Southern Health
He hauora, he kuru pounamu

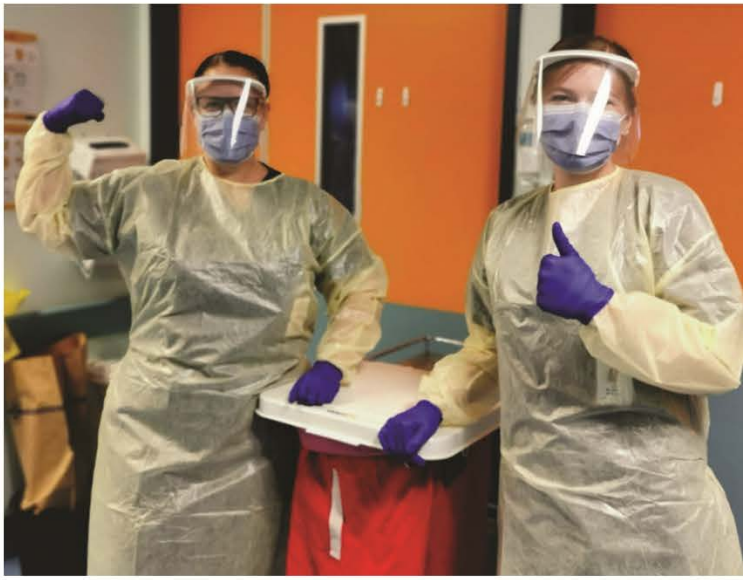
Southern District Health Board
Piki Te Ora

Southern DHB Annual Plan 2020/21

E90

Incorporating the Statement of Performance Expectations (SPE)

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



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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 positive attitude and are always looking to do things better.

Community Whānaungatanga

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)

Table of Contents

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.

Tahu Potiki (1966 – 2019)

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

FOREWORD FROM THE CHAIR AND CHIEF EXECUTIVE

Looking forward for any Annual Plan requires reflection on the past. In some instances this tells us where we may have needed greater focus, where goals need reshaping or where results have exceeded expectations. In the case of the past year, however, we learned several other lessons. That a theoretical pandemic plan pales next to the imminent arrival of a novel virus on our shores. That best-laid, milestone-based annual plans may find themselves scuttled with scant warning. And that, in the face of a near and present danger, requiring rapid systems and services to be overhauled almost overnight, we have the skills, relationships and capacity to respond.

The last quarter of 2019/20 was therefore, in some senses, both frightening and empowering, and inevitably provides a lens through which to plan for 2020/21. Certainly, our context has shifted. Every part of the health system, and indeed the social and economic environment in which we operate, functions in the understanding that a pandemic continues to reverberate around the globe. At the time of writing, Aotearoa New Zealand is largely COVID-19 free, and our borders are largely closed.

The immediate impacts of the pandemic on the health system have for the most part been managed, however both the long term economic impacts as well as the wider health and well-being impacts are yet to be felt. We know this situation can change at any stage and we must be vigilant moving forward.

The experience also brought into sharp relief the core and fundamental drivers that could enable a more effective health care system, as the most important actions were pursued with urgency. We needed to truly ask ourselves, how do we make sure that, in the midst of a crisis, we reach our most vulnerable populations and those in greatest need of our care? How do we prioritise our resources so no one is left behind?

In many ways this has been affirming; the aspects that were reinforced matched our existing direction of travel. We were already starting to reshape our public health function; progressing a primary and community care strategy centred on increased technology and better supporting patients to be cared for outside of a hospital context; and streamlining our secondary services. The challenge to ensure equity across our diverse populations, and to deliver services across our vast geographic area, remained top of mind for the Southern district.

What was thrown into greater clarity were the individual initiatives that could add greatest value to this direction, including virtual health, clinical health pathways, and opportunities for a specific programme for planned care that sees more services delivered in a primary setting and true collaboration with specialist services. We must also ensure our secondary services are supported by robust processes that enable us to deliver timely and appropriate specialist care and elective services to our community. These areas received a significant boost in momentum, and our 2020/21 planning aims to build on this.

We were also reminded of the strengths of more flexible working arrangements, devolved leadership and decision-making, and professionals working collaboratively, creatively and to the top of their scope. Our challenge here is to sustain this, and continue to enjoy the benefits of a more agile and enabled workforce, without reverting to previous patterns as the crisis recedes. Investment in leadership, building a strong culture and looking ahead to workforce requirements of the future therefore remain a priority, and this effort is strengthened by our ability to see more vividly what such an enabled workforce can look like.

In other areas, new opportunities have arisen. Our existing proposal to reconfigure our Public Health Unit was an effort to realise even greater value as a foundation stone of a health system, through better orienting it towards its critical analytics, policy and stakeholder engagement functions. This reshaping of services was predicated on working within existing resources. However the COVID-19 experience, on the back of a worrying measles outbreak in 2019, proved the point that those resources were never adequate for the sheer weight of responsibility the team must assume, both in terms of responding to a crisis, and preventing such events from developing. This has now been nationally recognised. We owe them a debt of gratitude and we have a responsibility to support our public health teams to succeed across the full range of their potential.

On top of maintaining our capacity to respond to any future waves of COVID-19, we also have to take steps to ensure those whose much needed care was delayed significantly as a result of the actions taken to manage COVID-19 receive their care as quickly as possible, while recognising that the learnings indicate there may be more integrated ways of delivering this care moving forward. We are also in the final stages of the development of the Detailed Business Case for the development of the New Dunedin Hospital which, in conjunction with Southland Hospital, will serve as the regional specialist hospital for the Southern district. Critical dependencies associated with the hospital development are furthering the gains made through the Primary and

Community Strategy, a redoubling of our effort in our Valuing Patients' Time programme, the development of a digital transformation pathway and business case, and strategic workforce planning. Progress on all of these fronts is essential during 2020/21.

A further critical pathway for which we are determined to make 2020/21 a pivotal moment will be our commitment to Te Tiriti o Waitangi, and the identification in partnership with our Iwi partners to make tangible inroads into equity. In the year 2020 it is unacceptable to still see persistent equity gaps between Māori and the rest of the population. We are determined to develop a pathway which is led through our Iwi Governance relationship to make tangible strides in finally reducing the persistent inequities. While this work will be focused on Māori, we also acknowledge there is work to do for other populations particularly Pacific people, disabled people and our community of former refugees.

These directions are captured in the Strategic Intentions and Priorities section of this Plan, reflecting our strategic pathway and change programmes. Underpinning this is a commitment to prioritising and backing those initiatives that will deliver the greatest value for our communities, reach those who are most in need, and set our health system up for the greatest success in the future. All of this activity must also be cognisant of the fact that the Government has committed one of the largest funding increases in New Zealand's history. For this they expect enhanced equity, improved access, optimised quality and a pathway to financial sustainability.

The recognition of the importance of a truly integrated health system is also reflected in the New Zealand Health and System Disability Review. While the government's response to this will inevitably inform our ongoing planning and opportunities, the alignment between the direction of travel that is being signalled, and our priorities as a Southern health system, is affirming.

More than ever, it endorses what we already well understand – that no part of the health system works in isolation. The health and well-being of all our community across our vast district depends on us truly working as a united Southern Health system.

We want to acknowledge the contributions of all our health care partners, including WellSouth PHN, general practices, Iwi providers, our rural hospitals, midwives, pharmacists, aged residential care and the many organisations (NGOs) that provide important community and primary health-care services in our communities every day, as well as the Community Health Council, which continues to provide constructive advice and feedback as a voice for patients and whānau.

The past months have surely tested us, as a health system, as a community, and as individuals. They have also revealed our core strengths and values. We are committed to drawing upon these to deliver the very best health system for our patients and their families in the Southern district.

Chris Fleming
Chief Executive
Southern DHB

Dave Cull
Chair
Southern DHB

MESSAGE FROM THE CHAIR, IWI GOVERNANCE COMMITTEE

The Iwi Governance Committee impresses upon the Southern health system that the Treaty of Waitangi affirms Māori rights to collective self-determination. This guarantees tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of health care. The Southern DHB through its relationship with the Crown is a partner to the Treaty of Waitangi and in carrying out its functions must honour this relationship with Māori and their rights as tangata whenua across our district. Within the health sector, Treaty of Waitangi obligations are specified in the New Zealand Public Health and Disability Act 2000.

He Korowai Oranga provides an overarching framework to help the health sector improve Māori health. It has an ultimate aim of Pae Ora (healthy futures for Māori) with three supports Whānau Ora (healthy families), Mauri Ora (healthy individuals) and Wai Ora (healthy environments). The framework sets out the principles for the Crown and Māori to work together, with pathways and key threads sitting under these aims. This approach is being reinforced through the recently released Ministry of Health's Te Tiriti o Waitangi framework (April 2020) for the health and disability sector.

The concept of equity in health is an ethical principle, closely related to human rights, particularly the right of all humans to experience good health. These concepts are articulated in a number of international treaties and declarations that New Zealand has ratified, such as the *Universal Declaration on the Rights of Indigenous People and the Universal Declaration on the Rights of Disabled Persons*. In our context, ōritetanga (equity) is an important concept within the Treaty of Waitangi and it is essential that we have a common understanding of equity in order to coordinate efforts and achievements in Māori health. The definition of equity does not reflect either the Te Tiriti o Waitangi relationship nor the Māori burden of disease.

Therefore, in line with the recommendation of the Iwi Governance Committee, the word 'ōritetanga' will now be used in the context of describing equity for Māori so not to confuse tangata whenua rights and these obligations within the wider generic use of the work 'equity'. We have an expectation that when we are talking about ōritetanga in a Māori context that this ought to relate to Māori equity in policy, funding, access, uptake and outcomes. At a minimum the DAP must consider 'ōritetanga' (Māori equity) as it relates to equity in access and equity in outcome across identified Māori health priorities.

The Waitangi Tribunal Health Services and Outcomes Inquiry (Wai 2575) is currently under way (Waitangi Tribunal, 2019b). Claimants in the first stage of the Kaupapa Inquiry focused on the Crown's failure to provide primary health care to Māori consistent with the principles of Te Tiriti o Waitangi. The claimants assert that primary health care is not sufficiently contributing to the achievement of health equity for Māori and as a result, Māori continue to experience significantly worse health outcomes than non-Māori.

The contemporary Te Tiriti o Waitangi principles used to inform this Inquiry included the principles of partnership, active protection, equity and options. The Iwi Governance Committee reinforces that these principles are to be included in designing health and disability systems and policy through strengthening the understanding of and commitment to reducing health inequities. We acknowledge the Southern DHBs organisational values and remind the Southern Health System of our Ngai Tahu values which underpin us as Runaka for this district which include Whanaungatanga, Manaakitanga, Tohungatanga, Kaitiakitanga, Tikanga and Rangatiratanga.

Odele Stehlin
Chair
Iwi Governance Committee

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. 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.

Te Tiriti o Waitangi (the Treaty) is New Zealand's founding document and Southern DHB is committed to meeting its legislative obligations. These obligations are specified in the New Zealand Public Health and Disability Act 2000, clause 22(1). This includes reducing health disparities by improving health outcomes for Māori and other population groups. In New Zealand, disparities between Māori and non-Māori are the most consistent and compelling inequities in health. The Treaty was signed to protect the interests of Māori and it is not in the interests 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.

In July 2019, Wai 2575 found that the Crown has breached the Treaty by failing to design and administer the current primary health care system to actively address persistent Māori health inequities and by failing to give effect to the Treaty's guarantee of tino rangatiratanga (autonomy, self-determination, sovereignty, self-government). The Waitangi Tribunal has made an interim recommendation that [sic] partners work together to further assess the extent of the problems in primary health care, and co-design a set of solutions. Further stages of Wai 2575 are ongoing.

He Korowai Oranga (the National Māori Health Strategy, 2014) sets a strong direction for Māori health. *Pae ora* (healthy futures) is the government's vision for Māori health and forms part of this strategy. Pae Ora is a holistic concept with three key elements:

- mauri ora – healthy individuals
- whānau ora – healthy families
- wai ora – healthy environments

This year we need to take a fresh look at how we are approaching the goal of reducing health equity gaps. For too long now we have made this commitment, and while health outcomes for Māori have improved, they have also for other populations and the equity gap has not substantially changed. If we are truly going to have an equitable society and uphold the principles of Te Tiriti o Waitangi we must take another approach.

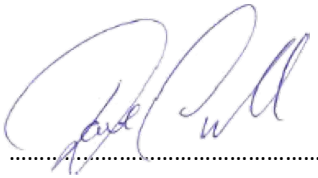
Our System Level Measures Improvement Plan will focus on Māori: ambulatory sensitive (avoidable) hospital admissions 0-4 and 45-64 years; acute admissions and readmissions to hospital; amenable mortality; acute bed days; stranded patients; and self-harm hospitalisation admissions. We will also focus on cervical screening for those aged 25-69, cancer treatment services and child respiratory inpatient admissions/readmissions. This will include the development of robust data sets, 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.

We recognise also that the above actions may not be enough, and that further, bolder steps may be required. These will be worked up through our partnership with Murihiku and Araiteuru rūnaka. We cannot stand back and simply accept the gaps that exist.

Activity also needs to aim at reducing health equity gaps. Much of our population resides 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.

SIGNATURE PAGE

This Annual Plan is signed and approved by the Minister of Health, Minister of Finance, the Chair and Chief Executive of the Southern DHB, as required under section 38(3) of the New Zealand Public Health and Disability Act 2000.



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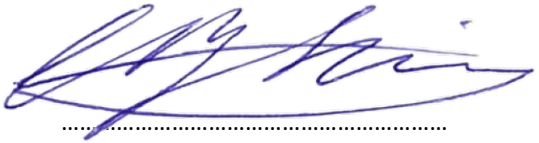
Dave Cull

Chair

Southern District Health Board

Date: 8 September 2020



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Chris Fleming

Chief Executive

Southern District Health Board

Date: 8 September 2020

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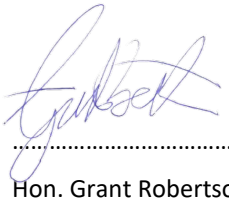
Hon. Chris Hipkins

Minister of Health

Date:



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Hon. Grant Robertson

Minister of Finance

Date: 19 / 10 / 2020

Hon Chris Hipkins

MP for Remutaka

Minister of Education
Minister of Health
Minister of State Services

Leader of the House
Minister Responsible for Ministerial Services

David Cull
Chair
Southern District Health Board
davecull@gmail.com

20 October 2020

Dear David

Southern District Health Board 2020/21 Annual Plan

This letter is to advise you that we have approved and signed Southern District Health Board's (DHB's) 2020/21 Annual Plan (Plan) for one year.

We are pleased that your plan provides a strong platform to deliver on the priorities identified in the 2020/21 letter of expectation and focuses on equity, sustainability and addressing the population groups with the highest needs.

We expect you to work with your fellow Chairs and continue discussions about how you can share skills and expertise in order to ensure that your financial performance is consistent with the agreed plan. We particularly encourage you ensure that your senior executives maintain the tight fiscal controls that will be necessary to sustain improvements in the out years. Your focus on strengthening financial management and performance, including through collaboration with your fellow Chairs, remains critical to creating a sustainable financial path. If financial performance deteriorates as has occurred in previous years, this deterioration limits our collective ability to invest more in new models of care and in primary care and population prevention approaches.

The Ministry will shortly engage with you on the $18.8 million of sustainability funding for DHB led improvement projects, that has been made available by the Government. We encourage you to accept offers from the Ministry to utilise this funding.

The approval of your Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health, including changes in FTE. I expect you to continue to engage with the Ministry of Health to ensure you have a strong rationale for any adjustment to planned FTE during the year. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval.

Please also note that approval of the Plan also does not constitute approval of any capital business cases or proposals for the Holidays Act Remediation equity injection of $37.85 million that you have included. A funding appropriation for the Holidays Act Remediation has not been confirmed by the Treasury and the Ministry of Health or

the Crown. Approval of your Plan does not constitute approval of any requests for equity that have not been approved through the normal process.

We are aware that an extension was provided to the requirements for finalising DHB planning documents required by the Crown Entities Act 2004 due to the impacts of COVID-19. If required, please update your published Statement of Performance expectations and Statement of Intent (if applicable) to align with your approved Plan.

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

Thank you for the work you and your team are doing to support equitable health outcomes for New Zealanders, during a time when our system has faced additional pressures from COVID-19.

We look forward to seeing further positive progress as you deliver your Plan.

Ngā mihi nui

Hon Chris Hipkins
Minister of Health

Hon Grant Robertson
Minister of Finance

Cc Chris Fleming
Chief Executive

1.0 OVERVIEW OF STRATEGIC PRIORITIES

1.1 Strategic Intentions And Priorities

Strategic Context

This Annual Plan for 2020/21 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.

In addition to the national direction and strategic priorities that have informed health planning in recent years, in 2020/21 we must acknowledge the fundamental shift in our strategic context brought by the COVID-19 pandemic. This demands a greater ability not only to rapidly adjust plans and activities as needed, but to proactively prepare for a wide range of scenarios to ensure wider health outcomes can be met during this uncertain time.

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'.

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

Southern DHB aligns health and disability services with *He Korowai Oranga*[1], 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*[2] - *Te Hauroa o Murihiku me Araiteuru* is in place between Murihiku and Araiteuru Rūnaka and the Southern DHB. The purpose of *Te Hauora o Murihiku me Araiteuru* is to improve Māori health and wellbeing outcomes in the Southern district.

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: Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-20-25[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 with an overarching emphasis on equity, as well as clinical and financial sustainability:

Improving child wellbeing:

Including actions to improve the health and wellbeing of infants, children, young people and their whānau; improve equity of outcomes; increase childhood immunisation rates;, especially for Māori; focus on family on family and sexual violence screening, early intervention and prevention; improve recruitment and retention of midwives and ensure access to maternity care, including maternal and infant mental health services.

[1] Ministry of Health – He Korowai Oranga- Māori Health Strategy (2013/14) http://www.health.govt.nz/our work/populations/ Māori-Health/he-korowai-oranga
[2] Principles of Relationship – Te Hauroa o Murihiku me Araiteuru http://www.southerndhb.govt.nz/files/15686_2015051993319-1431984799.pdf
[3] Ministry of Health - https://www.health.govt.nz/publication/ola-manuia-pacific-health-and-wellbeing-action-plan-2020-2025
[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/

Improving mental wellbeing:

Including work to support system transformation and the roll-out of the Government's priority initiatives; work on mental health and addiction promotion, prevention and early intervention; ensure those with the most need have access to sustainable quality mental health and addiction services; empower communities to engage in the transformation of mental health and addiction; support the sustainability of NGOs and contribute to the development of a sustainable and skilled workforce.

Improving wellbeing through prevention:

Including actions in relation to environmental sustainability, antimicrobial resistance; Smokefree 2025 and bowel screening.

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

Including actions in relation to cancer services, disability, Healthy Ageing, workforce, workplace violence, Health Research Strategy implementation; National Health Information Platform; planned care; Care Capacity Demand Management; reducing the length of emergency department stays and implementation of System Level Measures.

Better population health outcomes supported by primary care:

Including actions in relation to primary care; long term conditions; pharmacy, rural workforce, improving wellbeing through public health services delivery and supporting delivery of the Māori Health Action Plan.

Strategic and service planning:

DHBs are expected to demonstrate how strategic and service planning will support improved system sustainability; achieve equity in health outcomes and ensure fairness in access to and experience of care; meet Te Tiriti o Waitangi obligations as specified in the New Zealand Public Health and Disability Act 2000; deliver a wide range of quality health services while remaining within budget; continue to focus on capital planning; continue to engage with National Asset Management Work and participate in service user engagement.

This Annual Plan outlines how the Southern DHB will meet those expectations in 2020/21. However we note that we do not have all of the answers and to this extent our planning must remain flexible to enable us to try new initiatives and new ideas if we are truly going to deliver on our strategic intent.

Health and Disability System Review

At around the same time as this plan was being finalised the Government released the Health and Disability System Review. This indicates significant changes in the structures and systems across the New Zealand Health. The plan indicates the potential for changes to the role and shape of District Health Boards and Primary Health Organisations. This may well have a future impact on our organisation, however the overall direction of travel we are taking the Southern Health System is consistent with the direction and the intent set out in the review. As an organisation we will work actively with the Ministry of Health and any transitional bodies that may be established as Government determines the course of action to be followed.

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 (23.4%) 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 agreed regional activity 2020/2023. The Regional vision is a sustainable South Island health system, focused on regional support for the development of local health pathways to support local planned care initiatives. As well as strong regional pathways for vulnerable or at risk services.

Southern DHB Direction

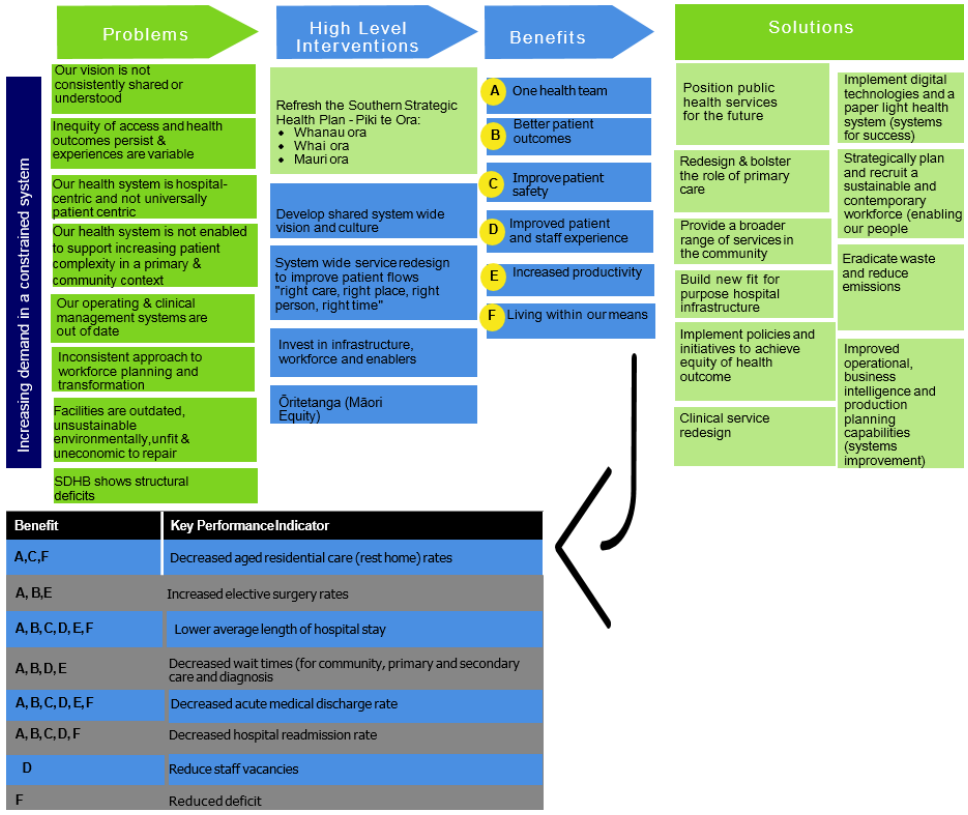
The advent of COVID-19 has required us to develop new ways of working. Many changes made as a result of COVID-19 have led to the development of more effective and efficient models of care.

Drawing from both the national guidance and the local service recovery activity that is underway as we plan to transition to a revised Business as Usual, Southern DHB will:

- Acknowledge there should be "a new normal", and there may be opportunities to address issues and develop new pathways
- Take a systems approach which encapsulates the patient flow through from primary, secondary, tertiary and return to primary, with the focus on mitigating demand for secondary and tertiary. Risk management frameworks will be essential

- Maintain the integrity of health care services by:
  - Prevention and early intervention to reduce impact on health systems
  - Integrate services with other agencies to deliver a "rounded" care model to our population
  - Continue to respond to everyday health situations – episodic and chronic care
  - Access to acute and complex care across the healthcare system
- Anticipate health inequalities and be proactive, especially for those vulnerable to poor health (children, older people, Māori, Pasifika, young workers, low-income families, refugees and people with chronic conditions)
- Recognise that this is a Public Health crisis with momentous economic and financial impact on our population for many years
- Enable environments to support behaviour change, in particular:
  - Build social capital in communities - partnerships
  - Contribute factual guidance to workplaces, schools, community organisations to enable them to operate safely and effectively. A multidisciplinary effort is essential to strengthen the health system, promote linkages and optimise the resources across our District.

The following intervention logic map (ILM) was developed as part of our Strategic Case to describe the range of change that would be required to support a successful transition to the New Dunedin Hospital (NDH). Our recent focus has been on incorporating the activity required to support the development of the NDH into our organisational strategic direction, of which this District Annual Plan forms a single year view.



Benefit	Key Performance Indicator
A,C,F	Decreased aged residential care (rest home) rates
A, B,E	Increased elective surgery rates
A, B, C, D, E, F	Lower average length of hospital stay
A, B, D, E	Decreased wait times (for community, primary and secondary care and diagnosis
A, B, C, D, E, F	Decreased acute medical discharge rate
A, B, C, D, F	Decreased hospital readmission rate
D	Reduce staff vacancies
F	Reduced deficit

These imperatives are integrated into our strategic directions and change programmes, that focus on the following areas.

1. **Ōritetanga (Māori equity):** Southern DHB is committed to fulfilling the special relationship between Māori and the crown under Te Tiriti o Waitangi and will engage and co-design programmes and initiatives with whānau, hapu and iwi and Māori communities. Southern DHB needs to reset and be fully accountable for achieving Ōritetanga. A greater focus is needed on understanding the health needs of Māori communities to provide more effective, responsive, patient-centred services, supported by targeted interventions, to achieve health equity. Improvements in Māori health outcomes will come from better community and primary care services that are provided in a way that is appropriate and more accessible for Māori communities.

Southern DHB Māori Health Priorities

- Mental Health and Addictions
- Cancer
- Long Term Conditions (Respiratory Child & Youth; Diabetes; Cardiovascular Disease – cardiac and stoke)
- Access to diagnostic testing
- Oral Health (reduction of caries)
- Explore use of navigators across the continuum of care

2. **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. 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 **evidenc**e; building effective **partnerships** across the health sector and other sectors; and remaining **responsive** to new and emerging health threats.

   Its role was highlighted in the final quarters of 2019/20 as it led the nation, and each DHB's response to the COVID-19 crisis. This underscored the importance of investing in the service's capacity, not only to manage epidemics that threaten our wider health and social systems, but to undertake a broad range of preventive and health-promoting strategies.

   Key focus areas 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)

3. **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 has formed a key plank to create system change, alongside the 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.
   A critical area of focus in 2020/21 is to establish a programme of work to deliver planned care for patients across the primary and secondary care settings. This is enabled through tools such as agreed clinical HealthPathways, greater clarity and shared decision-making as patient care pathways are agreed and finding better ways to facilitate collaboration among health care providers.

   Equity is a specific focus for this programme. The Southern Health system will need to be vigilant that existing inequities are not inadvertently made worse, and that there are processes in place to resolve unintended and unwanted consequences

   Among these are the continued 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[7]. 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. 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. **Clinical service redesign:** This builds on the gains we have made as a result of a dedicated programme of work in recent years, Valuing Patients' Time. While initially this focused on improving pathways within the hospital system, our work across 2020/21 will see this broadened to develop more seamless pathways for patients, which may involve journeys from primary care, through the hospital system, and back again depending on their condition. This requires well-defined HealthPathways, and a future focused approach to models of care that are alive to the possibilities that come with a reshaped primary health sector and the design for the new Dunedin Hospital. We continue to focus on efficient and streamlined secondary services,

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

strengthened by building our capacity in diagnostics, adopting an increasingly generalist model of care, supporting the uptake of virtual technologies, and improving systems to ensure timely and appropriate delivery of elective services.

4. **Enabling our people:** We continue to strengthen the foundations of our organisation through a focus on our workforce. Please see section 4.3 for further details.

5. **Systems for success.** We continue to focus on the underlying infrastructure business and quality processes that support the health system. The Clinical Council was established to focus on engagement, improving quality, reducing clinical risk and helping to foster an environment in which clinical care can flourish. The Quality and Clinical Governance Directorate works with the services across primary, community and secondary to improve systems and processes that reduce waste such as delays. A focus for the Clinical Council has been to review and redevelop a quality framework for the DHB, emphasising clinical governance and clarifying accountabilities and relationships at all levels of the organisation – from those involved in direct patient care through to board governance. Immediate priorities have included reviewing the role and function of the Clinical Council, and establishing a new Clinical Practice Committee.

   In addition we are progressing the roll out of our digital strategy that anticipates the requirements of the new Dunedin Hospital and reconfigured health system of the future.

   Please see section 4.4 for further details.

6. **System improvements.** 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
   - Leave management strategies and actions
   - Maximisation of procurement opportunities and rationalisation of variations
   - Optimisation of the nursing workforce

7. **Facilities and the Dunedin Rebuild Transition Programme:** Preparing for the New Dunedin Hospital is in itself a transformational programme of work, requiring us to envisage, develop and implement new models of care that encourage better, more integrated healthcare services closer to home. This includes integration of primary and secondary activity to best meet the needs of our employees and our patients. We are challenging each other to think differently and act differently to achieve optimal health outcomes for our patients and mitigate the need for hospital care.

   To achieve the system-wide readiness to enable the benefits of the new Dunedin Hospital, a change programme has been articulated that again reinforces our strategic priority areas.
   - Ōritetanga - Improve health equity for Māori
   - Cross Sector Work Programme/Health in all policies
   - Redesign and bolster the role of Primary and Community team
   - Provide a broader range of services in the community
   - Patient Flow/Quality Improvement (including Valuing Patient Time initiatives)
   - Public Health Equity
   - Digital
   - Workforce
   - Business intelligence and production planning capabilities
   - Eradicate waste and reduce emissions

   A programme of work has been developed to deliver safe and sustainable healthcare services primarily from our existing facilities until the opening of the new Dunedin Hospital. A critical element is the maintenance and development of physical capacity within the existing facilities' footprint to improve the work environment for our employees and delivery of timely healthcare services to our community.

   Please refer to section 4.2.1 for further details.

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. Following recent upgrades made to Lakes District Hospital, the Central Lakes Locality Network has been established to explore at the needs of the broader Lakes/Dunstan area, taking into consideration the projected population growth and where services are best placed. Southern DHB is working with CLLN to determine the best configuration of primary maternity facilities in this area, and steps will be taken towards implementing the outcomes in 2020/21.

Shift services into the community where appropriate

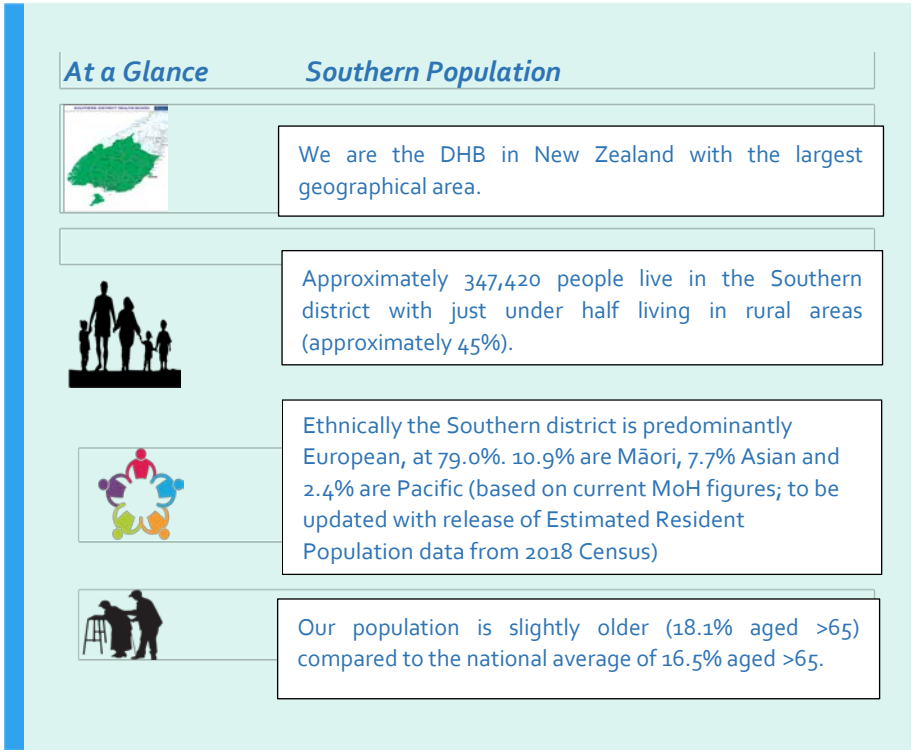
As part of the Primary and Community Care Action Plan, the DHB is in discussions with WellSouth on the development of the Community Health Hubs, in terms of the number, location and the range of services that will be provided from them. This work links in with the further work underway on revising the 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 and has recently changed leadership with the appointment of a new Alliance Chair. 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 community, 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 2020/21 year the CHC will focus on engaging and supporting CHC advisors working on projects across the health system. As of January 2020, the CHC has over 90 people registered as CHC advisors with approximately 35 people involved in projects across our health system. These figures change frequently depending on what projects are commencing.

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 Chair/Board and the Executive Leadership Team at Southern DHB.

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 2020/21 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.

2.0 DELIVERING ON PRIORITIES

2.1 GOVERNMENT PLANNING PRIORITIES

Overarching Government priorities were presented in the generic Minister's 2020/21 Letter of Expectations. DHBs are expected to consider and include actions in their Annual Plans that will help them to achieve health equity for 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.

2.1.1 GIVE PRACTICAL EFFECT TO HE KOROWAI ORANGA – THE MĀORI HEALTH STRATEGY

<table>
<tr><td colspan="5">Engagement and Obligations as a Treaty Partner
The NZPHD Act specifies the DHBs Treaty of Waitangi obligations. As a DHB we recognise and value our obligation to maintain processes that enable Māori to participate in, and contribute to, strategies for Māori health improvement. We have specific plans and strategies for Māori health improvement that outline how we will work in partnership with Māori to develop and implement these.</td></tr>
<tr><td>DHB activity

1. To reset the Southern DHB strategic direction of advancing Māori Health that incorporates and recognises Wai 2575 and upholds the Treaty principles of:
• Tino Rangatiratanga
• Equity
• Active Protection
• Options; and
• Partnership

2. In line with Government responses, Southern DHB will enact Wai 2575 and the Treaty principles, into all operational policies and procedures, specifically Service Plans with a focus on Māori health priorities:
• Cancer
• Child & Youth
• Long Term Conditions (Respiratory, Diabetes & Cardiovascular)
• Access to diagnostic testing
• Oral Health
• Mental Health & Addictions
• Explore use of navigators across the continuum of care</td><td>Milestone

Total amount of funding increased by Q4

Strategic direction reset by Q3

Specific programmes of work identified and reported on by Q3</td><td>Measure

Total amount of funding provided to Southern DHB and provider services will be greater than 2019/20.

Southern DHB will reset the strategic direction which will be reflected in all strategic and operational frameworks, policies and procedures.

Specific programmes of work and milestones to be identified and reported on that will focus on Māori health priorities.</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</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

<table>
<tr><td colspan="5">Māori Health Action Plan – Accelerate the Spread and Delivery of Kaupapa Māori Services
Accelerating the spread and delivery of Kaupapa Māori services is an important element in enabling Māori to exercise their authority under Article Two. It enables Māori to have options when choosing care providers and pathways. SDHB has plans to ensure that Māori capability and capacity is supported, enabling Māori to participate in the health and disability sector and provide for the needs of Māori in our District.</td></tr>
<tr><td>DHB Activity

1. Southern DHB to invest in the capacity and capability of kaupapa Māori health services to support better navigation of patient/whānau care across the health continuum.
• Promote funding opportunities to strengthen kaupapa Māori health services including support to access MoH Māori Provider Development Scheme (MPDS) funding (EOA).

2. Kaupapa Māori health services will engage and co-design the Southern Māori Cultural Education programme training and the Welcome Orientation programme to mainstream service. This will facilitate the development of networks and increase clinical and cultural support knowledge and skill base.

3. Promote the Hauora Health Workforce Funding (NZQA Level 3 – 7) to kaupapa Māori health services to increase workforce skills and capacity for clinical and cultural support services.</td><td>Milestone

Improvement in number of kaupapa Māori health services and programmes by Q4
Increase in funding opportunities by Q4

Report on number of services undertaking the training programme and participating in the orientation programme Q4

Report on number of Kaupapa Māori health service workforce funded for Level 3-7 study by Q4</td><td>Measure

Evidence of improvement and increase in the number of kaupapa Māori health service/ programmes
Evidence of increase in funding opportunities to strengthen capability of kaupapa Māori Health Providers

Number of health services undertaking the training programme.

Number of health services participating in the orientation programme.

Number of Kaupapa Māori health service workforce funded for Level 3-7 study</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</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

Māori Health Action Plan – Reducing Health Inequities- The Burden of Disease for Māori

Achieving equity in health and wellness for Māori is an overall goal of the health and disability system, and a goal of the Southern DHB. It is mandated by article three of Te Tiriti o Waitangi and is an enduring principle of Te Tiriti. Achieving equity for Māori will be a key element of activity described throughout the rest of this plan.

DHB Activity	**Milestone**	**Measure**	**Government theme:** Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
			We have health equity for Māori and other groups	Support healthier, safer and more connected communities
Iwi Governance Committee and the Southern Māori Health Directorate have identified Māori health priority areas to improve the health and wellbeing of whānau, hapu, iwi and Māori communities. The priority areas include: • Mental Health & Addictions • Cancer • Long Term Conditions • Access to diagnostic testing (2021/2022) • Oral Health • Explore use of navigators across the whānau ora continuum of care				
1. **Improving Mental Wellbeing** Mental Health and Addiction System Transformation • Whānau, hapu, iwi and Māori communities who use Southern DHB Mental Health Addictions and Intellectual Disability services will receive clinical care and cultural support from the Southern DHB Māori Mental Health workforce across both primary and secondary care. The teams integrated into MHAID services at the end of 2019-2020. • The number of Māori on Compulsory Treatment Orders will be reduced from the 2019/2020 period. (EOA) • Continue to support the Connecting Care – Improving Service Transitions (HQSC) project, which spans the care pathway for tangata whaiora Māori and tangata whaiora of all ages • Suicide Prevention - Specific district wide postvention group for Māori Q4 • Maternal Mental Health - Identify priority areas for implementation, including those for Māori (EOA)	Reduction in number of Māori on Compulsory Treatment Orders Q4 Analysis of baseline level of tangata whaiora Māori and tangata whaiora enrolment and engagement with GP practices to be completed in Q2 Specific district wide postvention group for Māori Q4 Development of an implementation plan that will achieve the changes required within the current resources Q2	MH01: Improving the Health Status of people with severe mental illness through improved access. MH05: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders Number of tangata whaiora Māori and tangata whaiora who access and engage with specialist mental health and addictions services (primary and secondary)		
2. **New Zealand Cancer Action Plan** Undertake quality improvement initiatives that align with the National Cancer Strategies to ensure Maori are supported and receive timely cancer services in the Southern district (EOA). There is a focus on the implementation of the Cancer Pathway for Māori Plan and appointment of a Māori Cancer Nurse Coordinator (EOA). Cancer Pathways • Implement the Improving the Cancer Pathway for Māori Plan (EOA) • Provide cultural support and navigation of cancer services for Māori newly diagnosed. Monitoring will occur. (EOA)	Implementation of Improving the Cancer Pathway for Māori Plan Q1-Q4 Monitor and navigate Māori newly diagnosed with cancer Q1-Q4 Appointment of a Māori Cancer Nurse Coordinator by Q4 Analyse journey and wait times for 20 Māori patients diagnosed with lung cancer. Assess opportunities to improve timeliness in primary and	MH03: Shorter waits for non-urgent mental health and addiction services. MH02: Improving mental health services using wellness and transition (discharge) planning SS01 Faster Cancer Treatment (31 day indicator) SS11 Faster cancer treatment (62 day indicator)		

• Engage with Māori for workforce cultural support, advice and guidance including cultural competency of the health workforce (EOA) • Appointment of a Māori Cancer Nurse Coordinator • Improve cultural resource for FCT and for cancer nurse coordinators, in order to improvement pathways, and increase supportive care. Survivorship - Work with Cancer Control Agency to explore evidence based equity tools/processes to identify disparities for Māori, the causes of disparities and the impacts (intended and unintended) of initiatives (EOA)	secondary and expected outcomes Q1-Q4 Work with Cancer Control Agency to explore evidence based equity tools/processes to identify disparities for Māori, the causes of disparities and the impacts (intended and unintended) of initiatives Q1-Q4			
3. **Long Term Conditions** In partnership with WellSouth PHN, establish a new programme targeting Māori aged 50 years and older for Hauora Wellness Checks across Southern district. The focus of these assessments will be on whānau health and wellbeing; reconnecting with General Practice; eligible screening services and connecting with Māori Health Provider services (EOA) WellSouth Primary Health Network have recently reviewed the District's Long term Condition Management Programme, Client Led Integrated Care (CLIC). For those Māori who require more intervention, a complex management pathway will still be in place and for those with less complexity, a more responsive, less intensive pathway for support will be developed. • We will support the remaining practices to transition from Care Plus to CLIC • All Māori patients who are enrolled on the CLIC programme will have a CHA (comprehensive health assessment) completed	Identify Māori aged 50 years and older by General Practice Q1-Q4 Undertake assessment using the WellSouth Call Centre, providing free GP visit and screening services, with referrals made as appropriate Q1-Q4 All Māori patients to have a CHA completed by the end of Q1	SS13: Improved management of Long term conditions Number of patients enrolled into CLIC Number of CLIC patients in LTC pilot referred to Community Pharmacy Number of CHAs		
4. **Diabetes** - Actions will be taken to support Maori to reduce their HbA1c to an optimal level within best practice guidelines. HbA1c to 80% Q2 and 90% Q4 (EOA), including: • The Local Diabetes Team will be reformed with new TOR and agreed membership • Virtual diabetes forums will begin to be delivered to GPs, enabling the further integration of primary and secondary services. • WellSouth Primary Care Network will work to actively design and support a catch-up programme for HbA1c DARs in primary care • WellSouth will design and support a programme to monitor the number of Māori with Diabetes identified as High Risk or Active Disease who are referred into secondary care • A Key part of the focus for the enhancement of the Diabetes pathway in the 202/21 year will be the Implementation of the Integrated Diabetic Foot Protection Service.	Increase the number of Māori patients with current HbA1c to 80% Q2 and 90% Q4	All Māori patients with current HbA1c 80% Q2 and 90% Q4		
5. **Respiratory admissions in children** - The WellSouth PHN and Southern DHB Māori Health Directorate will establish a new service targeting respiratory admissions for Māori children age 0-4 years in Dunedin (EOA) • Establish service	Service established Q1 Māori respiratory admissions identified Q1-Q4	All Māori patients with Diabetes identified as High Risk or Active Disease are		

• Identify Māori 0-4 respiratory admissions • Undertake assessments for all identified children, with assessments completed in the paediatric ward or in the home as required • Assessments will focus on social determinants according to Harti Hauora protocols. 6. **Cardiovascular disease-** Southern DHB Māori Health Directorate will actively participate in South Island Alliance groups that have a focus on Māori health equity such as the Cardiac Alliance The South Island Cardiac Workstream provides regional leadership for the overarching national goal of improving access, equity and quality of care for people living with cardiovascular illness, as well as reducing the number of people dying prematurely of heart disease (EOA) 7. **Oral health (reduction of caries)** - In partnership with our Community Oral health service, we will: • Establish a monthly community oral health outreach clinic for Māori, (utilising the findings from the PTO evaluation), attached to Southland Te Kakano Nurse Led Clinic (see also 2.1.3 Maternity and Early Years section) (EOA) • Investigate the establishment of a pilot programme for the Community Oral Health Service to be delivered via a mobile vehicle on two Southern district marae (location to be determined) to increase access for Māori children aged 0-18 year (see also 2.1.3 Maternity and Early Years section) (EOA) 6. **Maternal Smokefree Referral Pilot** - In partnership with our Primary Maternity providers, we will: • Assess and make recommendations on the Maternal Smokefree Referral Pilot currently being implemented with community midwives in Oamaru, Balclutha and Queen Mary birthing units. The focus of the pilot is to increase engagement in (SSS Incentive Scheme) especially for young Māori mothers, resulting in increased quit attempts (EOA) • Assessment will review acceptability, feasibility and efficacy of the new referral process to the Southern Stop Smoking Service (SSSS)	Assessments Q1-Q4 Referrals made Q1-Q4 Māori representation and participation across South Island Alliance groups to progress and improve health equity Q1-Q4 Community outreach clinic established with regular monthly attendance Q4 A plan developed for the introduction of the pilot programme Q2 Pilot programme up and running Q4 Assessment of referral approach/recommendations made Q4 Analysis completed Q4 Recommendations implemented Q4	referred into secondary care Māori 0-4 ASH rate for upper respiratory and ENT < 1,740. Q2 & Q4 Planned Care Measure 5: Cardiac Urgency Waiting Times Report prepared detailing system activities, achievements and challenges CW01: children caries free from five years of age CW02: Oral health – Mean DMFT at Year 8 CW03: Improving the number of children enrolled and accessing the Community Oral Health Service CW09: Better help for smokers to quit (maternity) Increased engagement in (SSS Incentive Scheme) Increased referrals of pregnant women to the SSSS		

Māori Health Action Plan – Shifting Cultural and Social norms

Shifting cultural norms within the health and disability system is critical to ensuring that Māori can live and thrive as Māori and that we address racism and discrimination in all its forms. The Southern DHB has plans to further these aims through actions that are described below.

DHB Activity	Milestone	Measure	Government theme: Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
In the 2020/21 year we will: 1. Develop and deliver a Māori Cultural Education Programme with micro credentialing within the New Zealand Qualifications Authority (NZQA) framework for the Southern health system. Delivery will include face to face and self-directed learning using a quality improvement framework (EOA). Delivery to Southern DHB staff, Rural Trust Hospitals, WellSouth Primary Health Network staff, Māori Health Providers, General Practices and Community Pharmacies for 2020/21. The programme will include: • Te Tiriti o Waitangi understanding the origins of Te Tiriti o Waitangi and its relevance today and how this is applied within a clinical and non-clinical environment. • Cultural Safety incorporating cultural competency and Tikanga best practice guidelines to support clinical and non-clinical staff to work in a way with whānau that is culturally responsive. • Cultural Humility incorporates Southern DHB values of Manaakitanga, Pono, Whaiwhakaaro, Whanaungatanga and how these relate to individuals own values and beliefs when providing care for whānau. • Te Reo in Health provides the basic introduction of Te Reo Māori language, mihi, the strength of building and maintaining engagement therapeutic relationships with whānau to improve health outcomes. • Māori Cultural Education Programme to be delivered to Aged Care Providers and other health services in 2021/22). • Cultural training content to be developed in consultation with IGC	Māori Cultural Education Programme in place by Q1, with attendance by 500 participants by Q4	Total number of Southern DHB staff in attendance at the Māori Cultural Education Programme. Participants indicate and give evidence in understanding of content at education sessions. 100% of Southern DHB Board members and Southern DHB Executive Leadership Team will be trained Participants give evidence of attendance through performance appraisals	We have health equity for Māori and other groups	Support healthier, safer and more connected communities
2. Southern DHB Board and Executive Leadership Team to undertake Te Tiriti o Waitangi training, understanding the origins of Te Tiriti o Waitangi and its relevance today and how this is applied within a clinical and non-clinical environment Q1	DHB Board and Executive Leadership Team to complete Te Tiriti o Waitangi training by Q1			
3. Te Reo Māori will be incorporated into the Southern Health website and strategic documents (e.g. Southern Health Needs Assessment) to ensure Māori health content is strengthened and following Tikanga best practice Q1-Q4	Te Reo Māori will be incorporated into the Southern Health website and strategic documents Q1-Q4			

Māori Health Action Plan – Strengthening System Settings DHBs have a role to play in ensuring that the system settings across their parts of the health and disability system support the overall goal of pae ora (healthy futures). Included in this area are matters to do with how services are commissioned and provided and joint ventures with other local agencies				
DHB Activity In the 2020/21 year, we will:	**Milestone**	**Measure**	**Government theme:** Improving the well-being of New Zealanders and their families	
1. Develop a Southern Māori Health Action Plan inclusive of primary, secondary, tertiary and the community that aims to strengthen systems and responsiveness for Māori. The plan will be developed based on guidance from the Ministry of Health and the proposed Te Tiriti o Waitangi framework developed under the COVID-19 Māori Action Plan and inclusive of Pae Ora • Māori Health Action Plan is developed collaboratively with IGC	Comprehensive Māori Action Plan developed Q2	Māori Health Action Plan sign off by IGC and the Board	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
2. Māori Health Directorate will actively participate in South Island Alliance groups that have a focus on Māori health equity including the Cardiac Alliance, South Island Public Health Partnership Alliance and Te Herenga Hauora o Te Waipounamu (Regional Māori DHB Alliance).	Māori representation and participation across South Island Alliance groups to progress and improve health equity Q1-Q4	Report prepared detailing system activities, achievements and challenges		
3. The Māori Health Directorate will participate in the Southern DHB local cancer control network, the Cancer Control Agency and Te Tumu Whakarae (National Māori DHB Network); these networks contribute to strengthening systems, policy and relationships that impact on Māori health equity and that improve Māori health equity in access and outcome (EOA)	Report prepared detailing system activities, achievements and challenges Q4			

2.1.2 Improving Sustainability

Improved Out Year Planning Processes

Financial

- Identify the three or four most significant actions the DHB will take to improve its outyear planning processes.
- At least two of the actions should identify milestones for delivery to be completed by December 2020 to support 2021/22 planning.

Workforce

- Identify the three or four most significant actions the DHB will take to improve its outyear planning processes.
- At least two of the actions should identify milestones for delivery to be completed by December 2020 to support 2021/22 planning.

DHB Activity	Milestone	Measure	Government theme: Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
1. Review and revise Southern DHB Asset Management Plan to define alignment of asset base with service delivery models now and into the future. The integration of the National Asset Management Programme work undertaken by the Ministry of Health is an important input to this process.	Asset Management Plan completed and approved by 20 December 2020.	Approved by Executive Management Team and Finance, Audit & Risk Committee by 20 December 2020.	We live longer in good health	Support healthier, safer and more connected communities
2. Continuation of the development of service plans and connectivity of individual plans between services and to the Southern DHB Annual Plan and Budget.	Draft 2021/22 Service Plans and Annual Plan & Budget completed by 10 February 2021.	Draft 2021/22 Service Plans, Annual Plan and budget reviewed by Executive Management Team. FTE Plan for 2021/22 and outyears to 2025/26 by 31 October 2020		
3. Develop analysis of population, services and workforce to improve understanding of demand for healthcare services now and into the future. The initial focus being on Southern DHB services and workforce which supplements the wider Health Needs Assessment (HNA).	Workforce Plan Q3			
4. Health needs assessment - A district-wide health needs assessment (HNA) was last undertaken in Southern in 2013. The Southern Health Needs Assessment (HNA) is being led by Southern DHB in 2020 to provide an objective, up to date, and comprehensive picture of the health and needs of the Southern district's population. It is a multi-purpose project that will serve to inform the future delivery and integration of health care services across the district, including the implementation of the Southern Primary and Community Care Strategy 2018 (and its subsequent monitoring and evaluation). This will be an important part of our planning processes, informing both our strategic planning and funding decisions.	HNA complete Q2	Completed Health Assessment is published on Southern Health Website		

Savings plans – In-Year Gains

Southern DHB plan to undertake appropriate cost analysis and develop realistic savings plans that do not risk compromising the quality and safety of services or improved equity for their populations. In our plan we highlight the activity expected to have the most significant impact in the 2020/21 year and include a brief rationale explaining why the action was selected.

DHB Activity	Milestone	**Measure**	**Government theme:** Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
Optimising Pharmaceutical Utilisation Southern district pharmaceutical utilisation continues to be an outlier nationally which has an impact on pharmaceutical expenditure. Southern DHB 19/20 forecast net reimbursement cost (after rebate) is $7.1M in excess of its Population-Based Funding Formula (PBFF) 'share' of the Combined Pharmaceutical Budget (CPB). Access to pharmaceuticals data on Māori and analysis on utilisation to be undertaken			We live longer in good health	Support healthier, safer and more connected communities
1. Ensure ongoing access to a system-wide, complete and up to date pharmaceutical database as a tool suitable for analysis and monitoring of Southern district pharmaceutical utilisation.	Database created Q1	Database complete with capacity to query and provide analysis of the data and monitoring of DHB actions		
2. Undertake analysis to understand pharmaceutical utilisation Ōritetanga (equity for Māori) (EOA) • Analysis undertaken by Q2 • Collaboratively develop actions to address under-utilisation and under prioritisation of pharmaceuticals for Māori Q4	Understand utilisation by Māori Q2 Development of actions to address underutilisation by Māori Q4	Outlier pharmaceuticals and practice clearly identified.		
3. Understand the utilisation, and cost drivers of Southern district pharmaceutical use, particularly the high-cost pharmaceuticals. Identify components of outlier practice that present the opportunity to improve efficiency, including known Southern district high-frequency community pharmacy dispensing. Actions will be identified to address overutilisation once usage patterns are known.	Pharmaceutical benchmarking framework against other DHBs complete Q1 Outlier providers have education and support to have reduced outlier status Q3 and ongoing	Southern district dispensing frequency is consistent with national average to deliver a reduction of $1.3m.		
4. Collaborate with South Island DHBs to understand drivers of pharmaceutical utilisation and expenditure relative to PBFF, in addition to quantification of the non-pharmaceutical on-costs of PHARMAC decisions for DHBs.	Draft report produced by South Island Alliance DHBs to explaining key factors driving pharmaceutical use and expenditure relative to PBF Q1	Report generated		
5. Collaborate with WellSouth to provide quality use of medicines practice support for general practice to address Southern district outlier status in target initiatives (including high-cost prescribing, inappropriate polypharmacy, use of high-risk medicines)	Practice support tools including dashboards and decision support piloted Q1 Target initiatives progressively rolled out Q2 and ongoing	Pilot goes live Target initiative metrics including polypharmacy in the elderly, falls medicines, high-risk medicines and high-risk combinations		

Age Related Residential Care 1. Falls and Fractures Prevention • Interagency Steering Group providing leadership • Development of Community Strength & Balance Classes • Development of Fracture Liaison through CLIC • Development of in home Strength & Balance	Falls Steering Group self-review by Q4			
2. HOME Team: Review the current scope of eligible patients with a view to expanding this to a larger number	Review completed by Q2			
3. Relaunch the Home as my First Choice Campaign and undertake refreshed education to teams Education	Post COVID Home as my First Choice Campaign by Q2	Reduction in Admission rate to ARRC with an associated reduction of $1.4 million.		
4. Restorative Home Care Support Services (HCSS): Develop revised model of care, including alignment with Primary and Community Strategy and consultation with key stakeholders. Prepare RFP with a view to greater restorative and integration approach.	RFP Q4			
5. Older Person's Assessment Liaison Unit (OPAL) Unit: continue quality improvements	Quality improvements Q4			
6. Collaboratively undertake age related residential care needs assessment focusing on Māori Q4	ARRC needs assessment with focus on Māori Q4			
Procurement and Clinical Supplies • The workplan for FY2021 is targeted to deliver expenditure management benefits from clinical and non-clinical products and services. • The review of clinical supplies with the goal of achieving greater consistency in produce use and minimisation of variation.	Monthly reporting against plan.	Reduction in price for products or services targeted to deliver expenditure management benefits totalling $1.0 million.		
Management of Workforce and Annual Leave • Training on the workforce policies and guidelines to leaders/line managers under the mandatory training programme. • Monitoring of leave liability including push reporting to leaders/line managers. • Review of Senior Medical Officer (SMO) leave balance and management practices • Finalise Holidays Act remediation work	Completed by Q2 Monthly reporting against plan	Reduction in the range of clinical supplies used across the hospitals to mitigate risk of redundancy and waste totalling $1.0 million All employees understand the importance of taking leave as part of health and wellbeing for the employee		

Valuing Patients Time (VPT) Continued focus to be placed on the various initiatives that collectively will create savings in patient wait times, which in 2020/21 will include a focus on: • Emergency Department (ED) services in both Dunedin and Invercargill, with focus on Māori presentations. • ED Escalation Protocols • Stranded Patients • Red to Green • Generalism [Refer also: Acute Demand]	Ongoing monitoring and reporting to ELT in respect to VPT baselines and targets Completion of ED Escalation pathway end of Q1 Generalism Business case signed off by the Board by end of Q1 Implementation plan for Generalism complete by end of Q2	and sustainability for the organisation. Reduction in excess leave entitlements by $2.5 million		
Mental Health Mental Health Expenditure is ring fenced, which essentially sets a minimum expenditure expectation for DHB's. Southern DHB's Mental Health expenditure is greater than the ring fence, contributing to the 2020/21 budgeted deficit. The actions below will assist with the Southern DHB bringing its Mental Health expenditure within the ring fence: A comprehensive review of the entire model of care for Mental Health services will be undertaken during the first half of 2020/21 which will highlight opportunities for services to be shifted closer to home, in alignment with objectives outlined in the Primary and Community Strategy. This is likely to lead to efficiencies through closer alignment to NGO community providers. In addition to the above, discussions will begin with key stakeholders for services that have been identified as out of scope for the new Dunedin Hospital. For Mental health this may present some opportunity for 'early adopters' such as Day Activity services and Needs Assessment and Service Co-ordination.	Review complete end of Q1 to deliver improved value of $3.4m Recommendations endorsed by Network Leadership Group (NLG) and Alliance Leadership Team (ALT) end of Q2 Implementation plan including model of care changes endorsed end of Q3			

Savings plans – Out Year Gains

DHBs plans to undertake appropriate cost analysis and develop realistic savings plans that do not risk compromising the quality and safety of services or improved equity for their populations. This section highlights activities that are expected to have most significant impact in the next two out years and include a brief rationale explaining why the action was selected.

Consideration of innovative models of care and the scope of practice of the workforce to support system sustainability

Ensuring workforce planning supports innovative models of care is a key factor supporting improved system sustainability in the medium term.
Please specify five key workforce development actions and initiatives the DHB will undertake during 2020/21 to support innovative models of care to be delivered in out years. At least one action should be focused on strengthening Māori workforce.

DHB Activity **Savings plans – Out Year Gains**	**Milestone**	**Measure**	**Government theme:** Improving the well-being of New Zealanders and their families	
1. Health System Structure and Healthcare Delivery mechanisms: *The Health and Disability System Review raises the efficiency of management and governance structures. Across the district there may be opportunities to rationalize existing management and governance structures.*	Under development	$2.0m Saving 21/22 and beyond	**System outcome** We live longer in good health	**Government priority outcome** Support healthier, safer and more connected communities
2. Consumable and Pharmaceutical Utilisation: *Continuing the program of review from 2020/21 into 2021/22 to rationalize use of consumables and obtain benefits from improvement in patient consumables to minimize waste* • Blood Utilisation • Clinical Supply Utilisation Improvements • Air Ambulance Utilisation	Under development	$2.0m Saving 21/22 and beyond		
3. Re-engineering the workforce to achieve better outcomes for workforce and patients: *Leveraging the digital strategy and workforce plan to progress evolution of how and who delivers healthcare across the district.* • Digitally Supported Change Opportunities • FTE Line By Line Review • Medical Workforce Realignment	Under development	$2.5m Saving 21/22 and beyond		
4. Procurement and Contract management: *Ongoing management of procurement to leverage benefits at local, regional and national levels.* • Continued review of clinical supplies with the goal of achieving greater consistency in produce use and minimisation of variation	Under development	$1.0m Saving 21/22 and beyond		
5. Bed and Theatre capacity scheduling to optimise the utilisation of in-house resources**:** *Review of service delivery streams to maximize in-house healthcare delivery and reduce outsourcing.* • Increase the Rate of Day of Surgery Admissions	Under development	$3.0m Saving 21/22 and beyond		

• Health Round Table Opportunities – Persistent Reds • Use of Specials and Watches • Consider Elective Lists in Weekends Instead of Outsourcing • Standardised Intervention Rates review • Hospital Escalation Plan / Flow • Southland Primary Care ED Presentations				
Consideration of innovative models of care and the scope of practice of the workforce to support system sustainability • Promote the Hauora Health Workforce Funding (NZQA Level 3 – 7) to kaupapa Māori health services to increase workforce skills and capacity for clinical and cultural support services. [Refer to Māori Health Action Plan – Accelerate the Spread and Delivery of Kaupapa Māori Services] • Establish or build upon multidisciplinary professional development activities on AMR, antimicrobial stewardship and infection prevention and control for primary care, hospital settings and age-related residential care settings. Infection, Prevention and Control (IPC) will continue to provide professional development activities through Age Related Residential Care (AARC) settings in Dunedin and Invercargill [Refer to Antimicrobial Resistance template] • Develop educational opportunities for cross sector health professionals to promote sexual health awareness across the Southern district. This will include the development of specific micro credentialing education to be developed for trainee GPs as well as the training of both Public Health and sexual health nurses across the district to undertake long-acting reversible contraception (LARCs) and other contraception interventions [Refer to Sexual Health template]. • Develop and deliver a Māori Cultural Education Programme with micro credentialing within the NZQA framework for the Southern health system. Delivery will include face to face and self-directed learning using a quality improvement framework. The Programme will be delivered to Southern DHB staff, Rural Trust Hospitals, WellSouth PHO staff, Māori Health Providers, General Practices and Community Pharmacies. The Programme is comprised of components on Treaty of Waitangi, Cultural Safety, Cultural Humility and Te Reo [Refer to Workforce template]. • 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 and Tū Tauira Hauora programmes of work within the Otago University Q1-Q4 and ongoing continuing through financial year (FY) 21/22 (EOA) [Refer to Workforce – Health Literacy template].				

Working with Sector Partners to Support Sustainable System Improvements

What follows are the three or four most significant actions that our DHB will undertake during 2020/21 collaboratively with sector partners to support sustainable system improvements that also support improved Māori health outcomes. These improvements also support improved Pacific health outcomes.

DHB Activity	**Milestone**	**Measure**	**Government theme:** Improving the well-being of New Zealanders and their families	
Health care systems have experienced major shock and upheaval in recent months due to the COVID-19 pandemic. Although the public health crisis has been contained for now, ongoing vigilance for further outbreaks of disease is essential especially should the border reopen and partnerships will be critical to ensure system sustainability and a focus on redressing the balance of health equity for our marginalised populations. In 2020/21, therefore we will:		Establishment of network Evidence of cross government Māori data collection and analysis	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
Engage with Southern government interagency Māori and Pacific network inclusive of the NZ Police, Ministry of Social Development, Department of Corrections, Ministry of Education, Te Puni Kōkiri (TPK) and Oranga Tamaki (as a minimum). The aim of this network is to support interagency collaboration that improves the coordination and service delivery to assist with community recovery and resilience, particularly for Māori and their whānau. The network will lead cross government data collection and intelligence (EOA). A representative from IGC participates in this network.	Establishment of government interagency network Q2	Increased screening of family harm in EDs and with Kaupapa Māori and Pacific Health Providers		
1. Continue to maintain and advance the Southern DHBs involvement in Whāngaia Ngā Pā Harakeke Rōpū Manawhakahaere a police sponsored initiative working in partnership with iwi and community to reduce family harm	DHB leadership involvement in Whāngaia Ngā Pā Harakeke Q1-Q4	Evidence of meeting held and progress made since the 2019 meeting		
2. Continue to support the Puketai Care and Protection Residence on their clinical governance multi-agency group aimed at improving the health status of Māori and Pacific children and young people in care in Dunedin	Evidence of strategies that support the improvement of health care in residence Q1-Q4	Evidence of DHB participation on this group and strategies adopted to improve health care for this population		

2.1.3 Improving Child Wellbeing

<table>
<tr><td colspan="5">Immunisation
The SDHB continues to contribute to healthier populations by establishing innovative solutions to improve and maintain high immunisation rates at all childhood milestones from infancy to age 5 years. Ensuring the Childhood Immunisation Schedule is maintained during New Zealand's COVID-19 response is essential.
Southern DHB has plans to improve delivery and uptake of immunisation from infancy to age 5 years in order to meet the needs of our overall population, including actions to improve Māori equity. We recognise that some groups within our population may find accessing childhood immunisations harder as a result of COVID-19 and have outlined action we will take to continue to immunise children on time in light of COVID-19. Our DHB Immunisation Leads will develop and maintain strong working relationships with our Māori Health Directorate to ensure they have a clear line of sight into immunisation work.</td></tr>
<tr><td>DHB Activity
In 2020/21 we will:
Maintain the Childhood Immunisation Schedule work programme, especially during the Southern district's COVID-19 response. Improving equitable immunisation coverage is key to the success of the programme so our focus is to ensure every immunisation is received on time for all children, particularly Māori, Pacific and other priority children by:

1. Increasing clinical governance to enable streamlining of vaccine preventable disease programmes (VPD) and National Immunisation Register (NIR) across the Southern district. The aim is to provide strong oversight by the Southern district's Chief Māori Health Strategy and Improvement Officer and joined up services to promote quality assurance and improvement, including general practice, occupational health, public health, maternity, public health nursing, vaccinating pharmacist and outreach teams.
• Membership of the Vaccine Preventable Disease Steering Group (VPDSG) is assessed and members added as required to ensure appropriate cross sector representation and a focus on equitable health outcomes for Māori, Pacific and those most needing support to access immunisation services. VPDSG will include representation from Māori and Pacific peoples
• IGC to appoint a representative to the VPDSG Q2
• Terms of reference (TOR) developed
• Quality assurance plan is developed and implemented with a focus on increasing equitable outcomes by ensuring on time immunisation for every immunisation as per the Childhood Immunisation Schedule

2. Immunisation data checking via NIR to support early enrolment with general practice and follow-up of babies identified on NIR as not immunised at 7 weeks of age. Notify GPs of babies not immunised on time
• Data checking of 8 month immunisation results, prioritising identification of Māori babies not immunised and forwarding notification to the outreach service and GPs
• Southern DHB Immunisation and NIR coordinators work with general practice and WCTO providers to encourage more timely referrals to outreach services of harder to reach, unvaccinated children, including Māori children (EOA)</td><td>Milestone

Assessment of VPDSG and members added as required Q1
TOR developed Q1
VPDSG meets quarterly Q1-4
Quality assurance plan implemented Q2-Q4
IGC representative appointed Q2

Data checking by NIR team Q1-Q4
NIR advises general practices of unenrolled babies Q1-4
General practices refer unimmunised babies to immunisation outreach service Q1-4</td><td>Measure

CW05: Immunisation coverage at 8 months of age and 5 years of age;

CW08: Immunisation coverage at 2 years of age

More consistent coverage rates for Māori children achieved Q1-Q4, across all milestones ages;

Revised VPD Steering Group meets regularly with good attendance;

Immunisation data complete and fully recorded in NIR and general practice;

CW07: New-born enrolment rate in primary care increases</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</td><td>Government priority outcome

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

3. Measles Immunisation Campaign for 15 to 29 year olds and active recall of children 5 to 14 years who have not had any or had only one measles, mumps & rubella (MMR) vaccine: • Finalise the Southern district's plan with the MoH and other key stakeholders and providers • Work with key stakeholders in primary care and the community to commence MMR vaccination catch up programme across the district primarily focussing on Māori youth and their whānau (EOA) • Work with key stakeholders in primary care and the community to commence MMR vaccination catch up programme across the district primarily focussing on Pacific youth and their whānau (EOA) • Ongoing collection of data and stories about the campaign and those who were vaccinated so at the end of the campaign an evaluation can be completed	SDHB Measles Immunisation Plan accepted and signed off by MoH Q1 MMR vaccines delivered to target groups and data collection processes are in place Q1-Q4 Evaluation processes established and information is collected Q1-Q4			

School-Based Health Services (SBHS)

Southern DHB is committed to providing quality School Based health Services. We are undertaking work to improve the responsiveness of primary care to youth and to ensure high performance of the youth service level alliance team (SLAT). As part of our SBHS work we will implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS.

DHB Activity	Milestone	Measure	Government theme: Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
1. Quantitative reports • A quantitative report will be submitted to the Ministry of Health (MOH) for decile 1 to 5 schools teen parent units and Alternative education facilities quarters two and four	Data is collected and submitted to MOH Q2 and Q4	CW12: Youth mental health services Completed report Q2, Q4	We have health equity for Māori and other groups	Make New Zealand the best place in the world to be a child
2. Additional School Based Health Services**:** Based on the *Youth Health Care in Secondary school (2013) Framework for continuous quality improvement* (EOA) • Public health nurses working with young people will undertake youth health nursing training inclusive of equity for Māori and other groups with commencement of training	Youth training tool in place and training of public health nurses commenced Q3	The number of nurses delivering SBHS who have completed youth competencies training		
• Evaluate and make recommendations on the youth health training guidelines which is inclusive of equity for Māori and others for public health nurses	Evaluation complete and available by the end of Q4	50% of all students in decile 1-5 schools will have been assessed and received year 9 health checks Q4		
3. School Based Health Services catch up for priority populations will be undertaken in collaboration with the school based Learning Support Coordinators to identify those young people most needing support and psychosocial assessments: • School based clinics will be established in decile 5 schools in the Southern district from the commencement of the 2021 school year	School based health services delivered in decile 1-5 schools Q3	Recommendations made following use of HEAT tool		
• Year 9 students in decile 1-5 will be assessed beginning with priority populations	Priority populations identified within decile 1-5 schools and receive SBHS including psychosocial assessments Q4			
4. Demonstrate commitment to the Treaty of Waitangi (EOA) • Utilising the Health Equity Assessment Tool (HEAT) tool, additional quality improvement initiatives will be identified and prioritised for delivery as part of the School Based Health Services programme for the 2021/22 year	Work programme for 2021/22 finalised by end of Q4			
5. Increase youth accessibility and utilisation of School Based Health Services • Explore options to improve interface with youth with a focus on ensuring confidentiality Youth client feedback received on how to increase engagement and ensure confidentiality	Youth client feedback received and assessed Q4	Youth are consulted and provided an opportunity to feedback		
• Quality improvement activity selected during quarter four, for the 2021/22 financial year				
6. Youth SLAT quarterly monitoring reports • A quarterly narrative report will be submitted to the Ministry of Health (MOH) detailing action of the SLAT to improve youth health outcomes Q1-Q4	Two monthly SLAT meetings occur	SLAT continues to meet two monthly and collaborative working relationships are established and maintained.		
• The Youth Service Level Alliance Team will meet no less than two monthly to monitor service delivery, identify gaps in responsiveness, access, and	Quarterly MoH reporting			

service provision and make recommendations to relevant services on gaps and issues identified				

Maternity and Midwifery Workforce

Southern DHB will ensure population needs for pregnant women, babies, children and their whānau are well understood. Here we identify key actions that to meet these needs, including realising a measurable improvement in equity. Actions include a comprehensive approach to prevention and early intervention across maternity, Well Child Tamariki Ora and primary care services.
We will continue to develop, implement, and evaluate a midwifery workforce plan to support:

- undergraduate training, including clinical placements
- recruitment and retention of midwives, including looking at the full range of the midwifery workforce within the DHB region especially rural areas
- service delivery mechanisms including strategies to address predicted seasonal changes in service demand and showing initiatives that make best use of other health work forces to support both midwives in their roles and pregnant people

DHB Activity	Milestone	Measure	Government theme: Improving the well-being of New Zealanders and their families	
1. Partner with Otago School of Midwifery to ensure that every midwifery student living within the Southern District has a welcome to SDHB maternity facilities and knows about midwifery opportunities within Southern • Midwifery First Year of Practice (MFYP) recruitment in place • Director of Midwifery presents to each of the three cohorts (Year 1, Year 2, Year 3)	MRYP recruitment in place Q4 International placement offered Q1	SDHB employs four MFYP new graduate midwives in 20/21 One MFYP position accepted by Australian new graduate midwife	**System outcomes** We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
2. Partner with Australian Schools of Midwifery to increase the profile of midwifery opportunities within Southern DHB • Advertise Midwifery First Year of Practice (MFY) positions to Australia School of Midwifery (SoM) students	Midwifery employment opportunities advertised Q1	Queen Mary and Southland Hospital fully staffed to existing FTE All women in Dunedin are able to book with a continuity-of-care midwife from the beginning of pregnancy		
3. Host an Open Day in each of the two hospital maternity facilities (Dunedin and Invercargill), for midwives, nurses and current and prospective nursing and midwifery students, to showcase midwifery and nursing roles in secondary and tertiary maternity care	Open Day hosted in Queen Mary Q1 Open Day hosted in Southland Maternity Q2	All women living in remote rural Southern District are able to access midwifery care		

4. Review rural sustainability package that provides top-up payments to rural self-employed midwives working with remote-rural-living women, to include consideration of an extension to urban self-employed midwives in Dunedin • Review occurs • Any changes agreed and implemented 5. Embed cultural competency education into midwifery education calendar (EOA) 6. Utilise nurses within maternity to support provision of safe maternity care within inpatient maternity wards • Offer Nursing Entry to Practice (NetP) nursing positions in Dunedin and Southland Maternity wards 7. Refer to Maternity and Early Years template for other actions	Review complete by the end of Q2 Changes agreed and implemented by the end of Q4 Calendar 20/21 includes cultural competency sessions Q4 NetP nursing positions offered Q1	100% of DHB employed midwives have engaged in cultural competency education Unfilled FTE reduced in inpatient maternity wards		

Maternity and Early Years

In our plan, we identify actions that contribute to the Strategy's Plan of Action to redesign maternity and early years interventions to support the needs of pregnant women, infants, babies, children and their whānau. In this section we demonstrate how we will meet these needs, including commitments to health equity. Our actions include comprehensive approaches to prevention and early intervention across pregnancy, parenting and Well Child Tamariki Ora services including integrated approaches with primary care and mental health and addiction services, as well as SUDI prevention initiatives.

Numerous activities are undertaken across the Southern district to promote and support maternity and early years health outcomes. These are undertaken in a partnership approach, bringing together a number of services. These include Southern Reproductive Health, Maternity, SUDI, School Based Health Services, Public Health Services, Immunisation, Family Violence and Sexual Violence Services, Tobacco Control, Alcohol Harm Reduction, Mental Health Services and others. An equity lens is applied across all areas, with specific activities identified as relevant.

For the first time, in 2020/21 the Maternity and Early Years work programme will become a formal part of the Southern Alliance, which will ensure that the activity outlined below, as well as any associated milestones will be monitored by the Alliance Leadership Team.

DHB activity	**Milestone**	**Measure**	**Government theme:** Improving the well-being of New Zealanders and their families	
In the 202/21 year, we will:			**System outcome**	**Government priority outcome**
1. Implement "Early Engagement with Your Midwife" programme for young Māori. Programme includes partnering with kaupapa Māori and Māori midwives to increase the number of women from priority populations who register with a midwife in the first trimester of pregnancy • Publish leaflet (developed 19-20) and distribute with partner Māori agencies	Leaflet published and distributed Q1		We have health equity for Māori and other groups	Make New Zealand the best place in the world to be a child
2. Implement "Early Engagement with Your Midwife" programme for young Pasifika mothers including partnering with Pasifika agencies and Māori midwives to increase the number of women from priority populations who register with a midwife in the first trimester of pregnancy • Publish leaflet (developed 19-20) and distribute with partner Pasifika agencies	Leaflet published and distributed Q1	Increased % of Māori and Pasifika women who book with a midwife in the first trimester of pregnancy		
3. Commence whole of system planning for development of a Maternal, Child and Youth Health and Wellbeing Model of Care for the Southern district • Planning includes consideration of barriers to Māori engagement with midwives and WCTO services	First planning day held Q1 Engagement continues on development of the model of care Q2-Q4	Decreased number of women have labour and birth care at Queen Mary from a midwife who is not known to them		
4. Pregnancy and Parenting • Request for Proposals (RFP) for modifications to Pregnancy and Parenting course to increase participation for Māori women by Q2 (EOA) • Plunket to work with the Pacific Trust Otago on incorporating culturally appropriate content into the pregnancy and parenting training sessions held at the Trust premises Q3. The intention is to increase the number of Pacific women and their whānau attending pregnancy and parenting sessions in Dunedin (EOA)	RFP Q2 Service specifications for new contract Q4 Content developed Q3 Number attending sessions reported in Q4	Agreement on strategic approach/themes, leadership, a framework and principles, development of model and plan of areas of focus		
5. SUDI • Socialise and implement the South Island Alliance (SIAPO) Safe Sleep Policy within Southern DHB upon release	Safe sleep policy implemented within SDHB Q3 Post-natal extension Q1	Plunket reporting indicates steady increase over time in attendance of Pacific first time parents attending pregnancy and parenting sessions.		

• Assess and make recommendations on the post-natal extension to Southern Stop Smoking Incentive Scheme (SSS Incentive Scheme) for pregnant women after it has been in place for six months (EOA). • Assess and make recommendations on the Maternal Smokefree Referral Pilot currently being implemented with community midwives in Oamaru, Balclutha and Queen Mary birthing units. Focus of the pilot is to increase engagement in (SSS Incentive Scheme) especially for young Māori mothers, resulting in increased quit attempts. Assessment will review acceptability, feasibility and efficacy of the new referral process to the Southern Stop Smoking Service (SSSS) • Analyse the number of Safe sleep devices (pepi pod and wahakura) distributed from 1 July to 31 December 2020 with a focus on who is receiving the devices to ensure they are reaching those identified as most in need (EOA). Implement recommendations for improvement across the Southern district (EOA) • Work with local weavers and other key stakeholders to establish whānau focussed wahakura wānanga across the Southern district	Assessment completed and recommendation made Q4 Assessment of referral approach/recommendations made Q4 Analysis completed Q4 Recommendations implemented Q4 Wahakura wānanga Q2	Quarterly CFA reporting New Safe Sleep Policy in place. Increased engagement in (SSS Incentive Scheme) Increased referrals of pregnant women to the SSSS Reduction in SUDI deaths across all groups. Numbers of safe sleep devices distributed Reduction of SUDI for Māori and Pacific whānau		
6. Breast feeding • Assess the Community Breast Feeding Support Service pilot based at Pacific Trust Otago to understand the challenges Māori women, Pacific women, refugees, and other women experience in establishing and maintaining breast feeding (EOA) • Hold a breast feeding hui with key stakeholders upon the release of the new national Breast Feeding Strategy with the aim of providing a more joined up approach to breast feeding activities across the Southern district • Following the hui, make recommendations on how to increase community based support for women and whānau (EOA) • Work with WellSouth PHO Health Promotion team to support and enhance the Breast Feeding Peer Support programme (EOA)	Assess pilot Q3 Breastfeeding hui Q3 Recommendations made Q3 Enhance Breast feeding peer support programme Q1-Q4	Breast feeding - CW06 – MoH quarterly reporting National breast feeding targets improve across all groups. Increased engagement with the Breast Feeding Peer Support Programme across the Southern district.		
7. Well Child/Tamariki Ora (WCTO) • Engage with WCTO providers and with lead maternity carers (LMCs) to ensure timely referrals to a WCTO provider by 28 days of age (EOA) o Undertake quality improvement project with local WCTO providers to increase timeliness and completion of all WCTO core contacts received by age 1 year, with particular focus on increasing Māori engagement o Implement an initiative where consistently late referrers will be contacted (EOA) o Quality improvement project will be identified and undertaken following discussion at WCTO QIF Steering Group meetings • WCTO Steering Group meets quarterly with representation by Māori • Review Southern Health He Hauora, He Kura Pounamu website to ensure all maternity, WCTO, SUDI and other first 1000 days information is up to date; update information as required	WCTO providers to provide list of late referrers Q1-Q4 Contact late referrers Q1-Q4 Quality improvement project Q3-Q4 Website information reviewed and updated Q3-Q4 WCTO Steering Group meets Q1-Q4	Improvement in quality indicator "WCTO referral by 28 days". SDHB SLM measure – decrease in dental ASH presentations 0-4 years. Increase in the percentage of Pacific and Māori caries free and reduction in dmft. SDHB SLM measure – decrease in dental ASH presentations 0-4 years Increase in the percentage of Māori: Increase in the percentage of Pacific:		

8. Community Oral Health Service • Evaluate the impact on Pacific children of the pilot community oral health outreach clinic established at Pacific Trust Otago (PTO) (EOA) • Establish a monthly community oral health outreach clinic for Māori, (utilising the findings from the PTO evaluation), attached to Southland Te Kakano Nurse Led Clinic (EOA) • Investigate the establishment of a pilot programme for the Community Oral Health Service to be delivered via a mobile vehicle on two Southern district marae (location to be determined) to increase access for Māori children aged 0-18 year (EOA) [Refer also 2.1.1 Māori Health Action Plan] 9. Promote early enrolment of newborns with GPs [Refer to Immunisation template bullet point no 2] 10. Decrease the distance women need to travel to access obstetric consultation in pregnancy • Evaluate the opportunity to expand obstetric telemedicine in the Southern district 11. Family violence interventions [Refer to Family violence template] 12. Evaluate the pilot the Kia Haumaru te Kaika project that is focused on hospitalisation of children with conditions attributable to their living conditions. [Refer to Māori Health Action Plan – Reducing Health Inequities- The Burden of Disease for Māori] 13. Implement the Maternal Care Child Protection Wellbeing (MCWCP) steering group recommendations [Refer to Family Violence and Sexual Violence template for more information] 14. Maternal Mental Health [Refer to Maternal Mental Health template] 15. Implement Southern DHB's expression of Kia kaha, Kia maia, Kia ora Aotearoa, the COVID-19 Psychosocial and Wellbeing Recovery Plan • Kia kaha, Kia maia, Kia ora Aotearoa, the COVID-19 Psychosocial and Wellbeing recovery plan implemented [Refer to Mental Health and Addiction System Transformation]	Evaluation Q3 Community outreach clinic established with regular monthly attendance Q4 A plan will be developed for the introduction of the pilot programme Q2 Pilot programme up and running Q4 Data checking by NIR Q1-Q4 NIR advises GPs of unenrolled babies Q1-Q4 Evaluation of expansion of obstetric telemedicine Q2 Evaluation completed Q4 Q2,Q4 report on progress and outcomes Implementation of MCWCP steering group recommendations Q1-Q4	CW01: children caries free from five years of age CW02: Oral health – Mean DMFT at Year 8 CW03: Improving the number of children enrolled and accessing the Community Oral Health Service CW07: Improving newborn enrolment with General Practice Process evaluation of pilot Ethnicity data of clients recorded		

Family Violence and Sexual Violence (FVSV)

Reducing family violence and sexual violence is an important priority for the Government. In partnership with communities and other agencies, Southern DHB plans to undertake key actions as outlined below. We acknowledge the need to recognise and address Māori inequity in this area.

DHB Activity	Milestone	Measure	Government theme: Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
We are committed to the prevention, early identification and management of actual or suspected cases of family violence. We recognise the important role and responsibilities all staff have in prevention, routine enquiry / identification, and the need to follow all Southern DHB policies, procedures and guidelines.		80% of all admissions to Paediatrics, Emergency Department and Maternity Services are screened	We have improved quality of life	Make New Zealand the best place in the world to be a child
Actions we are taking to reduce/address/remove family violence and sexual violence are:		Indicative increase in disclosure by 5% in Maternity admissions		
1. Implement Violence Intervention Programme (VIP) Portal with policies / procedures guidance to consolidate the portal	Portal established Q2			
2. Increase SDHB screening rates in Paediatrics, Emergency Department and Maternity Services. This is likely to also increase disclosure rates	Increase screening rates and disclosure rates Q2, Q4	Indicative increase in disclosure by 15% in Emergency Department admissions		
3. Establish a reporting programme for the SDHB Executive Leadership/Board for the VIP programme and to include ethnicity patterns (EOA)	Reporting programme established Q4	% Executive attending VIP		
4. The Executive Team and relevant members of the Senior Leadership Team will undertake the VIP training	100% Executive attend VIP training (Q4)			
5. Establish regular participation in the Whāngaia Nga Pa Harakeke (Police Initiative) on the Dunedin and Invercargill site to ensure health is contributing to a multi-agency approach to Family Violence	Regular attendance at Whāngaia Nga Pa Harakeke with the VIP coordinator Q1-Q4			
6. Actively engage with kaupapa Māori providers and services in relation to FV and SV Q2-Q4	Engagement with kaupapa Māori providers Q2-Q4			
7. Plan SDHB's approach to implementing a programme for Elder Abuse education and screening	Draft plan for Elder Abuse Q3-Q4			
8. Establish and maintain links with community providers to ensure early warning of increased violence in the community, as part of the Psychosocial and Mental Wellbeing Recovery Plan (under development) [Refer to Cross Sectoral Collaboration including Health in All Policies for milestones and measures]				
9. Implement the Maternal Care Child Protection Wellbeing (MCWCP) steering group recommendations	MCWCP milestones: • Midwifery coordinators for the MCWCP groups hired (one Dunedin, one Southland) Q2			

	• Refreshed Terms of Reference for MCWCP groups ratified Q1 • All MCWCP members sign Memorandum of Understanding Q1			

2.1.4 IMPROVING MENTAL WELLBEING

Mental Health and Addiction System Transformation

The Government's response to *He Ara Oranga* (the report of the Mental Health and Addiction Inquiry) confirmed a transformational direction for New Zealand's approach to mental health and addiction (https://www.health.govt.nz/our-work/mental-health-and-addictions/government-inquiry-mental-health-and-addiction). This approach is grounded in wellbeing and recovery. It is underpinned by a deliberate focus on achieving equity of outcomes, in particular for Māori, as well as for other population groups who experience disproportionately poorer outcomes including Pacific peoples and youth. Engagement and co-design must be undertaken with Māori, Pacific peoples, people with lived experience, NGOs, primary and community organisations, Rainbow communities 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.

We understand that collaborative engagement must be demonstrated with Māori, Pacific peoples, people with lived experience, NGOs, primary and community organisations, Rainbow communities 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.

In order to respond to these needs, the Southern DHB has committed to undertaking a comprehensive review of its Mental Health services in 2020/21. The review will take a whole of district whole of system view and will consider:

- The conditions that support current pockets of innovative and/or excellent practice.
- The pressure points in the mental health and addiction system and their underlying root causes, identifying barriers, gaps and opportunities for service development, configuration which is equitable across the Southern area.
- The changes and/or improvements that need to be made to the model of care in order to better meet the needs of the population in each locality.
- The best mix/configuration of resources and services and the preferred model of service delivery in each locality, including kaupapa Māori services in the community.

This review will be undertaken alongside several quality improvement initiatives in the 2020/21 year, and will outline a direction for substantive improvements to our model of care, leading to improved outcomes for service users in our District, that will begin to be implemented in the 2021/22 year. This review, coupled with a renewed commitment to align our Mental Health services to our Primary and Community Strategy, will provide a platform for the transformation required to ensure increased access and choice of supports for people, whatever their needs and wherever they are, and improved and equitable health and wellbeing outcomes for all.

This section is broken down to reflect our activity across the following key domains:

- Placing People at the Centre of all service planning, implementation and monitoring programmes
- Embedding a wellbeing focus
- Increasing access and choice of sustainable, quality, integrated services across the continuum
- Suicide Prevention
- Workforce
- Forensic services
- Commitment to demonstrating quality services and positive outcomes

DHB Activity	Milestone	Measure	Government theme: Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
1. Placing People at the Centre of all service planning, implementation and monitoring programmes Lived experience is valued across the Southern Mental Health and Addiction System. People and Whānau with lived experience are part of the Southern Mental Health and Addiction Network Leadership Group (NLG), local mental health and addiction networks and partner with us in the implementation of all key quality and service improvement initiatives. In the 2020/21 year, we will: • Strengthen support for Local Mental Health and Addiction Networks in North Otago, Queenstown/Central Lakes, Southland and Dunedin, particularly as the focus is strongly on supporting resilience within our communities as we recover from the adverse effects of COVID-19, and prepare for the potential next wave of the Virus. • Ensure that the whole system is appropriately represented on the Network Leadership Group (NLG) as we gear up for the commissioning of our Mental Health Review, which will be undertaken under the leadership and direction of the NLG • Undertake a robust procurement process to select an agency to partner with the NLG to design the details of the review, including a critical programme of engagement and consultation with key stakeholders including IGC, people with lived experience of our services, our workforce across Specialist and NGO providers, and those communities who are not able to enjoy an appropriate level of access to our services currently, for any number of reasons. • Whilst the review is underway, we will continue to build and connect people with existing lived experience to ensure the wider District is connected by way of a Network, that is supported by our broader system. • Listening forums will continue to be led by DHB Consumer and Whānau Advisors on a regular basis across the District with feedback of themes monitored and addressed by the NLG. • Marama Real Time Feedback (RTF) will continue to be collected across all DHB provided Mental Health and Addiction Service teams • In order to minimise compulsory or coercive treatment, particularly the number of Māori subject to Compulsory Treatment Orders, we will continue to participate in the Health Quality and Safety Commission (HQSC) programme for Zero Seclusion: towards eliminating seclusion by 2020, Connecting Care – Improving Service Transitions and Learning from Adverse Events • In the coming year, Māori Mental Staff will take a stronger role within clinical multidisciplinary teams following integration of these staff in clinical teams at the end of the 2019-20 year. The number of Māori on Compulsory Treatment Orders is monitored and reduced (EOA)	Lived experience networks established in Dunedin and Invercargill in Q1 Lived experience networks established in Waitaki and Central Lakes in Q3 Two listening groups are convened Q1-Q4 RTF is collected and shared with NLG Q2 HQSC programme milestones are met Q1-Q4 Procurement process is completed by Q2 Reduction in number of Māori on Compulsory Treatment Orders Q4	MH01: Improving the Health Status of people with severe mental illness through improved access. MH05: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders. Number of Metabolic Monitoring training sessions provided each quarter Number of tangata whaiora Māori and tangata whaiora who access and engage with specialist mental health and addictions services (primary and secondary) The number of young people presenting to ED with self-harm decreases. (SDHB SLM measure) MH03: Shorter waits for non-urgent mental health and addiction services.	We have improved quality of life	Support healthier, safer and more connected communities

2. Embedding a wellbeing and equity focus A large focus of the Mental Health Review will be on understanding the barriers our service has to improving health outcomes for tangata whaiora and tangata whaiora Māori, reorienting itself to being more focussed on health promotion, prevention, wellbeing and lower level intervention for people suffering from mild to moderate mental health conditions. Current practice within our system is not one that encourages seamless and fluid transition between primary, community and specialist services, and opportunities for a larger degree of care to be delivered in a primary setting is lost as a consequence. Accordingly, these barriers, and steps to shift care closer to people's homes will be a significant feature of the Mental Health review. In addition to the above, in 2020/21, we will: • Request IGC representation on the Steering Group for the Independent Review of the Southern DHB Mental Health and Addiction Service • Sign a heads of agreement (HoA) to signal our commitment to a partner with local iwi and MSD to create a high needs health Hub in South Dunedin that will bring together integrated ways of working across the three agencies, focussing on Primary Care, Mental Health and addictions and social responsiveness for high needs families in South Dunedin (EOA) [Refer to Primary Health Care Integration template] • Work in partnership with primary care to Improve the physical health outcomes for people with mental health and addiction conditions, through the establishment of a robust and inclusive health pathways programme • Continue to support the Equally Well Programme Steering Group, which oversees the refreshing the Metabolic Monitoring Guidelines in our district, we well as having a focus on workforce development, and ensuring tangata whaiora Māori and tangata whaiora are accessing the Consumer Led Integrated Care (CLIC) programme, which is a Long Terms Conditions programme delivered in primary care • Utilise existing baseline data to support tangata whaiora Māori and tangata whaiora to engage more proactively with primary care services, including the increasing of primary care enrolment and engagement (EOA) • Continue to support the Connecting Care – Improving Service Transitions (HQSC) project, which spans the care pathway for tangata whaiora Māori and tangata whaiora of all ages • Collaborate with community organisations, for example, Sport Otago and Sport Southland to build working relationships that support easy access to community activities that support wellbeing. • Partner with Public Health to ensure Mental Health clients are represented in the Smokefree programmes/campaigns, including the Vape to Quit trial which is scheduled for delivery in 2020/21 (EOA) 3. Increasing access and choice of sustainable, quality, integrated services across the continuum Expanding the range of available Mental Health and addiction services available in our District remains a key priority for the DHB, including a commitment to providing	IGC representative added to Review Steering Group Q2 HoA executed in Q1 Report in Q2 and Q4 on number of new clinical pathways Metabolic Monitoring Guideline is refreshed in Q1 Training sessions are held to ensure staff understanding of the refreshed guideline Q2-Q4 Analysis of baseline level of tangata whaiora Māori and tangata whaiora enrolment and engagement with GP practices for Hauroa wellbeing to be completed in Q2 Links with Smokefree programmes by Q4			

more equitable access across all parts of our District, which will require a combination of new investment, and the shifting of resources from the main centres of Dunedin and Invercargill, to more underserved areas such as Rural Southland and Central Lakes. To facilitate this, in the 2020/21 year we will: • Work with key social sector partners agencies to ensure there is a robust strategy and range of services available to people experiencing mild to moderate distress as a result of the COVID-19, and the economic impacts of the virus, particularly in the Queenstown and Central Lakes areas. • Utilise new funding secured via the Ministry of Health to establish a Mental Health Crisis programme, featuring Nurse educators in ED to build education, knowledge and capacity in Emergency Departments • As part of the same initiative, the NLG will lead the development of a model for a Peer Led (NGO) service to intervene and support people presenting in mental health distress and crisis in ED departments • We will partner with our Public Health colleagues to embed and strengthen our focus on mental health promotion, including a focus on the upskilling and education of Primary care and NGO's. • The Increasing Access to Psychological Therapies programme will continue to roll out across specialist services. The Psychosocial Therapy Steering Group will include Māori representation.	Educator roles are recruited and established in Dunedin and Southland ED Q2 Service model is developed Q2 and implemented Q4 Number of workshops delivered in Q1-Q2 Training model revised Q3 Training in inpatient setting commenced Q4 Service plan developed by Q1 Terms of Reference finalised and Review commenced in Q1 Review, with recommendations for change, completed by end of Q2 Analysis and recommendations completed by the end of Q3			
4. We will continue to work in partnership with other South Island DHBs under the facilitated guidance of the South Island MH Alliance to develop a sustainable South Island Addiction system that includes Alcohol & Other Drugs (AOD) residential care, social detoxification and continuing care. In the 2020/21 year, this will be informed by: • A review of Southern Mental Health and Addiction System Continuum of Care to inform future models of care and will include a review of demand, supply and configuration of community mental health and addiction residential beds in the Southern district and (Multidisciplinary team) MDT caseloads • A critical examination of current contracting mechanisms with particular reference to NGO contracted partners to test whether current arrangements are fit for purpose and robust enough to ensure NGO sustainability • Examine and assess the possibility of establishing a General Practitioner with Special Interest in Mental Health and Addictions in the Queenstown Lakes area in response to increased demand for mental health and addiction services as a result of COVID-19.	Engagement with General Practice in Queenstown Lakes. Develop a service specification and contract for service by end of Q1.			
5. Primary care services will be significantly expanded through the national Access and Choice programme, which has been approved for funded roll out across our District beginning in 2020/21.	In the first year, our Mental Health system, under the leadership of our Primary Health Network, will Recruit, train, and implement 10 Health Improvement Practitioners, 10			

	Health Coaches within General Practices across the district. 5 Community Support Workers will also be recruited within NGO's to support this programme of work.			
6. Public Health Actions: • Collaborate with youth stakeholders to support the implementation of the Kapehu Project aimed at measuring resiliency in Southern youth o Undertake survey of priority populations of youth in co-ed high schools across the southern district. o Report survey data to participating schools, organised into themes o Develop and implement action plan o Complete process evaluation of implementation • Implement plan aimed at reducing Youth Self Harm in accordance with the Ko Awatea Health Quality and Safety Commission Co-Design in care case study: o Complete health practitioner and consumer learnings project o Analyse data and organise into themes o Develop and implement action plan o Complete process evaluation of implementation	Survey priority populations Q1 Survey results reported to schools Q2 Action plan developed and implemented Q3 Process evaluation Q4 Complete learnings project Q1 Data Analysis completed Q2. Programme designed and implementation commences Q1			
7. Suicide Prevention The Southern District developed and released its Suicide Prevention Strategy in the second half of the 2019/20 year, which was developed by the WellSouth Primary Health Network on behalf of the broader system. The plan, which draws on the Ministry of Health's Every life Matters – He Tapu te Oranga o ia Tangata Strategy, outlines a range of prioritised actions that will be delivered in 2020/21, detailing our commitment to improving health outcomes for tangata whaiora Māori and tangata whaiora through prevention, intervention and postvention activity in our district, including: • Development and facilitation of clinical suicide and prevention training that meets the clinical needs of agencies working in the primary and secondary parts of our sector • Delivery of suicide and self harm prevention training programmes designed for health workers and community individuals using the suicide prevention 101 workshop developed by the suicide Prevention/ postvention coordinator, SafeTALK, QPR (Question, Persuade, Refer) and QPR Online and Keeping the Balance. • Increase collaboration between primary and secondary services, Māori Health Providers and NGO youth orientated services to deliver relevant education and training to young people on wellbeing and supporting each other through difficult times. • Ensure that people know where to seek support at a general population level and this is achieved through coordinating increased information	Specific district wide postvention group for Māori Q4 Establish effective linkages with the Suicide Mortality Review Q4 Collection of suicide/self harm data Q1-Q4 Process for submitting data developed by Q2			

dissemination via social media, agencies, in training sessions, presentations (e.g. to schools). • Continue to support and build the capability of nine current community postvention groups to operate according to best practice. Postvention groups have an agreed schedule of meetings and specific agendas for local activity Groups confirm local use of single postvention template. • Provide support for people and groups impacted by bereavement by working alongside them to assist in reducing the risk and increasing protective factors • Continue to gather data, information and evaluative reports around the monitoring and evaluation of mental health literacy and suicide prevention training, community-led prevention and postvention initiatives and integration of suicide prevention within mental health and addiction services. • Collect and make better use of data related to suicide deaths and self harm. Suicide Prevention Coordinator to ensure safe and effective bilateral flow of data and information at a local level on suicide prevention issues. 8. Workforce In the Southern district, the NLG continues to lead the sector wide mental health and addiction workforce development plan that aligns workforce development with Raise Hope – Hāpai te Tūmanako. The NLG supports the implementation of the Primary and Community Action plan to expand the ability of the sector and workforce to manage increasing demand for services in a changing environment and increasing numbers of people presenting with multiple and complex needs. Workforce development is a standing agenda item on the NLG agenda, with a dedicated focus on aligning to the draft national strategy at a local level to: • Facilitate the development of workforce action plan • Grow workforce size and skills and diversity • Develop skills and employment environments • IGC representation on NLG Q1 In addition, in the 2020/21 year, the following activity will be prioritised: • Te Pou will support the training of the Access and Choice workers, which will create a platform for a peer led train the trainer approach, building and strengthening our Health Coach and Health Improvement Practitioner Workforce in Primary Care. A key part of this training will be focussing on responsiveness of specialist support to this new workforce, ensuring that Primary care is empowered and supported to manage mild to moderate conditions in a primary care or community setting. • We will also embark on a series of facilitated co-design workshops with Primary care and MSD case managers in preparation for the delivery of an integrated service based on high needs whānau in South Dunedin (EOA). This is a first step in the implementation of the Southern Primary and Community Care Strategy towards improving access to services for Māori. • We will continue to participate in the Tokeke Research programme developing national guidelines for Individual Placement Support (IPS) into employment in collaboration with MSD and other agencies, including NGOs	Workforce development on NLG agenda Q1-Q4 Work in partnership with workforce centres Q1-Q4 Develop a local action plan to realise the recently released national strategy by Q4 Programme plan developed in Q1 Workshops designed and delivered Q2 – Q4 Report on progress Q2 and Q4. Peer workforce plan developed in Q2. Peer workforce plan endorsed for implementation in Q3 IGC representation on NLG Q1 Assist kaupapa Māori organisations to respond to RFP for He Ara Oranga implementation Q1-Q4			

• We will Include a CEP way of working in all workforce development strategies to raise understanding, promote a CEP way of working and support a harm minimisation approach • We will continue to work in partnership with mental health and addiction workforce centres to strengthen the current workforce with a focus on retention, recruitment and training • We will continue to support people with lived experience to fill critical roles, including the expansion of a peer workforce • In addition, we will continue to support workforce development of the appropriate knowledge and skills to support people with mental health and addiction needs, for example through the use of the Let's Get Real Framework. • We will build capability and capacity of kaupapa Māori services in the community.				
9. Forensic Services Southern has been successful in securing additional resource from the Ministry of Health to continue an expansion our range of forensic services locally, to better support the needs of this population, with particular attention to tangata whaiora Māori. Accordingly, in the 2020/21 year, this will enable us to: • Expand the capacity and range of forensic service options available to the people of the Southern district. This will involve a procurement process to identify an NGO partner to deliver a Forensic Step Down service. • Expand our prison inreach (liaison) service to provide a more comprehensive and responsive service, in line with increasing demand. • Expand our Youth forensic services to provide a more bespoke and tailored service for this sub group within our Forensic population. • We will also continue to play an active role as a member of the New Zealand Forensic Advisory Group (NZFPAG) to ensure consistency and alignment with other services	NGO partner for community step down beds identified through an RFP process by the end of Q1 Additional staff recruited for both prison in reach and youth forensic service by the end of Q1 Participate in NZFPAG Q1-Q4			
10. Commitment to demonstrating quality services and positive outcomes Southern DHB is committed to providing quality services with positive outcomes for our population across the Southern Mental Health and Addiction system which sits within the Southern Health System. NLG is aligned with the Alliance which drives integration and transformational change through the implementation of the Primary and Community Strategy and Action Plan. This year, our commitment will continue to be demonstrated by: • Ongoing participation in the Health Quality and Safety Commission (HQSC) programme for Zero Seclusion: towards eliminating seclusion by 2020, Connecting Care – Improving Service Transitions and Learning from Adverse Events.	The number of Māori on Compulsory Treatment Orders is monitored and reduced Q1-Q4.			

• Māori Mental Health Staff take a stronger role within clinical multidisciplinary teams following integration of these staff in clinical teams at the end of the 2019-20 year.				

Mental Health and Addictions Improvement Activities

To be successful and achieve Ōritetanga (Māori equity), we must recognise and respond appropriately to Māori health needs and ensure Māori world view and mātauranga Māori are embedded into services. In order to support an independent/high quality of life we are committed to mental health and addictions improvement activities with a continued focus on minimising restrictive care and improving transitions.

DHB Activity	**Milestone**		**Government theme:** Improving the well-being of New Zealanders and their families	
Southern DHB is committed to providing quality services with positive outcomes for our population across the continuum of care, and accordingly will undertake a comprehensive review of its services, both provided and contracted through NGO's in the 2020/21 year. In parallel to this review, opportunities will be explored to fast track other quality initiatives, to ensure that the Mental Health and addictions services are developed and delivered in line with the model of care changes proposed in the Primary and Community Strategy. This is likely to result in specific activity in regards to:		MH02: Improving mental health services using wellness and transition (discharge) planning. MH05: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
1. We will also focus on improving the quality of, and number of service users who have an up to date completed transition plan to enable smooth transition between services, and ease of data sharing between teams	Improvement in number/quality of transition plans Q1-Q4			
2. Southern DHB prioritises supported decision-making instead of substituted decision-making and will strengthen Mental Health Advance Preferences/Statements (MAPs) to get the personal choices of people receiving any form of compulsory treatments	Supported decision-making prioritised Q1-Q4			
3. We will also look for opportunities to support the delivery of key services as close to home for people as possible, and this will include a review of opportunities for services to be transferred from specialist services to community services delivered by the NGO and primary sector wherever it makes clinical sense to do so. In the 202/21 year this is likely to include day activity services across both the Dunedin and Invercargill sites.	Review of opportunities Q1-Q4			
4. Reducing Seclusion and Restraint: This is a priority for the DHB. Although our outdated physical environs and facilities continue to contribute to this issue, we will continue to participate in the Health Quality and Safety Commission (HQSC) programme for Zero Seclusion: towards eliminating seclusion by 2020, Connecting Care – Improving Service Transitions and Learning from Adverse Events to ensure that our holistic models of care are contemporary, in line with best practice and inclusive of Māori models of care.	Use of seclusion reduced Q1-Q4			
5. As a Ministry of Health priority, Supporting Parents Healthy Children (SPHC) will continue to be embedded into practice by ensuring that all staff are trained in the Single Session Family Therapy. Māori representation is included in the SPHC advisory Group.	Single Session Family Therapy training delivered Q1-4			

Addiction

Mental health and addictions services are a priority for Government. Our plan demonstrates our commitment to improving our performance to support an independent/high quality of life for people with addiction issues.

DHB Activity	Milestone	Measure	Government theme: Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
Southern DHB is committed to improving the options for people with addiction issues across the southern district. The configuration and location of addiction services is within the scope of the Review of the Southern Mental Health and Addiction System which will be undertaken under the leadership and direction of the NLG by an external partner agency. This is particularly important in face of the COVID-19 Recovery as many in our population will be impacted by the social and economic effects of the global pandemic, especially those areas involved in tourism and hospitality. The Southern Psychosocial and Wellbeing Recovery Plan will be a dynamic plan that recognises the needs of those people with addiction needs that emerge or are exacerbated and plan to support them across the continuum of care in partnership with local communities, organisations and agencies.	Procurement of agency to partner with NLG to undertake the Review of the Southern Mental Health and Addiction System in Q1 with review completed in Q2. Southern Psychosocial and Wellbeing Recovery Plan approved with implementation commencing in Q1. Addiction Plan in draft Q1 Plan endorsed by South Island Mental Health Alliance Q2 Implementation plan developed Q2 Participation in SI sector workshops in Q1 and Q4 Southern region Addiction Plan in draft Q1 Southern Region Addiction Plan endorsed by South Island Mental Health Alliance Q2 Social detoxification service at a local level is enhanced and expanded by the end of Q3	MH03 Shorter waits for no-urgent mental health and addiction services for 0-19 year olds. AOD wait times (adult) AOD wait times (adult). MH02 Improving Mental Health Services using wellness and transition planning. MH04 Mental Health and Addiction Service Development A South Island Addiction Hub and Spoke Model is confirmed by Q4.	We have improved quality of life	Support healthier, safer and more connected communities
1. While the review is in progress we will identify and implement opportunities as they come to hand to implement cost pressure funding to ensure that NGOs in our district are equitable and sustainable. For addictions this means working in partnership with other South Island DHBs to develop a sustainable South Island Addiction system that includes AOD residential care, social detoxification, continuing care and building a lived experience workforce that is set out in a Southern Region Addiction Plan endorsed by South Island Mental Health Alliance in Q2. This work will be accompanied by SI development forums, including a sector workshops to build a SI 'hub and spoke' model Q1 and Q4				
2. The NLG will champion the inclusion of a (Co Existing Problem) CEP way of working in service and workforce development strategies to raise understanding, promote a CEP working and support a harm minimisation approach by Q4.	NLG will develop a whole of system CEP workforce plan by Q3 with implementation to commence in Q4.			
3. Māori Mental Health Staff take a stronger role within clinical multidisciplinary teams (MDTs) following integration of these staff in clinical teams at the end of the 2019-20 year (EOA)	Māori Mental Health Staff have increased role within MDTs Q1-Q4			
4. The NLG and Addiction providers within the Southern area will participate in the development of the National AOD model of care Q1-Q4	Participation in development of AOD model of care Q1-Q4			

Maternal Mental Health Services

Southern DHB plans to undertake actions in 2020/21 to ensure a continuum of care for maternal mental health to increase responsiveness to women and their whānau during and post pregnancy, including services in primary, secondary and tertiary level.

DHB Activity	**Milestone**	**Measure**	**Government theme:** Improving the well-being of New Zealanders and their families	
Southern DHB will continue the work started in the previous year to establish an integrated Maternal Mental Health model of care that spans primary and secondary services and is integrated, collaborated and connected and equitable and guided by Te Pā Harakeke | Nurturing Care in the First 1000 Days. Māori equity focused insights and analytics are important to better understand the needs of Māori communities, to improve Māori health outcomes. To progress this, in the 2020-21 year we will: 1. Confirm the draft Maternal Mental Health model of care developed in collaboration with key stakeholders will be confirmed by NLG. This plan spans the maternal continuum of care, including mild to severe mental health problems Q2-Q3. This plan will be delivered in consultation with key stakeholders, including kaupapa Māori providers.	NLG confirms the Maternal Mental Health model of care in Q1 and endorses the implementation plan by Q2 with implementation commencing in Q3	MH01: Improving the health status of people with severe mental illness through improved access MH02 Improving Mental Health Services using wellness and transition planning. MH03: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
2. Identify priority areas for implementation, including those for Māori (EOA). Identify priority areas for implementation for Pasifika and others (EOA) • Develop an implementation plan that will achieve the changes required within the current resources Q2 • Utilise a whole of system integrated approach including: o First 1000 days Primary and Community Strategy project group o PHO services – primary care o Primary Maternity services o DHB Maternity and Mental Health and Addiction services o Plunket services o Supporting Parents Health Children (SPHC) programme o Other key stakeholders o Service development activity is consistent with Te Pa Harakeke: Nurturing Care in the First 1000 Days being undertaken across the Southern region (South Island) work programme.	Implementation Plan Q2			
3. Develop a maternal and infant mental health pathway in partnership with the Clinical Pathways team and key stake holders. 4. Integration with Supporting Parents, Healthy Children (SPHC) programme of work including Single Session Family Therapy training being available to this workforce, inclusive of kaupapa Māori providers.	Maternal and Infant heath pathway live Q3			

2.1.5 Improving wellbeing through prevention

<table>
<tr><td colspan="5">Environmental Sustainability
Southern DHB plans to undertake actions that mitigate and adapt to the impacts of climate change, and that enhance the co-benefits to health from these actions.</td></tr>
<tr><td>DHB Activity

The “Green Healthcare SDHB strategy” has the following goals;
1. Measure, monitor and report the carbon footprint of SDHB

2. Energy Supply and Efficiency
• Join Dunedin Energy Leaders Accord Q1
• Feasibility study with Pioneer Energy to convert Southland Hospital coal boilers to wood chip Q2
• Collaboration agreement with Energy Efficiency & Conservation Authority (EECA) Q3
• Reduce electricity use through behaviour education campaign Q1-Q4 (ongoing)

3. Waste
• Waste audit and stocktake of recycling facilities Q1-Q4
• Upgrade and standardise recycling facilities Q3
• Extend PVC recycling to Invercargill Q2
• Feasibility study of food waste composting Q1
• Eliminate single use plastic cups, straws, and cutlery - behaviour education campaign on waste minimisation Q1-Q4

4. Travel
• Increase use of telehealth (as part of existing telehealth strategy)
• Transition staff vehicle fleet to electric vehicles (EV) and Hybrids Q1
• Increase active transport (cycling and walking) for staff through education campaigns and facility development Q3
• Enhance access to videoconferencing for meetings, conferences, etc. (as part of existing telehealth strategy)

5. Procurement
• Develop sustainability criteria for procurement policies, tender documents and contracts Q3
• Investigate high use of nitrous oxide (N20) at Dunedin Hospital Q3
• Digital Hospital Strategy to reduce paper use (part of existing Digital Hospital Strategy)
• Paper use reduction behaviour change campaign Q4</td><td>Milestone

Reports on progress Q2, Q4

Dunedin Energy Leaders Accord joined Q1
Feasibility study Q2
Agreement with EECA Q3
Behaviour education campaign Q1-Q4

Waste audit/stocktake Q1-Q4
Upgrade Q3
PVC recycling extended Q2
Feasibility study Q1
Eliminate single use
Behaviour education campaign Q1-Q4

Staff transition to EV Q1
Education campaigns Q3

Sustainability criteria Q3
Investigation of N20 Q3
Paper use campaign Q4</td><td>Measure

Reduce the carbon footprint of SDHB by 80% by 2030

Zero coal use at SDHB by 2030
10% reduction in electricity consumption by 2030
50% reduction in waste to landfill in 2030

50% of fleet vehicles EV by 2030
10% reduction in patient NTA (National Travel Assistance) claims by 2030
50% of staff biking/walking or public transport o work by 2030
5% reduction in staff passenger km flown by 2030

100% of procurement contracts to have Green Healthcare criteria
Align N20 use with comp[arable DHB by 2030
50% reduction in paper use by 2030

New and refurbished SDHB buildings to have an Environmentally Sustainable Design (ESD) plan
Ensure Green Healthcare is built into decision making across SDHB</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)
System outcome
We live longer in good health</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

6. Built Environment • Green Healthcare Leadership Group to work with project leaders of new Dunedin Hospital to develop and implement Environmental Sustainability Design (ESD) plan Q1-Q4 • Green Healthcare Leadership Group to work with Facilities and Property SDHB to establish ESD policy for refurbishment projects Q3 7. Engagement of staff and culture change • Develop a Green Healthcare SDHB policy Q2 • Require all new policy and policies up for review to address principles of Green Healthcare outlined in Green Healthcare SDHB policy Q3 • Set up DHB wide "Green Healthcare Champions" network similar to Infection Control and Prevention representative network Q1 • Run Green Healthcare workshops Q1-Q4 • Develop online training and self-assessment tools Q2 • Develop robust communication strategy to share success stories and communicate progress Q2 • Foster research links (in particular with the University of Otago, Southern Institute of Technology and Otago Polytechnic) Q1-Q4 • Maximise opportunities to promote the "Green Healthcare SDHB Strategy" within the wider health care sector and when working with other sectors and our partner agencies Q1-Q4	ESD plan implemented Q1-Q4 ESD policy established Q3 Policy developed Q2 Requirement to address principles Q3 Green Healthcare Champions network Q1 Workshops Q1-Q4 Online training Q2 Comms strategy Q2 Research links Q1-Q4 Promote strategy Q1-Q4	Develop a staff culture of commitment to the principles of Green HealthCare		

Antimicrobial Resistance (AMR)

In our plan Southern DHB identifies activities that advance progress towards managing the threat of antimicrobial resistance, including alignment with the New Zealand Antimicrobial Resistance (AMR) Action Plan (2017 – 2022). These activities align with the NZ AMR Action Plan's five objectives of: Awareness and understanding, Surveillance and research, Infection prevention and control, Antimicrobial stewardship, Governance, collaboration and investment. We plan to undertake and advance AMR management across primary care, community (in particular age-related residential care services) and hospital services.

DHB Activity	**Milestone**	**Measure**	**Government theme:** Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
The following activities, which will be prioritised in 2020/21 align with the NZ AMR Action Plan's five objectives of: Awareness and understanding, Surveillance and research, Infection prevention and control, Antimicrobial stewardship, Governance, collaboration and investment. During the COVID-19 response the Infection, Prevention and Control team partnered with key clinical specialist teams to undertake readiness assessments of the ARRC facilities. To build on this critical work, we plan to take a whole of system approach to the management of AMR across primary care, given our recent experience of working together to support key community partners during our COVID-19 response. The COVID-19 Māori Response Action Plan supports this response. We will therefore undertake the following in 2020/21: 1. Awareness and understanding • Establish or build upon multidisciplinary professional development activities on AMR, antimicrobial stewardship and infection prevention and control for primary care, hospital settings and age-related residential care settings • Professional development activities will be held in Dunedin and Invercargill Hospitals • Professional development activities will be held in primary care settings in conjunction with our Primary care Alliance partner, WellSouth • Infection, Prevention and Control (IPC) will continue to provide professional development activities through Age Related Residential Care (AARC) settings in Dunedin and Invercargill • We will establish champions to promote consumer, community-based and hospital messages on AMR and mechanisms to prevent it, including a dedicated champion in Primary care • We will facilitate educational activities across primary care, acute hospitals and age-related residential care sector during WHO World Antibiotic Awareness Week November 2020 to educate staff about AMR • We will celebrate World Hand Hygiene Day (5th May) with activities and promotion • We will work with ARRC facilities to ensure that national and/or local guidelines for management of Multi-drug Resistant organisms (MDRO) including those titled "Infection Prevention and Control and Management of Carbapenemase-producing Enterobacteriaceae" (Ministry of Health, 2018) can be implemented in their setting	Six monthly report of professional development Q2, Q4 Champions established Primary care Q1 Hospital settings Educational activities week of Nov 2020 (Q2) World Hygiene Day celebrated 5 May (Q4) Work with age-related residential care (ARRC) Infection Prevention and Control (IPC) team members re (MDRO) Q2-Q4	Report on Annual Plan activity	We live longer in good health	Support healthier, safer and more connected communities

2. Surveillance and research • We will publish and disseminate local antibiograms to practitioners in primary care, age-related residential care and hospital settings with supporting information on implications for their practice, • IPC will implement active surveillance for MDRO in keeping with national guidance through ICNET • We will ensure that active surveillance for MDRO is performed in keeping with national and/or local guidelines including those titled "Infection Prevention and Control and Management of Carbapenemase-producing Enterobacteriaceae" (Ministry of Health, 2018). Surveillance of Healthcare Associated Infections (HAIs) with disaggregated data by ethnicity and other demographic factors; and regularly review of data as part of quality improvement initiatives (EOA) • We will provide annual cumulative susceptibility data to support empiric treatment options , including reports at a governance level • We will plan and/or conduct audits and qualitative assessments of antimicrobial prescribing in hospitals to identify opportunities to improve appropriate prescribing. 3. Infection prevention and control • An IP&C programme of work for ARRC facilities will be undertaken to ensure consistent application of standards including standardised policies and procedures, education and training, audit and outbreak management plans • Update active surveillance, patient screening and transmission-based precautions policies in line with latest evidence and national guidance and standards, including simplifying identification and isolation processes for patients with MDRO (hospital settings • Review organisational policies, staff induction content and ongoing education in primary care, age-related residential care and hospital settings to identify opportunities for improving environmental cleaning and hand hygiene best practice. o Primary care – ongoing review o Age-related residential care – reviewed annually o Hospital settings- reviewed annually 4. Antimicrobial stewardship • Liaise with Canterbury DHB to develop unified South Island institutional policy re documentation of antimicrobial indication and duration	Publication and dissemination of antibiograms Q4 Active surveillance and review of data Q1-Q4 IPC surveillance Q1-Q4 Report of audits conducted Q1 Report DHB rates of AMR at a governance level Q4 Audits to be conducted: Audit 1: 2 week audit of HML restricted priority antibiotics: Meropenem, Tazocin, Vancomycin, Clindamycin, Ciprofloxacin Q1 Audit 2: ICU Antifungal use Q1 Audit 3: National Antimicrobial Prescribing (hospital) – pilot audit performed in 2018; Future audits abandoned due to poor performance of software, inadequate IT support, and perceived low value for resource required to perform. Audit 4: Total antibiotic consumption data (pharmacy) Q1 Audit 5: Outpatient Parental antibiotic therapy – infuser pumps Q1 Active surveillance Q1-Q4 Report of policy review Q4			

• Develop, implement and/or audit an intravenous (IV) to oral antibiotic switch programme to reduce unnecessary exposure to invasive devices such as IV cannulae and reduce costs associated with IV antimicrobials o Southern DHB audits were completed in December 2019 and analysis is now underway. A roll-out programme is in preparation, with plan to begin implementation from June 2020 • Audit antimicrobial use against local antimicrobial treatment guidelines. Antimicrobial stewardship and Infectious Disease wards to take place o Twice weekly on ICU; o Once weekly for haematology. o Daily input as required for orthopaedics (DUN) o Phone liaison every 2 weeks with Invercargill orthopaedics. o Currently no oversite of Outpatient parental antibiotic program in Southland due to lack of ID physician on site. • SDHB to send information (accessed from Pharmac) on antibiotic prescribing rates to all GPs, with data presented on Thalamus • Community-based pharmacists to work with GPs to support best practice in the use of antibiotic agents.	Policy developed by Q4 Implement IV to oral switch programme Q1-Q4 Audits conducted Q1-Q4 Reports on antibiotic prescribing rates Q2, Q4 Pharmacists work with GPs Q1-Q4			
5. Governance, collaboration and investment • Ensure AMR is a priority for DHB senior executive management and Board meetings through Annual Plan reporting processes • Expand the DHB Infection Prevention and Control Committee to include multidisciplinary age-related residential care and primary care representatives for information-sharing and coordination of activities across different settings • Regular meetings of Antimicrobial Stewardship Steering Group (ASSG) consisting of members with wide expertise in making appropriate antimicrobial prescribing decisions • Build upon or develop processes and communication pathways for age-related residential care facilities and primary care to access Infection Prevention and Control and Antimicrobial Stewardship expertise. o SDHB Portfolio Manager, Health of Older People to act as conduit for information to ARRC settings o HealthPathways and PHO newsletter used as a communication pathway for disseminating information • Establish regular reporting to clinical governance committees and senior leadership teams on local AMR rates and activities to prevent and minimise AMR. Plan has been tabled to Medicines Management Committee (MMC). Reporting continues on a monthly basis through Chair of MMC and also forwarded to the Infection Prevention and Control Committee on a bi-monthly basis.	ASSG meets regularly Q1-Q4 Communication pathways for ARRC and primary care by Q4 Regular reporting to clinical governance/Senior leadership Q1-Q4			
6. Implementation of a work programme for antimicrobial stewardship services including: pharmacy, infectious disease and clinical microbiology expertise.				

7. Refer to numerous actions in the wider annual plan which will contribute to reducing infections and thus antibiotic use, including initiatives around our immunisation programme and work in communicable disease prevention and control (PHU). Equitable outcomes actions are included in activities throughout the Annual Plan in order to improve equity of access for Māori. Actions are also included to improve equity of access for Pacific people and other populations.	Work programme for AMR services Q1-Q4			

Drinking Water

Core function – Health Protection.
Our plan includes work to ensure high quality drinking water as outlined in the drinking water section of the environmental and border health exemplar. We are committed to delivering and reporting on the drinking water activities and measures in the exemplar

All compliance and enforcement activities are completed in accordance with the relevant legislation and Ministry of Health guidance. In Public Health South we are expanding our focus of Drinking Water to include all of Three Waters (Drinking Water, Recreational Water and Wastewater) **DHB Activity**	**Milestone**	**Measure**	**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
1. Undertake all duties and functions required by the Health Act 1956 and by the Ministry of Health.	Reporting of activities Q2, Q4	Joint work plan developed and MOU signed between stakeholders		
2. Facilitate stakeholder meetings with Iwi and Regional and Local Government in Southern District to address public health risks associated with Recreational water and Drinking Water quality. • Active engagement with iwi/Māori	Stakeholder meetings Q1, Q3 Plan developed by Q1 MOU signed Q3	Consistent messaging across the Southern District		
3. Complete the Southern Component of the annual survey of drinking water supplies in NZ with a focus on risk supplies.	Annual Survey completed Q1	Annual Survey completed by due date		
4. Increase the number of supplies that are compliant with (active plan in place) the Drinking Water Standards 2005/18.	Number of compliant supplies increased by Q4	Number of supplies compliant (or with an active plan in place)		
5. Complete risk assessment to identify priority supplies.	Risk assessment completed Q1 Progress and outcome reported Q2, Q4			

<table>
<tr><td colspan="5">Environmental and Border Health (note that the drinking water section is separate)
Core function – Health Protection.
Southern DHB will undertake compliance and enforcement activities relating to the Health Act 1956 and other environmental and border health legislation by delivering on the activities and reporting on the performance measures contained in the Environmental and Border Health exemplar.</td></tr>
<tr><td>DHB Activity – All compliance and enforcement activities are completed in accordance with the relevant legislation and Ministry of Health guidance.

1. Border Health response plan exercises run at Dunedin Airport and Port Otago with the relevant stakeholders with a focus on communication and information sharing.

2. Undertake surveillance of mosquitoes at international sea and airports (weekly over summer and monthly over winter).

3. Coordinated Incident Management System (CIMS) 4 Training completed for statutory officers and relevant staff.

4. Implement a quality improvement plan (developed in 19/20 year) for Southern DHB processes for issuing permits pursuant to Section 95 of the Hazardous Substances and New Organism Act 1996 for the use of 1080 and cyanide for the control of vertebrate pests.

5. Engage with Te Ao Marama and Aukaha in relation to environmental health decision making (EOA)</td><td>Milestone

Exercises completed Q4

MOH reporting Q4

Reporting on training completed Q4

Pathway developed Q3
Implement improvement plan Q1
Evaluate the improvements completed Q3

Engagement Q1-Q4</td><td>Measure

Border Health response plan exercise completed for Dunedin and Port Otago
Narrative reporting on learning from exercises
Mosquito incursions detected

% of statutory officers who have completed the training

Reports in Q1, Q2, Q3 and Q4.</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families

System outcome
We live longer in good health</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
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Healthy Food And Drink

Southern DHB will create supportive environments for healthy eating and health weight by continuing to implement our DHB Healthy Food and Drink Policy, and ensuring that it aligns with the National Healthy Food and Drink Policy. In addition we will continue to include a clause in our contracts with health provider organisations stipulating an expectation that they develop a Healthy Food and Drink Policy. Policies will align with the Healthy Food and Drink Policy for Organisations (https://www.health.govt.nz/publication/healthy-food-and-drink-policy-organisations)

DHB Activity	Milestone	Measure	Government theme: Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
1. In line with the implementation of the Healthy Active Learning initiative, we will continue to report in Q2 and Q4 on the number of Early Learning Services, primary, intermediate and secondary schools that have current: • water-only (including plain milk) policies • healthy food policies. Healthy food policies should be consistent with the Ministry of Health's Eating and Activity Guidelines.	Implement Healthy Food and Drink Policy Q1-Q4 Progress report Q2, Q4	Audit completed Dunedin, Invercargill, Wakari No. contracts with HF&DP clause appended upon renewal % of applicable contracts with HF&DP Clause appended upon renewal	We live longer in good health	Support healthier, safer and more connected communities
2. Continue to implement Southern DHB Healthy Food and Drink Policy (HF&DP), and ensure that it aligns with the National Healthy Food and Drink Policy • Annual audit to ensure ongoing compliance with the Southern DHB's healthy food and drink policy at cafeterias at Wakari, Invercargill and Dunedin Hospitals.	Audit completed by Q4	No. of Providers audited that have a HF&DP Comprehensive assessment of Southern Schools		
3. Southern DHB developed a healthy food and drinks policy (HF&DP) clause in Q1 2019/20 and will continue to append this clause into all applicable contracts upon their variation or renewal as they arise	HF&DP Clause developed in Q1 19/20 and appended to all contracts by Q4 2022	No. and percent of each setting with policies		
4. Southern DHB will add the HF&DP to the audit tool as applicable from Q1 20/21 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			
5. Healthy Active Learning initiative • Survey Southern Schools with a particular focus on schools in high Māori & Pacific populations and gather data on current-water only policies and develop tailored water-only strategies in collaboration with individual schools (EOA) Engage with Māori in the implementation of the survey.	Data gathered Q2 Progress report Q2, Q4			

Smokefree 2025

Core functions – Health Promotion, Health Protection, Health Assessment & Surveillance and Public Health Capacity Development.
Southern DHB will undertake compliance and enforcement activities relating to the Smoke-free Environments Act 1990, including delivering on the activities and reporting on the five regulatory performance measures contained in the previous Vital Few Report.

We plan to undertake activities to advance progress towards the Smokefree 2025 goal, including supporting the Ministry funded Southern Stop Smoking Service for people who want to stop smoking and which address the needs of hāpu wāhine and Māori. Examples are given below, including the assessment of the postnatal extension of the Stop Smoking incentive scheme for pregnant women and actions to increase the number of secondary referrals to the Southern Stop Smoking Service. Māori are a priority group for these actions.

DHB Activity	**Milestone**	**Measure**	**Government theme:** Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
Compliance and enforcement 1. Undertake compliance and enforcement activities in relation to the Smoke-free Environments Act 1990. Report measures via the vital few reporting template.	Reporting Q2, Q4	# tobacco retailer visits for education and/or compliance purposes completed	We live longer in good health	Support healthier, safer and more connected communities
Advance progress towards the Smokefree 2025 goal 2. Evaluate Postnatal extension to the Southern Stop Smoking incentive scheme • Assess and make recommendations on the postnatal extension to the Southern Stop Smoking incentive scheme for pregnant women after it has been in place for six months. • Assess and make recommendations on the Maternal Smokefree Referral Pilot currently being implemented with community midwives in Oamaru, Balclutha and Queen Mary birthing units. Focus of the pilot is to increase engagement in (SSS Incentive Scheme) especially for young Māori mothers, resulting in increased quit attempts. Assessment will review acceptability, feasibility and efficacy of the new referral process to the Southern Stop Smoking Service (SSSS) (EOA)	Assessment completed and recommendations made Q4 Assessment of referral approach/recommendations made Q4 Analysis completed Q4 Recommendations implemented Q4	# Controlled Purchase Operations (CPOs) conducted; # tobacco retailers visited during CPOs Updated analysis available to support Tobacco control Planning Increased referrals to the Stop Smoking Service from secondary care		
3. Increase the number of secondary care referrals to the Southern Stop Smoking Service by taking an opt off referral approach in secondary care.	Reporting Q1-Q4	New Smokefree policies/bylaws in place		
4. Vape to Quit pilot. A pilot supplying vapes to enrolled smokers over 18 will be trialled. • Vapes will be supplied through community pharmacies, with services such as the Southern Stop Smoking Service able to access through a local pharmacy. • Outcomes will be captured to inform the impact of the pilot (EOA) • Mental Health in patients and visitors to the facilities at the Wakari site to be prioritised as part of the trial. [Refer to section 2.1.4 for more information]	Pilot underway Q2 Report number of vapes supplied Q4 Report number of successful quits Q4 Report number of Māori smokers quitting Q4			
Leadership and governance 5. Smokefree Steering Group meets on a 2 monthly basis to coordinate smokefree activities, with representation from Southern Stop Smoking Service, WellSouth PHO, Southern DHB and Cancer Society.	Reporting Q2, Q4			
6. Undertake an updated smoking prevalence analysis for the Southern District. Data will be disaggregated by ethnicity, locality and age	Needs analysis complete Q3			

7. Develop and implement a programme to promote Smokefree Cars legislation promotion (once legislation enacted) 8. Develop and implement a programme around Vaping legislation (once legislation enacted) 9. Advocate with local councils for increased smoke free outdoor spaces.	Progress report Q2, Q4 Progress report Q4 Progress report Q2, Q4			

Breast Screening

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 Māori and non-Māori, Pacific and non-Pacific/non-Māori.

DHB Activity	**Milestone**	**Measure**	**Government themes:** 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
Southern DHB plans to implement initiatives that contribute to the achievement of national targets for Breast Screen Aotearoa (BSA). These initiatives demonstrate clear strategies for increasing health gains for priority groups and improving equitable participation and timely access to breast screening services and will lead to the elimination of equity gaps in participation between Māori and non-Māori/Non-Pacific woman and between Pacific and non-Māori/Non-Pacific woman, and achievement of a participation rate of at least 70% for Māori and Pacific woman aged 50-69 years in the most recent 24 month period. Our improvement activities are supported by visible leadership, effective community engagement and engagement with BSA Lead Providers with clear accountability for equity. This year therefore, we will prioritise: 1. Engage with Pacific Church groups to improve Pacific access (EOA) [Refer to Ola Manuia 2020-2025: Pacific Health and Well-being Action template] 2. Engage with kaupapa Māori health providers to improve screening rates for Māori Q2-Q4 (EOA) 3. Engage with Industry (large employers) where high numbers of Māori are employed, starting with Dunedin (EOA) 4. Engage with Industry (large employers) where high numbers of Pacific are employed, starting with Dunedin (EOA) 5. Data-matching with WellSouth PHO to identify screening gaps in the eligible population • Coordinator to engage with GP practices to enrol participants based on data matching results 6. Provide education to GP registrars on the breast screening service	Engagement with Pacific groups Q1 Engagement with kaupapa Māori health providers Q2-4 Engagement with industry employing Māori Q1 Engagement with industry employing Pacific Q1 Data matching complete Q2 Enrolled patients with no screening identified Q2 GP registrar training Q4	PV01: Improving breast screening and rescreening Māori rate 70% Pacific rate 70% Base Line: Māori 69.6%; Pacific 60.0%; total 71.6% for period ending 31 December 2019		

Cervical Screening Southern DHB has set measurable participation and equity targets from baseline data.				
DHB Activity Actions are described below 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. Our improvement activities are supported by visible leadership, effective community engagement, resources and clear accountability for equity. To achieve this in 2020/21, we will:	**Milestone**	**Measure**	**Government themes:** 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
1. Focus on the recruitment and workforce development of a registered nurse/s into the Cervical Screening Service to ensure knowledge across cervical screening, HPV and sexual health.	Recruitment of 1 FTE registered nurse and development of appropriate skills by Q1	Recruitment for an appropriate nurse completed		
2. Promote and build Māori workforce capability in primary and secondary care to deliver cervical screening services. (EOA)	Workforce development Q2	PV02: Improving cervical screening overall		
3. Kaupapa Māori health service navigators to ensure Māori engaged with General Practice are supported to receive cervical screening services. (EOA)	Support from Navigators on patient continuum of care Q1-Q4	Increased cervical screening coverage of Māori, Pacific and Asian women		
4. Southern DHB Cervical Screening Service to engage with kaupapa Māori health services (EOA)	Regular contact and engagement Q1-Q4			
5. As there are 20,000 women enrolled in general practices not engaging with the Cervical Screening Programme, we will undertake a trial with a large general practice, (supported by DHB interpreters), to target Māori women, to increase their participation in cervical screening (EOA). The trial will also target Pacific and Asian women, to increase their participation in cervical screening (EOA) • Identify a general practice with high numbers of target group women to plan the trial with a view to implementing trial in 21/22	Identify a general practice Q4	Steering Group established and regular meetings held. Increased data and information available to support service development.		
6. Engage with industries across the Southern district with high numbers of target group employees to promote and provide cervical screening services e.g. Alliance meat works (EOA)	Identification/ engagement with key industries Q1-Q4			
7. Establish a joint Steering Group that includes Sexual Health, Screening Support Services, Cervical Screening Programme, WellSouth Outreach service and kaupapa Māori services, to facilitate more joined up services delivery.	Joint Steering Group established Q2			

8. Develop a real time electronic report for Cervical Screening with flexibility to inform future work streams.	Steering group meetings regularly occur Q2-Q4 Real time report established and available for use Q2			

Reducing Alcohol Related Harm

Core function – Health Promotion, Health Protection, Health Assessment & Surveillance and Public Health Capacity Development. Actions will strengthen Māori health outcomes by reducing alcohol related harm.

DHB Activity	**Milestone**	**Measure**	**Government themes:** Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
Southern DHB is committed to undertake compliance activities relating to the Sale and Supply of Alcohol Act 2012. This will include delivering and reporting on the activities relating to the nine public health regulatory performance measures contained in the previous Vital Few report. In addition, we will undertake activities to reduce alcohol related harm. In 2020/21, we will:			We live longer in good health	Support healthier, safer and more connected communities
1. Undertake compliance activities relating to the Sale and Supply of Alcohol Act 2012 • Inquire into all on-, off-, club and, where appropriate, special licence applications, and provide Medical Officer of Health reports to District Licensing Committee, either where there are matters in opposition or recommendations • Undertake police-led Controlled Purchase Operations (CPOs), if any conducted, to reduce sale of alcohol to minors. • Develop a triage tool to assess and prioritise licence applications	Reporting Q2, Q4 Two CPOs undertaken Q2, Q4 Triage tool developed Q1	As outlined in reducing alcohol related harm reporting template Triage Tool developed Project evaluation completed Project evaluation completed		
2. Undertake an evaluation in Invercargill of the pilot of 'The Plan'. • This an initiative that aims to support parents to delay drinking and reduce alcohol related risk to their teens. • Capture learnings in relation to improving Māori health outcomes (EOA) • Using learnings from the pilot, develop and implement a district programme.	Evaluation completed Q1 Progress reporting Q2, Q4			
3. Evaluate the 'Good One' Party Register. This is a programme in Dunedin where young people having a party can register it on a website.	Evaluation completed Q4 Progress reporting Q2, Q4			

Sexual Health Core function – Health Promotion.				
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)	
Southern DHB plans to undertake a number of activities to advance sexual health services and sexual health promotion work. In 2020/21, these include:		Complete absence of congenital syphilis All contact tracing completed appropriately	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
1. Assessment of district staff mix to effectively drive innovations within the Sexual Health service to ensure alignment with the five strategic themes of the NZ Health Strategy: People powered, Closer to home, Value and high performance, One team, Smart system	Assessment of district staff mix completed Q2 District wide recommendations made Q2 Recommendations implemented Q2-Q4	Increased capacity and flexibility to meet population and service needs and enable new approaches to care delivery across Primary and community.		
2. Finalise the Southern district's Sexual Heath Syphilis plan, and an associated health promotion strategy (EOA). Implementation of the plan will be subject to key milestone reporting against objectives to the Sexual Health Steering Group.	Completed plan Q1 Implementation of Syphilis plan Q1-Q4 Regular updates Q1-Q4 Progress reporting Q2, Q4	Increased access to sexual health services for young people, particularly Māori and Pacific		
3. Develop educational opportunities for cross sector health professionals to promote sexual health awareness across the Southern district. This will include the development of specific micro credentialing education to be developed for trainee GPs as well as the training of both Public Health and sexual health nurses across the district to undertake long-acting reversible contraception (LARCs) and other contraception interventions	Micro credentialed workforce Q4 PHNs upskilled Q1	Reduced clinical appointments in sexual health clinics for complex presentations Patients seen in Sexual Health with reduction of referrals to Medical Outpatients		
4. Update standing orders to increase capabilities of nurses to administer medications/treatments in real time, to increase efficiencies and reduce barriers, to improve availability of appointments for more complex presentations	Standing orders updated Q2	Seamless and sustainable service provision.		
5. Introduce asymptomatic sexual health self-testing processes at the two hospital based sexual health clinics (EOA) Use of data to assess sexual health promotion priorities.	Pilot reviewed Q1	Increased participation/coverage in the Cervical Screening Programme		
6. Undertake a quality improvement survey to assess barriers for Māori young people to access sexual health service across the Southern district. (EOA). The survey will include assessment of barriers for Pacific young people (EOA)	Survey undertaken and recommendations made Q1 Recommendations implemented to reduce barriers Q2-Q4	Historical sexual abuse presentations have confirmed pathway and audit trail		
7. Promotion of the Genital Dermatology Services to primary care to ensure referrals are made to sexual health services as appropriate. This will include development of a HealthPathways, which will include a joint service pathway across Sexual and Women's Health (EOA)	Promotion of Genital Dermatology Services clinic to primary care Q1	Mental health patients and pregnant women have		

8. Establish a joint Clinical Steering Group with Cervical Screening and Screening Support Services to facilitate more joined up service delivery and the sponsorship of robust Health Pathways for Women's Health and Sexual Health conditions (EOA) [Refer to Cervical Screening template for more information] 9. Establish a Sexual Assault and Treatment (SAATs) six month pilot (September 2020 – March 2021) for a weekly clinic to assess and treat historical assault/abuse presentations.	HealthPathways established to identify referral pathways in Sexual Health and Women's Health Q1 Clinic processes established and weekly clinics held from Q2 Referral pathways in place for self-referrals, ED, NZ Police, Oranga Tamariki, ACC Q2 Evaluation of pilot Q2, re-evaluated Q3 Health Pathway developed Q3	increased access to sexual health and SAATs services		

Communicable Diseases

The focus for SDHB in respect of Communicable Diseases continues to be on our Covid19 preparedness for further cases. The service has been required to produce a capacity uplift plan to show how we intend to create the capacity to manage up to 24 and 34 cases a day. A plan has been developed but is based on a number of assumptions. These include that no border health work is required of the service, staff are released to support the response, the country is placed in a level of lockdown and that we have sustainable funding to support the capacity building that is required. A significant part of the capacity required is to support case management and monitoring which requires a nursing workforce. Some progress has occurred with implementing our plan, in particular around training and some preliminary conversations about where additional staff could be accessed from. Two key roles identified in the planning are an additional Public Health Physician (recruitment is underway) and a Covid19 Response Manager within the service to take a lead on this work.

Public Health will now use the national contact tracing solution (NCTS) as a means of managing case and contact information for any future cases. The key functionality that we were waiting on (daily email follow up of cases and contacts) has now been introduced.

The deep dive report into three Public Health units has been released to Southern DHB. We were selected for the audit as we have a large geographic area with rural populations and we had also managed clusters of cases. The audit investigated how we undertook contact tracing, what worked well, and what the challenges and barriers were. Recommendations and observations made in the report have been integral in the planning for our 2020/21 activity.

We acknowledge the contributions made by iwi and the work undertaken through Iwi, Marae and the Māori health providers during COVID-19 lockdown.

DHB Activity	**Milestone**	*Measure*	**Government theme:** Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
The Ministry of Health continues to advise that responding to Covid19 and disease outbreaks remains our top priority. However, issues are emerging in southern communities as a result of the lockdown and closure of the borders, in particular around community recovery and mental health and wellbeing. Accordingly, a balance of effort is being required this year to ensure we are confident in our readiness to manage additional waves of COVID-19, and ensure we are also monitoring other communicable disease risks, particularly in district hotspots such Queenstown/Central Lakes, and our university campuses. These activities will include:			We live longer in good health	Support healthier, safer and more connected communities
1. Implementation of a timely response to COVID-19 including assurance around capacity for case management and contact tracing Implement training plan to maintain competency in case management and contact tracing Implement quality improvement plan (including up-to-date documentation) Implement escalation pathway to increase capacity as required	Ongoing activity Q1-Q4	80% of new COVID-19 cases are contacted within 24 hrs of notification. 80% of close contacts are contacted within 48hrs		
2. Compilation and release of a 2020 notifiable disease surveillance report for Southern DHB, to include ethnicity patterns (EOA)	Notifiable Disease Surveillance Report released Q3 Notified Disease cases documentation is audited Q1	Report completed covering the 2020 year Reduction in Episurv errors		
3. Development of a quality improvement plan for the Public Health unit recording, managing and documenting notifiable disease cases and outbreaks, including data by ethnicity (EOA). This will enable improved audit of notified disease cases documentation and overall improved quality of plans	Quality improvement plan developed Q2 Audits of improvements implemented completed Q4	Ethnicity recorded for all cases		
4. Implementation of REDcaps (Research Electronic Data Capture) for notified enteric disease investigations.	REDcaps operational Q2 Evaluation of REDcaps Q4			

5. Auditing of Dunedin and Invercargill needle exchanges.	Audits completed Q4			

Cross Sectoral Collaboration including Health in All Policies

Health in All Policies (HiAP) is an approach to working on public policies across sectors (both health and non-health) and with communities. It systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and achieve health equity. HiAP is an evolving and ongoing process that works at both strategic and operational levels to ensure health, wellbeing, sustainability and equity issues are explicitly addressed in all policy, planning and decision-making processes. The HiAP approach has come to the fore nationally as a useful framework for recovery planning to be undertaken post the first wave of COVID-19, which is health led but reliant on multi agency partners to ensure a systematic response to resilient communities.
Southern DHB plans to undertake a number of activities through a cross sectoral collaboration approach, including using the HiAP model, to influence healthy public policy and thereby achieve equity, particularly as we plan for potential next waves of COVID-19, and the associated effects such as an imminent recession on our population.

DHB Activity	**Milestone**	**Measure**	**Government theme:** Improving the well-being of New Zealanders and their families	
New Zealand has used a 'team of 5 million' to work collaboratively across multiple societal sectors, to control the COVID 19 pandemic. Can this be continued by leveraging policy, systems, and environmental changes to assist in the recovery and drive sustained improvements in the public's health. Concepts such as "Health in All Policies" (WHO, 2013; Rudolph et al., 2013) and collective impact (Kania and Kramer, 2011) will help to structure the efforts. Improving community health is a challenge that requires the collective impact of non-profit organisations, government, business, and the public working together on a common agenda based on 5 conditions for collective success. These are • a **common agenda** across sectors (healthy, thriving communities), • generally consistent crosscutting approaches to **metrics**, • **activities across the initiatives that are mutually reinforcing.** • greater **communication** and sharing among these initiatives, • facilitated by the support and coordination of a **backbone sector** such as public health.	Establishment of a multi-agency governance group to steer and govern recovery responses across our populations, focussing on Māori and particular communities of collective interest, including rural and remote populations, Pacific populations and new migrants	Increased access to primary health care in critical areas of identified focus Increased access to mild to moderate mental health support in critical areas of identified focus Funded access to primary care, including mental health and psychosocial support for migrant workers	**System outcome** We live longer in good health	**Government priority outcome** Support healthier, safer and more connected communities
1. We will, therefore contribute to coordinating and implementing the public health actions of the COVID-19 Psychosocial and Mental Wellbeing Recovery Plan	Plan developed by Q2 Stakeholder meeting to develop programme Q1	Joint Work programme developed Joint work plan developed and MOU signed between stakeholders across the Southern District Stakeholder meetings convened		
In addition to our targeted COVID-19 recovery response, we will: 2. Facilitate stakeholder meetings with Iwi and Regional and Local Government in Southern District to develop an air quality programme focusing on Milton and South Invercargill (EOA). • Actively engage with Māori providers and local runaka.	Action plan completed Q2	Air quality plan implemented Q3		
3. Finalise a Health in All Policies (HiAP) action plan under the Southern Primary and Community Care Strategy to support intersectoral action	Report on progress Q2, Q4	Joint work plan developed Inclusion of public health approaches		
4. Evaluate the pilot Kia Haumaru te Kaika project that is focused on hospitalisation of Māori children age 0-4 in Dunedin with respiratory conditions attributable to their living conditions Q4 (EOA) [Refer to Māori Health Action Plan – Reducing Health Inequities]	Process evaluation of pilot by Q4	Process evaluation of pilot Ethnicity data of clients recorded		

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

<table>
<tr><td colspan="5">Delivery of Whānau Ora
DHBs are best placed to demonstrate, and action, system-level changes by delivering whānau-centred approaches to contribute to Māori health advancement and to achieve health equity. Southern DHB plans to undertake actions in this planning year to contribute to the strategic change for whānau ora approaches within our systems and services, across the district, and to demonstrate meaningful activity moving towards improved service delivery support. We also plan to collaborate, including through investment, with the Whānau Ora Initiative and its Commissioning Agencies and partners, and to identify opportunities for alignment.</td></tr>
<tr><td>DHB Activity

Southern DHB has been heartened by the direction outlined in the Health and Disability System Review. In the 2020/21 year therefore, we will:

1. Contribute to discussions regarding whānau ora approaches with Māori communities. Demonstrate meaningful activity moving towards improved service delivery. This will be undertaken under the auspices of a new Southern whanau ora policy. This will look towards the greater inclusion of whānau in health care plans and decision making that supports whānau and families to achieve their aspirations in life. It places whānau at the centre of decision making and supports them to build a more prosperous future. Importantly, this policy will overtly propose changes to the way that whanau ora services are purchased, and provide a new funding and contracting framework for our Kaupapa Māori health providers.

2. Support and collaborate, including through current and future investment, with whānau, hapu and iwi, and identify opportunities for alignment (EOA)</td><td>Milestone

Review in collaboration with Kaupapa Māori Health Providers, Southern DHB Māori health contracts with a whānau ora lens Q3

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

<table>
<tr><td colspan="5">Ola Manuia 2020-2025: Pacific Health and Well-being Action
Southern DHB is committed to supporting delivery of the Pacific Health Action plan once it is agreed.</td></tr>
<tr><td>Activity
1. Within the framework provided by Ola Manuia and the Child and Youth Wellbeing Strategy improve the health and wellbeing of Pacific children and young people by early intervention and provision of joined up services all with equity focus:
• Implement “Early Engagement with your Midwife” - cross ref Maternity and Early Year
• Pregnancy and Parenting – Plunket to work with Pacific Trust Otago (PTO) to incorporate culturally appropriate content into training sessions which are to be delivered from PTO premises
• Socialise and implement newly released Safe Sleep Policy along with SUDI harm reduction messaging
• Continue Community Breast Feeding Pilot based at PTO to support -
• Continue Pacific involvement in Well Child Tamariki Ora and the Child and Youth Networks to support enrolment within the WCTO programme and newborn enrolment in primary care
• Immunisation – ensure every immunisation is received on time for all Pacific pepi and children -
• Engage with Pacific on the Measles immunisation Catch up Programme targeting 15 to 29 year olds Q1-4
• Increase youth accessibility and utilisation of School Based Health Services
• by engaging with Pacific young people in decile 1 to 5 schools on how to do this
• Community Oral Health – evaluate the impact on Pacific children of the pilot community oral health outreach clinic –
• Sexual health – undertake quality improvement survey to assess access barriers for Pacific young people

2. Within the framework provided by Ola Manuia improve the health and wellbeing of Pacific people by early intervention and provision of joined up services all with equity focus:
• Working with Sector Partners to Support Sustainable System Improvements
• Mental Health and Addiction System Transformation
• Healthy Food And Drink
• Breast Screening
• Cervical Screening
• Care Capacity Demand Management (CCDM)
• Bowel Screening and Colonoscopy Wait Times
• Workforce
• Delivery of Regional Service Plan (RSP) Priorities (Hepatitis C)
This framework integrates with existing programmes [Refer to sections on Maternity and Early Years, School Based Health Services, Sexual Health, Mental Health, Screening, and Workforce]</td><td>Milestone

Status update report Q4</td><td>Measure

Promote and disseminate information to increase Pacific people’s knowledge and awareness of health and disability support services and systems thereby increasing access to culturally safe and appropriate local initiatives such as:
antenatal care and increase registration with lead maternity care providers for Pacific mothers;
the first 1000 days initiatives to give Pacific pepi the best start in life;
increased enrolment of new-borns in general practice and the WCTO programme;
Improve access to timely immunisations for Pacific children;
Reduce the burden of overweight Pacific children at B4SC;
SLM measure - decrease in the percentage of ASH presentations including dental 0-4 years; increase in the percentage of Pacific:
CW01, CW02, CW03 CW07.</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>
</table>

Care Capacity Demand Management (CCDM)

The actions we will take towards fully implementing Care Capacity Demand Management (CCDM) are detailed below for nursing and midwifery in all units/wards and on track for completion by June 2021.

DHB Activity	Milestone	Measure	Government theme: Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
Significant actions are outlined for progressing implementation of CCDM in 2020/21 for each component of the programme; governance, patient acuity data, core data set, variance response management and FTE calculations. These are as follows:		Ministry of Health quarterly reporting	We live longer in good health	Support healthier, safer and more connected communities
1. Governance The CCDM Council will continue to meet bimonthly during 2020/21, and a review of its Terms of Reference will take place to ensure relevance and currency. It will continue to provide regular reports to key stakeholders such as the Ministry, Safe Staffing Healthy Workplace Unit and our union partners and will ensure that all CCDM workplans are underpinned by existing or developing Southern DHB systems and processes designed to achieve equity for Māori & Pacific people, people with disabilities, people with enduring mental illness and people from lower socioeconomic and disadvantaged communities (EOA) • Monthly education will be delivered to all three sites in a formal way by designated CCDM & TrendCare Coordinators, and in an informal and formal way via Local Data Councils and drop in sessions • Allied Health will be introduced in to the programme during the 2020/21 year, starting with the development of a framework for Local Data Council formation • Local Data Councils meet monthly and focus on quality improvement activities related to core data set measures	Reports Q1-Q4 Terms of Reference (TOR) reviewed Q1 Reports to partners Q1-Q4 Standards assessment complete Q4 Annual Plan completed Q3 Annual plan status reported Q1-Q4 Monthly education reports Q1-Q4 Reports on CCDM implementation Q1-Q4 Framework developed Q1 Local Data Councils meet Q1-Q4			
2. Validated Patient Acuity Tool • Validated Patient Acuity committee – Acuity & Workforce Management Steering Group meets monthly • Inter-rater reliability (IRR) Testing • Annual SDHB TrendCare Business Rules review • Annual assessment of TrendCare Gold standards • Validated patient Acuity tool preferred vendor identified for Allied Heath • Implementation of Acuity tool Allied Health • TrendCare annual upgrade on release	Reports Q1-Q4 IRR Testing Q2 Business rules review Q3 Assessment of Gold standards Q2 Tool identified for Allied Health Q2 Tool implemented for Allied Health Q3 TrendCare upgrade Q1			
3. Core Data Set (CDS) Activity will include the implementation of an electronic CDS tool as well as education to Local Data Councils (LDC), and the implementation of the Allied Health CDS in line with its introduction to the programme. The CDS will be reviewed annually and measures will be improved and reported	Electronic CDS tool implemented Q1 LDCs education Q1 Allied Health CDS Q3 CDS report Q3 CDS stocktake Q3			

4. FTE calculation • In 2020/21 we will write and agree a detailed workplan for wards requiring full FTE calculations (9 wards) • In addition, we will collect and collate data inputs for 9 wards for annual budget informing • This will include, for the 9 wards involved: o Entering data into software, completing roster testing, drafting of a report and agreement of recommendations, implementing the FTE and monitoring variance. o There will be a strong emphasis on increasing the number of Māori health professionals where an increase in FTE is identified; this provides an opportunity for employment for Māori health professionals (EOA) o There will be a strong emphasis on increasing the number of Pacific health professionals where an increase in FTE is identified; this provides an opportunity for employment for Pacific health professionals (EOA)	Workplan agreed for wards Q4 Data inputs collected Q2-Q3 Data entered Q2-Q4 Roster testing Q1-Q4 Report drafted Q1-Q4 Roster and FTE implemented Q1-Q4; variance monitored Q1-Q4 Māori FTE increased Q4 Pacific FTE increased Q4			
5. Variance response management (VRM) We will focus on embedding Allied Health VIS tool as part of standard business, then on moving this to the electronic platform. We will review VRM action plans for effectiveness twice yearly.	VIS tool embedded Q1 VIS tool implemented Q3 VRM action plans reviewed Q1, Q3 Measurable reduction in variance, both positive and negative Q1-Q4			

Disability and Disability Action Plan

Statistics NZ surveys consistently show that disabled people experience poorer outcomes across multiple domains, including income, employment and health compared with non-disabled people. Disabled people are generally at higher risk of illness than non-disabled people. People with intellectual disabilities and Māori with disability have some of the poorest health outcomes of any group in the country, and are at higher risk of illness, disease, disability and early death. This is an important ongoing challenge for the health and disability system.

Inequity of access to health care and health outcomes for disabled people both within the health and disability support system and nationally is not comprehensively assessed or measured. In New Zealand, health data collection on disabled people is limited. Health data on the general disability population is needed to assess disabled peoples' health and wellbeing and examine inequalities in health and wellbeing outcomes within the group and with non-disabled people.

Southern DHB plans to provide 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. We will work with the Ministry of Health to ensure that key health information for the public and public health alerts and warnings are accessible by people with a disability.

DHB Activity	**Milestone**	**Measure**	**Government theme:** Improving the well-being of New Zealanders and their families	
Southern DHB has drafted a Disability Strategy & Action Plan which will be publically available for feedback for a period of 6 weeks. Feedback commenced Q3 19/20 and the Disability Strategy and Action Plan will completed by Q4 20/21 Key phases of the Disability Strategy and Action Plan (DS&AP) development to date have included: • Convening a Disability Strategy Steering Group • Engagement with Southern DHB leadership team throughout • Review of relevant International and National documentation such as the UN Convention of Rights of Persons with Disabilities • Undertaking of a series of regional forums across the Southern District • Undertaking of a series of engagement with Iwi governance and local Runanga • Engage with a wide range of Southern DHB staff (clinical, building & property, IT, administration, management) • Engagement with WellSouth • Rounds of consultation with key stakeholders to develop a draft document To build on the commitments made in our Disability Strategy and Action Plan, in the 2020/21 year, we will: 1. Continue to advance our efforts in respect to awareness training by making the Disability Awareness e-learning module compulsory for all staff to complete, new and existing, via our eLearning platform. 2. We will actively promote better collection of disability and language needs information on admission to ensure that staff can adequately respond to patients' needs. This will include review of the Admission form with input from consumers, particularly those with disability and language needs (EOA). 3. We will undertake to update our Community Engagement Roadmap to include targeted groups such as those with recognised Disability and those with specific language needs such as refugee communities (EOA). 4. We will put processes in place during 2020/21 to ensure that our key public information messages, public health alerts and are able to be communicated using sign NZ sign.	70% of all staff will have completed the Disability Awareness module by Q4 Completion of Disability Strategy and Action Plan Q2 Implementation of Disability Strategy & Action Plan Q4 70% of all staff will have completed the Disability Awareness module by Q4 200/21. Admission form reviewed Q1 Roadmap updated Q1 Number of messages will be reported to the Ministry by the end of Q4	70% Staff completed Disability Awareness eLearning module Implementation of the Southern DHB Disability Strategy & Action Plan	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities

5. We will continue to develop robust data collection processes to enable more confident planning that will ensure equity for disabled people, tāngata whaikaha, and Deaf people accessing services (EOA).	Data collection processes will be finalised by Q4 20/21.			
6. Staff education will include practical information, including but not limited to, tikanga, how to access interpreter services, and use of specialised equipment. The staff education plan will identify components that are mandatory for all staff and those that are necessary for specific groups of staff.	Staff education commenced in Q4 19/20 and will be completed by Q4 20/21			
7. We will continue to implement the Workforce Strategy and Action Plan to achieve a representative proportion of disabled employees at an organisational level. The plan is inclusive of appropriate support from recruitment through to establishing the person in the workplace with appropriate equipment and / or other accommodations [Refer to Workforce template for more information].	The Workforce Strategy and Action Plan commenced Q4 19/20 and will be completed Q4 20/21			
8. Staff education will include raising staff awareness of disabled people, tāngata whaikaha and Deaf people and their rights under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), the NZ Disability Strategy and Whāia Te Ao Mārama, continuing with development of the education strategy outlined in the Workforce Strategy and Action Plan, which will incorporate mandatory components [Refer to Workforce template for more information].	Staff education commenced Q4 19/20 and will be completed by Q4 20/21.			

Planned Care

The Ministry of Health vision for Planned Care is that 'New Zealanders receive equitable and timely access to Planned Care Services in the most appropriate setting, which supports improved health outcomes'. Planned Care is patient centred and a range of treatments funded by DHBs which can be delivered in inpatient, outpatient, primary and community settings. It includes selected early intervention programmes that can prevent or delay the need for more complex healthcare interventions. Planned Care includes, but is a wider concept than, the medical and surgical services traditionally known as Electives or Arranged services.
Planned Care is centred around five key principles, (Equity, Access, Quality, Timeliness and Experience) which build on the Electives Policy principles of clarity, timeliness and fairness

In 2020/21 DHBs will be in the first year of implementing their Three-Year Plans to improve Planned Care delivery. The Three-Year Plans will be address the five Planned Care Strategic Priorities of:

- Improve 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
- Optimise sector capacity and capability and
- Ensure the Planned Care Systems and supports are sustainable and designed to be fit for the future.

SDHB will engage with WellSouth Primary Health Network, our Iwi Governance Committee and our Community Health Council in the ongoing implementation of our plan.

DHB Activity	**Milestones**	**Measures**	**Government theme:**	
Quarter 1 (EOA) • Implement an equity lens over the referrals for planned care and address equity gaps through the Planned Care Equity Action Plan. • 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 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 case mix 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 continuing to roll out the prioritisation tool for access to First Specialist Assessment (FSA) to specialities which are in breach of Elective Services Patient Flow Indicators (ESPI) 2 targets • Increase the proportion of clinic appointments executed by telephone and video • Continue to monitor progress of COVID-19 recovery and variances through outpatient dashboards, recovery plan dashboards and effective communication with the surgical teams. Continue to improve theatre reporting, scheduling and list management by using Power BI analytics designed by Capacity and Demand Analyst • We will introduce the 'acuity tool' (implemented in Ophthalmology) to 8 more surgical and medical services over the year. This will allow services to develop plans to balance timely follow-up with urgent appointments in both new (FSA) and follow up appointments • Continue to maximise theatre utilisation over the usual breaks (Christmas/New Year, Easter, school holidays)	Quarter 1 Part one: Implementation of equity lens for referrals Achieve case weight and discharge target for the first quarter. Recovery plan commences for the recovery of the 1,200 case weights of lost surgical activity that occurred during COVID. Existing ESPI 2 and ESPI 5 plans continue to be followed. Acuity tool rollout continues in surgical and medical services Prioritisation tool roll out continues in surgical services Part two: Measures for Planned Care plan tbc	SS07: Planned Care Measures SS08: Planned care three year plan Quarter 1 Part one: Delivery of actions and improvement against Planned Care Measures expectations Medical specialties commence use of acuity tool Part two: Equity gaps in accepted FSA referral rates and access to planned care are identified through adding this to our dashboard reporting. As well as ethnicity we will also look at locality. Once identified equity gaps are addressed through the Planned Care Equity Action Plan which focuses on the Operationalisation of Equity, Whanau Centred Clinical Support Services, Virtual and Telehealth	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

• 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). • Continue the implementation of 3 year Plan for Planned Care and engagement with key stakeholders and consumer groups. • Develop new models of primary care supported by HealthPathways, with sustainable delivery of community based services, with reports on progress in Q2 and Q4. This may lead to disinvestment in some resources to allow further investment in primary care resources if this delivers a more sustainable solution across the Southern Health System. • Using skin lesions and the Ear, Nose and Throat (ENT) service (but also plastics and general surgery) as the first opportunity commence engagement with WellSouth Primary Health Network to systematically shift activity out of secondary care and into primary care for these minor procedures. • Develop muscular skeletal programme for Dunedin and Invercargill cities for spinal patients. This programme will be set up in a way that enables GP referral into the programme.		Services and Equity in Planned Care Services.		
Quarter 2: • Continue implementing the COVID-19 recovery plan and (ESPI 2) recovery for Urology, ENT, General Surgery, Orthopaedics and Gynaecology, • Continue implementing the COVID-19 recovery plan (ESPI 5) for Urology, General Surgery, Orthopaedics and Gynaecology, • Agree a contract with the new Southern Cross / CHT Hospital schedule to commence operating late 2021 to provide increased elective surgery at Queenstown • Apply the learnings from transferring skin lesion activity into a primary care setting and commence planning for a broader programme across other specialities, where this delivers a more sustainable solution. • Commence implementation of muscular skeletal programme. • Re-develop ESPI 2 and ESPI 5 recovery plans but also balancing urgent appointments (e.g. urgent follow up appointments).	Quarter 2 Part one: Achieve target against the case weight and discharge plan. Recovery plan no less than 85% complete by the end of quarter 2. Prioritisation tool rollout continues Progress report on new models of primary care Q2 Re-developed ESPI 2 and ESPI 5 planning discussed with Ministry prior to commencement of implementation.	Quarter 2 Part one: Delivery of actions and improvement against Planned Care Measures expectations Two medical specialties commence use of acuity tool		
Quarter 3: • Roll out COVID-19 recovery plan process to other specialities (all ESPI 2) • Pilot in one or more specialities the ESPI 5 recovery Plan • Commence transfer of activity from secondary to primary for one other speciality. • Work on opportunities for shifting further activity in other specialities. We will do this through pulling referral information for other specialities and engaging with both primary care and senior clinicians (e.g. Chief Medical Officer) to identify our next opportunities.	Quarter 3 Part one: Achieve target against the case weight and discharge plan. Implementation of the recovery plan concludes. Acuity tool rollout continues Prioritisation tool rollout continues	Quarter 3 Part one: Delivery of actions and improvement against Planned Care Measures expectations Two medical specialties commence use of acuity tool		

Quarter 4: • Review 3 year Plan for Planned Care and adjust as needed • Assess COVID-19 recovery plan for ESPI 5 forecast against actuals • Commence transfer of activity from secondary to primary for further specialities	Implementation of revised ESPI 2 and ESPI 5 plans once agreed with the Ministry. Quarter 4 Part one: DHB to identify milestone for actions identified to improve planned care Acuity tool rollout continues Prioritisation tool rollout continues Progress report on new models of primary care Q2	Quarter 4 Part one: Delivery of actions and improvement against Planned Care Measures expectations Two specialties commence use of acuity tool		

Acute Demand

Following on from our 2019/20 activities:
Our Acute Data Capturing plan demonstrates how we will implement SNOMED coding in Emergency Departments to submit to NNPAC by 2021.

Our Patient Flow Plan shows how we will address the growth in acute inpatient admissions. This will include detail on: how patients will be better managed in the community, emergency department and hospital, and the organisations that we will work with to plan and achieve improvements.

Acute Data Capturing	**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	Support healthier, safer and more connected communities
1. In 2020/21 we will investigate the technical IT issues to collect SNOMED codes in Emergency Department Information System (EDIS). There are several barriers to resolve to achieve this, will be prioritised for resolution in 20/21, which include the need to map partial SNOMED codes to full codes for interfacing to iPM, and the fact that the current EDIS Upgrade does not accommodate the field length required for SNOMED integration, however DXC have confirmed that version 21 should allow this.	Resolution of identified issues Q1 EDIS Version 21 upgrade complete Q1	SS10: Shorter Stays in ED Monitoring our performance (% breaches) on a quarterly basis		
Patient Flow - Performance Improvement of our 6 hour ED target Many people learned to self-manage during COVID-19 lockdown, with support provided by GPs/others mainly though virtual consultations.		Improvement in 6 hour target Reduction inpatient delays Number of complaints		
2. In the 2020/21 year, we will therefore embed learnings from COVID-19 related to primary care by continuing to support self-care/self-management through improving self literacy, including expansions of consumer portal access and provision of information through the Southern DHB website [Refer to Health Literacy template for deliverables].	Report on progress Q2, Q4 50% of primary care BAU to be delivered virtually by Q4			
3. Through Health Care Homes GPs will be supported to embed new ways of working, including GP triage, use of patient portals, virtual consultations, use of e-pharmacy and e-ordering. Secondary services will also provide virtual support to primary care through change to models of care, supported by HealthPathways, which will be a critical enabler to the improvement of patient flow in the 2020/21 year.	Review the model of care for Health Care Homes Q2. Implement recommendations by Q4			
4. Under the auspices of the Alliance Leadership Team, a Service Level Alliance will be established to focus on the provision of Urgent and After Hours care in both Dunedin and Invercargill. This will be clinically led and focus on the provision of affordable and sustainable access for both in and out of hours acute care, to ensure that Emergency Departments in both main centres are kept free for the most clinically acute needs.	SLAT established Q1 Gaps identified Q2 Strategies developed Q3			
5. Our Valuing Patient Time (VPT) strategy will continue to be a key change framework through 2020/21, with a focus on removing waste from the system to ensure people's journey through our system is as efficient as possible, and that in doing so we are not exposing people to additional risk of harm through delays to treatment and waiting for diagnostics. For 20/21 three broad groups will continue to meet to drive VPT activity (Medical, Surgical and Emergency) who will each be	Implementation of strategies commences by Q4 Establishment of Valuing Patient Time Groups Q1 ED escalation pathway completed by end of Q1			

	tasked to support and assist with implementation of these initiatives. An ED escalation pathway is one of the VPT initiatives that will be prioritised for 2020/21	Other initiatives identified by the end of Q1			
6.	An ED Performance Improvement Steering Group, which provides guidance, leadership and coordination of current and new initiatives to improve Dunedin ED Shorter Waiting Times Target will continue to meet to review data and provide recommendations for Quality Improvement in the department to improve patient flow.	Steering Group provides guidance Q1-Q4			
7.	We will continue to 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, including the addition of a dedicated resource focussing on education of ED staff in the management of psychiatric conditions, and liaising between ED and Emergency Psychiatric Service (EPS)	Introduction of new educator role Q1			
8.	A key strategy to be rolled out across our Inpatient service on the Dunedin site in 2020/21 is the Implementation of a Generalism Strategy, which will see the transition of several sub specialities in one larger general medicine team. This will assist with the timely movement of patients from ED and help facilitate greater integration of clinical teams, as well as improving patient flow of a Undertake work to reduce siloed thinking	Business case for generalism completed and submitted by Q1			
9.	In conjunction with the move to a generalist model of care, we will also progress the draft business case for the establishment of a Medical Assessment Unit collocated with the Emergency Department in Dunedin Hospital to assist with patient flow.	Internal Medicine takes patients from other specialities beginning Q2 Business case completed and submitted by Q1			
10.	Patient flow issues will also be prioritised for resolution in the 2020/2021 year on the Southland Hospital campus, with a process to assess the viability of a Medical Assessment Unit or dedicated short stay unit in Southland Hospital	Assessment completed by Q2			
11.	ED on both sites will work collaboratively to ensure that the services that are delivered are culturally appropriate and Māori have the best possible experience within our ED's (EOA) • Work in partnership to implement initiatives to improve care and the experience for Māori	Regular meetings established Q1			

Rural Health

Southern DHB plans to undertake a number of actions to improve access to services in rural communities, including use of technology, work with Localities networks and work with the Rural Hospitals Alliance group.

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	Support healthier, safer and more connected communities
1. The first Locality Network was established under the direction of the Alliance Leadership Team in 2019, which has a focus on the Central Lakes/Queenstown locality. This is in line with the objectives identified in our Primary and Community Strategy. This region was chosen for the first Localities Network in the District as it had the fastest growing population and was located furthest from base hospitals in Dunedin and Invercargill. In 2020/21 we will undertake a comprehensive evaluation of the Locality, to assure ourselves of its effectiveness, and to learn from the experience of members, and stakeholders before we commence on the development of additional networks in other parts of the District.	Commission review Q1 Agree TOR Q1 Review completed end of Q2 Findings from review shared by end of Q3	Review completed and findings applied to future groups		
2. We will undertake to refresh and refocus the Rural Hospitals Alliance that was established in 2018/19. This group comprises six rural hospitals including Gore, Balclutha, Oamaru, Ranfurly, Dunstan (Central Otago) and Lakes District Hospital (in Queenstown). Balclutha, Oamaru, Ranfurly, Dunstan (Central Otago) and Lakes District Hospital (in Queenstown). Five of these hospitals are independent legal entities operating as Rural Trusts holding contracts with Southern DHB. Lakes District Hospital is Southern DHB owned and operated. Southern DHB management is a strategic partner to this group. COVID-19 provided an opportunity for the group to work together and experience the benefit of a more united rural health system. The goal is to build on these gains to: • Ensure access to fundamental health services such as radiology, primary care and laboratory service is equitable across the District • Agree health outcomes that are equitable for each region • Work with Southern DHB to ensure Patient Transfer Services are sustainable and meet clinical demand	Programme of work agreed and resources identified Q1 Work programme monitored on a quarterly basis to determine progress towards goals Q2-Q4	Programme of work agreed and implemented		
3. Southern DHB has established an active programme to promote telehealth consultations. COVID-19 provided an opportunity to adopt telehealth options and discover they work. In the 20/21 year, we plan to: • Review the number of telehealth clinics provided	Review of number of telehealth clinics provided Q1 Solutions to barriers identified Q3	Number of clinics delivered and patients seen		

• Identify barriers to use of telehealth and work with clinicians and providers to seek solutions • Produce review document to demonstrate improved uptake of this virtual health capability in comparison with 2019-2020	Review document Q4			
4. Lakes District Hospital in Queenstown is a DHB owned and operated rural hospital. A CT scanner was installed in June 2019 and an upgrade of the Emergency Department was completed in August 2019. These developments have resulted in increased activity. COVID-19 has impacted on tourism in this area and changed the economic outlook for the short to medium term • Review activity compared with 2019/20 • Review leadership roles in the Radiology Department to ensure there is responsibility and accountability to advance the development of the service • Review model of care in the Emergency Department to ensure the right health professional sees and treats the patient at the right time thus reducing the dependence on SMO only led care	Review of activity Q4 Review leadership roles Q2 Review model of care Q2	Review of Lakes District Hospital activity and models of care		

Healthy Ageing

Southern DHB plans to 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:

- Work with ACC, HQSC and the Ministry of Health to promote innovative delivery of enrolment in Strength & Balance programs and improvement in data driven osteoporosis management especially in alliance with Primary Care as reflected in the associated "Live Stronger for Longer" Outcome Framework
- Work with ACC on the non-acute rehabilitation pathway service objectives to help older people regain or maintain their ability to manage their day-to-day needs after an acute episode
- Align our service specifications for home and community support services (HCSS) to the vision, principles, core components, measures and outcomes of the national framework for HCSS
- Implement our priorities for dementia services identified on the basis of our 2019/20 regional stocktake and consistent with priorities identified by the sector.
- Undertake activities in community and primary care settings to identify frail and vulnerable older people, with a focus on Māori and Pacific peoples, and put interventions in place to prevent the need for acute care and restore function

DHB Activity	**Milestone**	**Measure**	**Government theme:** Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
Significant strategic work is underway in the Southern district to embed contemporary models of care in our Healthy Ageing pathways to bring closer alignment between o these services and the models of care outlined in our Primary and Community Strategy. In the 2020/21 year, this work will continue through:			We live longer in good health	Ensure everyone who is able to, is earning, learning, caring or volunteering
1. A complete redesign of the current pathway, building on the work undertaken in 2019/20 that created the HOME team, and deliberately focussed on the closing of inpatient rehabilitation beds in exchange for increased levels of nursing and allied health resource in the community.	The detailed work programme highlighting critical milestones and objectives will be refreshed by the end of Q1	SS04: Delivery of actions to improve wraparound services for older people # of people assessed by primary care for falls risk to meet target of 2000 in 20/21 Decrease our number of over 65 neck of femurs (Live Stronger for Longer)		
2. Improvement of the Non-Acute Rehabilitation (NAR) pathway from inpatient admission into the community utilising InterRAI assessments, care bundles and flexible packages of Care for both ACC and Health clients	Pilot designed and approved end of Q1, including pilot wards identified and assessment requirements agreed Agreement on funding and reporting requirements with ACC and national GM's P+F agreed by end of Q1	HCSS RFP on GETS Q4 New HCSS Contracts include new service spec by 1 July 2022		
3. Building on the establishment of the HOME Team in Dunedin in 2019/20, in 2020/21 this will be expanded to add additional teams, and a greater number of locations across the district. This will ensure that there is seamless care journey for every patient. This will involve closer alignment of the Rehabilitation, HOME Team, Needs Assessment and Service Coordination (NASC) and Community Nursing.	Agree common geographical areas (locality) for community teams to align. Introduce locality based MDT meetings Q1 Expand locality MDT meeting to include general practice and home care Q4 Test co-location of community teams in a single locality as a proof of concept Q3	Reduce the number of ED presentations from ARRC residents in Dunedin and Southland EDs (16/17: 1597 17/ 18: 1708 18/19 1566) by 5% on each ED site. Target for 20/21 Dunedin: 936 Southland: 552		

4. In 2020/21 we will align our 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 will result in the development of an enhanced model of care delivery that will be subject to an RFP, which will be undertaken in the 2021/22 year in line with our obligations under the Government Rules of Sourcing.	Design of new model of care in conjunction with key stakeholders Q2/Q3 Consultation on new model of care Q4 in preparation for procurement process to begin in Q1/2 2021/22 Establishment of Steering group Q1 Development of ideas and recommendations to the Alliance Leadership Team Q2 Piloting and proof of concept undertaken Q3/4 with a view to new contracts being in place Q1 2021/22	Increase Home Team referrals from general practice and St Johns.		
5. We will take a critical and focussed look at how the partnership between specialist services and Age Related Residential Care (ARRC) can be further enhanced with a view to developing targeted programmes to avoid admission for frail elderly. These programmes are likely to focus on enhanced respite and rehabilitation, step up and step down facilities, and a focus on closer integration across the HOME team, Health of Older persons specialist services and the ARRC sector.					
6. We will look to Identify and address the drivers of acute demand for people 75 plus presenting at ED (or at lower ages for disadvantaged populations (EOA) by implementing solutions from previously completed work entitled “ED presentations from ARRC” utilising a PDSA methodology to test solutions HOME Team to continue service development using PDSA to test new innovations Q4	PDSA used to test solutions to ED presentations by Q1 PDSA used to test new HOME Team innovations Q3 Service development continues Q4			
7. 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 Strength & Balance programs and improvement of osteoporosis management especially in alliance with our Primary Care partners as reflected in the “Live Stronger for Longer” outcome framework	Hold a sector-wide Forum Q2 Update our Sector Wide Falls and Fractures Prevention Workplan Q4			
8. We will continue to support the Client-Led Integrated Care (CLIC) in general practice, linking assessments to supports and other services where required.	Link general practice into locality based MDT meetings for identified frail elderly where appropriate (see above in 2) Q4 Agree common geographical areas Q1			

9. We will continue to work to support the implementation of the NZ Framework for Dementia Care and improve dementia services. Specifically this will include ongoing participation in the South Island survey to increase understanding of the level of contracting to NGOs and the promotion of educational websites identified by the South Island Alliance that provide quality education on dementia and delirium for health professionals 10. We will promote HealthPathways as the source of appropriate referral to community supports, hospital and specialist services when required [Refer to Planned Care under section 2.1.6 for more information] 11. In specific relation to the significant amount of work that was undertaken across our sector to support ARRC and Home Based Support Services (HBSS) providers in readiness for the onset of COVID-19, in the 2020/21 year we will maintain a focus on developing cross-sector approaches for responding to a future public health emergencies. This will include the establishment of an ARRC steering group to support sector wide quality improvement, patient safety, increasing the need for Infection Prevention Control awareness and capability building, and workforce planning, and through the HCSS Alliance and ARRC steering group respectively, a continued focus on the development of public health/pandemic/emergency contingency plans for HCSS and ARRC. This includes maintaining essential services through supporting the provider workforce, and where necessary actively supplementing workforce gaps [Refer to section 2.1.5 for more information on both Communicable diseases and Antimicrobial Resistance].	Update/develop HealthPathways for frailty in older adults Q3 Locality based MDT established in first area Q1; expand MDT Q4 Co-located teams established Q3			

Improving Quality

1. Improving equity

Using the Health Service Access Atlas (Atlas of Healthcare Variation) which reports seven questions from the national primary care patient experience survey, we have identified that patients with diabetes are experiencing the most barriers. In our plan we specify improvement activity to address these barriers and drive equity of outcomes for these patients.

2. Improving Consumer engagement

We plan to participate in the quality and safety marker for consumer engagement by:

- Setting up a governance group (or an oversight group) of staff and consumers to guide implementation of the marker
- Uploading data onto the consumer engagement QSM dashboard using the SURE framework as a guide
- Reporting against the framework twice yearly.

System Level Measures

Implementation of the System Level Measures (SLMs) continues in 2020/21.

DHB Activity	**Milestone**	**Measure**	**Government theme:** Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
The area that we have chosen to focus on, which will form the basis of our quality improvement activity is Diabetes. Baseline: Percentage with any available HbA1c: 60.6% (Q2 2019-20). For Māori 57.9%. Target: Actions will be taken below to increase the number of patients including Māori with current HbA1c to 80% Q2 and 90% Q4 (EOA) To achieve these targets, in the 2020/21 year we will undertake the following activity to improve equity: 1. We will establish virtual diabetes forums, which will be delivered to GPs. This will include the provision of professional support provided through this platform, and having the added benefit of integrating primary and secondary services 2. We will explore the expansion of virtual diabetes consultations, building on the significant gains that this service made in respect of virtual health during our COVID-19 response. This will include consultations delivered by both primary care and secondary care, and will include integrated consultations as appropriate. 3. A catch up programme for Diabetes Annual Reviews will be designed and rolled out in conjunction with our Primary care partner WellSouth	Virtual diabetes forums delivered Q2, Q4 30% of consultations delivered virtually across the service by the end of Q4 Catch up programme designed and agreed by the end of Q1 Catch up complete by the end of Q2, and targets on track for year-end delivery	SS13: Improved Management for Long Term conditions (diabetes) All patients including Māori with current HbA1c 80% Q2 and 90% Q4 All GP practices using the Thalamus diabetes dashboard All patients with Diabetes identified as High Risk or Active Disease are referred into secondary care	We live longer in good health	Support healthier, safer and more connected communities

4. In addition, WellSouth will monitor and actively follow up referrals to secondary care for all patients with diabetes identified as High Risk or with Active Disease	All GP practices using the Thalamus diabetes dashboard by Q2 Number of diabetics referred into secondary care Q1-Q4			
Improving community, whānau and patient engagement				
1. Southern DHB will establish a governance group (including DHB Quality & Risk Manager, DHB Community Health Council (CHC) Facilitator, Chair of Clinical Council and CHC members) Q1. Executive Director for Quality & Clinical Governance is Executive Sponsor.	Governance group established Q1			
2. Quarterly updates are sent through to the Executive Leadership Team outlining where engagement is occurring with clinical services, opportunities for future engagement and what support staff need to engage with community, whānau and patients	Quarterly updates Q1-Q4			
3. We will profile Clinical Champions at the DHB and WellSouth who have engaged with community, whānau and patients and lessons learnt from this process	Clinical Champions profiled Q2			
4. Information around engagement with community, whānau and patients is uploaded to the Quality Safety Marker dashboard as outlined by HQSC	Information uploaded to Quality Safety marker Dashboard Q2, Q4			

New Zealand Cancer Action Plan 2019-2029

On 1 September 2019 the Prime Minister and Minister of Health launched the New Zealand Cancer Action Plan 2019-2029 (the Plan). We recognise that as a District Health Board, we have a responsibility for the successful achievement of these outcomes.

We are required to work with and take direction from the Cancer Control Agency. The Agency has a leadership and monitoring function and will be required to report progress against performance of the Plan to the Minister. The Plan requires that services are delivered against nationally agreed standards of care and that quality improvements will be made for agreed quality performance indicators as they are further developed across all tumour streams.

We have outlined below the actions we will take to sustain or improve cancer care and implement the Cancer Plan, including actions to ensure that the 31-day and 62-day cancer waiting time measures are met.

DHB Activity	**Milestone**	**Measure**	**Government theme:** Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
During the COVID-19 response, new referrals dropped significantly due to the reduction in face to face GP consults, suspension of screening programmes and reduced activity across diagnostic imaging and procedures. To manage the anticipated influx of patients we will: • Use virtual consults, where clinically appropriate • Monitor flows in referrals and cease non-urgent activity depending on capacity. The ethical challenges will be significant as this will place increased pressure on our services, in particular the diagnostics, surgical and medical and radiation oncology treatment services, To guide prioritisation decisions during 20/21 we have agreed the following: • Implement a systematic approach to monitoring and acting on 62 day pathway breaches; • Implement the 2+2 strategy (all patients First Specialist Assessment (FSA) within 2 weeks and then to start treatment within 2 weeks) for all patients (starting with pilot for colorectal cancer) • Support clinical staff to gain visibility of cancer patients on both 62-day and 31-day • Develop a dashboard for the main tumour streams which highlights bottle-necks in areas across the organisation associated with timely delivery in that tumour stream. • Enhance cultural pathways through the faster cancer treatment (FCT) journey (EOA) • Improve cultural resource for FCT and for cancer nurse coordinators, in order to determine gaps, make improvements in pathways, and increase supportive care In a collaboration specifically built to focus on improving access and timeliness of cancer treatment to Māori, we will undertake quality improvement initiatives that align with national cancer strategies to achieve health gain for Māori and equitable and timely access to cancer services (EOA). This will focus on the implementation of the improving the Cancer Pathway for Māori Plan and appointment of a Māori Cancer Nurse Coordinator (EOA). The National cancer strategies are designed to achieve better health gain for Māori, and to improve equitable and timely access to cancer services (EOA). In our commitment to supporting these strategies, we will undertake the following:	2+2 strategy implemented for colorectal cancer pilot by Q2 Work with Cancer Control Agency on implementing FCT indicator on patient's records undertaken during Q3 Electronic flag developed Q4 Appointment of a Māori Cancer Nurse Coordinator by Q4	SS01 Faster Cancer Treatment (31 day indicator) SS11 Faster cancer treatment (62 day indicator)	We live longer in good health	Support healthier, safer and more connected communities

1. Cancer Pathways • Contribute to a Medical Oncology 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 • Implement clinical quality and safety programmes in conjunction with Radiation Therapist (RT) and physics to improve quality and safety • Implement strategies to reduce variation and maximise use of the available capacity for early stage breast cancer • Implement the Improving the Cancer Pathway for Māori Plan (EOA) • Monitor and navigate Māori newly diagnosed with cancer (EOA) • Work with the MoH, Cancer Control Agency & 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 • Implement the Radiation Oncology plan • Collaborate with Southern DHB Māori Health Units to ensure equitable access for Māori and enhance the cultural competency of the health workforce (EOA) 2. Survivorship • Work with Cancer Control Agency to explore an end of treatment regional service initiative to improve quality of life for people who have recently completed cancer treatment • Implement the Primary Community Strategy to ensure maximal use of primary health community follow up, promote collaboration with Cancer Society and Physical Education school to increase utility of Bridge to Health and Exercise Training Beyond Breast Cancer (EXPINKT™) exercise programs • Expand EXPINKT™ exercise program to Queenstown Lakes area • Assist Cancer Control Agency in the development of a pilot initiative to address needs of people who have recently completed cancer treatment (survivorship guidance) • Participate in SI Cancer Service Reducing Inequities Equitable Access & Outcomes • Work with Cancer Control Agency to explore evidence based equity tools/processes to identify disparities vulnerable population groups, the	Bone and Soft tissue SABR MDM commences Q3 Strategies implemented for early stage breast cancer Q1-Q4 Implementation of Improving the Cancer Pathway for Māori Plan Q1-Q4 Implement the RO plan Q2 SDHB MDMs moved across to the HCS version by Q2 Monitor and navigate Māori newly diagnosed with cancer Q1-Q4 Analyse journey and wait times for 20 Māori patients diagnosed with lung cancer. Assess opportunities to improve timeliness in primary and secondary and expected outcomes Q1-Q4 Participation in SI digital systems Q3 Report of end of treatment services provided Q1-Q4 Expand EXPINKT™ exercise program to Queenstown Lakes area Q3 Business case Q3 Commence VC clinics beginning in Southland Q3 Measure data and identify any areas for improvement Q1-Q4 Stakeholder meetings held Q2 Analysis (DN and INV) Q2 and Q3			

causes of disparities and the impacts (intended and unintended) of initiatives (EOA) • Participate in an Cancer Control Agency 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 Faster Cancer Treatment (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 3. Focus on priority areas for quality improvement, as identified in the Bowel Cancer Quality Improvement Report 2019 • Measure and report on: o Patients with rectal cancer receiving short course pre-operative Radiation Therapy o Patients with rectal cancer receiving long course pre-operative Radiation Therapy +/- Chemotherapy o 'stoma free survival post surgery' o Stakeholder feedback and recommendations • Agree recommendations (with timelines) 4. The Cancer Plan • Work with the Ministry of Health, the NZ Cancer Control Agency and the Cancer Control Agency to further define and implement the cancer plan	Work with Cancer Control Agency to explore evidence based equity tools/processes to i Q1-Q4 Recommendations agreed Q4 Identify local actions within the Cancer Plan by Q1-Q4			

Bowel Screening and Colonoscopy Wait Times

To ensure all patients requiring diagnostic procedures are treated fairly and seen within maximum clinical wait times, the Ministry of Health has developed a dedicated framework for monitoring symptomatic colonoscopy and bowel screening performance. New reporting requirements sit alongside a new escalation process that ensures both the recommended colonoscopy wait times and the numbers of people waiting longer than maximum wait times receive equal focus.

In our plan we describe actions to ensure:

- recommended urgent, non-urgent and surveillance diagnostic colonoscopy wait times are consistently met
- there are no people waiting longer than the maximum wait times for any indicator.

DHB Activity	**Milestone**	**Measure**	**Government theme:** Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
In addition to above, we demonstrate clear strategies for improving equitable participation and timely access to bowel screening service. Post COVID -19, for bowel screening services, patient safety remains paramount and we will continue to ensure all procedures are completed within maximum wait times. In Quarters 1 and 2, we will prioritise colonoscopies to be completed within maximum wait times. We plan to meet all recommended and maximum wait time targets in Quarters 3 and 4. Our improvement activities are supported by visible leadership, effective community engagement, and clear accountability for equity. We will undertake the following activity to deliver this vision:			We live longer in good health	Support healthier, safer and more connected communities
1. We will utilise National Access Criteria for all primary care and non-GI specialist referrals and provide the appropriate triage and review process for all other referrals to ensure that the appropriate patients receive colonoscopy	National Access Criteria utilised Q1-Q4	SS15: Colonoscopy waiting time indicators are met Improving waiting times for colonoscopies Bowel Screening waiting time indicators		
2. We will undertake quarterly waiting list review to ensure that no patients are waiting beyond the maximum waiting time without appropriate reason	Quarterly waiting list review Q1-Q4			
3. We will engage with Māori populations and undertake activities specifically targeted to their populations to promote bowel screening (EOA).	Regular review of participation data to direct activities and ensure equity gaps do not develop and take action if they do (as above) Q1-Q4 Visit Māori health providers on an annual basis, by Q4 Arrange and attend meetings with Māori groups by Q4 Target active follow-up of patients for Māori populations Q1-Q4 Target promotional activity to areas of high Māori populations Q1-Q4	Māori and Pacific Island participation in Bowel Screen > 60% and consistent with overall participation rate Participation rate > 60% over the last 24 months		

4. We will engage with Pacific Island populations and undertake activities specifically targeted to their populations to promote bowel screening (EOA).	Arrange and attend meetings with Pacific Island groups by Q4 Target active follow-up of patients for Pacific island populations Q1-Q4 Target promotional activity to areas of high Pacific island populations Q1-Q4			
5. We will undertake active promotion of the Bowel Screening Programme and engagement with GP's, NGO's and community groups including visiting Māori health providers, utilising written, digital and spoken media to promote the Bowel Screening Programme and regular dialogue and discussion with WellSouth Primary Health Organisation	Active promotion of Bowel Screening Programme Q1-Q4			
6. We will review both our facility and personnel resourcing and resource utilisation via the Endoscopy Users Group on a quarterly basis	Review of facility and personnel resourcing and resource utilisation Q1-Q4			

Workforce

DHB workforce priorities

We have set out workforce actions that we intend to work on in the 2020/21 planning year, with consideration of:

- Ongoing responsibilities for the upskilling, education and training of health work forces
- The population health need that initiatives are designed to address, including improved equity in health outcomes and independence for Māori and Pacific peoples
- 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 transdisciplinary teams to support health workforces in their roles across primary, secondary and tertiary settings.

We have developed actions that support equitable funding for professional development for nurse practitioners.

Workforce Diversity

This action area builds upon actions set out in the previous planning year to better understand the workforce intelligence gathered at local, regional and national levels and how this intelligence assists DHBs in workforce planning. We will work in collaboration with DHB Shared Services and, where appropriate, with the Ministry of Health to:

- Collect workforce data and intelligence to support workforce planning at local, regional and national level develop actions to meet the six targets agreed by DHB Chief Executives in support of Te Tumu Whakarae's position statement on increasing Māori participation in health and disability work forces
- support our responsibility to upskill, provide education and train health and disability work forces
- provide training placements and support transition to practice for eligible health work force graduates and employees. Planning will 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
- continue to build 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 workforce with the right skills, in the right place, at the right time.

Health Literacy

We will build upon the health literacy review that we completed in the 2019/20 planning year towards developing a health literate organisation.

Cultural safety

The Health and Disability System Review Interim Report / Pūrongo mō tēnei wā recently released notes the need to both build cultural competence of the entire health and disability workforce and to reduce institutional racism. The Health Services and Outcomes Kaupapa Inquiry (Wai 2575) raises institutional racism as a significant issue for Māori health – both for staff and for people accessing services. In order to meet the needs of and improve outcomes for groups such as Māori, Pacific, migrants and refugees then our work places must be healthy and culturally reinforcing working environments that support health equity.

In the 2020-21 planning year we will consider how we 'do' cultural safety and to identify actions to support cultural safety within our DHB already underway.

Leadership

We plan to undertake

- Actions, initiatives and programmes to support staff who are in, and staff who are progressing into leadership, management and governance roles.
- Actions/initiatives/programmes to facilitate healthy and culturally reinforcing working environments that support health equity.

COVID-19

- We plan to work with the Ministry and wider community providers to plan a cross sector approach in responding to a public health need, such as COVID-19, that impacts on service delivery and on health and disability workforce availability to meet that need. Community providers include, and are not limited to, Māori and Pacific providers, aged residential care, home care and support services, disability support services, and mental health and addiction services.

Workforce	**Milestone**	**Measure**	**Government theme:** Improving the well-being of New Zealanders and their families
1. Strategic direction of Southern DHB Workforce plan agreed	Workforce plan agreed Q2		

• Review the workforce strategy plan to align with Southern DHB's change management programme, annual strategy plan, realisation plan and the impact of COVID-19		Approved and supported SDHB	**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
2. Workforce Planning • In conjunction with services across the organisation review and support planning processes related to public health needs e.g. COVID-19 Q1-Q4 • Additional actions will be undertaken in FY 21/22, identifying gaps in supply and demand	Review and support planning processes Q1-Q4 Planning processes by Q4 for actions to be undertaken in 21/22 Establish organisational demands Review external environment and impact on service deliverables Critical Talent Segmentation Identification Monitor and review progress of strategies and plans			
3. Leadership • Establish a leadership framework that enables leaders to deliver on the overall Southern DHB objectives aligned to the state services framework and strategic intent o Develop training and development framework geared to specific leadership segments e.g. manager of managers, managers of others, managers of functions etc. • Additional actions will be undertaken in FY 21/22, to include o Establish leadership competency requirements for Southern DHB's realities o Multi-Cultural Competency including Māori competencies (EOA) o Multi-Cultural Competency including Pacifica competencies (EOA) o Succession planning for senior leadership and critical roles enabled through technology solution to capture and track development / progress	Leadership framework Q2 Training and development framework Q4	Approved leadership framework 100% of Southern DHB Board members and Southern DHB Executive Leadership Team will be trained		
4. Culture & Change • Develop appropriate change management methodology and tools for Southern DHB o Provide training to the Executive Leadership Team (ELT) and the Board specific to Te Tiriti o Waitangi and Māori health and disability service improvement, to increase knowledge and understanding of Te Tiriti o Waitangi, what health inequities mean and how to achieve health equity for Māori • Provide change management training to first and second line managers where responsible for driving improvements o Improve workplace culture changes (including social media impact); living the values linked to Southern Future programme of work	Change management tools Q3 Change management training Q4 Te Tiriti o Waitangi training provided to ELT and the Board by Q1 Improved workplace culture Q3 Improved employee engagement	Fit for purpose change management methodology and training provided Tracking of attendance/completion rates Program of work linked to SDHB values and 7 staff priorities.		

o Improve employee engagement o Develop and deliver a Māori Cultural Education Programme with micro credentialing within the NZQA framework for the Southern health system. Delivery will include face to face and self-directed learning using a quality improvement framework. The Programme will be delivered to Southern DHB staff, Rural Trust Hospitals, WellSouth PHO staff, Māori Health Providers, General Practices and Community Pharmacies. The Programme is comprised of components on Treaty of Waitangi, Cultural Safety, Cultural Humility and Te Reo. [Refer to Engagement and Obligations as a Treaty Partner].	Q3 Delivery of Māori Cultural Education Programme Q2 Approval of HCM business case subject to Capital Approval process	Staff Engagement Survey results reflect upward trend in staff engagement. Delivery of relevant and appropriate cultural training for all staff Digital strategy including staff experience digital enabling technology		
5. Improve Staff Experience • Improve productivity through technological enablement and systems automation • Additional actions will be undertaken in FY 21/22, to include o Valuing staff time by automating and enabling HR processes – deliver and implement a Human Capital Management system o Enable better people decisions through data and analytics in real time	Improved productivity Q3	Approval of HCM business case Implementation of HCM system District and Regional H&S Committees meetings achieve a quorum on 2 and 4 occasions respectively		
6. Nurse Practitioner Professional Development • Approve and roll out the new Nurse Practitioner (NP) professional development guideline that recognises the support required and ongoing continuing education needs for this advanced scope of practice • Identify specific funding for NPs professional development from 20/21 by • Implement NP Professional Development guideline • Allocate funding for NPs in accordance with the guideline	NP guideline Q1 Funding identified Q1 Guideline implemented Q1 Funding allocated Q2-Q4	At least 85% of HSRs have attended basic HSR training. At least 25% of current staff (including all new staff) have digital OH records.		
7. Health, Safety and Welfare (HSW) - Lift worker engagement and participation in health and safety by: • Establishing District Health and Safety Committees • Creating informal opportunities for Health and Safety Representatives (HSRs) to network and collaborate together • Ensuring all HSRs have completed minimum training requirements, and can access further development opportunities	Regional committees formed Q1 District committee formed Q2 Annual HSR training day Q3	PSR self-assessment report submitted by 31 March 2021 (Q3)		
8. Health, Safety and Welfare (HSW) - Protect our people, information and assets by: • Initiating a security risk management programme, to meet Government Protective Security Requirements (PSR) • Designating a Chief Security Officer (CSO) and Chief Information Security Officer (CISO) • Convening reference groups for governance, information, personnel and physical security • Carrying out a self-assessment of organisational security capability and maturity, using assessment planning and reporting tools provided by the PSR Engagement Team	Designate CSO, CISO Q1 Complete PSR 'Roadmap' plan Q2 First annual report complete Q3 Continuing improvement process Q1-Q4			

9. Ensure confidentiality, integrity and availability of staff occupational health records by: • Transitioning staff pre-employment screening and health monitoring records to electronic format and repository.	System implemented and records transferred Q1-Q4			
10. Southern DHB will work with the Ministry and wider community providers, including iwi and WellSouth, to plan a cross sector approach in responding to a public health need, such as COVID-19, that impacts on service delivery and on health and disability workforce availability to meet that need. • Implement a Public Health and a Community EOC inclusive of community providers, mental health, Iwi/ Māori providers as part of Emergency CIMS response, as required • CIMS training is required for all personnel who operate within a DHB EOC / ECC and will continue to be offered to health partner agencies / organisations • Southern DHB Health Emergency Plan indicates the support of the DHB when service/facility plans are exceeded during an event • Through an integrated People forum, identify and address specific People considerations in anticipation for the Psycho-social impact resulting from COVID-19, referred to as the 4th Wave. This will entail a cross-discipline/multifunctional approach supporting staff with mental health, wellbeing and welfare support ranging from Psychological first aid, financial planning, mindfulness, building resilience, compassionate leadership and supporting flexible working arrangements where practical. Work has commenced and will be ongoing through. • Formalise Southern DHB redeployment strategy and process to support high priority essential services by • Implement a Māori COVID-19 Response Action Plan to look after the health and wellbeing of the Māori community by minimising and limiting the harm to Māori, as required	EOCs implemented as required Q1-Q4 Southern DHB Health Emergency Plan maintained Q1-Q4 Staff support provided Q1-Q4 Redeployment strategies formalised Q1 Implement a Māori Response Action Plan as required Q1-Q4 People Forum established Q1 with scheduled meetings and endorsed mandate.	50% of all records transferred to new repository 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 • 'Plan to be well this winter' campaign o Key messages about preventing serious illness through public education around the where and how to access services. o Inclusion of Healthy Home messages o Proactive management of long-term conditions • Promotion of influenza vaccine to over 65s o 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			
2. Expand and enhance consumer portal access • WellSouth to work with GPs to increase uptake of patient portals and GP portal enrolment	GP portal enrolment increased Q1-Q4	CW05:		

• Expand and enhance consumer portal access to provide consumers with access to all of their health information and care team o Consumer access expanded to virtual health consultations through patient portals (e.g. email, video, telephone, appointment bookings) 3. Explore and progress peer support approaches (for example consumer networks for mental health issues and addictions). [Refer to Mental Health and Addiction System Transformation]. 4. 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 and Tū Tauira Hauora programmes of work within the Otago University Q1-Q4 and ongoing continuing through financial year (FY) 21/22 (EOA) 5. Develop the health literacy competencies of the health workforce (disability) [Refer to Disability and Disability Action Plan] 6. Develop the health literacy competencies of the health workforce (electronic prescribing/laboratory requests) • PHO actively promotes use of electronic prescribing to GPs • PHO works with Southern Community Laboratory to promote use of electronically ordering lab tests 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) 8. Empower consumers, whānau 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 • Southern DHB info on Health Info localised and updated as required	Consumer portal access expanded Q1-Q4 Cultural education programme executed Q1-Q4 Electronic prescribing rolled out by Q4 Electronic lab tests increases by Q4 Patient participation and partnership model implemented Q1-Q4 Continued improvements of Southern district website Q1-Q4 SDHB info on Health Info localised and updated Q1-Q4	Immunisation at age 65 years and over Portal usage by patients reaches 20% by Q4 Portal GP enrolment to 65% by Q4 Practices offering virtual consults to 20% Q4 Number of consumers participating in consumer networks, group sessions and social media Health Promotion Plan developed by Q4 Number of GPs and pharmacies using e-prescribing by Q4 Number of GPs using e-lab		

Data and Digital

We describe our data and digital plans below:

- List of all major digital initiatives, and associated milestones, and indicate multi-year initiatives.
- Explain how our IT Plan is aligned with the Regional ISSP.
- Note the digital systems/investments that will improve equity of access to services.
- Note the initiatives that demonstrate collaboration across community, primary and secondary care.
- Describe plans/initiatives that will enable the delivery of health services via digital technology for example telehealth, integrated care and working remotely.
- Indicate plans for providing consumers with access to their health information.
- Indicate plans for taking part in the digital maturity assessment programme and/ or implementing an action plan following the assessment.
- Indicate plans for implementing/maintaining Application Portfolio Management to improve asset management.
- Indicate plans to leverage approved standards and architecture in all digital system initiatives and investments.
- Indicate how IT security maturity will be improved across all digital systems.
- Indicate plans for improving alignment with national digital services, national data collections and data governance and stewardship.

DHB Activity	**Milestone**	**Measure**	**Government theme:** Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
1. My Lab The vision of My Lab is to create a physical space where we can showcase new Digitally enabled models of care and demonstrate technologies that will both enhance the patient and staff experience and value their time. MyLab will highlight to staff and patients what technologies can be leveraged in a digital health care environment and how these can be utilised within the new Dunedin Hospital and the wider Southern District. MyLab will provide is the ability to research and understand the impact on change in people's behaviour and health outcomes as a result of the new digitally enabled models of care supported by new and emerging technology and real-time data analysis. The intent is for MyLab to be accessible across the region, country and internationally via technology networks. This is an important aspect as we need to ensure that we collaborate across all these dimensions, seeking feedback and identifying future opportunities. With the creation of MyLab we acknowledge that technology is not the answer, it supports the patient and staff experiences and draws together processes. MyLab will be a significant enable of the change management process within our region.	Signing of Heads of Agreement with My Lab partner agencies Q1 Finalisation of the implementation plan Q1 Identification of, fit out and opening of My Lab physical design space Q2 Procurement of initial technology show case partners Q3 Regular and ongoing reporting to the SPG Q1-Q4	Quarterly reports on the DHB ICT Investment Portfolio to Data and Digital Annual network lifecycle management All DHB sites have backup wide area network installed, Wakari pending capex for re-cabling Standardising Service Delivery processes and structure starting Gap Analysis.	We live longer in good health	Support healthier, safer and more connected communities
2. Early Works Team for the New Dunedin Hospital An "early works team' has been established. The team are establishing the high level plans and starting to implement solutions across the 18 ICT blueprint work streams which will lead to further proposals for resource to support implementation.	Continued recruitment of key roles to the Early Works Team Q1-Q4 Business case for the Data and Digital needs of the new Dunedin Hospital Q2 2020	Still progressing through Audit NZ recommendations and implemented Security Incident & Event Management system to provide real time analysis of security alerts.		

In 2020/21 the role of the team will continue to grow, with critical milestones across the year to support the continued development of Data and Digital for the New Dunedin Hospital. Other critical milestones for the Data and Digital strategy in 2020/21 include: 1. Review existing network architecture and implement a future proofed design that allows for reliable, secure, and flexible device connectivity (Q4 2019/20) 2. Continue to leverage IaaS to provide a stable platform that underpins the operations of our telephones, networks, datacentres and devices that our staff can trust. Continue to use partners to deliver best of breed IT Infrastructure services Q3 2019/20 • Citrix IaaS Migration • Wide Area Network Resiliency 3. Improve productivity of IS Operations whilst focusing on areas that present cost efficiencies. Take risk based approach address areas of greatest need Q4 2019/20 • Cherwell Service Desk Automation 4. Expand access to HealthOne across our Community Agencies, including ARRC Facilities and Kaupapa Māori organisations to improve the continuum of care for our patients (EOA) Work as One Health Service - One Network, Identity and Security 1. Implement a simplified and well-considered security model, making it easier for our people to have straightforward access to the information they need when and where they need it • Security Improvement Programme (Phase 1) Establish a Mobile ready platform 1. Implement ubiquitous Wireless access across all DHB sites Q3 2019/20 • Wireless Network Improvement Digital Strategy Goal 2: Digital Solutions 1. Implement Regional Solutions - Develop our solution foundations through the implementation of key regional solutions such as a regional EMR and patient management system (SI PICS). Other regional projects includes ERMs, E-Pharmacy, Epiphany, RSPI • Regional: e-pharmacy • South Island PICs (Patient Administration System) • Electronic Request Management system (ERMS) Phase 3 • ECG Regional Cardiac Test Repository	Network Replacement Pool Q1 Cisco DNA (Modern local area network, Dunedin Hospital) Q1 Activity undertaken to expand access Q1-Q4 Security model design Q1 20/21 e-pharmacy Go live Q1 20/21 SI PIC's MoH approval Q1 FY 20/21	Rollout across all sites complete		

List all major digital initiatives, and associated milestones, and indicate multi-year initiatives.

- Wireless Network Improvement - completed Q1 20/21
- ePharmacy Q1 20/21
- SI PICs approval Q1 20/21
- EDIS Upgrade Complete Q1 20/21
- Patientrack Approval Q1 20/21
- FPIM Complete Q3 20/21
- Tap 2 Go Extension Complete Q1 20/21
- Scanning Approval Q1 20/21
- Microsoft 365 migration complete Q1 20/21
- RIS Replacement Complete Q2 20/21
- Recruitment System Complete Q4 20/21
- Human Capital Management System (HCM) Approval Q1 20/21
- Development of a new HR dashboard that will include transparency of the ethnic breakdown of staff Q2 20/21 (EOA)

Wireless Network Improvement completed Q1 20/21
e-pharmacy Go live Q1 20/21
SI PIC's MoH approval Q1 FY 20/21
EDIS upgrade complete Q1 20/21
Patientrack Approval Q1 20/21
FPIM complete Q3 20/21
Tap 2 GO complete Q1 20/21
Scanning Approval Q1 20/21
Microsoft 365 complete Q1 20/21
RIS replacement complete Q2 20/21
Recruitment system complete Q4 20/21
HCM approval Q1 20/21
HR dashboard Q2 20/21

Other data and digital initiatives

1. Explain how your IT Plan is aligned with the Regional ISSP:
   - 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, Patientrack, FPIM, Microsoft 365

2. Note the digital systems/investments that will improve equity of access to services.
   - As part of our RFP processes we review any solution from any equity perspective to ensure fair and equal access.

3. Note the initiatives that demonstrate collaboration across community, primary and secondary care.
   - Pilot Community nursing agencies are being onboarded into Health One, which is the South Island wide clinical portal.
   - Pilot ARRC facilities to begin the onboarding process in March 2020.

Pilot Completed Q1 20/21

4. Describe plans/initiatives that will enable the delivery of health services via digital technology for example telehealth, integrated care and 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
   - New Telehealth Steering Group formed with a focus on embedding COVID-19 gains

Telehealth Steering Group formed Q1

• Working with service planning to identify digital initiatives and or opportunities. • Developing a business case for an Allied Health solution to monitor activity and data collection.	Business Case draft Q4			
5. Indicate plans for providing consumers with access to their health information. • Working closely with Primary care on their Consumer Portal roadmap. API being developed to surface secondary appointment information into the Consumer Portal.	Consumer portal Q1			
6. Indicate plans for taking part in the digital maturity assessment programme and/ or implementing an action plan following the assessment. • CCMM Assessment completed and summary and detailed recommendations have been identified. • EMRAM and OMRAM assessments complete. Gap analysis done and key actions are being incorporated into our service planning.	Digital maturity assessment programme ongoing			
7. Indicate plans for implementing/maintaining Application Portfolio Management to improve asset management. • Portfolio management resources have been created to provide a roadmap with timeframes for upgrades, replacement or redundancy.	Ongoing activity that feeds onto our long Term Investment Plan and budgetary processes			
8. Indicate plans to leverage approved standards and architecture in all digital system initiatives and investments. • 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 how IT security maturity will be improved across all 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. Security assessment underway to access current state and formulate roadmap.	Penetration testing results are available on request Security Assessment completed Q4			
10. Indicate plans for improving alignment with national digital services, national data collections and data governance and stewardship. • Activity underway to leverage existing data frameworks and adapt to our requirements.				
11. FAX end of life • Commence project planning to identify different workstreams involved	Complete FAX end of life project by Q3			

Implementing the New Zealand Health Research Strategy

Research and innovation, analytics and technology are all crucial for achieving an equitable, sustainable health system and better patient outcomes. Here we describe how we continue to develop the partnership with the University of Otago via Health Research South and ensure Māori participation on the Health Research South Board.

DHB Activity	**Milestone**	**Measure**	**Government theme:** Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
1. Continue to develop the partnership with the University of Otago via Health Research South to: • Provide strategic direction for high quality, relevant and well-resourced research in the shared research environment - District Health Board and Dunedin School of Medicine (DSM) • Keep an overview of health research within the Dunedin School of Medicine and Southern District Health Board • Develop policy and process for the governance and management of health research in the DSM and Southern DHB • Evaluate and improve the performance of the research activities in Southern DHB and DSM • Oversee management of individual DHB research and research group accounts • Budget appropriate expenditure of all research support funds • Make recommendations on the disbursement of internal contestable funds available for health research within Southern DHB and DSM • Advise the Dean of DSM, the Chief Executive Officer, Southern DHB, and other senior managers on relevant health research related matters • Identify any issues concerning any research or research related matter and manage appropriately • Provide supervision of Health Research South Research Office • Promote research as an important and relevant part of the Southern Health system	Continued agreement with the University of Otago Q1-Q4 Provide a one-page summary update on progress to the Ministry and the Board in Q4 Policy and process development Q1-Q4	Development of partnership with the University of Otago via health Research South Māori member of the Health Research South Board present at meetings	We live longer in good health	Support healthier, safer and more connected communities
2. Māori participation on the Health Research South Board (EOA) • Nomination of Māori member on the Health Research South Board in partnership with Chief Māori Health Strategy & Improvement Officer Q1 • Appointment of Māori member on the Health Research South Board Q4	Nomination of Māori member of Board Q1 Appointment Q4			

Delivery of Regional Service Plan (RSP) Priorities

Southern DHB has plans to support implementation of key priorities through our Regional Alliance Partners, these being the other South Island DHB's, and our Shared Service Agency, SIAPO.

DHB Activity	Milestone	Measure	Government theme: Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
In the 2020/21 year, the South Island Regional Alliance, via the regional group of GM's Planning and Funding, will undertake a review of the current activity underway under the auspices of the regional work programme to ensure congruency and value to the local activity outlined in our District Annual Plan. It is likely that an increased focus on regional support for the development of local health pathways to support planned care are prioritised, as are strengthening of regional pathway design for vulnerable services. In addition to the above, Southern DHB will continue to support the following regional activity in 2020/21: 1. Equity Our Māori Health Directorate will actively participate in South Island Alliance groups that have a focus on Māori health equity including the Cardiac Alliance, South Island Public Health Partnership Alliance and Te Herenga Hauora o Te Waipounamu (Regional Māori DHB Alliance). 2. New Zealand Cancer Action Plan 2019-2029 We will continue to participate in the South Island Cancer Service Reducing Inequities Equitable Access & Outcomes 3. Workforce We will participate in the collection of workforce data and intelligence to support workforce planning at local, regional and national level develop actions to meet the six targets agreed by DHB Chief Executives in support of Te Tumu Whakarae's position statement on increasing Māori participation in health and disability work forces 4. Digital Strategy Southern DHB will develop our solution foundations through the implementation of key regional solutions such as a regional EMR and patient management system (SI PICS). Other regional projects include: • Regional: e-pharmacy • South Island PICs (Patient Administration System) • Electronic Request Management system (ERMS) Phase 3 • ECG Regional Cardiac Test Repository 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, Patientrack, FPIM, Microsoft 365	Presentation of key findings and recommendations made to ALT by end of Q1 Recommendations implemented Q2 Participation in South Island activities Q2-Q4 Engagement with Māori providers Q4 Engagement with Pacific providers Q4	Sequentially increased number of patients tested for hepatitis-C, receiving fibroscans and receiving antiviral treatment. Percentage of Māori populations being treated to reflect the overall population of the Southern DHB Percentage of Pacific populations being treated to reflect the overall population of the Southern DHB	We live longer in good health	Support healthier, safer and more connected communities

5. Regional and National Hep C • Participate in the South Island Alliance Hepatitis-C action group to implement the Hep C pathway and the other activities • Engage with Māori Health providers to promote and support treatment of Hepatitis-C (EOA) • Engage with Pacific Island providers to promote and support treatment of Hepatitis-C (EOA) • Work in collaboration with WellSouth to support General Practice to identify, diagnose and treat patients with Hepatitis-C	Specialist nurse to provide education and advice for General Practice across Southern DHB including rural sites on hepatitis C Q2 Assist General Practice in the identification of patients with potential hepatitis C by identification of patients enrolled in the practice with known risk factors Q2 Provide education and advice for General Practice across Southern DHB, including rural sites, on hepatitis C Q3			

2.1.7 BETTER POPULATION HEALTH OUTCOMES SUPPORTED BY PRIMARY HEALTH CARE

<table>
<tr><td colspan="5">Primary Health Care Integration
Integration and strong local partnerships remain important to the delivery of high-quality health services. The Health and Disability System Review and actions developed from the Wai 2575 Hauora Report are likely to inform further support of integration. In the meantime, DHBs are expected to continue to strengthen integration and their relationship with their primary care partners.
We plan to undertake a number of actions to strengthen integration and improve access to a range of services for patients.</td></tr>
<tr><td>The Southern DHB maintains a strong commitment to the delivery of its Primary and Community Strategy, of which 2020/21 will be its third year of a five year implementation path.
The key priorities for this year, in addition to those already listed elsewhere in the document (achieving equity, planned care, urgent and acute care, First 1,000 days and Vaccination (as part of early years), integration across the Mental health continuum, CLIC long term conditions programme, and Rural Health, including Locality Networks) to be delivered across a team comprising of key Alliance personnel, are as follows:

1. Further roll out of the Health Care Homes (HCH) programme:
In the 2020/21 year we will enter into our third year of the HCH programme. Currently 15 of our practices are enrolled in the programme, with a significant proposal currently being considered by our Alliance Leadership Team (ALT) based on experiences of HCH practices during their COVID-19 response. In essence if supported, the programme will be condensed from a three year to a two year programme, with similar funds available for set up and establishment, but lesser amounts available per enrolled patient.

2. Heath Hubs:
• A key objective of the Primary and Community Strategy is the creation of Integrated care opportunities where traditional secondary care services come together with primary and community services to deliver team based care that is not only closer to home for patients, but also allows for upskilling of generalists to be undertaken by either visiting or permanently located specialists within the team.
• This is also a significant opportunity for domiciliary and community nursing services that currently operate as part of DHB services to be placed within extended primary care hubs to focus on the care and treatment of patients in clusters.
• In the 2020/21 year, it is likely that we will explore opportunities for colocation across three Dunedin sites, focussing on high needs whānau and Mental Health integration in South Dunedin, an acute and urgent care hub focussing on Accident and Medical and Diagnostics in Central Dunedin, and a combined domiciliary nursing integrated care space focussing on frail elderly in the Mosgiel area.</td><td>Agreement by the ALT of the proposed new model Q1
Roll out of next Tranche according to recommendations Q2
Reports to ALT as per HCH collaborative Q2, Q4
Plan for the 2020/21 year signed off by ALT Q1

Endorsement of the model specific to South Dunedin agreed, including signed Heads of Agreement Q1
Reports to ALT and IGC Q1-Q4
Concept designs completed Q3 for second two hubs
Plans for next stage of rollout 2021/22 completed end of Q4</td><td>Number of GP practices delivering the new condensed HCH programme</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td></td><td></td><td></td><td>System outcome
We have health equity for Māori and other groups</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

Pharmacy

Medicines related morbidity and mortality and inappropriate polypharmacy are a significant cost to the health system and contribute to poor health outcomes for New Zealanders
Here we describe significant initiatives

- To implement integrated models of care that ensure older people living in the community have equitable access to the medicines optimisation expertise of pharmacists.
- to implement integrated models of care that ensure people living in aged residential care facilities have equitable access to the medicines optimisation expertise of pharmacists.
- commissioned locally this year, under the Integrated Community Pharmacy Services Agreement (ICPSA), to reduce the difference in local access and outcomes for our population.

We also describe the local strategies we have initiated from 1 April 2020 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.

COVID-19
Southern DHB does not anticipate that COVID-19 will impact on capacity to deliver community pharmacy services.

DHB Activity	**Milestone**	**Measure**	**Government theme:** Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
LTC to CLIC (Client Led Integrated Care) Service 1. Remodel ICPSA LTC service, implementing a pilot testing the new model prior to a district wide roll out. • Link Long Term Condition (LTC) eligibility to WellSouth PHO Client Led Integrated Care programme for LTC patients. • Referral to a preferred community pharmacy will result in a Medicines Use Review (MUR) service plus MDT involvement for the patient. Monthly contact as per the current ICPSA LTC service will continue. • Patient's clinical record of pharmacy consultation information will be included in the patients' health record. • Data will provide information on access, including for Māori LTC patients (EOA). This will be used to inform the final service to be rolled out across the district. Data will be analysed and reported by ethnicity and age. • Evaluate pilot by Q4	Pilot launched Q2 Data analysis of Māori LTC patients access Q4 Pilot evaluation Q4	Implementation of pilot testing the new model of care Number of patients using new ICPSA LTC service Number of Māori patients using new ICPSA LTC service CW05: Immunisation at age 65 years and over	We live longer in good health	Support healthier, safer and more connected communities
2. 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	Reporting Q1-Q4			

Long-Term Conditions including Diabetes

In relation to long term conditions, Southern DHB has plans to:

- improve primary and community care activity to prevent, identify and support management of long-term conditions targeting those with the poorest outcomes
- monitor and use 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

Diabetes specific actions
Southern DHB plans to undertake a number of actions to:

- ensure that all people with diabetes will be effectively managed through diabetes annual reviews, retinal screening, access to specialist advice
- improve modifiable risk factors by targeting those at high-risk
- provide culturally appropriate diabetes self-management education (DSME) and support services and evaluate the effectiveness of the DSME
- identify health promotion and health protection activities to prevent diabetes and other long-term conditions.

DHB Activity	**Milestone**	**Measure**	**Government theme:** Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
Long Term Conditions WellSouth Primary Health Network have recently reviewed the District's Long term Condition Management Programme, Client Led Integrated Care (CLIC). The outcomes of this review will lead to further enhancements being made to the programme that are likely to focus on the establishment of two pathways of access for patients to receive support. For those patients who require more intervention, a complex management pathway will still be in place and for those with less complexity, a more responsive, less intensive pathway for support will be developed. Alongside the review, the following key activity will be undertaken in 2020/21 to improve long term condition management for clients:		SS13: Improved management of Long term conditions Number of patients enrolled into CLIC Number of CLIC patients in LTC pilot referred to Community Pharmacy	We live longer in good health	Support healthier, safer and more connected communities
1. We will support the remaining practices to transition from Care Plus to CLIC • All patients who are enrolled on the CLIC programme will have a CHA (comprehensive health assessment) completed	All patients to have a CHA completed by the end of Q1	Number of CHAs All patients including Māori with current HbA1c 80% Q2 and 90% Q4		
2. A pilot programme for Community Pharmacy service linking to CLIC patients launched will be progressed in the 2020/21 year, with initial cohort of patients identified and MDTs underway	MDTs underway by the end of Q1			
3. We will undertake further work, utilising Health Pathways, in conjunction with the Planned Care Steering Group to design and implement integrated models of care that work between the primary and secondary care teams.	Finalise and Implement the COPD Integrated Care Pathway Q1 Finalise and Implement the Cognitive Impairment Pathway Q2 Finalise the prioritisation of the Integrated Care work programme in conjunction with the Planned Care Steering Group end of Q2	All patients with Diabetes identified as High Risk or Active Disease are referred into secondary care		

Diabetes Baseline: Diabetes Percentage with any available HbA1c at Q2 2019-20: 60.6% for total population, 57.9% for Māori. Actions will be taken below to increase the number of patients including Māori with current HbA1c to 80% Q2 and 90% Q4 (EOA) 1. The Local Diabetes Team will be reformed with new TOR and agreed membership 2. In line with the Southern District Virtual health steering group, Virtual diabetes forums will begin to be delivered to GPs. This will be a key vehicle to provide professional support provided through this platform, enabling the further integration of primary and secondary services. 3. WellSouth Primary Care Network will work to actively design and support a catch-up programme for HbA1c DARs in primary care 4. In addition, WellSouth will design and support a programme to monitor the number of patients with Diabetes identified as High Risk or Active Disease who are referred into secondary care 5. A key part of the focus for the enhancement of the Diabetes pathway in the 2020/21 year will be the Implementation of the Integrated Diabetic Foot Protection Service.	LDT in place by the end of Q1 Number of diabetics referred into secondary care Q1-Q4 Catch up programme designed and rolled out Q1 Regular reporting to the LDT Q1-Q4 Targets met in line with national requirements by the end of Q3 Process in place to actively monitor patients identified as high risk or active Q1 New Health Pathway implemented Q2 MDT service available in Invercargill Q2 Single point of entry (SPOE) established for High Risk and Active Diseased feet Q2			

<table>
<tr><td colspan="5">Air Ambulance Centralised Tasking
We are committed to actively participating with National Ambulance Sector Office (NASO) in the design and planning phases to centralise the tasking of aeromedical assets in New Zealand. It is not proposed that the clinical co-ordination function currently undertaken by DHB staff will change through this process.</td></tr>
<tr><td>DHB Activity

Southern DHB remains committed to the Air Ambulance Services – 10 year modernisation programme to achieve a high functioning and integrated National Air Ambulance service and will participate through the National Ambulance Collaborative to achieve this. The DHB will support the implementation of changed Governance arrangements to include DHBs to effect improved partnership with MOH and ACC in all elements of leadership of the NASO work programme, and supports the development of a robust national process to scope the requirements of a national tasking and coordination service</td><td>Milestone

Status Update Report Q4</td><td>Measure

Status Update Report</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td colspan="3" rowspan="2"></td><td>System outcome
We live longer in good health</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

2.2 Financial Performance Summary

(Refer to the Statement of Performance Expectations for further detail)

2.2.1 Prospective Statement Of Financial Performance

Table 1: Comprehensive Income for 30 June 2021, 2022, 2023 and 2024

DHB Consolidated Statement of Prospective Financial Performance	2018/19 Actual $' 000	2019/20 Forecast $' 000	2020/21 Budget $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000
Revenue						
PBF Funding Package	883,467	945,394	1,027,690	1,065,715	1,105,146	1,146,037
Inter District Revenue	21,374	23,375	23,904	24,788	25,705	26,656
Funder Side Contracts	75,848	81,735	64,120	66,493	68,953	71,504
Provider Misc Revenues	51,351	50,483	50,766	51,388	52,842	54,333
Total Revenues	1,032,040	1,100,987	1,166,480	1,208,384	1,252,647	1,298,530
less Personnel Expenses						
Medical Personnel	(150,414)	(148,613)	(155,692)	(157,706)	(164,148)	(170,748)
Nursing Personnel	(171,077)	(172,192)	(174,254)	(176,508)	(183,719)	(191,106)
Allied Health Personnel	(59,445)	(60,568)	(63,042)	(63,857)	(66,466)	(69,138)
Support Services Personnel	(6,777)	(6,629)	(6,676)	(6,763)	(7,039)	(7,322)
Management/Admin Personnel	(54,298)	(55,179)	(56,894)	(57,630)	(59,985)	(62,396)
Personnel Costs Total	(442,010)	(443,180)	(456,558)	(462,464)	(481,357)	(500,710)
less Non Personnel Expenditure						
Outsourced Services Expenses	(49,437)	(48,797)	(49,122)	(47,114)	(49,139)	(51,224)
Clinical Supplies Expenses	(105,168)	(109,059)	(107,390)	(108,290)	(111,518)	(114,994)
Infrastructure & Non Clinical Supplies Expenses	(85,849)	(83,805)	(90,305)	(103,433)	(107,226)	(110,305)
Total Non-Personnel Expenditure	(240,453)	(241,661)	(246,817)	(258,837)	(267,883)	(276,523)
less Provider Payments						
Personal Health Expenses	(260,431)	(269,951)	(281,648)	(288,327)	(296,450)	(307,544)
Mental Health Expenses	(26,394)	(30,105)	(30,850)	(31,802)	(32,641)	(33,848)
Disability Support Expenses	(150,250)	(154,465)	(159,177)	(164,256)	(170,188)	(176,485)
Public Health Expenses	(640)	(10,331)	(469)	(484)	(499)	(517)
Maori Health Expenses	(1,206)	(1,344)	(1,879)	(1,938)	(2,008)	(2,082)
Total Provider Payments	(438,922)	(466,197)	(474,023)	(486,807)	(501,786)	(520,476)
Total Expenses	(1,121,385)	(1,151,038)	(1,177,398)	(1,208,108)	(1,251,026)	(1,297,709)
Net Surplus / (Deficit)	**(89,345)**	**(50,051)**	**(10,918)**	**276**	**1,621**	**821**
Supplemental Information						
Depreciation Charges	(23,439)	(25,063)	(27,834)	(42,893)	(44,343)	(40,372)
Interest Costs	(20)	(236)	(30)	0	0	0
Capital Charge	(11,017)	(9,651)	(12,605)	(13,598)	(14,645)	(13,426)
Total IDCC Costs	(34,475)	(34,950)	(40,469)	(56,491)	(58,988)	(53,798)
Medical FTE	580	613	656	651	658	665
Nursing FTE	1,764	1,834	1,815	1,802	1,821	1,840
Allied FTE	681	709	735	730	738	746
Support FTE	95	99	104	104	104	105
Management/Admin FTE	703	732	740	734	744	750
Total FTE	3,823	3,987	4,050	4,021	4,065	4,106
Note - 2020/21 has been re-stated to include as FTE the additional hours allowances to SMO's						

2.2.2 Prospective Performance By Output Class

Table 2: Prospective Performance by Output Class for the four years ended 30 June 2021, 2022, 2023 and 2024

Revenue & Expenditure by Output Class	2018/19 Actual $' 000	2019/20 Forecast $' 000	2020/21 Budget $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000
Prevention Services						
Revenue	9,424	20,245	10,877	11,184	11,537	11,908
Expenditure	(9,424)	(20,245)	(10,877)	(11,184)	(11,537)	(11,908)
Net Result	0	0	0	0	0	0
Early Detection and Management Services						
Revenue	208,230	219,747	220,998	228,366	236,429	246,723
Expenditure	(206,504)	(217,866)	(223,672)	(229,384)	(236,416)	(246,734)
Net Result	1,726	1,881	(2,674)	(1,018)	13	(11)
Intensive Assessment and Treatment						
Revenue	656,520	697,970	771,806	798,880	827,230	855,927
Expenditure	(749,595)	(752,087)	(776,943)	(796,403)	(825,636)	(855,082)
Net Result	(93,075)	(54,117)	(5,137)	2,477	1,594	845
Rehabilitation and Support						
Revenue	157,866	163,026	162,799	169,955	177,451	183,972
Expenditure	(155,862)	(160,841)	(165,905)	(171,138)	(177,437)	(183,985)
Net Result	2,004	2,185	(3,107)	(1,183)	14	(13)
Share of Loss in associates	0	0	0	0	0	0
Total Revenue per DHB Consolidated Financials	1,032,040	1,100,987	1,166,480	1,208,384	1,252,647	1,298,530
Total Expenditure per DHB Consolidated Financials	(1,121,385)	(1,151,039)	(1,177,397)	(1,208,108)	(1,251,026)	(1,297,709)
Net Surplus / (Deficit)	**(89,345)**	**(50,051)**	**(10,918)**	**276**	**1,621**	**821**

3.0 SERVICE CONFIGURATION

3.1 SERVICE COVERAGE

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

Responsibility for service coverage is shared between DHBs and the Ministry. DHBs are responsible for taking appropriate action to ensure that service coverage is delivered for their population, including populations that may have high or different needs such as Māori, Pacific and high-needs groups. Southern DHB may, pursuant to Section 25 of the New Zealand Public Health and Disability Act 2000, negotiate and enter into, or amend any current agreement for the provision or procurement of services.
Southern DHB is not seeking any formal exemptions to the Service Coverage Schedule in 2020/21. 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 resources. A redesign has been undertaken and the model of care and facility approach has been supported by the Director-General of Health for delivery.

3.2 SERVICE CHANGE

The table below describes all service reviews and service changes that have been approved or proposed for implementation in 2020/21.

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Health of Older Persons	Tiered approach to management of older people and those with multiple co-morbidities. Patients stratified according to complexity, with service clusters wrapped around communities. Case management for those with most complex needs; enhanced multidisciplinary primary care teams; rapid response to prevent hospital admission; early supported discharge from hospital; specialist community rehabilitation; and population health services New model of care finalised in preparation for RFP for new HBSS services in the 2021/22 year	Person-centred, Level of care proportional to health need, Improved equity of access, Improved service integration, Value for money	Local National
Primary Maternity Services	Implement project to better configure clinically sustainable maternity services for our rural communities	Improved access, Improved service integration	Local
Mental Health	Services Review undertaken Likely impact initially to focus on Day Activity and Vocational Services Mental Health Needs Assessment Service co-ordination	• Person-centred, • Care closer to home, • Improved equity of access, • Value for money, • Improved service integration	Local
Planned Care	Using a variety of ways to improve planned patient care in different services and across the primary/secondary care continuum (e.g. virtual clinics and telemedicine where clinically appropriate; new models of care, for example, in Diabetes)	• Care closer to home • Person-centred • Improved service integration • Enhanced clinician relationships between primary and secondary services	Local

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Generalist model of care for acute medical admissions at the Dunedin Hospital site	Model of Care change- generalist care for acute medical admissions (GAMA) model of care/shared care. The Complex Medical model generalist approach means most medical patients are admitted via a general take with sub-speciality consultation or a post take distribution. This applies particularly to patients with complex comorbidities or frailty.	• Reduction in the hospital beds occupied by internal medicine patients. • Support the Shorter Stays in ED (SSED) target	Local
COVID	There are no service changes as a result of the SDHB response to COVID-19 that will continue into 2020/21 There are no confirmed locally initiated reviews of SDHB's COVID-19 response. SDHB will update the MoH if a review is planned.		
Shifts or additions in workforce /FTE	• From 1 July 2020 the FTE on additional hours allowances paid to SMOs is included in our FTE measurement, with a resulting 28FTE increase. • Nursing - The budget increased to reflect commitment to CCDM/VRM 20 FTE and Patient watches 10 FTE. • Allied Health – includes 2FTE Physio increases for ICU, 7FTE for Child Development Service and 5FTE for Radiology. • Management and Admin – includes 3FTE increases for Human Resources and Information Services.		

4.0 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 optimising the resources available. In this way, 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 deliver high quality services in the face of increasing demands and constrained resources. At the same time, we seek to adapt to the 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 better understanding of our patients' experiences and priorities, this also demands a strong focus on our internal processes. Our future relies on a culture that encourages and 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 is committed to supporting and working in partnership with Public Health South 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.

4.1 Managing Our Business

4.1.1 Governance

In December 2019, Southern DHB governance transitioned from governance by a Commissioner, supported by Deputy Commissioners, to governance by a full Board including elected and appointed members, and two Crown Monitors.

4.1.2 Organisational Performance Management

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

4.1.3 Funding And Financial Management

Southern DHB's key financial performance is reported to the Finance Audit and Risk Committee (FARC) and the Board every month. Further information about Southern DHB's planned financial position for 2020/21 and out years is contained in the Financial Performance Summary section of this document on page 110, and the Statement of Performance Expectations on page 123.

4.1.4 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) 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 Treasury is currently undertaking a review of the efficiency and effectiveness of the ICR to consider what improvements might be needed going forward and then socialise and implement any changes to the ICR. The next ICR round is scheduled to commence in late 2021. Currently we are working with the Ministry of Health test framework to align our process with that of others in the sector. This incorporates the feedback from the Ministry of Health National Asset Management Programme review.

4.1.5 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.

4.1.6 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).

4.1.7 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.

4.2 Building Capability

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

4.2.1 Capital And Infrastructure Development

Interim Works

Work continues on the redevelopment at Dunedin Hospital of the Intensive Care Unit and High Dependency Unit. Phase 1 is completed and in use. However, although Phase 2 construction has been completed the clinical handover and completion is unlikely to be achieved until late 2020 when the historical air handling issues are anticipated to be resolved.

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 was compiled in the Dunedin Hospital Critical Infrastructure Works Single Stage Business Case. This has been approved and the various works have commenced.

Dunedin Hospital Build

The condition of major assets on the Dunedin Hospital campus are beyond remediation and the infrastructure is frail. The current state of Dunedin Hospital is also impeding the roll out of modern models of care required to improve efficiencies and effectiveness of hospital services. The deteriorating physical environment is eroding quality of care, creating safety risks, and causing distress to patients and staff. The poor condition of these major assets has resulted in the decision to design and build a new hospital in central Dunedin.

Southern DHB is working together with the Ministry of Health and Southern Partnership Group on the design and build of the new Dunedin hospital.

The Detailed Business Case (DBC) is being submitted to the Ministry of Health and Treasury in July 2020 for consideration by Cabinet in August 2020. Once the New Dunedin Hospital business case has been approved, Southern DHB will need to accelerate the depreciation on the current facility. The discussions between the Ministry of Health and Southern DHB are progressing on the basis the overall impact will be fiscally neutral. At this stage there has been no accelerated depreciation or offsetting funding from the Ministry of Health included in the 2021 Annual Plan.

Primary Maternity

At present there is only one primary birthing facility in Central Otago, which is a stand-alone unit located in Alexandra. Sustained population growth in Central Otago and Wanaka has resulted in the requirement for a new facility.

The Ministers of Health and Finance (joint Minister) have confirmed the Rural Primary Birthing Unit project is supported subject to a satisfactory business case being approved by the Capital Investment Committee (CIC) and the joint Ministers.

4.2.2 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.

4.2.3 Cooperative Developments

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

1. 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).
2. Alliance South is the Southern health system primary care alliance. The main body of work for the 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).
3. 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.
4. 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).*
5. 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.
6. 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.
7. 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.
8. 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.
9. Southern DHB engages in regular forums with the larger unions such as NZ Nursing Organisation, Association of Salaried Medical Specialists, New Zealand Resident Doctors Association and PSA to provide an opportunity to build relationships and a deeper understanding of the issues or challenges the sector faces in terms of workforce.

4.3 Workforce

The Workforce Strategy describes our vision and strategic goals for what a workforce of the future needs to look like, within the context of the overall Southern health system. An Action Plan to deliver on the vision and goals has been developed. In developing the Action Plan, we have considered:

- Our ageing workforce
- Our diversifying population
- Equity of Health Care for Māori
- The great expanse of area that our workforce is required to cover in this District
- Future models of care
- National policy messages being received from the Centre
- The needs and resources of our neighbouring DHBs
- The opportunities that present to our system when practitioners work to the top of their scope
- Our ability to influence new ways of working, within localities
- The role of volunteers, family, whānau and communities

Six workforce strategic goals (WSG's) have been identified for delivering on the Strategy:

- Interprofessional/integrated agency care
- People planning
- Making changes stick/accountability
- Leadership and change
- Highly valued staff
- People Partnership

These WSG areas form the basis of the Action Plan. The action areas will be progressed concurrently, with sequencing of activities and milestones. A roadmap for each of the action areas for the initial phases of executing the Strategy has been developed to guide early progress on achieving the vision for the Southern Workforce. Refer to Section 2: Government Planning Priorities (Workforce).

Southern DHB, in commitment to the house surgeon training program will:

- Provide ongoing development and delivery of high quality prevocational medical training and education.
- Provide sufficient Medical Council accredited community based attachments so that each intern can complete one in their two years working in Southern DHB.

4.3.1 Collective Agreements and Bargaining Strategies

Southern DHB is committed to constructive engagements with its union partners ensuring that our workforces are encouraged to grow and develop to the top of their scope to achieve better health outcomes and enhanced service deliveries. Bargaining strategies are aligned with Government expectations and managed in a fiscally responsible manner. Work continues in support of commitments made in the respective Accords for Nursing and Midwifery for safer staffing and to achieve CCDM deliverables.

Southern DHB's ability to attract the necessary skills and talent remains a challenge, not only for Senior Medical Officers and Allied Health but also in relation to Individual Employment Agreements where the current strategy is to pay at 96% of the Health Sector median. Whilst COVID-19 and the subsequent economic impact of potential job losses in the broader sector may have stemmed the anticipated turnover rate, it is important that we continue to review our remuneration strategy for IEAs to ensure we are able to attract the right skills and talent – the right person, at the right time and at the right cost.

4.3.2 Workforce – Leadership Development

Southern DHB is reviewing its internal capacity to deliver on the learning and development required to support leadership development as well as considering approaches to supporting training for Allied Health Staff. At present some constrains exist in being able to expand the very limited offering provided internally for leadership and management programmes due to internal capacity and limited resources. The prioritisation of establishing a leadership development framework as part of Southern DHB's Annual workforce plan is essential as is evidenced in the six workforce strategic goals.

4.4 Information Technology

The Southern Health Digital Strategy describes our vision and goals for transforming our digital capabilities, within the context of the overall Southern Health System.

The ultimate goal is to transform healthcare delivery across the Southern Health System by providing modern sustainable solutions built on resilient environments that can share insights with our community.

This Southern Health Digital Strategy and Action Plan (the 'Digital Plan') describes the strategic drivers, objectives, and actions that support our digital transformation.

The strategy recognises that in a changing health environment, long-term planning for the digital health system needs to outlive any changes in organisational structure, service delivery or delivery location. The action plan prioritises activities and identifies resources required, reflecting the need to take clear steps forward while managing current funding limitations and changes in care delivery models.

The Strategy includes 3 goals

1. Digital Environment
2. Digital Solutions
3. Digital Insights

Refer section 2.1.6, Data and Digital.

5.0 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 2020/21.

Performance Measure	Performance Expectation / Target		
CW01: Children caries-free at five years of age	Children caries-free at 5 years of age	2020	71%
		2021	71%
CW02: Oral Health - Mean DMFT score at Year 8	DMFT score at Year 8	2020	<0.68
		2021	<0.68
CW03: Improving the number of children enrolled and accessing the Community Oral Health Service	Percentage of 0-4 years enrolled	2020	≥95%
		2021	≥95%
	Percentage of children (0-12 years) not examined based on planned recall	2020	≤10%
		2021	≤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	2020	≥85%
		2021	≥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 The DHB has reached the "Total population" target for children enrolled with a general practice by 6 weeks of age (55%) and by 3 months of age (85%) and has delivered all the actions and milestones identified for the period in its annual plan and	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%

Performance Measure	Performance Expectation / Target			
has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group, for both targets.				
CW08: Increased immunisation (2 year olds)	95% of two years olds have completed all age appropriate immunisations due between birth and age 2 years, with no equity gap between Māori and non-Māori populations	Total Māori Pacific		≥95%
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%
CW12: Youth mental health initiatives	Initiative 1: Report on implementation of school based health services (SBHS) in decile one to five 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 TBC			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 Māori Other	3.75%

Performance Measure	Performance Expectation / Target			
		20-64 years	Total Māori Other	3.75%
		65+ years	Total Māori Other	1.0%
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 seen within 3 weeks and within 8 weeks		3 weeks 8 weeks	80% 95%
	Addictions (Provider Arm and NGO) - Percentage of young people seen within 3 weeks and within 8 weeks		3 weeks 8 weeks	80% 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			
MH07: Improving the health status of people with severe mental illness through	TBC			

Performance Measure	Performance Expectation / Target		
improved acute inpatient post discharge community care			
PV01: Improving breast screening coverage and rescreening	Percentage coverage for all ethnic groups and overall		70%
PV02: Improving cervical screening coverage	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 *to be revised*	Total	2865/100,000
SS07: Planned Care Measures			
Planned Care Measure 1: Planned Care Interventions	Total planned care interventions 2020/21 TBC		TBC
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%
	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 ents 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 The proportion of patients who were acutely re-admitted post discharge improves from base levels.	Yearend target for the acute readmission rate (standardised readmission rate) *To be revised - Base level*		≤11.7%
Planned Care Measure 7: Did Not Attend Rates (DNA) for First Specialist Assessment (FSA) by Ethnicity (Developmental)	Note: There will not be a Target Rate identified for this measure. It will be developmental for establishing baseline rates in the 2020/21 year.		
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			

Performance Measure	Performance Expectation / Target	
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%
	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 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*	

Performance Measure	Performance Expectation / Target	
	Count of enrolled people aged 15-74 in the PHO who have completed a DAR in the previous 12 months	
	Ascertainment: target 95-105% and no inequity	95-105% and no inequity
	HbA1c<64mmols: target 60% and no inequity	60% and no inequity
	No HbA1c result: target 7-8% and no inequity	7-8% and no inequity
Focus Area 3: Cardiovascular health	Provide reports as specified	
Focus Area 4: Acute heart service	Indicator 1: Door to cath Door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram	>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% of ACS patients who undergo coronary angiogram should be prescribed, at discharge - - Aspirin*, a 2nd anti-platelet agent*, and an statin (3 classes)	≥85%

Performance Measure	Performance Expectation / Target	
	- ACEI/ARB if any of the following – LVEF, 50%, DM, HT, in-hospital HF (Killip Class II to IV) (4 classes), -Beta-blocker if LVEF<40% (5-classes). * An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.	
	Indicator 5: Device registry completion Percentage of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement who have completion of ANZACS-QI Device PPM forms within 2 months of the procedure	≥99%
	Indicator 6: Device registry completion- ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device PPM (Indicator 5A) and ICD (Indicator 5B) forms within 2 months of the procedure.	≥ 99%
Focus Area 5: Stroke services	Indicator 1: ASU Percentage of stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital	80%
	Indicator 2: Reperfusion Thrombolysis /Stroke Clot Retrieval 12% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile, (Service provision 24/7)	12%
	Indicator 3: In-patient rehabilitation Percentage of patients admitted with acute stroke who are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission	80%
	Indicator 4: Community rehabilitation 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%
	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%
SS17: Delivery of Whānau ora	Appropriate progress identified in all areas of the measure deliverable	
SS18: Financial outyear planning & savings plan	Provide reports as specified	
SS19: Workforce outyear planning	Provide reports as specified	
PH01: Delivery of actions to improve SLMs	Provide reports as specified	
PH02: Improving the quality of ethnicity data collection in PHO and NHI registers	All PHOs in the region have implemented, trained staff and audited the quality of ethnicity data using EDAT within the past three-year period and the current results from Stage 3 EDAT show a level of match in ethnicity data of greater than 90 percent.	>90%
PH03: Access to Care (PHO Enrolments)	DHB has an enrolled Māori population of 95% or above	≥95%

Performance Measure	Performance Expectation / Target	
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	

6.0 APPENDICES

6.1 Statement Of Performance Expectations

This Statement of Performance Expectations sets out the four Output Classes that Southern DHB will deliver in the 2020/21 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: Chair Mr Dave Cull

Population: Approximately 344,900 people live within Southern DHB boundaries.

Staff: Southern DHB employs over 4,500 people.

Southern DHB's Statement of Intent (SOI)[8] 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[9].

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

[9]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 2029/21, the Southern DHB plans to spend approximately $1,177 million in delivering the following four Outputs funded through Vote Health:

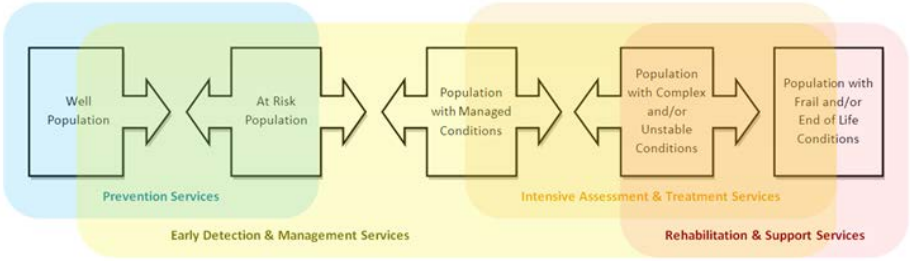
Output 1: Prevention Services;

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 overleaf presents a summary of the budgeted financial expectations for 2020/21, by output class.

Table 3: Revenue and expenditure by Output Class 2020/21

REVENUE	Total $'000
Prevention	10,877
Early Detection and Management	220,998
Intensive Assessment & Treatment	771,806
Rehabilitation & Support	162,799
Total Revenue	**1,166,480**

EXPENDITURE	Total $'000
Prevention	10,877
Early Detection and Management	223,672
Intensive Assessment & Treatment	776,943
Rehabilitation & Support	165,905
Total Expenditure	**1,177,397**
Net Surplus / (Deficit) – $' 000	**(10,918)**

Table 4: Revenue and expenditure by Output Class 2018/19 – 2023/24

Revenue & Expenditure by Output Class	2018/19 Actual $' 000	2019/20 Forecast $' 000	2020/21 Budget $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000
Prevention Services						
Revenue	9,424	20,245	10,877	11,184	11,537	11,908
Expenditure	(9,424)	(20,245)	(10,877)	(11,184)	(11,537)	(11,908)
Net Result	0	0	0	0	0	0
Early Detection and Management Services						
Revenue	208,230	219,747	220,998	228,366	236,429	246,723
Expenditure	(206,504)	(217,866)	(223,672)	(229,384)	(236,416)	(246,734)
Net Result	1,726	1,881	(2,674)	(1,018)	13	(11)
Intensive Assessment and Treatment						
Revenue	656,520	697,970	771,806	798,880	827,230	855,927
Expenditure	(749,595)	(752,087)	(776,943)	(796,403)	(825,636)	(855,082)
Net Result	(93,075)	(54,117)	(5,137)	2,477	1,594	845
Rehabilitation and Support						
Revenue	157,866	163,026	162,799	169,955	177,451	183,972
Expenditure	(155,862)	(160,841)	(165,905)	(171,138)	(177,437)	(183,985)
Net Result	2,004	2,185	(3,107)	(1,183)	14	(13)
Share of Loss in associates	0	0	0	0	0	0
Total Revenue per DHB Consolidated Financials	1,032,040	1,100,987	1,166,480	1,208,384	1,252,647	1,298,530
Total Expenditure per DHB Consolidated Financials	(1,121,385)	(1,151,039)	(1,177,397)	(1,208,108)	(1,251,026)	(1,297,709)
Net Surplus / (Deficit)	**(89,345)**	**(50,051)**	**(10,918)**	**276**	**1,621**	**821**

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.

✞ System Level Measure.

6.1.1 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 2018/19	Target 2019/20	Target 2020/21
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	92%	>95%	>95%
			Māori	85%		
	Percentage of children fully immunised at age 2 years	C	Total	94%	>95%	>95%
			Māori	95%		
	Percentage of eligible boys and girls fully immunised with HPV vaccine	C	Total	55%	>75%	>75%
			Māori	49%		
	Percentage of people (≥ 65 years) having received a flu vaccination	C	Total	56%	>75%	>75%
			Māori	45%		
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	88%	>90%	>90%
			Māori	87%		
	Infants exclusively or fully breastfeeding at 3 months	Q Δ	Total	63%	>60%	>60%
			Māori	49%		
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	91%		
	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	92%	>95%	>95%
	Percentage of eligible women (50-69 years) having a breast cancer screen in the last 2 years	C	Total	75%	>70%	>70%
			Māori	69%		
	Percentage of eligible women (25-69 years) having a cervical cancer screen in the last 3 years	C	Total	75%	80%	>80%
			Māori	69%		

6.1.2 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 2018/19	Target 2019/20	Target 2020/21
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	93%	>95 %	>95%
			Māori	71%		
	Percentage of children caries-free at five years of age	Q ❖	Total	70%	>70 %	>70%
			Māori	55%		
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[10] rates for children (0-4 years)	Q ✞	Total	5,869	<5,370	<5,570
			Māori	7,611	<5,370	<5,570
	Number of people receiving a brief intervention from the primary mental health service	V	Total	6,606	>6,000	>7,000
	Percentage of the eligible population who have had a CVD Risk Assessment[11] in the last 5 years	C	Total	81%	>90%	>90%
			Māori	80%		
	Percentage of the population identified with diabetes having good or acceptable glycaemic control[12]	C	Total	45%	60%	>60%
			Māori	38%		
Community Referred Testing & Diagnostics These are services which a health professional may use to help diagnose a health condition, or as part of treatment. While services are largely demand driven; faster & more direct access aids clinical decision-making, improves referral processes & reduces the wait for treatment.	Percentage of accepted referrals for Computed Tomography (CT) scans receiving procedure within 42 days	T	Total	74%	>85%	>85%
	Percentage of accepted referrals for Magnetic Resonance Imaging (MRI) scans receiving procedure within 42 days	T	Total	47%	>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	79%	>90%	>90%

[10] 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.

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

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

6.1.3 Intensive Assessment And Treatment

Intensive assessment and treatment services are 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 2018/19	Target 2019/20	Target 2020/21
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	4.40%	>3.75%	>3.75%
			Māori	4.90%		
	Percentage of adults (20-64 years) accessing specialist mental health services	C Δ	Total	3.70%	>3.75%	>3.75%
			Māori	7.50%	>5.22%	>5.22%
	Percentage of people who have a transition (discharge) plan	Q	Total	29%	>95%	>70%
	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	58%	>80%	>80%
			< 8 weeks	81%	>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	85%	>95%	>95%
	Number of people presenting at ED	V	Total	82,467	< 88,000	< 85,000

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 2018/19	Target 2019/20	Target 2020/21
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[15]	V E	Total	3,119	3,400	3,400
			Māori	481	560	560
	Percentage of pregnant women registered with a Lead Maternity Carer in the first trimester	Q	Total	78.9%	>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	25.4	<21.8	<21.8
			≥65 years	21.2	<18.5	<18.5
	Patients have improved physical functionality on discharge	Q ❖	<65 years	24.3	>26.1	>26.1
			≥65 years	19.7	>18.3	>19.7

[13] 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.

[14] While the level of Planned Care inpatient discharges has reduced compared to the 19/20 target, the increase in planned Minor Procedures results in a total increase in Planned Care discharges overall.

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

6.1.4 Rehabilitation & Support

Rehabilitation and support services 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.

How we will measure performance of our Rehabilitation and Support services

Output Class: Rehabilitation and Support					
Sub Output Class	Measure	Notes	Actual 2018/19	Target 2019/20	Target 2020/21
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[16] assessment within 6 months admission	Q Δ	93%	>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	4,565	4,400	4,800
	Percentage of HCSS support workers who have completed at least Level 2 in the National Certificate in Community Support Services (or equivalent)	Q Δ	82%	>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	2,108	1,050	2,000
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	6.11	<6.8	<6.11

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

6.2 Financial Performance

6.2.1 Forecast Financial Statements

The projected DHB deficit for 2020/21 is $10.9 million. This reflects the ongoing work implementing changes to operating models in the current year and the three out-years.

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 the Primary & Community Strategy continues as the catalyst for the fundamental shift in service delivery across the Southern district.

Table 5: DHB Consolidated Prospective Net Results

DHB Consolidated Prospective Net Results	2018/19 Actual $' 000	2019/20 Forecast $' 000	2020/21 Budget $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000
Governance	(374)	(220)	(4)	(1)	0	0
Funds	5,355	5,649	(7,717)	(2,939)	36	(33)
Provider	(94,326)	(55,480)	(3,197)	3,216	1,585	854
Net Surplus / (Deficit)	**(89,345)**	**(50,051)**	**(10,918)**	**276**	**1,621**	**821**

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 2020/21 continues to reflect the investments on the pathway to a sustainable future across all areas of healthcare delivery.

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.
- Continuing the focus on management of expenditure through regional alignment, national procurement and shared services activity.
- Effective capital expenditure to enhance service delivery and continue on the pathway to robust Asset Management Plan.
- Managing the working capital and cash position to minimise the cost of capital.
- Accelerated depreciation for Dunedin Hospital is not recognised until the Detailed Business Case is approved.
- There is no further deterioration in the financial performance from the Holidays Act 2003. The liability recognised at 30 June 2020 in the statement of financial position is sufficient to settle the obligations.

Significant Assumptions

The DHBs key assumptions relating to the 2020/21 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	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Southern	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	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Southern	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) are included.
- 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 2020/21 year and this will require additional funding to support the cashflow.

6.2.2 Capital Expenditure and Capital Funding

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

Table 8: Planned Capital Expenditure

Planned Capital Expenditure	2018/19 Actual $' 000	2019/20 Forecast $' 000	2020/21 Budget $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000
Clinical Capital	13,024	13,495	16,651	7,865	9,808	8,867
Building Capital	8,629	4,401	16,366	10,052	9,918	10,926
Strategic Capital	6,698	7,905	22,822	17,041	5,487	2,400
Information Systems Capital	4,279	7,106	12,806	11,868	9,527	8,336
Total capital expenditure budget	**32,630**	**32,907**	**68,645**	**46,826**	**34,740**	**30,529**

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 2020/21 year. There are ongoing deferred maintenance projects required to sustain the operational capability of Dunedin Hospital from 2020/21 through to the new Dunedin Hospital.

Baseline Clinical Capital

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, is obtained from the Ministry of Health to maintain working capital. We prepare 24-month cashflows and monitor working capital to ensure deficit support requests are submitted on a timely basis. The Ministry of Health deficit support contribution in April 2020 is expected to cover operational working capital.

Table 9: Planned Capital Financing

Planned Capital Financing	2018/19 Actual $' 000	2019/20 Forecast $' 000	2020/21 Budget $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000
Deficit Support	56,900	80,000	0	0	0	0
Equity for Capital Projects	12,973	4,746	8,650	9,951	6,300	0
Equity repaid	(707)	(707)	(707)	(707)	(707)	(707)
Cash Balance	(9,888)	31,011	(16,253)	(4,001)	16,190	29,324

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	603	603	Qrtly instalment	0.00%
Finance Leases	1,450	1,450	Mthly & Qrtly instalment	0.00%
	2,053	2,053		

Asset Valuations and Disposals

Land and buildings are revalued to fair value as determined by an independent registered valuer. The last revaluation was undertaken as at 30 June 2018. The revaluation is undertaken with sufficient regularity to ensure the carrying amount is not materially different to fair value. At each year-end a fair value assessment is undertaken to confirm the carrying amount is not materially different to fair value.

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 Minister of Health. 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. The Ministry of Health has commenced work with the concept design being developed, land purchased and demolition on-site in progress.

6.2.3 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	2018/19 Actual $' 000	2019/20 Forecast $' 000	2020/21 Budget $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000
Revenue						
PBF Funding Package	883,467	945,394	1,027,690	1,065,715	1,105,146	1,146,037
Inter District Revenue	21,374	23,375	23,904	24,788	25,705	26,656
Funder Side Contracts	75,848	81,735	64,120	66,493	68,953	71,504
Provider Misc Revenues	51,351	50,483	50,766	51,388	52,842	54,333
Total Revenues	1,032,040	1,100,987	1,166,480	1,208,384	1,252,647	1,298,530
less Personnel Expenses						
Medical Personnel	(150,414)	(148,613)	(155,692)	(157,706)	(164,148)	(170,748)
Nursing Personnel	(171,077)	(172,192)	(174,254)	(176,508)	(183,719)	(191,106)
Allied Health Personnel	(59,445)	(60,568)	(63,042)	(63,857)	(66,466)	(69,138)
Support Services Personnel	(6,777)	(6,629)	(6,676)	(6,763)	(7,039)	(7,322)
Management/Admin Personnel	(54,298)	(55,179)	(56,894)	(57,630)	(59,985)	(62,396)
Personnel Costs Total	(442,010)	(443,180)	(456,558)	(462,464)	(481,357)	(500,710)
less Non Personnel Expenditure						
Outsourced Services Expenses	(49,437)	(48,797)	(49,122)	(47,114)	(49,139)	(51,224)
Clinical Supplies Expenses	(105,168)	(109,059)	(107,390)	(108,290)	(111,518)	(114,994)
Infrastructure & Non Clinical Supplies Expenses	(85,849)	(83,805)	(90,305)	(103,433)	(107,226)	(110,305)
Total Non-Personnel Expenditure	(240,453)	(241,661)	(246,817)	(258,837)	(267,883)	(276,523)
less Provider Payments						
Personal Health Expenses	(260,431)	(269,951)	(281,648)	(288,327)	(296,450)	(307,544)
Mental Health Expenses	(26,394)	(30,105)	(30,850)	(31,802)	(32,641)	(33,848)
Disability Support Expenses	(150,250)	(154,465)	(159,177)	(164,256)	(170,188)	(176,485)
Public Health Expenses	(640)	(10,331)	(469)	(484)	(499)	(517)
Maori Health Expenses	(1,206)	(1,344)	(1,879)	(1,938)	(2,008)	(2,082)
Total Provider Payments	(438,922)	(466,197)	(474,023)	(486,807)	(501,786)	(520,476)
Total Expenses	(1,121,385)	(1,151,038)	(1,177,398)	(1,208,108)	(1,251,026)	(1,297,709)
Net Surplus / (Deficit)	**(89,345)**	**(50,051)**	**(10,918)**	**276**	**1,621**	**821**
Supplemental Information						
Depreciation Charges	(23,439)	(25,063)	(27,834)	(42,893)	(44,343)	(40,372)
Interest Costs	(20)	(236)	(30)	0	0	0
Capital Charge	(11,017)	(9,651)	(12,605)	(13,598)	(14,645)	(13,426)
Total IDCC Costs	(34,475)	(34,950)	(40,469)	(56,491)	(58,988)	(53,798)
Medical FTE	580	613	656	651	658	665
Nursing FTE	1,764	1,834	1,815	1,802	1,821	1,840
Allied FTE	681	709	735	730	738	746
Support FTE	95	99	104	104	104	105
Management/Admin FTE	703	732	740	734	744	750
Total FTE	3,823	3,987	4,050	4,021	4,065	4,106
Note - 2020/21 has been re-stated to include as FTE the additional hours allowances to SMO's						

Table 12: DHB Consolidated Prospective Balance Sheet

DHB Consolidated Prospective Balance Sheet	2018/19 Actual $' 000	2019/20 Forecast $' 000	2020/21 Budget $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000
Current Assets:						
Cash & Bank Accounts	7	31,079	7	7	16,190	29,324
Prepayments	2,479	3,635	2,868	2,923	2,979	3,035
Inventory	5,762	6,095	5,235	5,334	5,435	5,539
Accounts Receivable	44,874	47,377	45,962	46,835	47,725	48,633
Total Current Assets	53,122	88,186	54,072	55,099	72,329	86,531
Current Liabilities:						
Bank overdraft and current debt	(10,817)	(1,029)	(17,214)	(4,099)	(91)	(91)
Creditors provisions and payables	(176,519)	(194,318)	(150,028)	(158,679)	(163,206)	(167,571)
Total Current Liabilities	(187,336)	(195,347)	(167,242)	(162,778)	(163,297)	(167,662)
Net Working Capital	(134,214)	(107,161)	(113,170)	(107,679)	(90,968)	(81,131)
Non Current Assets:						
Land , Buildings, Plant and Equipment	327,555	334,459	375,271	379,203	369,599	359,755
Long Term Investments	0	0	0	0	0	0
Total Non Current Assets	327,555	334,459	375,271	379,203	369,599	359,755
Non Current Liabilities:						
Long Term Debt	(1,568)	(1,091)	(1,018)	(922)	(814)	(694)
Other Liabilities	(19,362)	(19,810)	(19,810)	(19,810)	(19,810)	(19,810)
Net Equity	**172,411**	**206,397**	**241,273**	**250,793**	**258,007**	**258,120**

Table 13: DHB Consolidated Statement of Prospective Changes in Equity

DHB Consolidated Statement of Prospective Changes in Equity	2018/19 Actual $' 000	2019/20 Forecast $' 000	2020/21 Budget $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000
Total Equity at beginning of period	192,589	172,410	206,398	241,273	250,793	258,007
Net Result for the period - Governance	(374)	(220)	(4)	(1)	0	0
Net Result for the period - Funds	5,355	5,649	(7,717)	(2,939)	36	(33)
Net Result for the period - Provider	(94,326)	(55,480)	(3,197)	3,216	1,585	854
Revaluation of Fixed Assets	0	0	0	0	0	0
Other movement	0	0	37,850	0	0	0
Equity Repaid (Revaluation funding)	(707)	(707)	(707)	(707)	(707)	(708)
Equity Injections for Capital	12,973	4,746	8,650	9,951	6,300	0
Equity Injections for Deficit	56,900	80,000	0	0	0	0
Total Equity at end of Period	**172,410**	**206,398**	**241,273**	**250,793**	**258,007**	**258,120**

Table 14: DHB Consolidated Statement of Prospective Cash Flows

DHB Consolidated Statement of Prospective Cash Flows	2018/19 Actual $' 000	2019/20 Forecast $' 000	2020/21 Budget $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000
Operating Cashflows						
Cash inflows from operating activities	1,029,740	1,097,414	1,167,279	1,207,336	1,251,550	1,297,411
Cash outflows from operating activities	(1,044,070)	(1,108,065)	(1,188,024)	(1,158,286)	(1,205,110)	(1,252,893)
Net cash inflows(outflows) from operating activities	(14,330)	(10,651)	(20,745)	49,050	46,440	44,518
Investing Cashflows						
Cash inflows from investing activities	182	312	232	228	232	237
Cash outflows from investing activities	(33,288)	(32,033)	(72,294)	(45,171)	(31,826)	(30,649)
Net cash flows from investing activities	(33,106)	(31,721)	(72,062)	(44,943)	(31,594)	(30,412)
Financing Cashflows						
Cash inflows from financing activities	69,878	84,744	46,500	9,950	6,300	0
Cash outflows from financing activities	(1,953)	(1,473)	(957)	(1,805)	(955)	(972)
Net cashflows from financing activities	67,925	83,271	45,543	8,145	5,345	(972)
Net increase/(decrease) in cash held	20,489	40,899	(47,264)	12,252	20,191	13,134
Add opening balance	(30,377)	(9,888)	31,011	(16,253)	(4,001)	16,190
Closing cash balance	**(9,888)**	**31,011**	**(16,253)**	**(4,001)**	**16,190**	**29,324**

6.3 Statement of Accounting Policies

6.3.1 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 its 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.

6.3.2 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 2020/21 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 Entities 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.

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
- Employee entitlements

6.3.3 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 services that are not supplied on a 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	2 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). The initial investment of $5.1m was impaired as at 30 June 2019. During the year to 30 June 2020, Southern DHB capitalised payments in respect of FPIM totalling $1.3m on the revised plan for implementation of FPIM which is scheduled to go live in February 2021.

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 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 Board 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 Board 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, interest 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.

System Level Measures Improvement Plan

2020/21

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. Alliances, which are comprised of DHB's and their Primary Health partners are expected to lead the development and implementation of System Level Measures plans.

Southern DHB is committed to honouring the relationship between Māori and the crown under Te Tiriti o Waitangi and will engage and co-design programmes and initiatives with whānau, hapu and iwi and Māori communities. Southern DHB is moving to better respond to ōritetanga (Māori equity) with a greater focus on understanding the health needs of Māori communities. Improvements in Māori health outcomes will come from better community and primary care services, provided in a way that is appropriately designed and more accessible for Māori communities. Southern DHB Māori health priorities have been identified for 2020/21 and include the following:

- Mental Health and Addictions
- Cancer
- Long Term Conditions (Respiratory Child & Youth; Diabetes; Cardiovascular Disease – cardiac and stroke)
- Access to diagnostic testing
- Oral Health (reduction of caries)
- Navigators across the continuum of care

In order to achieve ōritetanga and improved health outcome for other populations, Alliance South has developed the System Level Measures Improvement Plan, which includes a range of meaningful local clinically led quality improvement initiatives, which are underpinned by Contributory measures. Successful delivery of the plan requires DHB's, PHOs and other key agencies to work together to identify initiatives that 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 2020-21 therefore sets out agreed milestones for each of the following SLMs:

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

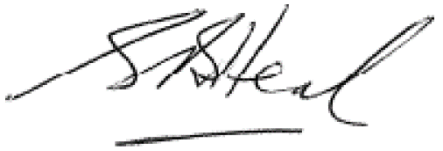
The areas within the 2019-20 SLM plan where we have achieved our milestones and are progressing well will be continued through into 2020-21, however they will not be the focus of the 2020-21 year.

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

Signatories:

Chris Fleming
CEO Southern DHB

Andrew Swanson-Dobbs
CEO WellSouth PHN



Stuart Heal
Chair of Alliance South

System Level Measures – Review

The 2019-20 year has seen a number of achievements for the SLM programme. The SDHB has built on previous years with an increase in capability to deliver the SLM actions within key Domains. In particular, a new group focused on the Youth Mental Health domain of Self Harm Presentation to ED has been formed and are working through a system level review of this measure. This work will continue into 2020-21. Along with building capability, a number of the SLM milestones have been met or have demonstrated improvement towards their milestone. There are also a number of measures that have not been achieved, most evident in our inability to improve Māori health outcomes.

This 2020-21 SLM plan has two main areas of strategic focus;

1. Ōritetanga, and a reset of the health system to address health inequities for whānau, hapu, iwi and Māori communities.
2. Continuing with the existing actions through into 2020-21 where the SLM measures are tracking well. This will allow time to embed the work that was started in the previous year where it can be demonstrated the contributory measure is trending towards continued improvement.

Achievements:	Challenges:
A number of measures were either achieved in the last year, or we made improvement towards their milestone for the 2019-20 year. These include: ASH 0-4 • All conditions: improved towards the milestone • Total upper Asthma & ENT: achieved the milestone • Dental conditions total: achieved the milestone Acute Hospital Bed Days • Trending towards the 2024 target of fewer than 373 per 1,000 population Patient Experience of Care • Did a Staff member tell you about medication side effects: achieved the milestone Youth Self Harm • Female and Age stratified measures: achieved the milestone. Babies living in smoke free homes • achieved the milestone	Conversely, a number of measures did not meet the expected milestone and demonstrate that there remains a significant equity gap in our system. These include: ASH 0-4 • Māori Asthma and upper ENT: equity gap improved through the period however ōritetanga persist • Māori Dental conditions: equity gap worsened through the period ASH 45-64 • Māori all outcomes: equity gap worsened through the period Amenable Mortality • Māori having a cervical smear in the past 3 years: not achieved Youth Self Harm • Māori milestone: not achieved

System Level Measures – Overview

System Level Measures:	1 Ambulatory Sensitive Hospitalisations	2 Acute Hospital Bed Days per Capita	3 Patient Experience of Care *Domain- Communication*	4 Amenable Mortality	5 Youth System Level Measure *Domain-Mental Health & Wellbeing*	6 Proportion of babies who live in a smoke-free household at six weeks
Contributory Measures: (ongoing)	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
Contributory Measures: (Equity Focus for 2020-21)	ASH 0-4 Asthma & Upper ENT. Māori	ASH 45-64 All conditions. Māori		4.1 Primary Health Organisation (PHO) enrolled Māori women aged 25 to 69 years who have received a cervical smear in the past 3 years	5.1 Hospitalisations due to self-harm Māori	
	ASH 0-4 Dental. Māori					

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 rates for Māori 0-4 year olds in Southern DHB has improved over the past 24 months, however there is still evidence of ongoing ōritetanga. 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 ōritetanga that is apparent in our base line data, our Kaupapa Māori Health Services within primary, community and secondary care will have a targeted approach to improve this measure, starting with a focus on the highest rate; Upper and ENT respiratory infection and Asthma.

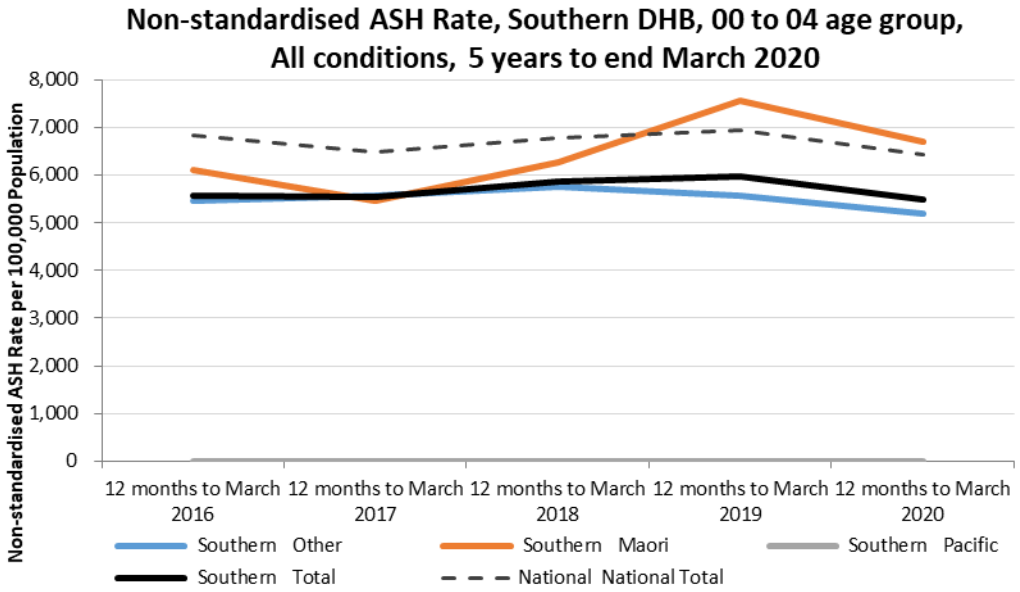
Measure description:

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

Baseline Data

Five year trend ASH 0-4 to March 2020

Hospital admissions for children aged up to four years- all conditions		12 months to March 2016	12 months to March 2017	12 months to March 2018	12 months to March 2019	12 months to March 2020
	Maori	6,108	5,460	6,257	7,569	6,685
	Total	5,580	5,536	5,866	5,965	5,496



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 2020/21: Māori rate <6,350 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.

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

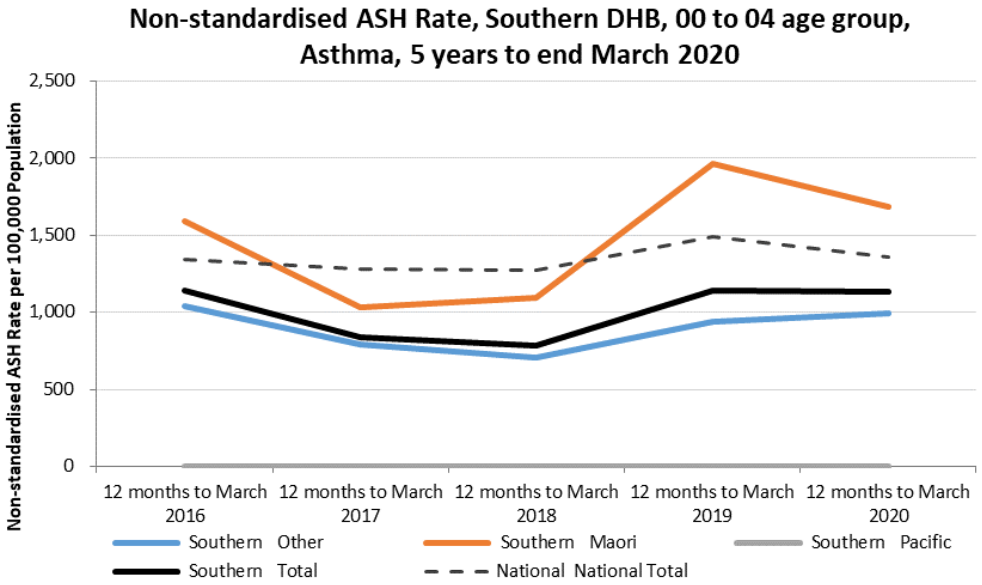
Measure description: Non-standardised rate per 100,000 as per non-financial quarterly measure – system integration 1

2020/21 Improvement Milestone: Māori children <1,600 (asthma)

2020/21 Improvement Milestone: Maori children <1,497(Upper and ENT)

Baseline Data:

Hospital admissions for children aged up to four years with a primary diagnosis of Asthma		12 months to March 2016	12 months to March 2017	12 months to March 2018	12 months to March 2019	12 months to March 2020
	Maori	1,591	1,031	1,093	1,961	1,685
	Total	1,143	840	781	1,140	1,133

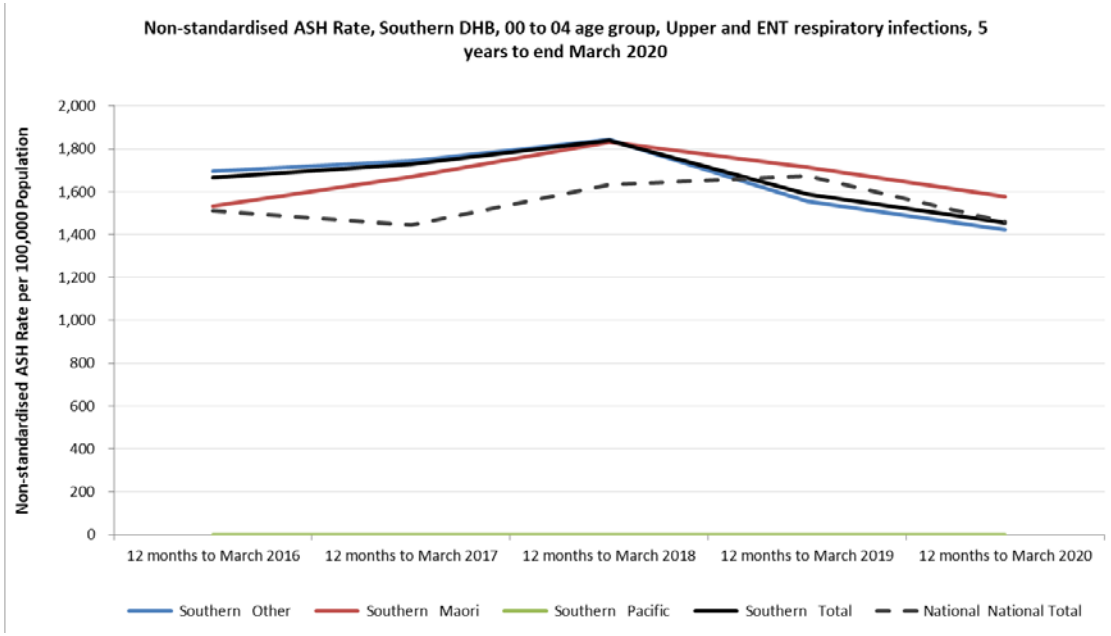


Activities that will enable us to achieve the Improvement Milestone

- The Māori Health Directorate will undertake an audit and provide quarterly monitoring reports to the Southern DHB Māori Health Directorate for ASH 0-4 admissions to paediatrics, improving our understanding of the health needs of these children and their whānau. The results of this audit will demonstrate the volumes and needs of Māori ASH presentations through the year. This will in turn support the planning for the implementation of the Southern Harti Hauora Assessment programme. This is a key enabler that will support the Southern Harti Hauora Assessment programme and ensure that referrals to key stakeholders in the programme are appropriate.

- Improved system linkages and service delivery of health services, with an emphasis on Kaupapa Māori health services across the health system. This better informs whānau of choices in care to ensure that the care and support that is needed. Referral to key stakeholders in the Southern Harti Hauora Assessment programme will ensure those identified needs are met. The outcome being a reduction of re-admissions for these children and their whānau. (EOA). This will be actioned through the Southern Harti Hauora Assessment programme and establishment of Māori health Navigators. Monitoring will be through the volumes of Māori that are referred to a service as a result of navigator access.

Hospital admissions for children aged up to four years with a primary diagnosis of Upper and ENT respiratory infection		12 months to March 2016	12 months to March 2017	12 months to March 2018	12 months to March 2019	12 months to March 2020
	Maori	1,534	1,671	1,831	1,713	1,576
	Total	1,666	1,728	1,841	1,587	1,454



- Complete relevant Health Pathways that identify linkages to relevant services. Measure utilisation and provide educate to increase use.

- Implementation of the Southern Harti Hauora Assessment programme for Maori ASH 0-4 that supports whanau self-management, referrals and engagement of health and wellbeing services e.g. kaupapa Māori health provider enrolment, general practice enrolments, enrolment with oral health services, stop smoking services, cosy homes, car seat rentals, safe sleep, and health screening programmes. Southland (Q1) (EoA)

- To develop a Respiratory Nurse Educator Role 0.2 focus within Child Health.

- 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. The key deliverable is to establish a sustainable and accessible after hour's service in Invercargill.

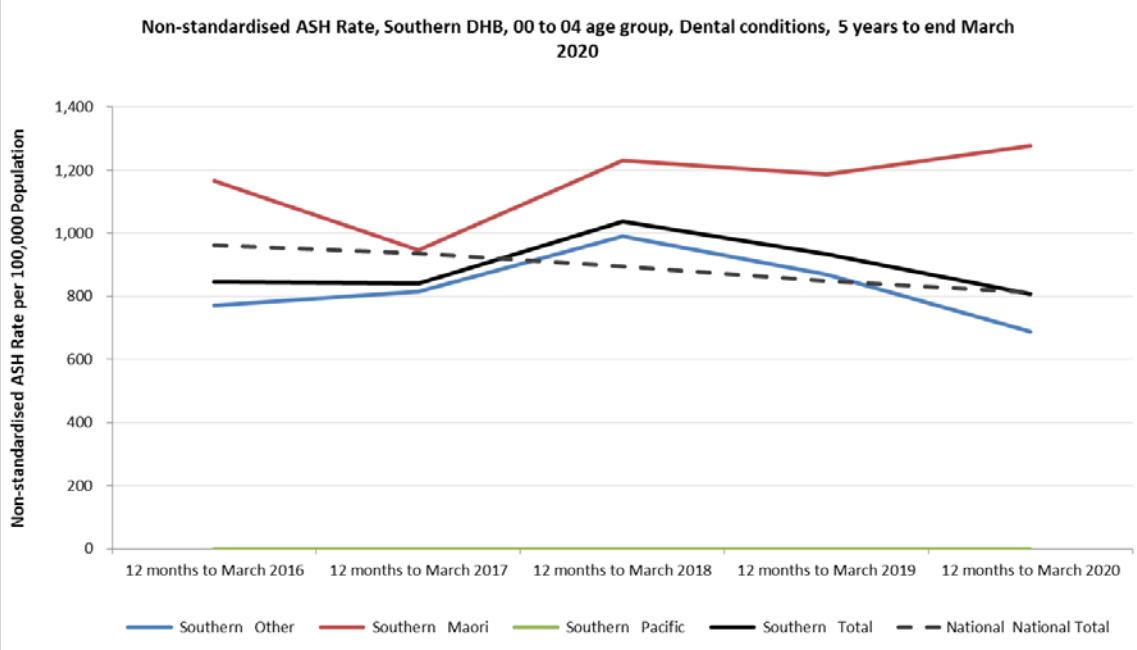
- Implement Ki Haumaru te Kaika pilots. A Cosy Homes Initiative in Dunedin and Invercargill that is modelled on the Ministry of Health's Healthy Homes programme in operation in selected North Island District Health Boards.

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
2020/21 Improvement Milestone: Maori children <1,213

Baseline Data:

Hospital admissions for children aged up to four years with a primary diagnosis of Dental conditions	Ethnic Group	12 months to March 2016	12 months to March 2017	12 months to March 2018	12 months to March 2019	12 months to March 2020
	Maori	1,165	947	1,230	1,188	1,277
	Total	873	785	1,005	1,003	855



Activities that will enable us to achieve the Improvement Milestone

- Promote oral health services through health promotion teams for preschool children to increase oral health examinations provided to children under two years, commencing at age six months Q1-Q4
- Increase engagement of the dental service with kaupapa Māori health services and WellChild providers and preschools to achieve a reduction in dental caries. This will be delivered through the Southern Harti Hauora Assessment programme. Actioned by Māori health Navigators.
- Prioritise Māori and Pacific children into the dental service with a targeted enrolment pathway. (EOA)
- Implementation of the Southern Harti Hauora Assessment programme for Maori ASH 0-4 that supports whanau self-management, referrals and engagement of health and wellbeing services e.g. kaupapa Māori health service enrolment, general practice enrolments, enrolment with oral health services, stop smoking services, cosy homes, car seat rentals, safe sleep, and health screening programmes. Southland (Q1) (EoA)

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 day's rate for Total population has reduced steadily since 2013. Our Māori and Pacific population generally has a higher bed days however the trend demonstrated in the data is improvement for both 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 day's 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

Actual Acute Bed Days per Capita Rates

	Estimated Popn	Acute Stays	Acute Bed Days	Standardised Acute Bed Days per 1,000 Popn		
DHB of Domicile	Year to Dec 2019	Year to Dec 2019	Year to Dec 2019	Year to Dec 2017	Year to Dec 2018	Year to Dec 2019
Southern	339,180	38,359	130,928	383.8	352.0	349.7
National	4,917,220	621,889	2,067,733	426.2	410.9	398.6

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 2019	Year to Dec 2019	Year to Dec 2019	Year to Dec 2017	Year to Dec 2018	Year to Dec 2019
Maori	35,980	4,068	10,529	432	418	402
Pacific	7,570	1,060	2,594	614	499	474
Other	295,630	33,231	117,805	379	343	341
Total	339,180	38,359	130,928	384	352	350

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 2020-21: 331 Standardised Acute Hospital Bed Days per 1000 Capita. 381 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 2020-21 year the SDHB along with WellSouth PHO will develop joint capability within our health system to use the SLM framework. Along with better coordination and building of capacity and capability, new initiatives will be prioritised for implementation that meets the health and wellbeing needs of the population. Key to reducing our ALOS is better management

To reduce acute admission for Māori, improved and timely coordination of care between secondary, primary and community is needed to better support Māori in health care choices, self-determination and management of health needs to stay well at home.

Activities that will enable us to achieve the Improvement Milestones

- The Māori Health Directorate will form a Clinical Māori Strategy Group to focus on the Acute Bed Days SLM.
- Programme initiatives will focus on ōritetanga to improve Māori health outcomes.
- Kaupapa Māori Health Services (secondary, primary and community based), the WellSouth Outreach Nursing Service and the Southern DHB Home Team will work to ensure a seamless pathway of patient/whānau care to minimize and reduce admissions.

Inpatient Average Length of Stay (ALOS) for acute admissions

Measure description: Non-Financial Quarterly Reporting – Ownership measure

2020/21 Improvement Milestone: Stay below the MOH target (2.35)

Baseline Data

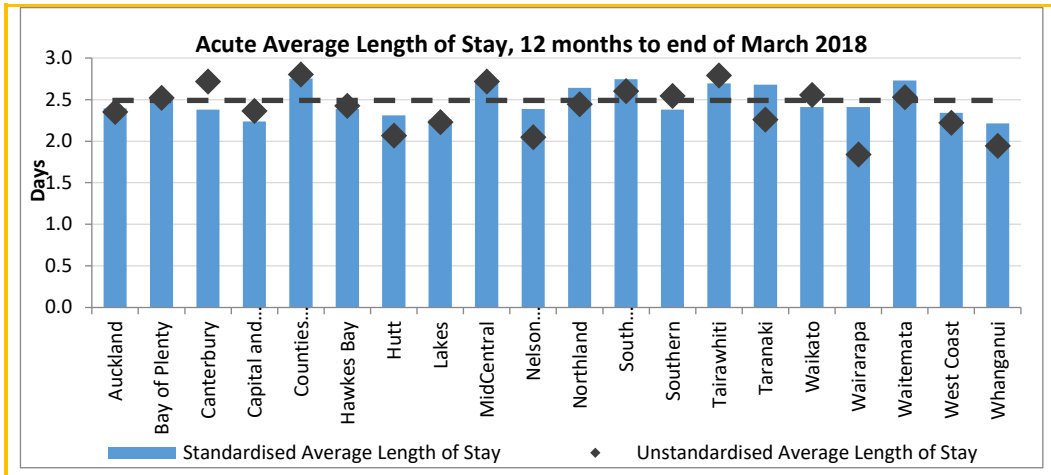
2020/21 Improvement Milestone: Stay below the MOH target (2.35)

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.

- Kaupapa Māori Health Services (secondary, primary and community based providers), WellSouth Outreach Nursing Service and the Home Team, will assist in the coordination of care for Māori who present to the hospital with the aim of minimizing and reducing admissions. Focus will be on the following conditions; (EOA)
  - ED presentations
  - DNA (Unable to attend)



- Maternity
- Respiratory
- Cardiovascular Disease
- Stroke
- Diabetes

Acute readmissions to hospital

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

2020/21 Improvement Milestone: <12.0%

Baseline Data

	Year to Sep 2017		Year to Sep 2018		Year to Sep 2019		
DHB of Service	**Readmission Rate**	**Standardised Readmission Rate**	**Readmission Rate**	**Standardised Readmission Rate**	**Stay Discharges**	**Readmission Rate**	**Standardised Readmission Rate**
National	11.80%	12.20%	12.00%	12.10%	951,766	12.30%	12.20%
Southern	12.20%	12.20%	11.90%	12.00%	55,961	12.00%	12.10%

Activities that will enable us to achieve the Improvement Milestone:

- Continue the 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 sharing of data and communication between primary, secondary and our Kaupapa Māori Health providers in following up Māori acute readmission.
- Kaupapa Māori Health Services (hospital and community providers) will be involved with discharge planning that supports the patient/whānau to stay well at home. A preventative approach to minimize readmissions will be the key focus. This will be delivered by Māori Health Navigators engaging with patients/whānau during their discharge planning process and ensuring that all appropriate referrals are undertaken to support the patient/whānau to stay well at home. EOA)

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

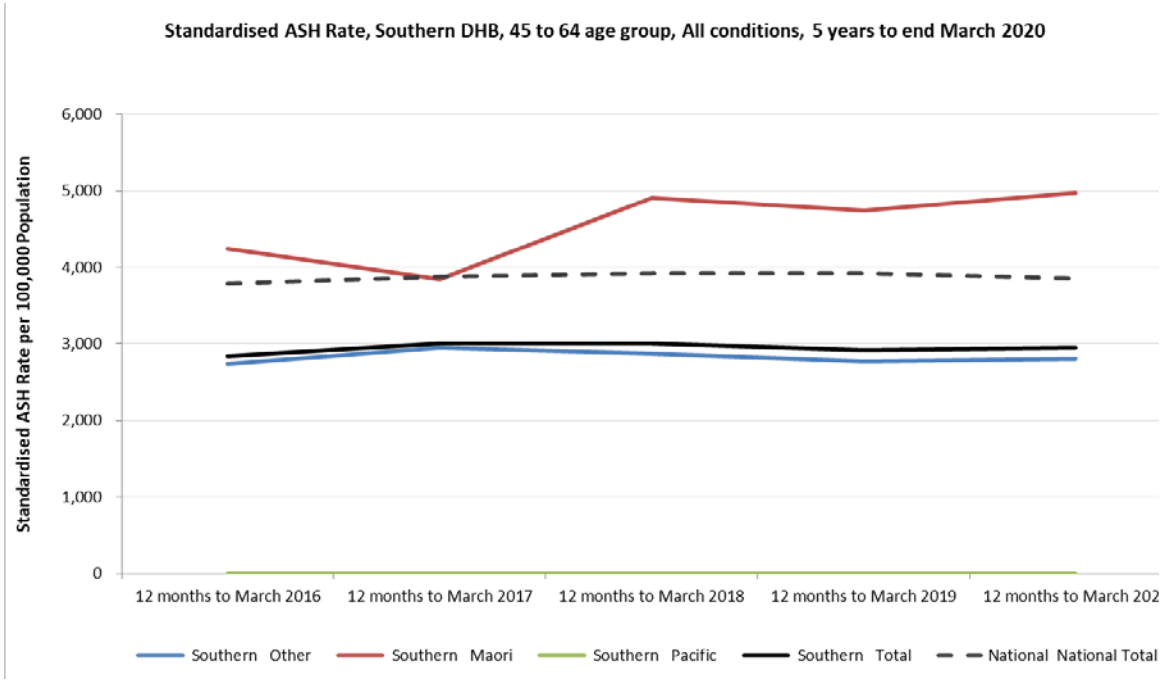
Measure description: Standardised rate per 100,000 as per non-financial quarterly measure – system integration

2020/21 Improvement Milestone: Maori Adults <4867

Baseline data:

Five year trend ASH 45-64 to March 2020

Ambulatory sensitive hospitalisations rate for 45-64 year olds (per 100,000)		12 months to March 2016	12 months to March 2017	12 months to March 2018	12 months to March 2019	12 months to March 2020
	Maori	4,249	3,848	4,909	4,746	4,976
	Total	2,837	3,002	3,006	2,914	2,952



Activities that will enable us to achieve the Improvement Milestone

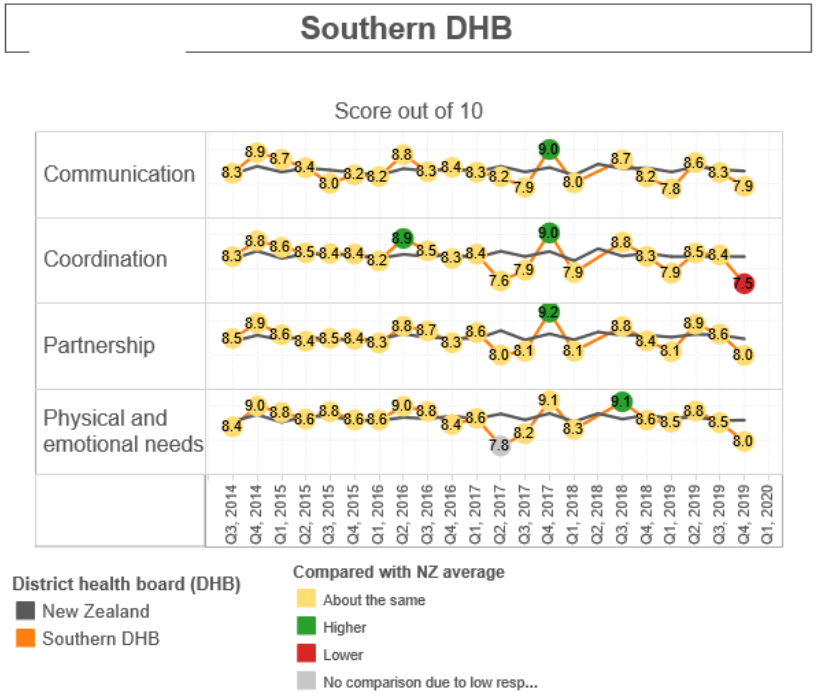
- Formation of a Māori Health Clinical Group by the Māori Health Directorate to review and advise on clinical activity that impacts on admissions and readmissions. This group will provide clinical governance for the Māori Health directorate.

- Kaupapa Māori Health Services (secondary, primary and community based providers) and the Home Team, will assist in the coordination of care for Māori who present to the hospital with the aim of minimizing and reducing admissions. Focus will be on the following conditions; (EOA)
  - ED presentations
  - DNA (Unable to attend)
  - Maternity
  - Respiratory/COPD
  - Cardiovascular Disease
  - Stroke
  - Diabetes

- Implementation of the Hauora Wellness Checks for Māori populations (aged 50 years+) using the WellSouth Call Centre with a specific focus on tikanga, manaakitanga and whanaungatanga. The aim is to minimize and reduce admissions to hospital by:
  - Enrolment to General Practice/Designated Practice, for those unenrolled.
  - Re-engaging Māori with their General Practice for self-management of care and access to screening programmes.

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 2020/21: As for 3.1 below

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 2020/21 SDHB and WellSouth PHO will focus on improving the lowest performing scores in the communication domain.

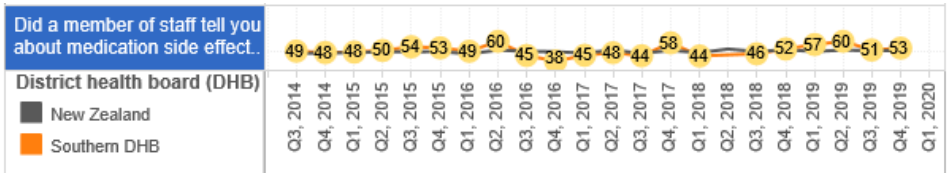
Did a member of staff tell you about medication side effects to watch for when you went home?

Measure description: As per HQSC patient experience reporting.

2020/21 Improvement Milestone: To improve SDHB **> 5.3** To improve WellSouth PHO **> 5.5**

Baseline Data

Southern DHB



WellSouth PHO

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?*	National	Southern
	5.5	5.5

Activities that will enable us to achieve the Improvement Milestone

- Continue to develop a coordinated approach to using the University of Otago polypharmacy clinic for SDHB patients.
- 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. Actions will be to provide medications advice on an as required basis to Home Team staff and their patients, and for clinical pharmacist's services to be able to be referred to by the Home Team as appropriate.
- Southern DHB staff to prioritize and engage with Kaupapa Māori Health services (hospital and community) who are already identified as working with the patient/whānau to support health literacy and medication management. This will be delivered by the Maori health navigators coordinating access between the patient and providers.
- Roll out the new LTC - CLIC service in partnership with WellSouth PHO and practices that are currently a part of the Health Care Home programme of work, delivered through a community pharmacy/general practice pilot. This will ensure that high risk stratified LTC patients in the community receive effective medicines support and have pharmacy involved in their MDT routinely. This will pilot will go live during 2020.

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 2016

Southern age standardised rates – Top amenable mortality deaths, 0-74 year olds, 2016	
Coronary disease	86
COPD	56
Suicide	40
Cerebrovascular diseases	33
Female breast cancer	24

	Māori		Pacific		non-Māori, non-Pacific		Total	
DHB of domicile	**Deaths**	**Rate**	**Deaths**	**Rate**	**Deaths**	**Rate**	**Deaths**	**Rate**
Southern	192	158.9	32	138.7	1729	86.1	1953	91
Total New Zealand	5972	197.4	2291	75.1	19181	75.1	27444	92.6

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 2020-21: 5% reduction in the Southern Maori rate to 150.9 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

- Formation of a Māori Health Clinical Group to provide advice, review current data and activities to address Māori health equity for 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 uptake of cervical screening for Māori women.

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
2020/21 Improvement Milestone: Maori Enrolled Women >80%

Baseline Data

	2017/18				2018/19				2019/20			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Southern	78%	78%	78%	77%	78%	78%	78%	75%	75%	75%	75%	
Maori	64%	63%	66%	68%	69%	69%	70%	69%	69%	69%	69%	

Activities that will enable us to achieve the Improvement Milestone

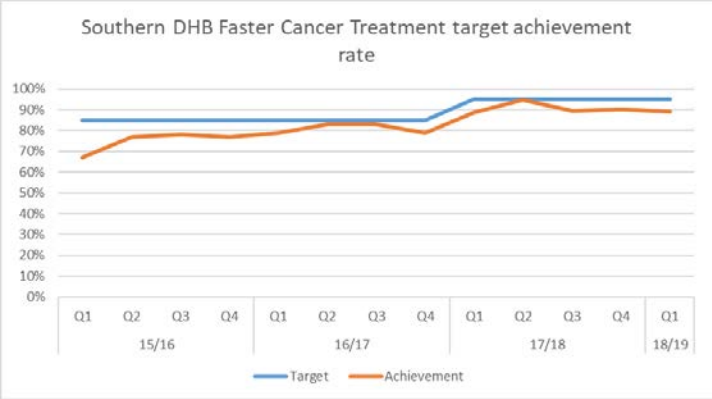
- Cervical Screening Events will be held in Dunedin and Invercargill 6 weekly with a focus on priority populations.
- Cervical Screening Events will be held bi-annual with a focus on rural areas of North Otago and Central Otago.
- A pilot project will occur in partnership with the Mornington Health Centre linking with the Interpreter Service to engage with women across all health determinants. (EOA)
- Māori Health Directorate to support the building of relationships and health literacy between Southern DHB Sexual Health Services and Kaupapa Māori Health Services that will increase the uptake of sexual health services for Māori populations, in particular to reduce DNA's (unable to attend appointments)." This will be delivered by Māori health navigators coordinating access between the patient and providers when patients are in secondary care. The Māori Health Directorate will support this activity by contacting Sexual Health Services and Kaupapa Māori Health Services directly on an ongoing basis to problem solve and connect these services in open dialogue.
- The Service to engage with women across all health determinants through direct contact with Key Stakeholders in the wider community. (EOA)

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

2020/21 Improvement Milestone: 95%

Baseline Data



Activities that will enable us to achieve the Improvement Milestone

- Formation of the Māori Health Clinical Group to monitor and provide advice for Faster Cancer Treatment with the Cancer Coordination team during 2020.
- Review resources for the Māori cancer Kaiarahi navigation services based in the community across the district and provide support to connect with Kaupapa Māori Health Services (hospital, primary and community). (EOA) this will be actioned by the below additional resource.
- Appointment of a Māori Cancer Clinical Nurse Specialist based at Dunedin Hospital to provide support for Māori whānau who receive cancer services.

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

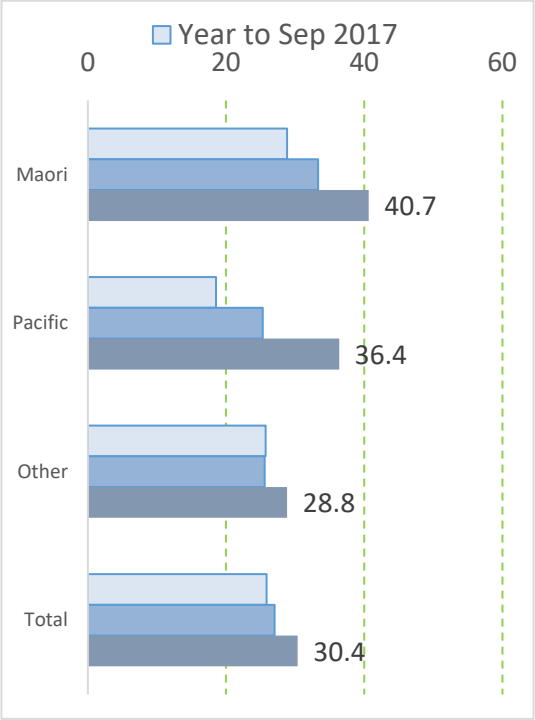
Measure description: Intentional self-harm hospitalisations (including short-stay hospital admissions through Emergency Department) for <25 year olds

Baseline Data

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

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

	Population	Number of Self Harm Hospitalisations - Total	Actual Self Harm Hospitalisation Rate (per 10,000 popn)	Age Standardised Self-Harm Hospitalisation Rate (per 10,000 population)		
Ethnicity	Year to Sep 2019	Year to Sep 2019	Year to Sep 2019	Year to Sep 2017	Year to Sep 2018	Year to Sep 2019
Maori	5,665	21	37.1	28.8	33.3	40.7
Pacific	1,175	4	34	18.5	25.3	36.4
Other	28,150	84	29.8	25.7	25.6	28.8
Total	34,990	109	31.2	25.8	27	30.4



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 2020/21: **To reduce the rates for Maori < 40.7**

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 activity in violence prevention programmes in Waitaki and other Districts.

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.

Hospitalisations due to self-harm

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

Baseline data - Southern DHB

	Population	Number of Self Harm Hospitalisations - Total	Actual Self Harm Hospitalisation Rate (per 10,000 popn)	Age Standardised Self-Harm Hospitalisation Rate (per 10,000 population)		
Ethnicity	**Year to Sep 2019**	**Year to Sep 2019**	**Year to Sep 2019**	**Year to Sep 2017**	**Year to Sep 2018**	**Year to Sep 2019**
Maori	5,665	21	37.1	28.8	33.3	40.7
Pacific	1,175	4	34	18.5	25.3	36.4
Other	28,150	84	29.8	25.7	25.6	28.8
Total	34,990	109	31.2	25.8	27	30.4

Activities that will enable us to achieve the Improvement Milestone

- Alliance Network Leadership Group (NLG) will use the SLM framework to inform actions for reducing mental distress in young people across the district in 2020 to 2021. The framework will be used to guide oversight of the operation and implementation of the actions below during 2020-21
- Implement plan aimed at reducing Youth Self Harm in accordance with the *Ko Awatea/Health Quality and Safety Commission Co-design in Care Case study*

- Complete Health Practitioner and Consumer Learnings projects Q1
- Analyse data and organise into themes Q2
- Develop and implement and action plan Q3
- Complete process evaluation of implementation Q4

- Supporting Parents, Health Children project activities

  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.

- 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 2020-21. 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 2020/21: 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%

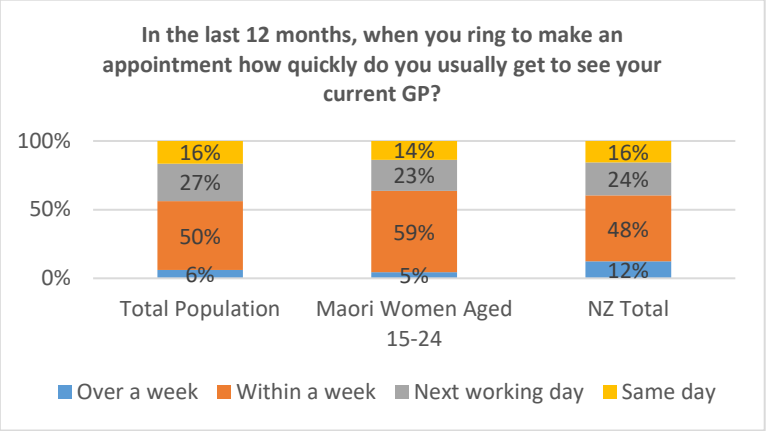
Use of Patient portals

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;

- There are two Health Improvement Practitioners (HIPs) and Health Coaches integrated with two General Practices in Southern currently, with another 8 FTE of each of these roles to be integrated over the next 12 months. These roles will work closely with kaupapa Māori health services, the General Practice staff to provide wellbeing support to patients in a responsive, goal orientated, solution focused wellbeing approach.



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 Mâori 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-Mâori 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 Mâori.

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

	Num	Denom	Rate of Smokefree Homes	
Year	**Jan 19 - Jun 19**	**Jan 19 - Jun 19**	**Jan 19 - Jun 19**	**July – Dec 19**
Maori	115	252	45.6%	46%
Pacific Peoples	39	81	48.1%	55%
Others	888	1,381	64.3%	71%
Total	1,042	1,714	60.8%	66%
New Zealand	16,945	30,648	55.3%	59%

Where do we want to be?

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

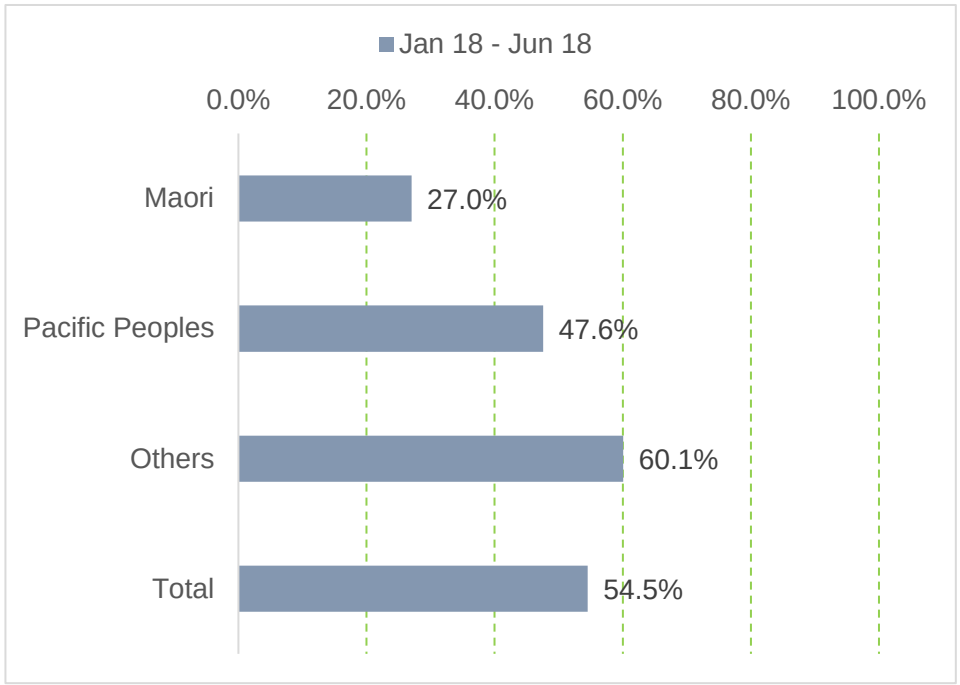
Improvement Milestone for 2020/21: Increase the total percentage of Māori households being smoke free to 60% with a long term goal of 70% by 2024

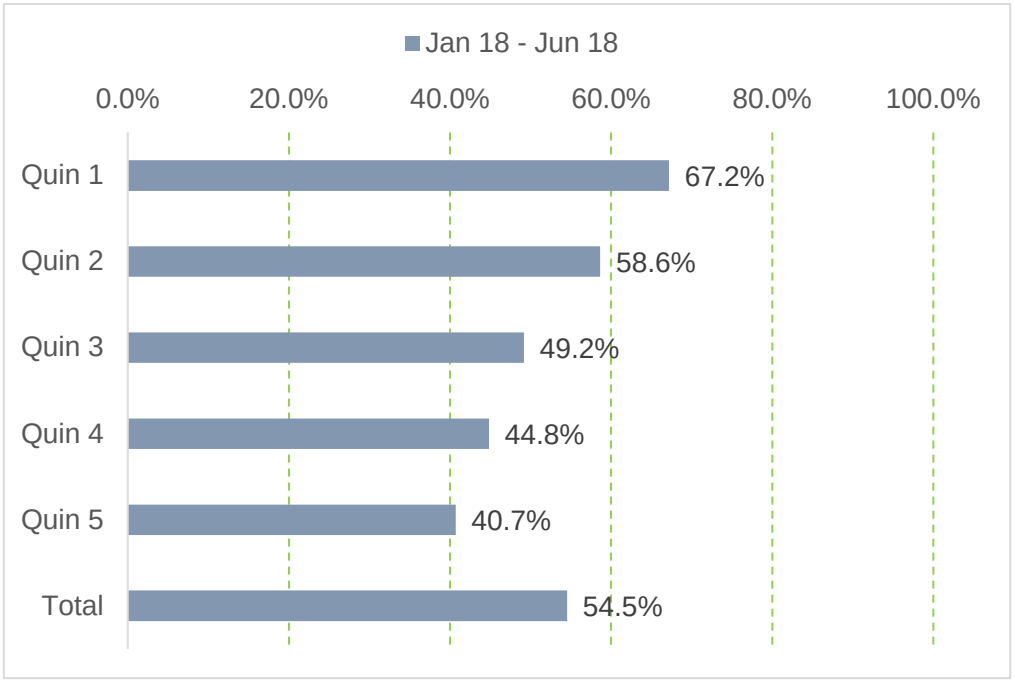
Rationale: A reasonable number of households are required to have smoking status recorded to provide meaningful results on the number of babies impacted by smoking.

Activities:

Increase the percentage of households having the smoking status checked and accurately recorded to 80%. In the 2020/21 year Southern DHB will continue to work with the four locally contracted WellChild Tamariki Ora providers and the MoH to improve data collection via the Ara Whānui reporting database. (Delete 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 quality and accessibility to live data to support the focus of collaborative district wide smokefree activities for pregnant women and whanau.

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

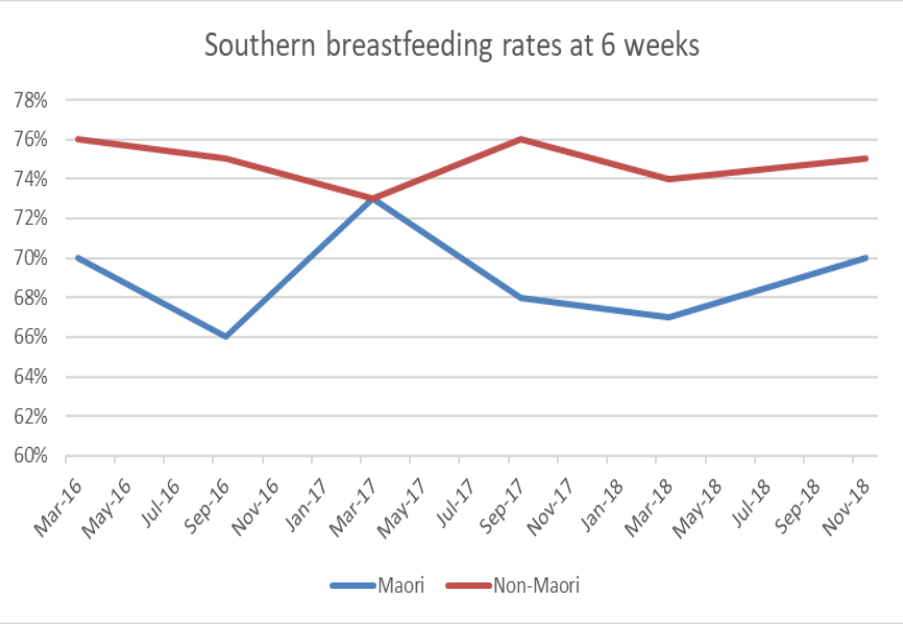
continuing with breastfeeding their child is more likely to remain smoke free. We will also look at a number of activities to increase the number of children at four years of age who are living in a smoke free home.

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)
2020/21 improvement milestone: 80% for both Maori and Non-Maori

Baseline Data: Infants who are exclusively or fully breastfed at six weeks

Infants who are exclusively or fully breastfed at six weeks	
Maori	71%
Other	73%



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)
- Assess the Community Breast Feeding Support Service pilot to understand the challenges Māori, Pacific, refugee, high dep women experience in establishing and maintaining breast feeding (EOA)
- Hold a breast feeding hui with key stakeholders upon the release of the new national Breast Feeding Strategy with the aim of providing alignment and a more joined up approach to breast feeding activities across the Southern district

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
2020/21 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.
- Prioritize pregnant Māori wahine and whānau for referral to the Southern district Stop Smoking Provider. This will be the focus of all referral sourced into the Stop Smoking Service, incentivised by the stop smoking incentive programme. The aim is to ensure engagement in the Smoke free Pregnancy Incentive programme and wahine are supported to stop smoking and continue to be Smoke free after baby is born. The service will report on referral numbers, enrolments and successful quits for pregnant Māori wahine and whānau.
- Assess and make recommendations on the post-natal extension to Southern Stop Smoking Incentive Scheme (SSS Incentive Scheme) for pregnant women after it has been in place for six months (EOA). Post-natal extension to take place Q1. Assessment will be completed and recommendations made in Q3.

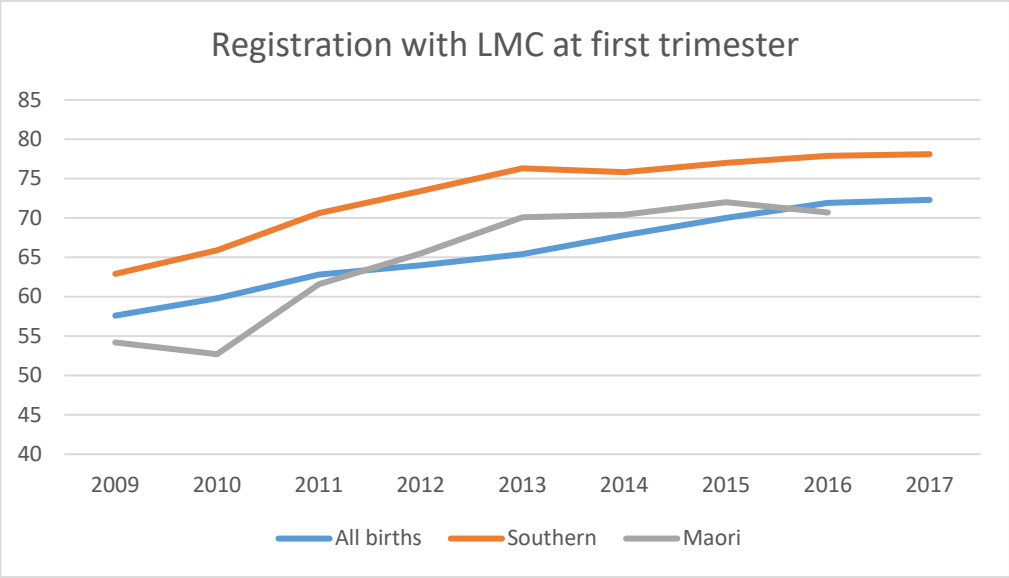
Pregnant women registered with a Lead Maternity Carer within first trimester of pregnancy

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
2020/21 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:

  Background: 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 Māori midwives and kaupapa Māori health services 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.

  Pregnancy and Parenting

- Plunket to work with the Pacific Trust Otago on incorporating pacific culturally appropriate content into the pregnancy and parenting training sessions held at the Trust premises Q3. The intention is to increase the number of Pacific women and their whanau attending pregnancy and parenting sessions in Dunedin by Q4 (EOA)