South Canterbury District Health Board

ANNUAL PLAN 2019-20

South Canterbury District Health Board

EVERY moment MATTERS

Enhancing the health and independence of the people of South Canterbury

Annual Plan dated 25th July 2019

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

Contents

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

11 NOV 2019

Mr Ron Luxton
Chair
South Canterbury District Health Board
rluxton@scdhb.health.nz

Dear Ron

South Canterbury District Health Board 2019/20 Annual Plan

This letter is to advise you I have approved and signed South Canterbury District Health Board's (DHB's) 2019/20 Annual Plan for three years. I am aware that you have advised the Ministry of Health (Ministry) of an improving out-years position. I appreciate your continued commitment to prudent financial management, as demonstrated over recent years.

I have made my expectations on improving financial performance very clear to all DHBs. Current national financial performance is not sustainable, despite Government providing significant funding growth to DHBs in the past two Budgets. I am approving your plan on the expectation that you will continue to focus on realising your financial plans for 2019/20 and into 2020/21 and beyond.

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

I am aware you are planning a number of service reviews in the 2019/20 year. My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

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

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

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

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

Yours sincerely

Hon Dr David Clark
Minister of Health

cc Mr Nigel Trainor, Chief Executive, South Canterbury District Health Board, ntrainor@scdhb.health.nz

Message from the Board & Chief Executive

A vision without a plan is just a dream. A plan without a vision is just drudgery…but a vision with a plan can change the world.

EVERY MOMENT MATTERS IS NOT ONLY OUR VISION, IT IS OUR COMMITMENT TO OUR PATIENTS, OUR STAFF AND OUR COMMUNITY.

Welcome to the South Canterbury District Health Board (DHB) Annual Plan for 2019/20. This plan is testament to the value we place on the health and independence of the people of South Canterbury. Working in partnership within our own organisation, with Primary Care, and cross-sectorial organisations, we are able to collectively achieve our vision of making *every moment matter.*

The Minister of Health's letter of Expectation outlines the Government's commitment to improving the wellbeing of all New Zealanders and their families, and ensuring that the economy is growing and working for all. This is a commitment we strongly endorse.

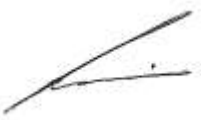
As a DHB we are committed to ensuring our public health system is strong and equitable, performing well and focused on the right things to make our New Zealanders' lives better. In this respect *every moment matters* is not only our vision, it is our commitment to our patients, our staff and our community.

The year ahead is not without its challenges. With an aging population that is getting older and life expectancy growing faster than health expectancy, we are already feeling the impact of more patients with greater complexity and co-morbidity. We are a nimble organisation with dedicated staff and are primed to be the center of excellence for the Health of Older Persons in New Zealand.

Health equity for our community remains a priority for our DHB. Connecting with our communities is an important part of understanding where there are inequities and provides us with an opportunity to improve. Every person has a say and we want our community to feel that what they say truly matters.

At South Canterbury DHB we have the vision to dream big. What you will read within these pages is but a snapshot of the dedication and commitment our staff and supporters will undertake this year. We cherish the opportunity to change the world, by enhancing the health and independence of the people of South Canterbury.

Ron Luxton, Chair, SCDHB



Nigel Trainor, CEO, SCDHB

SECTION ONE: Overview of Strategic Priorities

At South Canterbury DHB we believe that every moment matters

Our annual plan enables us to articulate how we will meet this vision, by outlining our key priorities, service configuration, stewardship and performance measures. Our key priorities have been presented to the Ministry of Health during strategic discussions. That is:

- Section 2: Identifies our actions against agreed Government Planning Priorities including:
    - Strong and equitable public health and disability system;
    - Mental health and addictions care;
    - Child wellbeing;
    - Primary health care;
    - Environmental sustainability and drinking water safety.
- Section 3: Notes our responsibility for ensuring service coverage for our population in accordance with the Service Coverage Schedule agreement.
- Section 4: Highlights how we build a support system around our services to ensure they can meet the commitments to key priorities and service coverage, including business management, infrastructure, workforce and IT strategies.
- Section 5: Outlines a framework for reporting to ensure we know how and when we have delivered on our commitments.

We do not look after the health of our community in isolation

As such we would like to acknowledge the partnership that has occurred in the development of our plan, in particular with our local Iwi, and our commitment to the principles embedded in the Treaty of Waitangi. The development of the plan is also guided by the principles of the United Nations Convention on the Rights of Persons with Disabilities.

As a region we are supported by the South Island Regional Alliance and are integrated into the Te Wai Pounamu Regional Health Services Plan. Working together we strive to provide a connected and equitable South Island health and social system that supports all people to be well and healthy.

Furthermore, our annual plan commitments are guided by a number of national strategies, including: He Korowai Oranga Maori Health Strategy; New Zealand Health Strategy; Healthy Aging Strategy; Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-18.

The plan is reflective of the vision provided by the South Canterbury District Health Board in the Navigating Our Future document, and aligns with our strategic goals of Productive Partnership, Integrated person-centred care, Valuing our people, Health equity for all, and Fit for future.

We are a fiscally responsible, well performing DHB dedicated to increasing equitable access and outcomes for our community

The Government has announced a long-term plan to build a modern and fairer New Zealand. South Canterbury DHB has an important role to play in bringing this goal to life. To do this we must ensure the health system in South Canterbury is strong and equitable, performing well, and focused on the right things to improve the wellbeing of our community.

In particular we look forward to performing against the Government Planning Priorities, including:

1. *Strong and equitable public health and disability system*

   Our community is old and getting older. This places tremendous pressure on our health and disability system. We see ourselves as a centre of excellence for the health of older persons and our actions against the healthy aging priority will enable us to demonstrate how our innovative Integrated Community Assessment Treatment Team model is decreasing presentations of those people aged over 75 years to the Emergency Department.

   With one of the highest rates of bowel cancer in New Zealand, we look forward to the roll-out of the National Bowel Screening programme. Improving the visibility of data, and building clinical leadership of those at the front-line are examples of two supporting strategies which will ensure we are well positioned to adapt to the impact from the programme once embedded.

2. *Mental health and addictions care*

   Our local Mental Health and Addictions Service review mirrored the feedback from the National Mental Health and Addictions Inquiry. A shift in focus is required to provide increased access to services across the spectrum. We look forward to further guidance from the Ministry of Health as to the national approach going forward, and in the meanwhile will begin conversations with local non-government organisations to inform our strategy.

3. *Child wellbeing*

   South Canterbury's strong sense of hapori, community, is evident in the cross-sectoral Maternal Child and Youth Alliance. The Alliance takes a holistic approach to understanding our local social determinants of health, and provides action for change, to improve the health and wellbeing of individuals, families and communities.

   With further guidance pending in the form of New Zealand's first Child and Youth Wellbeing Strategy, we look forward to aligning our own plan with the national strategy to work together to make New Zealand the best place in the world to be as a child.

4. *Primary health care*

   We are unique at South Canterbury DHB in that the DHB is also the Primary Health Organisation. This enables us to have greater collaboration across our primary and secondary services. This year we would like to further strengthen our integration by revisiting our population health committee governance structure.

5. *Environmental sustainability and drinking water safety*

   As a DHB over the past year we have made significant gains in reducing our carbon footprint, for example through the shift to hybrid cars. These efforts will continue with a review of our energy needs and exploration into alternative options for our current coal fire boiler.

Our rural populations in particular carry the burden of balancing the health need for clean drinking water with the cost of effective water treatment. Community and public health will continue to work with our district councils and Environment Canterbury to ensure compliance.

This is our plan to enhance the health and independence of the people of South Canterbury in the 2019/2020 year. By living our values of integrity, collaboration, accountability, respect, and excellence (ICARE) we can be confident to deliver on our vision, making *every moment matter*.

Signatories

Agreement for the South Canterbury DHB 2019/20 Annual Plan

between

Ron Luxton	Nigel Trainor,	Dr David Clark
Chair, SCDHB	CEO, SCDHB	Minister of Health
Date: 25 July 2019	Date: 25 July 2019	Date: 7/11/19

SECTION TWO: Delivering on Priorities

2.1 Government Planning Priorities

Improving Child Wellbeing					
Government Planning Priority	**DHB activity**	**Milestone**	**Measure**	**Government theme: Improving the well-being of New Zealanders and their families**	
				System Outcome	**Government Priority outcome**
Immunisation	Continue to strengthen the school-based immunisation programme to improve percentage of 12 year old girls and boys fully immunised.	Q1: To aim for 10% incremental increase in coverage for each cohort moving forwards. Q4: In 2019 all eligible young people who attend the DHB youth health clinic and sexual health clinics will be actively offered HPV immunisation. Q2: Investigate and understand HPV immunisation participation information across the eligible age range and genders. **EOA** - Q4: Explore opportunities to increase awareness and education about immunisation for young people, with particular focus on HPV, working alongside key community stakeholder groups such as: the education sector, non-government organisations, the South Canterbury Youth network, primary care, Maori health providers, Pacific and multicultural community groups.	CW05:75% of girls and boys immunised – HPV vaccine.	We live longer in good health	Support healthier, safer and more connected communities

School-Based Health Services	Continue to provide high quality school based health services to secondary schools, teen parent units and alternative education facilities.	Q2: Provide reports for ongoing activities taking place in secondary schools, teen parent units and alternative education facilities. Q3: Design of health promotion and education sessions in alternative education settings which is generated from the students "topics of interest" list. This helps to identify areas of need, such as lack of dental care, not enrolled with Primary Care, this then enables these items to be actioned.	CW12 – Youth mental health initiatives.	We have improved quality of life	Make New Zealand the best place in world to be a child
	SCDHB will continue to utilise Youth Health Care in Secondary Schools, a framework for continuous quality improvement.	Continue to utilise nurses to provide access to health services at school in our secondary schools. Our nurses also work alongside community organisations in providing safety and wellbeing initiatives in our schools.			
	SCDHB commit to providing quarterly narrative reports on the actions of SLAT to improve health of the DHB's youth population.	Q1-Q4: Provide reports on the actions of the Service Level Alliance Team to improve health of the DHB's youth population.			
	SCDHB to raise awareness of the Youth Service Alliance Team.	Q3: The South Canterbury Youth Sector Network will hold a networking session for organisations to share information on who they are and what they do. Membership to be reviewed to ensure we have the appropriate people on the team.			
Midwifery workforce – hospital and LMC	Development and implementation of the SCDHB Midwifery new graduate programme.	**EOA** - Q1: Development and implementation of the SCDHB Midwifery New Graduate Programme, ensuring the programme has an equity lens connecting to the MOH Health Equity Assessment Tool.	New graduate attraction and retention trending positively. Co-development of the graduate programme alongside key stakeholders, inclusive of MERAS, NZNO unions and Tertiary providers (Ara & OP).	We live longer in good health	Ensure everyone who is able to, is earning, learning, caring or volunteering
	Build a collaborative close working relationship with the local tertiary midwifery provider, Ara, and the local SC Iwi. Establish quarterly meetings to consolidate partnership in workforce development.	Q1: Meetings established.	Regular quarterly meetings taking place with evidence of effective outcomes developed in partnership.		

	Extend student placement opportunities to include placements from Otago Polytechnic school of midwifery in negotiation with Ara.	Q2: Establish contractual agreement with OP for student placements.	Otago Polytechnic midwifery student placements facilitated within SCDHB, in addition to Ara Students.		
	EOA: Review current Maori Midwifery workforce in order to develop a Maori Midwifery workforce target that matches our Maori population in South Canterbury.	Q4: Retrieval and understanding of data.	Understand known target of Maori Midwifery workforce to reflect South Canterbury's population, which will inform next steps.		
	Refer to the Workforce priority for further details (CCDM related detail etc.)				
First 1000 days (conception to around 2 years of age)	**EOA:** Enable the best possible start in life for our community, we will be working in partnerships to develop a programme to improve pre-conception health and wellbeing	Q1: Establish a working group across the health system to focus on the first 1000 days, working in partnership with our Maori Health provider.	CW11 Supporting child wellbeing.	We have improved quality of life	Make New Zealand the best place in the world to be a child
	Ensure alignment to the National Child Wellbeing Strategy.	Q4: Develop a workplan to align SCDHB to the National Child Wellbeing Strategy that is currently being developed.			
	EOA: Supporting healthy weight gain during pregnancy and in children during their first 1000 days.	Continued discussions with pregnant women, offering appropriate support services to dietician and diabetic specialist services. These discussions will take place in partnership with our Maori Health Provider to try and encourage pregnant women to access the required services. Encourage the use of the evidence based Ministry of Health guidelines for practitioners to support conversations with women and their families https://www.health.govt.nz/our-work/diseases-and-conditions/obesity/childhood-obesity-plan	Reduction in the number of women with gestational diabetes. 2017/18 – number of women recorded with gestational diabetes was 19. 2018/19 – number of women recorded with gestational women was 23.		

Family Violence and Sexual Violence (FVSV)	Improved support to staff to enable increased awareness and understanding of family violence and sexual violence.	**EOA** Q4: Providing nationally approved VIP core training locally, that will enable new staff to access training. This will take place in partnership with our Maori Health team, who will be actively involved in preparing for and providing this training. Q4: Increased visibility of the VIP team and increased staff awareness by providing refresher sessions to teams.	Intimate Partner Violence routine enquiry in the six designated services to meet the VIP programme expectation of >80%. 80% of children presenting to ED having a child protection assessment completed. Routine audits of designated services to report on compliance to understand areas for improvement. Programme Delphi audit score increase from 62 to 75.	We have improved quality of life	Support healthier, safer and more connected communities
SUDI	Continue to focus on the actions set out in the SCDHB SUDI prevention plan.	**EOA** - Q3: SCDHB to purchase Pepi Pods and contract weaving wahakura with the possibility of developing a programme to include pregnant women and their Whanau to learn to weave their own wahakura.	No. of attendees.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities
	Continue to provide educational sessions to the community to increase the awareness of SUDI risk factors.	**EOA** - Q1: Scheduled sessions with support from key stakeholders such as Arowhenua Maori Health, Oranga Tamariki, Community Oral Health Service, DHB Cessation service, Plunket, Continuity of Care Midwives, PHO, Key SCDHB internal stakeholders.	No. of attendees.	We live longer in good health	Support healthier, safer and more connected communities

Improving Mental Wellbeing					
Government Planning Priority	**DHB activity**	**Milestone**	**Measure**	**Government theme: Improving the well-being of New Zealanders and their families**	
				System Outcome	**Government Priority outcome**
Inquiry into mental health and addiction	SCDHB will undertake a comprehensive and transformational review of our Mental Health and Addiction Services.	Q1: A Mental Health Alliance Group formed. Q2: Development of a transformational plan with an agreed co-design approach, with a key focus on the priorities outlined in the Annual Plan Guidance. Q3: Implementation of the agreed priorities. Q4: Evaluation of the Alliance, check and adjust on priorities that were implemented and new priorities agreed for 2020/21.	Terms of Reference documented. Documented vision, key priorities and action plan. Documented evaluation process. New Priorities agreed for 2020/21.	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering
Population mental health	Explore alternative models for the provision of crisis response.	Q3: Develop a proposal for change. Q3: Consult with stakeholders to reach decisions that will meet the local need.	Improved crisis response.	We have improved quality of life	Support healthier, safer and more connected communities
	EOA: Establish links with the pasifika community by developing strong relationships with Fale Pasifica O Aoraki Trust Society Inc.	Q2: Through these relationships we aim to provide support and education in group settings and to those in the Pasifika community who support Pasifika people who have Mental Health concerns.	Relationships established with support and education being provided.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities
	Continue to implement the Supporting Parents, Healthy Children (COPMIA) project.	Q2: Collaborate with NGOs to provide support to families. Q4: To embed agreed procedures and processes.	Quarterly progress report.	We have improved quality of life	Make New Zealand the best place in world to be a child
	Increase support of suicide prevention and postvention.	Fund grief counselling to close family/whanau of those effected by suicide.	Commences 1 July 2019. Quarterly reporting.	We live longer in good health	Support healthier, safer and more connected communities

	SCDHB will continue to focus on improving access for people with severe mental health illness as well as reduced waiting times.	Continued strong links with Mental Health Services and ED interface agreement already in place. Q1: Shorter waiting times for non-urgent mental health and addition services for 0-19 year olds. Introduction of a reminder notice.	MH01 – Improving Access. MH03 – Shorter wait times.	We have improved quality of life	Support healthier, safer and more connected communities
	SCDHB to commit to ongoing reporting to PRIMHD.	Ongoing reporting to PRIMHD.	Reports submitted. Achieve compliance above 95%.	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering
	Improve mental health services using wellness and transition planning. SCDHB will plan to increase and monitor the quality of the plans, ensuring collaboration and partnership with the service user and family/whanau.	Q1: Develop and audit tool. Q2: Implement the audit tool. Q4: Evaluate the audit tool.	Audit developed, implemented and evaluated.	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering
Mental health and addictions improvement activities	Minimising restrictive care through the zero seclusion project working towards the goal of eliminating seclusion by December 2020.	Q1: Attendance and participation in all HQSC workshops for staff. Continue to monitor seclusion rates and balancing measures. **EOA** - Q3: Investigate how cultural support can be made available outside of core hours. Specifically aimed at people who are secluded, with the aim to reduce seclusion for our Maori population.	Reduced seclusion rates. Development of sensory kits specifically for our Maori Population.	We live longer in good health	Support healthier, safer and more connected communities
	Improve the transition of care from youth to adult services.	Q1: Attendance and participation in all HQSC workshops for staff. Embed the use of transition to wellness plans including the quality of them.	Transition to wellness plans embedded.		
	Learning from Adverse Events and Consumer experience.	Q2: Develop and agree on process measures. Q3: Implement process measures.	Agreed process measures.		
	Investigate improvement opportunities to increase Maori youth engaging with our services.	Q1: Engage with another service provider that currently has a higher than average number of Maori accessing their services (i.e. Adventure Development Timaru) to understand how SCDHB can improve engagement with our Maori youth.	Key opportunities identified and a plan drafted on what needs to be incorporated into SCDHB services to improve engagement.		

		Q2: Opportunities for improvement identified and recommendations put forward for consideration.			
Addiction	Develop a wellness approach to youth alcohol and drug usage.	Strengthen the collaborative approach with SCDHB, probation and NGOs. **EOA** - Q2: Involve the Hauora Maori team earlier in the process for Maori community. Q3: Model developed.	Model being developed/improved engagement with youth.	We have improved quality of life	Support healthier, safer and more connected communities
	SCDHB commits to providing a list of all existing and planned AOD services in our district.	Q1: Existing and planned AOD services provided to the Ministry of Health.	List of existing and planned AOD services provided.		
Maternal mental health services	**EOA:** Continue to provide community-based support for women requiring perinatal, antenatal, and post-partum maternal mental health services including continued partnership with our Maori provider, Arowhenua Whanau Services.	Q2: Approach Perinatal Anxiety and Depression Aotearoa (PADA) to conduct a gap analysis on current services to identify areas of improvement which may include education sessions to current health professionals on perinatal anxiety and depression. Establish links with the Pasifica community. Through these established relationships the aim is to provide support and education to those in the Pasifica community who provide support to mothers taking part in the Mother and Pepe programme.	Documented gap analysis and draft recommendations for consideration. Number of education sessions delivered. Documented process of establishing links with the Pasifica community including a plan to provide the support and education required.	We have improved quality of life	Support healthier, safer and more connected communities

Improving Wellbeing through Prevention					
Government Planning Priority	**DHB activity**	**Milestone**	**Measure**	**Government theme: Improving the well-being of New Zealanders and their families**	
				System Outcome	**Government Priority outcome**
Cross-sectional collaboration	Continue intersectoral oversight/governance of health promotion in education settings through the intersectoral steering group, comprising CPH, SCDHB, Arowhenua runanga, Ministry of Education, and Sport Canterbury.	Q1: WAVE annual plan approved by Steering Group.	Approved WAVE annual plan.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities
	EOA: Continue intersectoral input into WAVE operations, including education settings have a memorandum of agreement with WAVE, support alignment of health messages across multiple agencies, and provide input into Ka Toi Māori o Aoraki Incorporated Society with SC schools participating in FLAVA and ECE in Korohi o Te Pēpi.	Q2 & Q4: Updates provided to intersectoral Working Group.	95% of education settings have a memorandum of agreement with WAVE. 33% of South Canterbury schools participating in FLAVA and 40% of ECE in korohi o Te Pepi.		
Waste disposal	Continued awareness and education to actively promote the use of appropriate waste disposal within the DHB.	Continuous improvement on waste management within the DHB as this will be a long term focus.	PP 41 Waste disposal.	We have improved quality of life	Support healthier, safer and more connected communities
Climate change	Continue to mitigate or adapt to the effects of climate change through a focused effort on identifying actions to reduce carbon emissions across the DHB.	Q2: Undertake a review of our energy needs to explore alternative options to our current coal fire boilers.	PP 40 Responding to climate change.	We have improved quality of life	Support healthier, safer and more connected communities
Drinking water	Access water suppliers' water safety plans as required and provide a report to the water supplier within 20 working days.	Water Safety Plans approved within 20 days. Monitored Quarterly (September, December, March June).	% water suppliers' water safety plans assessed and reported on within 20 working days. % of network drinking water supplies with an approved WSP that have had an	We live longer in good health	Support healthier, safer and more connected communities
	Inspection of water supplies with Water Safety Plans (certify the implementation of water safety plans).	All drinking water supplies with a water safety plan are inspected every three years. Monitored Quarterly (September, December, March June).			

	Conduct the annual review of drinking-water supplies serving more than 100 people and provide a report to water suppliers on their compliance.	Annual survey completed for all supplies serving more than 100 people. Survey to be completed in August. Reports to be completed by December.	implementation (inspection) completed in the last 3 years (expected 100%). % networked water suppliers serving more than 100 people receiving a compliance report (expected 100%).		
	Continue to actively engage with our Community Public Health Unit on drinking water activities.	Ongoing collaboration with our Community Public Health Unit by supporting and working on drinking water activities. CPHU provides regular reports/updates to our Community and Public Health Committee.	Community and Public Health documented reports.		
Healthy food and drink	Review SCDHB Healthy Food Policy against the National Healthy Food and Drink Policy to identify opportunities for improvement.	SCDHB already require our food service provider to meet SCDHB healthy food and drink policy however, this will be updated if there are any changes to the national food and drink policy. Q2 & Q4: number of contracts with a Healthy Food and Drink policy, and as a proportion of total application contracts.	Maintain compliance.	We live longer in good health	Support healthier, safer and more connected communities
	EOA: Support education settings (early learning settings, primary and secondary schools) to have a) water-only (including plain milk) policies, and b) healthy food policies, with a focus on low decile schools.	Q2: Report on policies.	Policies developed.		
Breast Screening	**EOA**: Eliminate the equity gap in coverage for breast screening between Maori and non-Maori. Forge a strong connection between SCDHB, the ScreenSouth health promoter and Arowhenua Whanau Service, our Maori Health provider, to strengthen the promotion of breast screening in Wananga.	Q1: Hold engagement meeting between providers. Q1: Include promotion of breast screening in SCDHB communications and publications. Q2: Include breast screening promotion in Wananga. Q3: Work with Fale Pasifika to partner in an approach to promote and engage with our local eligible Pasifika women to encourage them to attend mammography scans.	Breast Screening coverage rates by ethnicity. Target 70% (PV01). Breast screening rates for Pasifika.	We live longer in good health	Support healthier, safer and more connected communities

	Improve breast screening coverage across the district through strengthened relationship with ScreenSouth.	Q2: To participate in ScreenSouth Hui to share opportunities for improvement and evaluation of co-agreed approach apart of regional planning.	Breast Screening coverage rate for total population.		
Smokefree 2025	Improve equity in access to smoking cessation services for our ethnic and rural communities by removing recognized barriers to access, such as service hours and locality, making it easier for people to engage.	Q2: Evaluate recently established evening clinics in Timaru, Temuka and Waimate. **EOA** - Q3: Partner with our local multi-cultural centre, Te Aitarikihi Trust, to develop a culturally appropriate approach to engage the diversity of migrants in our local community. **EOA** - Q3: Partner with Fale Pasifika, to develop a culturally appropriate approach to engage local Pasifika. Q4: Partner with local Disability Network to develop an appropriate response to engaging disabled persons who smoke in cessation services. **EOA**: Continue to include promotion of smoking cessation services in AWS wananga.	No. of clinics held No. of clinic attendances. No. of Hui's held. No. of wananga held including smoking cessation.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities
	Engage with local businesses, educational providers and sports clubs to assist in supporting a smokefree culture and take smokefree services to where people work, study and play.	Q1: Connect with 5 local employers to take smoking cessation services to the workplace.	No. of workplace referrals.	We live longer in good health	Support healthier, safer and more connected communities
	Work with DHB and non-government mental health services to minimize harm caused by cigarette smoking	Q2: Work in partnership with mental health providers to transition those clients currently smoking to the smoking cessation intervention of vaping.	No. of clients transitioned from smoking to vaping.		
	Support pregnant women who are smokers to quit prenatally and to remain abstinent post baby.	Q1: Continue the Pregnant Mama Incentive Programme (dependent on funding).	No. of women CO validated as smokefree at 4 weeks post-natal. CW09: Better help for smokers to quit (maternity).		

Cervical Screening	**EOA**: Eliminate the equity gap in coverage for cervical screening between Maori and non-Maori. Forge a strong connection between SCDHB, the ScreenSouth health promoter and Arowhenua Whanau Service, our Maori Health provider, to strengthen the promotion of cervical screening in Wananga.	Q1: Hold engagement meeting between providers. Q2: Include cervical screening promotion in Wananga. Q1: Include promotion of cervical screening in SCDHB communications and publications.	Cervical Screening coverage rates by ethnicity. Target 80% (PV02).	We live longer in good health	Support healthier, safer and more connected communities
	Improve cervical screening coverage across the district through strengthened relationship with ScreenSouth.	Q3: Participate in regional plan development with a focus on engagement of Primary Care in timely recall for our eligible population.	Breast Screening coverage rate for total population.		
	EOA: Partner with ScreenSouth to provide cervical screening recall support to practices with high numbers of wahine Maori, Pasifika and Asian.	Provide support and assistance using the practice patient management system and DHB cervical screening data match reports to contact and invite under screened wahine Maori, Pasifika and Asian.	Cervical screening coverage rates by ethnicity.		

Better population health outcomes supported by strong and equitable public health and disability system					
DHB activity		**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
				System Outcome	**Government Priority outcome**
Engagement and obligations as a Treaty partner	**EOA:** Ensure Māori as a Treaty partner, are consulted through the Māori Health Advisory Committee. This committee comprises of Iwi representatives from mana whenua Te Rūnanga o Arowhenua, Te Rūnanga o Waihao and Ngā Maata Waka Te Aitarakihi. The DHB seeks guidance in planning, advising and implementing strategies to improve Māori Health outcomes and reduce health inequities that exist between Māori and non-Māori within the South Canterbury DHB region.	Q2: Establish health consultation hui, in partnership with mana whenua Te Runaka o Arowhenua, Te Runaka o Waihao, Te Whare Mahana, and Nga Maata Waka Te Aitarakihi. To enable Maori participation and contribution to Maori health outcomes in the South Canterbury region. Hui will be organized to engage with whanau, hapu and Iwi, in designing solutions to improve the health services, improve health outcomes and reduce health inequity for Maori.	Evidence of quarterly meetings between SCDHB and Iwi Māori. Documented actions to target health inequities. Evidence of consultation hui between SCDHB and key stakeholders with South Canterbury region.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities

	EOA: To increase cultural competency within SCDHB health care system, in partnership with mana whenua and Iwi Maori. (more info detailed under Workforce regarding cultural competency).	Q1: Mihi Whakatau for all new staff at SCDHB. Increase awareness and support for staff to complete cultural competency training. Q1 2020: To develop and implement new cultural training/education to SCDHB workforce on Treaty of Waitangi, equity lens, Tikanga best practice, Whanau Ora and to introduce Takarangi Cultural Competency Framework.	Embedded Mihi Whakatau for all new staff. 100% of staff members complete cultural competency training. Training/education developed with a clear implementation plan on delivery.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities
Delivery of Whanau Ora	**EOA:** To form a partnership between SCDHB and commissioning agency of Whanau Ora Te Putahitanga o Te Waipounamu, to provide education to SCDHB on Whanau Ora.	Q3: Establish relationship with Te Putahitanga o Te Waipounamu and Whanua Ora navigators in South Canterbury.	Relationship established. The SCDHB will be guided by Iwi Maori, Te Putahitanga o Te Waipounamu and Iwi Health providers regarding consultation processes.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities
Care Capacity Demand Management (CCDM)	Create real time digital dashboards reflective of the SCDHB CCDM agreed core data sets. This will be visible and available across CCDM related activity from local data councils to governance.	Q3: Real time digital dashboard reflecting core data integrated across our system.	Local data councils, working groups and SCDHB governance activity is informed by data.	We live longer in good health	Support healthier, safer and more connected communities
	Develop a TrendCare Training package to support learning and development needs related to data entry, reflective of patient acuity.	Q2: Development of a training package related to capturing of data on TrendCare.	Reliable presentation of data through dashboards and increased staff confidence and competence in the use of TrendCare.		
	Establish a patient acuity committee which governs TrendCare data to support data integrity and reliability. Committee members work directly with clinical services to support reliable data entry.	Q1: Establishment of Patient Acuity Committee.	Evidence of meetings with actions that support data integrity and reliability.		
	Complete CCDM standards assessment with development of workplan reflective of standards activity.	Q4: Development of 2019/20 workplan linked to CCDM standards.	Workplan developed.		
	Support Midwifery CCDM leaders in national activity by attendance at national forums and learning activities. Clear partnership demonstrated across midwifery through CCDM council to support enhancement of CCDM related activity in midwifery.	Q2: Active participation by SCDHB midwifery leaders in national CCDM forums.	Workplan review at CCDM council meeting with resulting actions documented.		

	EOA: SCDHB CCDM council to consider their function in relation to equity outcomes.	Q3: CCDM council meeting discussion around impact on equity outcomes.	Documented discussion with actions monitored.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities
Disability	Commit to ongoing training for front line staff and clinicians to support positive interactions with people with disabilities.	Q4: Implement reporting on staff uptake of training.	SI14 Disability Support Services update reports.	We have improved quality of life	Support healthier, safer and more connected communities
	Understand SCDHBs current processes to collect patient information which ensures staff know which patients have visual, hearing, physical and/or intellectual disabilities.	Q3: Audit of current processes to collect patient information. Q4: Review referral processes to ensure it is built into the DHB's process where possible.	Understanding of what current practice is. Change in SCDHBs process (where possible).		
Planned care	Year one of our three year plan will focus on moving some minor procedures into primary care to reduce pressure on the hospital, and provide more timely access to minor procedures in the community.	Q2: To have discussed and agreed with primary care the ability to provide minor procedures in the community. Q4: Implementation plan has been completed with Primary Care.	Agreed range of procedures and process for delivery is completed. Completed implementation plan.	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering
	Continue to monitor access to services using ESPI indicators.	Q2: for indicators that are red ensure a plan is put in place to reach compliance.	Monitoring reports. Where non-compliance, develop and implement an action plan.		
	Review strategies to work with our affected community to improve DNA rates.	Q4: Identify gaps between deprivation groups and reasons for this.	Analysis of DNA rates for different groups. Develop a plan to address the inequalities.		

	Part Two: SCDHB commit to providing a three year plan to improve Planned Care services.	Q1: DHB will provide an outline of their engagement, analysis and development activities to develop the three year plan. Q2: DHB will undertake analysis of changes that can be made to their Planned Care services including consultation with DHB Consumer Council and other key stakeholders. Q3: DHB will submit their three year plan to improve Planned Care services. Q4: DHB provide the first update on actions taken to improve Planned Care.	A detailed plan is submitted that outlines the proposed approach. A summary report outlining the outcomes of the analysis and consultation processes to understand local health needs, priorities and preferences. Submission of the three year plan to improve Planned Care services. An update is provided on actions outlined in the three year plan to improve Planned Care Services.		
Acute Demand	SCDHB to provide a SNOMED implementation plan by 2021.	Q4: Implementation plan completed.	Documented workplan for implementation in 2020/21.	We have improved quality of life	Support healthier, safer and more connected communities
	Ensuring patients are in the right location with access to appropriate services.	Q2: Review the chest pain pathway patients to identify opportunities for improved patient flow.	SS10 Shorter stays in Emergency Department.	We have improved quality of life	Support healthier, safer and more connected communities
	EOA: Encourage cultural competency and recognise the diversity of the community we serve.	Q1: DHB consistent signage including Te Reo within ED.	100% signage changed to bilingual.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities
	Improved management of patients who present to ED with long term conditions.	Q4: Integration of single point of entry service to enhance the management of the COPD patients presenting to ED with long term conditions. All referrals for people who have COPD are triaged through a single point of entry which consists of representatives from Allied Health, District Nursing, Clinical Nurse Specialist and Needs Assessment Service. This will provide a proactive preventative approach and recommendations to the service that will case manage the individual.	Reduction of representation of COPD patients to ED within 72 hours.	We have improved quality of life	Support healthier, safer and more connected communities
	EOA: SCDHB aim to maintain wait times exemplar ED access targets.	Continued strong links with Mental Health Services and ED interface agreement already in place.	Maintain exemplar ED access targets.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities

	Improved patient flow for admitted patients. SCDHB will be investigating the standardising of admission communication through the Charge Nurse Managers.	Q1: Investigation of current gaps and drafting up of recommendations. Q2: Consultation with all stakeholders involved. Q3: Implementation of new standard. admission communication process. Q4: Evaluation of process.	Maintain SS10 access target - maximum 6 hours. Standardised admission communication implemented.	We have improved quality of life	Support healthier, safer and more connected communities
Rural health	***Refer to Primary Health Care section for activity.***				
Healthy Aging	Continue to promote and increase enrolment in Strength and Balance Programmes through the review of the Fracture Liaison Service which will focus on building on the alliance with Primary Care as reflected in the "Live Stronger for Longer" Framework.	Q1: Review the current fracture liaison service to identify if people over 50 following a fall are being offered appropriate treatment. Q3: Provide report and recommendations. Q4: Implement actions.	85% of people that fracture following a fall over the age of 50 are offered appropriate intervention.	We live longer in good health	Support healthier, safer and more connected communities
	EOA: Align the local home and community support services to the vision, principles, core components, measures, outcomes of the National Framework for HCSS, with particular reference to ensuring the needs of Maori have been taken into account.	Q1: RFP HCSS if appropriate. Q2: Evaluate RFP. Q3: Implement.	New service will be in place which aligns to the national framework.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities
	In May 2019 all people over the age of 75 years and Maori over the age of 65 years who have presented to ED will be screened by the duty work team who work within the Integrated Community Assessment Treatment Team. This team will identify the drivers for each presentation.	Q1: Identify trends. Q2: Action plan implemented to address identified trends. Q4: Evaluation.	Monthly reports. Less presentations of those people over the age of 75 years.	We live longer in good health	Ensure everyone who is able to, is earning, learning, caring or volunteering
Improving Quality	**EOA:** In response to the significantly lower rate of screening for renal disease highlighted in the Atlas of Healthcare Variation (2017) for our Maori community (50% compared with 63% nationally). Continue to work with Primary Care Provider and Maori Health Provider to raise importance of screening for renal disease specifically for high risk cohorts such as our Maori population.	Q3: CNS Diabetes clinic at Maori Health Provider each month. Quarterly monitoring of Atlas Variation to gauge improvement in monitoring rates.	Maori attending the clinic have improvement in their understanding and ability to self-manage their diabetes. This can be measured by HbA1c levels. Improvement in percentage for Maori screened for renal disease.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities

	EOA: Improve performance for the following question from the SCDHB Patient Experience Survey: "Did the hospital staff include your family/whanau or someone close to you in discussions about your care?" (Communication Domain)	Q2: Utilise baseline data from the Patient Experience Survey to establish targets to guide service improvement.	Quarterly reporting to Clinical Board and Consumer Council in place.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities
	A key issue for SCDHB is our low response rate to surveys amongst our highest need populations. We will be seeking to augment patient experience surveys as a primary source of data, in an initiative led by our consumer council to engage directly with targeted community networks, ideally inspiring self-empowering hui within these communities/ Iwi. Engagement will seek to understand for these communities; • the level of health literacy • common themes in the experience of health care • what matters most to them • how can we make our services more welcoming and accessible?	Q2: Continue to engage with the community to identify opportunities for improvement. **EOA** - Q4: Key initiatives to improve experience of care and reduce inequities identified.	Community engagement forums held. Improvement action plan for identified key initiatives.	We have improved quality of life	Support healthier, safer and more connected communities
	EOA: The community engagement is expected to generate key priorities for our council to engage with our health services, on targeted improvement activities of importance to all members of our community, including our Maori, and other high need communities.	Q4: Changes to standard procedures and communication with consumers implemented in key connection services, including booking office.	Documented changes.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities
	An Antimicrobial Stewardship Steering Group (ASSG) is formed and meets regularly. This group consists of members with wide expertise in prescribing antimicrobials.	Q1: Steering Group formed. Representation for the ASSG include Senior Medical staff, Microbiologists, Pharmacy, Primary/community link, RMO's nursing and IPC representative.	Documented Bi-monthly meetings with clear Terms of Reference established for the Steering Group.	We live longer in good health	Support healthier, safer and more connected communities
	The facility, RMO or other prescribers, have a policy for antibiotic prescribing which supports prudent use on the treatment of infections.	Q1: Canterbury's comprehensive "Pink Book" antimicrobial formulary has been adopted by SCDHB and is available electronically via HCS, and ihub.	Policy published and annual reviews conducted of the "Pink Book".		

	Policies for the use of antibiotic prescribing are consistent with current accepted good practice.	Q2: The antimicrobial formulary ("Pink Book") is developed and reviewed by the Clinical Microbiologist and team in Canterbury DHB, including review against best practice on sensitives within the region.	Regular reviews conducted and documented as part of Steering Group.		
	A process exists to evaluate compliance with prophylactic and therapeutic antimicrobial polies. This shall be linked to the Antimicrobial Stewardship programme.	Ongoing adherence auditing is undertaken as part of the SSI surveillance. Chart review enables review of adherence to antimicrobial formulary.	Documented adherence audits and chart reviews completed annually.		
	Information in relation to the prevalence of resistance to antimicrobial agents in the facility and community which it serves should be fed back to the prescribers and the IC team.	Q3: Information relating to resistance patterns are actively collected on a monthly basis	Information is documented as part of Steering Group. Information is presented to the various consumer groups of IPC within the organisation.		
	Improve the stewardship of antibiotic prescribing in Primary Care.	Q2: Community Clinical Pharmacist in their capacity within the ICATT will work alongside practices, where the introduction of new prescribing monitoring software indicates support is required to ensure prescription practices meet best practice in antibiotic prescribing Q3: Provide an education update for primary care practitioners on antimicrobial stewardship.	Practice prescription antibiotic monitoring report. Primary care educational forum attendance.		
	Improve the stewardship of antibiotic prescribing in Aged Residential Care facilities.	Q4: Community Clinical pharmacists will work with staff in the ARC facilities to raise awareness to ensure prescription practices meet best practice requirements.	Number of medication reviews undertaken by the Clinical Pharmacist.		
	Please refer to SLM for further details around Improving Quality.				

Cancer Services	**EOA:** Ensure equity of access to timely diagnosis and treatment for all patients on the Faster Cancer Treatment (FCT) pathway to minimise breaches of the 62 day FCT target for patient or clinical consideration reasons.	Live tracking of data to reduce breaches. Alliance with Southern Cancer Network (monthly meetings and guidance). Continued involvement in the development of PICS for the collection of FCT data.	SS01 Faster Cancer Treatment – 31 day indicator. SS11 Faster Cancer Treatment – 62 days.	We have health equity for Maori and other groups	Ensure everyone who is able to, is earning, learning, caring or volunteering
	Identify activities that support the quality improvement plan for bowel cancer care informed by the 2019 Bowel Cancer Quality Improvement Report.	Continued focus on the Elective Recovery Accelerated Service. Continued focus on the Enhanced Recovery Surgery Pathway.	Patient length of stay (avg 2.4 days).	We live longer in good health	Support healthier, safer and more connected communities
	Support people who have completed cancer treatment with services to improve quality of life and to live well beyond cancer.	Q1: Continue to support delivery of the survivorship workshop with the local cancer society.	Active support in the delivery of the Survivorship workshops.	We live longer in good health	Ensure everyone who is able to, is earning, learning, caring or volunteering
	SCDHB commit to working with the Ministry of Health to develop a Cancer Plan. It is expected that further direction from the Ministry of Health will be forthcoming as the New Zealand Cancer Action Plan is developed.	Q4: Develop local action plan with key deliverables and milestones.	Documented local action plan.	We live longer in good health	Ensure everyone who is able to, is earning, learning, caring or volunteering
Bowel Screening *Note: go live date for the Bowel Screening programme at SCDHB is set for July 2020*	Ensure colonoscopy wait times are consistently met regardless of implementation stage.	Q2: Implementation of SCOPE. Q3: Endoscopy User Group Forum to monitor delivery against the Scoping Recovery and Sustainability Plan.	SS15 – Improving waiting times for Colonoscopy. Meeting requirements of the Scoping Recovery and Sustainability Plan.	We live longer in good health	Ensure everyone who is able to, is earning, learning, caring or volunteering
	EOA: Ensure equitable access throughout the bowel screening pathway.	Working in partnership with our local Runaka and Nga Maata Waka Marae (Te Ai Tarakihi) through our Maori Health Advisory Committee to ensure the needs of the local Iwi are met. Work with our Maori Health Provider, Arowhenua Whanau Services to promote the National Bowel Screening Programme and connect with hard to reach populations.	Equity Promoter appointed. Improved participation in bowel screening for Māori, Pacific and high deprivation population groups.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities
Workforce	We will expand our leadership learning programme (Navigate) into the wider health system to drive stronger, more effective health services through a holistic approach to distributive leadership.	Q4: Navigate cohort open to Primary care and NGO participation.	Two cohorts held and 35 health staff members complete the Navigate Programme.	We have improved quality of life	Support healthier, safer and more connected communities

	EOA: We will embed cultural competency through adding workshops to our on-line offerings and introducing an advanced programme which develops champions and mentors in cultural competency. We will continue to include a Marae overnight stay for new RMOs as part of their orientation to SCDHB.	Q4: Establish cultural competency Mentors/champions in three in patient services.	At least four champions identified.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities
	EOA: SCDHB will build on the National ACP (advance care planning) programme through *Kia kōrero | Let's talk* to improve consumer and whanau literacy, targeting end of life care.	Q4: Kia Korero implemented. This will involve developing our workforce culture and capability to partner with consumers and whanau to plan for their future health care, with a focus on what matters to them.	In-service training and patient communication materials delivered across all inpatient services.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities
	EOA: We continue our progress with the HQSC deteriorating patient programme, by implementing *Kōrero Mai,* the second key element which will empower patients, family and whanau to speak up to clinical staff when they perceive a change in patient condition. We will then commence the third ("*shared goals of care*") component, supporting service co-design by patients, family and whanau.	Q2: Kōrero Mai implemented. Q4: "Shared goals of care" commenced.	Audit sample will be selected of which 80% of patient's clinical record will demonstrate contribution to shared goals of care.		
	EOA: We will embed the "Choosing Wisely" campaign which was introduced into Primary care in the 2018-2019 year, across the SCDHB health system.	Q4: Choosing wisely principles will be embedded across the SCDHB health system.	Q4: Identify two areas of opportunity and action these two areas of opportunity.		
	Implementation of SCDHB's new Maternity services model of care.	Q1: New Model in place.	By August 2019.	We have improved quality of life	Make New Zealand the best place in the world to be a child
	We will continue to develop service leadership and increase our SMO resource to improve continuity of care and develop our Mental Health service in line with local and national review recommendations.	Q1: SMO permanent FTE increased.	Psychiatrist employed FTE increased.	We have improved quality of life	Support healthier, safer and more connected communities
	We will continue to target recruitment to new graduate nurse positions in mental health as part of the NESP (Nurse Entry to Specialty Practice) programme as a key strategy for mental health workforce development.	Q3: Annual securement of NESP positions at SCDHB.	Evidence of annual recruitment of graduates into NESP positions at SCDHB.		

	We will improve our new Graduate experience by enhancing our New Graduate programmes to experience a multidisciplinary inclusivity and integrated learning experiences.	Q4: Annual securement of new graduate midwifery positions into the model of care.	Evidence of quarterly graduate advisory group meetings and activity aligned to interprofessional learning opportunities.	We have improved quality of life	Support healthier, safer and more connected communities
	EOA: The DHB will enhance connection with tertiary providers to ensure pipeline transparency to contribute to workforce planning.	Q1: We will connect on a quarterly basis with tertiary providers of the professional groupings. Q2: Development of a graduate advisory group to ensure interdisciplinary learning experience and connection is maximised.	Evidence of quarterly meetings achieved across the professional tertiary providers. Terms of reference for the group established and meetings commenced on a regular basis.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities
	Connection through the South Island Alliance to stocktake current funding streams for professional development for Nurse Practitioners.	Q3: Connection with professional leads across the South Island through SI Alliance.	Transparent report of South Island wide funding allocations.	We have improved quality of life	Support healthier, safer and more connected communities
	Regional South Island Alliance to form an equitable approach to professional development for Nurse Practitioners.	Q3: SCDHB involvement in Alliance meetings. Q4: Review of SCDHB Learning and Development policy and funding distribution to clearly distinguish a professional development allocation, and supporting process for Nurse Practitioners.	Development of a regional approach to equitable funding to support professional development for Nurse Practitioners. Local policy and process reviewed.		
Data and Digital	SCDHB will finalise our IT Strategy that will cover the next 5-10 years and will reflect a balance between our digital system requirements and our fiscal constraints.	Q2: Finalisation of an IT Strategy.	Prioritisation of IT investment.	We have improved quality of life	Support healthier, safer and more connected communities
	SCDHB will work closely with the IS SLA and regional CIOs to ensure close linkage with either national, regional or local IT requirements.	Q1: Actively engages with regional CIO and IS SLA meetings to ensure oversight of projects maintained within our IT strategy.	Prioritisation of IT investment.		
	SCDHB to commence planning and implementation of the Patient Information Care System.	Q2: Planning and implementation of PICS to start with possible implementation in 2021.	Approved SI PICS Business Case.		

	SCDHB has adopted a business case for Bowel Screening. The go live date has been set for May 2020.	Q4: Implementation of Bowel Screening programme.	SCDHB Bowel Screening Business Case with milestones and measures clearly documented.		
Collective Improvement Programme	SCDHB commit to supporting a Collective Improvement Programme.	Undertake activities of the Collective Improvement Programme.	Reports as required (once requirements are developed by MOH)	We live longer in good health	Ensure everyone who is able to, is earning, learning, caring or volunteering
Delivery of Regional Service Plan (RSP) priorities	**EOA**: Active participation in the Health of Older People SLA to progress work initiatives under Dementia Care as outlined in Te Waipounamu South Island Health Services Plan.	Q1: SCDHB will participate in the regional stocktake of dementia services and related activity as part of the national healthy aging priority. Q4: SCDHB to develop an approach for implementing the NZ Framework for Dementia Care using the stocktake to inform priorities and action. Q3 & Q4: Report on work to progress the implementation of the NZ Framework for Dementia Care.	Dementia stocktake completed. Stocktake addresses equity of services for Maori and Pacific population. Priorities and actions are identified to progress the NZ Dementia Framework. Specific actions identified to address equity for Maori and Pacific population. Progress reports completed.	We live longer in good health	Ensure everyone who is able to, is earning, learning, caring or volunteering

	Active participation in the South Island Hepatitis C workstream to progress local work initiatives as outlined in Te Waipounamu South Island Health Services Plan.	Q1: build linkages with the alcohol and drug services and needle exchange services in South Canterbury to promote Hepatitis C testing and treatment. Q1: Utilise allocated funding to provide free general practice based treatment for those identified as having Hepatitis C. Q1: Develop a public messaging programme to encourage those high risk cohorts to be tested for Hepatitis C, advising free treatment though general practice. Q2: Communication with individuals that have been lost, informing them that we can now treat. As well communication to GP's for those individuals lost so that they may follow up with those individuals for assistance to get them treated. Q3: Raise community and general practice team awareness and education of the hepatitis C virus and risk factors for infection; includes encouraging hepatitis C champions and collaboration with Primary and Secondary.	Partnerships formed and active promotion of Hepatitis C testing and treatment. Hepatitis C contract monitoring and reporting. Those lost to follow up are identified. Increased community and primary care awareness of HCV and collaboration across primary and secondary services.	We live longer in good health	Ensure everyone who is able to, is earning, learning, caring or volunteering

Better Population Health Outcomes Supported by Primary Health Care

Government Planning Priority	DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families	
				System Outcome	Government Priority Outcome
Primary Health Care Integration	Work with Primary Care to strengthen our response to the needs of our population and continue to support the unique symbiotic relationship between general practice and the DHB.	Q1: Implement the Access to Contraception contract to decrease unplanned pregnancy which can negatively impact physical and mental health, and social wellbeing of women aged 15 – 44 years. Q1: Review SCDHB's current committees and governance structures to remove duplication, strengthen diverse clinician involvement in service planning and build robust relationships between all providers across an integrated South Canterbury health system. Q3: Review all programmes currently operating under flexible funding streams to ensure these are meeting current priorities, evidencing efficacy and are value for money. Implement the workplan developed as an adjunct to the Primary Care Strategy.	Contract reports. Terms of Reference reviewed and approved. Utilisation rates Budget monitoring. Workplan implemented.	We have improved quality of life	Support healthier, safer and more connected communities
	Sustain a resilient model of service delivery for primary care in rural areas.	Q2: Re-activate the Rural Health Service Level Alliance for South Canterbury and negotiate a collectively agreed response for forward planning in the provision of rural services.	Rural Health Service Level Alliance Terms of Reference and work plan.	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering

	Expand medication management support to Primary Care through the inclusion of a Community Pharmacist as part of the integrated Community Assessment and Treatment Team.	Q1: Clinical Pharmacist employed and inducted. Q2: Prescription monitoring software programme utilised. Q3: Recommendations for medication practices to general practice initiated.	Prescription monitoring reports.	We have improved quality of life	Support healthier, safer and more connected communities
	Invest available funding realised, following review of current programmes supported through Primary Care flexible funding.	Q3: Tag funding to support initiatives aligned to the DHB Alcohol Harm Reduction Action Plan.	Programme and eligibility criteria.	We have improved quality of life	Support healthier, safer and more connected communities
Pharmacy	Build robust relationships with our community and hospital pharmacists so that we can work in partnership to realise the vision of Pharmacy Action Plan, support identified local need and supports equitable outcomes.	Q1: Circulate a consultation document to hospital and community pharmacies and the wider health working in Primary Health seeking input into what actions are required to support the implementation of the Pharmacy Action Plan.	No. of feedback responses.	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering
	In collaboration with DHB Immunisation Steering Group develop and implement a plan to increase influenza vaccination rates in Maori, Pacific and Asian people over 65 years of age.	**EOA** - Q2: Connect with Arrowhenua Whanau Services, Fale Pacifica and Te Aitarikihi Trust to promote the availability of free flu vaccinations to their elders and their whanua, fono through their general practice and/or pharmacies.	CWO5: Influenza immunisation - 75% of over 65 year olds immunised.	We live longer in good health	Ensure everyone who is able to, is earning, learning, caring or volunteering
	Promote fiscal prudency by removing pharmaceutical waste across South Canterbury DHB whole of system.	Q1: Collaboration with regional partners to collectively explore how we can reduce pharmaceutical expenditure in our respective DHBs.	DHB pharmaceutical expenditure variance against budget.	We have improved quality of life	Support healthier, safer and more connected communities
	Partner with community pharmacy to agree a plan for local commissioning as the ICPSA.	Q1. Continue to commission for LTC services and invest in workforce development. **EOA:** Q3. Partner with our local community pharmacists to identify opportunities to reduce inequity in health outcomes for Maori as part of local commissioning discussions. This will inform investment for 2020/21.	No. LTC vols. Audit Results.	We have improved quality of life	Support healthier, safer and more connected communities
	Work in partnership with Community Pharmacy to deliver on the Integrated Community Pharmacy Services Agreement.	Engage in the review of Schedule 1 of the ICPAS and implement agreed outcome.	Updated Integrated Community Services Agreement issued once confirmed.	We have improved quality of life	Support healthier, safer and more connected communities

	Work with community pharmacy to identify novel methods of improving influenza vaccination rates among Māori, Pasifika and Asian populations; ensuring availability meets their needs.	Inform planning for 2020/21.	Influenza vaccination uptake by ethnicity delivered by community pharmacy.	We have improved quality of life	Support healthier, safer and more connected communities
Diabetes and other long-term conditions	**EOA:** Support chronic disease (diabetes) to our Maori populations.	Q3: CNS Diabetes clinic at Maori Health Provider each month.	Maori attending the clinic have improvement in their understanding and ability to self-manage their diabetes. This can be measured by HbA1c levels.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities
	Eligible people living with diabetes have access to the Diabetes Encounter Programme. This entitles people to 6 fully funded consults with their Primary Care team. Eligibility is a. Newly diagnosed b. Commencing insulin therapy c. Re-engagement. History of poorly controlled diabetes	Q3: Improvement in the number of people with an HbA1c at or below their individual target. Targets are set with the person with diabetes and their health provider.	SS12: Improved management for long term conditions.	We live longer in good health	Ensure everyone who is able to, is earning, learning, caring or volunteering.
	EOA: The SCDHB has started running fortnightly dietician outpatient clinics as part of the Arowhenua Whanau Service South Canterbury. AWS is a free healthcare service providing a wide range of services to all Maori and non-Maori in the Arowhenua area. This service is situated locally with other health care providers and has been made available within AWS to ensure that access to dietician services are easily available.	Commenced in December 2018.	Dietician Outpatient numbers seen.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities
	Dieticians present at the Be Active programme run by Sport South Canterbury providing information to support healthy eating practices to reduce the risk of developing type 2 diabetes and other long term conditions. For those people who already have a long term condition such as diabetes, the information provided could support them to self-manage, to reduce their risk of complications and improve diabetes control.	Programme ongoing.	Numbers participating in the programme.	We have improved quality of life.	Support healthier, safer and more connected communities

	Dieticians in the community receive referrals from Primary Care for long term conditions including diabetes. These referrals are seen either as outpatients or domiciliary visits as required.	Meeting target volumes.	Contract volumes.	We have improved quality of life.	Ensure everyone who is able to, is earning, learning, caring or volunteering
	Continue to support WAVE as our investment in the future health of our population by installing health lifestyle choices in our young, leading to a reduction in the prevalence of long-term conditions and other long-term conditions.	Q2: Work with targeted education settings to include healthy eating and exercise as the focus in their WAVE setting plans.	Evaluation against WAVE education plans.	We have improved quality of life.	Ensure everyone who is able to, is earning, learning, caring or volunteering
	To improve the quality of primary care level data to inform service planning for the diabetes service.	Q1: Work with CDHB to data match primary care register data with labs warehouse data to provide more robust monitoring of HbA1c completion and control range.	Quarterly MOH Primary Care Diabetes HbA1c Monitoring reports.	We live longer in good health	Support healthier, safer and more connected communities

2.2 Financial Performance Summary

South Canterbury District Health Board Consolidated Financial Performance 2019/2020	2017/18 Audited Actual	2018/19 Forecast	2019/20 Plan	2020/21 Plan	2021/22 Plan	2022/23 Plan
Patient Care Revenue	197,572	205,521	209,700	214,383	219,468	224,556
Other Revenue	2,451	2,403	2,015	2,055	2,080	2,120
Finance Revenue	1,009	813	611	200	150	-
TOTAL OPERATING REVENUE	201,032	208,736	212,326	216,638	221,699	226,676
	-	-	-	-	-	-
Personnel Benefit Costs	65,861	68,412	70,593	71,161	73,187	75,283
Outsourced Services	8,195	10,766	9,086	9,268	9,453	9,643
Clinical Supplies	12,246	10,715	11,421	11,881	12,145	12,413
Infrastructure & Non-Clinical Supplies	9,281	9,941	9,845	9,351	9,380	9,767
Payments to Non DHB health providers	98,942	102,158	104,626	108,051	110,339	112,459
Depreciation and Ammortisation expenses	4,065	4,243	4,424	4,593	4,946	4,946
Finance Costs	38	-	-	-	-	-
Capital Charge	2,376	2,380	2,304	2,232	2,148	2,064
TOTAL OPERATING EXPENDITURE	201,004	208,615	212,299	216,537	221,598	226,576
SURPLUS/(DEFICIT)	**28**	**121**	**27**	**100**	**100**	**100**

South Canterbury District Health Board Consolidated Financial Position 2019/2020	2017/18 Audited Actual	2018/19 Forecast	2019/20 Plan	2020/21 Plan	2021/22 Plan	2022/23 Plan
Public Equity						
General Funds	16,662	16,481	16,264	16,011	15,758	15,505
Accumulated Surplus	10,205	10,326	10,353	10,453	10,553	10,653
Equity from Donated Assets	1,608	1,572	1,536	1,500	1,464	1,428
Revaluation Reserve	12,783	12,783	12,783	12,783	12,783	12,783
Total Equity	41,258	41,162	40,936	40,747	40,558	40,369
ASSETS						
Current Assets						
Cash and cash equivalents	8,311	10,003	4,203	3,203	6,003	6,003
Financial Assets	-	-	-	-	-	-
Debtors and other receivables		-	-	-	-	-
Debtors & Other Receivables	8,217	6,750	6,650	6,650	6,650	6,650
Invetories	1,061	1,170	1,170	1,170	1,170	1,170
Total Current Assets	17,589	17,923	12,023	11,023	13,823	13,823
Non Current Assets						
Financial Assets	13,713	13,634	13,925	7,340	1,147	1,147
Propert, plant and equipment	37,055	36,765	40,812	46,097	49,848	49,381
Intangible Assets	516	500	2,254	4,086	3,806	3,526
Total Non Current Assets	51,284	50,899	56,991	57,523	54,801	54,054
TOTAL ASSETS	68,873	68,822	69,014	68,546	68,624	67,877
LIABILITIES						
Current Laibilities						
Creditors and other payables	11,782	12,383	11,841	11,709	11,875	12,017
Employee Entitlements	8,819	8,671	8,765	8,634	8,735	8,735
Borrowings	-	-	-	-	-	-
Total Current Liabilities	20,601	21,054	20,606	20,343	20,610	20,752
Non Current Liabilities						
Finance Lease Laibility	506	506	506	506	506	506
Term Loans	49	-	16	-	-	-
Employee Entitlements	6,459	6,100	6,950	6,950	6,950	6,250
Total Non Current Liabilities	7,014	6,606	7,472	7,456	7,456	6,756
TOTAL LIABILITIES	27,615	27,660	28,078	27,799	28,066	27,508
NET ASSETS	**41,258**	**41,162**	**40,936**	**40,747**	**40,558**	**40,369**

South Canterbury District Health Board
Statement of Changes in Equity
2019/2020

	2017/18 Audited Actual	2018/19 Forecast	2019/20 Plan	2020/21 Plan	2021/22 Plan	2022/23 Plan
Total Equity at start of period	41,447	41,258	41,162	40,935	40,747	40,558
Net Surplus/ (Deficit) for year	28	121	27	100	100	100
Capital Movements						
Repayment to Crown	(217)	(217)	(217)	(217)	(217)	(217)
Other Movements	-	-	(36)	(71)	(72)	(72)
Total Equity at end of period	**41,258**	**41,162**	**40,935**	**40,747**	**40,558**	**40,369**

CASHFLOW & BANK
2019/2020

	1-Jul-17 Opening Balance	2017/18 Audited Actual	2018/19 Forecast	2019/20 Plan	2020/21 Plan	2021/22 Plan	2022/23 Plan
Total Receipts		196,938	208,736	211,781	216,638	221,700	226,678
Total payments		(198,080)	(204,197)	(207,958)	(206,136)	(210,687)	(222,954)
CASH FLOW FROM OPERATING ACTIVITIES		(1,142)	4,539	3,823	10,502	11,012	3,724
CASH FLOW FROM INVESTING ACTIVITIES		(2,609)	(2,847)	(9,623)	(11,502)	(8,212)	(3,724)
CASH FLOW FROM FINANCING ACTIVITIES		(490)	-	-	-	-	-
NET CASH FLOW		(4,241)	1,692	(5,800)	(1,000)	2,800	(0)
Plus: Cash (Opening)		12,552	8,311	10,003	4,203	3,203	6,003
YTD Net cash movements		(4,241)	1,692	(5,800)	(1,000)	2,800	(0)
Cash (Closing)	**12,552**	**8,311**	**10,003**	**4,203**	**3,203**	**6,003**	**6,003**

1. General Capital Expenditure

$000s	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	Total
Buildings, Plant & Equipment excl Clinical	289	295	301	307	313	320	326	332	339	346	3,169
Clinical Equipment	1,201	1,225	1,249	1,274	1,300	1,326	1,352	1,379	1,407	1,435	13,149
Other Equipments											-
IT/IS - devices/hardware	443	452	461	470	479	489	499	509	519	529	4,848
Intangible Assets (Software)	536	153	153	153	153	153	153	153	153	153	1,913
Vehicles	200	204	208	212	216	221	225	230	234	239	2,190
Contingency	255	260	265	271	276	282	287	293	299	305	2,792
Minor capital	219	223	228	232	237	242	247	252	257	262	2,398
Total General	3,143	2,812	2,865	2,920	2,975	3,031	3,089	3,148	3,208	3,269	30,459

2. Special Capital Projects

Special capital projects are targeted funding which is not available for redistribution should these projects not proceed. Explicit approval for each of these items is required before proceeding.

$000s	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	Total
Infrastructure	200	204	208	212	216	221	225	230	234	239	2,190
Dishwasker for Kitchen											-
Boilders	1,100										1,100
Morgue Chiller	150										150
Radiology	145										145
Front of Hospital Build/ Hospital Refurbishment		3,104	4,500								7,604
Emergency Upgrade	1,928										1,928
Cafeteria new	1,099	623									1,722
Outpatients Upgrade	669										669
Ambulance Bay	237										
Café-Outpatients Grounds/General areas	120	1,320									
Environmental Upgrades (Theatre Ventiliation)	200										200
Total Special	5,848	5,251	4,708	212	216	221	225	230	234	239	15,707

3. Regional/National Projects

These are regional / national projects that have been agreed. Explicit approval for each of these items is required before proceeding.

$000s	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	Total
Data Warehouse / architecture	150	-									150
E-Medication Reconciliations	51	48									99
E-Ordering Laboratory	-	64									64
E-Ordering Radiology	75	-									75
E-Pharmacy	374	-									374
E-Prescription Repository	10	-									10
E-Referrals - Stage 3 Triage	106	-									106
E-Referrals - Inter / Intra DHB	150	-									150
Growth Charts	6	-									6
MDM	12	-									12
Mental Health Module	112	-									112
Patient Track	300	-									300
Problem Lists	12	-									12
Provider Index	51	-									51
Emergency Department Solution	51	-									51
South Island PICS	1,000	2,000									3,000
National Oracle Solution (NOS) Tech 1	160										160
	2,620	2,112									4,732

SECTION THREE: Service Configuration

3.1 Service Coverage

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

Responsibility for service coverage is shared between DHBs and the Ministry. DHBs are responsible for taking appropriate action to ensure that service coverage is delivered for their population, including populations that may have high or different needs such as Māori, Pacific and high-needs groups. South Canterbury 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.

South Canterbury DHB is not seeking any formal exemptions to the Service Coverage Schedule in 2019/20.

3.2 Service Change

Change	Description of the Change	Benefits of the change	Change due to Local, Regional, or National reasons?
Laundry Services	The laundry building is earthquake prone and must be remediated within 10 years.	Due to cost associated with remediating the building to 67% of National Building Standards, SCDHB has agreed that for this service outsourcing is the best option.	Local
Maternity Services	With the cessation of the Secondary Care contract to South Canterbury Obstetrics (SCO) there is a need to review the model of care for Maternity services in South Canterbury. The rationale behind the cessation of the above contract is financial sustainability and alignment to a national consistent model of care.	Deliver a seamless transition from the SCO-supported model to a primary and secondary maternity service that has the patient at its heart. Build a model that supports the growth of the independent midwifery service in South Canterbury and strengthens the collegiality across all specialists in the maternity service. Closer alignment of the South Canterbury maternity to the nationally recognized model. Improve the financial sustainability of SCDHB maternity services.	Local
Home Based Support Services	Review of Home Based Support Services to identify areas for improvement.	Improve integration and increase efficiencies in delivery of care across the community services.	Local
Mental Health Services Review	Currently SCDHB specialist mental health and addition resources are organised into a traditional hub and spoke model, which directs flow into the mental health facility essentially creating comprehensive hospital-based services. Therefore, this change will involve transforming the service with emphasis on community-based services.	Balancing the emphasis of specialty, hospital and community based services to ensure mental health services in South Canterbury is designed to a contemporary model of care.	Local

SECTION FOUR: Stewardship

4.1 Managing our Business

Organisational performance management

South Canterbury DHB's performance is assessed using financial and non-financial metrics, which are measured and reported at operational, strategic and governance levels of the organisation. These are reported as appropriate. During 2019 SCDHB will conduct an overall review of the metrics employed, the quality of the information assembled, and the value created as the information is put to use.

Funding and financial management

South Canterbury DHB's key financial indicators are Statement of Financial Performance, Statement of Consolidated Financial Position and Statement of Changes and Equity. These are assessed against and reported through South Canterbury DHB's performance management process to operational, strategic and governance levels on a monthly basis. Further information about South Canterbury DHB's planned financial position for 2019/20 and out years is contained in the Financial Performance Summary section of this document on page 18 and in Appendix A: Statement of Performance Expectations.

Investment and asset management

All DHBs are required to complete a stand-alone Long-Term Investment Plan (LTIP) covering at least 10 years. LTIPs are part of the new Treasury system for monitoring investments across government, the Investment Management and Asset Management Performance (IMAP) system.

Shared service arrangements and ownership interests

South Canterbury DHB has 100 percentage ownership interest in South Canterbury Eye Clinic Ltd. The DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time.

Risk management

South Canterbury DHB has a formal risk management and reporting system, which entails incident management and consumer feedback management systems as well as our risk register, utilising the regional Safety 1st system. The DHB is committed to managing risk in accordance with the process set out in the Australian/New Zealand Joint Standard on Risk Management (AS/NZS ISO 31000:2009).

Quality assurance and improvement

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

SCDHB is working with the Health Quality and Safety Commission and our clinical leadership on a programme to improve the use of clinical process and outcomes information in targeted services. This effort will include a survey of all the quality information initiatives in place at present, and proposed.

South Canterbury District Health Board will report on implementing the New Zealand Business Whole-of Government Directions in its Annual Report.

4.2 Building Capability

Capital and infrastructure development

The SCDHB is undertaking refurbishment and some new buildings in the areas of emergency, outpatients, day stay services, hospital reception and the Café with a spend of $7m, which was approved by the Board in 2015. These projects commenced in the 2018/19 year and this development will continue in the 2019/20 year.

Co-operative developments

South Canterbury DHB recognises the impact of the social determinants of health and health equity. We work in partnership with a number of external public and private organisations to implement cross-agency programmes to 'support the health and independence of the people of South Canterbury'.

4.3 Workforce

Below is a short summary of South Canterbury DHB's organisational culture, leadership and workforce development initiatives. Further detail about the South Island regional approach to workforce is contained in the 2019/20 South Island Regional Service Plan.

For 2019/20 we continue to support our two overarching goals, to build SCDHB as a learning organisation and to build our community of learning professionals.

SCDHB began a cultural development programme in 2016, which continues. In 2018, we increased our investment in leadership development (through Navigate/Whakatere – our leadership learning programme), in strengthened partnerships, (particularly with our unions and consumers) and in support for a safe culture for patients and staff. In the coming year we will reinforce these organisational culture reset efforts. We will refresh our "Speaking Up" programme and extend this to our consumers, and build on Navigate by expanding into Navigate Teams and applying a cultural lens to the programme content. Our commitment to strong union engagement through our Joint Consultation Committee and Bi-Partite forums will continue as will progress with High Performance High Engagement (HPHE) activities in partnership with New Zealand Nurses Organisation, the Public Service Association and ETu. To expand the exposure of the HPHE concepts beyond staff involvement in key projects, and to ensure that distributive leadership is more widely visible and accessible, we will introduce the concept of "Engaged Teams" (HPHE everyday) into some pilot services by Q1.

A Focus on Learning & Improvement

As part of our culture programme we will continue to expand our leadership community, reaching more actively into the Primary and NGO sector with Navigate offerings to the wider sector.

'Navigators' (graduates from the programme) will increasingly champion our emphasis on high performance teams. A combination of "Team Navigate", the development of simulation methodology in formal training and HPHE every day, is set to reinforce high performance teams who make continuous adjustments, celebrate successes and direct resources and attention into service metrics which matter the most.

Building a diverse and capable workforce

We will embed our cultural competency framework to ensure our workforce is prepared to deliver equity and value in terms of health outcomes for our community. We will expand our WISH programme (schools experience programme in health careers) to work in partnership with community networks, to improve awareness and promotion of health career pathways for Maori and Pacific students. We will also extend our cultural supervision opportunities for new staff who identify as Maori to improve cultural connectedness for this key part of our workforce.

High standards of medical practice, education and training are a key priority for SCDHB. We employ prevocational

doctors and doctors in training, and also offer placements to medical students in both secondary and primary care settings. SCDHBs mission is to ensure that every RMO is provided with the education, supervision and pastoral support necessary to complete all MCNZ and SCDHB requirements to the highest standard, and to ensure the successful transition from prevocational training to their desired vocational college. Our vision is to be a centre of excellence in the provision of innovative medical education and training in conjunction with RMO support and development.

We will continue to drive simulation activities (within community and primary settings and in both clinical and non-clinical areas) as a key learning methodology for interdisciplinary team work capability development. In the current year we will be adding the Network Z programme in partnership with ACC to our simulation suite of programmes.

4.3.1 Healthy Ageing Workforce

We will continue to work as part of the region to support the non DHB aged care workforce data collection being undertaken by DHB Shared Services and the Ministry of Health as part of the role out of pay equity.

We will also support the work of the Ministry of Health to ensure that those working with older people with long-term conditions have the training and support they require to deliver high-quality, person-centred care in line with a healthy ageing approach. This includes work to regularise and improve training of the kaiāwhina workforce in home and community support services using the Calderdale Framework principles.

Our focus in the 2019/20 year will be progressing training packages to enhance the capacity and capability of the kaiāwhina workforce to support people with long term conditions and their families and whanau as part of the regional action plan.

4.3.2 Health Literacy

We will continue to build skills in health literacy practice among the health workforce across the health system. A key element of this will be expansion of the "Choosing Wisely" programme from primary care into our secondary services in the 2019/20 year. To enhance equity, we will refresh our cultural competency framework, following learnings from 2018/19 and continue to offer tools training in 'difficult conversations' for clinical staff as well as high level communications skills development through our leadership learning (Navigate) programme. We will also seek to better understand the level of health literacy (defined as the ability to read, comprehend and take action on their own health information) amongst targeted high need populations, through our Consumer Council led community engagement initiative.

4.4 IT

Developing a local Information Technology (IT) Strategy is one of the DHB's 15 strategic priorities as outlined in its strategic direction document and will be developed to align to the New Zealand Digital Health Strategy.

SCDHB will work to improve the digital capabilities within the organisation and continue to actively engage in the roll out of the South Island IT Alliance work programme. Further detail is contained in Te Waipounamu - South Island Health Services Plan 2018-2021.

The DHB plans to implement Application Portfolio Management including the lifecycle for IT systems (i.e., planned upgrades, support and licence renewal, etc.).

In addition, the DHB will also look to increase the utilisation of telehealth solutions between South Canterbury and tertiary care providers in neighbouring DHBs.

4.5 Care Capacity Demand Management

There has been immense progress made with regards to CCDM in the 2018/19 year and this will continue into the 2019/20 year. The following activity is expected to progress over the next 12 months:

- Development of local data councils in every clinical service.
- Development and implementation of the allied health core data set to inform staffing methodology.
- Continued governance over additional funding received to support immediate staffing relief and CCDM implementation.
- Development of a standardised dashboard reflecting clinical service core data set.
- Undertake staffing methodology FTE calculations using CCDM software where the trendcare gold standard quality checks enable.

SECTION FIVE: Performance Measures

5.1 2019/20 Performance Measures

Performance measure		Performance Expectation		
CW01	**Children caries free at 5 years of age**	Year 1	67%	
		Year 2	67%	
CW02	**Oral health: Mean DMFT score at school year 8**	Year 1	0.75	
		Year 2	0.75	
CW03	**Improving the number of children enrolled and accessing the Community Oral health service**	Children (0-4) enrolled	Year 1	≥95%
			Year 2	≥95%
		Children (0-12) not examined according to planned recall	Year 1	≤10%
			Year 2	≤10%
CW04	**Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years**	Year 1	>85%	
		Year 2	>85%	
CW05	**Immunisation coverage at eight months of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over**	95% of eight month olds fully immunised.		
		95% of five year olds have completed al age appropriate immunisations due between birth and five years of age.		
		75% of girls and boys fully immunised – HPV vaccine.		
		75% of 65+ year old's immunised – flu vaccine.		
CW06	**Child Health (Breastfeeding)**	70% of infants are exclusively or fully breastfed at three months.		
CW07	**Newborn enrolment with General Practice**	55% of newborns enrolled in General Practice by 6 weeks of age.		
		85% of newborns enrolled in General Practice by 3 months of age.		
CW08	**Increased immunisation at two years**	95% of two year old's have completed all age appropriate immunisations due between birth and age two years.		
CW09	**Better help for smokers to quit (maternity)**	90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.		
CW10	**Raising healthy kids**	95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.		
CW11	**Supporting child wellbeing**	Provide report as per measure definition.		
CW12	**Youth mental health initiatives**	Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement *Youth Health Care in Secondary Schools: A framework for continuous quality improvement* in each school (or group of schools) with SBHS.		
		Initiative 3: Youth Primary Mental Health.		
		Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population.		
CW13	**Reducing rheumatic fever**	Reducing the Incidence of First Episode Rheumatic Fever to 0.2 per 100,000 (Southern region)		

MH01	**Improving the health status of people with severe mental illness through improved access**	Age (0-19) Maori, other & total	5%
		Age (20-64) Maori, other & total	5%
		Age (65+) Maori, other &total	2%
MH02	**Improving mental health services using wellness and transition (discharge) planning.**	95% of clients discharged will have a quality transition or wellness plan.	
		95% of audited files meet accepted good practice.	
MH03	**Shorter waits for non-urgent mental health and addiction services**	Mental health provider arm	80% of people seen within 3 weeks.
			95% of people seen within 8 weeks.
		Addictions (Provider Arm and NGO)	80% of people seen within 3 weeks.
			95% of people seen within 8 weeks.
MH04	**Rising to the Challenge: The Mental Health and Addiction Service Development Plan**	Provide reports as specified	
MH05	**Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders**	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.	
MH06	**Output delivery against plan**	Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.	
PV01	**Improving breast screening coverage and rescreening**	70% coverage for all ethnic groups and overall.	
PV02	**Improving cervical screening coverage**	80% coverage for all ethnic groups and overall.	
SS01	**Faster cancer treatment – 31 day indicator**	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	
SS02	**Ensuring delivery of Regional Service Plans**	Provide reports as specified.	
SS03	**Ensuring delivery of Service Coverage**	Provide reports as specified.	
SS04	**Delivery of actions to improve Wrap Around Services for Older People**	Provide reports as specified.	
SS05	**Ambulatory sensitive hospitalisations (ASH adult)**	0-4	0-4 <or=4195
		45-64	3,331/100,000
SS06	**Better help for smokers to quit in public hospitals (previous health target)**	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.	Only applies to specified DHBs – N/A
SS07	**Planned Care Measures**		
	Planned Care Measure 1: *Planned Care Interventions*	4488	
	Planned Care Measure 2: *Elective Service Patient Flow Indicators*	ESPI	100% (all) services report yes (that more than 90% of referrals within the services are processed in 15 calendar days or less)
		ESPI 2	0% - no patients are waiting over four months for FSA.
		ESPI 3	0% - zero patients in Active Review with a priority score above the actual Treatment Threshold (aTT).

		ESPI 5	0% - zero patients are waiting over 120 days for treatment.	
		ESPI 8	100% - all patients were prioritized using an approved national or nationally recognized prioritization tool.	
	Planned Care Measure 3: *Diagnostics Waiting Times*	Coronary Angiography	95% of patients with accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days).	
		Computed Tomography (CT)	95% of patients with accepted referrals for CT scans will receive their scan, and the scan results are reported within 6 weeks (42 days).	
		Magnetic Resonance Imaging (MRI)	90% of patients with accepted referrals for MRI scans will receive their scan, and the scan results are reported within 6 weeks (42 days).	
	Planned Care Measure 4: *Ophthalmology Follow up Waiting Times*	No patient will wait more than or equal to 50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service.		
	Planned Care Measure 5: *Cardiac Urgency Waiting Times.*	Not applicable for South Canterbury DHB.		
	Planned Care Measure 6: *Acute Readmissions*	9.8%		
SS08	**Planned Care three year plan**	Provide reports as specified.		
SS09	**Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections**	Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error	Group C >1.5% and <= 6%
			Recording of non-specific ethnicity in new NHI registration	>0.5% and < or equal to 2%
			Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% and < or equal to 2%
			Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and < or equal to 85%
			Invalid NHI data updates	Still to be confirmed
		Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC, NBRS and NMDS for FSA and planned inpatient procedures.	Greater than or equal to 90% and less than 95%
			National Collections completeness	Greater than or equal to 94.5% and less than 97.5%

			Assessment of data reported to the NMDS	Greater than or equal to 75%
		Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)		Provide reports as specified
SS10	**Shorter stays in Emergency Departments**	95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.		
SS11	**Faster Cancer Treatment (62 days)**	90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.		
SS12	**Engagement and obligations as a Treaty partner**	Reports provided and obligations met as specified.		
SS13	**Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)**	Focus Area 1: Long term conditions	Report on actions to: Support people with LTC to self-manage and build health literacy.	
		Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care.*	
			Ascertainment: target 95-105% and no inequity HbA1c<64mmols: target 60% and no inequity No HbA1c result: target 7-8% and no inequity	
		Focus Area 3: Cardiovascular health	Provide report as per deliverables.	
		Focus Area 4: Acute heart service	**Indicator 1: Door to cath** - Door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram**.**	
			Indicator 2a: Registry completion- >95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and **Indicator 2b:** ≥ 99% within 3 months.	
			Indicator 3: ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (i.e. have had an echocardiogram or LVgram).	
			Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance >85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge - - Aspirin*, a 2nd anti-platelet agent*, statin and an ACEI/ARB (4 classes), and - LVEF<40% should also be on a beta-blocker (5-classes). ** An anticoagulant can be substituted for*	

			one (but not both) of the two anti-platelet agents.
			Indicator 5: Device registry completion - ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS Q1 Device forms within 2 months of the procedure.
		Focus Area 5: Stroke services	**Indicator 1** ASU: 80% of stroke patients admitted to a stroke unit or organised stroke service, with a demonstrated stroke pathway.
			Indicator 2 Thrombolysis: 10% of potentially eligible stroke patients thrombolysed 24/7.
			Indicator 3: In-patient rehabilitation: 80% patients admitted with acute stroke who are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission.
			Indicator 4: Community rehabilitation: 60 % of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.
SS15	**Improving waiting times for Colonoscopy**	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less 100% within 30 days or less.	
		70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less.	
		70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less.	
		95% of 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.	
SS16	**Delivery of collective improvement plan**	tbc	
SS17	**Delivery of Whānau ora**	Provide reports as specified.	
PH01	**Delivery of actions to improve system integration and SLMs**	Provide reports as specified.	
PH02	**Improving the quality of ethnicity data collection in PHO and NHI registers**	Provide reports as specified.	
PH03	**Access to Care (PHO Enrolments)**	Meet and/or maintain the national average enrolment rate of 90%.	
PH04	**Primary health care: Better help for smokers to quit (primary care)**	90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.	
Annual plan actions – status update reports		Provide reports as specified.	

APPENDIX A: System Level Measures Improvement Plan

APPENDIX B: Public Health Unit Plan