Southern Health
He hauora, he kuru pounamu

Southern District Health Board
Piki Te Ora

Southern DHB Annual Plan 2021/22

E90

Incorporating the Statement of Performance Expectations (SPE)

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

BLANK PAGE

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 Āraiteuru
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

If there is one thing we learned from 2020, it is that plans change.

Over the past year, we have faced significant disruption to our health services, adjusting our priorities and placing pressure on our systems that we still are working to address.

And while COVID-19 might have moved from the unknown-unknown to the known-and-not-done-with-us-yet category, the lesson remains that all aspects of our planning must include the ability to adapt.

COVID-19 will inevitably continue to loom large in 2021/22. It will be the year we undertake the most ambitious vaccination programme ever attempted in New Zealand, with no less of a goal than to curb a pandemic, restore our economy, reunite families and return to us some of the freedoms we once took for granted.

We must achieve this while continuing to provide the day to day health care our communities need – and while managing the postponed surgeries, delayed care and mental health burden that has been a continued reminder of the very real, if indirect, impact of COVID-19.

At the same time, our planning for this year and beyond needs to prioritise, with equal urgency, the areas that position us best to withstand future shocks to our operations, and support a robust, resilient health care system.

Importantly, we must ensure that our most vulnerable populations are served, and no one is left behind.

Achieving this means continuing to make steps in the directions that have been the backbone of our planning and development in recent years.

It means continuing 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, remains top of mind for the Southern district.

While public health, primary and community care and secondary services are the basic pillars of the services we provide, just as importantly our attention must be on how these areas intersect with each other. It is essential our patients can move between parts of our services in ways that are equitable, streamlined and efficient.

These principles underpin the reshaping of our models of care for a future-focused health care system. This is not an abstract concept; the commitment to doing things differently is literally being built into the new Dunedin Hospital. The way we expect to use the facility has informed decisions from how space is allocated to how people will move through the building.

In turn, we know change requires investment – in developing the workforce for the future, and ensuring our operations are supported by high quality digital and business systems.

Our ability to transform our health system demands that we embrace the digital opportunities that exist now, and that will continue to evolve in the decades ahead.

These directions are captured in the Strategic Intentions and Priorities section of this Plan, reflecting our strategic pathway and change programmes.

More than ever, we need to continue to bring to life 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. I want to acknowledge the contributions of all our health care partners, including WellSouth PHO, 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 year has tested us, as a health system, as a community, and as individuals. It has 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	Pete Hodgson
Chief Executive	Chair
Southern DHB	Southern DHB

MESSAGE FROM THE IWI GOVERNANCE COMMITTEE

The Iwi Governance Committee again 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 the Treaty of Waitangi obligations are specified in the New Zealand Public Health and Disability Act 2000.

Whakamaua the Māori Health Action Plan 2020-2025 released last year reinforced He Korowai Oranga which continues to provide the overarching framework in creating an environment that enables Māori to live healthier, happier lives. 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 Te Tiriti o Waitangi and the health and disability system as outlined in Whakamaua.

The New Zealand Health and Disability System Review (Hauora Manaaki ki Aotearoa Whānau) and the recently released Health Reforms are proposing system wide change to the health sector in ensuring our future health system achieves better and more equitable health and wellbeing outcomes for Māori. The Iwi Governance Committee is actively involved with discussion around the Māori Health Authority which will have implications for our relationship into the future. While we support a Māori Health Authority that monitors and reports to the Minister on the performance of the health and disability system in respect to Māori health outcomes and equity, we continue to support the commissioning function of this new Māori Health Authority.

The Waitangi Tribunal Health Services and Outcomes Inquiry (Wai 2575) Stage 2 continues to be heard (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. 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 include the principles of partnership, active protection, equity and options. The Iwi Governance Committee reinforces that these principles are to be embedded in designing health and disability systems and policy through strengthening the understanding of and commitment to reducing health inequities. We acknowledge the Southern DHB's organisational values and remind the Southern Health System of our Ngai Tahu values which underpin us as Rūnaka for this district which include Whanaungatanga, Manaakitanga, Tohungatanga, Kaitiakitanga, Tikanga and Rangatiratanga.

EQUITY OF HEALTH CARE FOR MĀORI

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage, require different approaches and resources to get equitable health outcomes. Achieving equity is not a series of discrete deliverables and milestones, instead it is recognising and taking opportunities to embed equity within the operation of the health and disability system at all levels. 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.

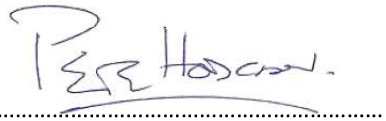
Our System Level Measures Improvement Plan will focus on Māori: ambulatory sensitive (avoidable) hospital admissions 0-4 and 45-64 years; acute admissions and readmissions to hospital; amenable mortality; acute bed days; stranded patients; and self-harm hospitalisation admissions. We will also focus 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.

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 Āraiteuru 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.



.....

Pete Hodgson

Chair

Southern District Health Board

Date: 9 August 2021

.....

Chris Fleming

Chief Executive

Southern District Health Board

Date: 9 August 2021

.....

Hon. Andrew Little

Minister of Health

Date: 27 September 2021

.....

Hon. Grant Robertson

Minister of Finance

Date: 26 September 2021

Hon Andrew Little

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

Pete Hodgson
Chair
Southern District Health Board
Pete.hodgson.nz@gmail.com

30 SEP 2021

Tenā koe Pete

Southern District Health Board 2021/22 Annual Plan

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

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

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

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

More broadly, we also acknowledge the importance of your Board delivering on the Plan in a fiscally prudent way and acknowledge that an intensive support programme will remain in place for Southern DHB.

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

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

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 $90.628 million that you have included (in 2022/23). 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.

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

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

Ngā mihi nui

Hon Andrew Little
Minister of Health

Hon Grant Robertson
Minister of Finance

Cc Chris Fleming
Chief Executive

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand
+64 4 817 8707 | a.little@ministers.govt.nz | beehive.govt.nz

1.0 OVERVIEW OF STRATEGIC PRIORITIES

1.1 STRATEGIC INTENTIONS AND PRIORITIES

Strategic Context

This Annual Plan for 2021/22 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 2021/22 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. Southern DHB is committed to supporting the roll out and success of the COVID-19 vaccination programme.

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

Figure 1:
Five strategic themes of the Strategy

Southern DHB aligns health and disability services with *He Korowai Oranga*[1], the New Zealand Māori Health Strategy and more recently to Whakamaua, which is the associated action plan providing more detailed guidance and direction to DHB's in respect of our obligations. We remain committed to our local iwi partnership and a *Principles of Relationship*[2] - *Te Hauroa o Murihiku me Āraiteuru* is in place between Murihiku and Āraiteuru Rūnaka and the Southern DHB. The purpose of *Te Hauora o Murihiku me Āraiteuru* is to improve Māori health and wellbeing outcomes in the Southern district.

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.

Priorities

The Minister's letter of expectations signals annual expectations and priorities for DHBs. This year, in addition to the continued focus on critical population groups, the expectation has been set for us to give practical effect to Whakamaua: the Māori Health Action Plan 2020-2025, as well as to continue to improve sustainability.

[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 Āraiteuru 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 ensure that we have a strong focus on the transformational direction to mental health and addiction as outlined in the national enquiry and the resulting strategy He Ara Oranga. This includes moving to a holistic approach grounded in wellbeing that recognises the social, cultural and economic foundations of mental wellbeing and looks across the life course as well as increasing access and choice to ensure all people access the support they need. These national objectives will be localised through the outcomes of our Mental Health continuum of care review which will be prioritised for implementation across multi years, beginning in 2021/22.

Improving child wellbeing:

There is an expectation that DHBs will actively work to improve the health and wellbeing of infants, children, young people and their whānau and carers with a particular focus on improving equity of outcomes. This will be delivered through targeted activity across a number of domains, including the recommendations from the Perinatal and Maternity Mortality Review Committee.

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

Including actions in relation to Whānau Ora, Ola Manuia, Healthy Ageing and ensuring improved outcomes for those in our population with a Disability as well as those that live rurally or remotely.

There will be a large amount of activity undertaken to inform our three year planned care approach, which involves gaining a much clearer picture of the needs of our population, our current intervention rates and our performance relative to our South Island partner DHB's.

For cancer services specifically we will work regionally to understand where our services are vulnerable and collaborate to ensure that access to screening, assessment and treatment is timely and equitable.

Better population health outcomes supported by primary care:

Working with our Primary Care partners, this will include actions in relation to increasing the capacity of primary care particularly for those in our population who live with long term conditions. We will expand our focus to others in the primary care workforce to ensure there is capability to respond to continued emerging need such as those on the front line involved in pharmacy, our rural workforce, NGO's and Māori health providers.

Strategic and service planning:

In addition to the above, 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.

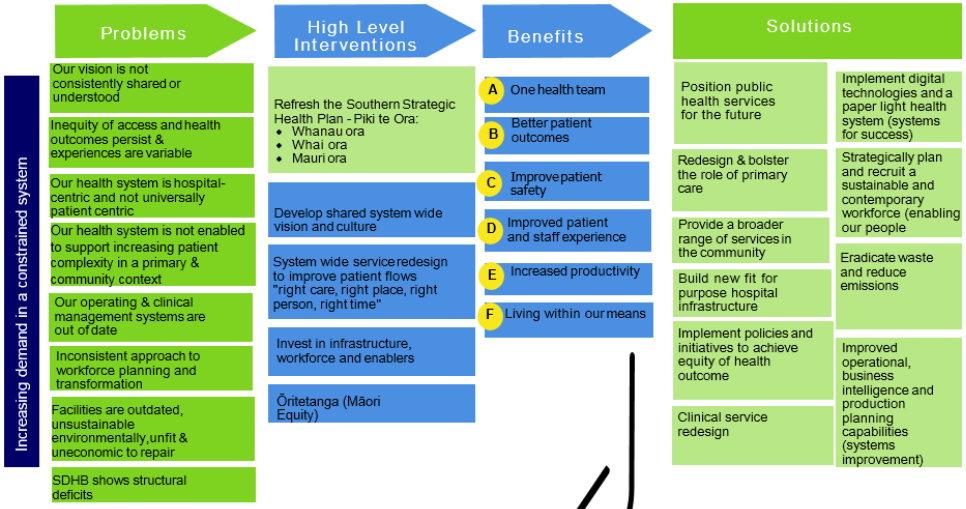
This Annual Plan outlines how the Southern DHB will meet those expectations in 2021/22. However we note that we do not have all of the answers and to this extent our planning must remain flexible to enable us to try new initiatives and new ideas if we are truly going to deliver on our strategic intent.

Health and Disability System Review

The review, which was released in 2020/21, highlighted 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. We expect this to 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.

Longer Term Planning

In the 2020/21 year the Southern DHB committed to undertaking a Strategic Refresh of its longer term vision, to galvanise the direction of travel over the short, medium and longer term. This is an important undertaking to ensure that the development of the New Dunedin Hospital (NDH) is viewed as just one plank in our strategy to deliver contemporary services to our population, but to remind ourselves that are also many others that are collectively critical to our success. The following intervention logic map (ILM) was developed as part of the Strategic Case to describe the range of change that would be required to support a successful transition to the (NDH). Our recent focus has been on incorporating the activity required into a structured programme of changes aligned with our organisation's direction and service planning, 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

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. Although a regional plan is not required to be submitted for 2021/22, there is a strong commitment from each of the five South Island Chairs, Boards and executives that a regional vision of strong collaboration is an ongoing priority, and a plan to outline the extent of this commitment and the detail of regional services is currently under development.

Our new normal

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.

Embedding key learnings

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 was made in the previous year to understanding the current health needs of our Māori communities. Accordingly, although this continues to be a work in progress, we are better placed 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.

   The role of Public Health has continued to be integral in our COVID-19 response, and the teams have worked hard to lead our resurgence plans to ensure we are ready to respond quickly to any further outbreaks. Planning in earnest is underway to ensure that the focus for 2021/22 is on delivering the largest immunisation programme of all time, to help protect our Southern population from ongoing disruptions posed by the presence of COVID-19.

   Other Key focus areas for Public Health 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 continues to be a framework for primary, community and secondary areas to reimagine their future. Importantly, it has also proven to be a valuable enabler for the delivery system to be reframed. It has formed a key plank to create system change, alongside the Valuing Patients' Time programme, which has focussed on efficiencies in the acute part of our patient's journey. 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 was the establishment of 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. This has only been achieved in part and needs to be carried forward to remain a clear and valuable enabler of success as we move into the delivery of our 2021/22 Annual Plan.

   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. Importantly, 2021/22 will see the completion of the HCH journey for our early adopter practices, and we will then need to ensure that we are embracing the learnings from the early adopter practices and adapting our future work programme to incorporate these insights.

4. **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 2021/22 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 health pathways, 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, 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.

5. **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.

6. **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, which was completed in the 2020/21 year and continues to support the important role of clinical council in choosing wisely. Please see section 4.4 for further details.

7. **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:

    - Developing district-wide approaches to connected and responsive clinical partnerships in relation to key areas (high needs Whānau in South Dunedin, frail elderly in Mosgiel, Urgent care in Central Dunedin and integrated maternity services in Central Otago)
    - Using InterRAI data to better understand our high utilisation of Age residential psychogeriatric care
    - Maximisation of virtual health as an alternative to traditional care delivery
    - Strengthened production planning to reduce elective surgery cancellations

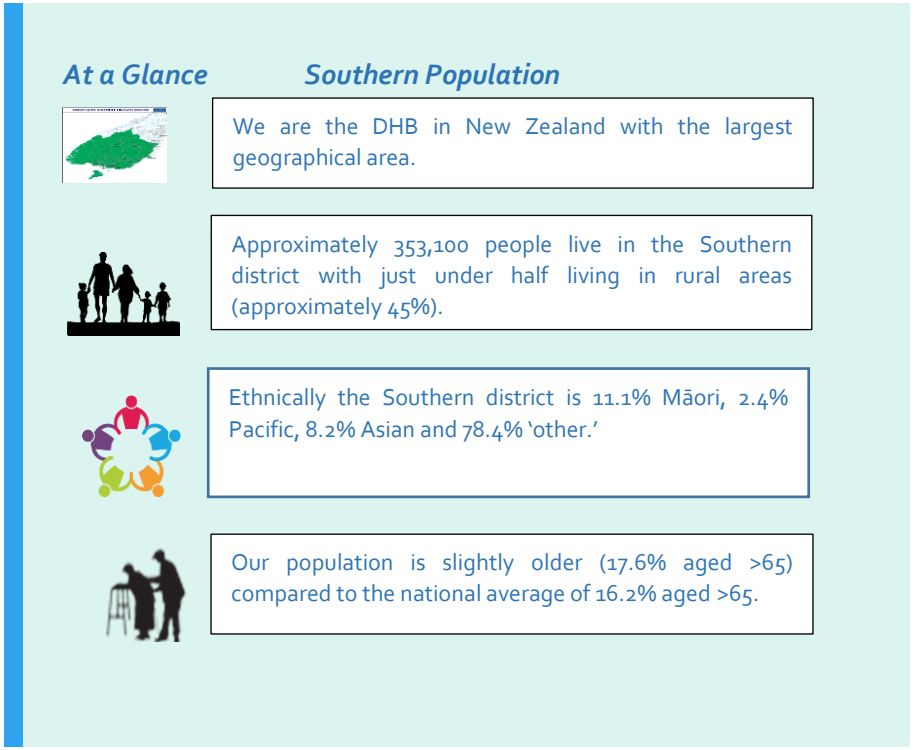
8. **Facilities and the Dunedin Rebuild Transition Programme:** Preparing for the New Dunedin Hospital is in itself a transformational programme of work, requiring us to envisage, develop and implement new models of care that encourage better, more integrated healthcare services closer to home. This 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.

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

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.



Source of data: Statistics NZ Population Projects 2020

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 (CLLN) has been established to explore 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 2021/22. This will be further explored as part of our Strategic Refresh process during the first half of 2021/22.

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 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.

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 2021/22 year the CHC will focus on engaging and supporting CHC advisors working on projects across the health system. As of January 2021, the CHC has over 120 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 Leadership

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 2021/22 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 2021/22 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

Give Practical Effect to He Korowai Oranga - 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.

Ministry of Health guidance:
The New Zealand Public Health and Disability Act 2000 (NZPHD Act) specifies the DHBs Te Tiriti o Waitangi obligations. In this plan we specify how we will meet these obligations. This includes information on:

- Our obligation to maintain processes that enable Māori to participate in, and contribute to, strategies for Māori health improvement. Note: these processes may already be established but a description of how they operate, and any improvements planned, should be included.
- Specific plans and strategies for Māori health improvement, including how we will work in partnership with Māori to develop and implement these.
- The training of Board members (as per the NZPHD Act) in Te Tiriti o Waitangi and Māori health and disability outcomes.

Our plan includes the actions for the upcoming year that we consider to be the most important for engagements and obligations as a Treaty partner, including the reasons why the action(s) are important and the expected impact (the following areas in Whakamaua specifically relate to our engagement and obligations as a Treaty partner). We will undertake actions to

Whakamaua Action 1.1 - develop iwi partnerships that support local-level Māori development and kaupapa Māori service solutions.
Whakamaua Action 2.3 - design and deliver professional development and training opportunities for Māori DHB board members and members of DHB/iwi/Māori partnership boards

Actions: Whakamaua Action 1.1: Develop iwi partnerships that support local-level Māori development and kaupapa Māori service solutions.	**Milestones**
Action 1.1: Increase the equity investment that accelerates the spread and delivery of kaupapa Māori health services	
• Review of current kaupapa Māori services and move to high trust contracts In 20/21 we undertook a review of our kaupapa Māori health provider contracts to better align the DHB's strategic Māori health contracts to our DHB strategic priorities including long term conditions and navigation. This review will inform our mahi to move to high trust whānau ora contracts in 21/22; we will report on our progress in Q2 and Q4.	Q2, Q4: Reporting
• Use of procurement processes to allocate funding Q2	Q2, Q4: Reporting

Procurement processes will be used to identify providers for delivery of whānau ora contracts. Open and transparent processes will be used to ensure equitable funding for Māori whānau ora providers.	
• Allocate funding by quarter 3 Funding will be allocated to whānau ora providers based on procurement processes undertaken in Q2	Q4: Reporting
Action 1.1: Advance tier one services in the community provided by Māori Health Providers, working with Māori health providers and other central government agencies to promote an integrated model of care in working with whānau. • Te Kāika General Practice plans for Health and Wellness Hubs were progressed in 20/21 – including plans for health, social and education services. Other community Health and Wellness Hubs will be identified and rolled out in 21/22.	Q1-Q4: Reporting
Whakamaua Action 2.3 - design and deliver professional development and training opportunities for Māori DHB board members and members of DHB/iwi/Māori partnership boards	
Action 2.3: Iwi Governance Committee (IGC) to undertake a full comprehensive orientation to the NZ health system as part of a professional development programme. This is to be inclusive of the NZ health structure, the role and function of the health boards, primary care and the public and private health system including disability. • Southern DHB IGC and Board members will participate in MoH training provided on the Treaty of Waitangi and Whakamaua	Q4: Reporting

Give Practical Effect to He Korowai Oranga - Māori Health Action Plan 2020-2025

Whakamaua: Māori Health Action Plan 2020-2025 is the implementation plan for He Korowai Oranga, New Zealand's Māori Health Strategy. Whakamaua will help us achieve better health outcomes for Māori by setting the government's direction for Māori health advancement over the next five years. In this template, Southern outlines our planned actions for the upcoming year that we consider to be the most important for Whakamaua: Māori Health Action Plan 2020-2025, including the reasons why the action(s) are important and the expected impact.

Whakamaua Objective Accelerate the Spread and Delivery of Kaupapa Māori Services and whānau-centred 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. Southern DHB 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. Our plan includes actions to:

- For Whakamaua Action 3.1 –expand existing Māori health workforce initiatives aimed at encouraging Māori to enter health careers, including supporting existing initiatives such as Kia Ora Hauora in their local area.
- For Whakamaua Action 4.4 –increase access to and choice of kaupapa Māori primary mental health and addiction services.
- For Whakamaua Action 6.1 –adopt innovative technologies and increase access to telehealth services that streamline patient pathways and provide continuity of care for Māori individuals and their whānau, especially building on recent experience of operating differently during COVID-19 alert levels 3 and 4

Whakamaua Objective: Shift 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.

- Whakamaua Action 3.3 –support the Māori health sector to attract, retain, develop and utilise their Māori health workforce effectively, including in leadership and management, such as actions to implement the Tumu Whakarae/DHB CEO agreement on workforce and any other local actions.

Whakamaua Objective: Reduce health inequities and health loss 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.

- Whakamaua Action 4.7 –Invest in innovative tobacco control, immunisation and screening programmes to increase equitable access and outcomes for Māori.
- Whakamaua Action 8.2 –publish our plans and progress in achieving equitable health outcomes for Māori including how we plan to communicate your plans and progress

Whakamaua Objective: Strengthen system accountability 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. Southern DHB has plans for the following:

- Whakamaua Action 1.4 –engage with local Iwi, using the engagement framework and guidelines, when developing major capital business cases
- Whakamaua Action 4.9 –invest in growing the capacity of iwi and the Māori health sector as a connected network of providers to deliver whānau-centred and kaupapa Māori services to provide holistic, locally-led, integrated care and disability support.
- Whakamaua Action 5.6 –support the delivery of Whāia te Ao Mārama 2018-2022: The Māori Disability Action Plan
- Whakamaua Action 8.5 –ensure that major system funding frameworks consider and adjust for unmet need and the equitable distribution of resources to Māori. These will likely be joint actions with other DHBs and the Ministry.

Actions: Whakamaua Objective: Accelerate and spread the delivery of kaupapa Māori and whānau-centred services	**Milestones**
Action 3.1: Establishment of a baseline for Māori employed with the Southern DHB across directorates by Q1	Q1: Establishment of baseline
Action 3.1: Implementation of the newly developed Māori workforce strategy in collaboration with other national workforce agencies, universities, polytechnics and health organisations commencing Q1	Q1: Implementation of Māori Workforce Strategy
Action 4.4: IGC and Māori health leadership to support the review of the Mental Health, Addiction and Intellectual Disability Review with view to increasing service responsiveness to Māori.	Q2, Q4: Report on work to increase responsiveness to Māori
Action 4.4: Southern DHB to monitor the roll out of the kaupapa Māori primary mental health and addiction service in the establishment phase.	Q1-Q4: Roll out of service is monitored
Action 6.1: Māori health leadership participation on the district telehealth working party under the GM Medicine, Women's and Children's directorate.	Q1-Q4: Participation in the working party
Actions: Whakamaua Objective: Shift cultural and social norms	**Milestones**
Action 3.3: Develop an allied health affirmative Māori employment approach that supports increased Māori employment interviewing and recruitment.	Q1: Baseline established
	Q2: Introduction of an affirmative employment programme into the allied health workforce recruitment programme
Action 3.3: Develop a Māori health leadership programme aimed at developing our Māori health workforce in health leadership, clinical and allied health.	Q2: Māori health leadership programme introduced
Actions: Whakamaua Objective: Reduce health inequities and health loss for Māori	**Milestones**
Action 4.7: Focus for the 2021/22 financial year is on Māori COVID-19 vaccination which includes the full vaccination of our over 16 year Māori population of 20,343 • Refer also to Smokefree, Cervical Screening and Breast Screening templates.	Q4: Reporting on vaccination programme.
Action 8.2: Publication of our Māori Health Directorate work plan for 21/22 and review throughout the year	Q1: Publication of Māori work plan in the public section of the Board meeting.
	Q1-Q4: Review of workplan
Actions: Whakamaua Objective: Strengthen System Accountability Setting	**Milestones**
Action 1.4: Engage with Te Rūnanga o Ngāi Tahu and local Māori communities when developing major business cases across the district, in consultation with Iwi Governance Committee	Q2, Q4: Reporting
Action 4.9: Engage with Kia Ora Hauora (KOH), the national Māori workforce development programme into the Southern district, working with WellSouth PHN and kaupapa Māori Health Providers to grow the number and increase the capacity of Māori working in the health and disability sector	Q2, Q4: Reporting
Action 5.6: Appoint an Iwi representative onto the Southern Health and Disability Steering Group	Q1: Appointment of an Iwi representative onto the Southern Health and Disability Steering Group
Action 8.5: Actions the DHB is undertaking to ensure that major system funding frameworks consider and adjust for unmet need and the equitable distribution of resources to Māori.	Q1-Q4: Information provided as required

• Provide information as required to the national team or systems to ensure the national framework consider this as part of the national review	
• Increase the equity investment that accelerates the spread and delivery of kaupapa Māori health services	Refer to whānau ora template for actions and milestones

2.1.2 IMPROVING SUSTAINABILITY

Improving Sustainability - Short term focus 2021/22

Actions to support improved sustainability in 2021/22 are outlined below. Southern DHB will be undertaking a wide set of activities to improve sustainability; actions are identified which are expected to have the most significant measurable sustainability impact in 2021/22, including actions initiated from/supported by

- sustainability funding initiatives
- national analytics
- strengthened production planning

Actions	Milestones
1. Sustainability funding initiatives Develop district-wide approach to connected and responsive clinical partnerships in relation to • Integrated services for frail elderly incorporating admission avoidance in Mosgiel (DN) • Integrated services for high needs whānau in South Dunedin, incorporating mental health • Primary maternity service configuration in Central Otago • Acute and urgent care incorporating community diagnostics in central Dunedin Initially this will require short term investment to develop the clinical partnership. The expectation is that $1.0m over the project in various forms. The main savings will be in Dunedin Public Hospital in terms of bed blockage, avoidable admissions and meeting the diagnostic requirements in terms of timely access.	Q1: District-wide approach developed Q2, Q3: Ideas tested Q4: District-wide approach implemented
2. Action initiated from/supported by national analytics – InterRAI analysis Comprehensive analysis of Psychogeriatric Age Related Residential Care cohort to better understand existing levels of Psychogeriatric utilisation and assess for variation against DHB's. Analysis will include: • Clinical and non-clinical characteristics • Inter DHB and Intra DHB (within Southern DHB) comparison We have made the assumption that a $1.0m savings will be made from this project.	Q1: Data scope and specification confirmed Q2: Analysis completed, reviewed and presented Q3: Scoping the automation of analysis for ongoing work plan
3. Strengthened production planning Through strengthened Production Planning, Southern DHB will reduce the number of elective surgery deferments due to acute theatre demand and due to bed availability, and that occur within 24hrs of the planned surgery. A district wide Day Cancellation Costs Report has been developed by the Executive Director Specialist Services (EDSS) and initiatives are being developed. Deferments cost the DHB in: • Lost theatre opportunity when beds are not available to proceed with the booked surgery • Staff rework and stress • Poor patient outcomes due to delays	Q2, Q3: Initiatives developed to strengthen production planning Q4: 25% reduction of elective surgery deferments within 24hrs due to acute theatre demand and bed availability compared with the previous year by Q4

Initiatives will be developed Q2 and Q3: • Forecast acute theatre demand hours to inform acute list planning • Use Bed Occupancy forecasting and engineering of elective list profiles to smooth the total demand on beds and optimise the use of operating lists • Work will be undertaken to achieve less variation in the provision of resourced beds The main benefit and savings from this project is to achieve 100% of the elective delivery. This will come from two areas: revenue not lost $2.0m and cost avoided in reducing outsourcing of $1.2m	
4. Refer also to pharmacy template for actions to understand utilisation and cost drivers of Southern district pharmaceutical use, especially high-cost pharmaceuticals.	

Improving Sustainability - Medium term focus (three years)

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 2021/22 year and include a brief rationale explaining why the action was selected.

Innovative approaches from COVID-19 learnings

- From the set of actions that the DHB is embedding as a result of COVID-19 learning/innovation (included throughout this plan), one action is identified that is expected to have the most significant impact on medium term sustainability.

Sustainable system improvements over three years

- One action is identified that will contribute the most to a reduction in cost growth over the next three years, (for example, in the areas of equity-based commissioning, integration of community and hospital services, using workforces in different ways)

Quantified actions from the DHB's path to breakeven

- This plan includes a subset of three actions/initiatives from Southern DHB's path to get to and/or sustain our path to breakeven over the next three years. Key milestones are identified for each of the 3 years and the impacts of each action to be realised in each year are quantified.

Actions	Milestone(s)
1. COVID-19 Learnings Embedding of Telehealth in Southern DHB Southern DHB has a large geographic area and lends itself well to the utilisation of Telehealth. Despite this prior to COVID the uptake of Telehealth was very low and it was identified as a key learning from COVID the need to ensure that Southern had a robust and sustainable Telehealth solution that could be easily accessed by both patients and staff and furthermore that all services were orientated to the use of the Telehealth solution. Orientation means that services have been appropriately set up to use Telehealth and given requisite training. • Southern DHB will commence a programme of work to build upon the work already undertaken to systematically bring services onto the Telehealth platform.	Q1: Programme of work to commence Q1 Q4: By the end of Q4, all hospital services in Southern DHB are orientated to the use of Telehealth
2. Sustainable system improvement over three years Enhanced investment in some key areas will see operational efficiencies gained in the medium to long term. These include: • Establishment of an ePMO (enterprise portfolio management office) whose aim will be to manage the definition & delivery of the DHB's portfolio in line with achieving our strategic objectives sustainably.	Q1: Programme of work underway

• Investment in a Medical Assessment unit, this is part of the Valuing Patient Time project • Investment in Production Planning at the hospital level which aims to optimise our resource utilisation and minimise waste. • Enhanced service planning to provide more support to services needing to consider their future models of care • Introduction of a full supported Service & accountability framework that drives operational clarity, efficiency and capability building. • Environmental sustainability – invest in the conversion of coal fired boilers to a sustainable source of energy. • Mental health transformation - models of care that are community based as the first option; this is intended to reduce the volume of inpatient bed nights.	Q4: Full establishment of ePMO completed and production planning, service planning enhanced capability embedded.
3. Quantified actions from the DHB's path to breakeven • Production Planning – reduced reliance on outsourced elective surgery. • Valuing Patient time – introduction of the MAU • Complete review of the number and value of maintenance agreements across the IT and IS systems	Annual reduction in outsourced electives by $1.0m per annum Annual benefits $2.5M Annual cost savings $1.0m

2.1.3 IMPROVING MATERNAL, CHILD AND YOUTH WELLBEING

Improving Maternal, Child and Youth Wellbeing - Maternity care

Equitable maternity care is a priority for the population. The overall way to achieve this in this planning cycle is through supporting a sustainable workforce, providing culturally safe services, ensuring integrated service models and supporting primary birthing.

This section includes the actions for the upcoming year that Southern DHB considers to be the most important for maternity care, including the reasons why the action(s) are important and the expected impact. Initiatives are highlighted to support a sustainable workforce through a positive culture. Actions are identified on implementation of recommendations from the Perinatal and Maternity Mortality Review Committee.

Actions: COVID-19 learnings	**Milestones**
1. COVID highlighted the importance of a well-coordinated network of primary maternity facilities, distributed across the District, to support the delivery of primary maternity care. • As a result of consultation with the community and with health care providers, Southern is developing purpose-built primary maternity facilities for Central Otago and Wanaka (to open 2024)	Q1: Final Board approval, RFP process initiated for identifying provider
	Q2: Business plan submitted to Treasury
	Q3: Provider/s identified
	Q4: Co-design of facilities begins
Actions: Integrated Service Model	**Milestones**
1. Social Services • Continue to improve the interprofessional support to whānau who are experiencing social complexity during pregnancy, including whānau who have family violence, alcohol or drug misuse, or significant mental health difficulties in pregnancy.	Q1: Midwifery Coordinators appointed in Dunedin and Southland Hospitals, working interprofessionally to implement Maternal Child Wellbeing and Child Protection (MCWCP) toolkit
	Q3: Audit of MCWCP shows evidence of effective and interprofessional safety and support plans in place for referred whānau
2. Ultrasound • Develop clear pathway and clinical governance for District's ultrasound services, including auditing of referral indications, to ensure that women receive clinically indicated and timely ultrasound services and do not receive non-clinically-indicated ultrasound.	Q1: Form pregnancy ultrasound reference group with SDHB and community providers of ultrasound services, and referrers, to develop clinical governance structure for pregnancy ultrasound
	Q3: Clear referral guidelines and auditing in place to identify gaps in access and referrals outside of clinical indications
3. Parenting Education • A Request for Proposal process, seeking to increase engagement of pregnant Māori and Pacific women and their whānau in pregnancy and parenting sessions, will be completed with the support of the Māori Health Directorate Q2 (EOA)	Q2: Pregnancy and Parenting RFP process completed

• New Pregnancy and Parenting contract/s in place and delivering services Q3 (EOA)	Q3: New pregnancy and parenting contract/s in place and delivering sessions
4. Well Child Tamariki Ora (WCTO) • Southern DHB contracted WCTO providers will all be supported to establish data management systems that capture, analyse and assist in reporting activity Q2 (EOA) (COVID-19 learning)	Q2: Data management systems are in place to support WCTO providers to capture, analyse and report data
5. Screening programmes • Established processes are in place to ensure that all babies have access to Newborn Metabolic screening and the Newborn Hearing screening programme according to established guidelines	Q2, Q4: Reporting of number of babies offered a newborn hearing screening by three months of age and total number of eligible babies
	Q2, Q4: Reporting of number of newborn babies offered Newborn Metabolic screening at age 48 hours and total number of eligible babies
6. Oral Health • Planning has been undertaken for a Māori outreach clinic to be established in Southland, combining dental therapists into the Te Kakano nurse led clinics entering the Kura. The plan was developed with Māori Health Directorate in consultation with the Kaupapa Māori Health Providers and clinical nurse specialists and will be implemented in 21/22.	Q1: Implement plan
	Q3: Review progress and develop evaluation
Actions: Midwifery Accord	**Milestones**
1. Support midwives in training, particularly Māori and Pasifika, to complete their midwifery training and consider working as midwives in Southern District	Q2: Applications advertised for scholarships to support 2022 second and third year midwifery students who live in Southern and are planning to work as midwives within Southern, to assist them with the on-call costs (phone and petrol) for students with hardship, with preference for Māori and Pasifika students
	Q4: Scholarships awarded
Actions: Recommendations from the Perinatal and Maternity Mortality Review Committee	**Milestones**
1. Identify and report on which recommendations from the Perinatal and Maternity Mortality Review Committee are being implemented • Provide bi-cultural competency workshops for all maternity staff at Southern	Q1: 10% of maternity staff sign up for new bicultural curriculum through OP/SDHB
	Q4: 20% of maternity staff have commenced bicultural curriculum
2. Monitor key maternity indicators by ethnicity to identify priorities for improvement	Q1: New dashboard reporting software displays key quality maternity outcomes by ethnicity
	Q2: Review by maternity clinical governance to identify priorities for improvement

3. Reduce preterm birth by increasing the identification of babies at risk antenatally and offering a comprehensive package of care to reduce risk	Q1: Begin implementation of the GROW/GAP programme to improve identification of babies at risk for growth-restriction and offer package of care for these babies/mothers including referral to smoke cessation services
	Q2: GROW/GAP programme is in place and identification of babies at risk for growth-restriction antenatally and at birth is in place.
	Q3: Audit of GROW/GAP programme and identification of priorities for improvement
4. Implement Health Quality & Safety commission (HQSC) maternal morbidity review toolkit	Q2: Maternal morbidity review group formed including community and whānau representatives; Terms of Reference (ToR) agreed
	Q3: Maternal morbidity review commenced
	Q4: Maternal morbidity review submits report with summary of learnings to Maternity Quality Safety Governance Group
Actions: Focus on Ambulatory sensitive hospitalisations for children age (0-4) (SLM)	**Milestones**
1. Implementation of the Southern Harti Hauora Assessment programme for Māori ASH 0-4 that supports whānau self-management, referrals and engagement of health and wellbeing services. Refer to SLM Plan.	Q1-Q4: SLM reporting
2. Māori Health Directorate will provide quarterly monitoring reports for ASH 0-4 admissions to paediatric services. Refer to SLM Plan.	Q1-Q4: Quarterly monitoring reports (SLM)

Improving Maternal, Child and Youth Wellbeing - Immunisation

Immunisation is an important priority for the Government as it is the best way to protect tamariki and whānau against a range of infectious and serious diseases. All DHBs are to contribute to healthier populations by establishing innovative solutions to improve and maintain high and equitable immunisation coverage at all scheduled immunisation events, from prenatal vaccinations through to adulthood vaccinations. Ensuring the Childhood Immunisation Schedule is maintained during New Zealand's COVID-19 response is essential.

The DHB Immunisation Lead will develop and maintain strong working relationships with the Southern Māori Health Leadership team to ensure they provide advice and guidance with immunisation work. This work includes:

- strategies on closing the equity gap
- prioritisation of Māori immunisation
- assisting to build networks through their contacts
- quarterly and annual reporting

Actions are identified for the upcoming year that we consider to be the most important for immunisation, including the reasons why the action(s) are important and the expected impact.

Focus on: Increased Immunisation at 2 years (CW05)

Key improvement actions are identified that are expected to have the most significant impact on performance improvement, along with contributory measures that will support measurement of progress.

Actions: Immunisation engagement and communications plan	**Milestones**
1. An Immunisation Engagement and Communication Plan will be developed in collaboration with key stakeholders. Q3 (EOA). Actions within the Plan will be prioritised with one or two actions identified to be delivered by Q4.	Q3: Immunisation Engagement and Communication Plan developed
	Q4: One to two actions identified and implemented
2. The Vaccine Preventable Disease (inclusive of Māori General Manager - Tumu Whakarare) and Well Child Tamariki Ora (WCTO) Steering Groups, and the Child and Youth Network will continue to meet and share up-to-date information with key stakeholders who deliver immunisations and support whānau access services Q1-Q4 (EOA)	Q1-Q4: Vaccine Preventable Disease and WCTO Steering Groups and the Child and Youth Network meetings meet regularly to ensure ongoing distribution of up to date immunisation information with key stakeholders
Actions: Increased Immunisation at 2 years (CW05)	**Milestones:**
1. Outreach Immunisation Services (OIS) Māori are more responsive to receiving health services and immunisations when they are Māori led and the setting for delivery is located within local communities known to them. This requires collaborative relationships with Māori providers and over time building immunisation capacity of Māori providers who employ nurses and working in partnership with the Māori Health Directorate. • Southern DHB Immunisation Coordinators will collaborate with Māori providers to deliver childhood immunisations, ensuring Māori engagement in delivery of services, closer to home Q1-Q4 (EOA) • This approach will also be used in relation to immunisation at age 8 months and 5 years.	Q1-Q4: Increased collaboration between Māori providers and outreach immunisation services to deliver childhood immunisations within local Māori communities

2. Māori Provider Development to increase vaccination capability Four Māori provider leads are working with WellSouth and Southern DHB to: • develop the COVID-19 vaccination model and delivery plan in 21/22 • train and credential of Māori vaccinators to undertake COVID vaccination • undertake childhood immunisations within the Māori community	Q1-Q4: Reporting on number of Māori vaccinators
3. To maintain the Childhood Immunisation Schedule and achieve equity for Pacific children, Southern DHB Immunisation Coordinators will work alongside Pacific providers to establish outreach services acceptable to Pacific communities Q1-Q4 (EOA).	Q1-Q4: Increased vaccinations of Pacific children as reflected in national target results
4. Contributory Measures Māori • Southern DHB Immunisation Coordinators will work alongside Māori providers wanting to establish capacity to deliver Q1-Q4 (EOA)	Q4: Increased number of Māori providers delivering childhood immunisations
	Q1-Q4: Increased vaccination of Māori children reflected in national target results
	Q1-Q4: Increased number of Māori vaccinators
5. Contributory Measures • Utilise National Immunisation Register (NIR) data for the early identification of children, particularly Māori and Pacific, who may need Immunisation Outreach Services to achieve immunisations on time Q1-Q4 (EOA)	Q1-Q4: Immunisations on the National Immunisation Schedule are received on time for Māori and Pacific children – reflected in national target results.
Action: MMR campaign	**Milestones**
1. Continue delivery of MMR vaccine and the campaign until the end August 2021 Q1 EOA. • Final reporting will be completed and submitted to the Ministry of Health (MoH), including a summary of numbers vaccinated, demographics, along with commentary on key observations, successes and challenges in getting 15-30-year-olds vaccinated Q2 (EOA)	Q1: Delivery of final vaccines for the MMR campaign completed
	Q2: Final reporting of the Southern MMR Campaign completed and submitted to MoH
Action: COVID-19 vaccine rollout	**Milestones**
1. Ongoing establishment and assessment of processes for the successful roll out of the COVID-19 vaccine according to the Ministry of Health's COVID-19 Immunisation Programme Q1-Q4 (EOA).	Q1-Q4: Narrative reporting
2. Ongoing delivery of the COVID-19 vaccine ensuring protection for Māori, Pacific peoples and the most vulnerable populations such as older people, disabled people, health and essential workers and border staff Q2-Q4 (EOA)	Q2-Q4: COVID-19 vaccine is delivered to the Southern population according to MoH's COVID-19 Immunisation Programme ensuring equity of outcomes
Action: Maintain immunisation coverage during the COVID-19 immunisation programme	**Milestones**
1. Southern DHB Immunisation Coordinators will collaborate with Māori providers to deliver childhood immunisations, ensuring Māori engagement in delivery of services, closer to home Q1-Q4 (EOA)	Refer to actions above for milestones
2. Additional support will be added to the immunisation workforce to address the equity gap for Māori	Q1: Identification of additional supports required

• Identify additional supports required by Q1. • Additional supports in place by Q3	Q3: Additional supports in place
3. Several children are not enrolled with a GP in the Southern district. • NIR staff will produce reports to identify children who are close to missing their milestone immunisation. These reports are utilised to enable Outreach Services to organise Outreach clinics (Q1-Q4)	Q1-Q4: NIR produce and use reports to identify children who are close to missing their milestone immunisation; information is used to facilitate immunisation of children through outreach clinics.
4. Southern DHB to employ an 0800 number to address enrolment enquires (Q1-Q4)	Q1-Q4: 0800 number used to address enrolment enquiries

Improving Maternal, Child and Youth Wellbeing - Youth health and wellbeing

Youth health and wellbeing sits under the Government's Child and Youth Wellbeing Strategy and Current Programme of Action. Youth access to and utilisation of youth appropriate health services (youth are healthy, safe and supported) is a quality improvement focus for DHBs as one of the six System Level Measures.

Southern DHB takes a youth health and wellbeing service planning and improvement approach in our Annual Plan, including a range of youth health service such as School Based Health Services (SBHS), mental health and wellbeing, sexual and reproductive health, alcohol and other drugs, and primary care. SBHS are aimed at increasing access to primary care for young people and provide clinical primary health care (both student-requested and nurse-initiated), referral onto required services, and support health promotion campaigns. Southern DHB will ensure that year nine students receive a comprehensive bio-psycho-social assessment.

Actions are included for the upcoming year that Southern DHB considers to be the most important for youth health and wellbeing. These include actions to improve the health and wellbeing of the priority youth populations: Māori rangatahi, Pacific rangatahi, rainbow rangatahi, rangatahi in care and disabled rangatahi. Additional actions are included that focus on SBHS quality improvement activities we will undertake (guided by Youth Health Care in Secondary Schools: A framework for continuous quality improvement, and the SBHS Enhancement Programme) in each school (or group of schools).

Actions: Additional School Based Health Services	**Milestones**
1. Te Punaka Oraka (Population Health) will complete establishment of processes to ensure delivery of school nursing support to all decile 1-5 schools (EOA).	Q1-Q4: School nursing services will be delivered in decile 1-5 schools.
2. School nurses will maintain contact with decile 1-5 schools and priority students especially during any future lockdown events Q1-Q4 (EOA), via phone calls and use of ZOOM	Q1-Q4: School nurses maintain contact with priority students
3. With the support of Learning Support Coordinators, complete year 10 catch up, for those who missed year 9 checks in Southland Girls High School (SGHS), prioritising Māori and Pacific and those needing additional support Q2 (EOA).	Q2: Catch up programme completed in SGHS for year 10 girls who missed the year 9 check
4. *Youth Health Care in Secondary Schools: A Framework for Continuous Quality Improvement* will guide engagement with young people accessing SBHS and support use of confidentiality surveys to be completed by young people on services received Q1-Q4 (EOA)	Q1-Q4: Ongoing confidentiality surveys completed in secondary schools receiving SBHS
Actions: Improve the health and wellbeing of the priority youth populations	**Milestones**
1. Enhanced Youth Health Clinics (EYHC) across the Southern district are prioritised so young people, especially in rural areas, can continue to engage and access contraception, especially during any future lockdown events Q1-Q4 (EOA)	Q2, Q4: Reports on EYHC
2. EYHC to provide access to testing for sexually transmitted diseases (STI) including chlamydia testing – services to be available at all times, especially during future lockdowns events Q2 and Q4 (EOA).	Q2, Q4: EYHC to provide access to chlamydia and other STI testing especially during any future lockdown events
3. Te Punaka Oraka (Population Health) will work to ensure workforce awareness of the five principles in *Whakamaua: Māori Health Action Plan 2020-2025* to support youth health services delivered by public health nurses (EOA).	Q1-Q4: Ongoing of training of public health nurses on *Whakamaua: Māori Health Action Plan 2020-2025* continues
4. Explore multiple youth focussed options (including telehealth, Zoom and Teams meetings) to support access to specialist sexual health and contraception consultations for remote areas	Q1-Q4: Exploration of youth focussed options
5. Refer also to youth mental health actions included in System Level Measures (SLM) Improvement Plan	

Improving Maternal, Child and Youth Wellbeing - 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.

Actions	Milestones
1. Implement Violence Intervention Programme (VIP) Portal with policies / procedures guidance to consolidate the portal	Q1: Development of programme portal with IT.
	Q1: All Family Violence policies updated on MIDAS in order for links to be incorporated into the portal
	Q1: Launch of the portal within SDHB using Pulse, Communications, VIP champions and education groups.
2. Regular participation in the Whāngaia Nga Pa Harakeke Rōpū Manawhakahaere (Police Initiative) on the Dunedin and Invercargill sites to ensure health is contributing to a multi-agency approach to Family Violence • This action is important as part of supporting family violence response work in this area (which commenced during COVID-19) and to ensure the work is embedded with safe and appropriate practices and processes.	Q1-Q4: Regular attendance at Whāngaia Nga Pa Harakeke
	Q1-Q4: Collaborate with mental health to ensure safe and appropriate response to SDHB family violence programme, policy and processes
3. Actively engage with kaupapa Māori providers and services in relation to FV and SV (EOA)	Q1-Q4: VIP team engagement with Māori Directorate for policy and programme development
	Q1: VIP team to develop a clear overview of kaupapa Māori services in relation to FV and SV services in the Southern district.
	Q2-Q4: VIP team engagement with kaupapa Māori services.
4. Implement Elder Abuse education and routine enquiry	Q1: Standalone training/education package for elder abuse and neglect education is developed

	Q1: Elder Abuse and Neglect (EA&N) component strengthened into VIP core training
	Q1: Elder Abuse community service participating in VIP Steering Group
	Q2: VIP representative established in the Elder Abuse and Neglect Community Steering Group at Age Concern
	Q3: Elder abuse training package is offered as a training option in SDHB
5. Develop a Quality Improvement Plan for the work of VIP	Q1: VIP team meeting to draft quality improvement plan
	Q3: Review of quality improvement plan and reporting outcomes
6. VIP team to review staff attitudes and understanding of family violence and impact on Māori as well as the VIP service's cultural competence when engaging with Māori staff.	Q2: Develop a survey seeking feedback on staff attitudes and understanding of family violence and the impact on Māori

2.1.4 IMPROVING MENTAL WELLBEING

Improving mental wellbeing

Improving the mental wellbeing of people in New Zealand remains a priority for the Government. *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* and the Government's response have set the direction for transforming New Zealand's approach to mental health and addiction. This includes:

- ensuring our approach works for and meets the needs of Māori and addresses inequitable mental wellbeing outcomes experienced by other groups including Pacific peoples, rainbow communities and children and young people
- moving to a holistic approach grounded in wellbeing that recognises the social, cultural and economic foundations of mental wellbeing and looks across the life course
- ensure access to mental health services, alcohol and drug treatment and harm reduction services
- increasing access to and choice of mental wellbeing supports to ensure all people in New Zealand receive the support they need, when and where they need it
- putting people and their whānau at the centre of their care and designing supports collaboratively with whānau, communities and people with lived experience
- ensuring suicide prevention and postvention approaches demonstrably align with Every Life Matters – He Tapu te Oranga o ia tangata Suicide Prevention Strategy 2019 – 2029 and Suicide Prevention Action Plan 2019 – 2024 for Aotearoa New Zealand, and that each DHB has a current Suicide Prevention Action Plan.

This transformation has become more critical in the wake of COVID-19 and the expected ongoing impacts on people's mental wellbeing.

Southern DHB actions will further this transformation and align with the mental wellbeing framework that underpins *Kia Kaha, Kia Māia, Kia Ora Aotearoa: COVID 19 Psychosocial and Mental Wellbeing Plan.* We will work collaboratively with sector partners, communities and whānau to provide a range of services that are of high quality, safe, evidence informed, equitable and provided in the least restrictive environment. Actions are included for the upcoming year that we consider to be the most important for improving mental wellbeing, including the reasons why the action(s) are important and the expected impact. Action are also included to address inequitable mental health and addiction outcomes experienced by Māori.

Focus on: Follow-up within seven days post-discharge from an inpatient mental health unit (MH07)

Follow-up within seven days post-discharge is important for the prevention of suicide, self-harm, and other negative outcomes such as readmission. Key improvement actions are included that are expected to have the most significant impact on performance improvement, along with contributory measures from the KPI programme.

Actions: Psychosocial response to and recovery from COVID	**Milestones**
1. The Central Lakes Wellbeing Recovery Group has been established to manage the local COVID-19 response. Central Lakes has been identified as an area within the Southern DHB catchment that has been disproportionately impacted by the COVID-19 pandemic. The area covers Queenstown Lakes and the Central Otago area. The Group's Terms of Reference are strongly aligned to the Guiding Principles of Kia Kaha, Kia Maia, Kia Ora Aotearoa: COVID-19 Psychosocial and Mental Wellbeing Plan, in particular the Principles of Equity, People and Whānau at the Centre, Community Focus and Collaboration. This Group is a collaboration of multi agencies and multi stakeholders for this geographic sub region. It will deliver: • A communications strategy which will, amongst other things, gather, share and monitor information about mental wellbeing and capacity of services in the area. • Advocate for the mental wellbeing needs of this community, particularly through developing and maintaining Iwi relationships and relationships with leaders in Councils, the DHB and other stakeholders.	Q1: Communication Strategy confirmed in Q1 and implemented in Q2,3,4 Q2-Q4: Communication Strategy implemented Q1: Mechanism to ensure connectivity between Iwi and all stakeholders to support advocacy for Māori and vulnerable populations scoped in Q1 Q2, Q3: Mechanism implemented to ensure connectivity between Iwi and all stakeholders to support advocacy for Māori and vulnerable populations

	Q4: Initial evaluation of effectiveness
2. Establish a navigator position in the Central Lakes sub region to enhance the integration of primary mental health and addiction services with specialist mental health and addiction services as part of the psychosocial response • The navigator, who will be appointed towards the end of 2020/21, will be part of the community (Central Lakes) and work to ensure direct access for individuals and groups to information resources and services including the interface between primary and specialist services.	Q1: Orientation to the role, community and services stakeholders
	Q2-Q4: Engagement and embedded within the local response
	Q1-Q4: Activity reports submitted to Governance Group of Central Lakes Wellbeing Recovery Group monthly
3. Principle 7 in Kia Kaha relates to innovation in response to the challenges raised by the COVID-19 pandemic. In particular, this involves making use of new ways of delivering services. The Mental Health, Addiction and Intellectual Disability Services (MHAID) Directorate is proposing a mixed model of face to face consultations and telemedicine consultations for Child and Youth Specialist clinics. This is particularly relevant given the geographical challenges faced with service delivery at Southern DHB against the backdrop of the COVID-19 pandemic.	Q1: Implementation of model by Q1
	Q3: Review of model of care by Q3
Actions: Evidence Based Equity Actions for Improving Mental Wellbeing for Māori	**Milestones**
1. The development of Mental Health Advanced Preferences/Statements (MAPS) MAPS are a tool which allows us to realise some of the key principles contained in Whakamaua: Māori Health Action Plan including Tino Rangatiratanga and equity of access.	Q1: Development of MAPS tool for Māori
	Q2: Prepare an implementation plan for further roll out of MAPS across the District
	Q2: Develop and deliver education resources/programme on the use of MAPS
	Q4: Review progress over the course of the year including numbers of MAPS developed and implemented and a localized study on looking at consumer satisfaction with the MAPS process.
2. Reducing Seclusion and Restraint remains a priority for Southern DHB. Our outdated facilities for service provision will continue to challenge us in this area. However, we will continue to participate in the Health Quality and Safety Programme for Zero Seclusion. • This work is closely linked with the ongoing work in Connecting Care – Improving Service Transitions and Learning from Adverse Events. This is particularly relevant for models of care are inclusive of the needs of Māori.	Q1-Q4: Use of seclusion is monitored on a monthly basis.
	Q4: Number of seclusion events is reduced compared to the same quarter in 2020/21, by Q4
	Q4: Number of hours for patients in seclusion is reduced from the same quarter in 2020/21, by Q4
3. The Independent Review of Southern Mental Health and Addiction System Continuum is currently underway (February 2021). We expect that the final report from the Review will be available in June/July 2021. The report will produce a set of recommendations for implementation which places tangata whaiora and whānau at the centre of the system.	Q1: System Review Report is available in Q1
	Q2: An implementation Plan for the recommendations from the Report is developed by Q2

	Q3, Q4: Reporting against progress on implementation of the recommendations
Actions: Follow up within 7 days post discharge from an inpatient mental health unit (MH07)	**Milestones**
1. Key Improvement actions: • Data reviewed for errors • Data is shared and discussed at Directorate level meetings with a quality improvement lens to determine what additional marginal gains can be made.	Q1-Q4: Data is subjected to quality review after each quarter and errors corrected/individual follow up is undertaken as required
	Q1-Q4: Data is shared and discussed
2. We have selected Inpatient Average Length of Stay (days) as the contributory measure from the KPI programme to focus on in relation to this particular action. • The Operational Management Team of the Mental Health and Addictions Directorate will meet monthly to measure and report on this indicator and to benchmark against the national ALOS.	Q1–Q4: The Team reviews, identifies and implements measures to manage AV LOS over each quarter.
Actions: Improving mental health services using wellness and transition (discharge) planning (MH02)	**Milestones**
1. The MHAID Directorate has a programme of work in place (since April 2019) focusing on this indicator. The programme has demonstrated some success with continual improvement in community based clients having a wellness/discharge plan in place. Similarly, the percentage of inpatient clients has in recent quarters achieved 100% compliance of patients having wellness/discharge plans in place. There are a number of specific actions that will continue to be undertaken to improve/maintain the outcome on this Key Performance Indicator (KPI).	Q1-Q4: Raise understanding amongst staff of the importance of this KPI at every appropriate opportunity (e.g. team meetings) so that it is embedded as BAU thinking
	Q1-Q4: Managers actively monitor compliance on a regular basis and target service areas that are below compliance
	Q1-Q4: Monitoring system established and utilized so that all managers receive and review weekly compliance reports
	Q1-Q4: Quality audits undertaken on a regular basis. Results are reviewed to determine opportunities for improvement
	Q1-Q4: Ensure that there is competency and confidence in entering data into IPM through the provision of refresher training to staff
	Q1-Q4: Meet the programme milestones of the HQSC Programme for Connecting Care, improving service transitions
	Q2, Q4: Implementation and embedding of the internal DHB review of Transition (discharge) Guidelines. This review identified 4 work streams that will result in improved outcomes for this KPI

Actions: Mental Health and Addiction Service Development – MH04 Focus Area 1 – Primary Mental Health.	Milestones
1. The Integrated Primary Mental Health Programme (Access and Choice) was implemented in Southern DHB during the 2020 calendar year. To date, the Programme has been established in 17 General Practices across the Southern DHB area. We will work with the MoH to extend this Programme (depending on funding) to other General Practices across the Southern district. Integrated health pathways (from primary care through to specialist mental health services) are a key feature of this programme and referral of patients from primary care to specialist services is a feature of this Programme.	Q1-Q4: Consolidate the programme where it has been established in General Practice Q1, Q2: Extend the programme into additional General practice settings.

2.1.5 IMPROVING WELLBEING THROUGH PREVENTION

Improving Wellbeing through Prevention - Communicable diseases

Current context – COVID-19

Aotearoa New Zealand has a strategy for the elimination of COVID-19. The aims are to eliminate transmission chains and to prevent the emergence of new transmission chains originating from cases that arrive from outside the country. COVID-19 is a public health emergency and global pandemic. It is fundamentally changing and challenging the way the New Zealand public health system responds, especially in terms of what and how public health services are delivered. The COVID-19 response and associated activities delivered by the DHB-based public health units (PHUs) are now integrated with the Ministry of Health (led by the COVID-19 directorate). Each outbreak is delivering significant learning opportunities for all parties, and the Ministry will ensure these learnings are shared across the sector and incorporated into future responses and activities.

This plan includes actions for the upcoming year that Southern DHB consider to be the most important for communicable diseases, including key actions the DHB will undertake to continue to support COVID-19 recovery and/or embed key learnings from our COVID-19 response in this priority area. The actions identified in this plan are those expected to have the most significant impact on improved outcomes.

Core functions – Health Promotion, Health Protection, Health Assessment & Surveillance and Public Health Capacity Development

As the response to COVID-19 is the Ministry's top priority for all DHBs/PHUs Southern DHB will continue to support the response both in your own DHB/s areas and also, where applicable, in other DHB/s areas. This plan includes key actions that Southern DHB will undertake to advance other communicable diseases control work, where resources and capacity allows.

Actions:Communicable disease Core functions – Health Promotion, Health Protection, Health Assessment & Surveillance and Public Health Capacity Development.	**Milestones**
1. Evaluate the roll out of Redcaps® as a means of managing notifications of common notifiable enteric diseases Q2.	Q2: Evaluation report completed
2. Respond to any emerging notified outbreaks or cases of disease as per the Communicable Disease manual	Q2, Q4: Narrative reports
Actions: COVID-19 response The Ministry of Health continues to advise that responding to COVID-19 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.	**Milestones**
1. Implement a timely response to COVID-19 including assurance around capacity for case management and contact tracing Q1-Q4.	Q1-Q4: Narrative reports
2. Ensure that surge response planning is in place for any community COVID cases and contact tracing.	Q1-Q4: Narrative reports on surge planning
3. Maintain ongoing training for current workforce and any surge workforce	Q1-Q4: Narrative reports
4. Support activity at our maritime borders aimed at keeping COVID-19 out Q1-Q4.	Q1-Q4: Narrative reports
5. Strengthen engagement and liaison with Māori and Pacific health providers in the Southern District around public health COVID response. (EOA)	Q2, Q4: Narrative reports

6. Develop the public health unit business continuity plan for alert level responses	Q1: Alert Level Plan developed
7. Support the roll-out of the COVID-19 vaccination programme and in particular advocate for ensuring its accessibility to vulnerable communities Q1-Q4 (EOA)	Q1-Q4: Narrative reports

Improving Wellbeing through Prevention - Environmental sustainability

Southern DHB will continue with actions that mitigate and adapt to the impacts of climate change, enhance the co-benefits to health from these actions, and support the health sector's response to the greenhouse gas emissions reduction targets under the Climate Change Response (Zero Carbon) Amendment Act. Actions will have a pro-equity focus.

Actions are include for the upcoming year that Southern DHB considers to be the most important for environmental sustainability, including actions we will undertake to support COVID-19 recovery and equity actioned focused on our Māori population. Southern DHB is undertaking actions to meet their obligations under the CNGP, including readiness to report emissions (emissions reporting defined under the CNPG) from 1 July 2022 and set reduction targets and plans for 2025 and 2030.

Actions	Milestones
1. Zero coal use at Southern DHB by 2030	
• Feasibility study to convert Dunedin Energy Centre to carbon neutral sustainable fuel	Q2: Feasibility study completed by Q2
• To be confirmed – this is commercially sensitive	Q4: Updates on progress
2. Reduce Electricity use through behaviour education campaign	
• Behaviour education campaign undertaken Q2 and Q3	Q2, Q3: Behaviour education campaign completed
3. Implement waste reduction initiatives	
• Six waste reduction initiatives implemented during 2021/22, with a 50% reduction in waste to landfill by 2030	Q4: Six waste reduction initiatives implemented by Q4
4. Engagement of staff and culture change	
• Develop sustainability criteria for procurement policies, tender documents and contracts Q3	Q3: 100% of procurement contracts to have Green Healthcare criteria by Q3
5. Increase use of telehealth by Māori providers and rūnanga (EOA)	
• Explore feasibility and funding options	Q1: Feasibility and funding options explored
• Consult with and provide education to Māori providers	Q2: Consultation/provision of education to Māori providers
6. COVID-19 led to an increase in the use of telehealth at all levels. • Refer to the Planned Care template for actions and milestones	

Improving Wellbeing through Prevention - Antimicrobial resistance (AMR)

Antimicrobial resistance (AMR) is an increasing global public health threat that requires immediate and sustained action to effectively prevent and mitigate its impact on individual and population health. DHBs have an important role in preventing and mitigating the impact of AMR. DHBs actions contribute to key areas of focus in the New Zealand Antimicrobial Resistance Action Plan (2017-2022) - raising awareness and understanding; surveillance and research; infection prevention and control; antimicrobial stewardship and governance; collaboration and investment.

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.

Our plan also includes

- Key actions the DHB will undertake to continue to support COVID-19 recovery and/or embed key learnings from our COVID-19 response in this priority area,
- Equity actions focused on our Māori population.

Actions: **COVID recovery**	**Milestones**
1. During COVID-19 the need for expanded Infection Prevention & Control (IP&C) Clinical Governance was highlighted in order to ensure the effective provision to Infection Prevention and Control across the whole of Southern Health Care System. The new Health & Disability Service Standards have combined IP&C with Antimicrobial Stewardship (AMS). • Southern DHB will develop the IP&C/AMS Clinical Governance systems and structure to ensure representation and engagement across primary and community care specifically ARC.	Q1, Q2: Meetings scheduled and reporting to Clinical Council established in line with the revised IP&C and AMS Committee TOR.
	Q3: Review of 2021/22 Work Plan and development of a high level work plan for 2022/23 year
	Q4: IP&C/AMS work plan 2022/23 approved by Clinical Council
Action: Advance progress towards managing the threat of antimicrobial resistance	**Milestones**
1. The ICNet information System platform purchased and rolled out in Q4 2021 will be fully implemented to maximise the IP&C surveillance capability within Southern DHB. Data reporting and analysis will be used to identify and manage IP&C clinical risks and reduce Healthcare Acquired Infections. The aim is to prevent infections thereby reducing the need for Antimicrobial use.	Q1: IP&C team have a clear understanding of the capability of the iCNet Surveillance system as applied to Southern DHB
	Q2: Development of the IP&C and Clinical Services workflows utilising iCNet
	Q3: Development of a suite of reporting for organisational and clinical governance systems
	Q4: Analysis of data to prioritise systems improvements for the 2022/23 IP&C/AMR work plan

Actions: Advance AMR management across primary care, community (in particular age-related residential care services) and hospital services	**Milestones**
1. Aged Residential Care ARC) has previously been identified as an area that requires increased Infection Prevention and Control support to keep their vulnerable population safe. This was further highlighted with the challenges of COVID-19 pandemic. Southern DHB has new fixed term IPC ARC resource supporting the sector. ARC services will be required to ensure they meet the new Health & Disability Services Standards as applied to IP&C and AMR. A programme of education will be implemented and reviewed. A plan will be made for sustaining the capacity and capability of the ARC services in relation to the standard.	Q1: Development and implementation of the AMR component for the standardised education programme for ARC facilities
	Q2: Continue to refine the education programme and determine a sustainable system for Q3, Q4
	Q4: Sustainable system implemented.

Improving Wellbeing through Prevention - Drinking water

Core function – Health Protection.

Through Public Health South, Southern DHB will undertake compliance and enforcement activities relating to the Health Act 1956, by delivering on the activities and reporting on the performance measures contained in the Drinking water planning and reporting document 2021/22.

Our plan also includes key actions the DHB will undertake to continue to support COVID-19 recovery and/or embed key learnings from our COVID-19 response in this priority area, as well as equity actions focused on our Māori population.

Actions	Milestones
1. Work with small water suppliers (under 100 users) to get them on a pathway to ensure they minimise public health risks through compliance with the current Drinking Water Standards for New Zealand	Q2: Project to increase compliance of small water suppliers with Drinking Water Standards completed
2. Ensure Southern DHB responds in a timely manner to transgressions, water supply contamination or interruptions to the supply, including taking appropriate measures to protect and advise the community.	Q2, Q4: # investigations related to incidents, complaints and notifications
3. Develop key messages to discourage use of drinking fountains in schools and community settings during any future COVID-19 lockdown events.	Q2, Q4: Communication of key messages developed and available if needed
4. Work with Kāti Huirapa Rūnaka ki Puketeraki as a follow-up to “lead in drinking water” to ensure water quality issues are appropriately addressed from a cultural perspective Q2 (EOA)	Q2, Q4: Follow up with Kāti Huirapa Rūnaka ki Puketeraki on drinking water quality
5. Complete the annual review compliance reporting for 2020/21 for all supplies over 100 people.	Q1: Complete annual review of compliance

Improving Wellbeing through Prevention - Environmental and border health

Core function – Health Protection.
Through Public Health South, 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 Health planning and reporting document.

Our plan also includes key actions we will undertake to continue to support COVID-19 recovery and/or embed key learnings from our COVID-19 response in this priority area as well as equity actions focused on our Māori population.

Actions	Milestones
1. Work to support Border Agencies as the COVID-19 risks are reduced and current controls are relaxed	Q2, Q4: Narrative report on progress
2. Process applications for Vertebrate Toxic Agent (VTA) operations that require public health permissions	Q4: # routine applications processed within 20 working days
3. 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 Q2	Q2: Evaluate the improvements completed
4. Update and renew relationship agreement between Southern DHB, Aukaha and Te Ao Marama for Murihiku environment health issues Q2-Q4 (EOA)	Q2: Draft relationship agreement developed
	Q4: Relationship Agreement agreed to and signed off by all parties

Improving Wellbeing through Prevention - Healthy Food and Drink environments

Southern DHB will create supportive environments for healthy eating and health weight by continuing to implement our 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)

Actions are included for the coming year that we consider to be the most important for healthy food and drink environments and improving equity, including the reasons why the action(s) are important and the expected impact. We will implement Healthy Active Learning in priority settings (decile 1-4 Schools/Kura, low equity index Early Learning Services/Early Learning Services with Māori/Pasifika rolls > 35%). Our plan also includes key actions we will undertake to continue to support COVID-19 recovery and/or embed key learnings from our COVID-19 response in this priority area.

Actions: Healthy Food and Drink Policy	**Milestones**
1. Continue to implement our Healthy Food and Drink Policy and ensure alignment with the policy in all our cafeterias Q1-Q4.	Q1-Q4: Ongoing implementation of the Healthy Food and Drink Policy in all Southern DHB cafeterias
2. Ongoing monitoring of Southern DHB cafeterias will occur to ensure compliance with the Healthy Food and Drink policy Q2 and Q4	Q2, Q4: Monitoring to ensure compliance with the Healthy Food and Drink Policy
3. Southern DHB will participate in and provide local data to the national survey being undertaken to monitor compliance against Southern DHB's Healthy Food and Drink Policy Q4.	Q4: Participation in the national survey
Actions: Healthy Active Learning	**Milestones**
1. Ongoing development of collaborative relationships between Southern DHB (Public Health South) and key stakeholders to assist the implementation of Healthy Active Learning in priority settings, Q2 and Q4, EOA.	Q2, Q4: Data collected on the number of up-to-date healthy food and drink policies embedded in priority settings
2. Work with Heart Foundation and Oral Health Teams in priority primary schools and early learning settings where we have a mutual interest. Look at where their outcomes align with ours and ways that we can share reporting data to assist the implementation of Healthy Active Learning in priority settings, Q2 and Q4 (EOA).	Q4: Success stories collected on the implementation of Healthy Food and Drink Policies in priority settings
Actions: COVID-19 response	**Milestones**
1. Identify and quantify food security issues in the community that have become apparent as a result of COVID-19 and work with collaborative partners to design and implement interventions aimed at addressing them	Q2: Issues identified and quantified. Report developed.
	Q4: Evidence based interventions designed and implementation commenced

Improving Wellbeing through Prevention - Smokefree 2025

Core functions – Health Promotion, Health Protection, Health Assessment & Surveillance and Public Health Capacity Development.

New Zealand has a goal of reducing smoking prevalence and tobacco availability to minimal levels, making us essentially smokefree by 2025. To reach Smokefree 2025, there are opportunities to improve on what we are doing now, as well as to do more, with a sharper focus on reducing inequities in smoking prevalence.

Southern DHB will undertake compliance and enforcement activities relating to the Smoke-free Environments Act 1990 and Regulated Products Act 1990 by delivering the activities and reporting on the performance measures contained in the Smokefree 2025 planning and reporting document.

This plan includes actions for the upcoming year that we consider to be the most important for Smokefree 2025, including the reasons why the action(s) are important and the expected impact. Our plan includes equity actions focused on our Māori populations. Our plan also includes key actions we will undertake to continue to support COVID-19 recovery and/or embed key learnings from our COVID-19 response in this priority area.

Actions	Milestones
1. Undertake compliance and enforcement activities in relation to the Smokefree Environments and Regulated Products Act 1990. Report measures as required once the implementation process has been made clear.	Q2, Q4: Reporting
2. Work with stakeholders and Councils to expand the range of smoke-free environments in the Southern District	Q1, Q4: Identification of new outdoor spaces created by Councils
3. Deliver training to clinical teams and promote the use of systems to increase referrals into the Southern Stop Smoking Service (SSSS) Q1-Q4 (EOA). Baseline 352 referrals for Q4 2019-20.	Q1-Q4: Southern DHB clinical staff trained to make referrals into the Southern Stop Smoking Service
	Q1-Q4: Systems in place to ensure clinical staff can make referrals.
4. Work to shift the ownership of smoke-free targets to the clinical teams responsible for implementing them.	Q4: Referrals from clinical services within the DHB will increase to pre COVID-19 levels by Q4. Target 600 per quarter.
5. Connect Southern Community Laboratory pregnancy data to WellSouth PHO smoking data base to identify all pregnant women who are smokers. • The WellSouth PHO call centre will use this information to contact all wāhine who are pregnant and smoking, to offer brief advice and referral to SSSS as appropriate. In this way every new mother in the southern district who smokes will be offered help to quit smoking.	Q2: Data base established
	Q2-Q4: All pregnant women who smoke are contacted by WellSouth PHO call centre
6. Complete the beta test for the Vape to Quit programme and initiate the pilot. • Vape to Quit offers an additional tool to assist more smokers to quit. The programme targets Māori by engaging directly with Māori Non-governmental organisations (NGOs) to maximise access by Māori smokers.	Q1: Beta test completed and pilot initiated
	Q4: Pilot evaluated

7. Continue the rollout of the call centre supporting the primary care catch up programme of work. This call centre will target the tobacco health target in general practice and assist in delivering brief advice to smokers who are overdue or due, in order to reach the target of 90%. Baseline for Māori 76%	Q4: 90% for Māori

Improving Wellbeing through Prevention - 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.

Our plan includes actions for the coming year that we consider to be the most important for breast screening and improving equity, including the reasons why the action(s) are important and the expected impact. Our plan also includes key actions we will undertake to continue to support COVID-19 recovery and/or embed key learnings from our COVID-19 response in this priority area.

Actions	Milestones
1. BreastScreen (BSA) will fully recruit and retain mammographers to ensure the service has maximum capacity to meet demand and catch up on delays caused by COVID-19. Baseline: Māori 63.3%, Pacific 56.5%	Q2-Q4: Recruit and retain full complement of FTE mammographers
	Q2, Q4: Six monthly reports. Target: Māori 70%, Pacific 70%
2. BSA will action a Māori and Pacifica priority booking process where appointments for mammography are held and prioritised for Māori and Pacific women.	Q1-Q4: Appointment prioritisation for Māori and Pacific women actioned
	Q4: Number of completed appointments by Māori and Pacific women.
3. BSA will initiate a Kaimahi service that supports the wider needs of Māori and Pacific women when accessing the BSA service. This may include support for transport and helping with children and family to eliminate barriers to access.	Q1-Q4: Kaimahi service actioned
	Q4: Number of women supported

Improving Wellbeing through Prevention - Cervical screening

Increasing coverage and improving equitable access to screening and colposcopy services, with a particular focus on Māori and Pacific women, will reduce the burden of cervical cancer in these priority groups.

Our plan includes actions for the coming year that we consider to be the most important for cervical screening and improving equity, including the reasons why the action(s) are important and the expected impact. Southern DHB has set measurable participation and equity targets from baseline data. Our plan also includes key actions we will undertake to continue to support COVID-19 recovery and/or embed key learnings from our COVID-19 response in this priority area. Actions are included to

- Improve coverage in Māori and Pacific women aged 25-69 years from the baseline as at February or March 2021. The baseline is measured using NSU NCSP monthly Shiny App coverage using February or March 2021 data as the baseline https://minhealthnz.shinyapps.io/nsu-ncsp-coverage/
- Reduce the equity gap for Māori and Pacific women from baseline as at February or March 2021. The baseline is measured using the NSU cervical screening Equity Matrix using February or March 2021 data as the baseline https://minhealthnz.shinyapps.io/nsu-ncsp-coverage/
- Improve equitable access to diagnostic and treatment colposcopies for priority groups referred with a high-grade result. The baseline is measured using available data in late 2020 or early 2021 from DHB colposcopy units.

Actions: Improve coverage in Māori and Pacific women aged 25-69 years from the baseline as at February or March 2021	**Milestones**
1. Data analysis will be undertaken to identify General Practices with high numbers of Māori, Pacific and Asian women not engaging with cervical screening.	
• With agreement from the practices, Cervical Screening Programme (CSP) staff will contact women identified by data analysis to encourage engagement, make free practice appointments and/or refer to Primary Care Outreach nurses Q1-Q4.	Q2: Increase in baseline coverage for Māori, Pacific and Asian women
• Monitor outcomes of this approach through six monthly reporting Q2 and Q4 (EOA). Baseline coverage will increase for Māori, Pacific and Asian women by June 2022. Milestone steps to achieving baseline target of 8o% (all populations): o Increase in coverage for Māori, from 63.7% to 70% by June 2022 o Increase in coverage for Pacific women, from 70% to 75% by June 2022 o Increase in coverage for Asian women, from 51.4% to 55% by June 2022	Q4: Increase in baseline coverage for Māori, Pacific and Asian women
Actions: Reducing the equity gap: Pacific	**Milestones**
1. Establish a collaborative initiative between Southern DHB and the Pacific Island Advisory and Cultural Trust (PIACT) in Invercargill and Pacific Trust Otago (PTO) in Dunedin, to provide a community based cervical screening programme for Pasifika women. Clinics will include a comprehensive nursing assessment of general health and wellbeing, smoking, breast screening, immunosuppression and HPV status, personal safety, contraception and sexually transmitted infection. Education will be provided and referrals will be made to other services as appropriate. • Six weekly clinics will occur at PIACT Q1-Q4 (EOA) • Eight clinics will be held at PTO Q1-Q4 (EOA)	Q4: Increase in cervical screening coverage for Pasifika women as reflected in Q4 reporting Q1-Q4: Six weekly clinics held at PIACT Q1-Q4: Eight clinics held at PTO
Actions: Reducing the equity gap: Māori	**Milestones**
1. CSP will cross match data to identify Māori women not participating in cervical screening.	Q4: Increase in cervical screening for Māori women as reflected in Q4 reporting

2. Regular outreach cervical screening events will be held at sites with high numbers of Māori women to support participation • Two monthly clinics will be held in Dunedin at various sites commencing Q1 (EOA) • Six monthly clinics will be held in Oamaru and Balclutha commencing Q1-Q2 (EOA) • Two monthly clinics will be held in Bluff Q1 (EOA)	Q1: Two monthly clinics held in Dunedin at various sites commence Q1, Q2: Six monthly clinics held in Oamaru and Balclutha commence Q1: Two monthly clinics held in Bluff
3. Six monthly reporting will be utilised to monitor increased participation of Māori women Q2 and Q4 (EOA).	Q2, Q4: Six monthly reporting utilised to monitor increased participation of Māori women
Actions: To increase access and support for Māori and Pacific women with disability	**Milestones**
1. To increase access and support for Māori and Pacific women with disability, WellSouth PHO Outreach Service will accept referrals for women identified as not registered on the Cervical Screening Register or unscreened for five or more years, for cervical screening, commencing Q3 (EOA)	Q3: Processes are in place for general practices to refer Māori and Pacific women with disability to WellSouth outreach services
2. Undertake an internal audit to assess uptake of women with disability receiving WellSouth PHO Outreach Services Q4.	Q4: WellSouth PHO Outreach Services will undertake an Internal audit of referrals to assess uptake
Actions: Improve equitable access to diagnostic and treatment colposcopies for priority groups referred with a high-grade result	**Milestones**
1. To increase access and support for Māori and Pacific women with high grade Colposcopy results, WellSouth PHO outreach service will accept referrals from the Colposcopy Intake meetings for women who need a cervical screen as follow up Q1-Q4 (EOA)	Q1: Processes established to refer Māori and Pacific women with high grade results post colposcopy to WellSouth PHO Outreach Services Q4. Increased number of Māori and Pacific women attending for cervical screening follow-up post Colposcopy
2. Review Southland Colposcopy wait times, DNAs and electronic discharge processes and compare to Otago processes Q2 (EOA)	Q2. Review of colposcopy processes across the district for wait times, DNAs and electronic discharge.
3. Identify and implement changes as required by the Review to ensure consistency of processes across the Southern district Q4 (EOA)	Q4: Colposcopy Review recommendations implemented to ensure a consistent district wide colposcopy service
4. Establish and implement processes to ensure clinical oversight of colposcopy outcomes and required follow-up within NCSP10 Guidelines are maintained in any future lockdown situation Q1 (EOA)	Q1: Clinical processes, to ensure follow-up of colposcopy are in place and socialised for future lockdown situations by Q1

Improving Wellbeing through Prevention - 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.

Southern DHB and our Public Health Unit, Public Health South, have a role in contributing to the reduction of alcohol related harm and improving the equity and wellbeing of our population. Our plan includes actions for the upcoming year that we consider to be the most important for reducing alcohol related harm and improving equity. Our plan includes key actions we will undertake to continue to support COVID-19 recovery and/or embed key learnings from our COVID-19 response in this priority area as well as equity actions focused on our Māori population.

Actions	Milestones
1. Develop messaging about healthy relationships, including a focus on alcohol harm reduction and sexual health for delivery in priority youth settings (E.g. Youth one-Stop Shops, Alternative Education Providers and low decile (Low Equity index when developed) high schools (EOA)	Q2: Ongoing development of messaging that is able to be assimilated by the audience
2. In collaboration with an education provider, develop a pilot to develop new ways of promoting this messaging in at least one priority youth education setting, to improve equity in alcohol related harm	Q4: Development of a pilot to promote this messaging in at least one education setting by Q4
3. Work with Emergency Departments in the Southern District to standardise the way alcohol harm data is recorded.	Q2: Standardised data recording established
	Q4: Dashboard set up as part of understanding alcohol harm trends in the Southern District.
4. Develop a process for addressing applications for additional alcohol licenses in high deprivation areas Q2 (EOA) including identifying flags for opposition, increasing community awareness of the application and supporting communities to object when they wish to.	Q2: Identify areas of concern to limit liquor licences
	Q1-Q4: Develop a process for addressing applications for additional alcohol licences in high deprivation areas
5. Undertake a review of the Southern district's Liquor Licencing functions to ensure that the programme is fit for purpose.	Q1: Terms of reference for review developed
	Q4: Review completed and recommendations implemented
6. Undertake compliance and enforcement activities relating to the Sale and Supply of Alcohol Act 2012. This includes delivering on the activities and reporting on the performance measures contained in the Reducing Alcohol Related Harm: Health Protection planning and reporting document. • Inquire into all on-, off-, club and, where appropriate, special licence applications, and provide Medical Officer of Health (MOsH) reports to District Licensing Committee, either where there are matters in opposition or recommendations	Q2, Q4: Reporting on performance measures (as outlined in the Reducing Alcohol Related Harm: Health Protection Planning/Reporting Template)
7. COVID-19 learning Review post-COVID alcohol consumption patterns disaggregated by ethnicity in post-COVID Aotearoa New Zealand (Southern district) and devise appropriate evidence-based interventions (EOA)	Q2: Review of consumption patterns.
	Q4: Evidence-based interventions designed and implemented

Improving Wellbeing through Prevention - Sexual health
Core function – Health Promotion

Actions are included for the upcoming year that we consider to be the most important for sexual and reproductive health. Our plan includes key actions we will undertake to continue to support COVID-19 recovery and/or embed key learnings from our COVID-19 response in this priority area as well as equity actions focused on our Māori population.

Actions	Milestones
1. Establish a joint Steering Group for Sexual Health, 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 Q1.	Q1: Sexual Health, Cervical Screening and Screening Support Services Steering Group established and meetings commenced
2. Access Improvement Project: • Conduct a survey to understand barriers for Māori and Pacific accessing sexual health services across the district, considering opening times, locations of clinics and any other opportunities Q2 (EOA) • Utilise survey findings to inform the sexual health model of care activity to be undertaken by Q4 (EOA)	Q2: Survey completed Q3: Analysis of survey completed Q4: Model of care reviewed, and changes implemented
3. Undertake a gap analysis of district wide sexual health services to inform development of a Sexual Health Strategy and Action Plan Q4	Q4: Gap analysis is available to inform development of district wide sexual health services
4. Develop a pathway for transgender people to remove barriers and improve access to primary care and endocrinology Q4 (EOA)	Q4: Establishment of a monthly, multidisciplinary team meeting to support the pathway for transgender people
5. Continue implementation of actions within the Southern district's Syphilis Action Plan 2019 Q1-Q4	Q1-Q4: Implementation of actions within the Syphilis Action Plan, with oversight by Southern district's Syphilis Group
6. Elab request processes • An ELab request process will be developed to include consideration of syphilis testing each time a HIV testing is requested Q2	Q2: Elab request process developed
• Elab changes for joint HIV and Syphilis testing are socialised with primary care Q4.	Q4: ELab processes for joint HIV and Syphilis testing are in place and being utilised
7. Sexual health clinical pathways • Review sexual health clinical pathways to understand differences in service delivery across the district Q2	Q2: Sexual health pathways reviewed
• Utilise review findings to establish consistent clinical pathways for sexual health services across the Southern district Q4	Q4: Consistent clinical pathways for sexual health services are established across the Southern district
8. Sexual Harm Assessment Clinic (SHAC) • Establish a Sexual Harm Assessment Clinic (SHAC), for non-forensic and historical sexual health care in Central Otago and Invercargill, based on the successful Dunedin pilot Q2	Q2: District wide Sexual Harm Assessment Clinics and services established
• Sexual Harm Assessment Clinic support to be available in any future lockdown events Q2-Q4.	Q2-Q4: District wide Sexual Harm Assessment Clinics to be available in lockdown events

• Undertake a trend analysis of referrals being received for Sexual Assault and Treatment (SAAT) Services to understand what is driving the current increase in demand Q3	Q3: Trend analysis undertaken and analysed
• Analysis will inform if changes need to be made to SAAT Services Q4.	Q4: Analysis used to consider any changes to resource allocated to SAATs services
• Assessment of child and adolescent access to SAAT Services to ensure equity with adult services Q3	Q3: Assessment undertaken
• Assessment to inform if changes need to be made to child and adolescent SAAT Services Q4	Q4: Consideration of the assessment to ascertain if changes need to be made
• Review SAATS IEA payment schedule against MECA remuneration to ensure staff are receiving appropriate payments for SAATs activity Q3	Q3: Review undertaken of SAAT Services IEA schedule
9. COVID-19 learning • Establish and implement processes to ensure sexual health services are maintained and accessible in any future lockdown events Q1	Q1: Sexual health will have processes established to ensure services are accessible in any future lockdown events

Improving Wellbeing through Prevention - Cross sectoral collaboration including Health in All Policies

The wider determinants of health play a major role in the health and wellbeing of the community. 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.

New Zealand has used a 'team of 5 million' to work collaboratively across multiple societal sectors, to control the COVID 19 pandemic. This will be continue to be 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 five 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

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. Our plan includes key actions we will undertake to continue to support COVID-19 recovery and/or embed key learnings from our COVID-19 response in this priority area as well as equity actions focused on our Māori population.

Actions	Milestones
1. Actively work with stakeholders who serve the needs of our most vulnerable groups to facilitate good coverage of the COVID-19 vaccine (EOA).	Q2: Progress report completed
2. Complete a Vulnerable Populations Needs Assessment that builds on the Southern DHB Health Needs assessment and provides a basis for future public health intervention planning.	Q2: Vulnerable populations needs assessment complete
	Q4: Vulnerable populations intervention plan developed
3. Evaluate the effectiveness of the multi-agency recreational water programme that has been operating across the Southern District for the past four years.	Q2: Evaluation report completed
4. Work collaboratively with Central Otago and Queenstown-Lakes Districts on strategies aimed at ensuring healthy housing is more accessible	Q2: Central Otago's supportive housing policy is clarified

	Q4: QLDC Housing Needs assessment is updated
5. Work with Regional Councils, Local Authorities, the National Institute of Water and Atmosphere (NIWA) and Iwi on strategies aimed at improving air quality in priority airsheds in the Southern District. In 2021-22, work will be focusing on South Invercargill and Cromwell. NWA will work with Environment Southland on a project looking at data gathering in Gore - Mataura.	Q2: Intersectoral hui. Cromwell air quality study completed and disseminated to key stakeholders
	Q4: Clean burning operated and evaluated.
	Q1-Q4: Activity reports
6. Actively engage with Māori providers and local Rūnaka to identify common issues and develop joint work programmes Q1-Q4 (EOA)	Q1-Q4: Activity reports
	Q4: At least one joint project by Q4
7. Regularly meet with all Southern Local Authorities to look at way we can effectively support their activity as it relates to their statutory obligation for Community Wellbeing. Two joint projects to be developed in collaboration with local authorities.	Q1-Q4: Activity reports completed
	Q4: At least two joint projects developed by Q4
8. Support the COVID-19 recovery plan • Evaluate the public health actions of the COVID-19 Psychosocial and Mental Wellbeing Recovery Plan - Kia Kaha, Kia Māia, Kia Ora Aotearoa	Q4: Completion of the Evaluation report of Kia Kaha, Kia Māia, Kia Ora Aotearoa public health actions in the Southern district
9. Conduct a process evaluation of the rollout of Kia Haumaru te Kāika Healthy Homes programme.	Q4: Evaluation complete
10. Refer also to collaboration with Police in Family Violence and Sexual Violence Template and Reducing Alcohol Related Harm Template	

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

Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System - 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. In 2021/22, the Ministry expects that DHBs continue to build on the progress made in the previous year towards enabling a strong, supportive and collaborative environment for research.

Our plan includes the actions for the upcoming year that we consider to be the most important for implementing the New Zealand Health Research Strategy, including the reasons why the action(s) are important and the expected impact. The focus of actions in our plan includes:

- For Implementing the New Zealand Health Research Strategy, how the DHB will undertake to continue to support COVID-19 recovery and/or embed key learnings from its COVID-19 response in this priority area. The actions identified in this plan are those expected to have the most significant impact on improved outcomes.
- How the DHB will continue working with the Ministry of Health to co-design and co-invest in a programme of work to build the capacity and capability across DHBs to enhance research and innovation.
- How we will work with research networks in our region to support staff engaged with research and innovation and build capacity and capability.
- How we will continue to build a supportive environment for clinical staff to engage in research and innovation activities, e.g., through the development and implementation of research policies and procedures.
- How we will provide opportunities for staff to undertake professional development to strengthen research capability.

The Ministry will request a one-page summary update on progress in Q4 to the Ministry and DHB Board.

Action	Milestone
1. Evaluation of the Primary and Community Care Strategy Implementation - Collaboration with University of Otago, Otago polytechnic, and WellSouth PHN	
Project 1: Healthcare homes. Initial report is scheduled for completion in April 2021 • Second phase of Healthcare Homes interviews will be completed in December 21/22	Q2: Healthcare Homes - Second phase of interviews completed
Project 2: Home Team Initial report. Initial report is scheduled for completion in April 2021 • Second phase Home Team interviews will be conducted in Q2 2021	Q2: Home team report - Second phase of interviews completed
Project 3: Customer Lead Integrated care. Report to Colloquium in April 2021.	
2. ED research on lack of presentations during COVID and what drives human behaviour to stay away • In collaboration with the university the Emergency Department have hired a 0.2 fixed term FTE research nurse for 2021 calendar year to help build research infrastructure. This research will guide operational change to ED preparedness for same or similar future events. We will revisit and refresh our ED plans based on the findings of this research. • There is ongoing participation in research in several multicentre studies in Emergency Departments across the Southern District. • An original research paper published in 2021 outlines what happened to ED presentations during COVID 2020. Continued research in the same area will continue until COVID-19 is no longer an international pandemic threat. *'Emergency department presentations in the Southern District of New Zealand during the 2020 COVID-19 pandemic lockdown'*	Q2: Southern DHB report published and findings disseminated

3. Improving Outcomes for older people with dementia in Aged Residential Care Facilities – post COVID learnings - A Research collaboration between University of Otago Postgraduate school of Nursing and Southern DHB. A study will be undertaken which involves a Dunedin rest home where staff lived in during lockdown in 2020. Resulting paper will include recommendations for improved outcomes for older people with dementia in ARC facilities, due for publication in September 2022. Implementation of recommendations to occur in July 2023.	Q2: Study undertaken re Improving Outcomes for older people with dementia in Aged Residential Care Facilities
4. Improvement movement to drive innovation The DHB has invested to train 250 staff members from across the district in improvement methodology. This is supported by workshops and coaching to drive improvement and innovation. Recruitment is underway for course commencement July 2021	Q1: Course commencement
	Q4: 80% course completion of course by end of Q4
5. Carpal Tunnel Syndrome (CTS) co-design study – pathways & improvement/innovation • This study aims to evaluate the impact of using a co-design process which aims to engage groups with lower care utilisation including Māori, Pacifica, rural, or low-income in developing a best practice localised care pathway for CTS and its evaluation in the Southern district. This pathway may include advances in technology, e.g., telehealth and web-based programmes, to deliver patient information and care, and embed routine collection of outcomes and patient/public feedback.	Q1: Co-design
	Q1: Evaluation
	Q2: Dissemination of findings

Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System - Delivery of Whānau Ora

DHBs are well placed to action system-level changes by delivering whānau-centred services to contribute to Māori health advancement and to achieve health equity, including for Pacific communities.

Actions are outlined for the upcoming year that Southern DHB considers to be the most important for the delivery of Whānau ora. This includes:

- Key actions with milestones the DHB will undertake to continue to support COVID-19 recovery and/or embed key learnings from its COVID-19 response in this priority area.
- Evidenced-based equity actions focused on our Māori populations within this planning priority. The actions identified in this plan are those expected to have the most significant impact on improving equity of outcomes.

Action	Milestones
1. Existing whānau ora navigators across the Otago region support Māori patients admitted with traumatic brain injury, and their whānau	Q2, Q4: Reporting
2. Implement Māori COVID-19 Response and Resurgence Plan • Four Māori provider leads are working with WellSouth and Southern DHB to develop the COVID-19 vaccination model and delivery plan to commence in May 2021. • We will undertake a whānau ora approach in rolling out implementation of our COVID-19 vaccination plan as one component of our Māori COVID-19 Response and Resurgence Plan. Through our COVID-19 Response programme, we will take opportunity to implement health prevention and health promotion measures for our Māori populations, including: o Enrolling Māori populations with GPs o Delivering health checks for adults o Providing childhood immunisations • From quarter 4, we will also be delivering a welfare package with advice and referrals to agencies in relation to housing, Work and Income and ACC), as need is identified.	Q1-Q4: Implementation of Māori COVID-19 Response and Resurgence Plan

Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System - Ola Manuia 2020-2025: Pacific Health and Wellbeing Action Plan

Actions are included for the upcoming year that we consider to be the most important for Ola Manuia. This template includes the most significant actions we will take to achieve equitable health and wellbeing outcomes for Pacific peoples. These actions contribute to the development of culturally responsive services for Pacific people to ensure the actions we do are carried out meaningfully and successfully for our Pacific population.

Actions: Improving wellbeing through prevention	**Refer to templates for milestones**
1. Breast screening • BreastScreen Aotearoa(BSA) will engage with Māori and Pacific health providers and groups to improve screening rates for Māori and Pacific populations • WellSouth to coordinate data matching with BSA to identify eligible women and support access into screening through the call centre. • COVID recovery efforts will prioritise Māori and Pacific women to improve participation to at least 70% for Māori and Pacific women aged 45-69 years.	Refer to Breast Screening template for milestones
2. Cervical screening • Establish a collaborative initiative between Southern DHB and the Pacific Island Advisory and Cultural Trust (PIACT) in Invercargill and Pacific Trust Otago (PTO) in Dunedin, to provide a community based cervical screening programme for Pasifika women. Clinics will include a comprehensive nursing assessment of general health and wellbeing, smoking, breast screening, immunosuppression and HPV status, personal safety, contraception and sexually transmitted infection will occur as part of the cervical screening process. Education will be provided and referrals will be made to other services as appropriate. Six weekly clinics will occur at PIACT Q1-Q4 (EOA). Eight clinics will be held at PTO Q1-Q4 (EOA) • To increase access and support for Māori and Pacific women with disability, WellSouth PHO Outreach Service will accept referrals for women identified as not registered on the Cervical Screening Register or unscreened for five or more years, for cervical screening, commencing Q3 (EOA)	Refer to Cervical Screening template for milestones
3. Sexual and reproductive health • Access Improvement Project: Conduct a survey to understand barriers for Māori and Pacific accessing sexual health services across the district, considering opening times, locations of clinics and any other opportunities. Utilise survey findings to inform the sexual health model of care activity to be undertaken.	Refer to Sexual and Reproductive Health template for milestones
Actions: Improving child and youth wellbeing	**Refer to templates for milestones**
1. Integrated service model • Pregnancy and Parenting – A Request for Proposal process, seeking to increase engagement of pregnant Māori and Pacific women and their whānau in pregnancy and parenting sessions, will be completed with the support of the Māori Health Directorate Q2 (EOA)	Refer to Maternity Care template for milestones

2. 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 • SLM measure - decrease in the percentage of ASH presentations including dental 0-4 years (CW01, CW01, CW03, CW04); increase in the percentage of Pacific newborns enrolled in General Practice (CW07)	Q1-Q4: Quarterly reporting re increased enrolment of newborns in general practice and the WCTO programme; reducing the burden of overweight Pacific children at B4SC
3. Immunisation • To maintain the Childhood Immunisation Schedule and achieve equity for Pacific children, Southern DHB Immunisation Coordinators will work alongside Pacific providers to establish outreach services acceptable to Pacific communities Q1-Q4 (EOA) • Utilise NIR data for the early identification of children, particularly Māori and Pacific that may need Immunisation Outreach Services to achieve immunisations on time Q1-Q4 • Ongoing delivery of the COVID-19 vaccine ensuring protection for Māori, Pacific peoples and the most vulnerable populations such as older people, disabled people, health and essential workers and border staff Q2-Q4 (EOA) • Engage with Pacific on the Measles immunisation Catch up Programme targeting 15 to 29 year olds Q1-Q4	Refer to Immunisation template for milestones
4. Maternity care • Support midwives in training, particularly Māori and Pasifika, to complete their midwifery training and consider working as midwives in Southern District	Refer to Maternity Care template for milestones
5. Youth health and wellbeing • School Based Health Services - With the support of Learning Support Coordinators, complete year 10 catch up, for those who missed year 9 checks in Southland Girls High School (SGHS), prioritising Māori and Pacific and those needing additional support Q2 (EOA).	Refer to Youth Health and Wellbeing template for milestones
Actions: Better population health outcomes supported by strong and equitable public health service	**Refer to templates for milestones**
1. Te Aho o Te Kahu – Cancer Control Agency • Work with the Māori Health Directorate to ensure staff receive appropriate Māori and Pacifica cultural competency training • Currently participation rates for priority populations are above 60% and accordingly we will look to maintain the current communication and engagement strategy for the National Bowel Screening Programme. • Participation rates for priority populations will be regularly reviewed and response targeted according to the demographic data that is provided.	Refer to Te Aho o Te Kahu – Cancer Control Agency and Bowel Screening templates for milestones

Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System - Health outcomes for disabled people

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.

Our plan includes actions for the upcoming year that Southern DHB considers to be the most important for improving health outcomes for disabled people, including the reasons why the action(s) are important and the expected impact. Our plan includes key actions we will undertake to continue to support COVID-19 recovery and/or embed key learnings from our COVID-19 response in this priority area as well as equity actions focused on our Māori population.

Actions	Milestones
1. Establish a Disability Working Group (DWG) with representatives from the DHB and wider disability community and report regularly into the Disability Support Advisory Committee, Community Health Council and Iwi Governance on progress that is being made	Q1: Disability Working Group established
	Q1-Q4: Regular reporting to Disability Support Advisory Committee, Community health Council and Iwi Governance
2. Disability Working Group to develop Action Plan from the Disability Strategy of key deliverables for Y1, Y2, Y3. • The Action Plan will take direction from the principles of partnership, participation and protection from Te Tiriti O Waitangi (EOA)	Q2: Action plan, to include specific actions for tangata whaikaha, will be developed with key deliverables for Y1-Y3
3. Provide ongoing training for front-line staff and clinicians, including advice and information on considerations needed when interacting with a person with a disability	Q1-Q4: Report on the number of staff who have completed the e-learning training module
4. Disabled people, tangata whaikaha and Deaf people will be encouraged and assisted to complete a Health Passport as an option to express their individual preferences	Q3: Launch undertaken to promote the Health Passport
5. In relation to COVID-19, provide information to people with disabilities about infection mitigating tips, public restriction plans, and services offered, in a diversity of accessible formats	Q1-Q4: Mass media communication relating to COVID information includes captioning, national sign language, high contrast and large print information.
	Q3: Digital media includes accessible formats to blind persons and other persons facing restrictions in accessing print.

Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System - 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 includes a range of treatments funded by DHBs, which can be delivered in inpatient, outpatient, primary or 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) reflect the principles of clarity, timeliness and fairness.

In 2021/22 DHBs will be in the second 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.

Our plan includes actions for the upcoming year that Southern DHB considers to be the most important for improving health outcomes for planned care, including the reasons why the action(s) are important and the expected impact. Our plan also includes key actions we will undertake to continue to support COVID-19 recovery and/or embed key learnings from our COVID-19 response in this priority area as well as equity actions focused on our Māori population. Southern DHB will engage with WellSouth Primary Health Network, our Iwi Governance Committee and our Community Health Council in the ongoing implementation of our plan.

Actions: Supporting COVID-19 recovery	**Milestones**
1. Embedding of Telehealth in Southern DHB Southern DHB has a large geographic area and lends itself well to the utilisation of Telehealth. Despite this prior to COVID the uptake of Telehealth was very low and it was identified as a key learning from COVID the need to ensure that Southern had a robust and sustainable Telehealth solution that could be easily accessed by both patients and staff and furthermore that all services were orientated to the use of the Telehealth solution. Orientation means that services have been appropriately set up to use Telehealth and given requisite training. • Southern DHB will commence a programme of work to build upon the work already undertaken to systematically bring services onto the Telehealth platform.	Q1: Programme of work to commence Q4: Measures for embedding of telehealth will be reported: • The number of services who have been set up for Telehealth – i.e. have been trained • The number of appointments that are undertaken by Telehealth
2. Skin lesion operations performed in the community • Q1: Southern DHB has designed a new model of care of the number for skin lesions that are suitable to be operated on in the community. These operations being performed in the community will have two benefits, firstly to free up theatre space in Secondary Care and allow us to perform operations that require more complex treatment and secondly to increase the number of patients in our community able to have non-malignant skin lesion operations in a timely manner.	Q1: Contract signed with primary health care providers
• Q2: The model of care involving Senior Medical Officers (SMOs), GPs and General Practitioner with Special Interest (GPSIs) is rolled out and education and support are provided where required. Funding and payments are successfully made for treatments and there is a feedback loop to identify improvement opportunities.	Q2: New model of care commences
• Q3: Continuation of programme with monitoring of patient numbers and data for each service. Feedback from clinicians and staff is used to improve the process.	Q3: Volume of patients increase for primary care and reduced volume for secondary care

• Q4: Continuation of programme with monitoring of patient numbers and data for each service. Monitoring of effect on interventions rates.	Q4: Volume of patients continue to increase for primary care and reduced volume for secondary care. Start to see a positive effect on intervention rates.
Actions: Planned Care Strategic Priorities	**Milestones**
1. Improve understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed. • The next stage of the Southern district Health Needs Analysis will be completed by Q2 with identified follow up in relation to equity for rural populations and Māori populations	Q2: Southern district HNA completed with recommendations for follow up actions
2. Balance national consistency and the local context Actions below are included in the Cervical Screening template and will be reported through that template: Data analysis will be undertaken to identify General Practices with high numbers of Māori, Pacific and Asian women not engaging with cervical screening • With agreement from the practices, Cervical Screening Programme (CSP) staff will contact women identified by data analysis to encourage engagement, make free practice appointments and/or refer to Primary Care Outreach nurses. • Monitor outcomes of this approach through six monthly reporting Q2 and Q4 (EOA). Baseline coverage will increase for Māori, Pacific and Asian women by June 2022. Milestone steps to achieving baseline target of 8o% (all populations): o Increase in coverage for Māori, from 63.7% to 70% by June 2022 o Increase in coverage for Pacific women from 70% to 75% by June 2022 o Increase in coverage for Asian women from 51.4% to 55% by June 2022	Q2: Increase in baseline coverage for Māori, Pacific and Asian women Q4: Increase in baseline coverage for Māori, Pacific and Asian women
3. Support consumers to navigate their health journeys • Expand and enhance consumer primary care portal access to provide consumers with access to all of their health information and care team. Consumer access will be expanded to virtual health consultations through patient portals (e.g. email, video, telephone, appointment bookings) • Action to be reported through Primary Care template	Q2, Q4: Patients registered with a portal. Target 40%
4. Optimise sector capacity and capability Much of specialised diabetes care that has been traditionally provided by diabetes specialists can potentially be provided by well-trained Diabetes Nurse Specialists with appropriate consultant supervision. • Diabetes Nurse Specialists led clinics with appropriate consultant oversight will be employed as the model for the majority of diabetes care provided in the endocrine department. Previously, the diabetes service in Dunedin had consultant clinics supported by a single Diabetes Nurse Specialist. The new model is the reverse of this setup, with four Diabetes nurse specialists supervised by a single consultant endocrinologist. This is a more sustainable model of care. • Diabetes Nurse Specialists will be encouraged to work at the top of their scope and care for many of the patients traditionally seen by specialists but with specialist support. Consultant endocrinologists will primarily see patients with diabetes with complex or unusual conditions.	Q2, Q4: Six monthly reports to evaluate how the specialist nurse-led clinics are working, using patient and health professional feedback as well as metrics Q3: Dunedin pilot roll out to increase numbers of Diabetes Nurse Specialist clinics per week. Q4: Second evaluation of pilot, with recommendations for future clinics
5. Ensure the Planned Care systems and supports are sustainable and designed to be fit for the future 5th theatre in Southland Hospital	Q1: Steering group is established and a project manager appointed

• Internal surgical capacity will be increased at Southland Hospital through the conversion of an endoscopy room into an operating theatre (12-18 month timeframe). Commissioning the fifth theatre will support the DHB to meet its ESPI targets and also enable the completion of a great deal more elective surgery in-house.	
• Project Manager presents plan for RFP process to the steering group. The tendering process commences and is completed with a contactor appointed.	Q2: RFP process is completed and a contractor is appointed
• Construction commences on 5th theatre as per plan. Regular updates to the steering committee from the project manager to identify and mitigate risks.	Q3: Final design is approved and construction commences
• Construction of 5th theatre continues as per plan and is on target for completion. Regular updates to the steering committee from the project manager to identify and mitigate risks.	Q4: Construction continues as per targets
Focus on: Planned Care Interventions (SS07)	**Milestones**
1. Computed tomography (CT)machine Patient safety risks are caused by the lack of CT capacity at Dunedin. These include the risk of delayed diagnosis, risk of patients deteriorating whilst awaiting follow up examinations and the risk of acute patient delays being caused by the available scanner being used for interventional procedure where the patient must be anaesthetised. • We will install and operationalise a second CT scanner and redesign workflows to separate acute and elective demand on our CT scanners. The addition of another CT scanner will also enable the DHB to achieve the Health diagnostic indicator for CT. • The contributory measure for this piece of work is planned care measure 3: diagnostic waiting times – Magnetic Resonance Imaging (MRI) That 90% of patients with accepted referrals for MRI scans will receive their scan, and the scan results are reported, within 6 weeks (42 days). Plans are as follows:	
• Q1: The tenders for construction have been received and assessed against the project criteria. The equipment procurement process for quotes has been completed. The capital expenditure has been approved and the equipment ordered. The building has been fitted out as per the design and plans and the equipment has been received and is in place. Once installed the room and equipment will need to be cleaned.	Q1: Tender and equipment procurement process completed
• Q2: The CT room and equipment are certified and approved as ready to start. Training for staff commences and issues are identified and resolved. Patients begin to be scanned.	Q2: Building work and equipment installation is complete and room cleaned. Patients commence scans in limited numbers
• Q3: The CT scan is fully utilised and the waitlists start to reduce in volume. Reporting on performance and reduced delays commences. Intervention rates for CT based on domicile and demographics are actively monitored.	Q3: Commencement of full service. Reduced delays to surgery as a result of scanning delays. Reduced waitlist for scans
• Q4: The CT scan is fully utilised and the waitlists start to reduce in volume. Reporting on performance and reduced delays commences. Intervention rates for CT based on domicile and demographics are actively monitored.	Q4: Continuation of full service. Reduced delays to surgery as a result of scanning delays. Reduced waitlist for scans
2. Rheumatology follow up service improvement: The contributory measure for this piece of work is planned care measure 2 – (Elective Services Patient Flow Indicators -ESPI 2)– patients waiting longer than four months for their first specialist appointment. Medical services similar to Rheumatology have large numbers of	

follow ups which reduce their ability to see First Specialist Appointments (FSAs). With the increased number of follow ups seen in the community under this proposal we would expect to see a reduction in the ESPI 2 breach number for this service. Plans are as follows	
• Q1: Work has commenced to resolve the long list of delayed planned appointments. This will involve a change to the current model of care to an integrated one with primary care, allied and community health services. Care will be delivered through a variety of ways such as GP practices, nurse clinics, shared medical clinics, and telehealth. This means change not just for those providing care but also for those who are receiving the care.	Q1: Specialist advice clinics for primary care have commenced. Physiotherapy led clinics have commenced.
• Q2: Education sessions for patients have commenced and upskilling and support for primary care teams is in place. A data base and integration of electronic health data across primary and secondary care to allow diagnosis and population based care has begun development.	Q2: Nurse led and community based clinics have commenced by Q2
• Q3: Partnerships with primary care continue to be developed and opportunities to improve the system and efficiency continue to be identified.	Q3: Development of a patient portal has commenced by Q3
• Q4: Support for new models of care and opportunities to improve the patient journey and review move to integrated care. Feedback is sort from the project participants and used for quality improvement. The development of the patient portal continues.	Q4: Review of progress for removal of delayed follow up appointments is complete. Programme of upskilling and supporting primary care is underway

Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System - Acute demand

Acute data capture

- We include how SNOMED data will advise DHBs on improving health pathways for long term conditions e.g. Diabetes, respiratory conditions than could be managed in the community with a focus on equity.

Acute demand

Actions are included for the upcoming year that Southern DHB considers to be the most important to improve the management of acute demand, including the reasons why the action(s) are important and the expected impact.

- Our Acute Data Capturing plan demonstrates how we will implement SNOMED coding in Emergency Departments.
- Our Patient Flow Plan shows how we will address the growth in acute inpatient admissions. This includes detail on: how patients will be better managed in the community, emergency department and hospital, the organisations that we will work with to plan and achieve improvements and the percentage reduction in the standardised rate of acute bed days, while reducing the discrepancy between Māori and total population standardised bed day.
- Our plan includes key actions we will undertake to continue to support COVID-19 recovery and/or embed key learnings from our COVID-19 response in this priority area as well as equity actions.

Acute Hospital Bed Days per Capita (refer to SLM plan)

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

Actions: Acute demand	**Milestones**
1. Complete and implement escalation plans in Dunedin and Southland Hospitals	Q1: Escalation plan in operation in Dunedin Hospital; commence planning of escalation plan for Southland Hospital
	Q3: Review of escalation plan in Dunedin and modify as needed. Review metrics especially Shorter Stay in ED target for improvements.
	Q3: Completion of final draft of escalation plan for Southland Hospital
	Q4: Escalation plan in operation in Southland Hospital
2. Implementation of Dunedin Generalism Business model of care • Dunedin Generalism Business Case approved	Q1: Clear project plan for implementation of Generalism including changes to model of care and clear timelines
	Q2: Plan for the establishment of an MAU completed with clear timelines for establishment

	Q3: Recruitment 3.7 FTE additional General Medicine physicians by end of quarter four supporting more equitable access and better patient flow.
	Q4: Track key metrics including reduction in the standardised rate of acute bed days including the reduction in discrepancy between Māori and total population
3. Establishment of dedicated Emergency Department (ED) SMO for Mental Health liaison and a dedicated Mental Health Educator in ED to improve communication with mental health services and therefore the care that is delivered to these patients	Q2: Dedicated liaison and Mental Health educator established
4. Dunedin and Southland EDs work collaboratively with Māori to improve cultural appropriateness of the service	Q1-Q4: Education for staff on Tikanga
	Q2: Commence cultural training for staff
	Q2: Introduction of Māori signage
	Q4: Commence basic Te Reo education for staff
5. Implement comprehensive Telehealth Strategy to enable timely and more equitable access to medical care across the Southern DHB district.	Q1: Employment of Telehealth Implementation manager
	Q4: All hospital services oriented and trained on the use of Telehealth
	Q4: Explore the use of Telehealth as a tool to improve communication between primary and secondary care
6. WellSouth to support the Heath Care Home programme through Tranche III. Practices to uptake GP Triage and hold acute daily appointments through the development of the HCH programme.	Q1-Q4: Increase in HCH practices delivering GP Triage and Acute Appointments
Actions: Acute data capture	**Milestones**
1. Use of SNOMED data • The current version of the Emergency Department Information System (EDIS) does not allow for SNOMED coding; the planned upgrade to the latest version has had some delays but once implemented we will be able to increase our SNOMED range. We will be able to use ED data/business intelligence to inform management decisions around LTC patients and their long term care. • This range will be further increased with the implementation of South Island Patient Information Care System (SIPICS) planned for Q 3 22/23. The current plan for the EDIS upgrade is for it be completed by Q1 1 21/22.	Q1: Completion of EDIS upgrade
Actions: Acute Hospital Bed Days per Capita	
1. Undertake actions through the SLM Improvement Plan to reduce the standardised rate of acute bed days, while reducing the discrepancy between Māori and the total population standardised bed day, including	Refer to SLM Plan

• 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 • Actions to be reported through the SLM Improvement Plan	

Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System - Rural health

Improving access for rural health is a priority for the Government and something all DHBs are expected to progress working closely with their rural primary care partners and community. Our plan includes actions for the upcoming year that Southern DHB considers to be the most important for improving health outcomes for planned care, including the reasons why the action(s) are important and the expected impact. Our plan also includes key actions we will undertake to continue to support COVID-19 recovery and/or embed key learnings from our COVID-19 response in this priority area as well as equity actions focused on our Māori population.

Actions: COVID responsiveness	**Milestones**
1. Improve rural hospitals' preparedness for a pandemic outbreak: • Continual review and update of the Southern DHB Rural Hospital COVID-19 Response Plan	Q1-Q4: Feedback to and from Rural Hospitals on developments from SDHB relating to COVID-19 management
• Rural participation in Southern DHB Technical Advisory Group (TAG) for COVID-19	Q1-Q4: Disseminate information to and from SDHB TAG and Rural Hospitals and Community Health Trusts.
Actions: Equity of access	**Milestones**
1. Develop pathway to enable population domiciled in Central Lakes to access MRI in Queenstown, to improve equity of access	Q2: Identify barriers to accessing MRI locally
	Q4: Agree pathway that will address these barriers
2. Review access to outpatient specialist clinics for rural populations and develop a plan using in-person and telemedicine clinics to reduce access barriers that impact on equity • Work with local Rūnaka to identify barriers and opportunities to improve equity of access for Māori Q1-Q4 (EOA)	Q1: Map where rural people are seeing specialists
	Q3: Identify gaps and quantify impact on individuals
	Q2, Q4: Barriers and opportunities to improve equity of access for Māori identified and reported
3. Support WellSouth in the development of sustainable and affordable after-hours primary care service in the Upper Clutha	Q2-Q4: Southern DHB engaged in processes to develop sustainable and affordable after-hours primary care services in the Upper Clutha
4. Identify where health hubs can benefit the health services provided to rural populations	Q3: Meet key stakeholders to seek opportunities to work collaboratively to provide services to the community
5. Participate in the refresh of the Southern Health Strategy to ensure clear decisions are made about the configuration of services in Central Lakes in the short / medium / long term, to enable planning to reflect agreed principles.	Q1: Meet with team conducting the strategic refresh to convey key messaging
	Q2-Q4: Work with providers in the Central Lakes region to develop plans that reflect the agreed strategic direction.

6. Undertake work to develop a single contractual relationship with the Rural Trust Hospitals in the Southern district by July 2022	Q2-Q4: Work undertaken with Rural Trust Hospitals to identify a process that meets the goal of a single contractual relationship

Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System - Implementation of the Healthy Ageing Strategy 2016 and Priority Actions 2019-2022

New Zealand's population is ageing, increasingly diverse, and living longer and in better health than in the past. However, as a result of living longer there are more older people with more complex health and disability needs. Inequitable health outcomes are also evident in New Zealand amongst populations with different levels of underlying social advantage/disadvantage. The Healthy Ageing Strategy (the Strategy) was released in December 2016 and sets the strategic direction for the delivery of services to older people for the next 10 years to meet these increasingly complex needs and contribute to achieving equity and eliminating disparities in health outcomes between population groups. Cabinet agreed to Priority Actions for the next phase of the Strategy's implementation 2019 – 2022 in November 2019. Implementing these actions will contribute to delivering on the Strategy's vision that: Older people live well, age well and have a respectful end of life in age-friendly communities.

Our plan includes actions for the upcoming year that we consider to be the most important for Implementation of the Healthy Ageing Strategy 2016 and Priority Actions 2019-2022, including the reasons why the action(s) are important and the expected impact. These include

- Key action(s) that contribute to a national process to improve preparedness for a pandemic outbreak (and COVID-19 resurgence) on services in the community for older people, using COVID-19 learnings (for example, workforce cover, staffing contingencies and education, how to provide support for vulnerable people and workers, new ways of working that can be used during BAU).
- Key action(s) in community and primary care settings to improve the identification of factors associated with early signs of emerging frailty, with a focus on Māori and Pacific peoples; and put interventions in place to retain and restore the function of older people.
- Key action(s) to implement the key priorities for dementia services identified from the 2019/20 regional stocktake and the sector's priorities in Improving Dementia Services in New Zealand – Dementia Action Plan 2020-2025, for improving equity.
- Key action(s) to improve our early supported discharge services and community-based support and restorative services to build older people's' resilience, with a focus on those with inequitable health outcomes.

Actions	Milestones
1. Improve Preparedness of a pandemic outbreak: • Continual review and update of Southern DHB ARC COVID-19 Response Plan and undertake regular Scenario Testing with feedback to DHB and ARC facilities	Q1-Q4: Scenario tests conducted and feedback communicated
• DHB Infection Prevention and Control (IPC) nurses work alongside ARC facilities on IPC training and pandemic preparedness.	Q2, Q4: IPC nurse contacts each facility every 6 months
2. Improve identification of factors associated with early signs of emerging frailty, with a focus on equity: • Health of Older Person services and WellSouth to co-design pathways that link primary care assessments (Client-Led Integrated Care -CLIC) to appropriate geriatric and/or support services. • Continue support for clinicians to be involved in shared care planning across teams and services (see below – project supported by MoH Sustainability Funding is aimed to enable this as well).	Q2: Initial pathways established
3. Implement key priorities for dementia services • Dementia Day Activity Programme established in Dunedin	Q4: RFP for Dementia Day activity in Dunedin
• Older Persons Health (OPH) and Mental Health Services for Older People (MHSOP) work closer together with a shared care approach to keep people with significant cognitive issues in their community.	Q2-Q4: Participation in mental health review
	Q3: Agree pathways and shared care arrangements

4. Improve early supported discharge services and community-based support and restorative services to build older people's resilience, with a focus on equity • Develop and implement RFP for Home and Community Support Services (HCSS) Services based on: o the new National HCSS Framework and HCSS Service Specification o Tier One services working together in a community /locality for patient outcomes o Working with other providers in shared care planning and delivery. • New HCSS service from 1 July 22	Q3: HCSS RFP completed
• As part of MoH Sustainability Funding, establish test sites to enable and empower providers to work collaboratively within a locality. This includes building and facilitation clinical relationships/partnerships, and trial care coordination roles. These test sites will be used to inform the wider implementation of care coordination across the district.	Q1: Test sites established Q4: Care Coordination Plan

Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System - Health quality & safety (quality improvement)
Our plan includes actions for the upcoming year that we consider to be the most important for improving quality, including the reasons why the action(s) are important and the expected impact.

Spreading hand hygiene practice

- As a result of learnings from COVID-19 actions are identified to increase compliance with best practice hand hygiene (as defined by the Hand Hygiene NZ programme) across hospital clinical areas and across categories of healthcare workers.

Improving equity

- Improvement actions are specified to improve equity of outcomes in one of the three identified topics diabetes, gout or asthma.

Improving consumer engagement
Southern DHB plans to progress the implementation of the quality and safety marker (QSM) for consumer engagement by:

- Continuing to support the governance group (or oversight group) of staff and consumers guiding implementation of the marker.
- Reporting against this QSM twice-yearly (Q1 and Q3) via the online form on the Commission's website using the SURE framework as a guide.

Actions: Spreading hand hygiene practice	**Milestones**
1. Spreading hand hygiene practice • During COVID-19 opportunities were identified for improved access of hand hygiene products, specifically Alcohol Based Hand Rub (ABHR) and the placement and consistent refilling to enable improved Hand hygiene for public patients and staff.	Q1: Develop audit tool and schedule
	Q2: Undertake audit of high risk areas and analyse results
	Q3, Q4: Implement improvements
2. Southern DHB has previously focused on increase of Hand Hygiene areas that are audited. The ED Southland and Dunedin Hospitals have inconsistent performance ≥80%. As a vital entry point to the hospitals and the likely place for a COVID-19 patient to present, we plan to focus and improve the performance.	Q1: Engage and implement improvement plan with ED teams
	Q2: EDs to have a compliance ≥ 80%
	Q3, Q4: Maintain ≥80%
Actions: Improving equity	**Milestones**
1. Local Diabetes Team to continue to meet and progress initiatives aimed at supporting patients with Diabetes. Key will be the reestablishment of the Virtual Diabetes Register (VDR).	Q2: VDR to be established Q2
2. LTC management through Multi Disciplinary Teams (MDTs) will be piloted between Southern DHB Diabetes services and three HealthCare Home general practices (Invercargill Medical Centre, Mornington Health Centre and Te Kāika Forbury). Telehealth services supporting clinical governance to be established Q2.	Q2: Telehealth MDT service initiated Q2
3. Diabetic Annual Review (DAR) catch up programme to be delivered Q2, with restoration of the achievement of the targets for DAR and HbA1c	Q1: DAR catch up programme delivered
	Q2: DAR to 80%; HBa1c to 90%

Actions: Improving consumer engagement	Milestones
1. Establish a Clinical Council subcommittee and structure to guide implementation of the Consumer Engagement Health Quality & Safety Marker (QSM)	Q1: Subcommittee established
2. Upload data onto the Consumer Engagement QSM dashboard and report against the framework twice yearly	Q1, Q3: Twice yearly reports against the framework
3. Conduct a mapping analysis identifying services where consumer engagement is occurring across service areas to help identify areas of improvement. Benchmark this against feedback that is coming into the DHB on services so this can help to identify areas of priority.	Q2: Mapping analysis conducted

Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System - Te Aho o Te Kahu – Cancer Control Agency

Te Aho o Te Kahu is a stand-alone departmental agency hosted by the Ministry of Health but reporting directly to the Minister of Health. These new arrangements provide the foundations for strong central leadership and oversight of cancer control and better recognise the impact that cancer has on the lives of New Zealanders. Te Aho o Te Kahu is equity-led, knowledge driven, person and whānau-centred and outcomes focused, taking a whole-of-system focus on preventing and managing cancer. The commitment to the goal of achieving equity is central in all Te Aho o Te Kahu processes and work programmes.

Cancer is the leading cause of death in New Zealand and presents some unique challenges to the health system. The number of people diagnosed with cancer is projected to double in the next two decades, the costs and complexity of care and the pace of change present major challenges for our system and services. Cancer survival is improving in New Zealand, but our rate of improvement is slower than other comparable countries, so we are at risk of falling behind. When diagnosed with cancer, survival is poorer for Māori than non-Māori. Te Aho o Te Kahu is committed to an equity first approach. It is expected that all actions and quality improvement resulting from the annual planning process will be inclusive of actions that improve outcomes for Māori, Pacific and those who are disadvantaged.

DHBs are required to monitor the impact of COVID-19 on cancer diagnostic and treatment services and use this information to plan and manage service volumes. In the event of a resurgence of COVID-19, DHBs are required to implement the guidance developed by Te Aho o Te Kahu on service delivery expectations at each of the hospital alert levels to ensure minimal impact on cancer patients.

The New Zealand Cancer Action Plan outlines four main goals

- New Zealanders have a system that delivers consistent and modern cancer care – He pūnaha atawahi
- New Zealanders experience equitable cancer outcomes – He taurite ngā huanga
- New Zealanders have fewer cancers – He iti iho te mate pukupuku
- New Zealanders have better cancer survival, supportive care and end-of-life care – He hiki ake i te oranga.

Te Aho o Te Kahu are responsible for setting the direction for change that delivers improved outcomes for New Zealanders. District Health Boards have key responsibility for the successful achievement of these outcomes locally and regionally. Te Aho o Te Kahu also works closely with the Ministry of Health to ensure were there are synergies in our expectations of DHBs that these are aligned i.e. prevention strategies, tobacco control, screening services and palliative care.

Equity First - New Zealanders have a system that delivers consistent and modern cancer care – He pūnaha atawahi

- To better understand the national provision of chemotherapy, Te Aho o Te Kahu is developing nationally agreed treatment regimens and associated data standards – the ACT-NOW project. This initiative will inform our knowledge of treatment delivery, identify issues relating to equity, and support resource planning and cost savings.
    - To realise these gains, DHBs need to implement ACT-NOW data standards in their oncology e-prescribing systems and the ability to message data to a national repository.
- Southern DHB will work implement cancer specific Health Information Standards issued by the Ministry of Health, including but not limited to:
    - HISO: 10038.4:2021 Cancer Multidisciplinary Meeting Data Standards
    - HISO: 10080:2021 Systemic Anti-Cancer Therapy Regimen Standard (SACT)
    - Associated FHIR messaging standards (to be released 2020/2021)

Equity First - New Zealanders experience equitable cancer outcomes – He taurite ngā huanga

- Te Aho o Te Kahu has an equity first approach to improving health outcomes. Southern DHB deliverables against the annual planning process demonstrate inclusive actions to improve outcomes for Māori, Pacific and those who are disadvantaged.

Equity First - New Zealanders have fewer cancers – He iti iho te mate pukupuku

- Preventing cancer is the best strategy for controlling cancer and reducing inequities. It is estimated that around 40 percent of health loss from cancers is potentially preventable. The modifiable risk factors can be influenced by socioeconomic and physical environments.

New Zealanders have better cancer survival, supportive care and end-of-life care- He hiki ake i te oranga

Te Aho o Te Kahu is committed to work in partnership with DHBs to undertake quality improvement activities that address unwarranted variation in care. Quality Performance Indicators (QPIs), both existing and yet to be developed, that measure performance against best practice, will be the foundation for improvement activity.

Southern DHB will use tumour specific Quality Improvement Action Plans developed by Te Aho o Te Kahu as guides for our quality improvement activity. Opportunities for improvement will be developed utilising the national cancer QPI monitoring reports, the national QPI action plans and internal DHB quality systems.

Our improvement actions include key actions

- To undertake to ensure that the 31-day and 62-day cancer waiting time measures are met and one action to improve FCT data quality
- Regarding engagement with Māori, Pacific, DHB Consumer Councils and other key stakeholders in the development of our cancer improvement plan.
- Based on the Bowel Cancer Quality Improvement Plan 2020
- Based on the Lung Cancer Quality Improvement Monitoring Report (February 2021)
- Prostate Cancer Quality Improvement Monitoring Report (draft March 2021
- To monitor of the impact of COVID-19 on cancer diagnostic and treatment services.

Actions: New Zealanders experience equitable cancer outcomes – He taurite ngā huanga	**Milestones**
1. Ensure the accurate collection of ethnicity data in our core systems	Q2: Process for the capture of ethnicity data is reviewed and changes implemented by end Q2
2. Work with the Māori Health Directorate to ensure staff receive appropriate Māori and Pacifica cultural competency training	Q4: Staff to receive cultural competency training by end Q4
3. Introduce Basic Te Reo into patient waiting areas • Signage • Basic language skills	Q3: Commence implementation by Q3
4. Continue to use Equity Tracking Tool to identify patients where assistance may be required to navigate health system but enhance to • Make information more widely available to areas outside of oncology • Flag these patients at multi-disciplinary (MDM) meetings to be able to offer continued support	Q2: Review and commence implementation by Q2
5. Southern DHB will participate in Te Aho o Te Kahu travel and accommodation project that aims to improve cancer patient equity of access and support to cancer services/treatment for our district and inter-district patient flow. We are committed to implementing the recommendations of this project, particularly those that ensure equity of access for Māori and rural communities who currently experience inequitable access to cancer services.	Q1-Q4: Participation in Te Aho o Te Kahu travel and accommodation project
6. Southern DHB will support the national work programme for the delivery of local community-based Māori Hui in partnership with Te Aho Te Kahu	Q1-Q4: Participation in the national work programme for the delivery of local

	community-based Māori Hui in partnership with Te Aho o Te Kahu
Actions: New Zealanders have better cancer survival, supportive care and end-of-life care- He hiki ake i te oranga	**Milestones**
1. Implement and report progress against the DHB Bowel Cancer Service Improvement Plan	Q1-Q4: Report progress against DHB Bowel Cancer Service Improvement Plan on a quarterly basis
	Q4: Revise plan once second QPI report for bowel cancer is released
2. Southern DHB will ensure that the 31-day and 62-day cancer waiting time measures are met. We will implement service improvements to improve timely access and demonstrate effective engagement with Māori, Pacific, Consumer Council and other key stakeholders that support local improvement initiatives. Southern DHB will • Work in partnership with Te Aho o Te Kahu and Ministry of Health to improve the FCT data quality and business rule changes as required • Implement a systematic approach to monitoring and acting on 62 day pathway breaches • Support clinical staff to gain visibility of cancer patients on both 62-day and 31-day • Ensure data integrity • Identify bottlenecks in the system • Identify resourcing issues or system issues that prevent being able to achieve the targets • Improve cultural resource for Faster Cancer Treatment (FCT) and for cancer nurse coordinators, in order to determine gaps, make improvements in pathways, and increase supportive care • Use the Quality Performance Indicators (QPI) reports to direct actions	Q1-Q4: Quarterly reporting Q4: Targets met by Q4 2021/22 Q4: Appointment of a Māori Cancer Nurse Coordinator by Q4
3. Develop a DHB Lung Cancer Service Improvement Plan based on the results of the Lung Cancer Quality Improvement Report (QPIs 2020) and the impending national Lung Cancer Quality Improvement Plan (2021).	Q2: Lung Cancer Service Improvement Plan written by Q2
4. Develop a DHB Prostate Cancer Service Improvement Plan based on the results of the impending Prostate Cancer Quality Improvement Report (QPIs 2021). This report will be published in quarter 4 2021. • Southern DHB will support clinician participation in an annual quality forum as requested, to facilitate development of a national Prostate Cancer Improvement Plan	Q4: Prostate Cancer Service Improvement Plan to be developed by Q4 Q4: Attendance at the annual quality forum by Q4
5. Southern DHB will monitor the impact of COVID-19 on cancer diagnostic and treatment services and use this information to plan and manage service volumes • In the event of a resurgence of COVID-19, Southern DHB will implement the guidance developed by Te Aho o Te Kahu on service delivery expectations at each of the hospital alert levels to ensure minimal impact on cancer patients.	Q1-Q4: Monitor the impact of COVID-19 on cancer diagnostic and treatment services and use this information to plan and manage service volumes
Actions: New Zealanders have a system that delivers consistent and modern cancer care - He pūnaha atawahi	**Milestones**
1. Work with Te Aho o Te Kahu Regional Hubs to contribute to and implement the recommendations of the national Radiation Oncology Service Plan and ensure that the model of service is fit for purpose to meet the current and future needs of the Southern district. Southern DHB will • Implement priorities in the Radiation Oncology Workforce Plan as the Plan is developed • Work with regional DHB partners to implement the agreed radiation oncology initiative	Q1-Q4: Implementation of recommendations

2. Linear Accelerator replacement Project for Southern DHB is completed • Consider future needs for Linear Accelerators in Southern DHB and the location of these.	Q4: Fully commissioned Linear Accelerator installed by Q4
3. Upgrade of Stereotactic surgery equipment is completed	Q2: Fully commissioned by Q2
4. Southern DHB will support the ACT-NOW project. We will implement ACT-NOW treatment regimens (national collection) for medical oncology and malignant haematology by: • Ensuring data standards are compliant in our oncology e-prescribing system • Through the implementation of our local data into a national repository	Q1-Q4: Implement ACT-NOW treatment regimens (national collection) for medical oncology and malignant haematology Q4: Develop a plan to address variation by Q4
5. Work with Te Aho o Te Kahu to plan and implement the adoption of the cancer related Health Information Standards Organisation (HISO) standards that will be issued via Data and Digital. These will include: • HISO:10038.4:2021 Cancer Multidisciplinary Meeting Data Standards • HISO: 10080:2021 Systemic Anti-Cancer Therapy Regimen Standard • And associated FHIR messaging standards (to be released 2020/2021) of service.	Q1-Q4: Work with Te Aho o Te Kahu to plan and implement the adoption of the cancer related Health Information Standards Organisation (HISO) standards
Actions: New Zealanders have fewer cancers – He iti iho te mate pukupuku	**Milestones**
1. Southern DHB will undertake activities that address the modifiable risk factor for cancer as referenced in the following sections • Tobacco Control • Reducing Alcohol Related Harm • Healthy Food & Drink	
2. Southern DHB will also support an increase in activities and programmes aimed at improving Māori and Pacific participation in National Screening Programmes as referenced in the following sections • Breast Screening • Cervical Screening • Bowel Screening	

Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System - Bowel screening and colonoscopy wait times

New Zealand has one of the highest rates of bowel cancer in the world. Bowel cancer is the second most common cause of cancer death in New Zealand, after lung cancer, with the third highest bowel cancer death rate in the OECD for women and the sixth highest for men. The National Bowel Screening Programme aims to reduce the mortality rate from bowel cancer by diagnosing and treating cancers at an earlier more treatable stage. Early identification and removal of precancerous advanced bowel adenomas aims to reduce bowel cancer incidence over time. Achieving equitable access is a key priority for the bowel screening programme because participation rates for Māori, Pacific and people living in our most deprived areas remain lower than other groups. The National Screening Unit has implemented an Equity and Performance Matrix in the annual planning reporting process. The Matrix measures both performance against a target and the equity gap between population groups notably, but not limited to, Māori and non-Māori. To ensure all patients requiring diagnostic procedures are treated fairly, the Ministry uses a dedicated monitoring framework to measure symptomatic colonoscopy wait time performance alongside bowel screening colonoscopy performance. This process ensures both the recommended colonoscopy wait times and the number of people waiting longer than maximum wait times receive equal focus.

This plan include the actions for the upcoming year that Southern DHB considers to be the most important for improving bowel screening and colonoscopy wait times, including the reasons why the action(s) are important and the expected impact. Southern DHB will ensure:

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

For bowel screening, this plan identifies key actions we will undertake to ensure:

- Participation rates for bowel screening priority population groups are at least 60% (EOA) AND
- An overall participation rate of at least 60% in the most recent 24 month period (EOA)
- Bowel screening indicator 306 is consistently met.

For bowel screening and colonoscopy wait times, this plan identifies key actions that we will undertake to continue to support COVID-19 recovery and/or embed key learnings from our COVID-19 response in this priority area.

Actions	Milestones
1. Given that the Waiting Time Indicators are currently being met for symptomatic and bowel screening colonoscopies, the Surveillance waiting time for colonoscopy is prioritised for recovery by: • Ensuring all available capacity is utilised • Recruitment of new gastroenterologist • New surveillance guidelines are adopted and retrospectively applied according to good clinical practice • Constant monitoring of recovery of the waiting list	Q2: Surveillance Colonoscopy waiting times indicator is met by end Q2 2021/22 with no patients waiting beyond their maximum waiting times whilst maintaining achievement of the waiting time indicator for symptomatic and NBSP
2. Currently participation rates for priority populations are above 60% and accordingly we will look to maintain the current communication and engagement strategy for the National Bowel Screening Programme.	Q1-Q4: Participation rates for priority populations (Māori , Pacifica and Quintile 5) remain above 60%
3. Participation rates for priority populations will be regularly reviewed and response targeted according to the demographic data that is provided.	Q1-Q4: Participation rates for priority populations (Māori , Pacifica and Quintile 5) remain above 60%

4. Following the reviews into the endoscopy service in Southern DHB, improvements will be made to the reporting capability and a new electronic internal referral form will be put in place. This will allow better tracking of the patient through the system and enhance the ability for clinicians to accurately triage patients by ensuring all necessary information is available.	Q1: New reporting functionality and electronic referral to be in place by end Q1

Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System - Health workforce

Strengthening the workforce is a high priority for the Ministry. Workforce accounts for nearly 70 percent of total public health expenditure. It is important to ensure there is a sufficient and sustainable supply of skilled workers to deliver high-quality health services in a timely manner, driving equity and system improvement.

Our plan includes actions for the upcoming year that Southern DHB considers to be the most important for health workforce, including the reasons why the action(s) are important and the expected impact. This includes:

- Key actions being planned/undertaken to use our health workforce differently, both locally and regionally, as a result of the learnings from our COVID-19 response (e.g. utilisation of the Kaiāwhina workforce).
- Key actions being planned/undertaken to engage with unions when considering or developing any new initiatives to increase workforce flexibility and mobility in order to respond to COVID-19.
- Key actions being planned/undertaken to increase the diversity of representation in leadership or decision-making roles.
- Key actions being planned/undertaken to drive sustained improvement in the number of professionals meeting standards of cultural competence and safety.
- Key actions being planned/undertaken to support the sustainability, and the health and safety/wellbeing including mental wellbeing of our workforce.

Action	Milestones
1. Actions being planned/undertaken to use our health workforce differently, both locally and regionally, as a result of the learnings from our COVID-19 response • As part of COVID-19 we are reviewing our recruitment processes including calling for volunteers. A database for both volunteers and contingent workforce is in progress.	Q2-Q3: Data base finalised and set up
• Existing staff who are considered to be vulnerable, have been advised and have been trained where possible in alternate duties (e.g. contact tracing) should the need arise.	Q1-Q4: Existing staff remobilised as required
• Work continues on establishing contingent workforce for Aged Residential Care facilities in the Southern district to support with surge workforce. Recruiting for surge capacity for Aged Residential Care facilities remain a challenge with a very limited pool available to support this work. Focus continues to ensure sufficient resources and plan of action is in place should the need to supplement workforce in ARC is required due to COVID-19 outbreak.	Q1: Workforce to be established
2. Actions being planned/undertaken to engage with unions • Southern DHB has established a working group with our union partners where we discuss COVID-19 related matters as and when required. Our local Bipartite Action Group (BAG) provides the foundation for this and is expanded to include non-BAG members when necessary.	Q1-Q4: Engagement with unions as required
3. Actions being planned/undertaken to increase the diversity of representation in leadership or decision-making • The implementation of a new recruitment system provides an opportunity to review our recruitment process to ensure it is attracting a diverse applicant pool. Our interview process and panel selection will include guidance around diversity and unconscious bias. We will also be able to more accurately capture data relevant to diversity metrics.	Q2-Q4: Implementation of a newly established recruitment system
• A diversity and inclusion policy is to be established which will include the joint collaboration with union partners, Māori Health Directorate and other stakeholders to ensure diversity in leadership roles as well as decision making within Southern	Q2: Diversity and inclusion policy established
• Work is progressing in reviewing existing recruitment processes and refining the new recruitment system to support Māori and Pacifica applicants who meet the minimum criteria of positions of being progressed to the interview stage. Good progress is being made in the Allied Health space in this regard and will be rolled out through the organisation in due course.	Q3-Q4: Review of recruitment processes to ensure positive experience for Māori and

○ Southern DHB will be using a similar process and practice to that which is in place in Capital and Coast DHB in this regard. ○ Our Job Descriptions and Interview questionnaires are being reviewed with a refresh and focus on the Tiriti o Waitangi.	Pacifica applicants who meet minimum criteria for positions.
4. Actions being planned/undertaken to drive sustained improvement in the number of professionals meeting standards of cultural competence and safety. • Southern DHB is establishing micro-learning and credentialing of cultural programs and education in support of health professionals to meet standards of cultural competence and safety. Working with Otago Polytechnic, we will offer a course to achieve a Certificate in Bicultural Competency in Otago and Southland Q1-Q4.	Q1-Q4: Course is offered to staff in Otago and Southland, with capacity for 630 staff per annum
	Q2, Q4: Report on numbers enrolled and numbers achieving the Certificate
	Q4: Evaluation
5. Actions to support the sustainability, and the health and safety/wellbeing of staff • The Southern DHB's People Forum has identified the need for a Welfare Advisor to be established. This role will enable the establishment of a welfare/wellbeing framework for Southern to focus on the wellbeing needs of our staff. This will include the oversight and management of the Employee Assistance programme, provision of Psychological First Aid training for managers and other similar programs designed and focussed on supporting the mental, emotional and physical wellbeing of our staff.	Q1: Establishment of a Welfare Advisor position
	Q2-Q4: Approval of budget for increase in FTE; recruitment and appointment of Welfare Advisor
• Provide a digital system to support the operational management of hazards and risks and to track H&S improvement actions.	Q1-Q3: Progressive rollout of Risk Manager modules to H&S Reps and Managers

Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System - Data and digital enablement

A modern, digitally and data enabled health and disability system can realise the potential of information and digital services to support people to look after their own health and improve decision-making across the system to improve experience, care and outcomes. It is a priority for the Government and DHBs are expected to work on this in partnership with other agencies, industry and consumers.

Our plan includes actions for the upcoming year that we consider to be the most important for data and digital enablement, including the reasons why the action(s) are important and the expected impact. In our plan, we have identified how digitally enabled changes to ways of working and the delivery of services as part of the COVID-19 response, will be adopted and normalised. Initiatives consider telehealth, changes to workforce practices including remote working, increased access to and sharing of data, increased use of data for reporting and analytics, acceleration of the use of cloud services and supporting the COVID-19 response such as electronic ordering of tests and results reporting and electronic tools for CBACs.
Our plan includes those initiatives that demonstrate data and digital enabled integrated care and collaboration across community, primary and secondary care in order to improve the pandemic response in the event of a resurgence, including:

- Key actions with milestones that will digitally enable health services to support COVID-19 recovery, sustain changes to service delivery models and/or embed key learnings from our COVID-19 response.
- Actions undertaken to address and resolve significant digital initiatives delayed by COVID-19.
- Actions with the most significant impact on improved outcomes.

Our plan also includes:

- Actions for the upcoming year that we consider to be the most important for improving digital inclusion with regard to health services, including the reasons why the action(s) are important and the expected impact.
- Actions for the upcoming year that we consider to be the most important for improving equity of access to health services through digitally enabled means (e.g. telehealth).

Actions for the upcoming year that Southern DHB considers to be the most important for data and digital enablement - Important Data and Digital Projects	**Milestones**
1. SIPICS – replacing our current Patient Administration System with the South Island Patient Information Care System • Awaiting joint Minister approval • Removal of two separately administered patient management systems that are unable to meet increasing demands of health services will allow the introduction of technology that supports emerging models of healthcare delivery • Will allow alignment of district business transformation with patient management workflows in a system suited to the digital future • Will allow alignment with regional patient management workflows as a step towards an integrated electronic health system across the South Island • Will be a driver for a move to a new integration platform o By end of March 2022 – Complete business process reengineering to suit business transformation o By end of May 2022 – Complete Data Migration planning (phase 1) for implementation Nov 2022 (phase 2) o By end of May 2022 – Complete master data and configuration planning (phase 1) for implementation Nov 2022 (phase 2) o By end of June 2022 – Complete integration planning (phase 1) for implementation Nov 2022 (phase 2)	Q3: Complete Business process reengineering to suit business transformation Q4: Complete Data Migration Phase 1 Q4: Complete master data and configuration Phase 1 Q4: Complete integration Phase 1
2. HCM – Human Capital Management System replacement (subject to Business Case Approval) • SAP Employee Central would support the simplification and integration of Employee data and information along with associated workflows and reduce the reliance on internal capability and capacity. It would strengthen authorisations and approvals and dramatically improve access to reliable real-time data for managers. It further provides an intuitive self-service platform which can	Q1: HCM Business Case approval

be accessed on the go reducing the need for dedicated workstations. Employee Central provides for the integration between organisational structures and personnel administration and record keeping • Employee Central supports more effective position management. Authorisations can be set to restrict the creation of new un-budgeted positions. It provides for more effective vacancy and recruitment management, allowing respective authorised tiers to view changes and plans at any given time • The major milestone is the approval of the Business Case, Once this achieved we will update the Annual Plan with the project milestones • HCM Business Case approval Q1	
Actions: Digitally enable health services to support COVID-19 recovery, sustain changes to service delivery models and/or embed key learnings from your COVID-19 response	**Milestones**
1. Voicera Handsfree Clinical Communication • Business Case Approval	Q1: Business Case Approval
2. iMedx transcription	
• Complete rollout at Southern DHB	Q1: Complete rollout at SDHB
• Roll out to our Rural Hospitals	Q2: Roll out to our Rural Hospitals
Actions undertaken to address and resolve significant digital initiatives delayed by COVID-19	**Milestones**
• No delays to identify	
Actions (with milestones) with the most significant impact on improved outcomes	**Milestones**
1. Southern Health Digital Blueprint	
• Ministry approval of the Digital Indicative Business Case	Q1: Ministry approval of the Digital Indicative Business Case
• Draft Digital Detailed Business Case	Q1: Draft Digital Detailed Business Case
• Sign off and Approval of Digital Detailed Business Case	Q3: Sign off and Approval of Digital Detailed Business Case
Actions for the upcoming year that Southern DHB considers to be the most important for improving equity of access to health services through digitally enabled means (e.g. telehealth)	**Milestones**
1. Telehealth – The Digital technology has been established and we continue to work with our Services to assist them with the adoption • Refer to Planned Care template	Q1-Q4: Work with services to assist with adoption of Telehealth
2. Increase use of telehealth by Māori providers and rūnanga (EOA)	
• Explore feasibility and funding options	Q1: Feasibility and funding options explored
• Consult with and provide education to Māori providers	Q2: Consultation/provision of education to Māori providers

3. Microsoft 365 and MS Teams – Technical implementation is complete and we continue to work with our internal and external stakeholders to identify opportunities and develop solutions that benefit our community	Q1-Q4: Work with services to assist with adoption of Microsoft 365 and MS Teams

Care Capacity and Demand Management (CCDM)

Key actions are outlined that the DHB will undertake in 2021/22 to complete and/or maintain the implementation of CCDM in each component of the programme; governance, patient acuity data, core data set, variance response management and FTE calculations.

Actions: Governance	**Milestones**
1. Ongoing consultation with stakeholders; development of Annual Plan by Q4	Q4: CCDM Annual Plan endorsed at CCDM Council Meeting
2. CCDM Council meets as per the Terms of Reference, with at least one meeting per quarter	Q1-Q4: At least one meeting held per quarter
3. Allied Health to develop a framework for Local Data Council formation by 30 September 2021	Q1: Allied Health LDC framework developed
4. Report on CCDM Programme implementation progress / completion to Health Union Partners, SSHWU/MoH and staff each quarter.	Q1-Q4: Progress reports to partners
	Q1-Q4: Increase in overall nursing/midwifery CCDM implementation each quarter or <5% decrease in inpatient implementation.
5. Inpatient Local Data Councils meet at least twice per quarter.	Q1-Q4: 100% of Local Data Councils / wards have met as per TOR
6. Lakes District Hospital included in CCDM quarterly reporting.	Q1: Lakes District Hospital added to quarterly report as new site
	Q2-Q4: Local Data Council meetings established at Lakes District Hospital. At least two meetings held each quarter.
7. Report on key results from evaluation of full implementation by the SSHW Unit	Q2: Key results and progress reported
Actions: Patient Acuity Data	**Milestones**
1. TrendCare upgraded to 3.6.1 on release by vendor.	Q1: TrendCare 3.6.1 upgrade completed
2. TrendCare implemented at Lakes District Hospital following 3.6.1 upgrade.	Q2: Proposal for implementation accepted
	Q4: TrendCare fully implemented at Lakes District Hospital
3. Annual Southern DHB TrendCare Business Rules reviewed and updated.	Q4: TrendCare Business Rules reviewed and updated
4. IRR testing undertaken by all inpatient wards.	Q2-Q4: 100% of wards have completed IRR Testing by end of quarter 4

	Q1-Q4: Report on % IRR testing completed each quarter
5. Implementation of preferred acuity tool for Allied Health	Q3: Acuity tool implemented for Allied Health
Actions: Core Data Set	**Milestones**
1. Core Data Set measures can be accessed by staff on PowerBI dashboard	Q1: At least 19 of the 23 CDS measures available to staff on electronic dashboard
	Q3: At least 21 measures are reported on the dashboard.
2. End of Shift Survey undertaken at least 6 monthly; results reported to stakeholders (survey encompasses the remaining 2 CDS measures not able to be reported on the dashboard, i.e. care rationing & staff satisfaction).	Q2, Q4: End of Shift Survey response rate > 65%
	Q2, Q4: Survey results shared with stakeholders
3. Implementation of Allied Health Core Data Set	Q4: Allied Health Core Data Set implemented
Actions: FTE calculations	**Milestones**
1. FTE calculation data is entered into the software.	Q3: Data entry for all wards eligible for FTE calculations is completed
2. Number of FTE calculations completed	Q1-Q4: Number of completed FTE calculations
3. FTE calculations have been agreed at executive level and are within budget.	Q1-Q4: FTE calculations are agreed and budgeted
4. Additional FTE have been recruited.	Q1-Q4: Number of additional FTE recruited
	Q1-Q4: % of total FTE recruited that are Māori
Actions: Variance Response Management	
1. VRM indicators and response plans reviewed for effectiveness annually at Local Data Councils.	Q4: 100% of VRM indicators and response plans have been reviewed at Local Data Councils.
2. Percentage of hours spent in red, and orange VRM.	Q1-Q4: Percentage of time in Red, Orange and Mauve each quarter for all 34 wards.
3. Allied Health Standard Operating Procedure completed.	Q2: Finalise Allied Health Standard Operating Procedure

4. Implementation of Allied Health VRM tool to electronic platform.	Q1: Allied Health tool incorporated on Capacity at a Glance (CaaG) screen

2.1.7 BETTER POPULATION HEALTH OUTCOMES SUPPORTED BY PRIMARY HEALTH CARE

Better Population Health Outcomes Supported by Primary Care - Primary care

Improving access to primary care services is a priority for the Government which all DHBs are expected to progress, working closely with primary care partners.

This plan includes actions for the upcoming year that we consider to be the most important for primary care, including the reasons why the action(s) are important and the expected impact.

- In this plan we include actions we will undertake to continue to support COVID-19 recovery and/or embed key learnings from its COVID-19 response in this priority area. The actions identified in this plan are those expected to have the most significant impact on improved outcomes.
- Two evidenced-based equity actions are included focused on our Māori populations.

Actions	Milestones
1. Continue the rollout of the call centre supporting the primary care catch up programme of work. The call centre will work to help people get enrolled at a general practice, make health check-ins for Māori patients over the age of 50, help people make appointments with designated practices to be tested for COVID-19, and other tasks as appropriate including catch up on health targets such as DAR and HbA1c. • CVD risk assessments. Baseline 74% • HbA1c. Baseline Māori 49% • Flu vaccinations. Baseline Māori 56% • Smoking brief advice Māori. Baseline 76% • Enrolment for Māori. Baseline 79%	Q2, Q4: CVD 90% Q2, Q4: HbA1c Māori target 60% Q2, Q4: Flu vaccination Māori 75% Q2, Q4: Smoking brief advice Māori 90% Q2, Q4: Māori enrolment 90%
2. Continue to support the roll out of GP and patient portals to increase access to services. • GP practices with portals baseline 66%. • Patients registered with a portal. Baseline 23.3%. • Refer telehealth actions in Planned Care.	Q2, Q4: GP practices with portals. Target 80%. Q2, Q4: Patients registered with a portal. Target 40%.
3. Client Led Integrated Care to be rolled out into primary care. • Increase Māori access to equitable levels. Baseline 3.48% of all CLIC patients	Q4: Māori CLIC to 11.1%
4. All Border workers are COVID-19 vaccinated during Q1	Q1: 100% border workers vaccinated
5. WellSouth PHO to participate in COVID-19 resurgence planning with the Southern DHB at the Technical Advisory Group and the COVID-19 Steering Group.	Q1-Q4: 100% participation at COVID-19 planning meetings

Better Population Health Outcomes Supported by Primary Care - Pharmacy

Over recent years DHBs have focused on developing pharmacist services, making better use of pharmacists' skills, within an integrated health and disability system that supports people to stay well throughout their lives. For 2021/22 the Ministry is requesting that DHBs consolidate this work with an emphasis on immunisation and the expansion of one DHB nominated pharmacy service development.

Our plan includes actions for the upcoming year that we consider to be the most important for pharmacy, including the reasons why the action(s) are important and the expected impact. Key actions include:

- Actions we will undertake to continue to support COVID-19 recovery and/or embed key learnings from its COVID-19 response in this priority area. The actions identified in this plan are those expected to have the most significant impact on improved outcomes.
- Actions from the local strategies we have initiated, or plan to initiate in 2021/22, that support pharmacy and other immunisation providers to work together to improve influenza vaccination rates in Māori, Pacific, refugee, or other locally targeted populations. Additionally, we will specify how we are increasing overall vaccination rates, and how we are closing the equity gap between populations using our pharmacist vaccinator workforce.
- Actions to build on and consolidate our 2020/21 work, taking forward pharmacy service actions described in our annual plan 2020/21, including how the action will be embedded, integrated and sustained at scale across our pharmacy providers as an integrated community pharmacy services agreement schedule 3C service.

Actions	Milestones
1. Continue to engage with Community Pharmacy sector through the Community Pharmacy Advisory Group (CPAG) to keep the sector informed of any significant changes/actions relating to COVID-19. • A dedicated Southern DHB COVID vaccination team is leading engagement with pharmacies, including targeted communications, planning of vaccine clinics, logistics of vaccine delivery, reporting of clinics held (location, numbers vaccinated, etc.	Q1-Q4: Reports on engagement with Pharmacy Sector
2. Public Health measles, mumps and rubella (MMR) response to engage with local community pharmacies to support the MMR catch up programme. Refer to Immunisation template for measures and milestones. • Southern DHB to continue to contract with new Integrated Community Pharmacy Services Agreement (ICPSA) holders to deliver the immunisation schedule, including influenza. Increasing the number of community providers will increase Māori access to immunisation options.	Q1-Q4: Number of ICPSA providers who have Flu Vaccination schedule in their ICPSA Q4: Review of Māori vaccination rates (data differentiated by provider where practicable)
3. LTC-CLIC pilot to undergo a redesign of eligibility to closer align the service to population need. Client Led Integrated Care (CLIC) level 2 risk criteria will be considered as a more appropriate population for this service. • Review level three CLIC patients to identify appropriate patients. • Review level two CLIC patients with 5 or more medicines to identify appropriate patients • Make the new list of patients available to participating pharmacies to undertake Medicine Utilisation Review (MUR) • Undertake a review of eligible patients with participating pharmacies following MUR	Q2: Confirm eligibility change to the pilot. Target is 3500 eligible patients for the Southern District. Q2: Review the appropriateness of the patient cohort. Q4: Evaluate the pilot

4. CLIC to be rolled out into primary care – actions undertaken to Increase Māori access to equitable levels. Baseline 3.48% of all CLIC patients	Q4: Māori CLIC to 11.1%
5. Undertake analysis to understand utilisation and cost drivers of Southern district pharmaceutical use, especially high-cost pharmaceuticals. Work with identified outlier practices to improve efficiency, once usage patterns are known and high frequency dispensing is identified amongst community pharmacists.	Q1: Complete pharmaceutical benchmarking, comparing Southern to other DHBs.
	Q2: Outlier pharmacists identified
	Q3, Q4: Education and support provided to outlier pharmacists.
	Q4: Demonstrated reduction in outlier status

Better Population Health Outcomes Supported by Primary Care – Long-term conditions

Long term conditions comprise the major health burden for New Zealand now and into the foreseeable future. This group of conditions is the leading cause of morbidity in New Zealand, and disproportionately affects Māori and Pacific peoples and people who experience mental illness and addiction. As the population ages and lifestyles change these conditions are likely to increase significantly.

The long-term conditions approach of this plan focuses on improving integrated services to enable primary, community and specialist services to work together to prevent, and manage and treat long term conditions to achieve equity and wellbeing for people with, or at risk of, long term conditions. A priority focus for 21/22 will be diabetes and gout, which are specifically identified in the Ministry of Health Whakamaua Māori Health Action Plan and the Ola Manuia Pacific Health Action Plan. There is also need for continued improvement and sustained focus on heart health, stroke, chronic kidney disease and hepatitis C[8].This plan includes actions that Southern DHB considers to be the most important, including the reasons why the action(s) are important and the expected impact. Actions include:

- Key actions with milestones the DHB will undertake to continue to support COVID-19 recovery and/or embed key learnings from its COVID-19 response in this priority area. The actions identified in this plan are those expected to have the most significant impact on improved outcomes.
- Action on how prevention is improved though evidence-based nutritional and physical activity advice provided to at-risk population groups (e.g. Green Prescription) and how we will work with population groups to identify the most effective advice or activity for prevention.
- Action on how identification, intervention and recall of people with high and moderate risk is being strengthened, such as through early risk assessment, and how PHO/practice level data is used to inform quality improvement and improve equitable access to services.
- Action on how the DHB is improving the management of people with long term conditions through actions such as those provided by multi-disciplinary teams (including allied health and kaiawhina) to support improved service delivery in primary care, with self-management, equitable access, identification and prioritisation of high-risk groups, support and education and the impact this will have.
- Action on how the DHB will support the delivery of the regional hepatitis C work and objectives including how we will work collaboratively to increase access to care and promote primary care prescribing of hepatitis C treatments and support implementation of key priorities in the National Hepatitis C Action Plan (once the plan is published).

Focus on: Ambulatory sensitive hospitalisations (ASH adult) (SS05)

A focus on improving ASH rates through improved system integration will contribute to a reduction in the total number of unplanned hospital admissions, a substantial proportion of which are ambulatory sensitive. Our plan includes

- Key improvement actions that are expected to have the most significant impact on performance improvement, with milestones for each quarter.
- Locally selected contributory measures that will support measurement of progress.

Actions	Milestones
1. COVID-19 recovery • Continue to support the roll out of GP and patient portals to increase access to services	Q4: GP practices with portals. Baseline 66%. Target 80%.
	Q4: Patients registered with a portal. Baseline 23.3%. Target 40%.

[8] New Zealand has the opportunity to eliminate hepatitis C in the next 10 years. Significant factors including access to publicly funded, highly effective, well-tolerated direct-acting antiviral (DAA) treatment, and activity from DHBs, primary care and affected communities means there is real prospect of curing hepatitis C for the 45,000 New Zealanders estimated to be living it. Priority groups, including Māori, are populations who have a high prevalence of hepatitis C and more of the long-term impact of infection. The priority settings are needle exchanges, prisons, primary and community care, and alcohol and other drug services (including opioid substitution therapy services).

2. Green Prescription (GRx) • Sport Southland and Sport Otago will develop a new pathway to GRx from WellSouth's Walking Away Programme (prediabetes education group sessions), to support patients set and achieve positive lifestyle changes around physical activity and nutrition, to reduce their risk of becoming diabetic Q1 (EOA).	Q1: New referral pathway developed and implemented from WellSouth Walking Away Programme to Green Prescription.
	Q2: Six monthly reporting to include referral numbers from Well South's Walking Away programme to Sport Southland and Otago's GRx service
	Q4: Six monthly reporting to include referral numbers from Well South's Walking Away programme to Sport Southland and Otago's GRx service
3. Identification, intervention and recall of people with high and moderate risk • LTC management through MDT will be piloted between Southern DHB Diabetes services and three Health Care Home general practices (Invercargill Medical Centre, Mornington Health Centre and Te Kāika Forbury). Telehealth services supporting clinical governance to be established.	Q2: Telehealth MDT service initiated
	Q4: Evaluation
4. Improving the management of people with long term conditions • Diabetic Annual Review (DAR) catch up programme to be delivered, with restoration of the achievement of the targets for DAR and HbA1c. This will be supported by the newly established call centre. • Refer to Primary Care template.	Q1-Q4: DAR catch up programme delivered
	Q2: DAR to 80% for Māori
	Q2: HBa1c to 90% for Māori
5. Support the delivery of the regional hepatitis C work and objectives	
• Assist General Practice in the identification of patients with potential hepatitis C by identification of patients enrolled in the practice with known risk factors	Q1-Q4: Assistance provided to General Practice
	Q1-Q4: Report on number of practices engaged per quarter
• Provide education and advice for General Practice across Southern DHB, including rural sites, on hepatitis C	Q1-Q4: Education and advice provided to General Practice across the district
• Support General Practice in the prescribing and monitoring of patients on Maviret	Q1-Q4: General Practices provided support in the prescribing and monitoring of patients on Maviret
	Q1-Q4: Report on number of patients being treated for hepatitis C-with Maviret in the southern district
• Make initial contact Māori health providers to provide education on hepatitis C and the treatments available	Q2-Q4: Initial contact made with Māori health providers to provide education on hepatitis C and the treatments available

6. Ambulatory sensitive hospitalisations (ASH adult) (SS05) • 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): o ED presentations; o DNA (Unable to attend); o Maternity; o Respiratory; o Cardiovascular Disease; o Stroke; o Diabetes. *Refer to SLM Plan. The 36 Southern DHB Māori Health Navigators will link into our Māori NGO providers. In this way, an in-reach to secondary services pathway will be achieved. For example, patients undertaking rehabilitation, following services in cardiac care and also (ISIS) trauma, will be supported to transition back into the community*	Q4: Number of patients supported through the Māori Navigator service
• 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. *Refer to SLM Plan*	Q4: Percentage of eligible population with a comprehensive Health Assessment

Better Population Health Outcomes Supported by Primary Care – Reconfiguration of the National Air Ambulance Service Project – Phase Two

Air ambulance services are a critical part of how we respond to health emergencies in New Zealand. This service contributes to equity by enabling timely access to specialist clinical interventions regardless of where you live. Cabinet have endorsed a two-phased 10-year reconfiguration of the national air ambulance service. Phase one is complete, preparation for phase two has begun.

Phase Two seeks to achieve the following:

1. A nationally integrated aeromedical service that is coordinated and interoperable across ambulance services and supports the wider health service into the future.
2. A service which ensures that an aeromedical asset is dispatched with a crew capable to save a life, in the time needed to save that life.
3. A service that is optimised to improve clinical effectiveness and standards and achieve better patient outcomes.
4. A service that is financially sustainable with transparent funding flows.
5. A national network of bases, aircraft and crew that provide optimal coverage across New Zealand, which is fully compliant with Civil Aviation Rules and based on world-class aeromedical standards.
6. An appropriate infrastructure model that achieves the best public value for money and supports better service delivery and patient outcomes

Project work streams include:

1. Centralised tasking and clinical coordination
2. Service system performance
3. Infrastructure and service configuration
4. Provider operational funding

Southern DHB will actively support and participate in the above project, led by the National Ambulance Sector Office (NASO).

For Reconfiguration of the National Air Ambulance Service Project – Phase Two, Southern DHB outlines key actions that the DHB will undertake to continue to support COVID-19 recovery and/or embed key learnings from our COVID-19 response in this priority area. The actions identified in this plan are those expected to have the most significant impact on improved outcomes.

Actions	Milestones
1. Maintain our commitment to the national plan to achieve a high functioning and integrated National Air Ambulance service and actively participate through the National Ambulance and Retrieval Quality and Safety Group (clinical governance) processes to achieve this. • Support changed Governance arrangements to improve the partnership with DHBs, MOH and ACC across all elements of the National Ambulance Sector Office (NASO) work programme and support the design and planning for tasking and coordination of aeromedical services. • Provide information on Post COVID responses to national planning	Q1-Q4: Ongoing commitment maintained
2. Design a flexible aero-medical workforce model that enables sustainable system improvements and supports service capacity in a COVID impacted health system	Q1-Q4: Ongoing commitment maintained
3. As part of a national DHB working group, develop clinical and operational quality measures and KPIs for inter hospital transfers.	Q1: Co-developed KPI framework with clinical leadership endorsed by DHBs

4. Through the national DHB working group endorse and implement the collection and reporting for KPIs through the NASO performance monitoring and reporting system.	Q2: DHB collection of data for KPIs
5. Provide timely and accurate safety issue reporting to clinical and operational governance for continuous quality improvement and to inform national standard operational procedures	Q3: National DHB working group review
6. Contribution is timely and complete.	Q4: National work programme delivery of KPIs
7. Participate in a stock take of clinical flight equipment and certifications. Contribute to the development of inter-operability and compatibility recommendations for aircraft and stretcher systems by the DHB working group to the national programme.	Q4: National stock take completed and recommendations for system improvement agreed
8. Achieve health equity for rural and priority populations by understand the challenges and plan the improvements required.	Q4: National review of ambulance and primary emergency service provision (e.g. PRIME services) in rural NZ locations completed and recommendations for system improvement agreed.

2.2 FINANCIAL PERFORMANCE SUMMARY

2.2.1 PROSPECTIVE STATEMENT OF FINANCIAL PERFORMANCE

Table 1: Comprehensive Income for 30 June 2022, 2023, 2024 and 2025

DHB Consolidated Statement of Prospective Financial Performance	2019/20 Actual $' 000	2020/21 Forecast $' 000	2021/22 Budget $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000	2024/25 Projection $' 000
Revenue						
PBF Funding Package	945,394	1,027,684	1,085,721	1,123,721	1,163,051	1,203,758
Inter District Revenue	23,648	26,870	27,338	28,344	29,387	30,469
Funder Side Contracts	80,541	88,743	75,342	77,979	80,708	83,533
Provider Misc Revenues	50,483	57,120	55,502	56,304	57,121	57,930
Total Revenues	1,100,066	1,200,417	1,243,903	1,286,348	1,330,268	1,375,690
less Personnel Expenses						
Medical Personnel	(156,219)	(158,411)	(162,133)	(165,899)	(171,705)	(177,714)
Nursing Personnel	(201,693)	(184,793)	(197,953)	(200,005)	(207,005)	(214,250)
Allied Health Personnel	(57,719)	(63,159)	(68,679)	(70,640)	(73,112)	(75,671)
Support Services Personnel	(6,169)	(6,877)	(6,999)	(7,187)	(7,439)	(7,699)
Management/Admin Personnel	(55,633)	(59,278)	(61,612)	(63,236)	(65,449)	(67,740)
Personnel Costs Total	(477,433)	(472,518)	(497,375)	(506,966)	(524,710)	(543,075)
less Non Personnel Expenditure						
Outsourced Services Expenses	(48,797)	(56,291)	(51,072)	(52,604)	(54,182)	(55,807)
Clinical Supplies Expenses	(109,059)	(122,098)	(119,173)	(123,721)	(127,293)	(130,548)
Infrastructure & Non Clinical Supplies Expenses	(88,494)	(88,601)	(93,791)	(99,945)	(106,118)	(107,794)
Total Non-Personnel Expenditure	(246,350)	(266,990)	(264,036)	(276,269)	(287,592)	(294,149)
less Provider Payments						
Personal Health Expenses	(270,490)	(282,220)	(289,403)	(299,532)	(310,016)	(320,866)
Mental Health Expenses	(30,105)	(33,143)	(36,816)	(37,736)	(38,679)	(39,646)
Disability Support Expenses	(154,465)	(161,966)	(171,169)	(175,448)	(179,835)	(184,330)
Public Health Expenses	(10,331)	(10,183)	(6,531)	(6,694)	(6,862)	(7,033)
Maori Health Expenses	(1,344)	(1,802)	(2,881)	(2,938)	(2,997)	(3,057)
Total Provider Payments	(466,736)	(489,314)	(506,799)	(522,349)	(538,389)	(554,933)
Total Expenses	(1,190,519)	(1,228,823)	(1,268,210)	(1,305,585)	(1,350,691)	(1,392,157)
Net Surplus / (Deficit)	**(90,454)**	**(28,406)**	**(24,307)**	**(19,236)**	**(20,423)**	**(16,467)**
Supplemental Information						
Depreciation Charges	(25,063)	(29,157)	(33,077)	(41,111)	(41,933)	(42,772)
Interest Costs	(236)	(4)	(50)	(100)	(100)	(100)
Capital Charge	(9,651)	(7,898)	(7,142)	(6,357)	(10,431)	(9,885)
Total IDCC Costs	(34,950)	(37,060)	(40,269)	(47,568)	(52,464)	(52,757)
Medical FTE	613	653	673	673	673	673
Nursing FTE	1,834	1,899	1,970	1,970	1,970	1,970
Allied FTE	709	730	772	772	772	772
Support FTE	99	102	104	104	104	104
Management/Admin FTE	732	751	752	752	752	752
Total FTE	3,987	4,134	4,272	4,272	4,272	4,272

2.2.2 PROSPECTIVE PERFORMANCE BY OUTPUT CLASS

Table 2: Prospective Performance by Output Class for the four years ended 30 June 2022, 2023, 2024 and 2025

Revenue & Expenditure by Output Class	2019/20 Actual $' 000	2020/21 Forecast $' 000	2021/22 Budget $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000	2024/25 Projection $' 000
Prevention Services						
Revenue	20,245	19,926	17,201	17,703	18,213	18,738
Expenditure	(20,245)	(19,926)	(17,201)	(17,703)	(18,213)	(18,738)
Net Result	0	0	0	0	0	0
Early Detection and Management Services						
Revenue	221,604	227,513	240,656	245,874	256,510	267,554
Expenditure	(219,815)	(230,464)	(239,131)	(248,355)	(257,889)	(267,763)
Net Result	1,788	(2,950)	1,525	(2,481)	(1,379)	(209)
Intensive Assessment and Treatment						
Revenue	695,300	787,708	805,717	842,514	869,326	897,017
Expenditure	(789,619)	(809,736)	(833,320)	(856,386)	(886,766)	(913,032)
Net Result	(94,319)	(22,028)	(27,603)	(13,872)	(17,441)	(16,015)
Rehabilitation and Support						
Revenue	162,918	165,271	180,328	180,258	186,219	192,381
Expenditure	(160,841)	(168,698)	(178,557)	(183,140)	(187,822)	(192,624)
Net Result	2,077	(3,427)	1,771	(2,882)	(1,603)	(243)
Share of Loss in associates	0	0	0	0	0	0
Total Revenue per DHB Consolidated Financials	1,100,066	1,200,418	1,243,903	1,286,349	1,330,268	1,375,690
Total Expenditure per DHB Consolidated Financials	(1,190,520)	(1,228,824)	(1,268,209)	(1,305,585)	(1,350,690)	(1,392,157)
Net Surplus / (Deficit)	**(90,454)**	**(28,406)**	**(24,307)**	**(19,236)**	**(20,423)**	**(16,467)**

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

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 2021/22. 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. COVID-19 highlighted the importance of a well-coordinated network of primary maternity facilities, distributed across the District, to support the delivery of primary maternity care. As a result of consultation with the community and with health care providers, Southern is developing purpose-built primary maternity facilities for Central Otago and Wanaka (to open 2024)

3.2 SERVICE CHANGE

The table below describes all service reviews and service changes proposed for implementation in 2021/22. Southern DHB will manage its functions in a way that supports the intended direction and anticipated system change programme.

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	Continued Implementation of project to better configure clinically sustainable maternity services for our rural communities	Improved access, Improved service integration	Local
Mental Health	The Independent Review of Southern Mental Health and Addiction System Continuum is currently underway (February 2021). We expect that the final report from the Review will be	• Person-centred, • Care closer to home, • Improved equity of access, • Value for money,	Local

	available in June/July 2021. The report will produce a set of recommendations for implementation which places tangata whaiora and whānau at the centre of the system. An implementation plan will be developed by Q2, with implementation undertaken Q2-Q4.	• Improved service integration	
Planned Care	Using a variety of ways to improve planned patient care in different services and across the primary/secondary care continuum **Endocrinology (1)**: Dunedin Pilot: establishment, piloting and roll-out of Specialist Supervised Nurse Clinics for majority of all patients referred for Diabetes and for their on-going care. Much of specialised diabetes care that has been traditionally provided by diabetes specialists can potentially be provided by a well-trained diabetes nurse specialist with appropriate consultant supervision. Diabetes Nurse Specialists are encouraged to work at the top of their scope and care for many of the patients traditionally seen by specialists but with specialist support **Endocrinology (2):** Use of Telehealth and improved	• Care closer to home • Person-centred • Improved service integration • Enhanced clinician relationships between primary and secondary services	Local

	primary care communication/access through virtual technologies to enhance endocrine care **Rheumatology (1):** Establishment, piloting and roll out of Nurse-led clinics for provision of follow-up care. Nurse clinics are being developed in Dunedin and Southland Hospitals to utilise the full scope of the Rheumatology nurse role. Nurse-led clinics are an important feature for managing planned care. **Rheumatology (2)**: Pilot of joint appointments of rural GP and Rheumatologist connecting by videolink/telehealth, and the patient is present in the GP rooms. The design of this clinic is to reduce patient travel, to partner with primary care to provide a seamless and efficient flow, and to develop a skills base within the GP workforce such that GPs with an interest will feel confident in managing patients with rheumatic disease and seek support from Rheumatologists appropriately when needed		

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Contractual relationship with Rural Trust Hospitals	Work undertaken with Rural Trust Hospitals to identify a process that meets the goal of a single contractual relationship	• Value for money • Improved service integration	Local
Community Health and Wellness Hubs	To establish and develop community based hubs to support health and wellbeing in the wider Southern district,	• Care closer to home • Improved service integration • Improved access to care, especially for Māori	Local
Shifts or additions in workforce/FTE	SMO: Moving to a Generalist model for secondary services will increase by 6 FTE Forensic Mental Health service increase 0.4 FTE Investment in an additional 1.0 FTE to be confirmed	SMO • The move to a Generalist model of care is to enable the ED and Sub Specialty services to be better aligned to their purpose and the General medical patients a faster flow through the health system • Forensic MH services to enable better patient outcomes and reduce SMO fatigue	
	Nursing – 163 FTE over the prior year budget and 129 over forecast. 2020/21 budget not recruited to, these are the ICU phase 15, CCDM 12.0 and Generalist model 2.1. Additions for the 2021/22 year are Forensic mental health 2.0, Air Ambulance crew 3.4, public health 0.5 and handling and moving 1.1 with the balance being the CCDM calculations increase 92.0 with and 34.3 FTE investment in ED, Equity and to be confirmed	Nursing • New ICU opening to increase Dunedin Hospital capacity. • CCDM is to cover the calculations of safe staffing, this will enable reduction of accrued annual leave, safe staff and ensure no beds are closed to enable a better elective delivery. • Forensic MH is to meet the volume that is being looked after in the service. • Ambulance crew is offset by reduced expenditure. Moving and handling is a health and safety issue for staff and ensure reduced unplanned leave. Investment is yet to be confirmed.	
	Allied Health: Generalist model 2.9. ACC non acute rehab 8.8, Forensic services 2.8, maternity study 0.7, MRT for additional CT scanner 8.0 and to cover off call moving to shifts.	Allied health • Generalist model to ensure rehab approach to facilitate earlier discharge. • ACC non rehab to change model to ensure there is a reduction in admissions. Covered by revenue. • Forensic to cover volume.	

		• MRT for additional CT machine to ensure cover for Dunedin is improved.	
	Support Staff; Increase maintenance staff by 2.0	Support staff • FTE to improve the maintenance of assets	
	Management/Admin Generalist model 0.5, records scanning 2.8, Simulation assistant 1.0	• Admin support to Generalist model. • Record scanning a move away from paper. • Simulation is an investment in staff development	
Moving of high and complex patients into community services	Movement of long term high and complex mental health patients into community services Southern DHB to exit service provision and undertake RFP for community service provision Model identified by 30 June 2021 with implementation by 31 December	• Person-centred, • Level of care proportional to health need	Local

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

SDHB Governance is made up of the Board of elected and appointed members, with additional advice from two Crown Monitors. The Board has a clear vision of a sustainable health system that has wellness, quality and equity as the foundation of services delivered to the people of the Southern District

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 2021/22 and out years is contained in the Financial Performance Summary section of this document on page 94, and the Statement of Performance Expectations on page 108.

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 collective DHB's and the MOH have increased the focus on National Asset Management Program of work to improve the planning, maintenance and investment cycle of health assets, not only in Southern DHB but also across the county. Southern DHB is fully engaged in this program and see it as a crucial program of work.

This will assist with a higher level of Investor Confidence Rating (ICR) for Southern DHB as this program of work matures. 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.

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 Clinical Council oversees clinical risks which provide key areas of focus for the council. 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 31000:2018). The risks held by Southern DHB that relate

directly to the NDH build project and its dependencies are reported via a MoH procured system (that captures all NDH risk) and reported to ELT/Board monthly.

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' experiences 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.

4.1.8 WORK HEALTH AND SAFETY

Actions include:

- Integrating work health and safety risk management into DHB operations and leadership, starting with Critical Risks
- Digitising processes for managing occupational health information, risk and hazard reviews, and improvement actions.

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 will occur in 21/22 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 aging design/layout/ 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 on the design and build of the new Dunedin Hospital. The Detailed Business Case (DBC) was considered and agreed by Cabinet in April 2021.

Southern DHB has begun 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 2021/22 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 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 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 implement CCDM by mid-2021 ensuring agreed budgeted FTE are in place for nursing and midwifery by 1 July 2021.

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. 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.
3. 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 Āraiteuru Rūnaka - *Principles of Relationship Agreement (2011).*
4. 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.
5. 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.
6. 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.
7. 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.
8. 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 current 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 and will be refreshed to factor in the change required to models of care associated with the new Dunedin hospital and primary and community strategy. In refreshing the Action Plan, we will consider:

- Our ageing workforce
- Recruitment of key roles and succession planning
- 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

The six workforce strategic goals (WSG's) will be reviewed in line with the broader organisational 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 current Action Plan. The action areas will continue to be progressed concurrently, with sequencing of activities and milestones. A roadmap for each of the action areas has been developed to guide 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 rural/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 developing a leadership development framework by May 2021. This will compliment and support existing leadership development initiatives within the public sector including a current leadership development proposal led by the Ministry of Health for all District Health Boards. A leadership development framework for Southern DHB is an essential key focus area within the annual workforce plan.

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

The expectation for a next generation digital hospital and health system within Southern will be delivered via the new digital blueprint. The development of the indicative business case and supporting detail business case / implementation cases will provide the rational for change and supporting benefit realisation. The development of these resources and the shared workplan is taking place in collaboration with our South Island DHB colleagues.

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 2021/22.

Performance Measure	Performance Expectation / Target		
CW01: Children caries-free at five years of age	Children caries-free at 5 years of age	2021	71%
		2022	71%
CW02: Oral Health - Mean DMFT score at Year 8	DMFT score at Year 8	2021	<0.68
		2022	<0.68
CW03: Improving the number of children enrolled and accessing the Community Oral Health Service	Percentage of 0-4 years enrolled	2021	≥95%
		2022	≥95%
	Percentage of children (0-12 years) not examined based on planned recall	2021	≤10%
		2022	≤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	2021	≥85%
		2022	≥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	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			
period in its annual plan and has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group, for both targets.				
CW08: Increased immunisation (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 health initiatives	Focus area 1 (Youth SLAT): Provide reports as required			
	Focus area 2 (School Based Health Services): Provide reports as required			
	Focus area 3: (Youth Primary Mental Health Services) refer MH04			
MH01: Improving the health status of people with severe mental illness through improved access	Percentage of the population accessing specialist mental health services	0-19 years	Total Māori Other	3.75%
		20-64 years	Total Māori Other	3.75%
		65+ years	Total Māori	1.0%

Performance Measure	Performance Expectation / Target			
			Other	
MH02: Improving mental health services using wellness and transition (discharge) planning	Percentage of clients discharged who have a quality transition or wellness plan			95%
	Percentage of audited files meeting accepted good practice			95%
MH03: Shorter waits for Mental Health Services for under 25-year olds	Provide reports as specified			
MH04: Rising to the Challenge: The Mental Health and Addiction Service Development Plan	Provide reports as specified			
MH05: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	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 improved acute inpatient post discharge community care	Provide reports as specified			
PV01: Improving breast screening coverage and rescreening	Percentage coverage for Māori, Pacific and total population			≥70%

Performance Measure	Performance Expectation / Target		
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%
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 TBC	Total	2865/100,000
SS07: Planned Care Measures			
Planned Care Measure 1: Planned Care Interventions	Total planned care interventions 2021/22 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		95%

Performance Measure	Performance Expectation / Target	
	Percentage of patients with accepted referrals for CT scans receiving their scan, and the scan results are reported, within 6 weeks (42 days)	
	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.	
SS09: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections		
Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (duplication)	>2% and ≤4%
	Recording of non-specific ethnicity in new NHI registration	>0.5% and ≤2%
	Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% and ≤2%
	Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and ≤85%

Performance Measure	Performance Expectation / Target	
	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	≥85% and <95%
Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)	Provide reports as specified	
SS10: Shorter stays in Emergency Departments	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, milestones and measures to support people with LTC to self-manage and build health literacy	
Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care*	
	Ascertainment: target 95-105% and no inequity	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

Performance Measure	Performance Expectation / Target	
Focus Area 3: Cardiovascular health	Provide reports as specified	
Focus Area 4: Acute heart service	Indicator 1: Door to cath Door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram	>70%
	Indicator 2a: Registry completion Percentage of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge	>95%
	Indicator 2b: Registry completion Percentage of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 3 months	≥99%
	Indicator 3: ACS LVEF assessment- Percentage of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (i.e. have had an echocardiogram or LVgram)	≥85%
	Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance ≥85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge - - Aspirin*, a 2nd anti-platelet agent*, and an statin (3 classes) - ACEI/ARB if any of the following – LVEF, 50%, DM, HT, in-hospital HF (Killip Class II to IV) (4 classes), -Beta-blocker if LVEF<40% (5-classes). * An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.	≥85%
	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%

Performance Measure	Performance Expectation / Target	
	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	70%

Performance Measure	Performance Expectation / Target	
	procedure in 84 calendar days or less of the planned date	
	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	
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%
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 2021/22 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 Pete Hodgson

Population: Approximately 353, 100 people live within Southern DHB boundaries.

Staff: Southern DHB employs over 4,500 people.

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

HOW WILL WE DEMONSTRATE SUCCESS?

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

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

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

There are two series of measures that we use to evaluate our performance: outcome and impact measures which show the effectiveness over the medium to longer term (3-5 years); and output measures which show performance against planned outputs (what services we have funded and provided in the past year).
On an annual basis, we evaluate our performance by providing a forecast of the services we plan to deliver in the coming year and the standards we expect to meet. We then report actual performance against this forecast in our end-of-year Annual Report[10].

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

CHOOSING MEASURES OF PERFORMANCE

To make all this happen we have to balance our investment so we can deliver services now and into the future. In 2021/22, the Southern DHB plans to spend approximately $1.3 billion in delivering the following four Outputs funded through Vote Health:

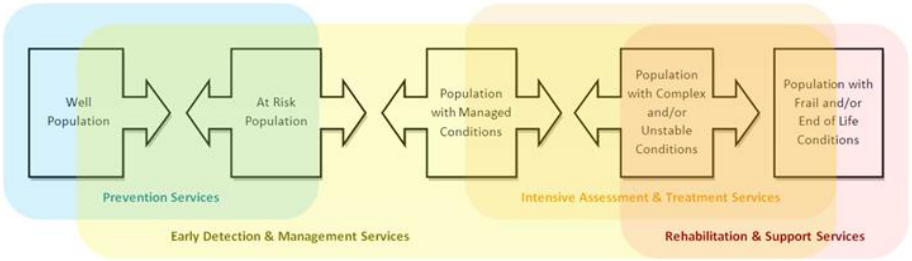
Output 1: Prevention Services;

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 2021/22, by output class.

Table 1: Revenue and expenditure by Output Class 2021/22

REVENUE	Total $'000
Prevention	17,201
Early Detection and Management	240,656
Intensive Assessment & Treatment	805,717
Rehabilitation & Support	180,328
Total Revenue	**1,243,903**

EXPENDITURE	Total $'000
Prevention	17,201
Early Detection and Management	239,131
Intensive Assessment & Treatment	833,320
Rehabilitation & Support	178,557
Total Expenditure	**1,268,209**
Net Surplus / (Deficit) – $' 000	**(24,307)**

Table 2: Revenue and expenditure by Output Class 2019/20– 2024/25

Revenue & Expenditure by Output Class	2019/20 Actual $' 000	2020/21 Forecast $' 000	2021/22 Budget $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000	2024/25 Projection $' 000
Prevention Services						
Revenue	20,245	19,926	17,201	17,703	18,213	18,738
Expenditure	(20,245)	(19,926)	(17,201)	(17,703)	(18,213)	(18,738)
Net Result	0	0	0	0	0	0
Early Detection and Management Services						
Revenue	221,604	227,513	240,656	245,874	256,510	267,554
Expenditure	(219,815)	(230,464)	(239,131)	(248,355)	(257,889)	(267,763)
Net Result	1,788	(2,950)	1,525	(2,481)	(1,379)	(209)
Intensive Assessment and Treatment						
Revenue	695,300	787,708	805,717	842,514	869,326	897,017
Expenditure	(789,619)	(809,736)	(833,320)	(856,386)	(886,766)	(913,032)
Net Result	(94,319)	(22,028)	(27,603)	(13,872)	(17,441)	(16,015)
Rehabilitation and Support						
Revenue	162,918	165,271	180,328	180,258	186,219	192,381
Expenditure	(160,841)	(168,698)	(178,557)	(183,140)	(187,822)	(192,624)
Net Result	2,077	(3,427)	1,771	(2,882)	(1,603)	(243)
Share of Loss in associates	0	0	0	0	0	0
Total Revenue per DHB Consolidated Financials	1,100,066	1,200,418	1,243,903	1,286,349	1,330,268	1,375,690
Total Expenditure per DHB Consolidated Financials	(1,190,520)	(1,228,824)	(1,268,209)	(1,305,585)	(1,350,690)	(1,392,157)
Net Surplus / (Deficit)	**(90,454)**	**(28,406)**	**(24,307)**	**(19,236)**	**(20,423)**	**(16,467)**

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.

SUMMARY TABLES: INDICATOR REPORTING PERIODS

Measure	Period value represents
Percentage of children fully immunised at age 8 months	Annual performance
Percentage of children fully immunised at age 2 years	Annual performance
Percentage of eligible girls and boys fully immunised with HPV vaccine	Annual performance
Percentage of people (≥ 65 years) having received a flu vaccination	flu season
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	Q4 value
Infants exclusively or fully breastfeeding at 3 months	Annual performance (calendar year)
Percentage of 4 year old children receiving a B4 School Check	Annual performance
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	Annual performance
Percentage of eligible women (50-69 years) having a breast cancer screen in the last 2 years	Previous two years
Percentage of eligible women (25-69 years) having a cervical cancer screen in the last 3 years	Previous five years
Percentage of eligible preschoolers enrolled in community oral health services	Annual performance (calendar year)
Percentage of children caries-free at five years of age	Annual performance (calendar year)
Avoidable Hospital Admissions rates for children (0-4 years)	Year to Q3
Number of people receiving a brief intervention from the primary mental health service	Annual performance
Percentage of the population identified with diabetes having good or acceptable glycaemic control	Annual performance
Ratio of repeat prescriptions to new prescriptions dispensed in pharmacies	Annual Performance
Percentage of accepted referrals for Computed Tomography (CT) scans receiving procedure within 42 days	Annual performance
Percentage of accepted referrals for Magnetic Resonance Imaging (MRI) scans receiving procedure within 42 days	Annual performance
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	Annual performance

Measure	Period value represents
Percentage of young people (0-19 years) accessing specialist mental health services	Year to Q3
Percentage of adults (20-64 years) accessing specialist mental health services	Year to Q3
Percentage of people who have a transition (discharge) plan	Year to Q3
Percentage of people (0-19 years) referred for non-urgent mental health or addiction DHB Provider services who access services in a timely manner	Year to Q3
People are assessed, treated or discharged from ED in under 6 hours	Annual performance
Number of people presenting at ED	Annual performance
Number of elective surgical service discharges	Annual performance
Percentage of elective and arranged surgery undertaken on a day case basis	Annual performance
Percentage of people receiving their elective and arranged surgery on day of admission	Annual performance
Number of elective surgical services (CWDs) delivered (elective initiative)	Annual performance
Outpatient appointments where the patient was booked but did not attend (DNA) **by ethnicity**	Annual performance
Number of maternity deliveries in Southern DHB facilities	Annual performance (calendar year)
Percentage of pregnant women registered with a Lead Maternity Carer in the first trimester	Annual performance (calendar year)
Proportion of AT&R inpatients discharged to their own home rather than ARC	Annual performance
Percentage of aged care residents who have had an InterRAI assessment within 6 months admission	Annual performance
Percentage of people ≥ 65 years receiving long-term home support who have a Comprehensive Clinical Assessment and an Individual Care Plan	Annual performance
Total number of eligible people aged ≥ 65 years supported by home and community support services	Average annual performance
Percentage of HCSS support workers who have completed at least Level 2 in the National Certificate in Community Support Services (or equivalent)	Snapshot reported as at 30 June
People (65+) accessing the community-based falls prevention service	Annual performance
Number of Rest Home Bed Days per capita of the population aged over 65 years	Annual performance

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 2019/20	Target 2020/21	Target 2021/22
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	95%	>95%	>95%
			Māori	90%		
	Percentage of children fully immunised at age 2 years	C	Total	95%	>95%	>95%
			Māori	96%		
	Percentage of eligible boys and girls fully immunised with HPV vaccine	C	Total	65%	>75%	>75%
			Māori	63%		
	Percentage of people (≥ 65 years) having received a flu vaccination	C	Total	54%	>75%	>75%
			Māori	44%		
Health Promotion & Education Services These services inform people about risks and support them to be healthy. Success begins with awareness and engagement, reinforced by programmes and legislation that support people to maintain wellness and make healthier choices.	Percentage of enrolled patients who smoke and are seen by a health practitioner in primary care and offered brief advice and support to quit smoking	C†	Total	73%	>90%	>90%
			Māori	74%		
	Infants exclusively or fully breastfeeding at 3 months	Q Δ	Total	64%	>60%	>60%
			Māori	57%		
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	78%	>90%	>90%
			Quintile 5	74%		
	Percentage of obese children identified in the B4 School Check programme offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions	Q†	Total	92%	>95%	>95%
	Percentage of eligible women (50-69 years) having a breast cancer screen in the last 2 years	C	Total	66%	>70%	>70%
			Māori	63%		
	Percentage of eligible women (25-69 years) having a cervical cancer screen in the last 3 years	C	Total	71%	80%	>80%
			Māori	63%		

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 2019/20	Target 20/21	Target 2021/22
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	84%	>95%	>95%
			Māori	63%		
	Percentage of children caries-free at five years of age	Q ❖	Total	69%	>70%	>70%
			Māori	56%		
Primary Health Care Services These services are offered in local community settings by general practice teams and other primary health care professionals, aimed at improving, maintaining or restoring people's health. High levels of enrolment or uptake of services are indicative of engagement, accessibility & responsiveness of primary care services.	Avoidable Hospital Admissions[11] rates for children (0-4 years)	Q ✞	Total	5,496	<5,570	<5,570
			Māori	6,685	<5,570	<5,570
	Number of people receiving a brief intervention from the primary mental health service	V	Total	7,025	>7,000	>7,000
	Ratio of repeat prescriptions to new prescriptions dispensed in pharmacies		Total	N/A	N/A	<1.0
	Percentage of the population identified with diabetes having good or acceptable glycaemic control[12]	C	Total	54%	>60%	>60%
			Māori	46%		
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	58%	>85%	>85%
	Percentage of accepted referrals for Magnetic Resonance Imaging (MRI) scans receiving procedure within 42 days	T	Total	44%	>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	65%	>90%	>90%

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

[12] 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 2019/20	Target 2020/21	Target 2021/22
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	5.29%	>3.75%	>3.75%
			Māori	6.02%		
	Percentage of adults (20-64 years) accessing specialist mental health services	C Δ	Total	4.33%	>3.75%	>3.75%
			Māori	8.96%	>5.22%	>5.22%
	Percentage of people who have a transition (discharge) plan	Q	Total	54%	>70%	>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	70%	>80%	>80%
			< 8 weeks	88%	>95%	>95%
Acute Services These are services for illnesses that may have a quick onset, are often of short duration and progress rapidly, for which the need for care is urgent. Hospital-based services include EDs, short-stay acute assessments and intensive care services.	People are assessed, treated or discharged from ED in under 6 hours	T†	Total	81%	>95%	>95%
	Number of people presenting at ED	V	Total	77, 311	< 85,000	< 85,000
Elective Services (Inpatient & Outpatient) These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. They include elective surgery, but also nonsurgical interventions (such as coronary angioplasty) and specialist assessments (either first assessments, follow-ups or preadmission assessments).	Number of elective surgical service discharges[13]	V†	Total	11,179	>12,588	12,588
	Percentage of elective and arranged surgery undertaken on a day case basis	Q	Total	57%	>60%	>60%
	Percentage of people receiving their elective and arranged surgery on day of admission	Q	Total	88%	>95%	>95%
	Number of inpatient elective and arranged surgical services (CWDs) delivered)	V	Total	17,292	>18,311	18,464

[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.

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 2019/20	Target 2020/21	Target 2021/22
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[14]	V E	Total	3,439	3,400	3,400
			Māori	453	560	560
	Percentage of pregnant women registered with a Lead Maternity Carer in the first trimester	Q	Total	79.2%	>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.	Proportion of AT&R inpatients discharged to their own home rather than ARC[15]	T	<65 years	N/A	N/A	>85%
			≥65 years	N/A	N/A	>75%

[14] This is a new measure for 21/22.

[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 2019/20	Target 2020/21	Target 2021/22
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	75%	>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	4,474	4,800	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	86%	>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.	People (65+) accessing the community-based falls prevention service[17]		N/A	N/A	1,865
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	5.8	<6.11	<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.

17 This is a new measure for 20/21

6.2 FINANCIAL PERFORMANCE

6.2.2 FORECAST FINANCIAL STATEMENTS

The projected DHB deficit for 2021/22 is $24.3 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 3: DHB Consolidated Prospective Net Results

DHB Consolidated Prospective Net Results	2019/20 Actual $' 000	2020/21 Forecast $' 000	2021/22 Budget $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000	2024/25 Projection $' 000
Governance	(220)	578	0	(680)	(709)	(739)
Funds	5,382	(9,095)	4,402	(6,483)	(3,274)	134
Provider	(95,616)	(19,888)	(28,709)	(12,073)	(16,440)	(15,862)
Net Surplus / (Deficit)	**(90,454)**	**(28,406)**	**(24,307)**	**(19,236)**	**(20,423)**	**(16,467)**

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 2021/22 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.
- Investment in cancer care and diagnostics to reduce patient waiting lists.
- 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 recognised and included in the budgeted deficit.
- The liability from the Holidays Act 2003 continues to be accrued, which is included in the budgeted deficit.
- The cost to complete a detailed business case for the digital investment for the new Dunedin hospital is included in the budget and contributes to the deficit.

SIGNIFICANT ASSUMPTIONS

The DHBs key assumptions relating to the 2021/22 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	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
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	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
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 once national decisions have been made on a number of issues. We have included the payment being made in the 2021/22 year and this will require additional funding to support the cashflow.

6.2.3 CAPITAL EXPENDITURE AND CAPITAL FUNDING

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

Table 8: Planned Capital Expenditure

Planned Capital Expenditure	2019/20 Actual $' 000	2020/21 Forecast $' 000	2021/22 Budget $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000	2024/25 Projection $' 000
Clinical Capital	13,509	15,103	19,950	9,043	7,471	6,565
Building Capital	2,413	5,895	19,574	17,628	13,137	6,419
Strategic Capital	5,475	2,181	21,766	20,253	6,391	3,194
Information Systems Capital	5,947	6,635	10,613	8,414	5,863	6,148
Total capital expenditure budget	**27,344**	**29,814**	**71,903**	**55,338**	**32,862**	**22,326**

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 2021/22 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. A significant number of projects are included and the final timing of these is to be refined. The most pressing are the new CT & MRI in Dunedin to reduce diagnostic wait times and the development of a MAU in Dunedin hospital to improve bed utilisation. In Southland Hospital the replacement of the CT and potential extension to the ED will be progressed, along with a fifth theatre.

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;

- The working cash flow will require careful management. This together with the extensive capital investments required will result in an overdraft facility being utilised. Deficit support will be required when the Holidays Act 2003 liability is to be paid to staff.
- We have a number of capital items coming off lease, e.g. CT scanners, and their replacements will also be leased due to cash flow constraint.

Table 9: Planned Capital Financing

Planned Capital Financing	2019/20 Actual $' 000	2020/21 Forecast $' 000	2021/22 Budget $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000	2024/25 Projection $' 000
Deficit Support	80,000	0	0	90,628	0	0
Equity for Capital Projects	4,744	1,308	9,314	10,792	10,216	0
Equity repaid	(707)	(707)	(707)	(707)	(707)	(707)
Cash Balance	31,011	7,582	(33,655)	(51,750)	(52,085)	(47,190)

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	0	0	Qrtly instalment	0.00%
Finance Leases	1,091	1,091	Mthly & Qrtly instalment	0.00%
	1,091	1,091		

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.

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.

6.2.4 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	2019/20 Actual $' 000	2020/21 Forecast $' 000	2021/22 Budget $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000	2024/25 Projection $' 000
Revenue						
PBF Funding Package	945,394	1,027,684	1,085,721	1,123,721	1,163,051	1,203,758
Inter District Revenue	23,648	26,870	27,338	28,344	29,387	30,469
Funder Side Contracts	80,541	88,743	75,342	77,979	80,708	83,533
Provider Misc Revenues	50,483	57,120	55,502	56,304	57,121	57,930
Total Revenues	1,100,066	1,200,417	1,243,903	1,286,348	1,330,268	1,375,690
less Personnel Expenses						
Medical Personnel	(156,219)	(158,411)	(162,133)	(165,899)	(171,705)	(177,714)
Nursing Personnel	(201,693)	(184,793)	(197,953)	(200,005)	(207,005)	(214,250)
Allied Health Personnel	(57,719)	(63,159)	(68,679)	(70,640)	(73,112)	(75,671)
Support Services Personnel	(6,169)	(6,877)	(6,999)	(7,187)	(7,439)	(7,699)
Management/Admin Personnel	(55,633)	(59,278)	(61,612)	(63,236)	(65,449)	(67,740)
Personnel Costs Total	(477,433)	(472,518)	(497,375)	(506,966)	(524,710)	(543,075)
less Non Personnel Expenditure						
Outsourced Services Expenses	(48,797)	(56,291)	(51,072)	(52,604)	(54,182)	(55,807)
Clinical Supplies Expenses	(109,059)	(122,098)	(119,173)	(123,721)	(127,293)	(130,548)
Infrastructure & Non Clinical Supplies Expenses	(88,494)	(88,601)	(93,791)	(99,945)	(106,118)	(107,794)
Total Non-Personnel Expenditure	(246,350)	(266,990)	(264,036)	(276,269)	(287,592)	(294,149)
less Provider Payments						
Personal Health Expenses	(270,490)	(282,220)	(289,403)	(299,532)	(310,016)	(320,866)
Mental Health Expenses	(30,105)	(33,143)	(36,816)	(37,736)	(38,679)	(39,646)
Disability Support Expenses	(154,465)	(161,966)	(171,169)	(175,448)	(179,835)	(184,330)
Public Health Expenses	(10,331)	(10,183)	(6,531)	(6,694)	(6,862)	(7,033)
Maori Health Expenses	(1,344)	(1,802)	(2,881)	(2,938)	(2,997)	(3,057)
Total Provider Payments	(466,736)	(489,314)	(506,799)	(522,349)	(538,389)	(554,933)
Total Expenses	(1,190,519)	(1,228,823)	(1,268,210)	(1,305,585)	(1,350,691)	(1,392,157)
Net Surplus / (Deficit)	**(90,454)**	**(28,406)**	**(24,307)**	**(19,236)**	**(20,423)**	**(16,467)**
Supplemental Information						
Depreciation Charges	(25,063)	(29,157)	(33,077)	(41,111)	(41,933)	(42,772)
Interest Costs	(236)	(4)	(50)	(100)	(100)	(100)
Capital Charge	(9,651)	(7,898)	(7,142)	(6,357)	(10,431)	(9,885)
Total IDCC Costs	(34,950)	(37,060)	(40,269)	(47,568)	(52,464)	(52,757)
Medical FTE	613	653	673	673	673	673
Nursing FTE	1,834	1,899	1,970	1,970	1,970	1,970
Allied FTE	709	730	772	772	772	772
Support FTE	99	102	104	104	104	104
Management/Admin FTE	732	751	752	752	752	752
Total FTE	3,987	4,134	4,272	4,272	4,272	4,272

Table 12: DHB Consolidated Prospective Balance Sheet

DHB Consolidated Prospective Balance Sheet	2019/20 Actual $' 000	2020/21 Forecast $' 000	2021/22 Budget $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000	2024/25 Projection $' 000
Current Assets:						
Cash & Bank Accounts	31,011	7,582	7	7	7	7
Prepayments	3,635	4,433	2,868	2,923	2,979	3,035
Inventory	6,095	6,159	5,235	5,334	5,435	5,539
Accounts Receivable	46,183	59,254	45,606	46,472	47,355	48,257
Total Current Assets	86,924	77,428	53,716	54,737	55,776	56,838
Current Liabilities:						
Bank overdraft and current debt	(962)	(235)	(35,642)	(53,738)	(54,072)	(49,177)
Creditors provisions and payables	(153,311)	(167,958)	(157,703)	(165,872)	(170,285)	(174,834)
Total Current Liabilities	(154,273)	(168,193)	(193,345)	(219,610)	(224,357)	(224,012)
Net Working Capital	(67,348)	(90,765)	(139,629)	(164,873)	(168,580)	(167,174)
Non Current Assets:						
Land , Buildings, Plant and Equipment	329,770	331,816	383,161	397,388	388,316	367,869
Long Term Investments	0	0	0	0	0	0
Total Non Current Assets	329,770	331,816	383,161	397,388	388,316	367,869
Non Current Liabilities:						
Long Term Debt	(1,091)	(856)	(10,754)	(8,888)	(7,022)	(5,156)
Other Liabilities	(95,338)	(102,007)	(110,290)	(19,662)	(19,662)	(19,662)
Net Equity	**165,993**	**138,188**	**122,488**	**203,965**	**193,051**	**175,877**

Table 13: DHB Consolidated Statement of Prospective Changes in Equity

DHB Consolidated Statement of Prospective Changes in Equity	2019/20 Actual $' 000	2020/21 Forecast $' 000	2021/22 Budget $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000	2024/25 Projection $' 000
Total Equity at beginning of period	172,410	165,993	138,188	122,487	203,964	193,051
Net Result for the period - Governance	(220)	578	0	(680)	(709)	(739)
Net Result for the period - Funds	5,382	(9,095)	4,402	(6,483)	(3,274)	134
Net Result for the period - Provider	(95,616)	(19,888)	(28,709)	(12,073)	(16,440)	(15,862)
Revaluation of Fixed Assets	0	0	0	0	0	0
Other movement	0	0	0	0	0	0
Equity Repaid (Revaluation funding)	(707)	(707)	(707)	(707)	(707)	(707)
Equity Injections for Capital	4,744	1,308	9,314	10,792	10,216	0
Equity Injections for Deficit	80,000	0	0	90,628	0	0
Total Equity at end of Period	**165,993**	**138,188**	**122,488**	**203,965**	**193,051**	**175,877**

Table 14: DHB Consolidated Statement of Prospective Cash Flows

DHB Consolidated Statement of Prospective Cash Flows	2019/20 Actual $' 000	2020/21 Forecast $' 000	2021/22 Budget $' 000	2022/23 Projection $' 000	2023/24 Projection $' 000	2024/25 Projection $' 000
Operating Cashflows						
Cash inflows from operating activities	1,097,687	1,191,393	1,250,571	1,285,196	1,329,068	1,374,469
Cash outflows from operating activities	(1,113,027)	(1,185,037)	(1,227,919)	(1,347,039)	(1,304,428)	(1,344,920)
Net cash inflows(outflows) from operating activities	(15,340)	6,356	22,652	(61,843)	24,641	29,549
Investing Cashflows						
Cash inflows from investing activities	312	391	336	339	342	346
Cash outflows from investing activities	(27,344)	(29,814)	(71,902)	(55,338)	(32,861)	(22,326)
Net cash flows from investing activities	(27,033)	(29,423)	(71,566)	(54,999)	(32,519)	(21,980)
Financing Cashflows						
Cash inflows from financing activities	84,744	1,308	9,313	101,420	10,216	0
Cash outflows from financing activities	(1,473)	(1,670)	(1,636)	(2,673)	(2,673)	(2,674)
Net cashflows from financing activities	83,271	(362)	7,678	98,747	7,544	(2,674)
Net increase/(decrease) in cash held	40,899	(23,430)	(41,237)	(18,095)	(335)	4,895
Add opening balance	(9,888)	31,011	7,582	(33,655)	(51,750)	(52,085)
Closing cash balance	**31,011**	**7,582**	**(33,655)**	**(51,750)**	**(52,085)**	**(47,190)**

6.3 STATEMENT OF ACCOUNTING POLICIES

6.3.2 REPORTING ENTITY

Southern District Health Board (Southern DHB) is a Crown Entity as defined by the Crown Entities Act 2004 and is domiciled and operates 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 ultimate parent is the New Zealand Crown.

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.

6.3.3 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 Board 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 2021/22 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) and all values are rounded to the nearest thousand.

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
- Intangible assets impairment
- Employee entitlements

6.3.4 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 bequeathed financial assets 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.

RESEARCH REVENUE

Revenue received in respect of research projects is recognised in the surplus/deficit in the same period as the related expenditure. Research costs are recognised in the surplus/deficit as an 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, Revenue from Exchange Transactions, 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.

FOREIGN CURRENCY TRANSACTIONS

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

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.

COST ALLOCATION

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.

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

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

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

PERSONNEL COSTS

Salaries and Wages

Salaries and wages are recognised as an expense as employees provide services.

Defined Superannuation Contribution Plans

Obligations for contributions to defined contribution plans are recognised as an expense in the Statement of Comprehensive Revenue an Expense as incurred.

CAPITAL CHARGE

The capital charge is recognised as an expense in the financial year to which the charge relates.

FINANCE COSTS

Borrowing costs are expensed in the financial year to which they are incurred.

OPERATING LEASES

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

CASH AND CASH EQUIVALENTS

Cash and cash equivalents comprise 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.

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.

PROPERTY, PLANT AND EQUIPMENT

Property, plant and equipment consists of the following asset classes, which are measured as follows:

- land at fair value
- buildings at fair value represented by Depreciated Replacement costs less accumulated depreciation and impairment losses
- plant and equipment at cost less accumulated depreciation and impairment losses
- motor vehicles 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 and 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.

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.

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.

Work in progress is recognised at cost less impairment and is not depreciated.

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.

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).

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	7 to 79 years
Plant and Equipment	4 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.

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 unit 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.

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.

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	5 to 10 years

TRADE AND OTHER PAYABLES

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

INTEREST BEARING LOANS & 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.

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.

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 :

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

Presentation of Employee Entitlements

Sick Leave, continuing medical education leave, annual leave, vested and non-vested long service leave, sabbatical leave and retirement gratuities 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.

HOLIDAYS ACT 2003

A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 ("the Act"). Work has been ongoing since 2016 on behalf of 20 District Health Boards (DHBs) and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business, Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any non-compliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a methodology for determination of individual employee earnings and for calculation of liability for any historical non-compliance.

For employers such as the DHBs that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing non-compliance with the Act and determining the additional payment is time consuming and complicated.

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through 2020/21 and into the 2021/22 financial year. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed. However, during the 2019/20 financial year the review process agreed as part of the MOU has commenced. Southern DHB has made progress in its review, however we have assessed there is further work required to reach a reliable estimate of the historic non-compliance under the MoU.

PROVISIONS

A provision is recognised for future expenditure of uncertain amount or timing when:

- there is 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
- a reliable estimate can be made of the amount of the obligation

Provisions are 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 may include a risk margin that represents the inherent uncertainty of the present value of the expected future payments.

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.

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 entity. 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.

CONTINGENCIES

A contingent liability is a possible or present obligation arising from past events that cannot be recognised in the financial statements because:

- the amount of the obligation cannot be reliably measured
- it is not definite the obligation will be confirmed due to the uncertainty of future events
- it is not certain that the entity will need to incur costs to settle the obligation

EQUITY

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components:

- contributed capital
- property revaluation reserves
- accumulated surplus/(deficit)

Property revaluation reserve

These reserves relates to the revaluation of property, plant and equipment to fair value.

Capital Management

Southern DHB's capital is its equity, which comprises Crown equity, reserves and retained earnings. Equity is represented by net assets. Southern DHB manages its revenues, expenses, assets, liabilities and general financial dealings prudently in compliance with the budgetary processes.

Southern DHB's policy and objectives of managing the equity is to ensure Southern DHB effectively achieves its goals and objectives, whilst maintaining a strong capital base. Southern DHB policies in respect of capital management are reviewed regularly by the Board.

System Level Measures Improvement Plan

2021/22

SYSTEM LEVEL MEASURES IMPROVEMENT PLAN

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. Southern DHB and our Primary Health partners are leading 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 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 by Māori, for Māori communities. Southern DHB Māori health priorities have been identified for 2021-22 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, Southern DHB 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.

This System Level Measures Improvement Plan for 2021-22 therefore sets out agreed milestones for each of the following SLMs:

- "Keeping Children Out of Hospital" → Ambulatory sensitive hospitalisations per 100,000 for 0-4 years olds
- "Using Health Resources Effectively" → Acute hospital bed day utilisation per capita
- "Person Centred Care" → Patient Experience of Care

- "Prevention and Early Detection" → Amenable Mortality
- "Youth are Healthy, Safe and Supported" → Youth Measure
- "A Healthy Start" → Proportion of babies who live in a smoke-free household at six weeks post-natal

The areas within the 2020-21 SLM plan where we have achieved our milestones and are progressing well will be continued through into 2021-22.

Southern DHB is 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.

Ministry Guidance:

COVID-19 has had a significant impact on the health system and this is likely to continue over 2021-22. As such, the Ministry is not expecting DHBs to develop a new Improvement Plan for 2021-22. The Ministry would like DHBs to review and update their 2020-21 plans, taking into consideration insights gained from COVID-19 response and health inequities at the local level. Furthermore, due to some significant impacts on the data relating to SLMs through the COVID period, the Ministry advises that we use 2020-21 milestones for the 2021-22 SLM Plan. We are, however, continuing to include the most current data for the sake of completeness and to maintain an accurate demonstration of the trends in all SLM domains.

Signatories:

Chris Fleming
CEO Southern DHB

Andrew Swanson-Dobbs
CEO WellSouth PHN

System Level Measures – Review

The 2020-21 year has seen several achievements for the SLM programme. Several the SLM milestones have been met or have demonstrated improvement towards their milestone, significantly several measures have achieved improvement in Māori outcomes, most notably in ASH rates and Acute Hospital Bed Days. Southern DHB has built on previous years with an increase in capability to deliver the SLM actions within key Domains. 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 2021-22. There are also measures that have not been achieved and actions to address these will continue through 2021-22.

This 2021-22 SLM plan has three principal 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 2021-22 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.

3. Within the Heath in all Policy, Southern DHB will engage with key stakeholders to positively impact on the social determinants of health. Work is underway on engaging district councils on their Long-Term Plans for the period 2021 – 2031. To date meetings have been held with senior staff of the Dunedin City, Queenstown-Lakes, Central Otago and Gore District Councils. All Councils have been proactive in indicating how Public Health South can best input into their Long-Term Plans. Dunedin City and Queenstown-Lakes District Councils have received letters providing input on what we believe should be prioritised from a Public Health perspective. Similar letters are being prepared for the Central Otago and Gore District Councils. A meeting with the newly appointed Chief Executive of the Southland District is in the process of being scheduled early in December. The Waitaki District Council have indicated they will be extending an invitation to us to showcase some of the work they have been doing with the support of the New Zealand Wellbeing Agency. Given the issues communities are facing in this post-COVID environment we have been active in supporting councils taking a community wellbeing approach in their 10-year plans.

Achievements

A number of measures were either achieved in the last year, or we made improvement towards their milestone for the 2020-21 year. These include:

ASH 0-4-Year-Olds

- SLM All conditions: achieved the milestone.
    - Contributory measures of Asthma, Upper ENT, and Dental Conditions all achieved their respective milestones.

Acute Hospital Bed Days

- SLM achieved the milestone.
    - Contributory measures of Inpatient average length of stay remained unchanged (slightly higher than MoH target);
        - ASH 45-64 achieved milestone for Māori equity.

Babies living in smoke free homes

- Contributory measure - Pregnant women who identify as smokers upon registration – milestone not achieved but trending favourably.
- Contributory measure – registered with LMC at first trimester – milestone achieved.

Patient Experience of Care

- SLM - Did a Staff member tell you about medication side effects? Achieved.

Challenges

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:

Acute Hospital Bed Days

- Contributory measure - acute readmissions to hospital did not achieve the milestone.

Amenable Mortality

- Contributory measure of women 25-26-year-old received a cervical smear < 3 years – milestone not achieved.
- Faster cancer treatment < 62-day target – milestone not achieved

Youth Self Harm

- SLM Total population, including Māori: milestone not achieved.

Babies living in smoke free homes

- SLM did not achieve the milestone.
    - Contributory measure – Babies breast-fed at 6 weeks – 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 2021-22)	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

Southern DHB 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. However, the equity gap appears to be reducing. 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. **We note the significant decline in ASH 0-4 and believe this may be primarily related to the impacts of COVID-19 (i.e., Lockdown).**

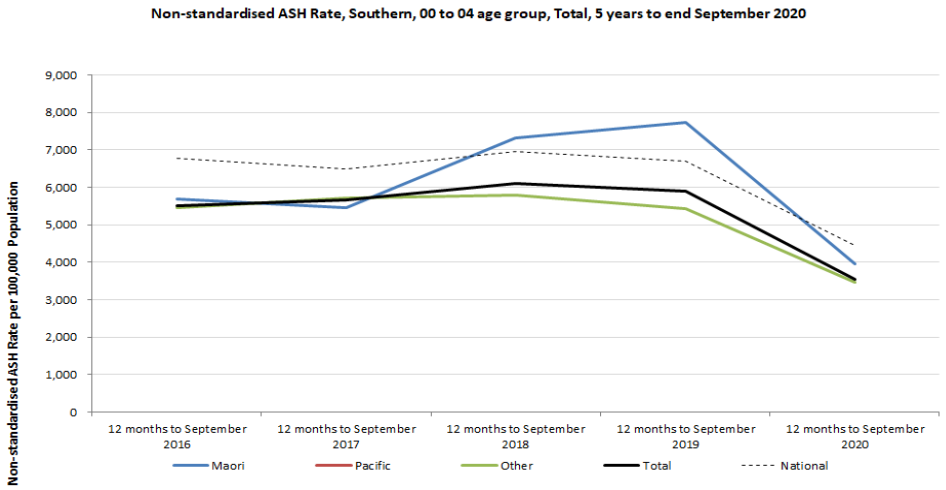
Measure description:

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

Baseline Data

Five-year trend ASH 0-4 to September 2020

Hospital admissions for children aged up to four years- all conditions		12 months to September 2016	12 months to September 2017	12 months to September 2018	12 months to September 2019	12 months to September 2020
	Māori	5,702	5,455	7,335	7,726	3,957
	Total	5,513	5,663	6,099	5,899	3,558



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

- For 2020, there was a <1% equity gap between Māori and Total Population ASH rates (0-4-year-old).
- Both Southern's total population (3,558/100K) and Māori (3,957/100K) population's ASH rates were below the national rate (4,500/100K).

Where are we going?

Improvement Milestone for 2021-22: Māori rate <6,350 per 100,000.
Rationale: Aiming for a 5% annual reduction, with a view to achieving a 25% reduction. **Note – the significant reduction in the ASH rate evident in 2019-20 may largely be due to the impacts of COVID-19; as such, we may see a bounce in rates subject to the ongoing response to COVID-19 in 2021-22. Consequently, milestones and targets have been maintained at the SLM 2020-21 Plan rates.**

How will we get there?

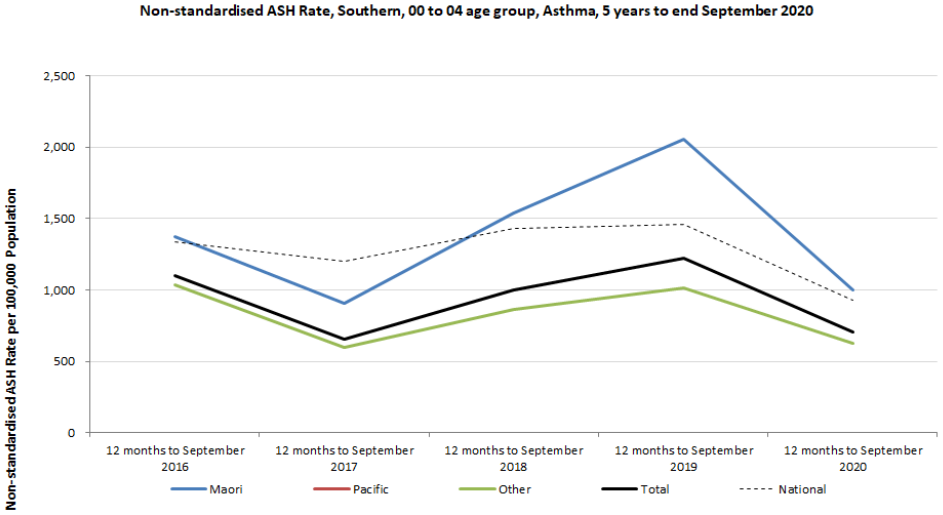
Over the next five years, Southern DHB and WellSouth PHN will work progressively to achieving the long term goal through the development and implementation of key actions to reduce hospital admissions for children, putting strategies in place to better manage children with a primary diagnosis of asthma or upper/ENT infection in the community.

1.1 Hospital admissions for children 0-4 years with a primary diagnosis of asthma and upper ENT

Measure description: Non-standardised rate per 100,000 as per non-financial quarterly measure – system integration 1
2021-22 Improvement Target: Māori children <1,600 (asthma)
2021-22 Improvement Target: Māori children <1497 (Upper and ENT)

Baseline Data:

		12 months to September 2016	12 months to September 2017	12 months to September 2018	12 months to September 2019	12 months to September 2020
Hospital admissions for children aged up to four years with a primary diagnosis of Asthma	Māori	1,367	909	1,538	2,055	1,003
	Total	1,102	658	998	1,220	702



		12 months to September 2016	12 months to September 2017	12 months to September 2018	12 months to September 2019	12 months to September 2020
Hospital admissions for children aged up to four years with a primary diagnosis of Upper and ENT.	Māori	1,573	1,763	1,868	1,726	786
	Total	1,668	1,832	1,768	1,443	881

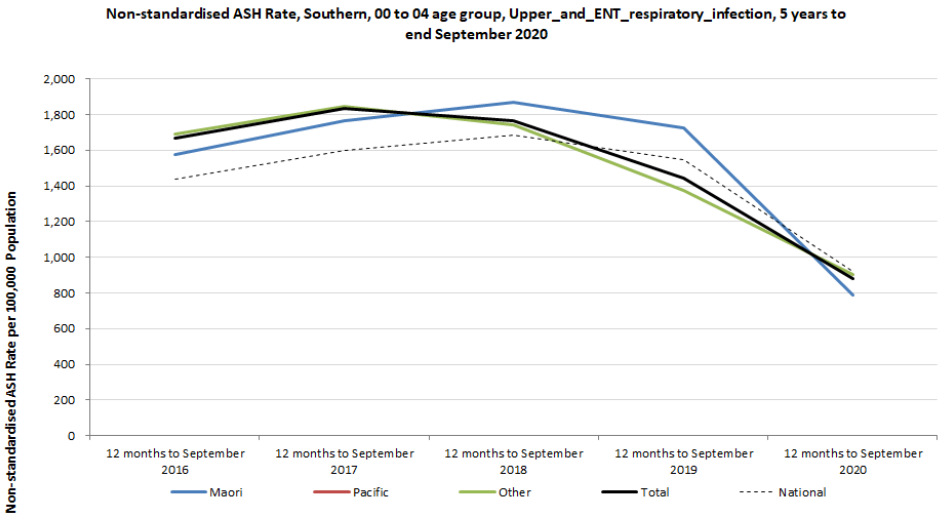
Activities that will enable us to achieve the Improvement Target

- Implementation of the Southern Harti Hauora Assessment programme for Māori ASH 0-4 that supports whānau 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)

  This action carries over from the 2020-21 SLM plan. It will now include two phases. The first being a follow up on historic presentations, approximately 286 children/families are being contacted by a registered nurse (RN) to further understand the drivers, including social determinants that may be negatively impacting children's' health. The second being the rollout of the Harti Hauora programme for current and future presentations. Once again, the RN is investigating causal determinants.

- 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.

  This action rolls over to support the Harti Hauora programme.



- 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 is known and available as required. Referral to key stakeholders in the Southern Harti Hauora Assessment programme will ensure those identified needs are met. The anticipated 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 the 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.

  This action rolls over. The IT tool and pathway supporting the Harti Hauora programme is complete and now being implemented by the Māori NGO, Awarua Whānau Services. The electronic assessment tool facilitates referrals from health services and the coordination of onward referrals to suitable support services, including social wellbeing NGOs.

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

  This action is complete. The newly appointed Respiratory Nurse Educator (0.2 FTE) within Southern DHB Child Health will liaise with WellSouth PHO to streamline respiratory care between hospital and primary care and build on the referral pathway with linking to the Southern DHB Cosy Homes team.

- WellSouth will work towards building a shared understanding of 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.

  This action rolls over. A Nurse Practitioner led service is being established in Invercargill through 2021-22.

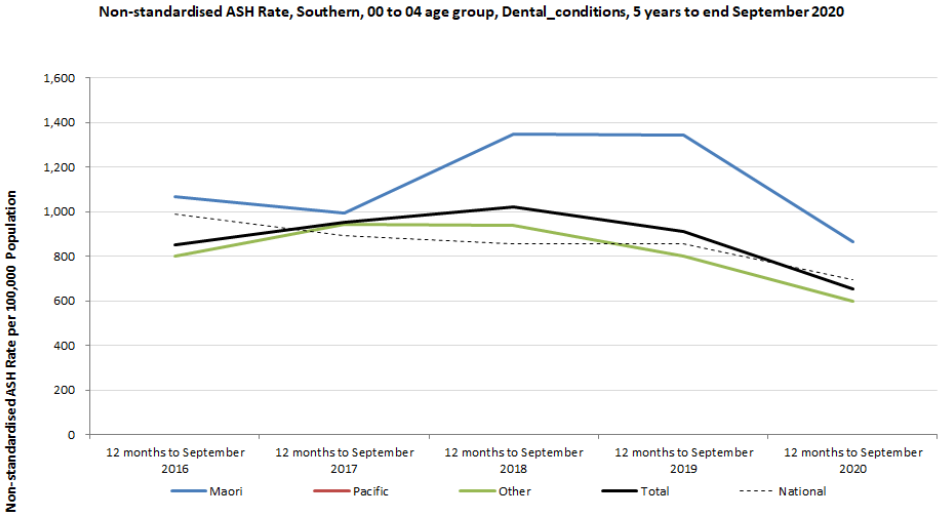
- Discussions will occur on the planning for wahakura wānanga, which will be held in different communities across the district. Under the Safe Sleep Programme work we will engage with communities to identify their needs in relation to development of harm reduction messaging for pēpi. An example of this could include the gifting of wahakura to marae and support to introduce marae based safe sleep champions.

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

Measure description: Standardised rate per 100,000 as per non-financial quarterly measure – system integration 1.
2021-22 Improvement Target: Māori children <1213.

Baseline Data:

		12 months to September 2016	12 months to September 2017	12 months to September 2018	12 months to September 2019	12 months to September 2020
Hospital admissions for children aged up to four years with a primary diagnosis of Dental conditions.	Māori	1,067	992	1,346	1,342	867
	Total	853	951	1,020	910	653



Activities that will enable us to achieve the Improvement Target

- 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.

  This action rolls over and will continue to be developed. For example, the service is looking to implement a tele-health service as an outreach tool through 2021-22.
- Increase engagement of the dental service with Kaupapa Māori health services and Well Child providers and preschools to achieve a reduction in dental caries. This will be delivered through the Southern Harti Hauora Assessment programme.

  Refer to ASH 0-4 actions above.
- Prioritise Māori and Pacific children into the dental service with a targeted enrolment pathway. (EOA)

  This action rolls over. Māori and Pacific children are categorised as medium or high risk by default. This ensures more frequent consultations and engagement
- Implementation of the Southern Harti Hauora Assessment programme for Māori ASH 0-4 that supports whānau 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)
  See ASH 0-4 actions above.

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 have a higher bed day rate; 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 days per capita rates are presented using the number of bed days for acute hospital stays per 1000 population domiciled within a District Health Board (DHB) with age standardisation. The measure is calculated quarterly with a rolling 12-month data period. Acute hospital bed days are calculated by adding up the length of stays in days for patients presented to a NZ hospital acutely that are publicly funded. A stay is counted if the first event in that stay is classified as an acute inpatient event. The acute bed days per capita measure can be age standardised at domicile DHB level.

Baseline Data – 5-year trend to September 2017

Actual Acute Bed Days per Capita Rates

	Estimated Pop	Acute Stays	Acute Bed Days	Standardised Acute Bed Days per 1,000 Pop		
DHB of Domicile	Year to Sept 2020	Year to Sept 2020	Year to Sept 2020	Year to Sept 2018	Year to Sept 2019	Year to Sept 2020
Southern	342,355	35,644	117,734	373.4	366.4	309.6
National	4,967,933	580,696	1,931,937	415.7	417.4	365.5

Ethnic Group Comparison- Standardised Acute Bed Days

	Estimated Pop	Acute Stays	Acute Bed Days	Standardised Acute Bed Days per 1,000 Pop		
Year	Year to Sept 2020	Year to Sept 2020	Year to Sept 2020	Year to Sept 2018	Year to Sept 2019	Year to Sept 2020
Māori	36,545	3,715	9,483	411	409	354
Pacific	7,720	913	2,514	492	447	526
Other	298,070	31,016	105,737	367	358	302
Total	342,355	35,644	117,734	737	366	310

Where are we going?

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 2021-22: 331 Standardised Acute Hospital Bed Days per 1000 Capita. 381 standardised bed days for Māori 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. **Note – due to the impacts of COVID-19, milestones and targets have been maintained at the SLM 2020-21 Plan rates.**

How will we get there?

Over the 2021-22 year, Southern DHB 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.

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

Measure description: Non-Financial Quarterly Reporting – Ownership measure
2021/22 Improvement Target: Stay below the MOH target (2.35)

Baseline Data

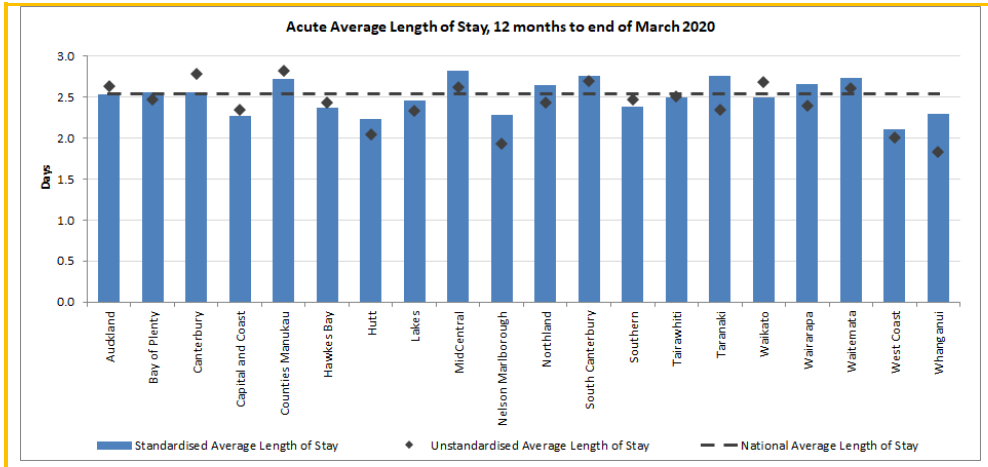
2021/22 Improvement Target: Stay below the MOH target (2.35)

DHB	Stays	Bed Day Equivalents	Unstandardised Average Length of Stay	Standardised Average Length of Stay
Southern	37,960	93,642	2.47	2.38

Activities that will enable us to achieve the Improvement Target

- Continue roll out the Home Team initiative, supporting early discharge and avoided admission with an integrated inter-professional team in Dunedin and Invercargill.
  This action is rolled over.

- 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.

This action is rolled over and has been further refined. The 36 Southern DHB Māori Health Navigators will link into our Māori NGO providers. In this way an in-reach to secondary services pathway will be achieved. For example, patients undertaking rehabilitation, following services in cardiac care and also (ISIS) trauma, will be supported to transition back into the community.

2.2 Acute readmissions to hospital - 0 to 28 Days

Measure description: Non-Financial Quarterly Reporting – Ownership measure 8
202/22 Improvement Target: <12.0%

Baseline Data

	Year to Sep 2018		Year to Sep 2019		Year to Sep 2020		
DHB of Service	**Readmission Rate**	**Standardised Readmission Rate**	**Readmission Rate**	**Standardised Readmission Rate**	**Stay Discharges**	**Readmission Rate**	**Standardised Readmission Rate**
National	12%	12.1%	12.2%	12.10%	902,296	12%	11.9%
Southern	11.9%	12%	12%	12.1%	53,940	11.8%	11.7%

Activities that will enable us to achieve the Improvement Target:

- 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.
  This action rolls over. Maximising utilisation is the focus through 2021-22.

- Clinical pharmacists to focus on polypharmacy and targeted conditions to reduce medicines related re-admissions.
  This action rolls over. The model of the Poly Pharmacy Clinic is still being refined.

- POAC (Primary Option for Acute Care). Further scale the use of these services in primary care to prevent hospital admission.
  This action rolls over. POAC will continue to support new initiatives into primary care as they develop.

- 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.
  This action rolls over

- 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)
  See action for Harti Hauora above (1.1).

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

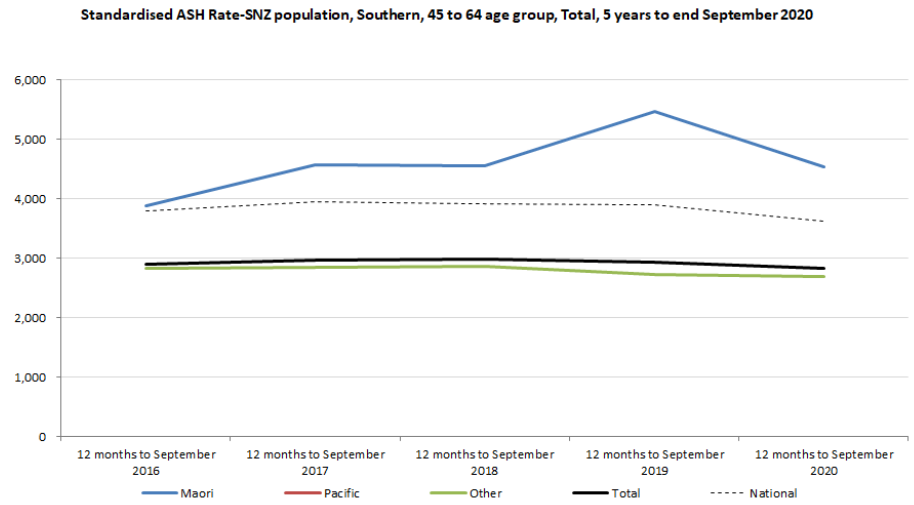
Measure description: Standardised rate per 100,000 as per non-financial quarterly measure – system integration.

2021-22 Improvement Target: Māori 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 Sept 2016	12 months to Sept 2017	12 months to Sept 2018	12 months to Sept 2019	12 months to Sept 2020
	Māori	3,876	4,575	4,552	5,467	4,538
	Total	2,893	2,967	2,982	2,925	2,830



Activities that will enable us to achieve the Improvement Target

- 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.
  This action rolls over, as it is still being developed.

- 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.

  This action is to roll over and is being supported by the newly established Call Centre at WellSouth.

3.0 Patient Experience of Care "Person Centred Care"

Measure Description
As per HQSC – patient experience reporting/Communication Domain.

Baseline Data

Highest performing results for Southern DHB

The table below shows the highest performing questions for Southern DHB in February 2021. Click on the question title to see more details on specific questions.

⚠ Low sample size

Question Click on a question to see more detail		Overall	C.I.	n
Patient definitely treated with respect by doctors.	Feb 2021	95.9%	(92.7%-99.1%)	147
Patient definitely treated with respect by nurses.	Feb 2021	95.2%	(91.7%-98.7%)	146
Patient definitely felt cultural needs were met.	Feb 2021	95.2%	(90.6%-99.8%)	83
Before the operation(s), staff definitely helped patient to understand what would happen and what to expect.	Feb 2021	92.7%	(87.1%-98.3%)	82
Patient definitely treated with respect by other members of health care team.	Feb 2021	92.6%	(88.2%-97.0%)	135
Always had name used and pronounced properly by those providing care.	Feb 2021	91.0%	(86.3%-95.7%)	145

Lowest performing results for Southern DHB

The table below shows the lowest performing questions for Southern DHB in February 2021.

⚠ Low sample size

Question Click on a question to see more detail		Overall	C.I.	n
Patient was definitely told the possible side effects of the medicine (or prescription for medicine) they left hospital with, in a way they could understand.	Feb 2021	65.7%	(56.6%-74.8%)	105
Patient definitely given enough privacy when talking about treatment or condition.	Feb 2021	66.2%	(58.6%-73.8%)	148
Hospital staff definitely talked with the patient about whether they would have the help they needed when they left the hospital.	Feb 2021	67.0%	(58.4%-75.6%)	115
Patient definitely had enough information about how to manage their condition or recovery after they left hospital.	Feb 2021	71.6%	(64.2%-79.0%)	141
Hospital staff definitely included patient's family/whānau or someone close to patient in discussions about the care received during visit.	Feb 2021	73.1%	(64.7%-81.5%)	108

Where are we going?

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 2021-22: As for 3.1 below.
Rationale: Southern DHB 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?

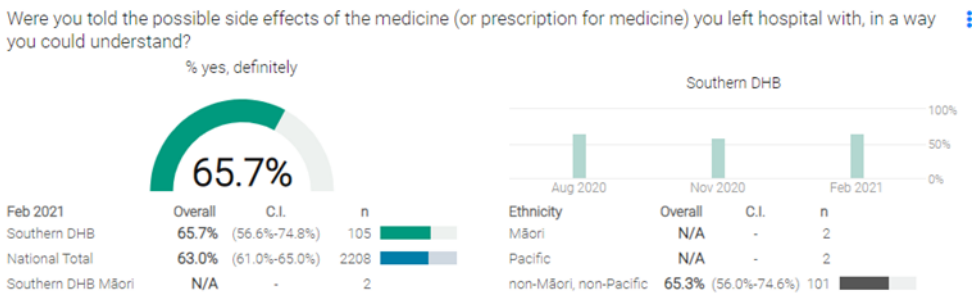
Focus for improvement will be on the lowest scoring areas in the previous year, aligning to government planning priorities. For 2021-22 Southern DHB and WellSouth PHO will focus on improving the lowest performing scores in the communication domain.

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

Measure description: As per HQSC patient experience reporting.
20201/22 Improvement Target: To improve Southern DHB **> 65.7%**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 Target

- Continue to develop a coordinated approach to using the University of Otago polypharmacy clinic for Southern DHB patients.
  This action rolls over.

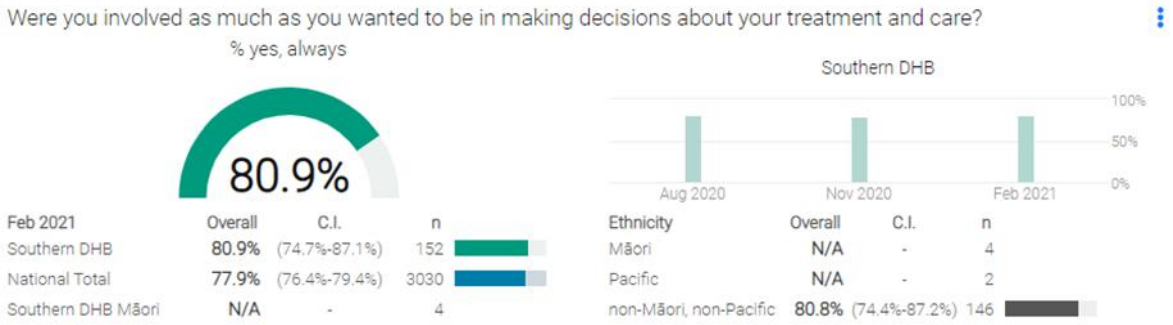
- Support medication management within the Southern DHB Home Team patients using WellSouth Clinical Pharmacists. WellSouth Clinical Pharmacists will work closely with the Southern DHB Home Team to support staff and patients with medication education and advice. This patient cohort represents high needs 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.
  This action rolls over

3.2 Were you involved as much as you wanted to be in decisions made about your care and treatment?

Measure description: As per HQSC patient experience reporting.
2021/22 Improvement Target: To improve Southern DHB **> 7.0**.

Baseline Data

Southern DHB



Did the health care professional involve you as much as you wanted to be in making decisions about your treatment and care?									
	Aug - 20			Nov - 20			Feb - 21		
	Overall	C.I.	n	Overall	C.I.	n	Overall	C.I.	n
WellSouth PHO	88.40%	(86.9%-89.9%)	1703	89.00%	(87.4%-90.6%)	1538	88.70%	(87.3%-90.1%)	2029
National Total	88.70%	(88.3%-89.1%)	20238	88.20%	(87.7%-88.7%)	18896	88.20%	(87.8%-88.6%)	24528
WellSouth PHO - Māori	82.50%	(76.3%-88.7%)	143	89.00%	(83.1%-94.9%)	109	84.40%	(78.3%-90.5%)	135

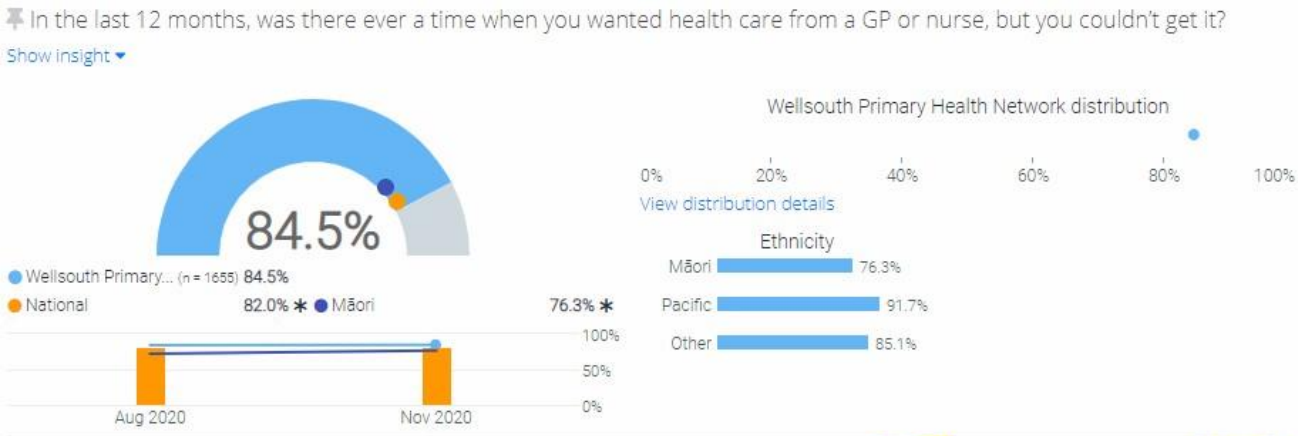
Activities that will enable us to achieve the Improvement Target

- 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 Māori Health Navigators coordinating access between the patient and providers.
  This action rolls over. See Harti Hauora actions above (1.1).

- 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 action rolls over. The pilot has been through a review and the recommendations will be implemented through 2021-22.

3.3 In the last 12 months, was there ever a time when you wanted healthcare from a GP or nurse, but you couldn't get it?	
Measure description: As per primary care patient experience reporting. **2021/22 Improvement Target:** To improve WellSouth PHO < 62.6 % for 'waiting time to get an appointment is too long'.	
Baseline Data	**Activities that will enable us to achieve the Improvement Target**

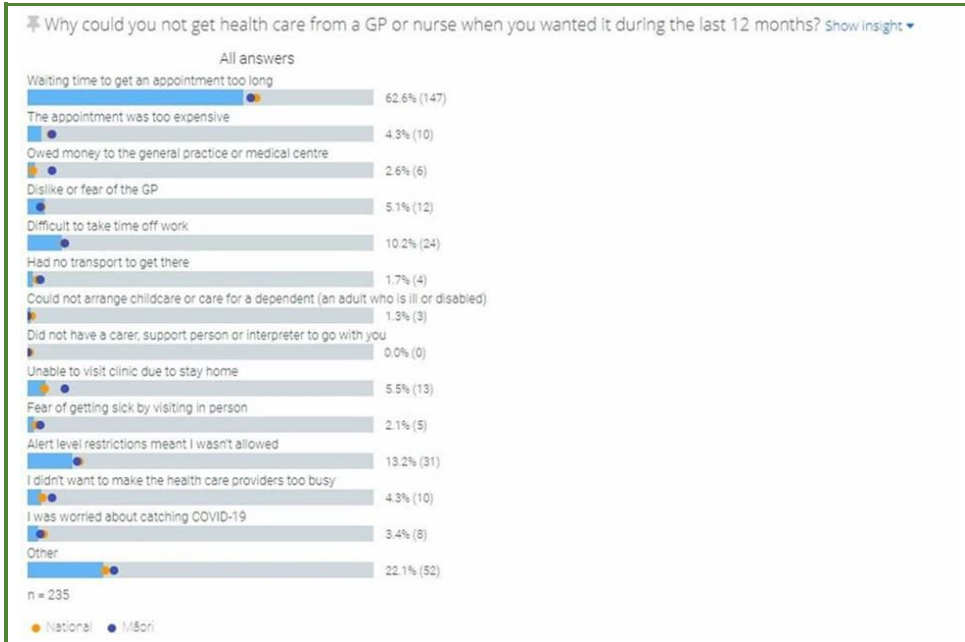
WellSouth PHO



	Aug 2020	Nov 2020
Wellsouth Primary...	84.0%	84.5%
National	82.5%	82.0%
Māori	72.2%	76.3%

- 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 Māori Health Navigators coordinating access between the patient and providers.
  This action rolls over. See Harti Hauora actions above (1.1).

- Health Care Home (HCH) programme of work. The Health Care Home programme has a number of outcomes that the practice works towards. One is the availability of urgent same day appointments and the duration to the third next available appointment. As the HCH programme develops improvements in these metrics will address the key issue identified in the patient survey.
- LTC - CLIC service in partnership with WellSouth PHO and practices that are currently a part of the, 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 action rolls over. The pilot has been through a review and the recommendations will be implemented through 2021-22.


Why could you not get health care from a GP or nurse when you wanted it during the last 12 months? Show insight
All answers
Waiting time to get an appointment too long
62.6% (147)
The appointment was too expensive
4.3% (10)
Owed money to the general practice or medical centre
2.6% (6)
Dislike or fear of the GP
5.1% (12)
Difficult to take time off work
10.2% (24)
Had no transport to get there
1.7% (4)
Could not arrange childcare or care for a dependent (an adult who is ill or disabled)
1.3% (3)
Did not have a carer, support person or interpreter to go with you
0.0% (0)
Unable to visit clinic due to stay home
5.5% (13)
Fear of getting sick by visiting in person
2.1% (5)
Alert level restrictions meant I wasn't allowed
13.2% (31)
I didn't want to make the health care providers too busy
4.3% (10)
I was worried about catching COVID-19
3.4% (8)
Other
22.1% (52)
n = 235
National
Māori

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.
* SLM Data for amenable mortality has not been updated since 2016, so assessment of progress against milestones is difficult to measure.

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 are we going?

Long term improvement milestone: Reduce and maintain amenable mortality rates to fewer than 46 people per 100,000 population by 30 June 2022, with equity of outcome for Māori.
Improvement Milestone for 2021-22: 5% reduction in the Southern Māori 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 2021-22 SLM Implementation plan. With an equity focus (EOA) Focus will initially be on improving uptake of cervical screening for Māori women.

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

Measure description: Measured on Rolling three-year basis, information provided by National Screening Unit.
2021/22 Improvement Target: Māori Enrolled Women >80%.

Baseline Data

DHB	Women screened in last 3 years		Hysterectomy adjusted population	3-year coverage		
	Old[a]	New[b]		Old[a]	New[b]	Difference
Southern Total	62,036	62,096	77,997	79.50%	79.60%	0.10%
Southern Māori	3,736	3,790	6,237	59.90%	60.80%	0.90%
Southern Pacific	873	872	1,119	78.00%	77.90%	-0.10%
Southern Asian	2,433	2,628	4,404	55.20%	59.70%	4.40%
NZ Total*	**908,395**	**908,760**	**1,184,129**	**76.70%**	**76.70%**	**0.00%**

Key: a – Register ethnicity and domicile; b – NHI ethnicity and domicile

*Total includes women of unknown domicile, and therefore is greater than the sum of DHB counts.

	≥80%		70-79.9%		<70%

Activities that will enable us to achieve the Improvement Target

- Cervical Screening Events will be held in Dunedin and Invercargill 6 weekly with a focus on priority populations.
  This is a carryover action. Priority women who have never had cervical screening or who are overdue 5+ years will be followed up. Initial focus is on establishing the process with three GP practices with high volumes of Māori, Pacific and Asian enrolments

- Cervical Screening Events will be held bi-annual with a focus on rural areas of North Otago and Central Otago.
  This is a carryover action. Through 2021-22 the service will coordinate with the Breast Screening Service to provide screening from the Breast Screening Bus in rural locations. Focus is on the priority groups noted above.

- 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)
  This action carries over to 2021-22.

- 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, with a particular focus on the reduction of DNA's (unable to attend appointments). This initiative 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.
This action carries over to 2021-22.

4.2 Faster Cancer Treatment - 62 Day Target

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.
2021-22 Improvement Target: 90%

Baseline Data

DHB Name	Target %	Achievement %
Auckland	90%	96.7%
Bay of Plenty	90%	95.3%
Canterbury	90%	96.3%
Capital and Coast	90%	85.4%
Counties Manukau	90%	86.0%
Hawkes Bay	90%	75.9%
Hutt Valley	90%	86.2%
Lakes	90%	94.7%
MidCentral	90%	93.6%
Nelson Marlborough	90%	91.8%
Northland	90%	61.0%
South Canterbury	90%	60.6%
Southern	90%	65.0%
Tairawhiti	90%	94.4%
Taranaki	90%	74.0%
Waikato	90%	84.6%
Wairarapa	90%	91.1%
Waitemata	90%	85.0%
West Coast	90%	81.0%
Whanganui	90%	96.2%
National	90%	84.9%

Activities that will enable us to achieve the Improvement Target

- Formation of the Māori Health Clinical Group to monitor and provide advice for Faster Cancer Treatment with the Cancer Coordination team during 2020.
  This action rolls over and aligns with the 2021-22 priorities for the Māori Health Directorate.

- Review resources for the Māori Cancer Kaiarahi Navigation Services based in communities across the district, while also providing support to connect with Kaupapa Māori Health Services (hospital, primary and community). (EOA) This will be actioned by the additional resource noted below.
  This action has now been implemented.

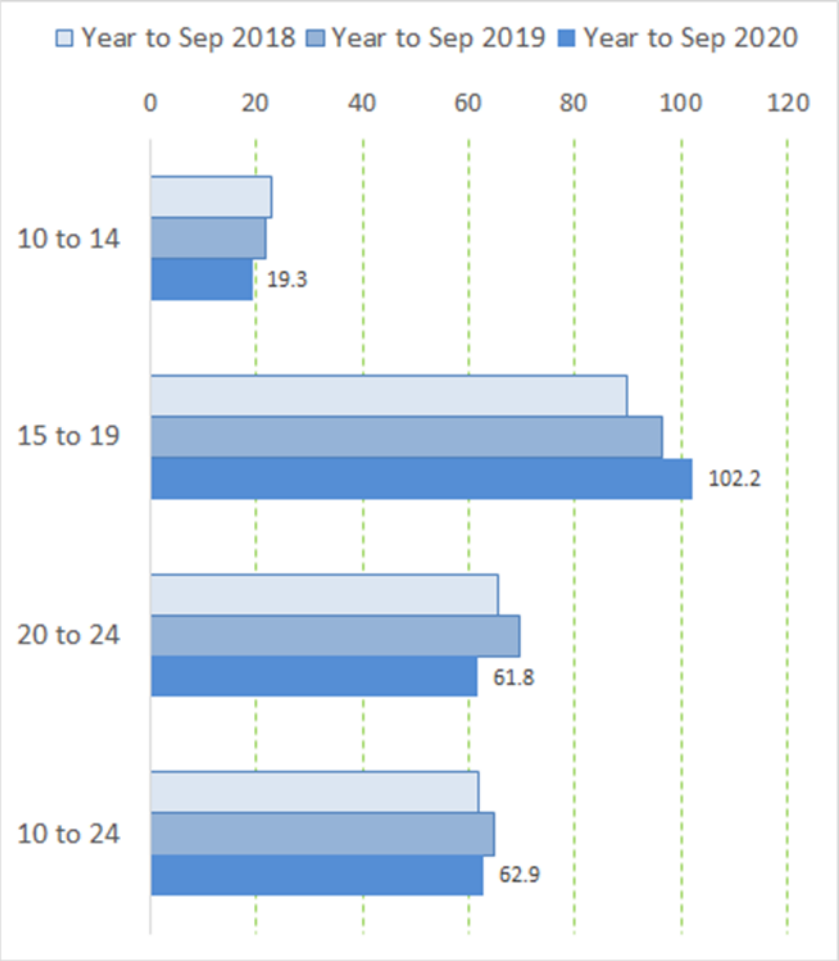
- Increased workforce in Māori Cancer Services. Target: 1.0 FTE Clinical Nurse Specialist based at Dunedin Hospital to provide support for Māori whānau who receive cancer services.
  This is a carryover action. Workforce development for a Māori CNS in Children's Health and in Cancer Services to be actioned.

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 Age-specific Self Harm Hospitalisation Rates (per 10,000 population)		
Age Group	**Year to Sep 2020**	**Year to Sep 2020**	**Year to Sep 2018**	**Year to Sep 2019**	**Year to Sep 2020**
10 to 14	20,760	40	23.0	21.8	19.3
15 to 19	23,770	243	89.8	96.4	102.2
20 to 24	25,870	160	65.5	69.6	61.8
10 to 24	**70,400**	**443**	**61.8**	**64.8**	**62.9**



Where are we going?

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 2021/22: To reduce the rates for Māori < 92.5/10,000

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.

5.1 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 Pop)	Age Standardised Self Harm Hospitalisation Rate (per 10,000 population)		
Ethnicity	**Year to Sep 2020**	**Year to Sep 2020**	**Year to Sep 2020**	**Year to Sep 2018**	**Year to Sep 2019**	**Year to Sep 2020**
Māori	11,315	108	95.4	79.7	84.3	97.4
Pacific	2,365	21	88.8	46.7	55.5	92.9
Other	56,720	314	55.4	56.4	60.5	53.8
Total	70,400	443	62.9	60.1	63.3	61.8

Activities that will enable us to achieve the Improvement Target

- 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.
  Action will roll over.

- The recently appointed 0.7 FTE MHAID Educator based in the ED environments has spent the last three weeks orientating to this new position which has also involved meeting the clinical and non clinical staff of the two main ED departments (Dunedin and Invercargill) with a plan to extend this to Lakes Hospital in February. While orientating there has been a focus on scoping out what Mental Health training is already available in the ED areas and where the gaps are which will inform our plan for the 2021 year. This new role will be monitored by the MHAID team and report the volume of patients supported through this role.

- The Central Lakes Mental Wellbeing Recovery group have developed a Terms of Reference and a workshop is planned for 3 December to confirm an action plan. The current focus includes amplifying key and relevant information for the community, plans continue with regard to funding for a Mental Wellbeing Navigator. Meetings with Central Otago District Council and Queenstown Lakes District Council are planned over the next two weeks. Alongside this relationships have been established across sectors including government (MOE, MSD), NGOs and Primary Health care providers.

- 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*:
  - Develop and implement and action plan Q3;
  - Complete process evaluation of implementation Q4.

  This action rolls over. A workshop is planned between all key stakeholders in Youth Self Harm. This will result in an action plan for improvement in services that support this measure.

	○ Supporting Parents, Health Children project activities. *This action rolls over. 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) ○ Southern DHB Public Health Service to monitor implementation of the Kapehu Youth Resilience Project. The Kapehu Project is a Southern DHB/Uni Otago initiative focused on measuring youth resilience, social identity, self-belief and mental wellbeing *This action will roll over. It has been successful at two Dunedin high schools; however, it has been delayed for additional schools. For 2021-22, the focus for implementation is for three lower decile high schools across the district.* ○ 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; ○ Identify how these priorities can be implemented collaboratively by all local community partners to achieve outcomes. *The Mental Health enquiry is an ongoing action.*
Baseline Data – WellSouth PHO	**Activities that will enable us to achieve the Improvement Target**
Where are we now WellSouth will focus on improving access to primary care through 2021-22. 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.	

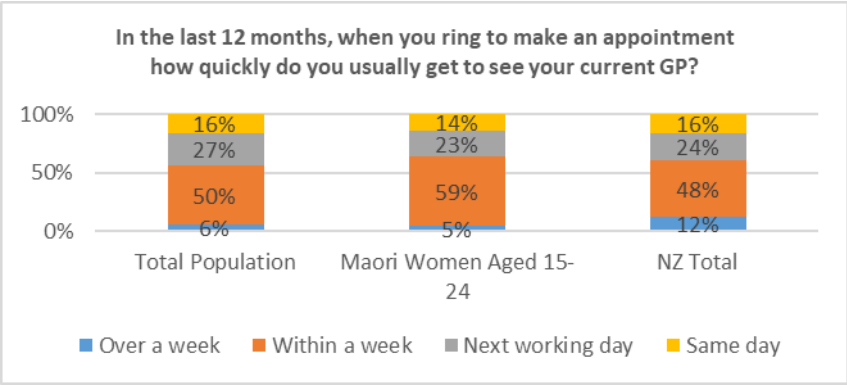
Improvement Target for 2021/22: Access on the same day > 14% for Māori Women aged 15-24. Patient portals offered by GPs > 60% and patient use > 15%

Access to usual GP

	Total Population	Māori 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%



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/whānau environment. The measure aligns with the first core contact which is when the handover from maternity to Well Child Tamariki Ora (WCTO) providers and general practitioners occur.

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

This measure promotes the roles which collectively, infant and child service providers play in the infant's life and the many opportunities for smoking interventions to occur. The patient benefit in this measure is a smoke-free 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 – 2020

Percentage of households being smoke free

	Numerator	Denominator	Rate of Smoke-free Homes	
Year	Jan 20 - Jun 20	Jan 19 - Jun 19	July 19 - Dec 19	Jan 20 – June 20
Māori	115	252	46%	42.2%
Pacific Peoples	39	81	55%	57.7%
Others	888	1,381	71%	66.1%
Total	1,042	1,714	66%	61.5%
New Zealand	16,945	30,648	59%	55%

Where are we going?

Long term improvement milestone: 95% of babies live in a smoke-free household at six weeks.
Improvement Milestone for 2021-22: 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 2021-22 Southern DHB will continue to work with the four locally contracted Well Child 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 Smoke-free 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 smoke-free activities for pregnant women and whānau.

	Numerator	Denominator	Rate of Smoke-free Homes
Year	Jan 20 - Jun 20	Jan 20 - Jun 20	Jan 20 - Jun 20
Māori	127	301	42.2%
Pacific Peoples	41	71	57.7%
Others	889	1,344	66.1%
Total	1,057	1,720	61.5%

	Numerator	Denominator	Rate of Smoke-free Homes
Dep Quintile	Jan 20 - Jun 20	Jan 20 - Jun 20	Jan 20 - Jun 20
Quin 1	330	505	65.3%
Quin 2	224	349	64.2%
Quin 3	254	417	60.9%
Quin 4	174	303	57.4%
Quin 5	75	146	51.4%
Total	1,057	1,720	61.5%

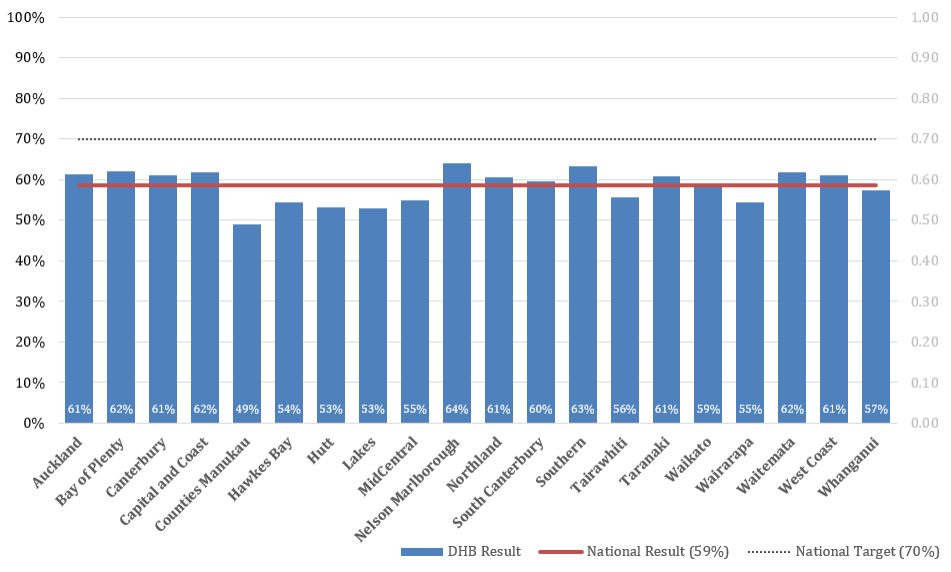
How will we get there?

Over the next five years, Southern DHB will look to ensure that all children have a healthy start to life. This will be achieved by ensuring babies are engaged with Well Child Tamariki Ora providers and are living in smoke free homes and environments. The focus to achieve this will be on activity to impact on breastfeeding rates. It is likely that a new mother who is continuing with breastfeeding their child is more likely to remain smoke free. We will also look at a number of activities to increase the number of children at four years of age who are living in a smoke free home.

6.1 Percentage or number of infants who are exclusively or fully breastfed at 3 months 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).
2021-22 improvement Target: 70% for both Māori and Non-Māori.

Baseline Data: Infants who are exclusively or fully breastfed at 3 months



Activities that will enable us to achieve the Improvement Target

- Confirm gaps in breast feeding support services.
  Action rolls over. The new National Breast-Feeding Strategy will inform further actions following a Hui with key stakeholders in late 2020-21.

- Work with WellSouth to increase access to the Southern District peer support programme, with a focus on Māori and Pacific women.
  Action rolls over. Following the pilot at Pacific Trust Otago, a revised strategy for increased health literacy will be actioned.

- Work with Māori and Pacific communities to support training of appropriate women to deliver the breast-feeding peer support programme to these communities. (EOA)
  This action will be supported through the outcomes of the community breast feeding pilot (see above).

- 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)
  Pilot is planned to extend through 2021-22. Support being provided by a Paediatric SMO.

- Upon the release of the new national Breast-Feeding Strategy, hold a breast-feeding hui with key stakeholders with the aim of providing alignment and a more integrated approach to breast-feeding activities across the Southern district.
  - *Hui to be held in late 2020-21.*

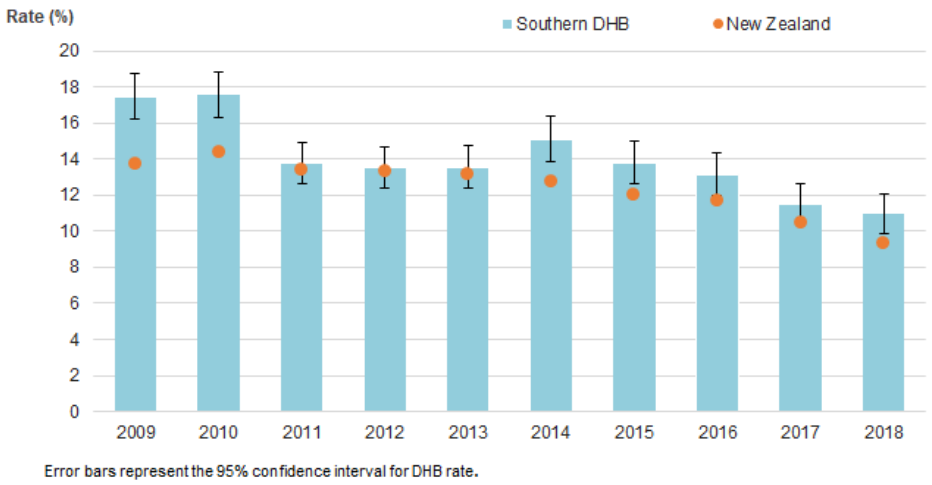
6.2 Pregnant women who identify as smokers upon registration

Measure description: Percentage or number of pregnant women who identify as smokers upon registration with a DHB employed midwife or Lead Maternity Carer who are offered brief advice and support to stop smoking.
Numerator: Number of pregnant women who identify as smokers upon registration with a DHB employed midwife or Lead Maternity Carer who are offered brief advice and support to stop smoking.
Denominator: Number of pregnant women who identify as smokers upon registration with a DHB employed midwife or Lead Maternity Carer.

2021-22 Improvement Target: (National target 90%).

Baseline Data

Total number of women with smoking status at 2 weeks after birth reported



Error bars represent the 95% confidence interval for DHB rate.

Activities that will enable us to achieve the Improvement Target

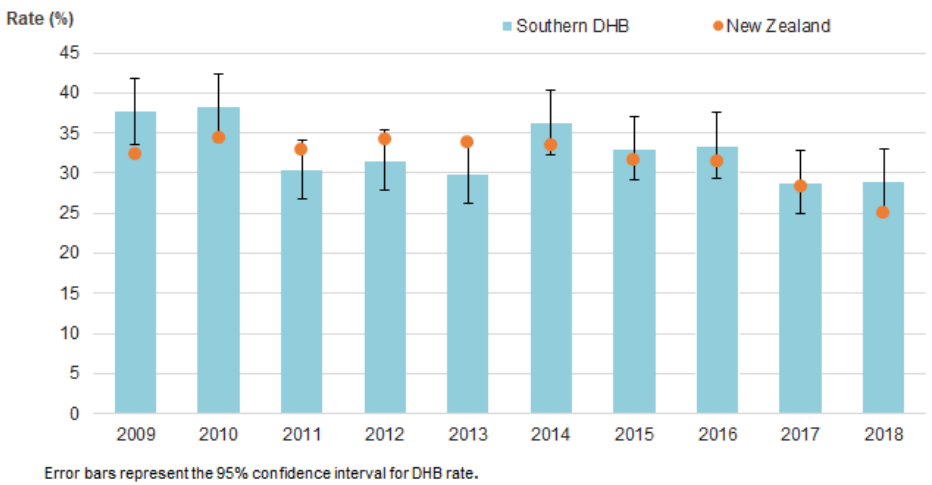
- Streamline the process for referral from LMC's to the Southern Stop Smoking Service and incentive programme, then progress to setting a quit date.
  This action rolls over. A new e-referral system for midwives to refer applicable women into the stop smoking service is a planned initiative.

- Provide education to the WCTO and Lead Maternity Carer workforce regarding the new measure and ensure questions and data recording is consistent.
  This action rolls over into 2021-22.

- Programme of education to General Practices around the first contact being an appropriate time to refer into the smoking cessation service.
  This has been actioned for women in their first and/or second trimesters.

- Prioritize pregnant Māori wahine and whānau for referral to the relevant Southern district Stop Smoking Provider. This will be the focus of all referrals into the Stop Smoking Service, and reinforced 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 the birth of their baby. The service will report on referral numbers, enrolments and successful quits for pregnant Māori wahine and whānau.
  Action to roll over. Southern Community Laboratory data will be filtered by smoking status to identify all pregnant women who are smokers and contact will be made to support smoking cessation.

Total number of Māori women with smoking status at 2 weeks after birth reported



- 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.
  This action has been completed.

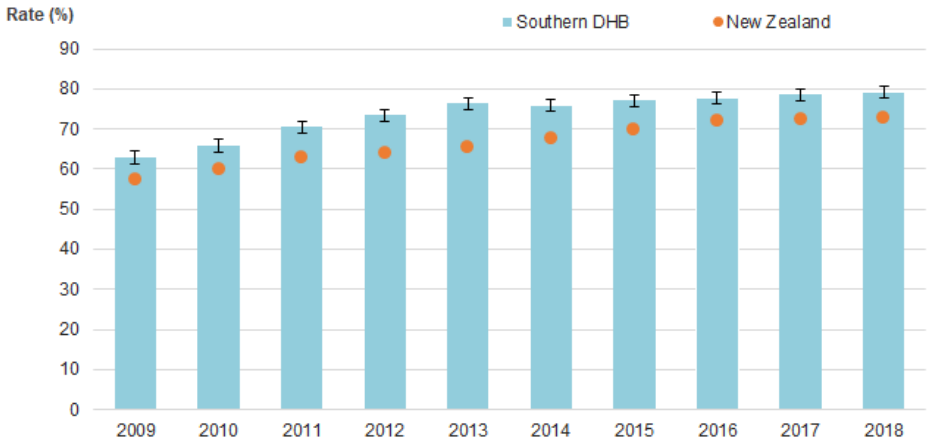
6.3 Pregnant women registered with a Lead Maternity Carer within first trimester of pregnancy

Measure description: Pregnant women registered with an 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.

2021-22 Improvement Target: >77% registration for Māori.

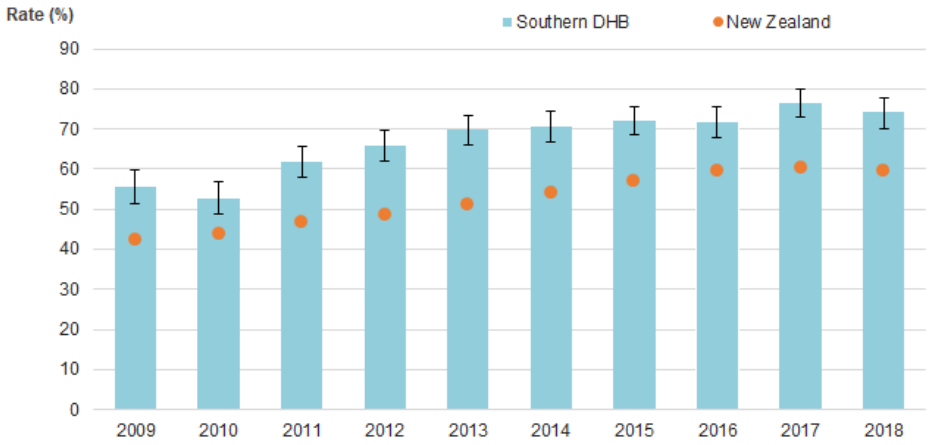
Baseline Data	Activities that will enable us to achieve the Improvement Target

Southern Total



Error bars represent the 95% confidence interval for DHB rate.

Southern Māori



Error bars represent the 95% confidence interval for DHB rate.

- 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 Māori and Pasifika women are more likely to miss out on care in the first trimester. Young and Māori 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.

  This action rolls over. In 2020, a new Pregnant, See a midwife leaflet was launched with a targeted distribution of over 1000 copies into the community. Community visits ensued to discuss barriers to access / uptake of early care. On the new MQSP 2021-2023 workplan, work is planned to continue strengthening those community connections and hopefully it will be a platform for any new smoke cessation initiatives developed between WCTO and MQSP. An audit is planned, focussing on preterm birth, with ethnicity and smoking expected to be placed high as risk factors. Objectives on how to target these will follow.

- At the November 2020 Smokefree Steering Group meeting it was agreed a process would be undertaken to match pregnancy laboratory results with WellSouth smoking status data so that women could be contacted by the WellSouth Call Centre to encourage referrals to the Southern Stop Smoking Service (SSSS). The Call Centre contact is to be based on smoking status rather than pregnancy status. Where appropriate following discussion, referrals will be made to the SSSS and the Stop Smoking Incentive Scheme. This process will be operational by Q2 2021-22.

- We will work with Māori midwives and kaupapa Māori health services and Pasifika community agencies to develop written and video resources targeting young Māori and Pasifika women and their families to reinforce the message to get care with a midwife as soon as they are pregnant.

  This action is complete.

- 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.
  This action is complete.

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 whānau attending pregnancy and parenting sessions in Dunedin by Q4 (EOA)
  This is a carryover action. Following feedback, the sessions will be more 1:1 sessions/ small group sessions that are specific to Pasifika Peoples rather than offering full courses that are open to all. The education and support will continue to be provided at the Pacific Trust Otago venue by a local facilitator who is well respected in the Pasifika community.