporting recovery or slowing the progression of illness. Improved access and shorter wait times are seen as indicative of a well-functioning and sustainable system, able to match capacity to demand and managing the flow of patients to ensure people receive the service they need when they need it.

This goal also considers the effectiveness and the quality of the treatment we provide. Adverse events, ineffective treatment or unnecessary waits can cause harm and result in longer hospital stays and complications that have a negative impact on the health of our population, people's experience of care and their confidence in the health system. Ineffective or poor-quality treatment and long waits for treatment also waste resources and add unnecessary cost.

We are in the midst of a significant facilities redevelopment and repair programme and we are transforming the way we deliver services to increase capacity with the resources we have available. We are focusing on improving the flow of patients across our system and reducing duplication of effort to maintain service access while reducing waiting times for treatment. We also aim to increase the value from our investment in technology to support clinical decision making and improve the quality of the care we provide.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

A REDUCTION IN AMENABLE MORTALITY

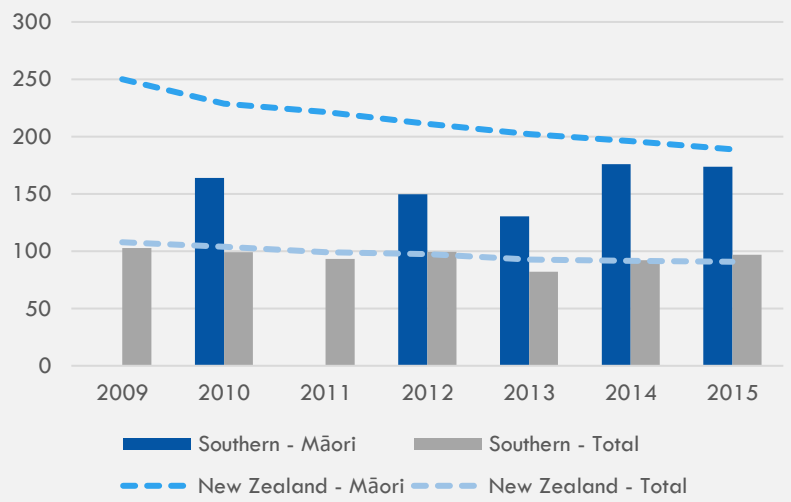
Amenable mortality is defined as premature death (before age 75) from conditions that could have been avoided through lifestyle change, earlier intervention, and the effective and timely management of long-term conditions.

There are many economic, environmental and behavioral factors that have an influence on people's life expectancy. However, timely diagnosis, improved management of long-term conditions and access to safe and effective treatment are crucial factors in improving survival rates for complex illnesses such as cancer and heart disease.

A reduction in the rate of amenable mortality can be used to reflect the responsiveness of the health system to the needs of people with complex illness, and as an indicator of access to timely and effective care.

Data Source: National Mortality Collection[17]

Measure: rate of amenable mortality for people aged under 75 (age standardised, per 100,000 people)



[17] The performance data for this measure is sourced from the national mortality collection which classifies the underlying cause of all deaths registered in New Zealand. Data is released three years in arrears and the 2015 results are provisional. Amenable mortality rates are excluded where there are fewer than 30 deaths recorded. This affects small DHBs as well as ethnicity reporting.

A REDUCTION IN ACUTE READMISSIONS

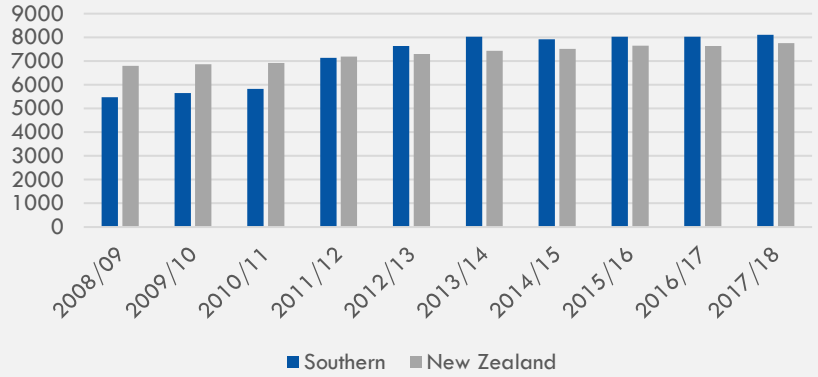
As well as reducing public confidence and driving unnecessary costs, patients who are readmitted to hospital are more likely to experience negative longer-term outcomes.

Key factors in reducing acute readmissions include patient safety and quality standards, discharge planning and care coordination at the interface between services. Ensuring people receive effective treatment in our hospitals and appropriate support and care on discharge.

Readmission rates are therefore a useful marker of the quality of care being provided, and the integration between service providers. These rates are also a good balancing-measure to productivity measures such as reductions in lengths of stay.

Data Source: Ministry of Health Performance Reporting [18]

Measure: rate of acute readmissions to hospital within 28 days of discharge (standardised) per 100,000 people



IMPACT MEASURES - CONTRIBUTING TOWARDS OUR STRATEGIC OBJECTIVES

SHORTER WAITS FOR URGENT CARE

Emergency Departments (EDs) are often seen as a barometer of the effectiveness, efficiency and responsiveness of the hospital and wider health system.

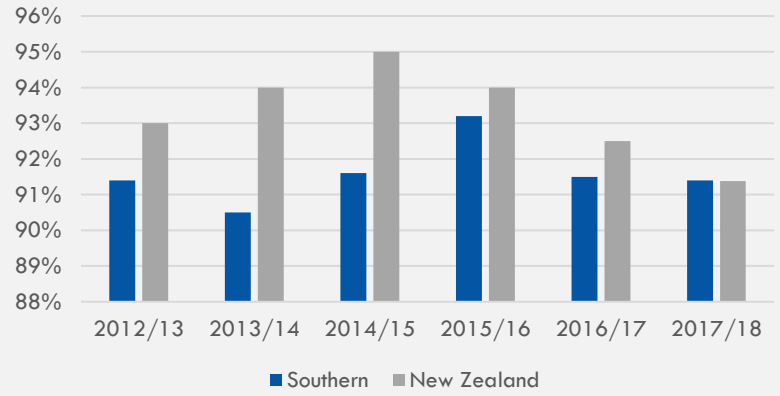
Long waits in ED are linked to overcrowding, poor patient experience, longer hospital stays and negative outcomes for patients. Enhanced performance will not only contribute to improved patient outcomes by enabling early intervention and treatment, but will improve public confidence and trust in our health services.

Solutions to reducing ED wait times address the underlying causes of delay and span not only hospital services but the wider health system, ensuring that only those who require emergency services present to ED. In this sense, this indicator is a marker of the responsiveness of our whole system to the urgent care needs of our population.

Data Source: DHB Patient Management System [19]

Measure: people admitted, discharged or transferred from ED within 6 hours

Base	Target			
17/18	19/20	20/21	21/22	22/23
91%	95%	95%	95%	95%



[18] This measure is a national DHB performance indicator (OS8) providing data three months in arrears, with results being the year to March 2018. This is a newly introduced measure, a longer-term view will build over time

[19] This measure is a national performance measure (Shorter Stays in ED). Standards are set nationally and in line with national expectations and reporting, the results presented refer to the final quarter of each year (April – June).

SHORTER WAITS FOR PLANNED CARE

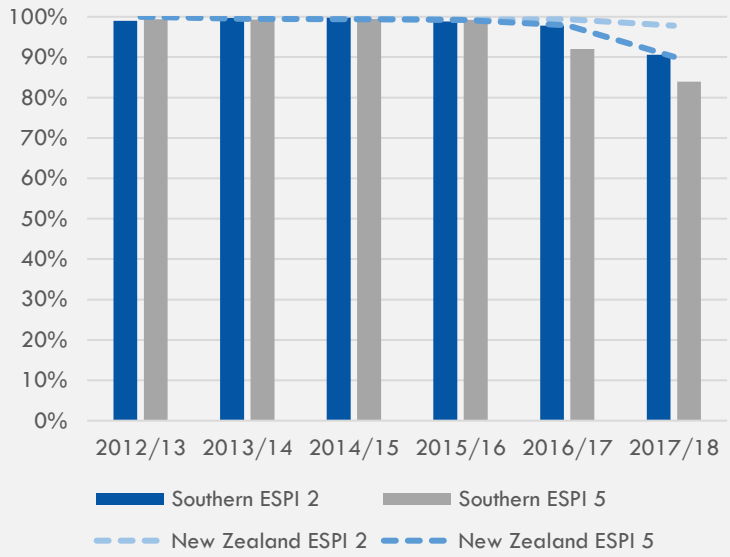
Access to elective services (including specialist assessment, treatment and surgery) improves the quality of people's lives by removing pain or discomfort, slowing the progression of disease and helping to restore independence and wellbeing.

Improved performance against these measures requires us to make the most effective use of our limited resources to ensure wait times are minimised, while a year-on-year increase in volumes is delivered.

In this sense, these indicators are a marker of hospital efficiency and, with constrained capacity across our system, a proxy for how well we are managing the flow of patients across our services.

Data Source: Ministry of Health Elective Services Website [20]

Measure: people receiving specialist assessment and treatment within set time frames	Base	Target			
	17/18	19/20	20/21	21/22	22/23
	ESPI2 91%	100%	100%	100%	100%
	ESPI5 84%	100%	100%	100%	100%



[20] These measures are part of the national Elective Services Patient Flow Indicators (ESPIs) set and are a measure of whether DHBs are meeting expectations at key point in a patient's journey. ESPI 2 refers to the wait from referral to a person's first specialist assessment. ESPI 5 refers to the wait from the point from when treatment was agreed until treatment is delivered. Standards are set nationally and in line with national expectations and reporting, the results presented refer to the final month of each year (June).

3. DELIVERING ON PRIORITIES

3.1 LOCAL PLANNING PRIORITIES

The Local Planning Priorities are those which Southern DHB has identified because either we are outliers nationally, or we are poor performers when compared to other DHB's in our peer group. We believe that these areas provide specific opportunities for us to demonstrate improved efficiency, and in turn provide a more stable platform for system wide improvement and overall sustainability as we look to 2019/20 and beyond.

Efficient Utilisation of Pharmaceuticals

Southern DHB continues to be an outlier in respect of Pharmaceutical Utilisation, which impacts on pharmaceutical expenditure. Based on the latest HQSC data (2016) nationally, we have the highest rate of polypharmacy.
In August 2018, Pharmac took on responsibility for the national purchasing of Hospital Medicines in addition to the CPB, which presents an opportunity for more streamlined purchasing, and increased efficiencies in terms of this part of the portfolio. It has also been agreed that Pharmac will take on responsibility for Medical Devices, although this is viewed as less familiar territory for Pharmac, and it has therefore been agreed that more of a collective DHB/Pharmac shared approach will be taken to how this is implemented and managed.

DHB activity	Milestone	Measure
1. Build a single Southern, system wide pharmaceutical database	Database created Q1	Reports generated out of database
2. Provide reporting dashboards to General Practice in line with other target initiatives to ensure that prescribing patterns are clear and outliers are identified	Dashboards piloted Q1	Dashboards go live
3. Understand the utilisation, cost and cost drivers of the high cost Biologics and Pharmaceutical Cancer Treatments (PCT's)	DHB understands the real cost of pharmaceutical expenditure by Q1 Pharmaceutical Benchmarking against other DHBs calculated Q1-Q2	Disease Burden, Treatment Duration
4. Investigate and address Southern DHB dispensing	Dispensing benchmarching complete Q1-Q2	Dispensings per prescription Prescriptions per capita

SMO Remuneration Review Programme

Benchmarking information indicates that whilst Southern DHB accounts for 6.2% of national health expenditure, we account for 6.6% of the national expenditure on the medical workforces. I.e. proportionally we spend more than other DHB's do on their medical workforces.

DHB activity	Milestone	Measure
1. Implementation of a handbook developed in 18/19 for use when making new appointments or considering remuneration changes that are outside of the standard MECA provisions	Handbook implemented across GMs, SMs and HR Q1	Use of handbook in Southern DHB
2. Systematic implementation of service reviews commences Q1	Service reviews commence Q1	Reviews completed at a targeted rate of 30-60 FTE per quarter over the financial year

Maximisation of Procurement Opportunities

There are three areas of purchasing – services, products and capital. The procurement process across these three areas is devolved through national, regional and local streams of activity. The Southern DHB Procurement team interacts with the national and regional teams and then manages the local procurement. A review of procurement processes is required to create a cohesive team approach to procurement, that incorporates changes to models of care which deliver optimal outcomes for the organisation and members of our community.

DHB activity	Milestone	Measure
1. Establish Clinical Practice Committee (CPC)	CPC formed with diverse membership CPC develops the work program for review of clinical practice	Clinical practices are reviewed and models of care consistently adopted
2. Review service/maintenance contracts	Identification of all service/maintenance contracts	Review value of existing contracts Develop risk matrix for assessment of contracts.

Optimisation of the Nursing Workforce

The Safe Staffing and CCDM Effective Implementation Accord was signed by NZNO, DHBs and the Director General of Health to ensure safe staffing levels for nurses and midwives. The Accord commits DHBs to fully rolling out CCDM by 2021 and places safe staffing as a top priority for DHBs. Safe Staffing is described in the Safe Staffing Committee of Inquiry Report (2005) as an appropriately resourced, well organised, healthy, care delivery environment in which patients achieve the planned outcomes.

Although Southern DHB is accelerating progress on CCDM implementation, there are considerable opportunities to improve workforce management by making more precise, proactive adjustments to address safe staffing and inefficiencies.

DHB activity	Milestone	Measure
1. Understand the opportunity to improve workforce management, using analysis of data by ward, service and site to identify the priority areas where there are significant negative and positive variance trends.	Benefits of pilot solutions evaluated by Q1 Roll out plan proposed by Q1	Evaluation of pilot solutions
2. Establish safe and effective staffing solutions	FTE calculations completed for each ward by Q1	FTE calculations for each ward Percentage of wards with VRMs completed
3. Embed flexibility to respond to unexpected variance	Implementation of VRMS by Q1	Optimisation of skill mix
4. Fully leverage the skills and training of each team member	Recommended skill mix composition is established (by attrition and staff replacement) by Q2	

3.2 Government Planning Priorities

Overarching Government priorities were presented in the generic Minister's 2019/20 Letter of Expectations. 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.

3.2.1 Improving Child Wellbeing

<table>
<tr><td colspan="3">Immunisation
All DHBs are to contribute to child wellbeing and healthier populations by establishing innovative solutions to improve and maintain high immunisation rates at all childhood milestones from infancy to age 5 years</td><td colspan="2">This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes)</td></tr>
<tr><td rowspan="2">DHB activity

Southern DHB's overarching responsibility is to ensure that each member of our community is offered those immunisations to which they are entitled.

1. Maintain Immunisation target work to ensure services are 'Reaching Every Child' striving for 'on time every time' (EOA)
• Service delivery model is responsive to the needs of Māori and supports One Team approach
- Services support families in a more integrated way, focusing on vulnerable families (including Māori) e.g. those not currently engaged with GPs and/or WCTO providers, to improve equity of care Q1-Q4
- Active integration between child health services such as dental, immunisation, B4 School Check and Public Health Nursing to identify and follow up children missing out on services Q1-Q4
- Work to increase delivery opportunistic vaccinations Q1-Q4

2. Continue to work to combine Vaccine Preventable Disease (VPD), Human Papillomavirus (HPV) and Influenza steering groups to lead the One Team approach Q1-Q4</td><td rowspan="2">Milestone

Improved coverage rates of Māori children at 6 months of age Q1-Q4
More consistent coverage rates for Māori children is achieved by Q1-Q4, across all milestones ages</td><td rowspan="2">Measure

CW05: Immunisation coverage at eight months of and 5 years of age; immunisation coverage for human papilloma virus (HPV) and influenza vaccination at age 65 years and over
CW08: Immunisation coverage at 2 years of age</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td>System outcome
We have health equity for Māori and other groups</td><td>Government priority outcome
Make New Zealand the best place in the world to be a child</td></tr>
</table>

<table>
<tr><td colspan="3">School-Based Health Services

• Commit to providing quantitative reports in quarter two and four on the implementation of school based health services (SBHS) in decile one to five secondary schools, teen parent units and alternative education facilities
• Outline the current activity the DHB will undertake to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS
• Outline the current activity the DHB is taking to improve the responsiveness of primary care to youth
• Commit to providing quarterly narrative reports on the actions of the SLAT to improve health of the DHB's youth population
• Outline the actions the DHB is taking to ensure high performance of the youth service level alliance team (SLAT) (or equivalent)</td><td colspan="2">This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes)</td></tr>
<tr><td>DHB activity

1. Provide quantitative reports in quarter two and four on the implementation of school based health services (SBHS) in decile one to five secondary schools, teen parent units and alternative education facilities

2. Continuous SBHS quality improvement
• Work alongside the MoE with the Communities of Learning Kāhui Ako. Public Health Nurses school allocation will align (where applicable) with local Communities of Learning (CoL), to allow active participation in achievement challenges and working collaboratively, to support every child and young person to achieve their full potential Q1-Q4
• Continue advancing practice of nurses working in SBHS to ensure youth friendly service provision (EOA). Priority focus: primary mental health, sexual health and diversity Q1-Q4
• In 2019/20 the focus will be on one quality improvement initiative across all existing and new SBHS. The introduction of electronic patient records will release time to increase client contact, create visibility and improve interface with other health service providers/systems in real time and enhance data collection and reporting by capturing trends/needs for future quality improvement initiatives by Q4

3. Undertake actions to improve the responsiveness of primary care to youth
• Undertake actions to ensure high performance of the youth service level alliance team (SLAT) Q1-Q4
• SLAT to undertake actions to improve health of the DHB's youth population Q1-Q4 (refer SLM)</td><td>Milestone

Quantitative reports provided Q2 and Q4

Introduction of electronic patient records by Q4

Report on actions to ensure the high performance of the SLAT (Q1-Q4)
Narrative report on actions undertaken to improve health of the youth population Q1-Q4</td><td>Measure

CW12: Youth mental health initiatives

Annual report on number of SBHS nurses who have completed youth health vocational training</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families

System outcome
We have health equity for Māori and other groups

Government priority outcome
Make New Zealand the best place in the world to be a child</td></tr>
</table>

<table>
<tr><td colspan="3">Midwifery workforce – Hospital and LMC

<u>Midwifery workforce:</u>
• All DHBs will develop, implement, and evaluate a midwifery workforce plan to support:
  ○ undergraduate training, including clinical placements
  ○ recruitment and retention of midwives, including looking at driving changes for models of care that use the full range of the midwifery workforce within DHBs
  ○ service delivery mechanisms that make best use of other health work forces to support both midwives in their roles and pregnant people
• DHBs who were asked to develop midwifery workforce plans as part of the 2018/19 annual planning cycle are expected to continue working on midwifery workforce plans if this has not been completed during the 2018/19 year
• Please detail the actions that you will take towards implementing Care Capacity Demand Management (CCDM) for midwifery by June 2021 in your annual plans. (New requirement May 2019)
• Please outline the most significant actions the DHB will undertake in 2019/20 to progress implementation of CCDM for midwifery. Ensure the equitable outcomes actions (EOA) are clearly identified</td><td colspan="3">This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcome)
Examples of equity actions that could be included in your plan:
• increase Mâori participation and retention in midwifery workforces and ensure that Mâori have equitable access to training opportunities as others
• build cultural competence across the whole midwifery workforce
• increase participation of Pacific people in midwifery workforces
• form alliances with educational institutes (including secondary and tertiary) and local iwi to identify and implement best practices to achieve Māori midwifery workforces that matches the proportion of Māori in the population</td></tr>
<tr><td>DHB activity

1. Develop a Southern DHB midwifery workforce plan as a collaboration between the Primary Maternity Strategy and DHB hospital services Q3

2. By June 2021 Southern DHB will have fully implemented care capacity demand management (CCDM) in its secondary/tertiary facilities

3. In 2019/20 Southern DHB will:
• Ensure accuracy of Trendcare data is of a standard to that will enable timing to studies to be undertaken:
- Interrater reliability will meet the gold standard of greater than 90%
- Actualisation of patient acuity is 100%

• Variance response management processes will be implemented and embedded in daily practice
- Developed and introduced by Q2
- Usage reviewed Q3</td><td>Milestone

Midwifery workforce plan developed Q3

CCDM fully implemented by June 2021

Achieved consistently by Q4 2020
Achieved consistently by Q3 2020
Developed and introduced by Q2
Usage reviewed Q3</td><td>Measure

Workforce plan operationalised
Numbers of midwives attending cultural competence education
Increased number of Māori and Pasifika midwifery students
Findings implemented
Increased rural LMC workforce</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families

System outcome
We have health equity for Māori and other groups

System outcomes
We live longer in good health</td><td>Government priority outcome
Ensure everyone who is able to, is earning, learning, caring or volunteering</td></tr>
</table>

4. Provide cultural competence education Q3 • Work with the Māori Health Directorate to facilitate increased access to cultural competence education for midwives	Cultural competence education provided Q3		**System outcomes** We have improved quality of life	
5. Work towards achieving a Māori and Pasifika midwifery workforce that reflects the birthing population of Southern DHB. • Work with communities to identify, encourage and support Māori and Pasifika women to undertake study to become midwives (EOA) Q3 • Inform potential Māori and Pasifika midwifery students of the various funding support streams to study Q3 • Portray midwifery as a profession in a positive light to encourage potential students, particularly Māori and Pasifika, to undertake education to become midwives - Work with Otago Polytechnic to showcase the midwifery profession Q1	Māori and Pasifika women encouraged/supported to undertake study to become midwives Q3			
6. Evaluate the implementation of the Primary Maternity Strategy recommendations and their impact on recruitment and retention of the Lead Maternity Carer (LMC) workforce. • Implement the findings of the evaluation Q3	Findings of the evaluation implemented Q3			
7. Work with the Ministry of Health Otago Polytechnic and the NZ College of Midwives to ensure that student midwives have access to high quality clinical placements Q2 • Undertake work to ensure that midwives are supported to accept midwifery students on clinical placements in the community Q2	Work undertaken to enhance quality of clinical placements Q2			
8. Work in partnership with the rural workforce in relation to obstetric emergencies in the rural context • Develop an inter-professional rural emergency maternity education day, for LMC and primary maternity facility midwives, primary maternity facility nurses, PRIME nurses and doctors, and emergency responders in Otago and Southland. Curriculum to include: obstetric emergencies in the rural context, recognising the deteriorating patient, emergency transport	Deliver a minimum of one session each in rural Otago and Southland in Q4			

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

- Identify the most important focus areas to ensuring the population needs for pregnant women, babies, children and their whānau are well understood; and identify key actions that demonstrate how the DHB will meet these needs including realising a measurable improvement in equity for your DHB. Actions should include a comprehensive approach to prevention and early intervention services across priorities (see below) via maternity, Well Child Tamariki Ora, National SUDI Prevention Programme, and other services
- Identify what action you will take to identify barriers to achieving well integrated services across the first 1000 days

Healthy weight in children

- Identify the actions the DHB is taking to increase the proportion of children at a healthy weight in their first 1000 days, to be measured by the proportions of children at a healthy weight at age 4

This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes)

DHB activity	Milestone	Measure	Government theme: Improving the well-being of New Zealanders and their families	
First 1000 Days (conception to around 2 years of age) Southern DHB focus areas for the First 1000 Days are listed below. An equity lens is applied across the board for all areas, with specific activities identified as relevant. Numerous activities are also undertaken in the Southern district to promote preconception health, including implementation of the Southern Sexual and Reproductive Health Strategy, School Based Health Services, Public Health Services, Immunisation, Family Violence and Sexual Violence Services, Tobacco Control Plan, Alcohol Harm Reduction, Immunisation and others. 1. Encourage early enrolment with LMCs • Develop and distribute information for pregnant women through Southern DHB Maternity Quality Safety Programme (MQSP) by Q4 • Refer actions below to increase timely uptake of universal entitlements 2. Promote smokefree healthy women/smokefree homes and cars • Identify and implement activities that advance progress towards the Smokefree 2025 goal, including supporting Ministry funded wrap-around stop smoking services for people who want to stop smoking and which address the needs of hāpu wāhine and Māori (*refer Smokefree 2025*) (EOA) • Refer Sudden Unexplained Death in Infancy (SUDI) template 3. Build stronger working relationships across maternal and child health sectors to address the key modifiable risk factors for SUDI • WCTO providers to provide SUDI prevention information provided to all families at core WCTO visit before 50 days of age • Monitor WCTO SUDI indicator and identify/implement quality improvement actions as required • Smokefree Babies programme provided through Southern Stop Smoking Service (EOA)(Refer SLM Improvement Plan/SUDI) 4. Undertake actions in 2019/20 to further improve access to maternal mental health services and to address any identified issues	Info distributed for pregnant women by Q4 Refer SUDI and Smokefree 2025 All families are provided SUDI information before 50 days, Q1-Q4	Percentage of women giving birth registered with an LMC in first trimester Percentage of women identified as smokers at first registration with their primary maternity care provider Percentage of babies living in a Smokefree home SUDI rates per 1000 live births in the Southern district SUDI prevention information provided to all families at core WCTO visit before 50 days of age WCTO Quality Improvement Framework Indicators: Oral Health Service	**System outcome** We have health equity for Māori and other groups **System outcome** We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child

• Inform health care providers of links to maternal health in Health Pathways • Include Mental Health Directorate in child and youth health planning groups • Encourage health workforce participation in "Healthy Conversations' seminars as available • WCTO providers to routinely undertake screening for PND and refer as appropriate • Refer Maternal Mental Health template 5. Promote oral health services for preschool children • Oral health examinations provided to children under two years, commencing at age six months Q1-Q4 • Refer to actions to increase timely uptake of universal entitlements 6. Promote early enrolment with WCTO services • Six monthly reviews of WCTO Quality Improvement Framework (QIF) indicators • Quality improvement projects undertaken to improve the timeliness of WCTO visits Q1-Q4 • Refer Midwifery Workforce • Refer actions to increase timely uptake of universal entitlements 7. Promote early enrolment of infants with GPs • Undertake projects to increase enrolments with GPs once NES has been initiated • Undertake actions to improve the timeliness of WCTO visits (see above) 8. Implement innovative solutions to improve and maintain high immunisation rates at childhood milestones • Continue to aim for targets from infancy to age 5 years (EOA) (Refer to Immunisation) - Refer to actions to increase timely uptake of universal entitlements 9. Undertake actions to reduce family violence • Ongoing screening for family violence through WCTO service and LMCs; referral as appropriate • Southern DHB MCWCP project (Maternity Care Wellbeing and Child Protection) Group have completed review and will implement quality improvement initiatives resulting from review completed in 2018/19 Q1-Q4 • Refer Family Violence and Sexual Violence (FVSV) template 10. Promotion of breastfeeding • Refer SUDI template 11. Identify barriers to achieving well integrated services across the first 1000 days • WCTO QIF Steering Group to meet quarterly to identify and address barriers to achieving well integrated services across the first 1000 days	Refer maternal mental health Children 0-4 are enrolled with oral health service Six monthly reviews of QIF indicators Q2, Q4 Quality improvement projects undertaken Q1-Q4 Age appropriate immunisation targets met for children in the first 1000 days Q1-Q4 Quality improvement initiatives undertaken Q1-Q4 Refer FVSV Refer to SUDI Quarterly meeting of WCTO QIF Steering Group	enrolment rates for children in first 1000 days Infants receive WCTO core contact 1 before 50 days of age Infants receive all WCTO core contacts in their first year of life Newborn enrolment with general practice by three months % of children who turned the milestone age of 24 months who have completed their age appropriate immunisations Infants are exclusively or fully breastfed at two weeks Infants are exclusively or fully breastfed at discharge from LMC Infants are fully breastfed at three months Number of referrals to Cosy Homes for 0-4s Ambulatory care-sensitive hospitalisations of children aged 29 days to 4 years		

Healthy weight in children - Identify the actions the DHB is taking to increase the proportion of children at a healthy weight in their first 1000 days 12. Southern DHB is undertaking a range of actions to increase the proportion of children at a healthy weight in their first 1000 days • WCTO QIF Steering Group to meet quarterly to review actions • As a health promotion priority, Southern DHB supports the development and implementation of the DHB healthy food and drink policy (refer Healthy Food and Drink Template) Q1-Q4 • Promotion of Breastfeeding (refer SUDI Template) Q1-Q4 • LMCs discuss healthy weight gain in pregnancy with every woman as appropriate; available printed resources are distributed as required Q1-Q4 • LMCs make referrals to the Green Prescription Programme as required Q1-Q4 • Health Pathways are maintained and updated for the following - Health Pathway for Low Birth Weight Infants - Health Pathway for Diabetes in Pregnancy - Health Pathway for Weight Management in children (referral is made to Public Health Nursing as required) - *Health Pathways provide condition management and referral information for clinicians working in the Southern district	Quarterly meeting of WCTO QIF Steering Group LMC referral to Green Prescriptions Q1-Q4 Health Pathways maintained/updated Q1-Q4	CW06: Breastfeeding Proportion of children at a healthy weight at age 4		

<table>
<tr><td colspan="3">Family Violence and Sexual Violence (FVSV)
Reducing family violence and sexual violence is an important priority for the Government, and something we want all DHBs to be working on, in partnership with communities and other agencies. Please provide the actions for the upcoming year that your DHB considers is the most important contribution to this, including the reasons why the action(s) are important and the impact you expect them to achieve</td><td colspan="2">This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes)</td></tr>
<tr><td>DHB activity

1. Increase visibility of the Violence Intervention screening with the Executive Leadership Team Submission of reports outlining programme trends and activity Q2 and Q4

2. Executive Leadership Team and key members of the senior leadership team attend core Violence Intervention Programme Training Q4

3. Establish a working group to look at how to increase the ownership of and quality of Violence Intervention Programme screening in the designated services (EOA)
• Establish working group in Q1
• Develop implementation plan Q4</td><td>Milestone

Reports at Q2, Q4

Report on attendance Q4

Formation of working group in Q1
Implementation plan developed Q4</td><td>Measure

CW11: Supporting child wellbeing Report on activities

% of ELT/SLT that attend VIP training</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families

System outcome
We have improved quality of life

Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

SUDI Describe contributions towards building stronger working relationships across the Maternal and Child Health sector to address the key modifiable risks factors for SUDI			**This is an equitable outcomes action (EOA) focus area** (equity focus and clear actions to improve Māori health outcomes)	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Child and Youth Portfolio Manager, as the central co-ordination point, will ensure co-ordinated SUDI prevention services work collaboratively across primary, secondary and NGO health care providers and agencies and other key stakeholders. • SUDI will be included as a standing agenda item on the WCTO QIF Steering Group Q1-Q4	SUDI included on WCTO QIF Steering Group agenda Q1-Q4		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Make New Zealand the best place in the world to be a child
2. Work with the South Island Alliance SUDI Co-ordinator to ensure SUDI related activity in the Southern district learns from and aligns with other South Island DHB SUDI activities.	SI SUDI Co-ordinator is member of the WCTO Steering Group Q1-Q4		**System outcome** We live longer in good health	
3. Work with the Southern Stop Smoking Service to increase participation of pregnant women in ante and post natal stop smoking services – particularly focus on young women – Māori and Pacific (EOA) • Provision of appropriate cessation support for young women Q1-4 • Assess impact of increased funding for the Stop Smoking Incentive Scheme for pregnant women and whānau Q4	Cessation support provided Q1-4 Assess impact Q4	Number of women staking up the stop smoking incentive scheme		
4. Increase access to safe sleep devices, both pepi pods and wahakura across the Southern district; working with local communities on the introduction of wananga wahakura at marae and other locally recommended locations (EOA) • Distribute 500 pepi pods and wahakura across the Southern district by Q4	500 pepi pods and wahakura distributed by Q4	Number of pepi pods and wahakura distributed		
5. Provide funding to Plunket to enable delivery of 60 individual packages of care for Kōpūtanga (pregnancy and parenting) (EOA) • Monitor number of packages of care delivered by q4	60 packages of care delivered by Q4	Number of Individual packages of care delivered		
6. Deliver SUDI workforce education and development to those engaging with women and whānau • Engage an appropriate subject matter expert to provide workforce education updates, including introduction of consistent messages about SUDI by Q4 • Establish SUDI champions across the Southern district Q4 • Monitor need for additional training Q1-Q4	Engagement of expert Q4 SUDI champions established Q4 Training needs monitored Q1-Q4			
7. Implement actions to promote breast feeding to lay the foundations for a baby's healthy life. A specific focus will be on increasing breast feeding in high needs population groups (EOA) (Refer to First 1000 days and Public Health Plan) • Establish local initiatives to be included in a Southern district implementation plan to support the new national Breast Feeding Strategy Q4	Local breastfeeding initiatives by Q4	CW06: WCTO Breast feeding indicators		

• Work with WellSouth PHO on the Breast Feeding Peer Support programme to improve coverage Q1-3 8. Increase support for young mothers • Extend the young mother's story sessions (started by the South Island Alliance) to learn more effective and culturally appropriate ways of engaging with young mothers to support breast feeding, stop smoking, increased use of safe sleep devices, encourage early engagement with LMCs and participation in Kōpūtanga – pregnancy and parenting (EOA**)** • Hold story sessions with young women across the Southern district Q2-3 • Report on learnings re supporting young mothers to engage in health and wellbeing services • Apply learnings from story sessions, using e-hine as a guide, to achieve more equitable health outcomes Q4 (EOA)	Work with PHO Q1-Q3 Story sessions held Q2-Q3 Report on learnings applied Q4			

3.2.2 Improving mental wellbeing

Inquiry into mental health and addiction Please outline how your DHB will work to implement Government agreed actions following the Mental Health and Addiction Inquiry Report and implement relevant Budget 2019 appropriations (Further guidance will be provided following Government decisions) The Government's response to He Ara Oranga (the report of the Mental Health and Addiction Inquiry) confirms our first steps in the transformation of the mental health and addiction system in New Zealand. This transformation will likely be a multiyear programme. DHBs must work in partnership with Māori, people with lived experience, NGOs, primary and community organisations, and other stakeholders to build a whole-of-system, integrated approach to mental health, addiction and wellbeing that provides options for New Zealanders across the full continuum of need. It is expected that DHBs will work along with the Ministry of Health to implement Government's agreed actions following the Mental Health and Addiction Inquiry and implement relevant Budget 2019 initiatives. DHBs are to outline actions contributing to the direction signalled by the Government in response to He Ara Oranga. DHBs should identify opportunities to build on existing foundations and include actions in relation to improving and / or addressing **all** of these areas of focus: Embedding a wellbeing focus • Demonstrate a focus on wellbeing and equity at all points of the system • Improve the physical health outcomes for people with mental health and addiction conditions Building the continuum / increasing access and choice • Work in partnership with the Ministry, Māori, Pacific people, young people, people with lived experience, NGOs, primary and community organisations, and other stakeholders to plan an integrated approach to mental health, addiction and wellbeing and roll out new primary level responses from Budget 2019 • Strengthen and increase focus on mental health promotion, prevention, identification and early intervention • Continue existing initiatives that contribute to primary mental health and addiction outcomes, and align with the future direction set by *He Ara Oranga,* including strengthening delivery of psychological therapies • Identify options to strengthen connections and build support across the full continuum of care, including in the primary and community mental health and addiction space Suicide prevention • Contribute to the implementation of the Suicide Prevention Strategy, and any associated plans • Continue existing suicide prevention and postvention efforts to provide a range of activities such as mental health literacy and suicide prevention training, community-led prevention and postvention initiatives (ie, bereavement counselling) and integration of mental health and addiction services Crisis response • Improve options for acute responses including improving crisis team responses and improved respite options, and work with the Ministry to plan future responses	**This is an equitable outcomes action (EOA) focus area** (equity focus and clear actions to improve Māori health outcomes)

NGOs

- Identify how you will use cost pressure funding from Budget 2019 to ensure NGOs in your district are sustainable, particularly any providing AOD residential care, detoxification and continuing care

Workforce

- Work in partnership with workforce centres to strengthen current workforces, including a focus on retention, recruitment and training.
- Demonstrate a commitment to lived experience and whānau roles being supported and employed across all services
- Support workforce development of the appropriate knowledge and skills to support people with mental health and addiction needs, for example through use of the Let's Get Real framework

Mental Health and Wellbeing Commission

- Work collaboratively with any new Commission

Forensics

- Work with the Ministry to improve and expand the capacity of forensic responses from Budget 2019
- Contribute, where appropriate, to the Forensic Framework project

DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Embedding a wellbeing focus • Demonstrate a focus on wellbeing and equity at all points of the system. - Current best practice for clinicians continues focus on wellbeing and equity at all points of the system. - Southern DHB will explore this further following the Ministry regional hui to gain a better understanding of relevant actions Q2 • Improve the physical health outcomes for people with mental health and addiction conditions - Inform and support tangata whaiora to engage with GP practices. Analysis of baseline level of tangata whaiora enrolment and engagement with GP practices (EOA) Q2 - Communicate changes to Community Services Cards to the Mental health and Addictions sector (EOA) - Remove or reduce barriers to accessing primary care (refer to population mental health template) (EOA) - Include CEP way of working in all workforce development strategies to raise understanding, promote a CEP way of working and support a harm minimisation approach Q4 - Complete and action Suicide Prevention Plan Q2 (EOA) - Scope the development of a Community Support Worker role/s with additional knowledge of primary care access and funding model Q4 - Scope options for developing a Healthy Living training package for CSWs with appropriate community providers (e.g. Sport Otago and Sport Southland) and build relationships with those organisations to facilitate better access for tangata whaiora to healthy lifestyle activities Q4 - Refer also to Population Mental Health template	Connecting Care –Supporting Transitions (HQSC) project spans the care pathway for tangata whaiora of all ages Q1-Q3 MHAID review and refresh of CEP programme of work including action plan for improvement and increased integration Q4 One CEP whole of mental health and addiction system activity occurs by Q4 Report on progress of scoping development of a Community	Number of tangata whaiora who access specialist mental health and addiction services (primary and secondary) access and engage with GP practices The number of young people presenting to ED with self-harm decreases by 5% (SDHB SLM measure)	**System outcome** We have health equity for Māori and other groups **System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering

2. Building the continuum / increasing access and choice • Work in partnership with the Ministry, Māori, Pacific people, young people, people with lived experience, NGOs, primary and community organisations, and other stakeholders to plan an integrated approach to mental health, addiction and wellbeing and roll out new primary level responses from Budget 2019. - As a wide ranging stakeholder group, the Network Leadership Group will lead these changes Q1-Q4 - Undertake review of NLG structure to ensure it has capacity and capability to meet any new planning requirements Q2 • Strengthen and increase focus on mental health promotion, prevention, identification and early intervention (EOA) - Continue this focus through the work of the NLG Q1-Q4 • Continue existing initiatives that contribute to primary mental health and addiction outcomes, and align with the future direction set by *He Ara Oranga,* including strengthening delivery of psychological therapies. - Continue to work with WellSouth to redesign existing primary care brief intervention psychological services Q4 • Identify options to strengthen connections and build support across the full continuum of care, including in the primary and community mental health and addiction space. - MHAID will continue to participate as an active partner in Implementation of the Southern DHB Primary and Community Care Strategy Q1-Q4	Support Worker role Q4 Report on progress of scoping options for developing a Healthy Living training package for CSWs Q3 Feasibility paper presented to NLG, in regard to roles and training requirements Q2			
3. Suicide prevention • Contribute to the implementation of the Suicide Prevention Strategy, and any associated plans. - Appoint new suicide prevention coordinator Q1 - Complete district co-designed Suicide Prevention Plan for submission and implementation Q2, with alignment to the national plan • Continue existing suicide prevention and postvention efforts to provide a range of activities such as mental health literacy and suicide prevention training, community-led prevention and postvention initiatives (i.e., bereavement counselling) and integration of mental health and addiction services. (EOA) - Further extend the reach of this work through community integration through the Mental Health and Addiction NLG locality groups Q1-4 - Deliver Safeside Education to MHAID Clinical Staff Q1-4	New suicide prevention coordinator appointed Q1 Completion of Southern district co-designed suicide plan for submission and implementation Q2 Safeside Education delivered to			

4. Crisis response • Improve options for acute responses including improving crisis team responses and improved respite options, and work with the Ministry to plan future responses. - Launch a co-design process for the acute care continuum that will include these goals. Q2 5. NGOs • Undertake processes to identify use of cost pressure funding from Budget 2019 to ensure NGOs in our district are sustainable, particularly any providing AOD residential care, detoxification and continuing care Q3 6. Workforce • Continue to work in partnership with workforce centres to strengthen current workforces, including a focus on retention, recruitment and training Q1-Q4 • Southern DHB is committed to lived experience and whānau roles being supported and employed across all services. - Implement plan to expand peer workforce; this will be a part of the acute care continuum co-design work. • Continue to support workforce development of the appropriate knowledge and skills to support people with mental health and addiction needs, for example through use of the Let's Get Real framework Q1-Q4 7. Mental Health and Wellbeing Commission • Work collaboratively with any new Commission throughout 19/20 8. Forensics • Work with the Ministry to improve and expand the capacity of forensic responses from Budget 2019 - Undertake a stocktake of the current youth and adult workforce; develop service (including workforce) plan for current and future resource with particular attention to prison population with serious mental illness Q1 - Participate in the Ministry Forensic Mental Health Workforce project Q1-4 - Identify and confirm the establishment of any new youth and/or forensic roles required in the Southern area Q2 (EOA) - Contribute, where appropriate, to the Forensic Framework project through active engagement and participation in New Zealand Forensic Advisory Group (NZFPAG) to ensure consistency and alignment with other services Q1-4 - Identify the gaps in meeting the needs of special groups, Maori and Pacific Island people in forensic care Q4	MHAID Clinical Staff each quarter Launch of a co-design process for the acute care continuum Q2 Report on workforce development undertaken with a focus on retention, recruitment, training Q1-Q4 Active plan in place to expand peer workforce Q3 Stocktake of current youth and adult workforce Q1 Gaps identified Q4			

Population Mental Health

Outline actions to support healthier safer and more connected communities through better access to affordable, quality health care and better health outcomes for everyone. How will you improve population mental health and addiction by increasing uptake of treatment and support earlier in the course of mental illness and addiction, further integrating mental health, addiction and physical health care, and co-ordinating mental health care with wider social services, especially for priority populations including vulnerable children, youth, Māori and Pacifica.

DHBs must include actions in relation to improving the below focus areas (relevant actions may be cross referenced to the Inquiry response section):

- Options for early intervention across the primary care spectrum to help ensure early intervention and continuity of care
- Improved options for acute responses including improving crisis team responses and improved respite options
- Suicide prevention and postvention to provide a range of activities such as mental health literacy and suicide prevention training, community-led prevention and postvention initiatives (ie, bereavement counselling) and integration of mental health and addiction services
- Actions in relation to Equally Well to improve the physical health outcomes for people with low prevalence mental health and addiction conditions
- Improving access (MH01) and reducing waiting times (MH03)
- Ongoing commitment on reporting to PRIMHD
- Ongoing commitment to transition/discharge plans and care plans for people using mental health and addiction services

DHBs should include actions in relation to improving some of the below areas of focus:

- Supporting Parents Healthy Children (COPMIA) to support early intervention in the life course
- Improving co-existing problems responses via improved integration and collaboration between other health and social services
- Reducing inequities including reducing the rate of Māori under community treatment orders
- Improving employment and education and training options for people with low prevalence conditions including, for example, Individual Placement Support
- The implementation of models of care for addiction treatment, with particular reference to the Substance Addiction (Compulsory Assessment and Treatment) Act 2017

This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes)

DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
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 • Establish operational links with stop smoking campaigns/services Q2 • Prioritise management of long term conditions with GPs through Consumer Led Integrated Care (CLIC) programme (refer Primary Care), and prototype and test personalised care plan for mental health consumers Q4 • Develop and implement mental health pathways for primary care to support appropriate onward referral and service access for treatment and support Q3	Operational links established with smoking campaigns/services Q2 Number of consumers registered with and accessing PHO increased by Q4 from baseline of 2016	Number of consumers registered with and accessing PHO MH01: Improving the health status of people with severe mental illness through improved access	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
			System outcome We live longer in good health	**Government priority outcome** Ensure everyone who is able to, is earning,

• Disseminate the best practice that is part of Supporting Parents Healthy Children (SPHC), particularly through work-based learning events for Community Mental Health Teams (CMHT) Q4 2. Promote and support use of low cost primary practices especially for Māori to reduce over-representation in inpatient services (EOA) • Report on progress for the promotion and support of low cost primary practices in Q2 and Q4, highlighting number of Māori enrolled & accessing (EOA) 3. Monitor and evaluate the implementation of the day activity and vocational services RFP, which includes the development of a new Individual Placement and Support (IPS) based vocational support service to support consumer wellbeing • Collaborate with "Work Counts" to establish fidelity audits for new IPS based vocational district-wide service, after RFP completed for day activity and vocational services Q4	By Q4, all CMHTs have received single session family therapy briefing. By Q4, all locality groups have received SPHC briefing Mental health pathways implemented Q3 Pathway established for access to healthy housing Q4 Report on progress re low cost primary practices in Q2 and Q4 Fidelity audits undertaken for new IPS based vocational district-wide service Q4	MH03: Shorter waits for non-urgent mental health and addiction services MH04: The Mental Health & Addiction Service Development Plan SS06: Better Help for Smokers to quit in public hospitals MH05: Reduce the rate of Māori under the Mental Health Act: section 29 Community Treatment Orders Number of CMHT and locality meetings attended by SPHC coordinator. Number of IPS fidelity audits scheduled for future years	**System outcome** We have improved quality of life	learning, caring or volunteering

<table>
<tr><td colspan="3">Mental Health and Addictions Improvement Activities

In order to support an independent/high quality of life please outline your commitment to the HQSC mental health and addictions improvement activities with a continued focus on minimising restrictive care (including the aspirational goal of eliminating seclusion by 2020) and improving transitions and engagement with the next steps of the programme.

Please note the percentage and quality of transition plans forms part of the PP7 performance measure. The other three programmes that will be led by the HQSC over the life of the programme are; learning from serious adverse events and consumer experience, maximising physical health and improving medication management and prescribing issues. This programme will support standardised, evidence-based processes and practices for prescribing and management.</td><td colspan="2">This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes)</td></tr>
<tr><td>DHB activity

1. Engage with the Health Quality & Safety Commission (HQSC) co-design process for reducing use of seclusion, follow up after discharge (transition) and advanced directives work (EOA)
• Q1-Q3, participate in National HQSC projects including:
- Reducing the use of seclusion
- Connecting care – transition planning
- Learn from adverse events
• Support programme roll out through co-design workshops Q1-Q4

2. By Q2, complete implementation of the Supporting Families, Healthy Children project, subsequent to gap analysis, followed by implementation plan roll out. This work looks at extending the service, subject to MoH funding, and further engages with CMHTs, including training for single session family therapy by Q4.</td><td>Milestone

Completion of National HQSC projects Q1-3
Recruitment of project team members Q1
HQSC Co-design workshops roll out is supported Q1–Q4

Gap analysis completed Q1
Engagement with CMHTs completed by Q3, includes KPI of whānau engagement to map progress.
50% training completed by Q4</td><td>Measure

Project adheres to national timelines
MH02: Improving mental health services using wellness and transition (discharge) planning</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families

System outcome
We have improved quality of life</td><td>Government priority outcome
Ensure everyone who is able to, is earning, learning, caring or volunteering</td></tr>
</table>

Addiction

- For those DHBs that are not currently meeting the PP8 addiction related waiting times targets (for total population or all population groups), please identify actions to improve performance to support an independent/high quality of life for people with addiction issues
- Please outline for quarter one the existing and planned AOD services for your region including those for women, Māori and Pacific, older people, opioid substitution and criminal justice clients and LGBTIQ communities, ensuring equitable health for all New Zealanders. Please also outline how your DHB will ensure the quality of AOD services to support healthier New Zealanders live an independent and high quality of life. See the FAQs on the NSFL to support you with this task
- Noting that mental health and addictions services are a priority for Government please describe how your DHB is giving appropriate priority to meeting service demands within baseline funding

Note: DHBs should take into account both DHB provided services and those that are DHB funded but provided by NGOs

This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes)

DHB activity	Milestone	Measure	Government theme: Improving the well-being of New Zealanders and their families	
1. 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: • Undertake review of Co-Existing Problems (CEP) across system and identify action for improvement and increased integration Q3 • Refresh Specialist Services for Co-Existing Problems Q2 • Comprehensive assessments reflect co-existing approach Q4 • Explore opportunities for re-contracting for kaupapa Māori CEP service (EOA) Q3 • Strengthen integration of local and regional services to support vulnerable groups e.g. LGBTTi and Māori (EOA) Q4 • Early alcohol and other drug (AOD) interventions for young people focussing on Māori and Pasifika (EOA) Q3	Review completed by Q3 Specialist services plan refreshed by Q2 System CEP improvement plan Q4 Co-design workshops by Q4 Shorter wait times for young people accessing services – early AOD intervention by Q4	Review and report activity & report completion Specialist services review MH03: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds AOD wait times (adult)	**System outcome** We live longer in good health	**Government priority outcome** Support healthier, safer and more connected communities
2. Outline for quarter one of the existing and planned AOD services for the Southern district, including those for women, Māori and Pacific, older people, opioid substitution and criminal justice clients and LGBTIQ communities, ensuring equitable health for all New Zealanders. • Outline how SDHB will ensure the quality of AOD services to support healthier New Zealanders live an independent and high quality of life	Quarter 1 outline of existing and planned AOD services		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering

<table>
<tr><td colspan="3">Maternal Mental Health Services
Informed by the outcome of your 2018/19 stocktake of the primary maternal mental health service provision in your district, and the volumes of women accessing these services, please advise the actions you plan to take in 2019/20 to further improve access and to address any identified issues. Your plans should indicate how equity of access and outcomes for Māori and Pacific women will be addressed and measured</td><td colspan="2">This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes)</td></tr>
<tr><td>DHB activity

1. Using service review, develop recommendations and action plan for change implementation Q1, including (EOA):
• Identification of priority areas from the review, including those for Māori and Pasifika (EOA)
• Adopt implementation science informed approach for change process, specifically how change might be effected within current resources.
• Ensure analysis of ethnicity and of rural and remote communities is robust and reliable (EOA). Analysis to include Māori and Pasifika, along with refugee communities, as an identified area to understand better (EOA)
• Utilise all of system approach including:
- PHO services – primary care integration approach
- DHB services (variable across district) – including option to replicate Southland model
- Plunket services – options for integration and district wide service model
- Supporting Families, Healthy Children - integration
• Work with relevant sections of the Southern health system to develop a maternal & infant mental health pathway by Q4.
- Infant and maternal mental health will include mild to severe mental health problems, along the continuum</td><td>Milestone

Review is finalised Q1
Improvement Plan developed Q2, including identification of need for Māori Health Pathway completed Q4
Framework established for joint working across system by Q4
Maternal and mental health pathway developed by Q4</td><td>Measure

Health pathway operational Q4
MH01: Improving the health status of people with severe mental illness through improved access
MH03: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families

System outcome
We have improved quality of life

Government priority outcome
Support healthier, safer and more connected communities

Government priority outcome
Make New Zealand the best place in the world to be a child</td></tr>
</table>

3.2.3 IMPROVING WELLBEING THROUGH PREVENTION

<table>
<tr><td colspan="3">Cross-sectoral Collaboration
Please outline in your plan how the DHB has, and will continue to, demonstrate leadership in the collaboration between and integration of health and social services, especially housing</td><td colspan="3">This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes)</td></tr>
<tr><td>DHB activity</td><td>Milestone</td><td>Measure</td><td colspan="2" rowspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td>1. Facilitate a multi-agency working group to support improved air quality and warmer drier homes with a focus on priority air sheds in Central Otago, South Invercargill and Gore. Ongoing Q1-Q4[21]

2. Review and formalise a memorandum of understanding (MOU) with councils for a joined up district wide approach to recreational water by Q2

3. Commence the development of a Health in all policy (HiAP) action plan to support intersectoral action by Q4

4. Well Child Tamariki Ora (WCTO) Quality Improvement Framework Steering Group will continue to work as a multi-disciplinary and intersectoral group focussing on improving outcomes for the first 1000 days (EOA) (Refer First 1000 days)
• WCTO QIF will meet quarterly throughout the 2019/20 year

5. The Child and Youth Network (SLAT), a multidisciplinary and intersectoral group will continue to meet every two months with a focus on supporting collaboration and integration between health, other government agencies and social services working to support children and young people. This is the Southern district health group that will support implementation of the Child and Youth Wellbeing Strategy (EOA)

6. Southern DHB will continue to participate in the Building a Children's Workforce initiative. This initiative brings Runaka, Oranga Tamariki and community organisations together to build a more connected and competent children's workforce in Dunedin.
• Participate in the Governance group for Building a Children's workforce initiative Q1-Q4
• Participate in integrated pilot opportunities Q1-Q4</td><td>Ongoing Q1-Q4

MOU by Q2

Draft plan Q4

Quarterly meetings

Meetings two monthly

Participation in workforce initiative Q1-Q4
Participation in pilots Q1-Q4</td><td>District wide consistent approaches to recreational water monitoring and responses</td><td>System outcome
We live longer in good health</td><td>Government priority outcome
Support healthier, safer and more connected communities

Government priority outcome
Make New Zealand the best place in the world to be a child</td></tr>
</table>

[21] An air shed is a geographic boundary for air quality standards

Waste Disposal

This work is a continuation of the climate change and waste disposal planning priorities from the Annual Plan Guidelines 2018/19, and is aligned with the Government's priority outcome of environmental sustainability. It is also related to the priority outcome of a strong public health system.

- Identify further areas for action (for example, via gaps identified in the 2018/19 stocktake of waste disposal actions) to support the environmental disposal of hospital and community (eg, pharmacy) waste products (including cytotoxic waste)

<table>
<tr><td>DHB activity

1. Increase recycling
• Extend PVC recycling to Invercargill
• Conduct feasibility study of food waste composting
- Assessment to quantify impact and methods and develop associated recommendations by Q2 19/20

2. Work with local government on sustainability approaches to minimise the production of waste, increase recycling and mange the hazards from waste disposal (Refer Public Health Plan)</td><td>Milestone

PVC recycling programme rolled out by Q3
Recommendations by Q2

Report complete Q3</td><td>Measure

Report on activities in Annual Plan</td><td colspan="2">Government themes:

Improving the well-being of New Zealanders and their families

Build a productive, sustainable and inclusive economy (priority outcome is: Transition to a Clean, Green and Carbon Neutral New Zealand)</td></tr>
<tr><td rowspan="2"></td><td rowspan="2"></td><td rowspan="2"></td><td>System outcome

We live longer in good health</td><td>Government priority outcome

Transition to a clean, green carbon neutral new Zealand</td></tr>
<tr><td>Government priority outcome

Support healthier, safer and more connected communities</td></tr>
</table>

Climate Change

This work is a continuation of the climate change and waste disposal planning priorities from the Annual Plan Guidelines 2018/19, and is aligned with the Government's priority outcome of environmental sustainability. It is also related to the priority outcome of a strong public health system.

- Identify and undertake further areas for action (for example, via gaps identified in the 2018/19 stocktake of climate change actions) to positively mitigate or adapt to the effects of climate change and their impacts on health. Where appropriate and able, these should be underpinned by cost-benefit analysis of co-benefits and financial savings.
- As appropriate, identify actions that improve the use of environmental sustainability criteria in procurement processes

DHB activity	**Milestone**	**Measure**	**Government themes:** **Improving the well-being of New Zealanders and their families** **Build a productive, sustainable and inclusive economy** (priority outcome is: Transition to a Clean, Green and Carbon Neutral New Zealand)	
1. Roll out of DHB-wide Green Health Strategy by the end of Q1	Rollout of the DHB Green Health Strategy Q1	Report on activities in Annual Plan	**System outcome** We live longer in good health	**Government priority outcome** Transition to a clean, green carbon neutral new Zealand
2. Develop framework to incorporate climate change and sustainability objectives in to 20/21 service plans • Incorporate climate change objectives into service planning templates by the end of Q2 • Inclusion of climate change objectives (either population protection or sustainability initiatives) in service planning templates by the end of Q4	Service plan templates include climate change objectives by Q4			
3. Reduce electricity use • Undertake cost-benefit analysis of transitioning to low energy lighting and timer solutions with implementation of recommendations complete by Q3 • Undertake DHB wide education campaign regarding electricity usage (e.g., computer and lighting overnight) - KPIs developed to assess impact Q2 - Education campaign commenced by Q3	Cost-benefit analysis by Q3 KPIs Q2 Education campaign commenced by Q3			**Government priority outcome** Support healthier, safer and more connected communities
4. Reduce consumption • Reduce carbon footprint of anaesthetic gases through education and behaviour change • Commence transition planning and actions to achieve a >50% electric vehicle fleet by 2030 - Infrastructure requirements assessed by Q2 - Teams with high vehicle usage (and lower travel distances) engaged with by Q2 - Limitations of range and charging requirements quantified and mitigation strategies prepared by Q3 - Feasible cross-organisational collaboration options assessed by Q3 - Rollout plan complete by Q4 including procurement strategy -	Education campaign commenced by Q2 Infrastructure requirement report complete by Q2 Rollout plan complete by Q4			
5. Conduct cost benefit analysis of Telehealth comparing costs of expended telehealth infrastructure investment against fuel miles saved • Report complete with associated recommendations by Q3	Report complete Q3			

<table>
<tr><td colspan="3">Drinking Water
Provide actions the DHB will undertake to support their PHU to deliver and report on the drinking water activities in the environmental health exemplar.

Activities that DHBs could carry out to support their PHU drinking water work (and other public health regulatory service) can be found on the FAQ page (new information)</td><td colspan="3">This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes)</td></tr>
<tr><td>DHB activity</td><td>Milestone</td><td>Measure</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td rowspan="2">1. Facilitate an effective Joint Working Group to promote drinking water quality and safety across the district ongoing
• Agree work plan and information sharing between agencies by Q2

2. Complete the annual survey of drinking water supplies serving populations over 100 to determine compliance with sections 69V and 69Z of the Health Act (EOA)
• Undertake annual survey undertaken by August
• Write compliance letters to water suppliers by Q2

3. Review the Public Health Unit 6-month contract reports and, if any advice provided about drinking-water (and other public health regulatory activities) identify significant public health risks from inadequate or unsafe drinking-water supplies (or other environmental exposures or communicable disease), support the Public Health Unit’s efforts to manage and mitigate the public health risks. This may include discussing the issues with Council CEOs and Mayors/Chairs, business CEOs, district offices of government agencies, and other key stakeholders Q1 and Q3</td><td rowspan="2">Work plan and information sharing agreed between agencies by Q2

Annual survey undertaken by August 2019
Compliance reports written to water suppliers by Q2

6 month contract reports reviewed Q1 and Q3</td><td rowspan="2">Report on actions in Annual Plan

Compliance reports written to water suppliers

Support undertaken outlined in Q1,Q3 reports</td><td>System outcome
We live longer in good health</td><td>Government priority outcome
Grow and share New Zealand’s prosperity more fairly</td></tr>
<tr><td></td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

Healthy Food and Drink

Create supportive environments for healthy eating and health weight by undertaking the following activities:

- Commit to implementing Healthy Food and Drink Policies in DHBs that align with the National Healthy Food and Drink Policy
- Commit to including a clause in your contracts with health provider organisations stipulating an expectation that they develop a Healthy Food and Drink Policy covering all food and drinks sold on site/s, and provided by their organisation to clients/service users/patients[22], staff and visitors under their jurisdiction. Any policy must align with the Healthy Food and Drink Policy for Organisations (https://www.health.govt.nz/publication/healthy-food-and-drink-policy-organisations)
- Commit to reporting in Q2 and Q4 on the number of contracts with a Healthy Food and Drink Policy, and as a proportion of total contracts
- Work with your PHU to commit to reporting in Q2 and Q4 on the number of Early Learning Settings, primary, intermediate and secondary schools that have current 1) water-only (including plain milk) policies, and 2) healthy food policies. Healthy food policies should be consistent with the Ministry of Health's Eating and Activity Guidelines (new guidance)

This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes)

DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Southern DHB fully implemented the Healthy Food and Drinks Policy on 1 December, 2018. The DHB also removed all carbonated drinks from sale on its site and continues to work with food retailers to identify further opportunities to introduce more healthy options as they become available.		100% compliance	**System outcome** We live longer in good health	**Government priority outcome** Support healthier, safer and more connected communities
2. Southern DHB will develop a healthy food and drinks policy (HF&DP) clause in Q1 2019/20 and will append this clause into all applicable contracts upon their variation or renewal as they arise effective from 1 July 2019.	HF&DP Clause developed in Q1 and appended to all contracts by June 2022	F&DP Clause developed Q1 No. contracts with HF&DP clause appended upon renewal		
3. Southern DHB will add the HF&DP to the audit tool as applicable Q1 and will audit the number of contracts with a HF&DP as part of our 4 yearly audit schedule with providers	HF&DP clause added to the audit tool Q1	% of applicable contracts with HF&DP Clause appended upon renewal No. of Providers audited that have a HF&DP		
4. Over 12 months Public Health will survey the Early Learning Settings, primary, intermediate and secondary schools to determine if they have a current 1) water-only (including plain milk) policies and 2) healthy food policies. Progress reports will be provided at Q2 and Q4.	Q2 and Q4 reporting	No. and percent of each setting with policies		

[22] Excluding inpatient meals and meals on wheels

<table>
<tr><td colspan="3">Smokefree 2025
Identify activities that advance progress towards the Smokefree 2025 goal, including supporting Ministry funded wrap-around stop smoking services for people who want to stop smoking and which address the needs of hāpu wāhine and Māori</td><td colspan="3">This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes)</td></tr>
<tr><td>DHB activity

1. Work with the Southern Stop Smoking Service to increase participation of pregnant women in ante and post-natal stop smoking services – particularly focus on young women – Māori and Pacific (EOA)
• Provision of appropriate cessation support for young women Q1-4
• Assess impact of increased funding for the Stop Smoking Incentive Scheme for pregnant women and whānau Q4
• Refer to SUDI template</td><td>Milestone

Appropriate cessation support provided for young women Q1-4
Assessment of impact of increased funding for the Stop Smoking Incentive Scheme for pregnant women and whānau Q4</td><td>Measure

Number of women taking up the offer of the stop smoking incentive scheme</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families

System outcome
We have health equity for Māori and other groups

System outcome
We live longer in good health</td><td>Government priority outcome
Make New Zealand the best place in the world to be a child</td></tr>
</table>

Breast Screening

Breast cancer is the most commonly diagnosed cancer among women in Aotearoa. BreastScreen Aotearoa (BSA) aims to reduce women's mortality and morbidity from breast cancer by identifying cancers at an early stage, allowing treatment to commence sooner than might otherwise have been possible. Women screened by BSA have a third lower risk of dying from breast cancer than women who are not screened.

Improving access to screening for wāhine Māori and Pacific women is a priority focus for BSA. The effect of the equity gap is especially significant because Māori and Pacific mortality rates from breast cancer are disproportionately higher than those of other women. More equitable outcomes could be achieved if more wāhine Māori and Pacific women were diagnosed at an earlier stage.

The National Screening Unit is implementing an Equity and Performance Matrix to the annual planning reporting process.
The Matrix measures both performance against a target and the equity gap between population groups notably, but not limited to, Māori and non-Māori.

The Ministry of Health, DHBs and Breast Screening Lead Providers all have an important role in ensuring that participation targets are achieved and in eliminating equity gaps between Maori and non-Māori, Pacific and non-Pacific/non-Māori.

DHBs will describe and implement initiatives that contribute to the achievement of national targets for BSA. All initiatives will demonstrate clear strategies for increasing health gains for priority groups and improving equitable participation and timely access to breast screening services.

ALL DHBs will describe actions to:

- Eliminate equity gaps in participation between Māori and non-Māori/Non-Pacific woman and between Pacific and non-Māori/Non-Pacific woman.
- Achieve a participation rate of at least 70% for Māori and Pacific woman aged 50-69 years in the most recent 24 month period.

Improvement activities must be supported by visible leadership, effective community engagement and engagement with BSA Lead Providers, and clear accountability for equity. Activities must be SMART ie, specific, measurable, achievable, realistic and have a time frame.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs)

DHB activity	**Milestone**	**Measure**	**Government themes:** **Improving the well-being of New Zealanders and their families**	
1. Data match to identify women who are not enrolled with Breast Screening services, enrol and provide breast screening. • BreastScreen Otago Southland visit Practices to promote screening services to analyse data match reports and work to implement strategies for enrolment and screening services Q1-Q4 • BreastScreen Otago Southland – Screening Support Service will provide targeted support to priority group women in order to facilitate screening (EOA) • Very Low Cost Access (VLCA) GP practices and Maori Health Providers to support the facilitation of priority group women breast screening enrolments (EOA)	Data matching undertaken Q4 Report on number of new Māori and Pacific women enrolled Q2 and Q4	PV01: Improving breast screening coverage and rescreening	**System outcome** We have health equity for Māori and other groups **System outcome** We live longer in good health	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
2. Undertake targeted promotion of the breast screening programme through individual and joint breast and cervical screening events. • Continue joint Breast and Cervical Screening clinics at fixed and mobile sites in the Southern district Q1-Q4 (refer to Cervical Screening template)	Report on number of new Māori and Pacific women screened Q2 and Q4			

3. BreastScreen Otago Southland Community Screening Coordinator provides Practice level education to outline the programme and help GPs understand the difference between screening and symptomatic women to ensure they are referred on the correct pathway Q1-Q4 4. BreastScreen Otago Southland Kaimahi work with priority women to support engagement and access to screening appointments Q1-Q4 (EOA)	Education provided Q1-Q4 Breast and cervical screening clinics Q1-Q4 Report on number of new Māori and Pacific women enrolled and screened Q2 and Q4			

Cervical Screening

Cervical cancer is one of the most preventable forms of cancer. Through cervical screening pre-cancerous cell changes can be identified and women offered treatment before the cells develop into cervical cancer. In New Zealand around 170 women are diagnosed with cervical cancer 50 women die from the disease each year. Since the beginning of the National Cervical Screening Programme (NCSP) in 1990 the incidence of cervical cancer in New Zealand has reduced by 60 percent and deaths by 70 percent.

Achieving equitable access is a key priority for the NCSP because participation rates for Māori, Pacific and Asian women and people living in our most deprived areas remain lower than other groups. A focus on equity is expected throughout the screening pathway.

The National Screening Unit is implementing an Equity and Performance Matrix to the annual planning reporting process. The Matrix measures both performance against a target and the equity gap between population groups notably, but not limited to, Māori and non-Māori.

ALL DHBs will set measurable participation and equity targets from baseline data and describe actions to:

- Eliminate equity gaps in participation between Māori and non-Māori/non-Pacific/non-Asian woman and between Pacific and non-Māori/non-Pacific/non-Asian women and between Asian and non-Māori/non-Pacific/non-Asian woman.
- Achieve a participation rate of at least 80% for Māori, Pacific and Asian woman aged 25-69 years in the most recent 36 month period.

Improvement activities must be supported by visible leadership, effective community engagement, resources and clear accountability for equity. Activities must be SMART ie, specific, measurable, achievable, realistic and have a time frame.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs)

DHB activity	**Milestone**	**Measure**	**Government themes: Improving the well-being of New Zealanders and their families**	
1. Use data matching to identify women who have not received a cervical screening and systematically invite them for screening • Work with WellSouth to progress the Cervical Screening Practice specific Health Cloud. This allows both the Practice and the Screening Programme to data match and identify women who are unscreened or under screened. • Breast Screen Otago Southland and the Southern DHB Cervical Screening Programme to visit a minimum of 15 Practices to promote screening services, analyse data match reports and implement strategies as appropriate to increase screening rates.	Data matching undertaken Q4	PV02: Improving cervical screening overall	**System outcome** We have health equity for Māori and other groups **System outcome** We live longer in good health	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
2. Reduce barriers to screening by undertaking targeted promotion of the cervical screening programme and providing free cervical screening to priority group women through regular cervical screening events Q1-Q4 (EOA) • Breast Screening Otago Southland - Screening Support Services and WellSouth provide free cervical screening to priority group women • Hold joint Breast and Cervical Screening Clinics at fixed and mobile sites in the Southern district (6 weekly in Dunedin and Invercargill and bi-annually in rural areas of North and Central Otago) Q1-Q4	Screening events undertaken Q1-Q4			
3. The Associate Maori Health Strategy and Leadership Officer will mentor, guide and build the cultural competency of cervical screening providers Q1-Q4	Quarterly reporting of number of Maori smear takers mentored			

4. Plan, implement and evaluate a pilot project with one large General Practice linking with the Southern DHB Interpreter Service to facilitate Asian women engaging in cervical screening • Discussion of processes for engagement Q1-Q2 • Implement and evaluate pilot project Q3-Q4 5. Participate in South Island Cervical Screening Leaders six monthly meetings to work together and share lessons learned • Participate in focus groups with other NCSP team members to gain understandings of our region and identify opportunities to leverage off each other Q2-Q4 6. Evaluate the current model of care in the Southern district to facilitate increased screening capacity in collaboration with the WellSouth, to better support community needs • Circulate submission documents and assimilate feedback. Complete a review of the model of care Q3	Interpreter service pilot undertaken Q3-Q4 Participation in South Island groups Q2-Q4 Model of care review completed Q3			

3.2.4 BETTER POPULATION HEALTH OUTCOMES SUPPORTED BY STRONG AND EQUITABLE PUBLIC HEALTH AND DISABILITY SYSTEM

<table>
<tr><td colspan="3">Engagement and Obligations as a Treaty Partner

The NZPHD Act specifies the DHBs Treaty of Waitangi obligations; please specify in the annual plan the processes the DHB uses to meet these obligations. This includes, but is not limited to, information on:
1. meeting the DHBs obligation to establish and maintain processes that enable Māori to participate in, and contribute to, strategies for Māori health improvement
2. meeting processes that enable Māori to participate in, and contribute to, strategies for Māori health improvement
3. fostering the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori
4. building the capability of all DHB staff in Māori cultural competency and Te Tiriti o Waitangi</td><td colspan="3">This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes)</td></tr>
<tr><td>DHB activity
1. Meet the DHBs obligation to establish and maintain processes that enable Māori to participate in, and contribute to, strategies for Māori health improvement
• Maintain and strengthen the Southern DHBs relationship with their Iwi Governance Committee as our Treaty of Waitangi partner Q1 (EOA)
• Development of a Southern DHB Treaty of Waitangi Policy Q1 (EOA)

2. Meet processes that enable Māori to participate in, and contribute to, strategies for Māori health improvement
• Establish a regular forum for meeting with the Māori community across the district Q2 (EOA)

3. Build the capability of all DHB staff in Māori cultural competency and Te Tiriti o Waitangi
• Establish an audit system to monitor DHB staff compliance against individual professional accreditation standards specific to Māori cultural competency Q3 (EOA)
• Review of our Treaty of Waitangi training modules Q3 (EOA)

4. Foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori (EOA)
• Develop a Māori workforce development plan by Q2 (EOA)</td><td>Milestone
Partnership agreement reviewed Q1
Policy developed Q1

Meeting schedule in place Q2

System developed to monitor compliance Q3
Review training content, delivery & frequency Q3

Development of a Māori workforce plan Q2</td><td>Measure
SS12: Engagement and obligations as a Treaty partner
Reports provided and obligations met as specified</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families

System outcome
We have health equity for Māori and other groups

Government priority outcome
Support healthier, safer and more connected communities</td></tr>
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<table>
<tr><td colspan="3">Delivery of Whānau Ora

DHBs are best placed to demonstrate, and action, system-level changes by delivering whanau-centred approaches to contribute to Māori healh advancement and to achieve health equity.

Please identify the significant actions that the DHB will undertake in this planning year to:
• contribute to the strategic change for whānau ora approaches within the DHB systems and services, across the district, and to demonstrate meaningful activity moving towards improved service delivery
• support and to collaborate, including through investment, with the Whānau Ora Initiative and its Commissioning Agencies and partners, and to identify opportunities for alignment. (All Pacific priority DHBs need to also include Pasifika Futures in this activity)</td><td colspan="2">This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes)</td></tr>
<tr><td>DHB activity

1. Contribute to the strategic change for whanau ora approaches within the DHB systems and services, across the district, and demonstrate meaningful activity moving towards improved service delivery
• Develop and commence implementation of Southern DHB whānau ora policy Q2

2. Support and collaborate, including through investment, with the Whānau Ora Initiative and its Commissioning Agencies and partners, and identify opportunities for alignment
• Develop an MOU with Te Pūtahitanga o Te Waipounamu by Q3
• Review Southern DHB Māori health contracts with a whānau ora lens Q3</td><td>Milestone

Whānau ora policy in place Q2

MOU in place Q3
Contracts reviewed Q3</td><td>Measure

SS17: Delivery of Whānau ora</td><td colspan="2">Government theme:

Improving the well-being of New Zealanders and their families

System outcome

We have health equity for Māori and other groups

Government priority outcome

Support healthier, safer and more connected communities</td></tr>
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Care Capacity Demand Management (CCDM) • Please detail the actions that you will take towards implementing Care Capacity Demand Management (CCDM) for nursing by June 2021 in your annual plans. • Please outline the most significant actions the DHB will undertake in 2019/20 to progress implementation of CCDM for nursing. Ensure the equitable outcomes actions (EOA) are clearly identified.			**This is an equitable outcomes action (EOA) focus area** (equity focus and clear actions to improve Māori health outcomes)	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Bi-monthly reports are completed as per our DHB commitment to the signed Accord i.e. reports to staff and MoH Q1-Q4	Completion of bimonthly reports Q1, Q2, Q3, Q4	Report on actions in Annual Plan	**System outcome** We live longer in good health	**Government priority outcome** Support healthier, safer and more connected communities
2. Ensure each ward has a functional Local Data Council (LDC), which meets on a regular basis and reports on their progress against their agreed action plans, by Q1	LDC in place in all wards Q1 Report on agreed action plans by Q1			
3. Implement an agreed Action Plan for 2019/20 that supports accelerated progress on CCDM rollout. Complete Action Plan by Q3	Action Plan completed by Q3			
4. All inpatient units will have their FTE calculation completed on an annual basis Q3	FTE calculation completed by Q3			
5. All clinical areas develop Variance Response Management (VRM) action plans and review effectiveness 6 monthly, Q2 and Q4	VRM fully implemented with 6 month reviews Q2, Q4			
6. Report monthly on effectiveness of VRM plans Q1-Q4	Monthly reporting Q1-Q4			
7. Ensure VRM visibility across the organisation on Capacity at a Glance (CaaG) screens in clinical areas Q1	VRM visible on CaaG screens Q1			
8. Ensure ongoing education is available for all levels of the organisation. Report on education provided at all levels 6 monthly Q2 and Q4	Reports Q2 and Q4			
9. BOARD Reporting Tool becomes the standardised way for reporting 23 CCDM Core Data Set measures. • Commence movement of current Local Data Set measures onto BOARD Q1 and continue movement through Q4 • Monthly reporting to line management Q1-Q4 • Bimonthly reporting to CCDM Council Q1-Q4	Local Data Set measures moved onto BOARD commencing Q1			

	Monthly reporting and bimonthly reporting Q1-Q4			

Disability • Commit to ongoing training for front line staff and clinicians that provides advice and information on what needs to be considered when interacting with a person with a disability. Report on what percentage of staff have completed the training by the end of quarter 4 2019/20. • Outline in your plan how the DHB collects and manages patient information to ensure your staff know which patients have visual, hearing, physical and/or intellectual disabilities			**This is an equitable outcomes action (EOA) focus area** (equity focus and clear actions to improve Māori health outcomes)
DHB Activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**
1. Develop and launch the Disability Action Plan Q2 (EOA) • Develop Southern Disability Action Plan Q2 • Establish a Southern Health Disability Steering Group to implement the improvement actions identified in the DHB's Disability Action Plan Q2 • Refer Workforce Template	Action Plan developed Q2 Southern Health Disability Steering Group established Q2	Report on activities in the Annual Plan	
2. Launch Patient Stories about disabled people at the same time as Disability Action Plan, to raise awareness of the experiences people have when in the health system (EOA) Q2	Patient Stories launched Q2		
3. Disability awareness e-training to be provided to all front line staff and clinicians (EOA) by Q4			

4. Install an IT alert system on the DHB inpatient system to collect information on patients who wish to disclose a disability Q4 (EOA) 5. Working with disabled people and their whānau, capture their experiences in our system to improve Southern DHB processes Q4 (EOA)	Q4 report on percentage of staff that have undertaken training (target 85% at one year) Alert system in place & data capture underway Q4 Report of experiences/ SDHB processes Q4	Report on number patients who have been through SDHB disclosing a disability Q4	**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering

Planned Care Planned Care Vision: 'New Zealanders receive equitable and timely access to Planned Care Services in the most appropriate setting, which supports improved health outcomes'. Planned Care is a broader concept than medical and surgical services traditionally known as Electives or Arranged services. Planned Care is patient centred and includes a range of treatments funded by DHBs delivered in both inpatient, outpatient, primary and community settings. It also includes selected early intervention programmes that can prevent or delay the need for more complex healthcare interventions. Planned Care is centred around five key principles, which are built on the earlier principles of clarity, timeliness and fairness under the Elective Policy. The five principles for planned care are: 1. Equity – People will get the healthcare that safely meets their needs, regardless of who they are or where they are. 2. Access – People can access the care they need in the right place, with the right health provider. 3. Quality - Services are appropriate, safe, effective, efficient, and respectful and support improved health. 4. Timeliness – People will receive care at the most appropriate time to support improved health and minimise ill-health, discomfort and distress. 5. Experience –People and their family or whanau work in partnership with healthcare providers to make informed choices and get care that responds to their needs, rights and preferences. DHBs need to outline the actions they will take in order to support the following: **Part One: Current Performance Actions** 1. DHBs are required to outline what actions they will take to sustain or improve Planned Care delivery to meet increasing population health need and to maintain timely access to Planned Care services including Radiology Diagnostics and Elective services. Actions need to include how DHBs will enable delivery of the agreed level of Planned Care interventions; and ensure that patients wait no longer than four months for a First Specialist Assessment and Treatment. Delivery and improvements will be measured against the agreed Planned Care Measures, and quarterly qualitative reports.	**This is an equitable outcomes action (EOA) focus area** (equity focus and clear actions to improve Māori health outcomes) DHBs should be identified for both part one and two of this advice who in their population is experiencing inequities and include actions or strategies to be implemented to address the identified inequities.

Part Two: Three Year Plan for Planned Care

2. In 2019/20 DHBs are required to plan, design and start implementation of a Three Year Plan to improve Planned Care services.

The plan is required to include a description of actions that demonstrate how DHBs will address the five Planned Care Priorities of:

- Gain an improved understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed.
- Balance national consistency and the local context
- Support consumers to navigate their health journeys
- Optimises sector capacity and capability and
- Ensures the Planned Care Systems and supports are designed to be fit for the future

DHBs are expected to engage with DHB Consumer Councils and other key stakeholders in the development of their plan.

<table>
<tr>
<td rowspan="2">Quarter 1:
• Increase internal surgical capacity through the upgrade of an anaesthetic procedure room into a minor operating theatre (12-18 month timeframe) at Dunedin Hospital and additional theatre space and beds at Southland Hospital
• Continue planned outsourcing and outplacing surgery throughout the year
• Increase discharges by maximising the number of patients who receive surgery through a casemix adjustment of surgical procedures
• Assess current intervention rates against national standard and take steps to adjust internal delivery as needed
• Provide care at the right level for access to specialist service by rolling out the prioritisation tool for access to FSA to other specialities
• Continue to monitor progress and variances through the production plan tool and effective communication with the surgical teams. Improve theatre reporting, scheduling and list management by introduction of a new tool
• We will introduce the 'acuity tool' (implemented in Ophthalmology) to 8 more services over the year. This will allow services to develop plans to balance timely follow-up in both new (FSA) and follow up appointments
• Continue to maximise theatre utilisation over the usual breaks (Christmas/New Year, Easter, school holidays)
• Action plan for strawman and final draft of the 3 year Plan for Planned Care is prepared
• Monitor accepted referrals for FSA and access rates to Planned Care by ethnic group and where there are equity gaps investigate and address the barriers driving these (EOA).

Quarter 2:
• Continue implementing the Recovery Plan (ESPI 2) for Urology, ENT, General Surgery, Orthopaedics</td>
<td>Milestone
Quarter 1
<u>Part one:</u>
Discharge targets met for the Recovery services (ESPI 2)
Acuity tool rollout is initiated
<u>Part two:</u>
Action plan to submit draft 3 year Plan for Planned Care to MOH by Q3</td>
<td>Measures
SS07: Planned Care Measures
SS08: Planned care three year plan

Q1

<u>Part one:</u>
Delivery of actions and improvement against Planned Care Measures expectations
Two specialties commence use of acuity tool
<u>Part two:</u>
A plan is submitted that outlines the proposed approach to develop the Three Year Plan.
Equity gaps in accepted FSA referral rates and access to planned care narrow for Q1, Q2, Q3, & Q4</td>
<td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td>
</tr>
<tr>
<td>Quarter 2
Part one:
Discharge targets met for the Recovery services (ESPI 2)
Acuity tool rollout continues
Part two:
Summary report outlining the outcomes of the</td>
<td>

<u>Part one:</u>
Delivery of actions and improvement against Planned Care Measures expectations
Two specialties commence use of acuity tool
<u>Part two:</u></td>
<td>System outcome
We live longer in good health

System outcome
We have improved quality of life</td>
<td>Government priority outcome
Support healthier, safer and more connected communities</td>
</tr>
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• Develop an “ESPI5” recovery plan that is aligned with FSA/surgery conversion rates • Consultation with stakeholders on health needs and preferences • Prepare “strawman” *3 year Plan for Planned Care*, for discussion • Explore partnerships to provide increased elective surgery at Queenstown Quarter 3: • Roll out Recovery Plan process to other specialities (all ESPI 2) • Pilot in one or more specialities the ESPI 5 recovery Plan • Review the draft *3 year Plan for Planned Care* with key stakeholders such as Clinical Leads and the Consumer Council • Submit the first draft of a 3 year Improvement Plan for Planned Care Services to MOH Quarter 4: • Review *3 year Plan for Planned Care* and adjust as needed • Establish the monitoring framework • Commence actions within plan	analysis and consultation processes to understand local health needs, priorities and preferences	A summary report outlining the outcomes of the analysis and consultation processes to understand local health needs, priorities and preferences.		
	Quarter 3 Part one: Recovery Plans for other specialities (ESPI 2 and 5) Acuity tool rollout continues Part two: Submit 3 year Plan for Planned Care	<u>Part one:</u> Delivery of actions and improvement against Planned Care Measures expectations Two specialties commence use of acuity tool <u>Part two:</u> Submission of the Three Year Plan for Planned Care		
	Quarter 4 Part one: DHB to identify milestone for actions identified to improve planned care Acuity tool rollout continues Part two: Report on progress of implementation of the 3 year Plan for Planned Care	<u>Part one:</u> Delivery of actions and improvement against Planned Care Measures expectations Two specialties commence use of acuity tool <u>Part two:</u> An update is provided on actions outlined in the Three Year Plan for Planned Care.		

<table>
<tr><td colspan="3">Acute Demand
Acute Data Capturing:
Please provide a plan on how the DHB will implement SNOMED coding in Emergency Departments to submit to NNPAC by 2021. For example, this should include a description of the information technology actions and ED clinical staff training actions, milestones and timeframes.
Patient Flow:
Please provide an action that improves patient flow for admitted patients
Please provide an action that improves management of patients to ED with long-term conditions</td><td colspan="2">This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes)
Please provide an action focused on improving wait times for patients requiring mental health and addiction services who have presented to the ED
Please provide an action to improve Māori patients experience in ED</td></tr>
<tr><td>Acute Data Capturing

1. Investigate the technical IT issues to collect SNOMED codes in Emergency Department Information System (EDIS)
EDIS fields' lengths are too short. There are significant issues to map part SNOMED codes to full codes for interfacing to iPM.
Southern DHB will investigate technical issues to collect SNOMED codes in EDIS Q1
Outcome of investigations is to wait for EDIS upgrade
Southern DHB will submit detailed plans once DXC upgrade has firm date Q4
2. Request DXC to increase code field length to accommodate SNOMED Presenting Complaint, Diagnosis and Procedure codes in EDIS

3. Engagement of EDSIS User Group
Inform EDIS User Group of the delay in SNOMED coding in ED Q1
4. Upgrade complete. EDIS able to collect SNOMED codes Q2 2020
SNOMED Coding will provide valuable information on the reasons patients are presenting to ED. When available, these data will be grouped by ethnicity (EOA)</td><td>Milestone

Timeframe and cost requested from DXC Q1

EDIS User Group informed of the delay in SNOMED coding in ED Q1

EDIS Presenting Complaint, Diagnosis and Procedure field lengths increased to accommodate SNOMED codes Q2 2020 (estimated)</td><td>Measure

Plan to implement SNOMED Coding in ED</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families

System outcome
We live longer in good health

Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

Patient Flow **Performance Improvement of our 6 hour ED target** From 01 March 2018 to 28 February 2019 the percentage of patients admitted, discharged or transferred from ED in less than six hours was 89%. We aspire to increase this to 95%, but there may be mitigating factors including, capacity constraints and models of care that may impact on this being achieved. We put the following initiatives in place to facilitate our objective: 1. We have engaged an external consulting group , who are working with us to enable new models of care. This work is occurring at both Dunedin & Southland EDs and the initiatives include Fit 2 Sit, Introducing an Early Assessment Zone and scoping out opportunities for facility upgrades to provide a dedicated short stay unit. 2. ED Performance Improvement Steering Group provides guidance, leadership and coordination of current and new initiatives to improve Dunedin ED Shorter Waiting Times Target, ongoing, Q1-Q4 3. 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 by establishing HOME Team (established February 2019 (ongoing Q1-Q4) • Evaluate impact of additional allied health workforce by Dec 2019 4. Work closely in an integrated manner with Mental Health services to ensure ED is responsive to the needs of those suffering acute or chronic mental health conditions Q1-Q4 5. Undertake work to reduce siloed thinking • Move to all adult medical admissions to be admitted to General Medicine Q1-Q4 6. Work with the Māori Health Directorate to ensure that the services that are delivered are culturally appropriate and Maori have the best possible experience within our ED's (EOA) • Establish Southern DHB steering group, to include Māori Health Directorate, to identify actions to address needs of Māori patients Q1 • Māori Health Directorate to work with ED staff to identify their training needs Q1 • Cultural training delivered to ED staff to address training needs by Q4	Improvement of our 6 hour target performance (Q1,2,3,4) Steering Group provides guidance Q1-Q4 HOME team in place by Q1 Evaluation of impact of HOME Team by Q2 Integration with mental health services commenced Q1 Internal Medicine takes patients from other specialities Q1-Q4 Steering group established Q1 Cultural training delivered Q4	SS10: Shorter Stays in ED Monitoring our performance (% breaches) on a quarterly basis Improvement in 6 hour target Reduction inpatient delays Number of complaints		

Rural Health Please outline in your plan how the DHB has considered the health needs and the factors affecting health outcomes for rural populations when making decisions regarding access to and sustainability of health services.			**This is an equitable outcomes action (EOA) focus area** (equity focus and clear actions to improve Māori health)	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Establish Locality Networks across the Southern DHB area. Commencing with the Central Otago/Queenstown Lakes network in 2019/20. Most of the Locality Networks will be based on rural catchments. Locality Networks are a component of the Southern DHB's Primary and Community Care Strategy and will provide a platform for the consideration of localised health needs. The Networks are tasked with considering the health needs of their respective populations and making recommendations to the Southern Alliance. Membership of the Locality Networks will comprise a range of stakeholders including Māori representation (EOA) • Terms of reference agreed including clear equity focus Q1 • Membership confirmed Q1 • Network workplan agreed Q1 • Programme drafted outlining the timing for the development of the remaining Locality Networks Q2	Central Lakes Network operational Q1 Other Locality Networks in the SDHB catchment by Q4	Health status profile for locality is completed Q2	**System outcome** We live longer in good health	**Government priority outcome** Support healthier, safer and more connected communities
2. A Rural Hospitals Alliance group was established in 2018/19 in the Southern DHB. This comprises of six rural hospitals including Oamaru, Balclutha, Gore, Dunstan, Ranfurly and Lakes District hospitals. With the exception of Lakes District hospital (which is a Southern DHB hospital) all the others are independent legal entities under contract to the Southern DHB. Southern DHB management is a strategic partner to the group. This Alliance grouping has agreed a list of areas to focus on which will have a direct impact on improved access to services and improved health outcomes for rural populations within the Southern DHB, these include the following priority areas: • Facilitating implementation of the Southern DHB's Primary and Community Care Strategy • Improved access to outpatient clinics for rural residents • Coordination of funding arrangements for Ambulance patient Transfer Services • Strategic Workforce Development across rural facilities • Joint procurement strategies • Improved clinical culture	Agree programme of work and identify resources Q1 Work programme monitored on a quarterly basis to determine progress against each of the priority areas Q1–Q4	Agreed programme of work Q1 Report of programme monitoring Q1-Q4		
3. Southern DHB has an active programme developing telehealth or virtual health capability. The benefits of telehealth in improving access to services, particularly for rural communities, is well				

documented. Southern DHB has been moving to a new platform for providing telehealth services over the past 12 months (from Vivid to Vidyo) and steadily increasing the number and type of clinics going operational. • Review progress to date Q1 • Produce revised and updated implementation plan Q2 • Increase the number of clinics delivered and patients seen by virtual means, compared to 2018/19 numbers, Q1-Q4 • Produce review document which identifies opportunities for progress Q2	Progress reviewed Q1 Production of implementation plan Q2 Increase in number of clinics delivered and patients seen by virtual means Q1-Q4 Review document dentifies opportunities for progress Q2	Review document produced Q2 Number of clinics delivered and patients seen Refurbished Lakes Hospital is completed and commissioned			
4. Lakes District Hospital in Queenstown is a DHB owned and run rural hospital with 10 medical beds, a Level 2 Emergency Department, a maternity service, some allied health services and specialist visiting clinics. The facility commenced a significant capital redevelopment in 2018/19 which will principally see an extended Emergency Department and the commissioning of CT as a radiology modality. The facility is experiencing increasing activity in line with the increasing demographics of the area. There is a clear need for services to keep pace with the rapidly increasing population. • Install and commission CT Q1 • Complete and commission extended ED Q1 • Practical completion of other building works Q1 • Recommence surgical bus visits at Lakes after practical completion of building works Q1	CT is installed and commissioned Q1 Extended ED is completed and commissioned Q1 Other building works achieve practical completion Q1 Surgical bus visits are recommenced Q1	Review of services provided at a local level compared to known need			
5. Southern DHB contracts with a number of independent rural hospitals and health service trusts to provide a range of health services across the Southern DHB catchment area. This diversified model assists the Southern DHB achieve its service coverage obligations in the Crown Funding Agreement. The DHB provides approximately $38m per annum to the entities mentioned above to provide local services to rural populations (excluding funding for primary care services). The amount of funding invested is reviewed annually and changes made where deemed necessary. This process ensures that services are funded on a sustainable basis and makes provision for local access to clinically appropriate services. There is scope/opportunity for more services to be provided at a local level rather than at our two base hospitals. • Agree funding schedules/contract for services Q1 and Q2 • Review and implement new Local Models of Care Q1 to Q4	Funding schedules agreed and contracted for Q1 and Q2 New Local Models of Care reviewed and implemented commencing in Tuapeka and Waitaki Q1 to Q4				

Healthy Ageing

Implement actions identified in the Healthy Ageing Strategy 2016 and contribute to the Government's priority of 'Improving the wellbeing of New Zealanders and their families', as follows:

- Working with ACC, HQSC and the Ministry of Health to promote and increase enrolment in S&B programs and improvement of osteoporosis management especially in alliance with Primary Care as reflected in the associated "Live Stronger for Longer" Outcome Framework (This expectation aligns most closely to the Government's 'Prevention and Early Detection' priority outcome; and the Ageing Well and Acute and Restorative Care goals of the Healthy Ageing Strategy)
- Aligning local DHB service specifications for home and community support services (HCSS) to the vision, principles, core components, measures and outcomes of the national framework for HCSS (This expectation aligns most closely to the Government's 'Health Maintenance and Independence' priority outcome; and the Living Well with Long-Term Conditions goal of the Healthy Ageing Strategy)
- In addition, please outline current activity to identify and address the drivers of acute demand for people 75 plus presenting at ED (or at lower ages for disadvantaged populations) (This expectation aligns most closely to the Government's 'Prevention and Early Detection' priority outcome; and the Acute and Restorative Care goal of the Healthy Ageing Strategy.)

This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes)

DHB activity	Milestone	Measure	Government theme: Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
			We live longer in good health	Ensure everyone who is able to, is earning, learning, caring or volunteering
1. Our Southern Falls and Fracture Prevention Steering Group will continue to work with ACC, HQSC and the Ministry of Health to promote and increase enrolment in S&B programs and improvement of osteoporosis management especially in alliance with Primary Care as reflected in the associated "Live Stronger for Longer" Outcome Framework by • Hold a sector-wide Forum Q2 • Update our Sector Wide Falls and Fractures Prevention Workplan Q4	Sector-wide forum held by Q2 District-wide Falls plan updated by Q4	SS04: Delivery of actions to improve wraparound services for older people # of people assessed by primary care for falls risk to meet target of 1052 in 19/20 Decrease our number of over 65 neck of femurs		
2. Establish the OPAL (Older Personal Assessment & Liaison) Unit at Dunedin Hospital which provides a quick turn-around admission to reduce harm events (eg falls) and deconditioning	Unit established by Q1			
3. Align local DHB service specifications for home and community support services (HCSS) to the vision, principles, core components, measures and outcomes of the national framework for HCSS • Request for Proposal (RFP) for Home and Community Support Services (HCSS) on Government Electronic Tenders Service (GETS) Q2. New HCSS contracts include new service spec HCSS RFP includes National Framework principles. Commence new HCSS on 1 July 2020. • Through the RFP process, ask providers to demonstrate how they will configure services to be responsive to the needs of Māori (EOA) • RFP evaluation panel to include Māori Health Directorate representation • Contribute to and use updated national service specification in new contracts	RFP Q2 New HCSS commences 1 July 2020	HCSS RFP on GETS Q2 New HCSS Contracts include new service spec by Q3		
4. Identify and address the drivers of acute demand for people 75 plus presenting at ED (or at lower ages for disadvantaged populations (EOA) • Develop and implement solutions from "ED presentations from ARRC" Work - Use 'Plan, Do, Study, Act' PDSA to test solutions to ED Presentations from ARRC by Q1	PDSA used to test solutions to ED presentations by Q1 PDSA used to test new HOME	Reduce the number of ED		

• HOME Team to continue service development using PDSA to test new innovations Q3	Team innovations Q3	presentations from ARRC residents in Dunedin and Southland EDs (16/17: 1597 17/ 18: 1708) by 10% on each ED site. Target for 19/20 Dunedin: 974 Southland: 563		

Improving Quality Identify actions to improve equity in outcomes and patient experience by demonstrating planned actions to: • work to improve equity in outcomes as measured by the Atlas of Healthcare Variation (DHB to choose one domain from: gout, asthma, or diabetes) • improve patient experience as measured by your DHB's lowest-scoring responses in the Health Quality & Safety Commission's national patient experience surveys Please ensure that the local measure included in your plan relates to the action in your plan. Note: Please reference your jointly developed and agreed System Level Measure Improvement Plan that is attached as an Appendix. <u>System Level Measures</u> Implementation of the System Level Measures (SLMs) continues in 2019/20. The *Guide to Using the System Level Measures Framework for Quality Improvement* (SLM guide), which has been updated and should be used for the development of the Improvement Plans and should be used in conjunction with *The System Level Measures – Annual Plan guidance 19/20*. <u>Antimicrobial resistance</u> High quality health care needs to address the challenge posed by antimicrobial resistance to current and future care pathways. Hospitals, primary care and residential care settings all need to ensure that front-line infection prevention and control practices are implemented continuously, effectively and consistently. DHBs need to continue to align their activities with the *New Zealand Antimicrobial Resistance Action Plan* (MoH 2017).			**This is an equitable outcomes action (EOA) focus area** (equity focus and clear actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs)
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**
1. Work to improve equity in outcomes as measured by the Atlas of Healthcare Variation			

• A new Local Diabetes Team (LDT) will be formed in the Southern DHB in Q1. This group will oversee the assessment, implementation and measurement of any change to current Southern DHB Diabetes pathways and services. Particular focus will be on the standards where the DHB we found to have gaps, following The Diabetes Standards 2016, MoH Review. - Update LDT Terms of Reference Q1	LDT ToR updated Q1 LDT TOR is finalised Q1 MoH is provided with ToR at the end of Q1	Diabetes action plan finalised by Q4 (EOA)	**System outcome** We live longer in good health	**Government priority outcome** Support healthier, safer and more connected communities
2. Improve patient experience as measured by your DHB's lowest-scoring responses in the Health Quality & Safety Commission's national patient experience surveys: Did a member of staff tell you about medication side effects to watch for when you went home? • Finalise service specification for joint medication clinic run by the University of Otago Pharmacy School Q1 • Finalise referral pathways for entry into clinic Q1 • Analyse referral volumes into the joint medication clinic by ethnicity (EOA) Q1-Q4	Service specification finalised Q1 Referral pathways finalised Q1 Analysis of referral volumes Q1-Q4	Referral volumes into the joint medication service Volumes of Home Team referrals with intervention by Clinical Pharmacist Service		
3. System Level Measures (SLM) • See the 2019-20 SLM Implementation Plan attached to the Annual Plan				
4. Antimicrobial resistance • Antimicrobial Consumption Q2 - Undertake audit using National Antimicrobial Prescribing Audit (NAPS) template. - Data extraction from electronic prescribing and administration system link with iPM data Q2 • Antimicrobial Consumption Q3 - Extract bulk data from pharmacy dispensing system for inpatient antimicrobial consumption during 2018 Q3 - Create standardised report using defined-daily doses (DDD) for year-to-year comparison Q3 • IV-to-Oral SWITCH Campaign Q1 - Design and implement an IV-to-oral switch audit to collect baseline data when - Design IV-to-oral SWITCH campaign documentation when - Educate and enlist ward pharmacists to continue to promote this activity when • Metronidazole Dosing - Prescriber education around metronidazole prescribing, focusing on twice daily versus thrice daily dosing, and oral rather than intravenous dosing where possible Q1 - Ongoing mini-audit of prescribing practices • Outpatient Parental Antibiotic Therapy Audit Q1 - Extract bulk data for outpatient parental antibiotic over the last two years Q1 • Outpatient Cellulitis Pathway Audit - Audit consumption of dispense cefazolin for outpatient cellulitis pathway and estimate cases treated Q4 • High-cost antifungal Audit Q2 - Review antifungal use in Dunedin Intensive Care Unit (ICU). Evaluate if restriction of sputum Candida reporting has impacted antifungal use Q2 • HML compliance audit Q3	Results analysed and compared with previous year audit Data extract Q3 IV Oral Switch campaign launched Q1 Data extracted and reviewed Q1 Audit undertaken Q1 Audit undertaken Q4 Audit undertaken Q2 HML Audit undertaken	Report about defined-daily doses (DDD) for year-to-year comparison Q3 IV Oral Switch campaign completed Q1 Reduction in thrice daily Metronidazole Dosing Granular data on use and duration of OPAT Q1 Audit results analysed Q4 Audit results analysed Q2		

5. Primary Care • SDHB Antimicrobial Stewardship Group to include primary care representative by Q2 • Monitor resistance patterns for antibiotics in the community through annual review of antibiograms Q4 • Health Pathways content on IPC reviewed and updated as required by Q4 6. Residential care • Encourage hospitals and aged residential care facilities to use the Australian Commission on Quality and Safety in Health Care, for messaging the appropriateness of their antimicrobial consumption - Email all Aged Residential Care (ARC) facilities to encourage use of the Australian Commission on Quality and Safety in Health Care in relation to antimicrobial consumption by Q2 - Communicate with ARC facilities at regular forums to encourage use of the Australian Commission on Quality and Safety in Health Care in relation to antimicrobial consumption, by Q4	Q3 Primary care rep on Stewardship Group Q2 Review of antibiograms Q4 Health Pathway content reviewed by Q4 Facilities emailed by Q2 Communication with ARC facilities at forums by Q4	HML Audit results analysed Q3		

Cancer Services

Cancer is the leading cause of morbidity in New Zealand, accounting for nearly one third of all deaths with 22,000 new cases diagnosed each year. Inequalities between Māori and non-Māori persist. Māori have a higher incidence of many cancers, are diagnosed with more advanced cancers, experience issues that impact on treatment options and are 1.7 times more likely to die from cancer than non-Māori New Zealanders.

Key strategies and plans to help inform DHB Annual Plans are listed below:

- New Zealand Cancer Plan
- Cancer Health Information Strategy
- National Radiation Oncology Plan

DHBs will describe and implement improvements in accordance with national strategies and be able to demonstrate initiatives that support key priority areas as outlined below. All initiatives will demonstrate clear strategies for addressing Māori health gain, equitable and timely access to services and the use of data to inform quality improvement across those initiatives.
DHBs will describe actions to:

- ensure equity of access to timely diagnosis and treatment for all patients on the Faster Cancer Treatment (FCT) pathway (e.g. system/service improvements to minimise breaches of the 62 day FCT target for patient or clinical consideration reasons)
- each DHB is expected to identify two priority areas for quality improvement identified in the Bowel Cancer Quality Improvement Report 2019 (the Report). DHBs received the draft Report in October 2018. Each DHB is expected to review their results and identify two areas for service improvement that are focused on improving outcomes for people with bowel cancer in their DHB area. DHBs are required to provide evidence that priorities have been identified and will be addressed. These activities could include service improvement initiatives undertaken at a regional or national level; particularly where the DHB relies on the wider region to undertake improvements in the areas it has identified. (new)
- Commit to working with the Ministry of Health to develop a Cancer Plan. Commit to implement and to deliver on the local actions from within the Cancer Plan. New guidance May 2019)

This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health)

DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Enable equity of access to timely diagnosis & treatment for all patients on the Faster Cancer Treatment (FCT) pathway (EOA): • Undertake system/service improvements to deliver the FCT target including systematic approach to monitoring and acting on 62 day pathway breaches - Implement 2+2 strategy (all patients First Specialist Assessment (FSA) within 2 weeks and then to start treatment within 2 weeks) for all patients but starting with pilot for colorectal cancer Q2 - Undertake work with Southern Cancer Network (SCN) on implementation of FCT indicator on patient's records Q1 - Support clinical staff to gain visibility of cancer patients on both 62-day and 31-day FCT pathways - Accurate collection and reporting of ethnicity data for FCT to assist in the development of an electronic flag to the Southern DHB Māori Health Units for patients that are newly diagnosed that identify as Māori Q1-Q4 - Develop an electronic flag to alert Southern DHB Māori Health Units patients that are newly diagnosed that identify as Māori Q3 • Enhance cultural pathways through the FCT journey (EOA) Q2	2+2 strategy implemented for colorectal cancer pilot by Q2 Work with SCN on implementing FCT indicator on patient's records undertaken Q1 Electronic flag developed Q3 Māori Cancer Nurse	SS01 Faster Cancer Treatment (31 day indicator) SS11 Faster cancer treatment (62 day indicator)	**System outcome** We live longer in good health **System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities

• Improve resource for FCT and cancer nurse coordinators in the DHB to determine gaps, make improvements in pathways and increase supportive care • Appoint Māori Cancer Nurse Coordinator by Q3	Coordinator appointed by Q3			
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) Q3-Q4 - Contribute to MO data base to determine & reduce variations in care across NZ - Institute a Bone and Soft tissue Stereotactic Ablative Body Radiotherapy (SABR) Multidisciplinary Meeting (MDM) to reduce delays and expedite decision making Q4 - Implement clinical quality and safety programmes in conjunction with Radiation Therapist (RT) and physics to improve quality and safety Q1 - Implement strategies to reduce variation and maximise use of the available capacity for early stage breast cancer Q1-Q4 - Implement the Improving the Cancer Pathway for Māori Plan Q1-Q4 (EOA) - Monitor and navigate Māori newly diagnosed with cancer Q1-Q4 (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 (RO) National Plan 2017-2021 Q2 - Implement the RO plan by Q4 • Collaborate with Southern DHB Māori Health Units to ensure equitable access for Māori and enhance the cultural competency of the health workforce Q1-Q4 (EOA)	Bone and Soft tissue SABR MDM commences Q4 Strategies implemented for early stage breast cancer Q1-Q4 Implementation of Improving the Cancer Pathway for Māori Plan Q1-Q4 Implement the RO plan Q4 SDHB MDMs moved across to the HCS version by Q1			
3. Cancer Information Strategy • Participate in South Island (SI) alignment of digital systems to collect and report consistent, accessible and accurate cancer data Q2 • 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) Q2				
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 - Implement the Primary Community Strategy to ensure maximal use of primary health community follow up, promote collaboration with Cancer Society and Phys Ed school to increase utility of Bridge to Health and EXPINKT exercise programs Q1 - Expand EXPINKT exercise program to Queenstown Lakes area Q1 - Business Case Proposal for ongoing funding for psycho-social initiatives - CPSSS beyond 2020, to continue to increase access for patients Q1 • 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 Q2	Report of end of treatment services provided Q1-Q4 ExpandEXPINKT exercise program to Queenstown Lakes area Q1			

5. Participate in SI Cancer Service Reducing Inequities Equitable Access & Outcomes • 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) - Implement videoconference (VC) clinics commencing with Southland Q4	VC clinics commenced, beginning in Southland Q4			
6. Priority areas for quality improvement identified in the Bowel Cancer Quality Improvement Report 2019 • Measure & report on the percentage of people with rectal cancer receiving short course pre-operative Radiation Therapy, identifying referral to treatment wait-times and ethnicity to assess any areas for improvement • Measure & report on the percentage of people with rectal cancer receiving long course pre-operative Radiation Therapy +/- Chemotherapy, identifying referral to treatment wait-times and ethnicity to assess any areas for improvement • Undertake analysis of the of the quality indicator 'stoma free survival post surgery' as highlighted in the Bowel Cancer Quality Improvement Report 2019 • Hold stakeholder meetings to identify data, analysis and review issues Q1 • Undertake analysis by site (Dunedin and Invercargill) to identify issues and risks. Q2 & Q3 • Agree recommendations with stakeholders (with timelines) Q4	Q1-Q4 measure data and identify any areas for improvement Stakeholder meetings held Q1 Analysis (DN and INV) Q2 and Q3 Recommendations agreed Q4	Access Radiation Ocology Collection (ROC) data for reporting		
7. Work with the Ministry of Health and the Southern Cancer Network to develop a Cancer Plan. Commit to implement and to deliver on the local actions from within the Cancer Plan Q4	Identify local actions within the Cancer Plan by Q4			

Bowel Screening

New Zealand has one of the highest rates of bowel cancer in the world. Bowel cancer is the second most common cause of cancer death in New Zealand, after lung cancer, with the third highest bowel cancer death rate in the OECD for women and the sixth highest for men. The National Bowel Screening Programme aims to reduce the mortality rate from bowel cancer by diagnosing and treating cancers at an earlier more treatable stage. Early identification and removal of precancerous advanced bowel adenomas aims to reduce bowel cancer incidence over time.

Achieving equitable access is a key priority for the bowel screening programme because participation rates for Maori, Pacific and people living in our most deprived areas remain lower than other groups.

The National Screening Unit is implementing an Equity and Performance Matrix in the annual planning reporting process.
The Matrix measures both performance against a target and the equity gap between population groups notably, but not limited to, Māori and non-Māori.

The Ministry of Health, DHBs and the National Coordination Centre all have an important role in ensuring that participation targets are achieved and in eliminating equity gaps between Maori and non-Māori, Pacific and non-Pacific/non-Māori.

It is important that diagnostic colonoscopy wait times are not negatively impacted when the bowel screening programme is implemented. To monitor and manage the diagnostic colonoscopy (urgent, non-urgent and surveillance) wait time indicators the National Bowel Screening Programme adopted the 2018/19 Elective Funding and Performance Policy. The Policy's escalation process has been adapted to include an Amber zone (tolerance period) and to enable alignment with DHB non-financial quarterly reporting requirements.

All DHBs will describe actions to:

- Ensure diagnostic colonoscopy wait time indicators are consistently met; this requires active management of demand, capacity and capability.

DHBs providing the National Bowel Screening Programme will describe actions to:

- Implement initiatives that contribute to the achievement of national targets for NBSP. All initiatives will demonstrate clear strategies for increasing health gains for priority groups and improving equitable participation and timely access to services.
- Ensure screening colonoscopy wait time indicators (indicator 306: time to first offered diagnostic assessment) is consistently met.
- Achieve participation of at least 60% of people aged 60-74 years in the most recent 24 month period.
- Ensure participation equity gaps are eliminated for priority groups.

Improvement activities must be supported by visible leadership, effective community engagement, and clear accountability for equity. Activities must be SMART ie, specific, measurable, achievable, realistic and have a time frame.

This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes)

DHB activity	**Milestone**	**Measure**	**Government theme:**
Colonoscopy wait time indicators			**Improving the well-being of New Zealanders and their families**

1. Adhere to a robust, consistent and transparent process for referral triage and prioritisation, ensuring maximal use of available operational time by flexible rostering of endoscopists and provision of additional out-of-hours endoscopy lists Q1-Q4 2. Continue to train two non-medical two endoscopists Q1-Q4 3. Increase capacity by opening another endoscopy room in Dunedin by Q2 **Equitable access** 1. Monitor participation in the National Bowel Screening Programme (NBSP) to identify any equity gaps Q1-Q4 2. Put additional supports in place where inequities in participation are identified • This may include targeted promotion of the programme through local media, additional advertising, meetings with relevant local groups and other strategies appropriate to the populations in question. It may also include the development of additional informational resources Q1-Q4 (EOA) 3. Community engagement • Continue engagement with priority populations directly Q1-Q4 (EOA) • Continue engagement through community-based Māori and Pacific providers under contract to WellSouth for promotion of the programme to clients and communities Q1-Q4 (EOA)	Colonoscopy wait time indicators are met Q1-Q4 Endoscopy room opened in Dunedin by Q2 All priority populations meet at least the 60% indicator for participation, Q1-Q4	S15: Improving waiting times for colonoscopies R Shiny participation data shows participation at least 60% for priority populations	**System outcome** We have health equity for Māori and other groups **System outcome** We live longer in good health	**Government priority outcome** Support healthier, safer and more connected communities

Workforce

In responding to this priority area please cross-reference to Section four: Stewardship - Workforce section

DHB workforce priorities

Set out any workforce actions, specific to your DHB that you intend to work on in the 2019/20 planning year. Outline how these actions relate to both a strong public health system and EOA focus area actions. Ensure that you have considered workforce actions for the priority areas in your plan, especially mental health and child health.

Any workforce actions should be mindful of:

- Ongoing responsibilities for the upskilling, education and training of health work forces
- The population health need that initiatives are designed to address
- The desired health outcomes the initiatives will help to address, including equitable outcomes for populations
- An assessment of how the initiatives align with the priority areas of strong fiscal management, strong public health system, and primary care
- Evidence that consideration has been given to making best use of the service delivery mechanisms that make best use of interdisciplinary teams to support health workforces in their roles across primary, secondary and tertiary settings.

DHBs are expected to develop a sustainable approach to nursing career pathways.

- In 2019-20, it is expected that DHBs will develop actions that support equitable funding for professional development for nurse practitioners.

Workforce Diversity

This action area builds upon actions set out in the 2018/19 Regional Services Plans to better understand the workforce intelligence gathered at local, regional and national levels and how this intelligence assists DHBs in workforce planning.

DHBs will work in collaboration with DHB Shared Services and, where appropriate, with the Ministry of Health to:

- identify workforce data and intelligence that is collected across services and DHB areas, understanding workforce trends to inform workforce planning
- understand the workforce data and intelligence requirements that best supports DHBs in order to undertake evidence-based workforce planning
- support your responsibility to upskilll, provide education and train health work forces
- provide training placements and support transition to practice for eligible health work force graduates and employees. Planning must include PGY1, PGY2 and CBA placements, and how requirements for nursing, allied health, scientific and technical health work forces in training and employment will be met
- form alliances with training bodies such as educational institutes (including secondary and tertiary), professional colleges, responsible authorities, and other professional societies to ensure that we have a well trained workforce.

Health Literacy

The purpose of the actions set out in this advice is to build upon the health literacy review that your DHB completed in the 2018/19 planning year towards developing a health literate organisation.

As a result of the health literacy review, and if you do not have one already in place, develop a Health Literacy Action Plan that describes the service improvements you plan to make in the short, medium and long term.

Outline any actions within the Health Literacy Action Plan that support a health system focus on:

This is an equitable outcomes action (EOA) focus area

(equity focus and clear actions to improve Māori health outcomes)

Examples of equity actions that could be included in your plan:

- increase Māori participation and retention in health workforces and ensure that Māori have equitable access to training opportunities as others
- build cultural competence across the whole health workforce
- increase participation of Pacific people in health workforces
- form alliances with educational institutes (including secondary and tertiary) and local iwi to identify and implement best practices to achieve Māori health workforces that matches the proportion of Māori in the population.

- services being easy to access and navigate
- effective health worker communication
- clear and relevant health messages that empower everyone to make informed choices.

Where health literacy actions are set out in other sections of the annual plan ensure that these are considered within the Health Literacy Action Plan, as well as briefly cross-referencing these actions in this section.

Workforce	**Milestone**	**Measure**	**Government theme: Improving the well-being of New Zealanders and their families**	
			System outcome We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
1. Interprofessional care/integrated agency care - Deliver services where care is provided by the right person (not a specific profession), in the right place at the right time. • Redesign Workforces based on 'valuing patients time' programme of work, and new models of care - Identify geographic location and skill set deficits to deliver future service models including targeting staff to develop extended scope of practice Q3 - Co-design with Unions a process of service reviews and benchmarking to ensure multi-disciplinary resources across the health system are aligned Q2 • Prepare to implement redesign - Implement learning and development opportunities to strengthen inter-professional teams and working relationships across the health system Q2 • Co-develop Partners - Work in partnership to strengthen the skill levels of our partners (social services, NGO, Ngai Tahu, Education and Research Q4	Geographic location and skill sets identified Q3 Service review and benchmarking co-designed Q2 Learning and development opportunities implemented Q2 Work undertaken to strengthen skills of partners Q4	Report on activities in Annual Plan		
2. People Planning - Work with, and develop our people to proactively manage recruitment and retention to fit the workforce plan and future need. • Identify and build talent architecture - Identify talent architecture and develop strategies to meet the core areas of talent needs. Develop and implement 'Sourcing Strategy' and align this to new models of care associated with new hospital redevelopment Q2 - Broaden Equitable Outcome Actions (EOA) for diversity (Māori, Pacific, Disability, Peer, New Migrant) using tools such as matrix of staff group Q3 • Use Data to Support Diversity -Complete gap analysis across the workforce for succession planning (by locality) and update workforce data across the whole of system e.g.: ethnicity, disability, gender and age (EOA) Q3 • Address Shortages - Stocktake, plan for and target current specialist shortages Q2 • Disability Support Services (Also refer to Disability Template) - Develop a disability action and communications plan to raise awareness for staff and communities and investigate different methods of communicating with different members of the public which provided information on what might be important to consider when interacting with a person with a disability Q3 - Develop a disability awareness programme for staff to increase awareness and training on identification of disability support needs and the impact on recovery from acute medical conditions Q4	Sourcing strategy Q2 Use of tools to broaden EOA Q3 Gap analysis Q3 Stocktake to address shortages Q2 Disability Action Plan created Q3 Disability awareness programme created Q4			
3. Making Changes Stick/ Accountability - Engage workforce in decision making that results in efficient and effective organizational processes.				

• Systems to Enable Action - Connect the dots – Communications and systems that make connections between operational plans and strategies Q3 • Make changes to workforce culture - Improve workplace culture changes i.e. social media impact, living the values linked to Southern Future Programme of work. Q1-Q4 - Empower staff to make decisions and change – delegations at the right level and culture of trust and accountability Q1-Q4 • Implement Pathway for Primary and Community Care Strategy - Invest in workforce planning as an enabler for the step change required to implement the P&C Strategy. This includes defining how we work in Southern, being open minded in how delegations work, reviewing how initiatives are flexibly funded and being open to different workforce configurations within Community Health Hubs Q1-Q4 • Digital Upskilling - Increase digital literacy for workforce, support the workforce to better understand the benefits and values Q3 - Educate the workforce on technology; obtain feedback on the Digital Strategy Q3	Connect the dots Q3 Programmes undertaken to effect workforce culture changes Q1-Q4 Investment in workforce planning Q1-Q4 Digital literacy increased Q3 Workforce education Q3			
4. Leadership and Change - Foster leadership that drives forward transformation of Southern Health and excites and empowers staff in the services that we will provide. • Clarify Managerial Accountability - Clarify roles and responsibilities of organisational units and managers; devolution of decision making Q2 • Reduce Isolation - Engage staff in understanding our vision and defining how we will implement it Q2-4 - Reach consistency and agreement on 'How we work together at Southern' e.g.: staff as inter-professional teams. Planning what is most appropriate for the future not replacing like for like, Funding that fits that population Q2-4 - Reduce geographic and professional isolation by building on personal connections and working on collaborative projects Q2-Q4 • Change leadership - Provide change leadership training to first and second line managers where there is a responsibility for driving change Q1	Managerial accountability clarified Q2 Programmes undertaken to reduce staff isolation Q2-Q4 Leadership training provided Q1			
5. Highly Valued Staff - Be a health system that recognizes that staff are highly valued (it is through staff that we will work in partnership with our people) • Make changes to support recruiting and retaining staff - Encourage recruitment, retention and leadership development for all staff Q1 - Create an environment that is attractive and healthy for all staff while acknowledging the changing age demographic Q1 - Work with Unions to co-create flexibility and staff autonomy in the workplace Q1 • Make changes that respond to staff needs - Support staff/families with childcare arrangements Q1 - Annual staff engagement survey as a measure of positive staff culture Q1-Q4 - Implement improvements associated with seven staff priority areas Q1-Q4 • A High performing service - Co-design (high performance, high engagement) a process with Unions that brings together improvement work in key service delivery areas ensures staff are satisfied that they are providing effective and efficient care Q1	Changes made to support recruitment and training of staff Q1 Changes made to respond to staff needs Q1-Q4 Co-design process Q1 Reviews for key service areas Q1-Q4			

- Run a series of reviews for key service areas which applies and refines the process with accountability through change delivery framework Q1-Q4				
6. People Partnership - Grow a workforce that empowers our people to take charge of their own care • Patient Participation in Care - Implement active patient participation and partnership model (develop and implement self-management tools) working alongside the Community Health Council Q1 • Southern Health System Workforce Development - Work in partnership with healthcare and tertiary providers to develop an integrated workforce Q3 • Build the primary and community care workforce - Define the scope and objectives of the shared health and business intelligence function, including an equity approach to support improving access and outcomes for Māori and rural populations (Q3) - Partner with tertiary and education providers to ensure a sufficient future supply of primary and community care professionals aligned with desired models of care and future demand, and to better support teaching and learning (Q2) - Promote and invest in growing Māori and Pacifica primary and community care workforce in partnership with education providers Q2 (EOA) • Identification of actions needed to develop the workforce culture required to deliver on the Strategy - Develop a values-based charter that outlines the expected behaviour of all workforce participants Q1 - Develop mandatory education modules to train all workforce members on values based ways of working, and engaging in a respectful way with Māori people, understanding their world view to enable the delivery for culturally appropriate care Q1 (EOA)	Implementation of active patient participation model Q1 Workforce development to develop integrated workforce Q3 Partnership with tertiary and education providers Q2 Investment in Māori and Pacific workforce Q2 Value based charter developed Q1 Mandatory education models created Q1			
7. Develop a Nurse Practitioner (NP) professional development guideline that recognises the support required and ongoing continuing education needs for this advanced scope of practice • Work with other DHBs to ensure the development of a guideline that is consistent and equitable Q1 • Develop draft guideline, with consideration of any equitable funding implications Q2 • Finalise and approve guideline for 2020/21 Q3 • Prioritise ongoing funding for Nurse Practitioner professional development through the Nursing Study and Conference Leave Budget, Q1-Q4. Funding will be available upon application. • Undertake further work to identify and increase specific funding allocations for Nurse Practitioners from 20/21 to reduce inequities (Q4)	Guideline finalised and approved for 2020/21 Q3 NP funding allocated Q1-Q4, upon application. Specific funding identified for NPs professional development from 20/21, by Q4			

Health Literacy Action Plan				
1. Targeted focus on public education about the core role of primary care, including when, how and where to access services for urgent needs (to be confirmed on 21 March) • 'Plan to be well this winter' campaign - Key messages about preventing serious illness through public education around the where and how to access services. - Inclusion of Healthy Home messages - Proactive management of long-term conditions • ED Performance Improvement Steering Group provides guidance, leadership and coordination of current and new initiatives to improve Dunedin ED Shorter Waiting Times Target Q1-Q4 • Promotion of influenza vaccine to over 65s - Support community pharmacists in their contracting with Southern DHB to deliver influenza immunisations for those over 65 years of age Q1-Q4	'Plan to be well this winter' campaign Q1 Community pharmacists supported in SDHB contracting to deliver influenza vaccine Q1-Q4	Report on activities in Annual Plan Decrease in number of ED attendances Number of patients through winter clinics Influenza vaccine uptake		
2. Expand and enhance consumer portal access • WellSouth to work with GPs to increase uptake of patient portals and GP portal enrolment Q1-Q4 • Expand and enhance consumer portal access to provide consumers with access to all of their health information and care team Q1-Q4 - Consumer access expanded to virtual health consultations through patient portals (e.g. email, video, telephone, appointment bookings) Q1-Q4	GP portal enrolment increased Q1-Q4 Consumer portal access expanded Q1-Q4	Portal usage by patients reaches 20% by Q4 Portal GP enrolment to 65% by Q4 Practices offering virtual consults to 20% Q4		
3. Explore and progress peer support approaches (for example consumer networks for mental health issues and addictions • Symposium on Peer Support Networks to grow mental health and addiction understanding of peer support roles Q2 • Work to improve connections to community resources – including existing social networks through networks such as hapu, faith-based and LGBTTi (lesbian, gay, bisexual, trans, takatapui and intersex) EOA Q1-Q4 and ongoing	Peer workforce focus of Network Leadership Group Activity Q1-Q4 Symposium Q2 Work undertaken to improve connections to community resources Q1-Q4	Report on activities in Annual Plan Number of consumers participating in consumer networks, group sessions and social media		
4. Develop a Southern District Heath Promotion Strategy by Q4	Health Promotion Plan developed by Q4			
5. Develop the health literacy competencies of the health workforce to become increasingly culturally competent (long term – 36 months) • Work alongside tertiary organisation to support and grow diversity and cultural competency and execute the cultural education programme e.g. Kia Hauora Hauora and	Cultural education programme executed Q1-Q4	Report on activities in Annual Plan		

Tū Tauira Hauora programmes of work within the Otago University Q1-Q4 and ongoing continuing through financial year (FY) 21/22 (EOA) • Refer Workforce Template					
6. Develop the health literacy competencies of the health workforce (disability) • Develop a Disability Communications Plan to raise awareness for staff and communities and investigate different methods of communicating with different members of the public which provides information on what might be important to consider when interacting with a person with a disability Q3 • Develop programme for staff to increase awareness and training on identification of disability support needs and the impact on recovery from acute medical conditions Q4 • Offer a disability awareness programme via e-learning for front line staff and clinicians to increase awareness and training on identification of disability support needs Q4 • Refer Disability Template	Disability Communications Plan created Q3 Disability awareness programme created Q4 Offer an e-Learning module Q1-Q4, with 85% of staff having undertaken training by Q4	Number and percent of staff completing e-training Report on % of staff who completed training by end of Q4			
7. Undertake actions to foster a workforce culture that is consumer-focused, including promoting health literacy and self-care • Implement active patient participation and partnership model (develop and implement self-management tools) working alongside the Community Health Council Q1-Q4 FY19/20 and FY20/21 (24 month programme)	Patient participation and partnership model implemented Q1-Q4 FY19/20	Report on activities in Annual Plan			
8. Empower consumers, whanau and communities to drive and own their own care • Enhance health literacy through facilitating consumer access to Southern district health information websites (Health Info and Healthpoint) • Maintenance/update and continued improvements of Southern district website (Southernhealth.nz), including Healthpoint Q1-Q4 • Southern DHB info on Health Info localised and updated as required Q1-Q4	Continued improvements of Southern district website Q1-Q4 SDHB info on Health Info localised and updated Q1-Q4	Report on activities in Annual Plan			

Data and Digital

In responding to this priority area please cross-reference to Section four: Stewardship - IT section

All DHBs:

- Demonstrate how you are improving equity in your current and future digital systems/investments
- Indicate plans for complying with approved standards and architecture in all future systems/investment
- Indicate plans for the provision of health services (such as public health, mental health, child wellbeing, primary care) via digital technology across the health system; for example telehealth, integrated care and working remotely.
- Explain how your IT Plan is aligned with the Regional ISSP including your risk mitigation.
- Demonstrate where you are aligning with national/regional initiatives and those leveraging investments.
- Demonstrate how you plan to implement Application Portfolio Management including the lifecycle for IT systems i.e. planned upgrades, support, licence renewal, etc.
- Submit quarterly reports on the DHB ICT Investment Portfolio to Data and Digital to support decision making and to maximise the value of sector ICT investment

Demonstrate how you will incorporate IT security maturity improvement across all your digital systems.

Additional actions for Southern DHB:

- Indicate progress for business cases approved in 2018/19
- Indicate plans for the implementation of the SI PICS in the Southern DHB
- Indicate plans to implement the plan developed in 18/19 to expand and enhance access to the consumer portal
- Indicate plans regarding the digitalisation to be included in the new hospital build.

This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes

DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Indicate progress for business cases approved in 2018/19. • Radiology Information System (RIS) Business Case fully approved. Project initiation commenced April 2019 • Public Website – Project is underway with a go live of the end of April 2019 • Recruitment System for all employees – RFP process has just closed and we have shortlisted down to two providers. Once this selection is made a Business Case will be completed and submitted for approval end of April 2019. • Wifi - RFP process has just closed and we have shortlisted down to three providers. Once this selection is made a Business Case will be completed and submitted for approval. • Tap2Go – RFP complete and vendor chosen. Project starts in April 2019 with pilot group go live end of May 2019. Capex budget request for 19_20 for further rollout to the organisation. Tap2Go pilot go live May 2019 • Digital Signage – Phase 1 is complete, Phase 2 rollout is underway and scheduled for completion by Q1. Shift to business as usual (BAU) over the next 6months. • E-Pharmacy – Pending internal approvals the Business Case has been completed with an anticipated start date of May 2019 with an expected implementation of 8 months. Go live is planned for end of January 2020. • Paging Replacement – Business Case, project underway. Go live end of April 2019.	Quarterly reports submitted on the DHB ICT Investment Portfolio to Data and Digital to support decision making and to maximise the value of sector ICT investment Q1-Q4 Digital Signage Phase 1 completion by Q2 E-Pharmacy go live by Q3	Report on activities in Annual Plan	**System outcome** We live longer in good health	**Government priority outcome** Support healthier, safer and more connected communities

2.	Indicate plans for the implementation of the SI Patient Information Care System (PICS) in the Southern DHB • Draft Business Case has been developed from a technology perspective and we are working with the organisation to understand the change impact and associated costs. - Business case for SI PICS in Southern DHB completed by June 2019				
3.	Indicate plans to implement the plan developed in 18/19 to expand and enhance access to the consumer portal • The consumer portal project is managed by WellSouth and funded by Southern DHB and the implementation design and plan is still being developed (Refer to Health Literacy Action Plan)				
4.	Current plan: Displaying of selective secondary data (i.e. Southern DHB future appointments in read only) • Roadmap: - Expanding to other secondary information (possible examples: education materials (i.e., discharge instructions), summaries of clinical notes, secondary meds). Expansion to secondary information systems by April 2020. - Booking appointments – giving the patient the ability to interact with secondary systems to schedule / change their appointment -	Expansion to secondary information systems by Q4			
5.	Indicate plans regarding the digitalisation to be included in the new hospital build. • Continue to focus on the rollout of 'paper light' strategic projects including e-Pharmacy, Epiphany (regional Electrocardiograph ECG repository), RIS, Electronic Request Management System (ERMS) Phase 3 (e-Triage) and SI PICS. Roll out of 'paper light' strategic projects over the next 12 to 24 months • Workshops to be held with Clinicians through to Sept 2019 to identify new models of care and technology requirements for the new Digital Hospital.	Reports on roll out of 'paper light' strategic projects Q1-Q4 Workshops with clinicians Q1			
6.	Southern DHB is the pilot DHB for the Digital Maturity Assessments being undertaken in March 2019 alongside Healthcare Information and Management Systems Society (HIMSS) and the MoH; we expect actions to come out of this assessment that will inform the plans regarding the digitisation of the new hospital				
7.	Demonstrate how you are improving equity in your current and future digital systems/investments: • As part of our RFP processes we review any solution from any equity perspective to ensure fair and equal access	Architectural review includes this measure			
8.	Indicate plans for complying with approved standards & architecture in all future systems/investment: • Architectural review is now included as standard in our RFP process and are aligned to national standards and guidelines	Architectural review of new solutions			
9.	Indicate plans for the provision of health services (such as public health, mental health, child wellbeing, primary care) via digital technology across the health system; for example telehealth, integrated care & working remotely:				

• Southern supports working remotely and also offers Telehealth where appropriate. Work is just starting on reviewing the Mental Health solutions to enable better outcomes for all. Our Telehealth programme is currently under review to see how we can maximise the opportunity. 10. Explain how your IT Plan is aligned with Regional ISSP including your risk mitigation: Southern continues to work closely with the South Island Alliance Programme Office to ensure alignment & risk mitigation for all national/regional initiatives. Current examples of this are ePharmacy, SIPICS 11. Demonstrate where you are aligning with national/regional initiatives and those leveraging investments: • Southern continues to work closely with the South Island Alliance Programme Office to ensure alignment & risk mitigation for all national/regional initiatives. Current examples of this are ePharmacy, SIPICS 12. Demonstrate how you plan to implement to implement Application Portfolio Management including the lifecycle for IT systems i.e. planned upgrades, support, licence renewal, etc.: • Portfolio management resources have been created to provide a roadmap with timeframes for upgrades, replacement or redundancy. 13. Demonstrate how you will incorporate IT security maturity improvement across all your digital systems: • Architectural review is now included as standard in our RFP process and are aligned to national standards and guidelines. Additionally we are conducting annual penetration testing against our perimeter firewalls and cloud risk assessments on all cloud hosted solutions.	Mental Health solution kick off in 2018/19 Telehealth review underway with output expected Q1 ePharmacy project kick off Q1 SIPICS business case in 2018/19 Ongoing activity that feeds into our Long Term Investment Plan and budgetary processes Penetration testing results are available on request			

<table>
<tr><td colspan="3">Collective Improvement Programme
• Commit to supporting a collective improvement programme.</td><td colspan="2">This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs)</td></tr>
<tr><td>DHB activity

1. Commit to supporting a national collective improvement programme when developed</td><td>Milestone</td><td>Measure

SS16: Delivery of Collective Improvement plan</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td rowspan="2"></td><td rowspan="2"></td><td rowspan="2"></td><td>System outcome
We have improved quality of life</td><td>Government priority outcome
Ensure everyone who is able to, is earning, learning, caring or volunteering</td></tr>
</table>

Delivery of Regional Service Plan (RSP) Priorities Identify any significant actions the DHB is undertaking to deliver on the Regional Service Plan. Please provide actions for the following: Implementation of the New Zealand Framework for Dementia Care • provide input into a regional stocktake of dementia services and related activity, which will be completed and provided to the Ministry by the end of quarter two (via the S12 measure). • using the stocktake, work with your regional colleagues to identify and develop an approach to progress your DHB's priority areas for implementing the Framework by the end of quarter four. • report on work to progress the implementation of the New Zealand Framework for Dementia Care in quarters three and four. Hepatitis C • DHBs are asked to identify their role in supporting the delivery of the regional hepatitis C work and objectives. Action include for example how DHBs will: o work in collaboration with other DHBs in the region to implement the hepatitis C clinical pathway o work in an integrated way to increase access to care and promote primary care prescribing of the new pangenotypic hepatitis C treatments.			**This is an equitable outcomes action (EOA) focus area** (equity focus and clear actions to improve Māori health)	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
Hepatitis C 1. Review and update Health Pathway as required by Q4	Health Pathway reviewed by Q4	SS02: Delivery of Regional Service Plans Quarterly narrative report on progress of the key actions Number of patients diagnosed with Hepatitis C who are supported with hepatitis C treatment	**System outcome** We live longer in good health	**Government priority outcome** Support healthier, safer and more connected communities
2. Use Clinical Nurse Specialists to build and develop relationships with the GP's in the Southern District, supporting them to prescribe the new pangenotypic hepatitis C treatments by Q4				
3. Increase input into organisations involved with needle exchange programmes (e.g. Drug Intravenous Organisation) and support the medical staff in assessing and prescribing new pangenotypic hepatitis C treatments, by Q4. This allows outreach to those groups that often do not attend appointments due to stigma.	Support provided to needle exchange programmes Q1-Q4			
4. Develop a memorandum of understanding with student services (SAS) in Dunedin to develop a shared care pathway for treating hepatitis C in this setting with existing patient-doctor relationships by Q4	MOU developed by Q4			
5. Run regular rural clinics to support GP's in the rural centres to assess, fibroscan and support hepatitis-C treatment Q1-Q4	Rural clinics run Q1-Q4			
6. Increase number or clinics at OCF (Otago Regional Corrections) to reduce the wait list for inmates to be seen, with the aim of enabling more patients to commence treatment at an earlier time Q1-Q4	Number of clinics held at OCF Q1-Q4			
7. Deliver Community education sessions targeted at vulnerable populations e.g. Salvation army groups Q1-Q4	Community education sessions delivered Q1-Q4			

8. Conduct a retrospective audit to identify patients waiting for treatment who are either treatment naïve or treatment experienced with a view to identify those that would benefit from treatment by Q4 Dementia 1. Contribute to regional dementia stocktake • Participate in SI refining of MOH stocktake questions regarding dementia services and related activity Q1 • Participate in SI discussions to use the Stocktake report to agree priorities and action to progress the NZ Dementia Framework Q4 2. Undertake dementia stocktake survey in the Southern district • Finalise a circulation list for the Southern district Q1 • Share the dementia stocktake survey. Encourage all relevant groups to participate and complete the stocktake by Q1 • Include whanau ora providers in the stocktake survey, to identify equity issues for older Māori (EOA) Q1 South Island Health Services Plan 1. Southern DHB will participate in work programmes to accelerate progress towards improving health outcomes for Southern district communities. These include: • First 1,000 Days and Vulnerable Children • Advance Care Planning • Acute Demand Management • Social Determinants of Health • Mental Health and Addictions • Data into Information	Retrospective audit conducted by Q4 Participation in South Island Alliance work programmes Q1-Q4 Stocktake completed Q1	Report on activities in Annual Plan		

3.2.5 BETTER POPULATION HEALTH OUTCOMES SUPPORTED BY PRIMARY HEALTH CARE

<table>
<tr><td colspan="3">Primary Health Care Integration
DHBs are expected to continue to work with their district alliances on integration including (but not limited to):
• ensure clear accountability throughout the entire alliance structure. Annual Plans must include a description of this accountability cascade from PHO and DHB Boards to the Alliance Leadership Team and then to individual Service Level Alliance Teams including decision making, reporting, budget to support the alliance and total budget available to the ALT for service planning and delivery.
• strengthening their alliance (e.g., appointing an independent chair, establishing an alliance programme office, expanding the funding currently considered by the alliance)
• broadening the membership of their alliance (eg, pharmacy, maternity, public health, WCTO providers, mental health providers, ambulance)
• developing services, based on robust analytics, that reconfigure current services and address equity gaps
• describe at least one action you are taking with your rural Service Level Alliance Team to develop resilient rural primary care services.

In addition, please identify actions you are undertaking in the 2019/20 year to:
• assist in the utilisation of other workforces in primary health care settings, particularly the use of nurses and pharmacists in rural areas
• improve access to primary care services, particularly for high needs patients

Note: Some or all of the actions in this section may form part of your System Level Measure Improvement Plan. If this is the case it is not necessary to provide that information here but rather indicate that the assessor should refer to the SLM Improvement Plan.</td><td colspan="2">This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes)

At least one action in this section must address identified equity gaps</td></tr>
<tr><td>DHB activity

1. District Alliances
• Southern DHB has a functioning Alliance Leadership Team (ALT) with an Independent Chair.
• As indicated in the Southern DHB Primary and Community Care Strategy, Locality Networks are to be formed across the Southern District (refer Rural). The first Locality Network to be formed is Central Lakes. This representative group will help inform planning to ensure rural health in this area is appropriate and targeted. Southern DHB will support this group with locality level data and resource.

2. Client Led Integrated Care (CLIC) rollout to 100% of GP practices
• Six monthly analysis by ethnicity (EOA) Q2, Q4
• Practices that have transitioned to CLIC will review their enrolled Maori and Pacific populations to ensure appropriate enrolment into CLIC and access to extended services (commencing Q4)</td><td>Milestone

Formation of the Central Lakes Locality Network Q1

All practices enrolled into the CLIC programme Q2
Six monthly analysis by ethnicity Q2, Q4

Planned GP COPD reviews start Q2</td><td>Measure

Development of a recommendations and action plan for Alliance South, from the Central Lakes Locality Network

Number of referrals to cosy homes

Number of LTC patients having their care plan completed

Number of post discharge COPD consultations</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families

System outcome
We live longer in good health

Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

3. The newly established Chronic Obstructive Pulmonary Disease (COPD) pathway starts a planned GP follow-up service, following discharge from Secondary Respiratory Services • Start planned GP COPD reviews, following referral from secondary respiratory services Q2 4. Ensure clear accountability throughout the entire alliance structure • The Alliance represents a consortium of the DHB and PHO, collaborating to provide services falling within the scope of our Alliance Activities. Our Alliance is directed and lead by our Alliance Leadership Team, made up of the chairperson and those clinical leaders, key managers and other experts, who can successfully lead our Alliance to achieve our Alliance Objectives. An agreed decision-making process makes clear which decisions remain with the DHB and the Government, and which decisions are devolved to Alliance representatives. The day-to-day affairs of our Alliance are delivered by a combination of DHB and PHO resources. • Southern DHB does not currently have SLATs. Southern DHB have taken a deliberate decision to only establish working groups when we are clear that there is a clear problem for them to solve. • In the past successful local SLATS have included the allocation of rural funding. We are just about to make a formal connection from the Alliance Leadership Team (ALT) to the SDHB Child Health and Mental Health Networks, which although are all of system, have up until now operated outside of the Alliance framework. • The establishment of the Central lakes Locality is also key – we will establish this Locality with accountability to the ALT and then begin to replicate this structure across the 6 localities identified in the Primary and Community Care Strategy. • While the Alliance is not a formal entity both the DHB Commissioner Team and the WellSouth Board have agreed that a ringfenced fund will be made available for the progression of the Primary and Community Care Strategy, and that this will be overseen by the ALT. For 2019/20 this is a combined fund of $4 million which has largely been reallocated from other services, or secured from underspend in other areas. The priority for investment remains the rollout of Healthcare Homes across our district, with other identified Alliance activity for 2019/20 including Access to Diagnostics and Mental health. • The executive officer accountable for the management of the Alliance is the Executive Director of the Strategy, Primary and Community Directorate. And although there is no formal support office, there is a Service Improvement Group that acts as the operational arm of the Alliance Leadership Team. • The Alliance has a strong workforce focus and in the 2019/20 will sponsor a critical piece of work to reform the way secondary and primary teams work together. This model of care development will be critical in informing the right sizing of the new Dunedin Hospital, but will also inform what services will integrate across the district in the new Community Health Hubs, which are being scoped in the coming year. 5. Actions Southern DHB is undertaking in the 2019/20 year to: • Assist in the utilisation of other workforces in primary health care settings, particularly the use of nurses and pharmacists in rural areas - WellSouth clinical pharmacist services will continue to provide pharmacy services to high needs patients across the district	Actions undertaken to assist in utilisation of other workforces in			

• Improve access to primary care services, particularly for high needs patients - Refer to CLIC in action item number 2 above	primary health care settings Q1-Q4			

<table>
<tr><td colspan="3">Pharmacy
• Continue to support the vision of the Pharmacy Action Plan and the Integrated Community Pharmacy Services Agreement (ICPSA) by working with pharmacists, the public, primary care and the wider health care team to commission integrated local services that prioritise local need and support equitable health outcomes.
• Support the work to enable the separation of dispensing into separate ICPSA schedules (medicine and supply and clinical advice) by June 2020.
• Commit to developing and reporting by quarter three local strategies that support pharmacy and other immunisation providers to work together to improve influenza vaccination rates in Māori, Pacific and Asian people over 65 years of age, for implementation from 1 April 2020 (start date for the annual influenza immunisation programme).
• Commit to reporting the outcomes of these local strategies to improve influenza vaccination rates in quarter two of the following financial year.
We recommend that you work with your district alliance System Level Measure (SLM) team(s) to investigate if influenza vaccination rates for those populations should be part of the SLM Improvement Plan. In particular those working groups developing actions for Acute hospital bed days and Patient experience of care SLMs. If the vaccination rates of these populations are seen to impact any of these SLMs, specific actions to improve influenza rates could be part of your SLM Improvement Plan.</td><td colspan="3">This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes)</td></tr>
<tr><td>DHB activity

1. Continue to support the vision of the Pharmacy Action Plan and the Integrated Community Pharmacy Services Agreement (ICPSA) by working with pharmacists, the public, primary care and the wider health care team to commission integrated local services that prioritise local need and support equitable health outcomes for all populations, including Maori
• Refer Rural Template
• Through the ICPSA, we will commission services for Long Term Conditions with all contract holders (pharmacies) Q2 (EOA)
- SDHB will purchase Professional Advisory Services from our ICPSA contract holders. This service funding will have increased weighting applied based on an equity of access focus.
- In 2019-20, Maori with CSC/HUHC will increase from x1.4 to x1.8, Maori without CSC/HUHC will have their multiplier increased from x1.2 to x1.4. Non Maori will have a multiplier of x1.0 (EOA)
• Community pharmacy workforce development will be provided to all contract holders Q2
• Through local ICPSA holders, SDHB will pilot a new LTC programme through Schedule 3B (Q4). This pilot will address equity issues for our LTC population. Workforce development funding will support this initiative (EOA).

2. Support the work to enable the separation of dispensing into separate ICPSA schedules (medicine and supply and clinical advice) by June 2020.
• Contribute discussion through TAS (Technical Advisory Services

3. Develop local strategies that support pharmacy and other immunisation providers to work together to improve influenza vaccination rates in Māori, Pacific and Asian people over 65 years of age (EOA)
• Support community pharmacists in their contracting with Southern DHB to deliver influenza immunisations for those over 65 years of age Q1-Q4</td><td>Milestone

Services commissioned for LTCs with all pharmacies Q2
WFD to all pharmacies Q2
Workforce requirements for LTC programme identified Q2
Pilot underway by Q3 and completed Q4</td><td>Measure

Report on activities in the Annual Plan</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families

System outcome
We have improved quality of life</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

• Report outcomes of these local strategies to improve influenza vaccination rates in quarter two of 2020/21 4. Support University of Otago Pharmacy School/Southern DHB joint medication clinic involving pharmacy students, run by the University of Otago Pharmacy School • Refer Quality Template	Support provided to community pharmacists Q1-Q4 Coverage is greater than 63% by Q4			

Diabetes and Other Long-Term Conditions

- Identify the most significant actions the DHB will take across the sector to strengthen public health promotion to focus on the prevention of diabetes and other long term conditions.
- Identify how the DHB will ensure all people with diabetes will have equitable access to culturally appropriate diabetes self-management education (DSME) and support services and how the DHB will measure programme outcomes or evaluate the effectiveness of the DSME.
- Monitor PHO/practice level data to improve equitable service provision and inform quality improvement.
- Improve early risk assessment and risk factor management efforts for people with high and moderate cardiovascular disease risk by supporting the spread of best practice from those producing the best and most equitable health outcomes.

This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori health outcomes)

DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
			System outcome We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
1. Following the MoH review of the Southern DHB diabetes service in 2018, Southern DHB will establish a new Local Diabetes Team (LDT). This group will oversee the assessment, implementation and measurement of any change to current Southern DHB diabetes pathways and services. Particular focus will be on the standards where the DHB was found to have gaps in the MoH Review of Diabetes Standards 2016. • Establish LDT Q1 • Finalise LDT Terms of Reference (TOR) Q1 • Quarterly meetings to oversee the assessment, implementation and measurement of any change to current Southern DHB Diabetes pathways and services • Finalise diabetes action plan by Q2. • Plan to include specific actions identifying how the DHB will ensure all people with diabetes will have equitable access to culturally appropriate self-management education and support services (EOA) • Review coverage for high risk diabetic feet services across the district Q2 • Complete a review of high risk diabetic foot pathway by Q2 • Review and approve access criteria into secondary services for high risk diabetic foot Q2	LDT formed Q1 LDT TOR are finalised Q1 Diabetes action plan by Q2 Review coverage for high risk diabetic feet Q2 Complete review of high risk diabetic foot pathway Q2 Review and approve access criteria into secondary services for high risk diabetic foot Q2	Diabetes action plan finalised by Q4 SS13:Improved management for long term conditions – diabetes services		
2. Monitor PHO/practice level data to improve equitable service provision and inform quality improvement • Southern DHB to monitor data quarterly Q1-Q4	Data monitored quarterly			
3. WellSouth to educate GPs in use of new CVD risk stratification tool when approved for use.				
4. Public Health will use the Health in All Policies (HiAP) framework to work with partners and stakeholders to develop policies, practices and environment that supports health choices and behaviours, e.g. healthy transport Q1-Q4	Narrative reporting on actions Q2 and Q4			
5. Public Health will engage with communities around action that supports health choices and behaviours Q1-Q4, e.g. healthy transport (also refer to Public Health Plan)	Narrative reporting on actions Q2 and Q4			
6. Refer to Healthy Food and Drink template				

3.3 Financial Performance Summary

(Refer to the Financial Performance on page 107 for further detail)

3.3.1 Prospective Statement Of Financial Performance

Table 1: Comprehensive Income for 30 June 2020, 2021, 2022 and 2023

DHB Consolidated Statement of Prospective Financial Performance	2017/18 Actual $' 000	2018/19 Forecast $' 000	2019/20 Budget $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000
Revenue						
PBF Funding Package	852,077	883,467	945,188	982,175	1,019,176	1,055,432
Inter District Revenue	21,777	21,374	23,167	24,071	24,975	25,861
Funder Side Contracts	57,646	75,848	62,738	65,197	67,655	70,064
Provider Misc Revenues	48,488	51,351	50,299	51,303	52,296	53,262
Total Revenues	979,988	1,032,040	1,081,392	1,122,746	1,164,102	1,204,619
less Personnel Expenses						
Medical Personnel	(125,879)	(150,413)	(146,852)	(151,992)	(157,312)	(162,817)
Nursing Personnel	(142,782)	(171,077)	(166,963)	(172,806)	(178,854)	(185,115)
Allied Health Personnel	(50,560)	(59,445)	(58,248)	(60,287)	(62,397)	(64,581)
Support Services Personnel	(5,696)	(6,777)	(6,343)	(6,559)	(6,782)	(7,012)
Management/Admin Personnel	(44,711)	(54,298)	(52,975)	(54,262)	(55,581)	(56,931)
Personnel Costs Total	(369,628)	(442,010)	(431,381)	(445,906)	(460,926)	(476,456)
less Non Personnel Expenditure						
Outsourced Services Expenses	(45,237)	(49,437)	(44,863)	(46,433)	(48,058)	(49,740)
Clinical Supplies Expenses	(93,481)	(105,168)	(103,747)	(107,897)	(112,212)	(116,701)
Infrastructure & Non Clinical Supplies Expenses	(73,463)	(85,849)	(85,208)	(86,912)	(88,651)	(90,424)
Total Non-Personnel Expenditure	(212,181)	(240,454)	(233,818)	(241,242)	(248,921)	(256,865)
less Provider Payments						
Personal Health Expenses	(249,643)	(260,431)	(268,622)	(275,337)	(283,596)	(292,104)
Mental Health Expenses	(24,673)	(26,394)	(30,059)	(30,661)	(31,274)	(31,899)
Disability Support Expenses	(143,740)	(150,250)	(154,240)	(158,096)	(162,049)	(166,100)
Public Health Expenses	(601)	(640)	(512)	(522)	(533)	(544)
Maori Health Expenses	(900)	(1,206)	(1,272)	(1,304)	(1,337)	(1,370)
Total Provider Payments	(419,557)	(438,921)	(454,705)	(465,920)	(478,789)	(492,017)
Total Expenses	(1,001,366)	(1,121,385)	(1,119,904)	(1,153,068)	(1,188,636)	(1,225,338)
Net Surplus / (Deficit)	**(21,378)**	**(89,345)**	**(38,512)**	**(30,322)**	**(24,534)**	**(20,719)**

3.3.2 Prospective Performance By Output Class

Table 2: Prospective Performance by Output Class for the four years ended 30 June 2020, 2021, 2022 and 2023

Revenue & Expenditure by Output Class	2017/18 Actual $' 000	2018/19 Forecast $' 000	2019/20 Budget $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000
Prevention Services						
Revenue	4,834	5,378	4,991	5,123	5,270	5,422
Expenditure	(4,834)	(5,378)	(4,991)	(5,123)	(5,270)	(5,422)
Net Result	0	0	0	0	0	0
Early Detection and Management Services						
Revenue	186,856	176,223	205,836	214,330	223,460	232,121
Expenditure	(194,261)	(207,172)	(219,177)	(224,834)	(231,959)	(239,298)
Net Result	(7,405)	(30,949)	(13,341)	(10,504)	(8,499)	(7,177)
Intensive Assessment and Treatment						
Revenue	650,842	733,854	729,183	754,694	780,389	806,401
Expenditure	(656,213)	(756,300)	(738,858)	(762,312)	(786,552)	(811,606)
Net Result	(5,371)	(22,446)	(9,675)	(7,618)	(6,163)	(5,205)
Rehabilitation and Support						
Revenue	137,456	116,585	141,381	148,599	154,983	160,675
Expenditure	(146,058)	(152,535)	(156,877)	(160,799)	(164,855)	(169,012)
Net Result	(8,602)	(35,950)	(15,496)	(12,200)	(9,872)	(8,337)
Share of Loss in associates	0	0	0	0	0	0
Total Revenue per DHB Consolidated Financials	979,988	1,032,040	1,081,392	1,122,746	1,164,102	1,204,619
Total Expenditure per DHB Consolidated Financials	(1,001,366)	(1,121,385)	(1,119,904)	(1,153,068)	(1,188,636)	(1,225,338)
Net Surplus / (Deficit)	**(21,378)**	**(89,345)**	**(38,512)**	**(30,322)**	**(24,534)**	**(20,719)**

4. SERVICE CONFIGURATION

4.1 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 2019/20. As part of our commitment to ensuring service coverage for our population, Southern DHB is implementing a project to better configure clinically sustainable maternity services for our rural communities.

Southern DHB has a focus on primary maternity services to make sure that maternity facilities and the maternity workforce are best supporting access to maternity care in an environment of constrained recources. A redesign has been undertaken and the model of care and facility approach has been supported by the Director-General of Health, with an implementation plan that is to be further delivered in 2019/20 and outyears.

4.2 SERVICE CHANGE

The table below describes all service reviews and service changes that have been approved or proposed for implementation in 2019/20.

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.	Person-centred, Level of care proportional to health need, Improved equity of access,	Local
	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	Improved service integration, Value for money	

Table continued

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Primary Maternity Services	Implement project to better configure clinically sustainable maternity services for our rural communities	Improved access, Improved service integration	Local
Mental Health	Day Activity and Vocational Services Mental Health Needs Assessment Service co-ordination Community Based Rehabilitation Acute continuum	Person-centred, Care closer to home, Improved equity of access, Value for money, Improved service integration	Local

5. STEWARDSHIP

Good stewardship is about managing our business now and into the future. Our task is to envisage, prepare for and adapt to the constantly changing health care environment, while operating effectively and efficiently to make the best use of the resources available. This is so we can fulfil our primary objective to provide high quality, equitable health care, and achieve the best health outcomes for our communities whilst living within our means.

Like many health systems around the world, we face significant challenges as we seek to sustain high quality services in the face of increasing demands and constrained resources, while positioning ourselves for continual changes driven by a globally connected and digitally enabled community, and innovations in technology and health care practices. Southern DHB is focused on transforming our health system to ensure it is truly patient-centred, fit for purpose and to ensure it is sustainable across a range of dimensions; clinical, quality, workforce and finance.

As well as looking outward to gain a strong understanding of our patients' experiences and priorities, this also demands a strong focus on our internal processes. Our future requires an internal culture that enables different ways of working and a more joined up approach to planning and delivery, supported by strong governance and leadership. This can only be achieved by a capable and engaged workforce, effective partnerships and alliances, and information systems and infrastructure that enable and enhance integrated service delivery.

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.

5.1 Managing Our Business

5.1.1 Governance

Southern DHB has been governed by a Commissioner, supported by Deputy Commissioners, since June 2015. We are now undertaking the work required to transition to a full Board in December 2019.

5.1.2 Organisational Performance Management

Southern DHB's performance is assessed on both financial and non-financial measures, which reported at governance and management levels within the organisation.

5.1.3 Funding And Financial Management

Southern DHB's key financial performance is reported to the Finance Audit and Risk Committee (FARC) and Commissioner team every month. Further information about Southern DHB's planned financial position for 2019/20 and out years is contained in the Financial Performance Summary section of this document on page 89, and the Statement of Performance Expectations on page 99.

5.1.4 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 resulting in a D rating. The next ICR audit is scheduled to be undertaken during 2020. Currently significant work is underway to revise the Asset Management Plan and the Long Term Investment Plan to support achievement of an improved assessment.

5.1.5 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.

5.1.6 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).

5.1.7 Quality Assurance And Improvement

Southern DHB is developing a quality framework that aligns to the IHIs triple aim adopted within healthcare in New Zealand. The framework will reach across primary, community, secondary and tertiary care delivery within Southern DHB. We expect the same standard of care to be delivered in any (*Southern DHB funded*) healthcare setting to ensure our patients experience and healthcare outcomes continuously improve. Alongside the quality

framework will sit a clear clinical governance framework. It will articulate responsibilities and accountabilities to our population and to the Board. Clinical governance will act as the internal watch dog for the quality frameworks success and ensure continuous improvement.

5.2 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.

5.2.1 Capital And Infrastructure Development

Interim Works

Work continues on the redevelopment at Dunedin Hospital of the Intensive Care Unit and High Dependency Unit; with Phase 1 completed and in use and Phase 2 in progress with completion expected by 29 November 2019.

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. A programme of works to continue remediation of the critical infrastructure has been compiled in the Dunedin Hospital Critical Infrastructure Works Single Stage Business Case submitted to the Ministry of Health for approval in March 2019 and updated for QS assessments at the request of the Ministry of Health in September 2019.

Dunedin Hospital Rebuild

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

Southern DHB is working with the Ministry of Health and Southern Partnership Group on the design of a new hospital in Dunedin to ensure Southern DHB has a hospital that is fit for purpose and meets the future needs of our communities.

The Detailed Business Case (DBC) is expected to be submitted to the Ministry of Health and Treasury in February 2020.

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 for the coming years. The refurbishment is underway and comprises reconfiguration of the emergency department and diagnostic capacity including a CT scanner and ultrasound services, specialist audio-visual suite to enable telemedicine and refurbishment of other areas as required.

5.2.2 Workforce and Information Technology And Communications Systems

There is a considerable amount of work currently underway in the Southern district to strategise, plan and implement our workforce, digital and organizational culture transformation. The new Workforce and Digital Strategies have been triggered in part, through the Dunedin hospital redevelopment process, but also in line with the aspirations we have recently articulated in our Primary and Community Care Strategy, which has been a significant driver. The new strategy and action plans now complete the suite of strategic plans, and paint the vision for our way forward.

The Workforce and Digital plans will bring together complementary information in one place using a patient and staff-centric design approach. The Southern Health Workforce and Digital Strategies describe our vision and goals for transforming our workforce, technology enablement and culture, within the context of the overall Southern Health System. The ultimate goal of Strategies is to create a sustainable and contemporary workforce and digital experience that transforms our staff and patients experiences', as well as improving workplace culture.

This work is being carried out by Southern District Health Board and WellSouth as key partners in Southern Health. It recognises that in a changing health environment, long-term planning for the health workforce and future technology solutions needs to outlive any changes in organisational structure, service delivery or delivery location.

The action plan reflects the need to take clear steps forward while managing current funding limitations and changes in care delivery models by identifying resources required, and prioritising actions.

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 has been implemented as agreed between the DHB's CCDM Council and the Safe Staffing Healthy Workplaces Governance Group. This will be reported on bi-monthly in accordance with the signed Accord.

5.2.3 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 the Southern health system primary care alliance. The main body of work for the new Alliance is 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).
- 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 (NZHPL) has the broad aim to enable DHBs to collectively maximise shared service opportunities for the benefit of the sector.
- 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 a 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 developing career pathways.
- Southern DHB continues to work across multiple agencies and sectors. These include the Ministries of Social Development, Education, Police, local and regional Councils to deliver 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 and PSA to provide an opportunity to build relationships and a deepen understanding of the issues or challenges being faced by each party.

6. PERFORMANCE MEASURES

6.1 2019/20 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 2019/20.

Performance Measure	Performance Expectation / Target			
CW01: Children caries-free at five years of age	Children caries-free at 5 years of age		2019	70%
			2020	70%
CW02: Oral Health - Mean DMFT score at Year 8	DMFT score at Year 8		2019	0.72
			2020	0.72
CW03: Improving the number of children enrolled and accessing the Community Oral Health Service	Percentage of 0-4 years enrolled		2019	≥95%
			2020	≥95%
	Percentage of children (0-12 years) not examined based on planned recall		2019	≤10%
			2020	≤10%
CW04: Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	School Year 9 up to and including age 17 years		2019	≥85%
			2020	≥85%
CW05: Immunisation coverage at eight months of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	Percentage of eight month olds fully immunised			95%
	Percentage of five years olds fully immunised (completed all age appropriate immunisations between birth and five years of age)			95%
	Percentage of boys and girls fully immunised – HPV vaccine			75%
	Percentage of 65+ year olds fully immunised – flu vaccine			75%
CW06: Child health (breastfeeding)	Percentage of infants exclusively or fully breastfed at three months			70%
CW07: Newborn enrolment with 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%
CW08: Increased immunisation (2 year olds)	95% of two years olds have completed all age appropriate immunisations due	Total		≥95%
		Māori		
		Pacific		

Performance Measure	Performance Expectation / Target			
	between birth and age 2 years, with no equity gap between Māori and non-Māori populations			
CW09: Better help for smokers to quit (maternity)	Percentage of pregnant women who identity as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer offered brief advice and support to quit smoking			90%
CW10: Raising healthy kids	Percentage of obese children identified in the Before School Check (B4SC) programme offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions			95%
CW11: Supporting child wellbeing	Provide report as per measure definition			
CW12: Youth mental health initiatives	Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement *Youth Health Care in Secondary Schools: A framework for continuous quality improvement* in each school (or group of schools) with SBHS			
	Initiative 3: Youth Primary Mental Health			
	Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population			
CW13: Reducing rheumatic fever	Reducing the Incidence of First Episode Rheumatic Fever to 0.2/100,000			0.2/100,000
MH01: 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	

Performance Measure	Performance Expectation / Target			
		65+ years	Total	1.0%
			Māori	
			Other	
MH02: Improving mental health services using wellness and transition (discharge) planning	Percentage of clients discharged who have a quality transition or wellness plan			95%
	Percentage of audited files meeting accepted good practice			95%
MH03: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	Mental health provider arm – Percentage of young people (0-19 years) seen with 3 weeks and within 8 weeks		3 weeks	80%
			8 weeks	95%
	Addictions (Provider Arm and NGO) - Percentage of young people (0-19 years) seen with 3 weeks and within 8 weeks		3 weeks	80%
			8 weeks	95%
MH04: Rising to the Challenge: The Mental Health and Addiction Service Development Plan	Provide reports as specified			
MH05: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduction in rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year			≥10% by end of reporting year
MH06: Output delivery against plan	Volume delivery for specialist Mental Health and Addiction services is within ▪ 5% variance (+/-) of planned volumes for services measured by FTE ▪ 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day ▪ Actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan			
PV01: Improving breast screening coverage and rescreening	Percentage coverage for all ethnic groups and overall			70%

Performance Measure	Performance Expectation / Target		
PV02: Improving cervical screening overall	Percentage coverage for all ethnic groups and overall		80%
SS01: Faster cancer treatment – 31 day indicator	Percentage of patients receiving their first cancer treatment (or other management) within 31 days from date of decision-to-treat		85%
SS02: Ensuring delivery of Regional Service Plans	Provide reports as specified		
SS03: Ensuring delivery of Service Coverage	Provide reports as specified		
SS04: Delivery of actions to improve Wrap Around Services for Older People	Provide reports as specified		
SS05: Ambulatory sensitive hospitalisations (ASH adult)	ASH rates for 45-64 year olds	Total	2865/100,000
SS06: Better help for smokers to quit in public hospitals (previous health target)	Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital offered brief advice and support to quit smoking		95%
SS07: Planned Care Measures			
Planned Care Measure 1: Planned Care Interventions	Total planned care interventions 2019/20		21,279
Planned Care Measure 2: Elective Service Patient Flow Indicators	ESPI 1: Percent of services that report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less		100% (all)
	ESPI 2: Percent of patients waiting over four months for FSA		0%
	ESPI 3: Percent of patients in Active Review with a priority score above the actual Treatment Threshold (aTT)		0%
	ESPI 5: Percent of patients waiting over 120 days for treatment		0%

Performance Measure	Performance Expectation / Target	
	ESPI 8: Percent of patients prioritised using an approved national or nationally recognised prioritisation tool	100%
Planned Care Measure 3: Diagnostics waiting times	Coronary Angiography: Percentage of patients with accepted referrals for elective coronary angiography receiving their procedure within 3 months (90 days)	95%
	Computed Tomography (CT): Percentage of patients with accepted referrals for CT scans receiving their scan, and the scan results are reported, within 6 weeks (42 days)	95%
	Magnetic Resonance Imaging (MRI): Percentage of patients with accepted referrals for MRI scans receiving their scan, and the scan results are reported, within 6 weeks (42 days)	90%
Planned Care Measure 4: Ophthalmology Follow-up Waiting Times	Percentage of patients who wait more than or equal to 50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service.	0%
Planned Care Measure 5: Cardiac Urgency Waiting Times	Percentage of patients (both acute and elective) receiving their cardiac surgery within the urgency timeframe based on their clinical urgency	100%
Planned Care Measure 6: Acute Readmissions	Year end target for the acute readmission rate (standardised readmission rate)	≤11.7%
SS08: Planned care three year plan	Provide reports as specified	
SS09: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections		
Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (duplication)	>2% and ≤4%
	Recording of non-specific ethnicity in new NHI registration	>0.5% and ≤2%
	Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% and ≤2%

Performance Measure	Performance Expectation / Target	
	Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and ≤85%
	Invalid NHI data updates	Still to be confirmed
Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC, NBRS and NMDS for FSA and planned inpatient procedures.	≥90% and <95%
	National Collections completeness	≥94.5% and <97.5%
	Assessment of data reported to the NMDS	≥75%
Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)	Provide reports as specified	
SS10: Shorter stays in Emergency Departments	Percentage of patients admitted, discharged or transferred from an emergency department (ED) within six hours	95%
SS11: Faster Cancer Treatment (62 days)	Percentage of patients receiving their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	90%
SS12: Engagement and obligations as a Treaty partner	Reports provided and obligations met as specified	
SS13: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)		
Focus Area 1: Long term conditions	Report on actions to support people with LTC to self-manage and build health literacy	
Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care*	
	Ascertainment: target 95-105% and no inequity	95-105% and no inequity
	HbA1c<64mmols: target 60% and no inequity	60%
	No HbA1c result: target 7-8% and no inequity	7-8% and no inequity

Performance Measure	Performance Expectation / Target	
Focus Area 3: Cardiovascular health	Provide reports as specified	
Focus Area 4: Acute heart service	Indicator 1: Door to cath Door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram	>70%
	Indicator 2a: Registry completion Percentage of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge	>95%
	Indicator 2b: Registry completion Percentage of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 3 months	≥99%
	Indicator 3: ACS LVEF assessment- Percentage of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (i.e. have had an echocardiogram or LVgram)	≥85%
	Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator In the absence of a documented contraindication/ intolerance >85% ACS patients who undergo coronary angiogram should be prescribed, at discharge -aspirin, a second anti-platelet agent, statin, and an ACEI/ARB (4-classes) - LVEF<40% should also be on a beta-blocker (5 classes) *An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents	>85%
	Indicator 5: Device registry completion Percentage of patients who have pacemaker or implantable cardiac or implantable cardiac defibrillator implantation/replacement who have completion of ANZACS QI Device forms within 2 months of the procedure	≥99%
Focus Area 5: Stroke services	Indicator 1: ASU	80%

Performance Measure	Performance Expectation / Target	
	Percentage of stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway	
	Indicator 2: Thrombolysis Percentage of potentially eligible stroke patients thrombolysed 24/7	10%
	Indicator 3: In-patient rehabilitation Percentage of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	80%
	Indicator 4: Community rehabilitation Percentage of patients referred for community rehabilitation who are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge	60%
SS15: Improving waiting times for Colonoscopy	Percentage of people accepted for an urgent diagnostic colonoscopy who receive (or are waiting for) their procedure in 14 calendar days or less	90%
	Percentage of people accepted for an urgent diagnostic colonoscopy who receive (or are waiting for) their procedure within 30 days or less	100%
	Percentage of people accepted for a non-urgent diagnostic colonoscopy who receive (or are waiting for) their procedure in 42 calendar days or less	70%
	Percentage of people accepted for a non-urgent diagnostic colonoscopy who receive (or are waiting for) their procedure within 90 days or less	100%
	Percentage of people waiting for a surveillance colonoscopy who receive (or are waiting for) their procedure in 84 calendar days or less of the planned date	70%
	Percentage of people waiting for a surveillance colonoscopy who receive (or are waiting for) their procedure, within 120 days or less	100%

Performance Measure	Performance Expectation / Target	
	Percentage of participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system	95%
SS16: Delivery of collective improvement plan	Provide reports as specified	
SS17: Delivery of Whānau ora	Provide reports as specified	
PH01: Delivery of actions to improve system integration and SLMs	Provide reports as specified	
PH02: Improving the quality of ethnicity data collection in PHO and NHI registers	Provide reports as specified	
PH03: Access to Care (PHO Enrolments)	Meet and/or maintain the national average enrolment rate	90%
PH04: Primary health care: Better help for smokers to quit (primary care)	Percentage of PHO enrolled patients who smoke offered help to quit smoking by a health care practitioner in the last 15 months	90%
Annual plan actions – status update reports	Provide reports as specified	

7. APPENDICES

7.1 Statement Of Performance Expectations

This Statement of Performance Expectations sets out the four Output Classes that the Southern DHB will deliver in the 2019/20 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 Richard Thomson
	Mr David Perez
	Ms Jean O'Callaghan

Population: Approximately 336, 000 people live within Southern DHB boundaries.

Staff: Southern DHB employs over 4,500 people.

Southern DHB's Statement of Intent (SOI)[23] 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[24].

[23]Southern DHB's Statement of Intent (SOI) is available on the DHB's website http://www.southerndhb.govt.nz

[24]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 2019/20, the Southern DHB plans to spend approximately $1,120 million in delivering the following four Outputs funded through Vote Health:

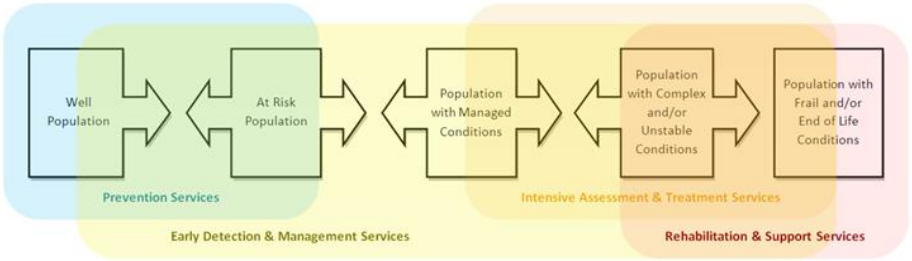
Output 1: Prevention Services;

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 99) presents a summary of the budgeted financial expectations for 2019/20, by output class.

Table 4: Revenue and expenditure by Output Class (page 99) presents a summary of budgeted financial expectations through until 2022/23. 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 2019/20

REVENUE	Total $'000
Prevention	4,995
Early Detection and Management	205,315
Intensive Assessment & Treatment	729,705
Rehabilitation & Support	141,381
Total Revenue	**1,081,396**

EXPENDITURE	Total $'000
Prevention	4,995
Early Detection and Management	218,655
Intensive Assessment & Treatment	739,380
Rehabilitation & Support	156,878
Total Expenditure	**1,119,908**
Net Surplus / (Deficit) – $' 000	**(38,512)**

Table 4: Revenue and expenditure by Output Class 2017/18 – 2022/23

Revenue & Expenditure by Output Class	2017/18 Actual $' 000	2018/19 Forecast $' 000	2019/20 Budget $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000
Prevention Services						
Revenue	4,834	5,378	4,991	5,123	5,270	5,422
Expenditure	(4,834)	(5,378)	(4,991)	(5,123)	(5,270)	(5,422)
Net Result	0	0	0	0	0	0
Early Detection and Management Services						
Revenue	186,856	176,223	205,836	214,330	223,460	232,121
Expenditure	(194,261)	(207,172)	(219,177)	(224,834)	(231,959)	(239,298)
Net Result	(7,405)	(30,949)	(13,341)	(10,504)	(8,499)	(7,177)
Intensive Assessment and Treatment						
Revenue	650,842	733,854	729,183	754,694	780,389	806,401
Expenditure	(656,213)	(756,300)	(738,858)	(762,312)	(786,552)	(811,606)
Net Result	(5,371)	(22,446)	(9,675)	(7,618)	(6,163)	(5,205)
Rehabilitation and Support						
Revenue	137,456	116,585	141,381	148,599	154,983	160,675
Expenditure	(146,058)	(152,535)	(156,877)	(160,799)	(164,855)	(169,012)
Net Result	(8,602)	(35,950)	(15,496)	(12,200)	(9,872)	(8,337)
Share of Loss in associates	0	0	0	0	0	0
Total Revenue per DHB Consolidated Financials	979,988	1,032,040	1,081,392	1,122,746	1,164,102	1,204,619
Total Expenditure per DHB Consolidated Financials	(1,001,366)	(1,121,385)	(1,119,904)	(1,153,068)	(1,188,636)	(1,225,338)
Net Surplus / (Deficit)	**(21,378)**	**(89,345)**	**(38,512)**	**(30,322)**	**(24,534)**	**(20,719)**

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

7.1.1 Prevention Services

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

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

Preventative services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services.

On a continuum of care these services are public wide preventative services.

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 2017/18	Target 2018/19	Target 2019/20
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	94%	>95%	>95%
			Māori	92%		
	Percentage of eligible boys and girls fully immunised with HPV vaccine	C	Total	68%	>75%	>75%
			Māori	71%		
	Percentage of people (≥ 65 years) having received a flu vaccination	C	Total	52 %	>75%	>75%
			Māori	44%		
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	91%	>90%	>90%
			Māori	90%		
	Infants exclusively or fully breastfeeding at 3 months	Q Δ	Total	60%	>60%	>60%
			Māori	52%		
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	91%	>90%	>90%
			Quintile 5	90%		
	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	94%	95%	>95%
	Percentage of eligible women (50-69 years) having a breast cancer screen in the last 2 years	C	Total	74%	>70%	>70%
			Māori	67%		
	Percentage of eligible women (25-69 years) having a cervical cancer screen in the last 3 years	C	Total	77%	80%	>80%
			Māori	68%		

7.1.2 Early Detection And Management

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

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

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

Why is this Output Class Significant for 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 2017/18	Target 2018/19	Target 2019/20
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 successful preventative treatment and education.	Percentage of 0-4 enrolled in community oral health services	C ❖	Total	79%	95%	>95%
			Māori	68%		
	Percentage of children caries-free at five years of age	Q ❖	Total	67%	70%	>70%
			Māori	53%		
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[25] rates for children (0-4 years)	Q ✞	Total	5,756	<5,190	<5,370
			Māori	6,323	<5,190	<5,370
	Number of people receiving a brief intervention from the primary mental health service	V	Total	6,882	>6,000	>6,000
	Percentage of the eligible population who have had a CVD Risk Assessment[26] in the last 5 years	C	Total	84%	>90%	>90%
			Māori	83%		
	Percentage of the population identified with diabetes having good or acceptable glycaemic control[27]	C	Total	48%	>58%	60%
			Māori	41%		
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	81%	>85%	>85%
	Percentage of accepted referrals for Magnetic Resonance Imaging (MRI) scans receiving procedure within 42 days	T	Total	32%	>67%	>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	85%	>90%	>90%

[25] 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.

[26] 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.

[27] 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.

7.1.3 Intensive Assessment And Treatment

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

Intensive assessment and treatment services include:

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

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

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 2017/18	Target 2018/19	Target 2019/20
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	430%	>3.75%	>3.75%
			Māori	4.90%		
	Percentage of adults (20-64 years) accessing specialist mental health services	C Δ	Total	3.80%	>3.75%	>3.75%
			Māori	7.70%	>5.22%	>5.22%
	Percentage of people who have a transition (discharge) plan	Q	Total	30%	>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	67%	>80%	>80%
			< 8 weeks	84%	>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	84,110	< 80,000	< 88,000
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 inpatient elective and arranged surgical service discharges [28]	V†	Total	11,380	12,588	12,588
	Percentage of elective and arranged surgery undertaken on a day case basis[29]	Q	Total	67%	>60%	>60%
	Percentage of people receiving their elective and arranged surgery on day of admission	Q	Total	83%	>95%	>95%
	Number of inpatient elective and arranged surgical services (CWDs) delivered)[29]	V	Total	17,032	18,134	18,134

[28] This measure is based on the MOH Planned Care Initiative, which replaces the Elective Initiative for 2019/20. 2017/18 Actual and Target 2018/19 have been recalculated using the new planned care definition.

[29] 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 2017/18	Target 2018/19	Target 2019/20
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[30]	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	77.9%	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	21.8	<28.3	<21.8
			≥65 years	20.2	<18.5	<18.5
	Patients have improved physical functionality on discharge	Q ❖	<65 years	26.1	>24.2	>26.1
			≥65 years	18.3	>16.9	>18.3

[30] 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.

7.1.4 Rehabilitation & Support

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

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

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 2017/18	Target 2018/19	Target 2019/20
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[31] assessment within 6 months admission	Q Δ	97%	>95%	>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	4,464	4,400	4,400
	Percentage of HCSS support workers who have completed at least Level 2 in the National Certificate in Community Support Services (or equivalent)	Q Δ	76%	>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	849	100	1,050
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	6.7	<7.0	<6.8

[31] 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.

7.2 Financial Performance

7.2.1 Forecast Financial Statements

The draft projected DHB deficit for 2019/20 is $38.5 million. This is draft as work continues to assess the impact of changes to operating models on the current year and the three out-years.

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	2017/18 Actual $' 000	2018/19 Forecast $' 000	2019/20 Budget $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000
Governance	576	(374)	0	0	0	0
Funds	(7,858)	5,355	5,171	3,091	2,790	2,899
Provider	(14,096)	(94,326)	(43,683)	(33,413)	(27,324)	(23,618)
Net Surplus / (Deficit)	**(21,378)**	**(89,345)**	**(38,512)**	**(30,322)**	**(24,534)**	**(20,719)**

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 2019/20 continues to reflect 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 contnue 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 2019/20 budgeted financial statements are summarised below:

- 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	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Southern	6.79%	6.77%	6.75%	6.73%	6.70%	6.67%

- Despite the decreasing share of PBF revenue, Government allocated revenue is forecast to increase.
- 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	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Southern	2.30%	2.22%	1.99%	1.85%	1.64%	1.55%

- Incremental savings and efficiency targets have been built into baseline budgets.
- Costs associated with the activities of New Zealand Health Partnership Ltd (NZHPL) have been factored in.
- Acute demand continues to increase, however the DHB plans to meet the elective targets set.
- The Holidays Act 2003 requirements will be remediated in the 2019/20 and 2020/21 years, this will require additional funding.
- The detailed business case for Dunedin Hospital Rebuild will be submitted in the 2019/20 year

7.2.2 Capital Expenditure and Capital Funding

Southern DHB has an on-going need for capital expenditure. Capital Expenditure is shown in Table 8.

Table 8: Planned Capital Expenditure

Planned Capital Expenditure	2017/18 Actual $' 000	2018/19 Forecast $' 000	2019/20 Budget $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000
Clinical Capital	(11,228)	(12,980)	(13,226)	(11,960)	(7,870)	(11,825)
Building Capital	(1,507)	(8,629)	(19,730)	(17,948)	(10,515)	(11,638)
Strategic Building Capital	(12,118)	(6,698)	(10,437)	(7,000)	(7,000)	(2,900)
Information Systems Capital	(2,563)	(4,323)	(13,745)	(13,656)	(14,737)	(9,256)
Total capital expenditure budget	**(27,416)**	**(32,630)**	**(57,138)**	**(50,564)**	**(40,122)**	**(35,619)**

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 on the Dunedin Hospital site.

Interim Works

The ICU redevelopment will be completed and fully operational in the 2019/2020 year. There are ongoing deferred maintenance projects required to sustain the operational capability of Dunedin Hospital from 2019/2020 through to the new Dunedin Hospital.

Queenstown Lakes Hospital Redevelopment

The Queenstown Lakes Hospital Redevelopment is progressing to plan and equity injections are being sought as the project progresses. The budget for the project is $9.8m.

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 2019/20 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 continue to be a requirement until the DHB is in a better financial position. Once a sound base it achieved, the level of deficit support will be dependent on maintaining that position, particularly when undergoing a significant rebuild that will incur a capital charge on the funding.

Table 9: Planned Capital Financing

Planned Capital Financing	2017/18 Actual $' 000	2018/19 Forecast $' 000	2019/20 Budget $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000
Deficit Support	15,000	56,900	47,260	60,590	15,000	15,000
Equity for Capital Projects	5,706	12,973	7,290	0	0	0
Debt financing for Capital Projects	0	0	0	0	0	0
NZHPL Investment (Capital component)	0	0	0	0	0	0
Equity repaid	(707)	(707)	(707)	(707)	(707)	(707)
Cash Balance	(30,377)	(9,888)	(44,580)	(42,150)	(45,005)	(45,326)

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	1,116	1,116	Qrtly instalment	0.00%
EECA Loans	53	53	Qrtly instalment	0.00%
Finance Leases	1,321	1,321	Mthly & Qrtly instalment	0.00%
	2,490	2,490		

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. This determination is made each year. The last revaluation was undertaken as at 30 June 2018.

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 2019 the concept design 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 2020 Annual Plan was calculated based on the revaluation of property at 30 June 2018. Once the concept design is available there is potential for the depreciation charge to alter to reflect the reassessment of the remaining useful life of the existing buildings at Dunedin Hospital.

7.2.3 Prospective Financial Statements

In accordance with the new Accounting Standards Framework the 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	2017/18 Actual $' 000	2018/19 Forecast $' 000	2019/20 Budget $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000
Revenue						
PBF Funding Package	852,077	883,467	945,188	982,175	1,019,176	1,055,432
Inter District Revenue	21,777	21,374	23,167	24,071	24,975	25,861
Funder Side Contracts	57,646	75,848	62,738	65,197	67,655	70,064
Provider Misc Revenues	48,488	51,351	50,299	51,303	52,296	53,262
Total Revenues	979,988	1,032,040	1,081,392	1,122,746	1,164,102	1,204,619
less Personnel Expenses						
Medical Personnel	(125,879)	(150,413)	(146,852)	(151,992)	(157,312)	(162,817)
Nursing Personnel	(142,782)	(171,077)	(166,963)	(172,806)	(178,854)	(185,115)
Allied Health Personnel	(50,560)	(59,445)	(58,248)	(60,287)	(62,397)	(64,581)
Support Services Personnel	(5,696)	(6,777)	(6,343)	(6,559)	(6,782)	(7,012)
Management/Admin Personnel	(44,711)	(54,298)	(52,975)	(54,262)	(55,581)	(56,931)
Personnel Costs Total	(369,628)	(442,010)	(431,381)	(445,906)	(460,926)	(476,456)
less Non Personnel Expenditure						
Outsourced Services Expenses	(45,237)	(49,437)	(44,863)	(46,433)	(48,058)	(49,740)
Clinical Supplies Expenses	(93,481)	(105,168)	(103,747)	(107,897)	(112,212)	(116,701)
Infrastructure & Non Clinical Supplies Expenses	(73,463)	(85,849)	(85,208)	(86,912)	(88,651)	(90,424)
Total Non-Personnel Expenditure	(212,181)	(240,454)	(233,818)	(241,242)	(248,921)	(256,865)
less Provider Payments						
Personal Health Expenses	(249,643)	(260,431)	(268,622)	(275,337)	(283,596)	(292,104)
Mental Health Expenses	(24,673)	(26,394)	(30,059)	(30,661)	(31,274)	(31,899)
Disability Support Expenses	(143,740)	(150,250)	(154,240)	(158,096)	(162,049)	(166,100)
Public Health Expenses	(601)	(640)	(512)	(522)	(533)	(544)
Maori Health Expenses	(900)	(1,206)	(1,272)	(1,304)	(1,337)	(1,370)
Total Provider Payments	(419,557)	(438,921)	(454,705)	(465,920)	(478,789)	(492,017)
Total Expenses	(1,001,366)	(1,121,385)	(1,119,904)	(1,153,068)	(1,188,636)	(1,225,338)
Net Surplus / (Deficit)	**(21,378)**	**(89,345)**	**(38,512)**	**(30,322)**	**(24,534)**	**(20,719)**
Supplemental Information						
Depreciation Charges	(21,592)	(23,438)	(28,012)	(32,059)	(36,858)	(41,575)
Interest Costs	(10)	(20)	0	0	0	0
Capital Charge	(9,122)	(11,017)	(10,500)	(10,710)	(10,925)	(11,143)
Total IDCC Costs	(30,724)	(34,475)	(38,512)	(42,769)	(47,783)	(52,718)
Medical FTE	542	580	615	615	615	615
Nursing FTE	1,690	1,764	1,754	1,754	1,754	1,754
Allied FTE	661	681	718	718	718	718
Support FTE	100	95	103	103	103	103
Management/Admin FTE	677	703	721	721	721	721
Total FTE	3,670	3,823	3,911	3,911	3,911	3,911

Table 12: DHB Consolidated Prospective Balance Sheet

DHB Consolidated Prospective Balance Sheet	2017/18 Actual $' 000	2018/19 Forecast $' 000	2019/20 Budget $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000
Current Assets:						
Cash & Bank Accounts	8	7	7	7	7	7
Prepayments	3,258	2,479	2,868	2,923	2,979	3,035
Inventory	5,032	5,762	5,235	5,235	5,235	5,235
Accounts Receivable	40,472	44,874	42,345	43,149	43,969	44,804
Assets held for resale						
Total Current Assets	48,770	53,122	50,455	51,314	52,190	53,081
Current Liabilities:						
Bank overdraft and current debt	(31,610)	(10,817)	(45,371)	(42,822)	(45,557)	(45,775)
Creditors provisions and payables	(126,816)	(176,519)	(154,486)	(146,911)	(158,624)	(159,838)
Total Current Liabilities	(158,426)	(187,336)	(199,857)	(189,733)	(204,181)	(205,613)
Net Working Capital	(109,656)	(134,214)	(149,402)	(138,419)	(151,992)	(152,532)
Non Current Assets:						
Land , Buildings, Plant and Equipment	318,380	327,555	356,681	375,188	378,451	372,495
Long Term Investments	4,469	0	0	0	0	0
Total Non Current Assets	322,849	327,555	356,681	375,188	378,451	372,495
Non Current Liabilities:						
Long Term Debt	(2,455)	(1,568)	(783)	(712)	(643)	(573)
Other Liabilities	(18,149)	(19,362)	(18,755)	(18,755)	(18,756)	(18,756)
Net Equity	**192,589**	**172,411**	**187,741**	**217,302**	**207,061**	**200,634**

Table 13: DHB Consolidated Statement of Prospective Changes in Equity

DHB Consolidated Statement of Prospective Changes in Equity	2017/18 Actual $' 000	2018/19 Forecast $' 000	2019/20 Budget $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000
Total Equity at beginning of period	159,398	192,589	172,410	187,741	217,302	207,060
Net Result for the period - Governance	576	(374)	0	0	0	0
Net Result for the period - Funds	(7,858)	5,356	5,171	3,091	2,790	2,899
Net Result for the period - Provider	(14,096)	(94,326)	(43,683)	(33,413)	(27,324)	(23,618)
Revaluation of Fixed Assets	34,570	0	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	5,706	12,973	7,290	0	0	0
Equity Injections for Deficit	15,000	56,900	47,260	60,590	15,000	15,000
Total Equity at end of Period	**192,589**	**172,411**	**187,741**	**217,302**	**207,061**	**200,634**

Table 14: DHB Consolidated Statement of Prospective Cash Flows

DHB Consolidated Statement of Prospective Cash Flows	2017/18 Actual $' 000	2018/19 Forecast $' 000	2019/20 Budget $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000
Operating Cashflows						
Cash inflows from operating activities	971,514	1,029,740	1,082,593	1,121,752	1,163,087	1,203,584
Cash outflows from operating activities	(970,585)	(1,044,070)	(1,113,128)	(1,128,512)	(1,139,987)	(1,182,471)
Net cash inflows(outflows) from operating activities	929	(14,330)	(30,535)	(6,761)	23,100	21,113
Investing Cashflows						
Cash inflows from investing activities	325	182	187	191	195	198
Cash outflows from investing activities	(27,415)	(33,288)	(57,138)	(50,564)	(40,122)	(35,619)
Net cash flows from investing activities	(27,090)	(33,106)	(56,951)	(50,373)	(39,927)	(35,421)
Financing Cashflows						
Cash inflows from financing activities	20,706	69,878	54,550	60,590	15,000	15,000
Cash outflows from financing activities	(2,082)	(1,953)	(1,756)	(1,026)	(1,028)	(1,014)
Net cashflows from financing activities	18,624	67,925	52,794	59,564	13,972	13,986
Net increase/(decrease) in cash held	(7,537)	20,489	(34,692)	2,430	(2,855)	(322)
Add opening balance	(22,840)	(30,377)	(9,888)	(44,580)	(42,150)	(45,005)
Closing cash balance	**(30,377)**	**(9,888)**	**(44,580)**	**(42,150)**	**(45,005)**	**(45,326)**

7.3 Statement of Accounting Policies

7.3.1 Reporting Entity

Southern District Health Board (Southern DHB) is a Crown Entity as defined by the Crown Entities Act 2004 and is domiciled in New Zealand. The relevant legislation governing Southern DHB's operations is the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000.

Southern DHB's primary objective is to deliver health, disability services and mental health services to the community within it's district. Southern DHB does not operate to make a financial return.

Southern DHB is designated as a public benefit entity (PBE) for the purposes of complying with generally accepted accounting practice.

7.3.2 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.

Going Concern

Southern DHB's Commissioner received a letter of support from the Ministers of Health and Finance that the Government is committed to working with them over the medium term to maintain its financial viability. It acknowledges that equity support may be required and the Crown will provide such support should it be necessary to maintain viability. The letter of support is considered critical to the going concern assumption underlying the preparation of the financial statements as the 2019/20 Annual Plan has yet to receive approval from the Ministry of Health.

Statement of Compliance

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

The financial statements have been prepared in accordance with and comply with Tier 1 Public Sector PBE standards.

Presentation Currency and Rounding

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 starting 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
- 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 amendments to PBE IPSAS 39, Employee Benefits. This amendment is effective for annual financial statements beginning on or after 1 January 2019.

Southern DHB expects there will be no effect in applying this amendment.

Standards, amendments, and interpretations issued that are not yet effective and have been early adopted

The Crown has resolved to early adopt PBE IFRS 9 Financial Instruments for financial statements prepared for periods beginning on or after 1 January 2018.

Southern DHB has applied PBE IFRS 9 and has accordingly changed its measurement of accounts receivable impairment (provisioning for doubtful debts) for the year ended 30 June 2019.

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;

- Asbestos Impairment
- Fixed assets revaluations
- Deferred maintenance
- Remaining useful lives
- Intangible assets impairment
- Employee entitlements

7.3.3 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, unless there are substantial use or return conditions. A liability is recorded if there are substantive use or return conditions and the liability released to revenue as the conditions are met. For example, as the funds are spent for the nominated purpose.

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

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. Research costs are recognised in the Statement of Comprehensive Revenue and Expense as incurred.

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 their face value less an allowance for expected losses.

In measuring expected credit losses, short term receivables have been assessed on a collective basis as they possess shared credit risk characteristics. They have been grouped based on the days past due.

Short term receivables are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include the debtor in default by way of liquidation. At this point the debt is no longer subject to active enforcement.

Previously, the allowance for credit losses was based on the incurred credit loss model. An allowance for credit losses was recognised only when there was objective evidence that the amount due would not be fully 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 held for distribution or consumption in the provision of aservices that are not supplied ona commercial basis are measured at cost (using the FIFO method), adjusted , when applicable, for any loss of service potential.

Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in the surplus or deficit in the year of write-down.

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 of major classes of assets have been estimated as follows:

Buildings	1 to 79 years
Plant and Equipment	3 to 40 years
Motor Vehicles	5 to 12 years

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 Health Finance, Procurement and Information Management System (FPIM), previously known as Finance, Procurement and Supply Chain (FPSC) is a national initiative and is managed on behalf of DHBs by NZ Health Partnerships Limited (NZHPL). During the year to 30 June 2019, Southern DHB capitalised payments in respect of FPIM totalling $0.7m (2018: $nil). The total value of payments capitalised by Southern DHB since the inception of FPIM to 30 June 2019 was $5.1m (2018: $4.5m).

In return for these payments, Southern DHB gained rights to access the FPIM asset. In the event of liquidation or dissolution of NZHPL, Southern DHB shall be entitled to be paid from the surplus assets, an amount equal to their proportionate share of the liquidation value based on its proportional share of the total FPIM rights that have been issued.

The FPIM rights have been tested for impairment at 30 June 2019, by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to Southern DHB's share of the DRC of the underlying FPIM assets. An impairment charge of $5.1m has been recognised in the Statement of Comprehensive Revenue and Expense in 2019 (2018: Nil).

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
Software	3 to 10 years

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 public authority and consequently is exempt from the payment of income tax. Accordingly, no provision has been made for income tax under section CW38 of the Income Tax Act 2007.

Budget Figures

The budget figures are derived from the Statement of Performance Expectations as approved by the Commissioner at the beginning of the financial year. The budget figures have been prepared in accordance with GAAP, using accounting policies that are consistent with those adopted by the Commissioner in preparing these financial statements.

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, 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 surplus or deficit. Except for those items covered by a separate accounting policy, all financial instruments are shown at their estimated fair value.

Exposure to credit, interst rate and currency risks arise in the normal course of Southern DHB's operations.

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.

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

'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.

7.4 Public Health Plan

7.4.1 Introduction

Keeping our people well

Public health is the part of our health system that works to keep our people well. Our goal is to improve, promote and protect the health and wellbeing of populations and to reduce inequities. Our 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 use of legislation.
5. Supporting preventive care: supporting our health system to provide preventive care to everyone who needs it (e.g. 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.

This plan describes how we will work to keep our people well in 2019-20.

Public Health and the New Zealand Health Strategy

Guidance for public health unit (PHU) planning is included in the Ministry of Health's 2019/20 DHB Annual Plan and Priorities Guidance. It acknowledges the value of PHU work and the importance of PHU roles in supporting greater integration of public health action and effort. PHU annual plans are to be included as Appendix 3 of DHB annual plans.

The Director-General's key message for strengthening public health action is to increase collaboration and integration to address determinants of health and achieve health equity and wellbeing.

The Government priorities included are: improving Māori health, achieving equity in health and wellness, child and youth wellbeing, mental health, drinking water, prevention, identification and management of long term conditions, and primary health care.

Regional Context and Priorities

The five South Island DHBs together form the South Island Alliance, which is committed to the vision of "A connected and equitable South Island health and social system that supports all people to be well and healthy".

Public Health South's principal role in regional activity is as a member of the South Island Alliance's Public Health Partnership Workstream (SI PHP), which aims to "Improve, promote and protect health and well-being of populations and reduce inequities".

The SI PHP has identified the following regional priorities for public health in 2019-20:

- Collective impact and partnerships

- Cross-sector and inter-health capacity development and initiatives to improve outcomes in the first 1,000 days
- Partnership with Te Herenga Hauora to improve equity for Māori.

- Facilitating a health promoting health syste.
  - A "Health in All Policies" approach toward the social and environmental determinants influencing oral health, housing, environmental sustainability and water
- Strategic and operational alignment of South Island public health units
  - Consistent and coordinated regional strategic and operational approaches to key public health concerns, with particular foci on: planning, community resilience and psycho-social wellbeing, alcohol harm reduction, healthy eating and active lifestyles, and regional systems to support on call, after-hours health protection services

District Health Board Priorities

Southern District Health Board (SDHB) is the southern most DHB in NZ and has responsbility for a population of over 335,000 people.

SDHB has a statutory purpose to:

- Improve, promote and protect the health of our population.
- Promote effective care and support for people in need of personal health or disability services.
- Reduce health outcome disparities.
- Manage national strategies and implementation plans.
- Develop and implement strategies for the specific health needs of our local population.

Southern DHB's priorities are set out in a variety of documents.

Southern Strategic Health Plan - Piki te Ora[32] sets out a 10 year strategic plan around the principles of 'Be well' – supporting a healthy life, 'Stay well' – support and services to maintain good health, and 'Get well' – support and services for injury and illness. Both 'Be Well' and 'Stay well', support public health approaches across a number of areas such as facilitating exercise, smokefree, healthy eating, active transport, clean air and water, safe alcohol use, violence free, social connectedness, education, healthy housing and waste management.

The Southern Health Profile[33] also sets out a number of priorities and links population and personal health action to address these:

- Tobacco smoking
- Obesity and nutrition
- Hazardous alcohol consumption
- Chronic disease management – particularly diabetes and cardio-vascular disease (CVD)
- Access and use of primary care – in-hours and after-hours
- Mā ori health - particularly child health and chronic disease
- Pacific health - particularly child health and chronic disease
- Access to mental health service access – particularly through strengthening of community services.

Specific activities in the Southern Primary and Community Care Strategy Action Plan (P&CS)[34] have been addressed in this plan. In particular this covers activities in Action 1.4 - "Take a Health in All Policies (HiAP) approach to address the major risk factors that contribute to inequities, avoidable acute demand and amenable mortality". This plan outlines how Public Health will contribute to these activities.

[32] Southern Strategic Health Plan - Piki te Ora https://www.southerndhb.govt.nz/pages/sshp/

[33] Southern District Health Board Health Profile 2013 https://www.southerndhb.govt.nz/files/14975_20141030856 50-1414612610.pdf

[34] Southern Primary and Community Care Action Plan, June 2018 https://www.southerndhb.govt.nz/files/22782_20180704152735-1530674855.pdf

The Southern DHB values underpin all the work we do.

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. We treat people how they would like to be treated.
Positive **Whaiwhakaaro**	*Best action:* We are thoughtful, bring a positive 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.

Statutory Responsibilities

As a public health unit, Public Health South employs and trains medical officers of health, health protection officers, and other public health statutory officers. Our staff fulfils a range of statutory responsibilities and requirements as set out in the national Public Health Service specifications. This includes meeting statutory reporting requirements.

Working in Partnership

In addition to our partnership with the other South Island Public Health Units, our work is based on strong partnerships with other parts of our health system and other key agencies, including:

- Alliance South
- Regional Councils
- Territorial Authorities
- Ngai Tahu
- Papatipu Rūnanga and Māori Health Environmental Providers
- Non-Government Organisations

Key Challenges/Priorities for Keeping our People Well

A key priority for Public Health South is to identify and respond to the needs of our communities, and use 'health in all policies' and collaborative partnerships approaches to improve health and well-being, address health inequalities and improve health. Priority issues include: child wellbeing/first 1000 days, equity and environmental issues including air quality, water and housing. A focus on improving Māori health outcomes underpins our work. These approaches work to address the social determinants of health as the underlying causes of ill health and inequalities in health.

Another key priority for the service is to complete the project looking at how we work - 'Public Health – a new way of working'. This project commenced at the start of 2019 and will continue throughout the year. The aim of the project is to achieve three interdependent outcomes:

- Transition to ways of working that include quality collaborative partnerships, health in all policies, a health promoting workforce across the health sector and a multi-agency health promotion strategy
- Strengthen the skills and ability of staff through workforce development to work in these ways, and
- Ensure our service has the appropriate organisational structure to support working in these ways

Public health activities are undertaken by a range of other providers including health promotion staff at WellSouth Primary Health Network and other promotion staff in other population health programmes. A key emphasis will be on how preventive approaches create opportunities to influence the health system to become a health promoting health system.

Southern DHB covers the largest geographical area of any health board in New Zealand. The unique physical environment in which we live, learn, work and play is both an asset and a challenge. As a service we work with eight local councils and two regional councils as well as many key stakeholders from government and NGO sectors. Our population and its needs can be described under three main groupings, reflecting differences in populations' needs and requiring us in turn to respond in tailored ways. Our two main urban centres (Dunedin and Invercargill) are currently experiencing unexpected growth in their populations. Our rural districts host small and dispersed populations stretching from Stewart Island through rural Southland and Otago and into the Waitaki. These districts are characterised by a strong sense of belonging and identity but there are many hidden issues and often poor infrastructure. We need to engage in ways that build resilience and consider how best to connect with these communities. The Central Otago/Queenstown Lakes area is undergoing rapid expansion and experiencing significant pressures on basic physical and social infrastructure. The economic activity driving this expansion is exacerbating inequalities and threatening the environment. There is a fourth group which is often overlooked and that is our visiting population which at peak seasons can comprise a significant addition. They

bring with them pressures on the physical environment and the threat of imported disease that needs careful management.

As a service we need to be agile enough to respond to the different health needs across our district in ways which are better aligned with the needs of our communities. A key challenge is for us to move away from attempting to deliver 'public health' ourselves to an approach which works closely with key stakeholders such as councils to develop policies that support health and wellbeing and which protect and enhance our physical environment. This underpins the approaches we have outlined above.

Quality Improvement

Our work is underpinned by a Quality Strategy that prioritises:

- A continuous improvement culture and robust quality systems
- Accessible public health information for staff and other workers
- A highly skilled, culturally appropriate public health workforce
- Clear, robust planning and reporting
- Effective communication to staff and communities

The following key components of health excellence will be managed by our Leadership Team in 2019-20:

- Te Tiriti o Waitangi
- Leadership (including culture and communications)
- Strategy
- Partnerships
- Workforce
- Operations
- Results

Reporting

- We will meet reporting requirements for statutory activities required by the Ministry of Health through the vital few reporting.
- We will provide formal reports to the Ministry of Health and our DHBs in January and July. Reports will relate to the priorities and outcomes described in this plan, and will outline key achievements for the previous six months and describe any challenges and emerging issues.

The remaining sections of this plan will describe the work programmes the public health unit will be focusing on in 2019-20.

7.4.2 Work Programmes for 2019-20

The approach taken in this plan differs from previous public health annual plans. Specific issues such as smokefree, alcohol harm reduction, housing, mental health and wellbeing, and sustainability will not be represented as stand-alone work programmes. Instead they are covered as activities within the following work programmes (healthy public policy, health-promoting health systems and supporting community action) that provide a framework for how we will undertake our work.

Surveillance/Monitoring

"Tracking and sharing data to inform public health action"

Our key surveillance/monitoring priorities for 2019-20 are to:

- Improve capacity development to undertake surveillance and monitoring.
- Monitor communicable disease/ outbreak trends.
- Support the development of the inaugural South Island Population Health Report.
- Develop linkages with Councils, WellSouth and internal business intelligence functions to improve and establish a surveillance system around wider determinants of health.

The surveillance/monitoring **outcomes** we work towards are:

- Prompt identification and analysis of emerging communicable disease trends, clusters and outbreaks
- Robust population health information available for decision making

Evidence/Research/Evaluation

"Providing evidence and evaluation for public health action"

Our key evidence/research/evaluation priorities for 2019-20 are to:

- Ensure current work programmes/ projects have measures and an equity focus.
- Develop evidence to support emerging priorities.

The evidence/research/evaluation **outcomes** we work towards are:

- Population health interventions are based on best available evidence and advice
- Robust evaluation for public health initiatives

Healthy Public Policy

"Supporting development of healthy public policy and approaches in other agencies"

Our key healthy public policy priorities for 2019-20 are to:

- Implement the 'Public Health – a better way of working' project to embed a health in all policies framework.
- Commence the development and implementation of a health in all policies action plan to support intersectoral action (P&CS 1.4a).
- Enhance local partnerships that act to improve health in our communities.
- Influence the development of Healthy Public Policy.

The healthy public policy **outcomes** we work towards are policies, practices and environments that support health and wellbeing, improve Māori health, and reduce disparities.

Health-Promoting Health System

"Supporting development of health-promoting policies and approaches across our health system"

Our key health-promoting health system priorities for 2019-20 are to:

- Develop a southern district health promotion strategy outlining how Public Health, WellSouth and other key stakeholders will work together (P&CS 1.4b).
- Support the implementation of the DHB healthy food and drink beverage policy.
- Support the development of a DHB endorsed South Island wide sustainability position statement.
- Advocate within SDHB to role model healthy policies.

The health-promoting health system **outcomes** we work towards are policies, practices and environments in healthcare settings that support health and wellbeing, improve Māori health, and reduce disparities.

Supporting Community Action

"Supporting communities to improve their health"

Our key supporting community action priorities for 2019-20 are:

- Help communities (including education and workplace settings) to identify their priorities and provide support for addressing them.
- Utilise both settings and life course approaches.
- Work collaboratively to support positive health outcomes.
- Improve community resilience to build mental health and wellness.

The supporting community action **outcomes** we work towards are:

- Effective community action supports healthy choices and behaviours
- Coordinated inter-sectorial action to improve mental health wellbeing

Education Settings

"Supporting our children and young people to learn well and be well"

Our work in education settings is delivered within the following programme areas:

- Supporting community action
- Communicable disease control
- Healthy physical environments
- The Health Promoting Schools contract

The education settings **outcomes** we work towards are:

- Education settings make the healthy choice the easy choice for students, whānau and staff.
- Education settings have the skills and resources to enable students to learn well and be well.

Communicable Disease Control

"Preventing and reducing spread of communicable diseases"

Our key communicable disease control priorities for 2019-20 are to:

- Undertake notifiable disease follow-up and outbreak detection and control.
- Undertake border health control activities.
- Support implementing systems to reduce effects of disease e.g. immunisation, infection prevention and control measures, and antimicrobial stewardship.

The communicable disease control **outcomes** we work towards are:

- Reduced spread of communicable diseases
- Outbreaks rapidly identified and controlled
- Protection against introduction of communicable diseases into New Zealand
- Improved immunisation rates

Healthy Physical Environment

"Supporting communities to improve their health"

Our key physical environment priorities for 2019-20 are to:

- Work with territorial authorities on the quality and safety of the environment e.g. air quality, planning, water.
- Develop relationships with the decision makers to support health environments e.g. Government agencies, DOC, transport.
- Joint working group on water quality issues.

The healthy physical environment **outcomes** we work towards are:

- Improved air quality
- Improved quality and safety of drinking water
- Improved quality and safety of recreational water
- Improved safeguards and reduced exposure to sewage and other hazardous substances
- Environments support connectivity, mental health, and physical activity

Emergency Preparedness

"Minimising the public health impact of any emergency"

Our key emergency preparedness priorities for 2019-20 are to:

- Contribute to district planning for pandemic and other public health emergencies.
- Participate in exercises to improve readiness.
- Develop community resilience as an important harm reduction measure.
- Public health emergency response plans are up-to-date.

The supporting emergency preparedness **outcomes** we work towards are:

- Plans, training and relationships in place.
- Public health impact of any emergencies mitigated.

Sustainability

"Increasing environmental sustainability practices"

Our work in sustainability is delivered within the following programme area:

- Healthy Public Policy
- Health Promoting Health System

The sustainability **outcomes** we work towards are reduced environmental impact within and outside our health system.

Smoking Cessation Support

"Supporting smokers to quit"

Smoking cessation support delivered to the Southern Stop Smoking Service (Nga Kete Matauranga Pounamu).

Smoking cessation support is only one aspect of a comprehensive tobacco control plan. Our work supports the Smokefree 2025 goal and the Southern Stop Smoking Service in the following areas:

- Healthy Public Policy.
- Health Promoting Health System.
- Supporting Community Action

The smoking cessation support **outcome** we work towards is for more smokers to stop smoking.

Wellbeing and Mental Health Promotion

"Improving mental health and wellbeing"

Our work in wellbeing and mental health promotion is delivered in the following areas:

- Healthy Public Policy
- Health Promoting Health System
- Supporting Community Action

The wellbeing and mental health promotion **outcome** we work towards is co-ordinated intersectoral action to improve mental health and wellbeing.

Alcohol Harm Reduction

"Reducing alcohol-related harm"

Our work in alcohol harm reduction is delivered in the following areas:

- Healthy Public Policy
- Health Promoting Health System
- Supporting Community Action

The alcohol harm reduction **outcomes** we work towards are:

- Effective working relationships with other agencies and organisations to reduce alcohol harm
- Reduced risk of alcohol harm at premises and events
- A culture that encourages a responsible approach to alcohol

7.4.3 Public Health Annual Plan - Programme Plans

Surveillance and Monitoring Programme Plan 2019-20

Purpose: Tracking and sharing data to inform public health action.

Our key priorities for 2019/20 are to:

- Improve capacity development to undertake surveillance and monitoring
- Monitor communicable disease/outbreak trends
- Develop the inaugural South Island Population Health Report
- Develop linkages with Councils, WellSouth and with internal business intelligence functions to improve and establish a surveillance system around wider determinants of health

Key relationships/stakeholders:

- Ministry of Health
- Institute of Environmental Science and Research
- Territorial Authorities
- WellSouth Primary Health Network (PHN)
- South Island Alliance
- Southern District Health Board

	Outcomes	2019-20 activities	Measures	Reporting
1.1	Prompt identification and analysis of emerging communicable disease trends, clusters and outbreaks. Disease trends are flat or declining when compared to historical data.	Undertake weekly communicable disease surveillance to monitor trends with analysis as required.	Trends and outbreaks identified in a timely way.	Number of clusters/outbreaks reported to ESR/Ministry
1.2	Robust population health information available for decision making	Information and advice provided on communicable diseases and control as required.		Monthly newsletter to stakeholders
		Work with WellSouth PHN and DHB strategy and planning to develop data extraction and analysis.		Range of possible indicators and analyses are available across the health sector

EVIDENCE/RESEARCH/EVALUATION PROGRAMME PLAN 2019-20

Purpose: Supporting communities to improve their health.

Our key priorities for 2019/20 are to:

- Ensure current work programmes/projects have measures and an equity focus.
- Develop evidence to support emerging priorities.

	Outcomes	2019-20 activities	Measures	Reporting
2.1	Population health interventions are based on best available evidence and advice.	Develop a district wide evidence base	Public Health view is represented in the design of population based interventions	Number of literature reviews commissioned to support planning
2.2	Monitoring and evaluation for public health initiatives.	All projects/programmes having monitoring and/or evaluation incorporated	Monitoring and or evaluation is built into all plans	Number of staff/projects using a PDSA cycle
2.3	Identify staff and support the development of evaluation skills.	Staff trained in evaluation skills	Number of staff trained in evaluation skills	

HEALTHY PUBLIC POLICY PROGRAMME PLAN 2019-20

Purpose: Supporting development of healthy public policy and approaches in other agencies.

Our key priorities for 2019/20 are to:

- Implement the 'Public Health – a better way of working' project to embed health in all policies framework
- Develop and implement a Health in all Policies (HiAP) action plan to support intersectoral action (P&CS 1.4a)
- Enhance local partnerships that act to improve health in our communities
- Influence the development of Healthy Public Policy

This year's priorities include developing and implementing a Health in All Policies Action Plan to support effective inter-sectoral action; developing a Southern District Health Promotion Strategy as outlined in the Southern Primary Care and Community Action Plan; as well as a continued focus on improving Mā ori health and reducing disparities. Using these frameworks, specific issues including housing, water, fluoridation, alcohol harm minimisation, nutrition and physical activity, community resilience, sustainability and Smokefree 2025 will be addressed.

Key relationships/stakeholders:

- Settings and Lifestyle Team
- Communicable Diseases Team
- WellSouth and GPs
- Ministry of Health
- Mā ori Providers
- Ngai Tahu
- NGOs
- Aukaha and Te Ao Marama
- Alliance South
- Regional Councils
- Territorial Authorities

	Outcomes	2019-20 activities	Measures	Reporting
3.1	The healthy public policy **outcomes** we work towards are policies, practices and environments that support health and wellbeing, improve Mā ori health, and reduce disparities.	'Public Health – a new way of working' project to refocus and embed the Health in all Policies (HiAP) framework into PHS work Priority areas include housing, air quality, water, smoking, alcohol, breastfeeding, active transport	Completion of 'Public Health – a new way of working' project. Health in all policies framework embedded.	Narrative reporting on project milestones.
		Commence the development of a HiAP action plan to support intersectoral action (P&CS 1.4a)	Engage with relevant stakeholders on the development of a HiAP Plan. Consultative workshop held and draft HiAP action plan developed through a co-design process. Effective local partnerships that work to improve health in our communities.	Report on the nature and extent of engagement with stakeholders.
3.2	Public harm associated with tobacco and alcohol are effectively reduced through regulatory action.	Inquire into all on, off, club and special licence applications and provide Medical Officers of Health reports to District Licensing Committee (DLC) Annual report summarising the district alcohol regulatory activity and trends	Percentage of matters in opposition that were accepted by the receiving authority. Annual alcohol regulatory report submitted to CPHAC.	6 monthly vital few reporting.
3.3		Undertake controlled purchase operations (CPOs) with tobacco retailers around compliance with the Smokefree Environments Act Promote new smokefree cars and vaping legislation (once enacted)	Number of tobacco retailers compliant at time of CPOs.	6 monthly vital few reporting.

HEALTH-PROMOTING HEALTH SYSTEM PROGRAMME PLAN 2019-20

Purpose: Supporting development of health promoting policies and approaches across our health system

Our key health promoting health system priorities for 2019/20 are to:

- Develop a southern district health promotion strategy outlining how Public Health, WellSouth and other key stakeholders will work together (P&CS 1.4b).
- Support the development and implementation of the DHB healthy food and drink policy.
- Support the development of a DHB endorsed South Island wide sustainability position statement.
- Use the South Island Alliance Sustainability Project group as a vehicle to develop sustainable practice.

Through a health-promoting health system approach we will be promoting specific issues including housing, nutrition and physical activity, alcohol harm minimisation, mental health and wellbeing, sustainability and Smokefree 2025.

Key relationships/stakeholders:

- Southern DHB Executive Leadership Team
- Executive Director, People Culture and Technology
- Health and Safety Manager
- Southern DHB Sustainability Committee
- DHB Healthy Food and Drink Committee
- Southern Smokefree Steering Group
- WellSouth Public Health Network
- Cancer Society
- Heart Foundation
- Healthy Families Invercargill.

	Outcomes	2019-20 activities	Measures	Reporting
4.1	Develop a Southern district health promotion strategy outlining how Public Health, WellSouth and other key stakeholders will work together (P&CS 1.4b).	'Public Health – a new way of working' project to support the development of the district wide health promotion strategy. Develop a district health promotion strategy (P&CS 1.4b) including consideration of Making Every Contact Count (MECC) and health literacy. Engage with stakeholders on the development of the strategy.	Completion of 'Public Health – a new way of working' project. Documented local partnerships with key health promotion stakeholders. Consultative workshops held and draft strategy developed through a co-design process.	Narrative report on 'Public Health – a new way of working', and nature and extent of engagement with stakeholders.

4.2	Southern DHB role models healthy public policy: • Southern DHB sets a good example through its policies and practices • Southern DHB demonstrates healthy behaviours through actions of staff including their contact with patients (for example making every contact count)	Nutrition and Physical Activity: • Support the ongoing implementation of Southern DHB Healthy Food and Drink policy • Support health provider organisations to adopt a healthy food and drink policy Breastfeeding: A3 review of breastfeeding spaces at Wakari and Dunedin Hospital completed	Number of organisations supported to adopt a healthy food and drink policy Recommendations from A3 review of breastfeeding spaces at Wakari and Dunedin Hospital Implemented	Narrative report on progress towards implementation of Healthy Food and Drink policy Narrative reporting of breastfeeding project
		A systematic approach to achieve Smokefree 2025 including: • Support and promote smokefree sites • Staff and patients supported to be smokefree • Referral pathways to Southern Stop Smoking Services • Support Mā ori pregnant women to be smokefree	Increased number of referrals to the Southern Stop Smoking Service from secondary care 95% of patients in hospitals who are smokers are given advice about support to stop smoking Increased number of of Mā ori pregnant women supported to be smokefree Initiatives in place with Human Resources and Occupational Health and Safety to support staff to be smokefree	Quarterly report from Southern Stop Smoking Service Quarterly report - Better help for smokers in hospitals Report on staff smoking rates
		Support DHB sustainability activities including reducing our carbon footprint and waste. *(SDHB Annual Plan Climate Change/Waste)*	South Island sustainability position statement adopted by Southern DHB	Narrative reporting on activities
		Healthy Homes: work to support a strategic approach achieving warm, dry, affordable and available housing in the Southern district Subject to funding support, roll out the pilot of the Kia Haumaru Te Kaika project aimed at improving housing of children hospitalised with housing related conditions and their whanau to prevent further hospitalisations	South Island Housing Position Statement adopted by Southern DHB Strategic approach developed for healthy homes This project aims to contribute to the Service Level Measure relating to Ambulatory Sensitive Hospitalisation	Narrative report on programme rollout and any measurable outcomes

4.3	Workplace Wellness Approach	Provide support to the People, Culture and Technology Directorate, (via human resources, health and safety/occupational health) to develop a workplace wellness strategy using WorkWell *(subject to DHB adopting this approach)*	Health Needs Assessment of Southern DHB staff is completed identifying priority areas for the strategy	

Supporting Community Action Programme Plan 2019-20

Purpose: Supporting communities to improve their health

Our key priorities for 2019/20 are to:

- Help communities (including education and workplace settings) identify their priorities and provide support to address them
- Utilise both settings and life course approaches
- Work collaboratively to support positive health outcomes
- Improve community resilience to build mental health and wellness.

Through taking an approach to support communities to improve their health, issues such breastfeeding, healthy weight and reduction of sugar sweetened beverages, active transport, sustainability, mental health and wellbeing, housing and becoming smokefree will be addressed.

Key relationships/stakeholders:

- Mental Health Alliance, Networks and Locality Groups
- Smokefree Networks
- Nutrition and Physical Activity Networks
- Alcohol Harm Reduction Networks
- Healthy Families Invercargill
- Employers and Human Resources Networks
- Housing Networks and Governance Groups
- Iwi
- Education settings and networks

	Outcomes	2019-20 activities	Measures	Reporting
5.1	Effective community action that supports healthy choices and behaviours	Engage at a community level to support action that addresses priority needs that support healthy choices and behaviours. This is by: • Providing a tailored health needs assessment to inform community action • Supporting communities to adopt evidence based programmes that reduce health care demand • Adopting place based approaches that build on the existing community resources and strengths Priority areas include housing, air quality, water, smokefree spaces, alcohol, breastfeeding, active transport, and healthy outdoor spaces.	Proportion of community identified issues where evidence based public health approaches have been adopted	Narrative reporting outlines communities and approaches adopted
		Explore a South Island approach to the delivery of the Health Promoting Schools agreement		Narrative reporting on the new model for Health Promoting Schools/Health and Wellbeing
		Work with communities to develop local approaches to contribute to improving Mā ori health and fostering equity Collaborative work with Aukaha and Te Ao Marama in particular around physical environments and housing Building collaborative arrangements with the Mā ori Health Directorate to measure progress to achieve equity for Mā ori	Joint work plan in place identifying collaborative projects Improved Māori health equity measures	Evaluation of projects indicates progress is being made on identified priorities Reporting on a suite of Mā ori health indicators including with non-Mā ori comparisons, e.g. smoking rates, life expectancy at birth, and breastfeeding
		Workforce development to increase Mā ori cultural competencies for Public Health staff	Equity training for Public Health staff completed by 30/6/2020 Stocktake of workplace cultural development undertaken to determine existing staff level of competency	Number of staff attended equity training Stocktake completed
		Improve infant and child nutrition by fostering breastfeeding.	Increased breastfeeding and Mā ori breastfeeding rates	Narrative reporting indicates outcome of initiatives to promote breastfeeding

			Survey early learning settings, primary, intermediate and secondary schools to determine if they have a current 1) water-only (including plain milk) policies and 2) healthy food policies, prioritising those that are low decile and have high numbers of Mā ori students.	Narrative reporting will outline progress
		Smokefree environments are normalised by working with councils on increasing smokefree outdoor spaces.	Number of new outdoor smokefree spaces in the southern district	Narrative reporting indicates outcome of initiatives
		Healthy Housing: Work to support a strategic approach to healthy housing to achieve warm, dry, affordable and available housing. • Public health input to local housing strategic groups • Work with councils and agencies to promote warm and dry housing especially for vulnerable groups	*Cross reference measures and reporting to healthy housing activities in Health promoting health systems programme plan.*	
5.2	Coordinated inter-sectoral action to improve community resilience and mental wellbeing	Explore a South Island approach to building community resilience and wellbeing initiative. Undertake the Kapehu Proiect – a pilot project aimed at building resilience in Youth.	Reduction in the prevalence of youth self-harm in the Southern district	

Communicable Disease Control Programme Plan 2019-20

Purpose: Preventing and reducing spread of communicable disease.

Our key priorities for 2019/20 are:

- Notifiable disease follow-up and outbreak detection and control.
- Border health control activities.
- Support the DHB to implement systems to reduce effects of disease e.g. immunisation, infection prevention and control measures, and antimicrobial stewardship.

The objective of the communicable disease programme is to protect the public from an outbreak of infectious (notifiable) disease.

Currently suspected or confirmed cases of communicable disease are followed up with the aim of interrupting transmission and therefore reducing morbidity and mortality. This year the key priority is to move to a more electronic model of follow up and recording, ensuring consistency across the district and faster timeframes for reporting while maintaining client confidentiality. A secondary priority is to work upstream to reduce the incidence of disease. All work is undertaken in accordance with the Ministry of Health Communicable Disease Control Manual, Immunisation Handbook and ESR Guidelines for the Investigation and Control of Disease Outbreaks.

	Outcomes	**2019-20 activities**	**Measures**	**Reporting**
6.1	Reduced spread of communicable diseases. Outbreaks rapidly identified and controlled.	Maintain an effective system for receiving, considering and responding to notifications of suspected and confirmed cases of communicable diseases of public health concern. • Implement and embed (Research Electronic Data Capture) REDcaps for communicable disease investigations • Implement and embed a district wide triage system for managing diseases Provide education session as required.	A quality improvement programme is implemented in relation to internal processes for handling cases of notifiable disease cases and outbreaks including use of REDcaps, triage system and SharePoint site. Number of education sessions delivered	Number of changes/systems improvements implemented Episurv quality reports

6.2	Protection against introduction of communicable diseases into New Zealand.	Maintain strong relationships with border agencies and ports of entry. Maintain on-call coverage to respond to incidents and emergent issues as required. Undertake two multi-agency border response exercises (Dunedin International airport and South Port). Mosquito interception response exercise completed for health protection officers. Undertake surveillance of mosquitoes at international sea and air ports and provide for mosquito interception responses.	Number of international points of entry that meet requirements of annual verification assessment under International Health Regulations 2005 Number of international points of entry that have contingency plans to deal with ill travellers and other border health responses Multi-agency border response exercises completed and learnings incorporated into plans Number of exotic mosquitoes that have crossed the border and established	12 month vital few report for border health Annual border health report completed 12 month vital few report for exotic mosquitoes
6.3	Needle Exchange Programme	Authorisation of needle exchange premises	Number of authorised needle exchanges Audits of needle exchanges completed	
6.4	Improved immunisation rates	Contribute to strategic and operational approaches to increase vaccination coverage.	Public Health participates in Vaccine Preventable Disease Steering Group. Review of internal processes around authorised vaccinator approvals completed.	Vaccine Preventable Disease Steering Group Report

Healthy Physical Environment Programme Plan 2019-20

Purpose: Working with stakeholders and their frameworks to improve Public Health.

Our key priorities for 2019/20 are to:

- Work with Territorial Authorities on the quality and safety of the environment including water, air quality and other planning matters
- Develop relationships with decision makers to support healthy environments e.g. government agencies, Department of Conservation, and NZ Transport Agency
- Develop a joint working group for water quality issues

Work undertaken within the Healthy Physical Environments Programme is in accordance with the requirements of the Ministry of Health Environmental Health exemplars, manuals and guidance, policy and advice, Health Protection Service Specifications, and designated officer statutory and legislative requirements. Public Health will provide technical advice on resource management issues to runaka representatives - Te Ao Marama and Aukaha where appropriate.

Key relationships/stakeholders:

- Ministry of Health
- ESR
- Territorial (Local) Authorities
- Regional Councils
- Planning/policy development staff (Councils)
- Drinking water suppliers
- Ministry of Education
- Ministry for the Environment
- Aukaha
- Te Ao Marama

	Outcomes	2019-20 activities	Measurements	Reporting
7.1	Drinking water supplies are effectively managed so as not to pose any unnecessary risks to human health.	Undertake all duties and functions required by the Health Act 1956 as it relates to water supplies. Facilitate and enhance an effective Joint Working Group to promote drinking water quality and safety across the district. Develop and embed escalation pathway for managing non-compliant drinking water supplies.	Annual Survey of Drinking Water Supplies in New Zealand is completed Joint work plan developed Number and proportion of serious drinking water incidents/suspected or confirmed water borne disease outbreaks reported to the Ministry of Health Escalation pathway for non-compliant water supplies embedded IANZ accreditation maintained	12 month vital few reporting regarding water supplies
7.2	Risks to public health through the management of hazardous substances are effectively managed.	Process applications for Vertebrate Toxic Agent (VTA) operations that require public health permissions. Represent public health interests at meetings of the area HAZMAT Coordination Committee and provide advice when required to attend HAZMAT incidents.	Number of audited VTA operations compliant with approval conditions Number of HAZMAT incidents attended Environmental Protection Agency reports completed following all incidents attended	12 month vital few report regarding VTAs Completion of annual HSNO Activities and Intentions Report by 30/6/2019 Narrative reporting following incidents and learnings from debrief
7.3	Environments are managed so that communities are protected from hazards and are supported to be connected, active in the outdoors, and are safe and have good mental health.	Work with local government and communities to address air quality, recreational water and waste. Review and formalise a memorandum of understanding with councils for a joined up district wide approach to recreational water. Facilitate a multi-agency working group to support improved air quality and warmer drier homes with a focus on priority air sheds in Central Otago, South Invercargill and Gore. Work with local government on sustainability approaches to minimise the production of waste, increase recycling and manage the hazards from waste disposal.	Actions in the Southern DHB Air Quality Position Statement are implemented Southern wide consistent approaches to water monitoring and responses Reduced PM exceedances in winter months New waste diversion initiatives implemented	

Emergency Preparedness Programme Plan 2019-20

Purpose: Minimising the public health impact of any emergency.

Our key priorities for 2019/20 are to:

- Contribute to district pandemic planning and other public health emergencies.
- Participate in exercises to improve readiness.
- Develop community resilience as an important harm reduction measure.
- Public health emergency response plans are up-to-date.

The objective of the emergency preparedness programme is to ensure public health staff are familiar with the local structures, agencies and personnel involved in emergency management.

Key relationships/stakeholders:

- Ministry of Health
- Southern DHB Emergency Planners
- Emergency Management Otago
- Emergency Management Southland
- Territorial Authorities.

	Outcomes	2019-20 activities	Measures	Reporting
8.1	Public health emergency response plans are up-to-date.	Maintain and regularly review plans for responding effectively to a range of public health emergencies. • Documentation and templates streamlined. Undertake staff training to familiarise them with the revised plan. Support district wide pandemic planning with the DHB Emergency Manager.	Public Health Emergency plan reviewed and updated annually	12 month vital few reporting
		Maintain public health emergency response capacity, including staff trained in emergency management. 100% of regulatory staff completed CIMS 4 Participate in emergency exercises to improve readiness as appropriate	Number of health protection officers, medical officers of health and communicable disease nurses completing CIMS 4 training Number of non-regulatory staff completing introductory CIMS training Number of non-regulatory staff completing CIMS 4 training	12 month vital few reporting Narrative reporting on exercises completed and learnings from debrief
		Develop and maintain relationships with key emergency management stakeholders, e.g. CDEM, Regional Councils, and District Councils about public health infrastructure.	Number of joint workshops and training activities participated in	Narrative reporting on exercises completed and learnings from debrief
8.2	Public health impact of any emergencies is understood and processes are in place to manage.	Take appropriate public health emergency actions as required. Promote community resilience as a harm reduction measure. Provide assistance to DHB psychosocial support team.	Number of emergency responses that public health has participated in	Narrative reporting on involvement in public health emergencies and learnings from debriefs

7.5 System Level Measures Improvement Plan

AllianceSouth
Better health together

WellSouth
Primary Health Network
Kaiwora Matua Ki Te Tonga

Southern District Health Board
Piki Te Ora

System Level Measures Improvement Plan

2019/20

Table of Contents

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 lead 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 local clinically led quality improvement initiatives, which in turn are underpinned by Contributory measures. 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 2019/20 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"

Through 2019-20 SDHB will focus on increasing capability in continuous quality improvement, using the SLM framework. During the 2019-20 year a number of actions will take place to enable this. They include:

- 2018-19 established a SLM group focusing on ASH 0-4 and Babies who live in a Smoke-Free Households. This team will continue to develop actions that have been identified during the 2018-19 year and will be implemented during the 2019/20 year. Capability in the team focusing on the health of our children include, Paediatric Specialists, Respiratory Specialists, Oral Health, Maternity, WellSouth PHO, SDHB strategy and Child Health.
- During 2019-20. The SDHB, Mental Health- Alliance Network Leadership Group (NLG) will use the SLM framework to develop actions targeting the Youth Measure; Mental Health Domain.
- SDHB Māori Health Directorate will form a new Clinical Māori Strategy Group, and focus on reducing the equity gaps that are evident in the ASH 45-64, Amenable Mortality and Acute Hospital Bed Days SLMs'. This represents building new capability within the SDHB using the SLM framework.
- SDHB and WellSouth PHO will continue to develop the SLMs' into our Outcomes Framework reporting tool. This will allow immediate 'dashboard' style reporting on all of our SLMs including the ability to drill into the SLM trend over time.

In selecting Actions, Contributory Measures, and end of year Milestones, the review process has looked to ensure that each action 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.

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.

Signatories:

Chris Fleming
CEO Southern DHB

Andrew Swanson-Dobbs
CEO WellSouth PHN

Dr Carol Atmore
Chair of Alliance South

System Level Measures – Overview

System Level Measures:	1.0 Ambulatory Sensitive Hospitalisations	2.0 Acute Hospital Bed Days per Capita	3.0 Patient Experience of Care *Domain-Communication*	4.0 Amenable Mortality	5.0 Youth System Level Measure *Domain-Mental Health & Wellbeing*	6.0 Proportion of babies who live in a smoke-free household at six weeks
Contributory Measures:	1.1 Hospital admissions for children 0-4 years with a primary diagnosis of asthma or upper/ENT respiratory infection	2.1 Inpatient Average Length of Stay (ALOS) for acute admissions	3.1 Did a member of staff tell you about medication side effects to watch for when you went home	4.1 Primary Health Organisation (PHO) enrolled women aged 25 to 69 years who have received a cervical smear in the past 3 years	5.1 Hospitalisations due to self-harm	6.1 Percentage or number of infants who are exclusively or fully breastfed at six weeks from Lead Maternity Carer (LMC) care
	1.2 Hospital admissions for children with a primary diagnosis of dental conditions	2.2 Acute readmissions to hospital		4.2 Faster Cancer Treatment		6.2 Pregnant women who identify as smokers upon registration
		2.3 Ambulatory sensitive hospitalisations rate for 45-64 year olds.				6.3 Pregnant women registered with a Lead Maternity Carer within first trimester of pregnancy

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

Where are we now? Ambulatory Sensitive Hospitalisations Summary

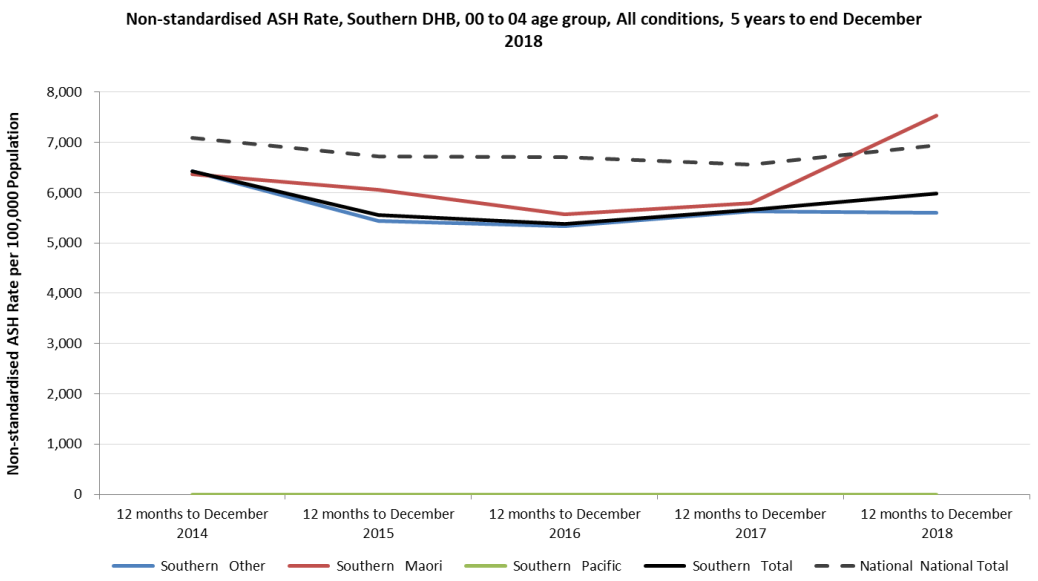
SDHB continue to have rates equal to or below national levels. SDHB rates for Maori 0-4 year olds in Southern DHB has had a significant increased over the past 12 months. The ASH rate for our Pacific 0-4 children is significantly higher than all other groups. The most prevalent clinical conditions that contribute to this ASH rate include respiratory conditions (infections and asthma), gastroenteritis, dental conditions and cellulitis. In response to the equity gap that is apparent in our base line data, our Kaupapa Maori General Health Services will have a focus on impacting this measure, starting with a focus on the highest rate; Upper and ENT respiratory infection.

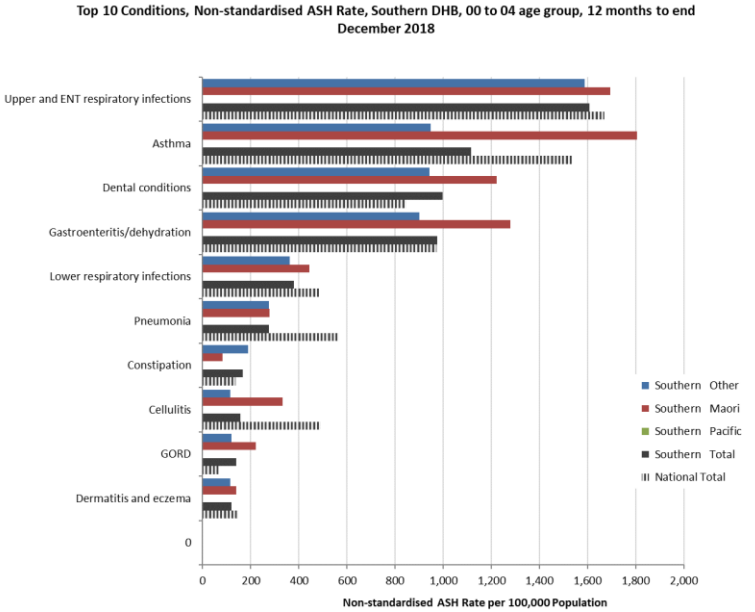
Measure description:

Non-standardised Rate per 100,000 as per non-financial quarterly measure

Baseline Data

Five year trend ASH 0-4 to December 2018





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

Improvement Milestone for 2019/20: <5,678 per 100,000

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

How will we get there?

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.

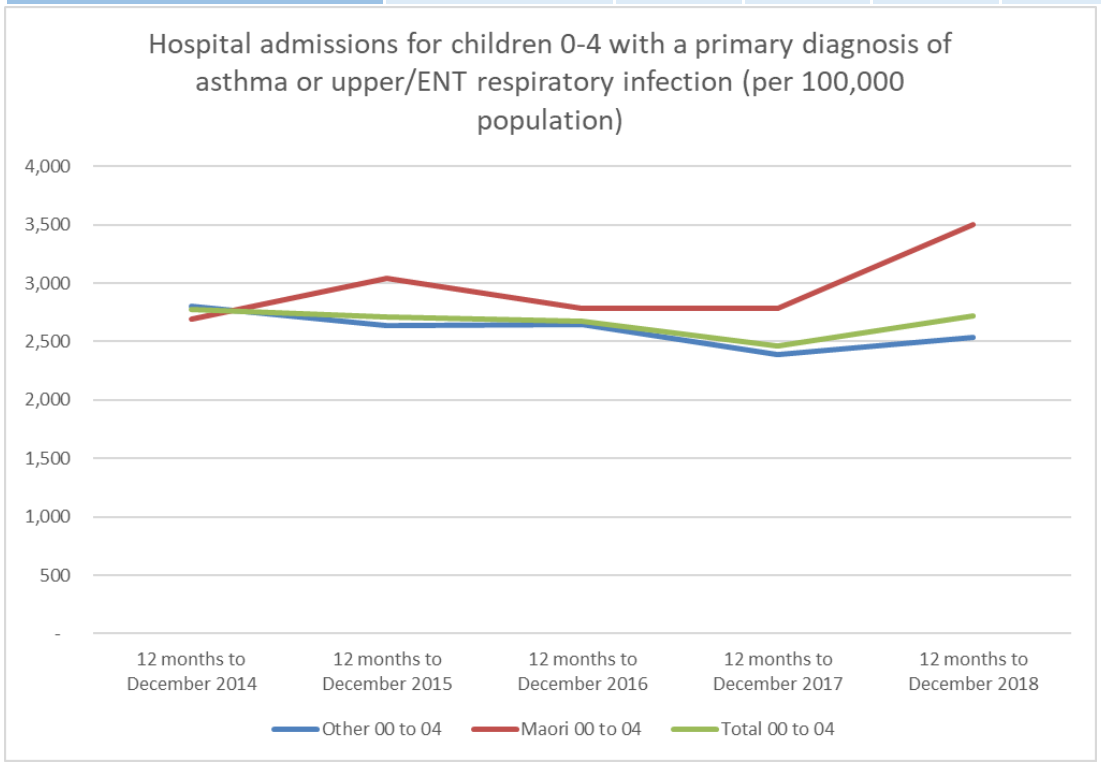
1.1 Hospital admissions for children 0-4 years with a primary diagnosis of asthma or upper/ENT respiratory infection

Measure description: Non-standardised rate per 100,000 as per non-financial quarterly measure – system integration 1
2019/20 Improvement Milestone: <2,586
2019/20 Improvement Milestone: Maori children <3,325

Baseline Data:

Hospital admissions for children aged up to four years with a primary diagnosis of Asthma or Upper and ENT respiratory infections

	12 months to December 2014	12 months to December 2015	12 months to December 2016	12 months to December 2017	12 months to December 2018
Maori	2,691	3,040	2,789	2,786	3,500
Total	2,779	2,712	2,671	2,462	2,723



Activities that will enable us to achieve the Improvement Milestone

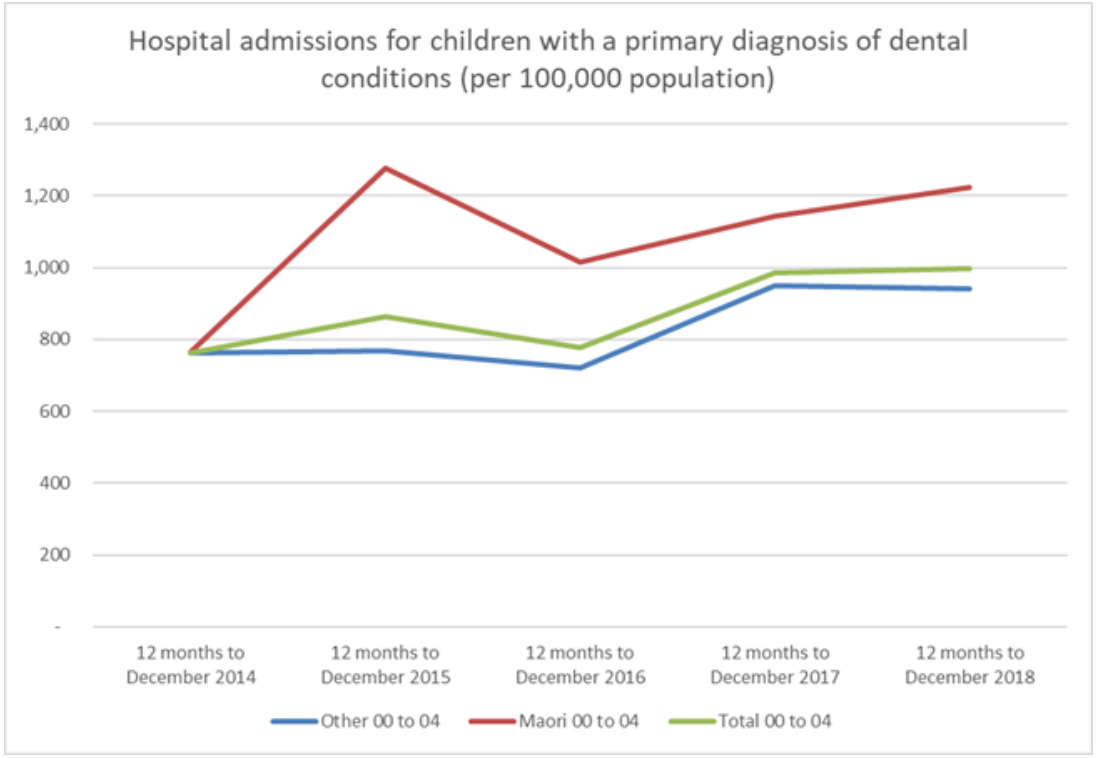
- Undertake an audit of the ASH 0-4 admissions to paediatrics, improving our understanding of these children and their families
- Screening admissions to paediatrics to ensure WellSouth enrolment for all presentations
- To develop a Respiratory Nurse Educator Role 0.2 focus within Child Health.
- To develop a process and referral pathway between Paediatric Department 0-4 year presentations to the Cosy Home Service.
- Introduce Stop Smoking Incentivised Programmes for families of children admitted to Paediatrics with a primary diagnosis of asthma / respiratory infection. (EoA)
- Kaupapa Maori General Health Services will focus exclusively on respiratory ASH admissions for 0-4 year olds. Analysis matching ED and PHO data will identify where services will be targeted. Families will be supported by Kaiawfuna (support person) to have appropriate services wrapped around these children including WellSouth PHO outreach nursing services and Maori Health NGO providers. (EOA)
- Complete the implementation of relevant Health Pathways. Measure utilisation and educate to increase use. Ensure that the pathways identify linkages to relevant services.
- WellSouth will work towards building a shared understanding for the need for change in the model of primary care access in Invercargill, particularly after hours.

1.2 Hospital admissions for children 0-4 years with a primary diagnosis of dental conditions

Measure description: Standardised rate per 100,000 as per non-financial quarterly measure – system integration 1
2019/20 Improvement Milestone: <946

Baseline Data:

Hospital admissions for children aged up to four years with a primary diagnosis of Dental conditions	12 months to December 2014	12 months to December 2015	12 months to December 2016	12 months to December 2017	12 months to December 2018
	763	863	776	987	996



Activities that will enable us to achieve the Improvement Milestone

- Promote oral health services for preschool children to increase oral health examinations provided to children under two years, commencing at age six months Q1-Q4
- Increase fluoride varnish applications to 0-4 year olds
- Increase engagement of the dental service with Maori NGOs and WellChild providers and preschools to identify equity gaps
- Prioritise Maori and Pacific children into the dental service with a targeted enrolment pathway. (EOA)
- Southern DHB will develop a healthy food and drinks policy (HF&DP) clause in Q1 2019/20 and will append this clause into all applicable contracts upon their variation or renewal as they arise effective from 1 July 2019.

2.0 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 and Pacific population generally has a higher bed days rate and has lifted in the 2018 year.

Acute hospital bed days rates are highly correlated with age, with the exception of 0-4 years olds, and Southern DHB performs better than the national average showing sustained reduction in rates in **all** age groups, especially the older age groups.

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.

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

Deprivation Quintile Comparison - Actual Acute Bed Days per Capita Rates

	Estimated Popn	Acute Stays	Acute Bed Days	Actual Acute Bed Days per 1,000 Popn		
Dep Quintile	Year to Dec 2018	Year to Dec 2018	Year to Dec 2018	Year to Dec 2016	Year to Dec 2017	Year to Dec 2018
1	75,549	6,307	21,702	322	272	287
2	76,829	6,121	19,759	303	289	257
3	66,941	8,778	33,859	567	521	506
4	64,426	8,565	28,593	594	486	444
5	38,265	5,792	16,400	512	460	429
Total	322,010	35,563	120,312	445	393	374

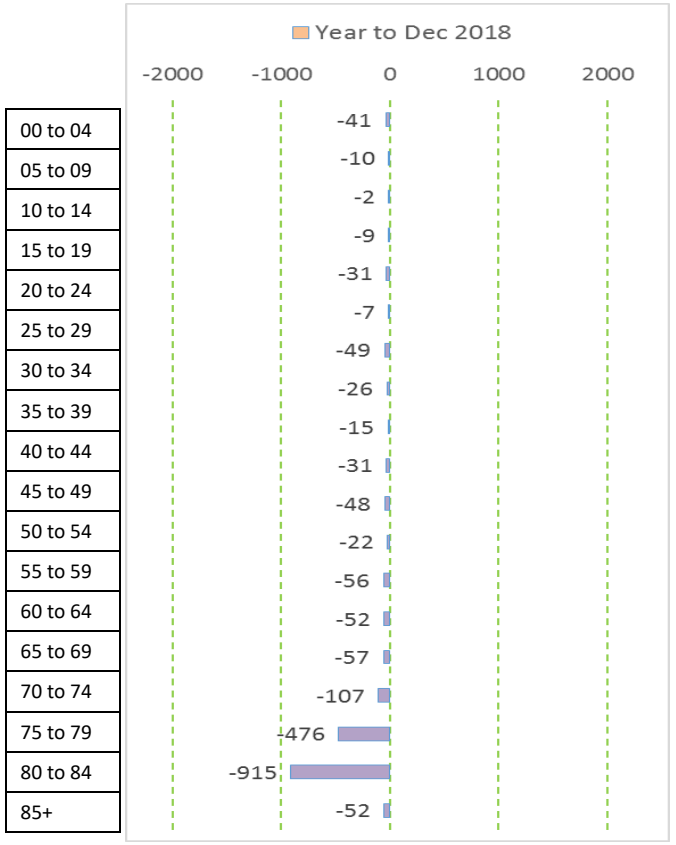
Ethnic Group Comparison- Standardised Acute Bed Days

	Estimated Popn	Acute Stays	Acute Bed Days	Standardised Acute Bed Days per 1,000 Popn		
Year	Year to Dec 2018	Year to Dec 2018	Year to Dec 2018	Year to Dec 2016	Year to Dec 2017	Year to Dec 2018
Maori	33,290	3,730	9,562	438	389	393
Pacific	6,540	924	2,430	458	512	493
Other	282,180	30,909	108,320	394	344	324
Total	322,010	35,563	120,312	399	350	333

Key contributing clinical conditions/1000

	Southern DHB of Domicile			National		
	Estimated Popn	Acute Bed Days	Actual Acute Bed Days per 1,000 Popn	Estimated Popn	Acute Bed Days	Actual Acute Bed Days per 1,000 Popn
Top 50 DRG Clusters	Year to Dec 2018	Year to Dec 2018	Year to Dec 2018	Year to Dec 2018	Year to Dec 2018	Year to Dec 2018
B70 Stroke and Other Cerebrovascular Disorders	322,010	5,571	17	4,799,800	83,778	17
E62 Respiratory Infections/Inflammations	322,010	3,389	11	4,799,800	64,713	13
I08 Other Hip and Femur Procedures	322,010	3,555	11	4,799,800	50,481	11
F62 Heart Failure and Shock	322,010	2,397	7	4,799,800	49,350	10
E65 Chronic Obstructive Airways Disease	322,010	1,975	6	4,799,800	34,831	7
J64 Cellulitis	322,010	2,224	7	4,799,800	47,526	10
G70 Other Digestive System Diagnoses	322,010	2,670	8	4,799,800	38,287	8
L63 Kidney and Urinary Tract Infections	322,010	1,763	5	4,799,800	36,574	8
A06 Tracheostomy	322,010	4,208	13	4,799,800	36,356	8
I68 Non-surgical Spinal Disorders	322,010	1,272	4	4,799,800	29,027	6

Difference Between SDHB and NZ Rates



Where do we want to be?

Long term improvement milestone: 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.

Improvement Milestone for 2019/20: 316 Standardised Acute Hospital Bed Days per 1000 Capita. 373 standardised bed days for Maori per 1000 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?

Over the 2019-20 year the SDHB along with WellSouth PHO will develop joint capability within our health system to use the SLM framework. The Maori Health Directorate will form a Clinical Māori Strategy Group team who will focus on reducing the equity gaps that are evident in this measure. Along with building capability, a number of initiatives will continue to be developed. Key to reducing our ALOS is the Kaupapa Maori General Health Services. This service will integrate specifically with primary care, through WellSouth PHO outreach nursing and Maori NGO providers, and hospital services such as the Home Team.

Activities that will enable us to achieve the Improvement Milestones

- The Maori Health Directorate will form a Clinical Maori Strategy Group to focus on the Acute Bed Days SLM. Actions will be delivered by Kaupapa Maori General Health Services

2.1 Inpatient Average Length of Stay (ALOS) for acute admissions

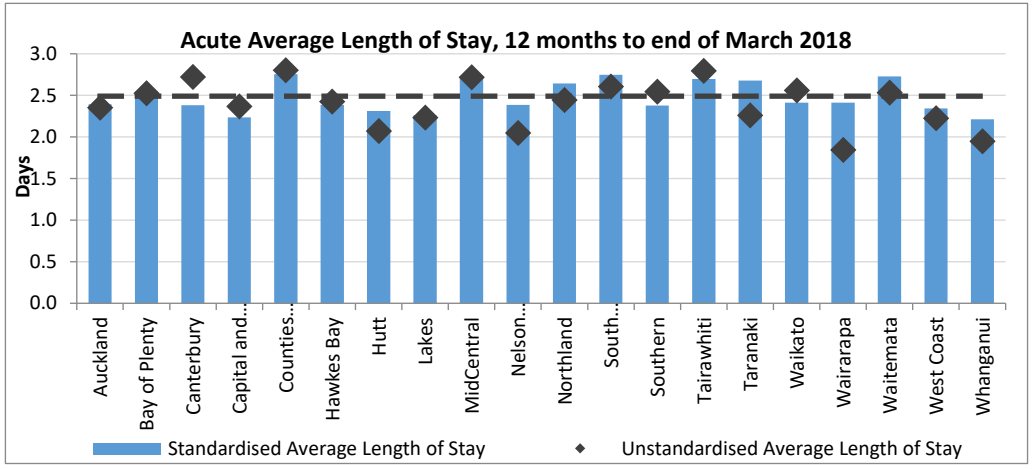
Measure description: Non-Financial Quarterly Reporting – Ownership measure

2019/20 Improvement Milestone: Stay below the MOH target (2.35)

Baseline Data

2019/20 Improvement Milestone: Stay below the MOH target (2.35)

DHB	Stays	Bed Day Equivalents	Unstandardised Average Length of Stay	Standardised Average Length of Stay
Southern	36,061	91,761	2.54	2.38



Activities that will enable us to achieve the Improvement Milestone

- Continue roll out the Home Team initiative, supporting early discharge and avoided admission with an integrated inter-professional team in Dunedin and Invercargill.
- Provide cultural advisory/liaison services to the SDHB Home Team through the Māori general hospital services.
- Kaupapa Maori General Health Services RN and Kaiawfuna will coordinate care for Maori who present to the hospital. Focus for this team will be on the following conditions; (EOA)
  - Respiratory
  - ED presentations
  - CVD
  - Stroke
  - Diabetes
  - Dialysis
  - Maternity
- Kaupapa Maori General Health Services will coordinate their activity with the Home Team, WellSouth PHO outreach nursing services and Maori Health NGO providers. This will ensure integration of care between hospital and community care, into the home. (EOA)

2.2 Acute readmissions to hospital

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

2019/20 Improvement Milestone: <12.0%

Baseline Data

	Year to Sep 2016		Year to Sep 2017		Year to Sep 2018				
DHB of Service	Readmission Rate	Standardised Readmission Rate	Readmission Rate	Standardised Readmission Rate	Stay Discharges	Readmission Rate	Rank	Standardised Readmission Rate	Rank
National	11.5%	12.1%	11.8%	12.2%	925,917	12.0 %		12.1%	
Southern	11.5%	11.9%	12.2%	12.2%	53,972	12.0 %	10	12.0%	11

Activities that will enable us to achieve the Improvement Milestone:

- Rollout 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.
- Clinical pharmacists to focus on polypharmacy and targeted conditions to reduce medicines related re-admissions.
- POAC (Primary Option for Acute Care). Further scale the use of these services in primary care to prevent hospital admission.
- Development of a Māori data policy that enables communication between primary, secondary and our Kaupapa Māori Health providers in following up Māori acute readmission.
- Kaupapa Maori General Health Services within the hospital setting will be involved with discharge planning. This team will also identify readmissions (above data policy) and focus their services with these patients, supporting the family and ensuring appropriate care into the home. (EOA)

2.3 Ambulatory sensitive hospitalisations rate for 45-64 year olds (per 100,000)

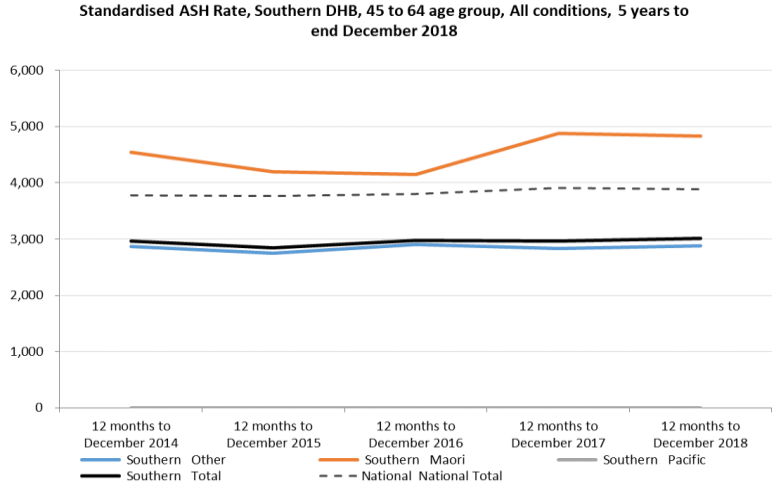
Measure description: Standardised rate per 100,000 as per non-financial quarterly measure – system integration

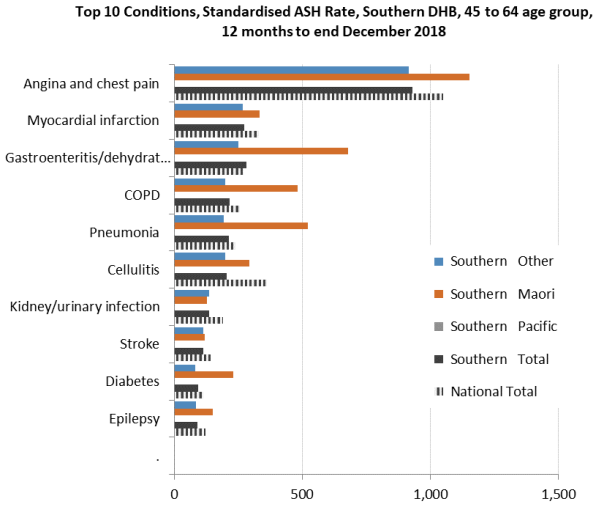
Improvement Milestone for 2019-20: <2,865

Baseline data:

Five year trend ASH 45-64 to December 2018

	12 months to December 2014	12 months to December 2015	12 months to December 2016	12 months to December 2017	12 months to December 2018
Southern DHB total ASH rate per 100,000 (standardised)	2,996	2,840	2,982	2,966	3,016



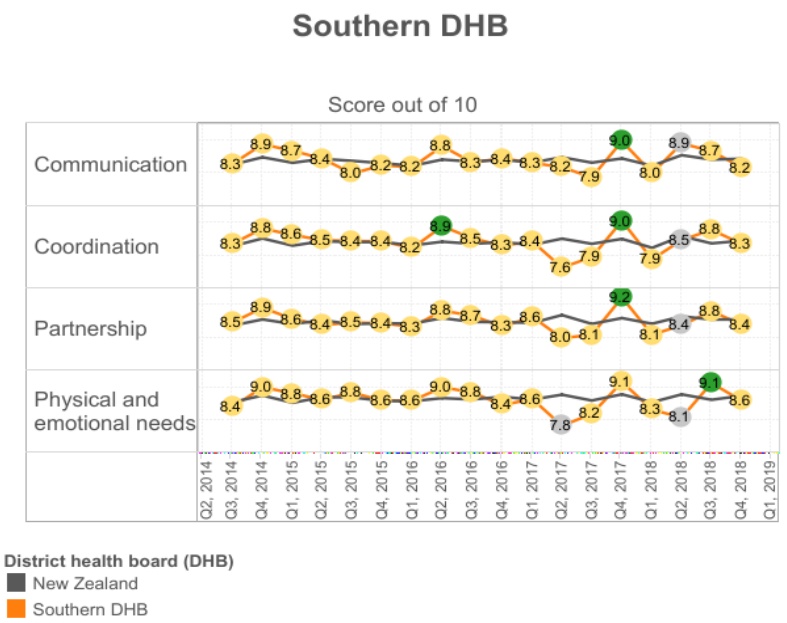


Activities that will enable us to achieve the Improvement Milestone

- Formation of a Clinical Māori Strategy Group by the Māori Health Leadership Team.
- The newly established group will undertake a stocktake of activity impacting on ASH 45-64.
- A list of actions, milestones and key accountabilities will be presented to ALT for inclusion in the 2020-21 SLM Implementation plan. With an equity focus (EOA)
- Kaupapa Maori General Health Services RN and Kaiawfuna (support person) will coordinate care for Maori who present to the hospital, manage discharge and plan services that will be provided in the community. Focus for this team will be on the following conditions:
  - Respiratory
  - ED presentations
  - CVD
  - Stroke
  - Diabetes
  - Dialysis
  - Maternity

3.0 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 the New Zealand average. The primary care patient experience survey has been taken up by all but 9 General Practices in Southern DHB. Those who have not engaged with this survey undertake their own survey of patient experience.	
Measure description	
As per HQSC – patient experience reporting/ **Communication Domain**	
Baseline Data	



Where do we want to be?

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

Improvement Milestone for 2019/20: Communication Domain. Milestone > 8.2

Rationale: The SDHB will focus on its worst performing measure and implement actions to improve this measure. Currently this sits within the communication domain relating to medication advice provided to patients going home.

How will we get there?

Focus for improvement will be on the lowest scoring areas in the previous year, aligning to government planning priorities. For 2019-20 SDHB and WellSouth PHO will focus on improving the lowest performing scores in the communication domain.

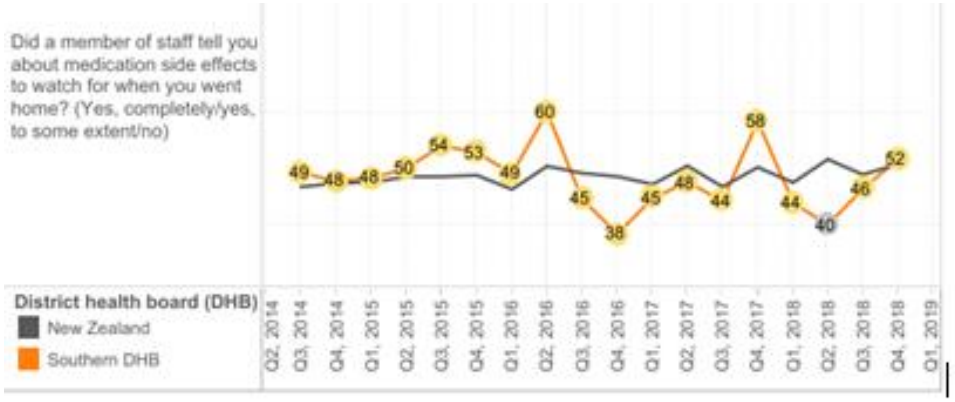
3.1 Did a member of staff tell you about medication side effects to watch for when you went home?

Measure description: As per HQSC patient experience reporting.

2019/20 Improvement Milestone: To improve SDHB **> 5.2** To improve WellSouth PHO **> 4.6**

Baseline Data

Southern DHB



WellSouth PHO

	National	Filtered
Here are some questions about your medications prescribed or recommended by a doctor, nurse or pharmacist (outside hospital). *Were you told what to do if you experienced a side effect?*	6.7	4.6

Activities that will enable us to achieve the Improvement Milestone

- Implement a coordinated approach to using the University of Otago polypharmacy clinic for SDHB patients.
- The Quality team will increase the mail out to 500 to ensure that the actual returns for this survey are increased, based upon our existing return rate.
- The quality team will develop actions to be implemented for the next quarterly survey

- Support medication management within the SDHB Home Team patients using WellSouth Clinical Pharmacists. WellSouth Clinical Pharmacists will work closely with the SDHB Home Team to support staff and patients with medication education and advice. This patient cohort represents high needs LTC patients who are discharged from hospital but require additional support at home.

4.0 Amenable Mortality "Prevention and Early Detection"

Where are we now? Amenable Mortality Summary

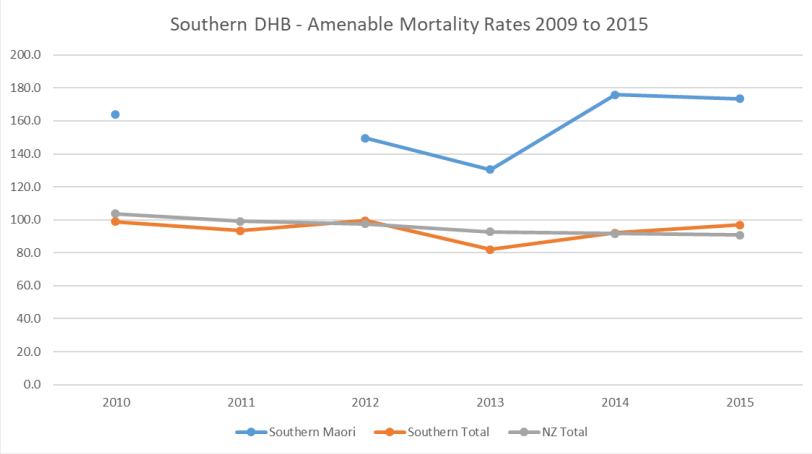
Total amenable mortality rates have been declining in Southern DHB. The data is still presented by the Ministry of Health individually for Otago and Southland rather than a single Southern DHB view, and it is not possible to combine the data without a clear numerator and denominator. It is noted that 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 2015



Southern – Top amenable mortality deaths, 0-74 year olds, 2010-2015	
Coronary disease	611
COPD	269
Suicide	236
Cerebrovascular diseases	202
Female breast cancer	177

	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

	2010	2011	2012	2013	2014	2015
Southern Maori	163.9		149.6	130.4	175.9	173.5
Southern Total	99.0	93.3	99.4	81.9	92.2	96.9
NZ Total	103.7	99.1	97.5	92.8	91.6	90.8

Where do we want to be?

Long term improvement milestone: 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.

Improvement Milestone for 2019/20: 5% reduction in the Southern Maori rate to 164.8 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?

Activities that will enable us to achieve the goals

- The Maori Health Leadership Team will form a Clinical Māori Strategy Group to undertake a review of how we address equity gaps in our amenable mortality outcomes.
- A list of actions, milestones and key accountabilities will be presented to ALT for inclusion in the 2020-21 SLM Implementation plan. With an equity focus (EOA) Focus will initially be on improving access to cervical screening for Maori women

4.1 Primary Health Organisation (PHO) enrolled women aged 25 to 69 years who have received a cervical smear in the past 3 years

Measure description: Measured on Rolling three year basis, information provided by National Screening Unit
2019/20 Improvement Milestone: >80%

Baseline Data

	2016	2017	2018
Screened last 3 years	68,475	68,844	70,261
Eligible Population	92,925	94,002	94,859
Achievement rate	**74%**	**73%**	**74%**

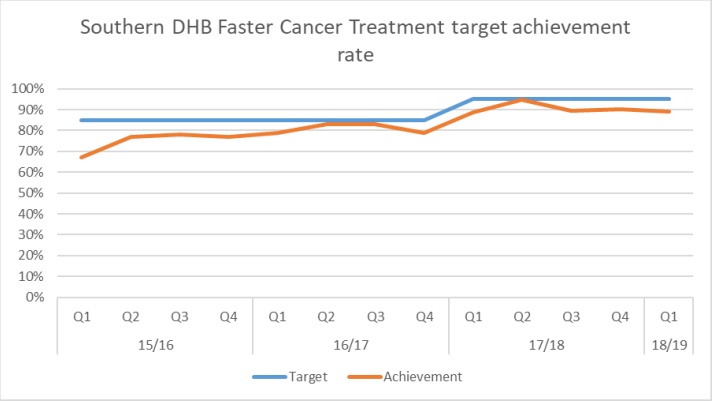
Activities that will enable us to achieve the Improvement Milestone

- The Associate Māori Health Strategy and Leadership Officer continues to mentor, guide and build the cultural competency cervical screeners.
- Cervical Screening Events will be held in Dunedin and Invercargill 6 weekly with a focus on priority populations.
- Cervical Screening Events will be held bi-annual with a focus on rural areas of North Otago and Central Otago.
- A pilot project will occur in partnership with the Mornington Health Centre linking with the Interpreter Service to engage with women across all health determinants. (EOA)

4.2 Faster Cancer treatment

Measure description: Patients who receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer and are seen within two weeks to receive their first cancer treatment
2019/20 Improvement Milestone: 95%

Baseline Data



Activities that will enable us to achieve the Improvement Milestone

- The newly formed clinical Māori Strategy group will monitor and provide advice for Faster Cancer Treatment with the Cancer Coordination team.
- Provide support and review resources for the Māori cancer Kaiarahi navigation services in the community across the district. (EOA)

5.0 Youth System Level Measure "Youth are healthy, safe and supported"

Where are we now? Youth System Level Measure Summary

We have selected the Domain **"Mental Health and Wellbeing".**

Measure description

Measure description: Intentional self-harm hospitalisations (including short-stay hospital admissions through Emergency Department) for <25 year olds

Baseline Data

Numerator Total number self-harm hospitalisations (10-24)

Denominator Youth Domicile Population (10-24) Source: MoH provides annually

	Population	Total Number of Self Harm Hospitalisations	Actual Self Harm Hospitalisation Rate (per 10,000 popn)	Age Standardised Self Harm Hospitalisation Rate (per 10,000 population)		
Gender	Year to Sep 2018	Year to Sep 2018	Year to Sep 2018	Year to Sep 2016	Year to Sep 2017	Year to Sep 2018
Male	35,150	97	27.6	25.4	25.3	26.3
Female	34,520	328	95.0	80.4	101.2	92.6
Total	69,670	425	61.0	52.8	63.2	59.3

	Population	Total Number of Self Harm Hospitalisations	Actual Age-specific Self Harm Hospitalisation Rates (per 10,000 population)		
Age Group	Year to Sep 2018	Year to Sep 2018	Year to Sep 2016	Year to Sep 2017	Year to Sep 2018
10 to 14	19,320	45	17.4	22.4	23.3
15 to 19	23,360	210	83.4	106.8	89.9
20 to 24	26,990	170	55.9	58.3	63.0
10 to 24	**69,670**	**425**	**54.9**	**65.0**	**61.0**

	Population	Total Number of Self Harm Hospitalisations	Actual Self Harm Hospitalisation Rate (per 10,000 popn)	Age Standardised Self Harm Hospitalisation Rate (per 10,000 population)		
Ethnicity	Year to Sep 2018	Year to Sep 2018	Year to Sep 2018	Year to Sep 2016	Year to Sep 2017	Year to Sep 2018
Maori	5,180	19	36.7	37.8	30.1	36.8
Pacific	955	3	31.4	22.2	22.9	31.7
Other	29,015	75	25.8	23.8	24.8	24.1
Total	35,150	97	27.6	25.4	25.3	26.3

Where do we want to be?

Long term improvement milestone: DHB has primed our Network Leadership Group to be aware of the potential impact of the implementation of the Mental Health Inquiry recommendations

Improvement Milestone for 2019/20: **To reduce the rates for Maori Females aged 15-19 by 5%. (34.96%, 87.97%, 85.4% respectively)**

Rationale:

Intentional self-harm typically expresses an attempt at emotional regulation in the face of trauma or distress. It is typically triggered because of relationship difficulties, trauma, bullying, alcohol or drug misuse, adjustment and stigma for sexuality or gender issues, or similar stressors.

Alignment to annual plan will offer a better fit with resource allocation and potentially engage other sectors to contribute to this outcome, for example, through community engagement and activity in something like violence prevention in Waitaki.

The data interrogation will enable a better understand of the principal cause of self-harm across the district and allow for more focussed interventions, for example, if alcohol and drugs are the main contributory to self-harming in most areas, then programmes that focus on AOD awareness and harm reduction should be more successful in reducing self-harm numbers at ED.

How will we get there?

Through the identified activities that contribute to self-harm reduction – based on a more detailed understanding of the contributory factors to self-harm presentations at ED.

Data interrogation and alignment to get full picture, alongside deeper understanding of the cause of self-harm to help inform appropriate interventions for reduction.

5.1 Hospitalisations due to self-harm

Measure description: Intentional self-harm hospitalisations (including short-stay hospital admissions through Emergency Department) for <25 year olds

Baseline data - Southern DHB	Activities that will enable us to achieve the Improvement Milestone
See above (total number self harm hospitalisations)	○ Alliance Network Leadership Group (NLG) will use the SLM framework to inform actions for reducing mental distress in young people across the district in 2019 to 2020. The framework will be used to guide oversight of the operation and implementation of the actions. ○ Supporting Parents, Health Children project activities By Q2, complete implementation of the Supporting Families, Healthy Children project, subsequent to gap analysis, followed by implementation plan roll out. This work looks at extending the service, subject to MoH funding, and further engages with CMHTs, including training for single session family therapy by Q4. ○ Resilience programme for youth (public health) SDHB Public Health Service to monitor implementation of the Kapehu Youth Resilience Project ○ Mental Health Inquiry activities Plan, with alignment to the government's timeline for implementation of the Inquiry recommendations and the government guidance Create workgroups in each locality group to identify priorities from Inquiry report recommendations that are relevant to local communities and Identify how these priorities can be implemented collaborative by all local community partners to achieve outcomes

Baseline Data – WellSouth PHO

Where are we now

WellSouth will focus on improving access to primary care through 2019-20. The rationale is that improving the ability for our young people to access primary care in a timely way will reduce the incidence of, and need to present to ED for self-harm.

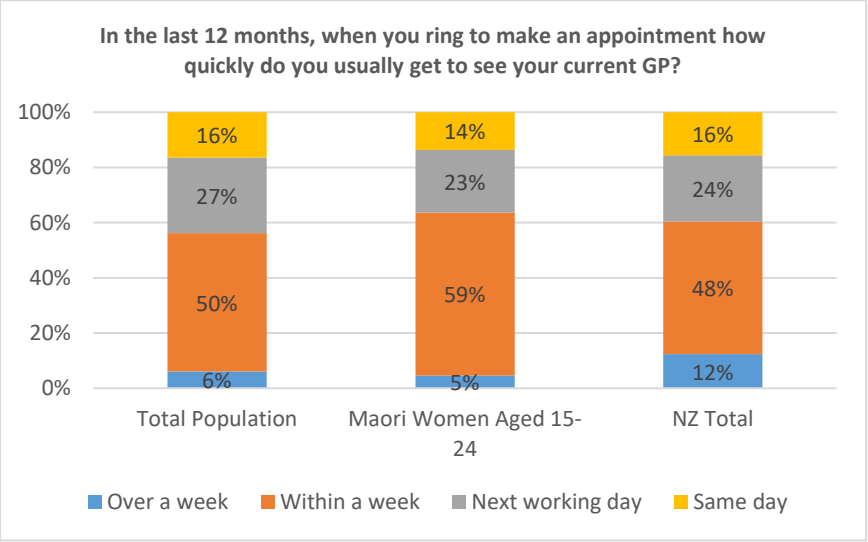
Improvement Milestone for 2019/20: Access on the same day > 14% for Maori Women aged 15-24. Patient portals offered by GPs > 60% and patient use > 15%

Access to usual GP

	Total Population	Maori Women Aged 15-24	NZ Total
Over a week	6%	5%	12%
Within a week	50%	59%	48%
Next working day	27%	23%	24%
Same day	16%	14%	16%

Use of Patient portals

WellSouth PHO	Registered	% total
Patients using Portals	35135	11.40%
Practices with Portals	43	55%



Activities that will enable us to achieve the Improvement Milestone

WellSouth and Southern DHB are addressing issues of access in primary care with their long-term conditions management programme: **CLIC and their Health Care Home (HCH) Programme.**

16 practices to go through the Health Care Home transformation represent around 123,000 enrolled patients (approx. 39.7% of the enrolled population) and 13,800 Maori or Pacifika patients (approx. 38.7% of the total Maori/Pacifika people enrolled in Southern). Our goal when considering how to expand the programme in 2019-20 is how to increase the number of high-needs patients who are affected by the programme. In the most recent reported month

- 1097 triage calls were made in June
- 44% were resolved in triage, with 81% of those requiring advice only
- 443 extra appointments were made available in June as a consequence

The CLIC programme is intended to free up capacity by allowing practices to proactively manage patients with long-term conditions and reduce the number of acute presentations across the system. We are currently transferring patients away from CarePlus into CLIC and all practices will be part of the CLIC programme by the end of December 2019.

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

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

This measure promotes the roles which collectively, infant and child service providers play in the infant's life and the many opportunities for smoking interventions to occur. The patient benefit in this measure is a smokefree outcome for the baby's home and therefore no exposure of baby to cigarette smoke. This includes benefit for whoever is smoking in the house becoming an ex-smoker.

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

Measure description

Numerator
Number of new babies, up to 56 days of age, with 'No' recorded for their WCTO contact question: 'Is there anyone living in the house who is a tobacco smoker?' (source: WCTO data set)

Denominator
Number of registered births by DHB of domicile (source: Ministry of Health NHI register)

Baseline Data – 2018

	Number of babies who live in a smokefree household (Num)	Total number of registered births (Denom)	Total number of babies enrolled and recorded with WCTO providers	Rate of Smokefree Homes*
DHB of Domicile	**Jan 18 - Jun 18**	**Jan 18 - Jun 18**	**Jan 18 - Jun 18**	**Jan 18 - Jun 18**
Southern	952	1,746	1,397	54.50%
New Zealand	16,351	30,366	23,094	53.80%

Where do we want to be?

Long term improvement milestone: 95% of babies live in a smoke-free household at six weeks

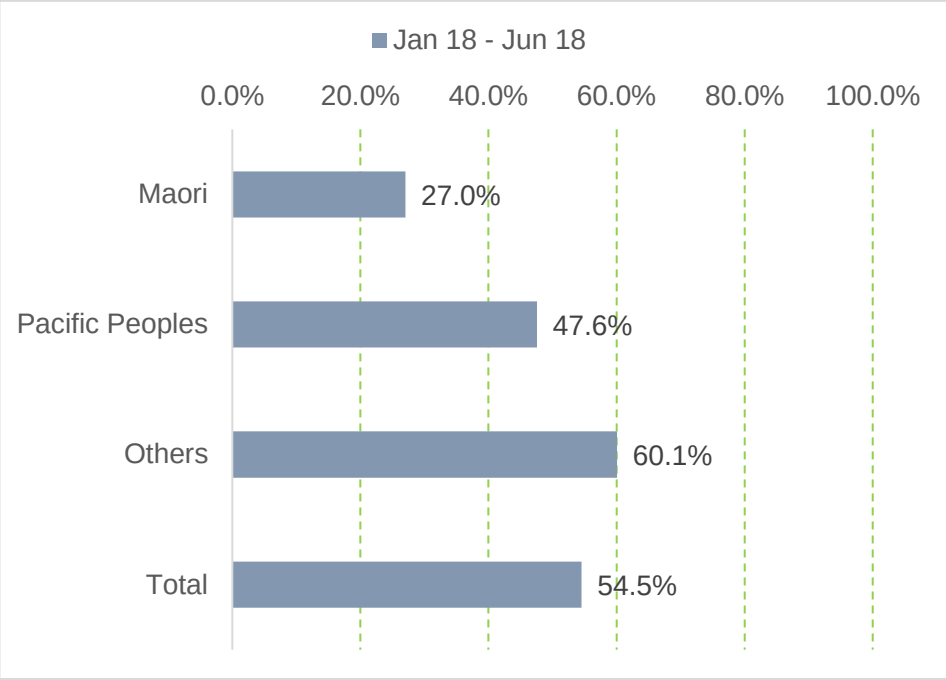
Improvement Milestone for 2019/20: Increase the total percentage of households being smoke free to 60%

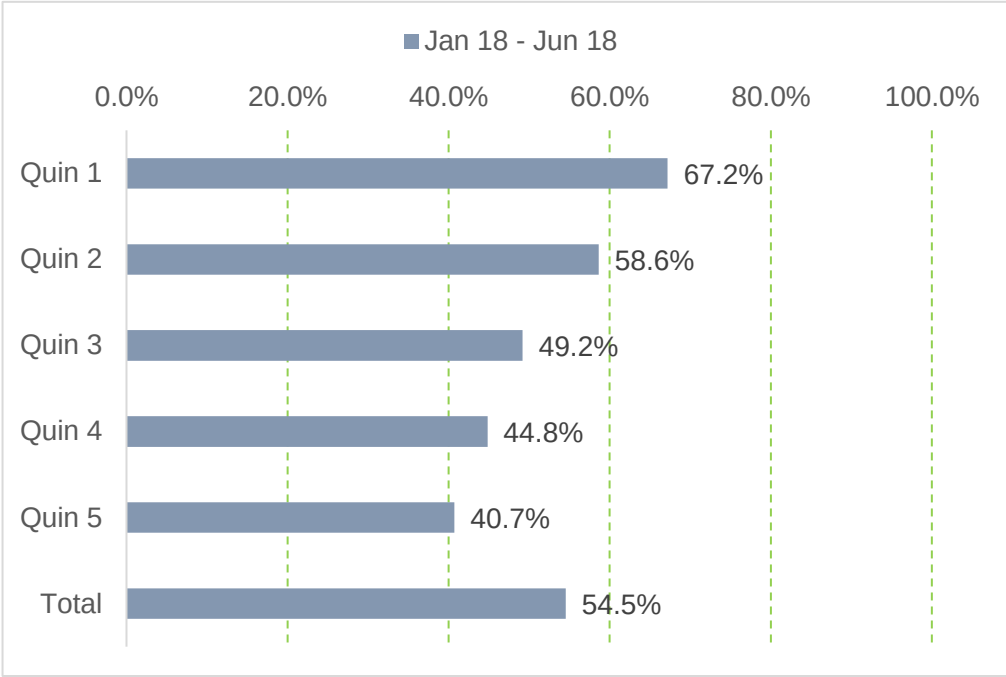
Rationale: A reasonable number of households are required to have smoking status recorded to provide meaningful results on the number of babies impacted by smoking.

Activities:

Increase the percentage of households having the smoking status checked and accurately recorded to 80%. 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.

Percentage of households being smoke free





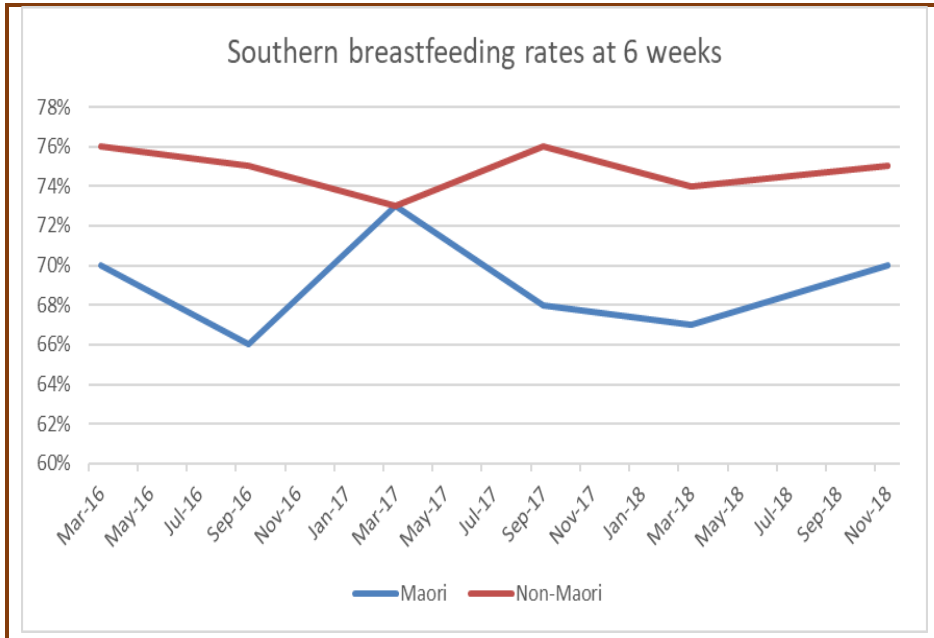
How will we get there?

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 smoke free homes and environments. The focus to achieve this will be on activity to impact on breastfeeding rates. It is likely that a new mother who is continuing with breastfeeding their child is more likely to remain smoke free. We will also look at a number of activities to increase the number of children at four years of age who are living in a smoke free home.

6.1 Percentage or number of infants who are exclusively or fully breastfed at six weeks from Lead Maternity Carer (LMC) care

Numerator: Babies born during the reporting period with a breastfeeding status at LMC discharge of 'Exclusive' or 'Full' recorded in the National Maternity Collection (MAT)
Denominator: Babies born during the reporting period with a breastfeeding status at LMC discharge of 'Exclusive', 'Full', 'Partial' or 'Artificial' recorded in the National Maternity Collection (MAT)
2019/20 improvement milestone: 80% for both Maori and Non-Maori

Baseline Data: Infants who are exclusively or fully breastfed at six weeks	Activities that will enable us to achieve the Improvement Milestone
	○ Confirm gaps in breast feeding support services ○ Work with WellSouth to increase access to the Southern District peer support programme, with a focus on Maori and Pacific women ○ Work with Maori and Pacific communities to support training of appropriate women to deliver the breast feeding peer support programme to these communities. (EOA) ○ Align local activities to the National Breast Feeding Strategy, which is currently being developed


Southern breastfeeding rates at 6 weeks
78%
76%
74%
72%
70%
68%
66%
64%
62%
60%
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Jul-18
Sep-18
Nov-18
Maori
Non-Maori

6.2 Pregnant women who identify as smokers upon registration

Measure description: Percentage or number of pregnant women who identify as smokers upon registration with a DHB employed midwife or Lead Maternity Carer who are offered brief advice and support to stop smoking
Numerator: Number of pregnant women who identify as smokers upon registration with a DHB employed midwife or Lead Maternity Carer who are offered brief advice and support to stop smoking
Denominator: Number of pregnant women who identify as smokers upon registration with a DHB employed midwife or Lead Maternity Carer
2019/20 Improvement Milestone: (National target 90%)

Baseline Data

Percentage of women identified as smokers at first registration.

Overall	Smokers	%	Women giving Birth
Total	7411	13.1	56607
Southern	477	14	3419

Nationally, Maori women have a smoking rate of 34.5% on first contact with an LMC

Percentage of women identified as smokers two weeks after birth.

Overall	Smokers	%
Total	5680	10.5
Southern	378	11.5

Activities that will enable us to achieve the Improvement Milestone

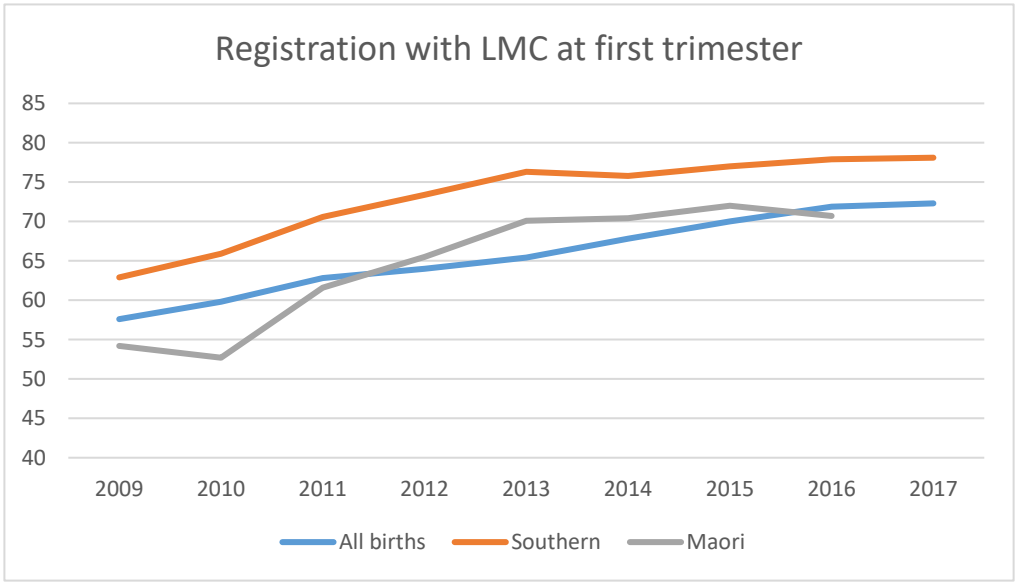
- Streamline the process for referral from LMC's to the Southern Stop Smoking Service and incentive programme, then progress to setting a quit date.
- Provide education to the WCTO and Lead Maternity Carer workforce regarding the new measure and ensure questions and data recording is consistent.
- Programme of education to General Practices around the first contact being an appropriate time to refer into the smoking cessation service.
- Ensure pregnant women and whānau are referred to the Southern district Stop Smoking Provider that they are engaged in the Smoke free Pregnancy Incentive programme and are supported to stop smoking and continue to be Smoke free after baby is born.
- Evaluate the impacts of increasing the value of the stop smoking voucher scheme

6.3 Pregnant women registered with a Lead Maternity Carer within first trimester of pregnancy

Measure description: Pregnant women registered with a LMC within the first trimester of pregnancy
Numerator: Total number of women who register with an LMC in the first trimester of pregnancy.
Denominator: Total number of women who register with an LMC
2019/20 Improvement Milestone: >77% registration for Maori

Baseline Data

Registration with an LMC in the first trimester of pregnancy Rate (%) of women giving birth (all ethnic groups), residing in the Southern DHB area, 2009–2016									
	2009	2010	2011	2012	2013	2014	2015	2016	2017
All births	57.6	59.8	62.8	64	65.4	67.8	70	71.9	72.3
Southern	62.9	65.9	70.6	73.4	76.3	75.8	77	77.9	78.1
Maori	54.2	52.7	61.6	65.5	70.1	70.4	72	70.7	



Activities that will enable us to achieve the Improvement Milestone

- Increased booking in first trimester project: Although more than 78% of all pregnant women in our District book with a midwife in the first trimester of pregnancy, young Maori and Pasifika women are more likely to miss out on care in the first trimester. Young and Maori women are more likely to use tobacco while pregnant. Missing care in the first trimester is a missed opportunity to make health behaviour changes at an early point in the pregnancy to decrease risk of harm such as preterm birth, intrauterine growth restriction, and SUDI.
  - We will work with a Maori midwife and kaupapa Maori and Pasifika community agencies to develop written and video resources targeting young Maori and Pasifika women and their families to reinforce the message to get care with a midwife as soon as they are pregnant.
  - Once developed, the written and video resources will be distributed in culturally appropriate venues to reach the target audience, as well as available online and on social media.