South Canterbury
District Health Board

The South Canterbury District Health Board

# Annual Plan

2014-2015

*Enhancing the health and independence of the people of South Canterbury*

**www.scdhb.health.nz**

**Office of Hon Tony Ryall**

Minister of Health
Minister for State Owned Enterprises

2 JUL 2014

Mr Murray Cleverley
Chair
South Canterbury District Health Board
Private Bag 911
TIMARU 7940

Dear Mr Cleverley

**South Canterbury District Health Board 2014/15 Annual Plan**

This letter is to advise you I have approved and signed South Canterbury District Health Board's (DHB) 2014/15 Annual Plan for three years.

I appreciate the significant work that goes into preparing your Annual Plan and I thank you for your effort. I look forward to seeing your progress over the course of the year.

While recognising these are tight economic times, the Government is dedicated to improving the health of New Zealanders and continues to invest in key health services. In Budget 2014, Vote Health again received the largest increase in government spending, demonstrating the Government's on-going commitment to protecting and growing publicly funded health services.

***Better Public Services (BPS): Results for New Zealanders***
Of the ten whole-of-government key result areas, the health service is leading these result areas:

- increased infant immunisation
- reduced incidence of rheumatic fever
- reduced assaults on children.

It is important that DHBs continue to work closely with other social sector organisations, including NGOs, on initiatives including Whanau Ora, Children's Action Plan and Youth Mental Health.

***National Health Targets***
Your plan generally includes a good range of actions that will lead to improved or continued performance against the health targets. As you are aware, there will be one new addition to the target set for 2014/15. From quarter two, the 62 day Faster Cancer treatment indicator will become the cancer health target with a target achievement level of 85% by July 2016. I look forward to seeing your progress during the year.

South Canterbury DHB is performing well in most health target areas however, I am asking all DHBs to focus on ensuring appropriate actions are implemented to support immunisation service delivery.

***Improving Quality***
I understand guidance on Quality Accounts for 2014 was recently provided by the Health Quality and Safety Commission. My expectation is that the presentation of your quality accounts will follow as closely as possible to the release of your Annual Report. I expect that

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quality improvement initiatives will include evidence based staffing practice that accurately matches staffing resource to demand for patient care.

***Care Closer to Home***
I am pleased to see an enhanced commitment to tangible actions in your Annual Plan demonstrating how you will broaden the scope of diagnostic and treatment services directly accessible to primary care. I look forward to seeing the results of your work to improve the breadth of services with direct access from primary care.

It is also important that the development of rural service level alliance teams (SLATs) progresses during the year. It is expected that a rural SLAT is established by the end of quarter one and the SLAT develops and agrees a plan for the distribution of rural funding in accordance with the PHO Services Agreement Version 2 (July 2014).

***Health of older people***
The Government expects DHBs to continue to work regionally, and alongside clinical leaders, primary care, and community care to deliver integrated services and improve the quality of the care that older people receive.

This year, the Government is particularly focused on achieving results through your commitments to:

- continue implementing dementia care pathways
- support aged residential care facilities to use interRAI
- use health of older people specialists to advise and train health professionals in primary and aged residential care
- improve rapid response and discharge management services.

In addition, I am pleased with your commitments to continuing to implement your fracture liaison service, continuing price or volume increases in home and community support services, and using interRAI-based quality indicators.

***Regional and National Collaboration***
Greater integration between regional DHBs supports more effective use of clinical, financial and other resources, such as technology. I expect DHBs to make significant contributions to delivering on regional planning objectives; and to priorities specific to your region that will contribute to your financial and clinical sustainability. This requires sharing of expertise as a region and working together to realise the benefits of regional and sub-regional collaboration. I look forward to seeing delivery on your agreed Regional Service Plan actions.

Guidance on national entity priorities was provided to all DHBs in February 2014, for inclusion in Annual Plans, following the completion of the Health Sector Forum lead work between the Ministry, national entities and DHBs. DHBs have committed to work in partnership with HBL to progress its Food Services, Linen and Laundry Services and National Infrastructure Platform business cases; and to factor in benefit impacts for HBL's Finance Procurement Supply Chain Initiative (FPSC), where these are available. I expect that your DHB will deliver on these business cases within your bottom line.

***Living within our means***
DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance in order to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of your DHB's operation and service delivery. Improvements through national, regional and sub-regional initiatives are expected to continue to be a key focus for all DHBs.

I am pleased to see that your DHB is planning net surpluses for the four years of the plan and I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result for 2014/15.

***Budget 2014***

The expectation is that you will deliver on Budget 2014 initiatives. This includes extending free doctors' visits and prescriptions for children aged under six years to all children aged under 13 years from July 2015.

***Annual Plan Approval***

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the NHB. All service changes or service reconfigurations must comply with the requirements of the Operational Policy Framework. The NHB will contact you where change proposals need further engagement or are agreed subject to particular conditions. You are reminded that you need to advise the NHB of any proposals that may require Ministerial approval as you review services during the year.

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 2014/15 Annual Plan. I am looking 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 Tony Ryall
**Minister of Health**

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# CHAPTER 1: INTRODUCTION & STRATEGIC INTENTIONS

## 1.1 Executive Summary

The South Canterbury District Health Board (SCDHB) will continue to progress a number of initiatives to ensure the future sustainability of health services in South Canterbury. In our 2014/15 Annual Plan the SCDHB continues to achieve fiscal sustainability, maintain high levels of access to services across the continuum of services and high quality standards evidenced by consistent achievement through accreditation and certification processes, as well as maintaining low staff vacancy and turnover rates. We enjoy high confidence from our community and upper quartile performance in most of the indicators which DHBs are measured against including the national health targets. We are continuing to work actively locally, regionally and nationally to ensure that this performance is maintained and to develop and deliver integrated health and disability services for our population.

The SCDHB is committed to contributing to the Government's key aims of New Zealanders living longer, healthier and more independent lives, continuing economic growth and to the Governments Better Public Services.

The SCDHB faces a range of challenges which centre on a number of factors including:

- Maintaining and enhancing the level of access to health and disability services our community enjoys given the changes to our population projections following the 2013 census;
- Ensuring and enhancing the quality and safety of the services we both fund and deliver;
- Developing an integrated health system which supports seamless patient journeys;
- Supporting the existing health and disability workforce and creating a sustainable health workforce for the future;
- Achieving greater productivity and efficiency gains to enable reinvestment in the South Canterbury health system; and
- Upgrading our facilities to meet the changing requirements of changed models of care.

SCDHB continues to participate in the development of South Island wide services and to ensure the DHB is well placed to meet these challenges. Government priorities, the South Island Regional Health Services Plan, the South Canterbury Health Service Plan, the SCDHB Workforce Development Plan and the Facilities Master Plan underpin the development of the DHB Annual Plan. These plans are inter-woven and provide the direction of travel and guidance for the South Canterbury health system development and prioritisation of resources and activity in 2014/15 and out years.

This Annual Plan which is a legal requirement and is the primary accountability document between the Minister of Health and SCDHB is informed by:

- The Minister's Letter of Expectation, Appendix 1;
- The Government's priorities;
- The South Island Regional Health Service Plan; and
- Local priorities.

## 1.2 DHB Scope of Operations

SCDHB is one of 20 District Health Boards (DHBs) that were established under the Health and Disability Act 2000 and is the Government's funder and provider of public health services for the 55,626[1] people resident in the South Canterbury District.

DHB objectives[2] are to improve, promote and protect the health, wellbeing and independence of our population and to ensure effective and efficient care of people in need of health services or disability support services. Our mission statement is "Enhancing the health and independence of the people of South Canterbury"[3] and to achieve this we work with our consumers, our communities, health and disability service

[1] *Usually resident population - Statistics New Zealand for 2013*

[2] *DHB performance objectives are specified in section 22 of the NZPHD Act*

[3] *Independence related to enabling people with disabilities to fully participate in society*

providers and other agencies to ensure the quality, safety and coordination of health and disability services for our population.

## 1.3 Funding and Provision of Services

DHBs are allocated funding on a national Population Based Funding Formula. South Canterbury has a very stable population (neither growing nor declining significantly). We have one of the highest percentages of population over 65 years which will continue to place unique pressures on us. South Canterbury will receive a 1.5% increase in funding in 2014/15 including transition funding of $581K. This is the lowest percentage increase allocated to any DHB which has resulted in the requirement to seek further efficiencies in our resource allocation to ensure we are able to submit and then deliver against a fiscally sustainable plan. Within the 1.5% increase in funding we will receive 0.61% contribution to cost pressures and additional demographic funding amounting to a 0.89% increase in our funding which is 1.47% of the total devolved health funding that the government allocates directly to DHBs.

We will again meet our Annual Plan through continuing to make Value for Money an intrinsic component of all service development and delivery and through a number of efficiencies and productivity initiatives and line by line review of funding allocations.

SCDHB will work actively with Health Benefits Limited (HBL) through its programme to deliver efficiencies from back office functions and infrastructure over a five year period. We are committed to engage in any initiative that contributes to this objective; however this plan assumes that any initiative will deliver a net gain financially.

In 2014/15 we will earn an additional $9.198M from other sources such as MOH direct funding (outside the funding envelope), ACC, interest income, sale of goods and other commercial activities such as laundry and Talbot Park.

The DHB's strategy, planning and accountability role has oversight and responsibility for:

- Driving strategic direction;
- Oversight of planning;
- Funder role; and
- Maintaining accountability.

This role includes working with services to plan and implement service development which reflects our strategic direction and includes funding and monitoring performance of all health services we fund for the people of South Canterbury including Secondary Services, Primary and Community Services, Non- Government organisations or other DHBs through Inter District Flows.

The Funder faces cost pressures from demand within secondary services and primary and community services and also faces significant risk in Inter District Flows and in increased demand for DSS services for older people (aged related residential care and home and community support services). The DHB will utilise $22K from our mental health ring fence and $300K from our primary care ring fence in the 2014/15 year.

DHBs have been advised that Annual Plans should be prepared using the planning assumption that funding increases in out years will be of the same nominal value as that contained in the 2014/15 funding envelope and while that assumption does place pressure on the DHB to continue to live within its means this Annual Plan has been prepared on that basis.

We are able to reinvest funding in 2014/15 derived from efficiencies in enhanced service provision and quality initiatives in:

- Primary care initiatives targeted at integrated service development;
- Developing one point of entry to health and support services for older people and to the development of integrated and coordinated services in South Canterbury – implementing the outcomes from the Centre of Excellence for Health of Older Persons project undertaken in 2013;
- Regional alliance health action plans;
- Regional alliance IT initiatives including e-Prescribing, e-Medicine Management, e-Dispensing, e-Shared Care Record View, South Island Patient Administration System, Advance Care Plans, Patient Portal;

- Vulnerable children; and
- Care Capacity Demand Coordination.

Primary and Community Services includes the role of a Primary Health Organisation (PHO) and other DHB provided community services. This structure has provided the platform for the development of integrated health services and in 2014/15 we will be consolidating progress to date and increasing the services being delivered in primary care, further increasing access to diagnostic services in conjunction with Aoraki HealthPathways development.

Secondary Services includes the services provided by Timaru Hospital and Talbot Park (an aged residential care hospital and psychogeriatric level facility for older people). Timaru Hospital provides 24 hour 7 day a week acute medical and surgical services, maternity, neo-natal and paediatric services, mental health services and also provides Assessment Treatment and Rehabilitation (ATR) services. It also provides a range of tertiary services through visiting clinicians and outreach services.

Primary & Community Services and Secondary Services outputs in 2014/15 are set out in the DHB's Summary Production Plan which is Appendix 3 to this Annual Plan.

SCDHB is committed to maintaining the same range of services and level of access to services identified in this plan and ensuring continued emphasis on improving the quality and safety of services provided while balancing this against ensuring efficiency and productivity gains are maximised. We are also committed to the national elective service requirements and to meet the new health targets for Elective Service Performance Indicators (ESPIs) and the faster cancer treatment target times. We will also work with the Southern Cancer Network Alliance and Elective Services work stream to implement regional service plans for cancer and elective services.

We have no plans to exit or significantly alter any services and to prioritise service access based on clinical need and will work with South Island DHBs towards achieving equitable access to services across the South Island.

Our South Canterbury Public Health Plan for 2014/15, developed by Public and Community Health (Canterbury DHB) in conjunction with the South Canterbury DHB and other health promotion providers in South Canterbury is attached as Appendix 4 to this Plan. This joint planning enables a whole of system approach to developing integrated models of care i.e. to include public health and health promotion in the development of all models of care and to ensure our investment in health promotion is coordinated and contributing to achieving improved outcomes for our population.

## 1.4 Purchasing of Services

In order to deliver new health services and programmes described in our Annual Plan, and to continue to deliver the range of health services which we must provide, or provide access to for our population under our Service Coverage Schedule obligations, we will enter into Service Agreements with a range of primary health providers and NGOs for the provision of services and planned activities to be delivered in accordance with this Annual Plan.

## 1.5 Treaty of Waitangi

**DHB's responsibilities to Māori**
Through our Māori Consultation Framework which is used by our Iwi/Māori Health Relationship Partners and our organisation we will ensure Māori participation and partnership in health planning, service design, development and delivery, and in the protection of Māori well-being. Our Māori Health Plan for 2014/15 includes national and local Māori health priorities. We are committed to our statutory obligations to Māori under the NZ Public Health & Disability Act and we are advised by our Māori Health Advisory Committee.

**Investment in Māori Services**
As an agent of the Crown we are committed to the principles of the Treaty of Waitangi and we will continue to maintain our investment in Māori Provider services and in mainstream services provided for Māori in 2014/15.

## 1.6 Population Profile

**Figure 1: Population Profile**

South Canterbury District Health Board

# What the 2013 Census Tells Us

The census was held on the 5th of March 2013, two years after it was cancelled as a result of the 2011 Christchurch earthquake and seven years after the previous census. The census is a snapshot in time that indicates how the profile of our population is changing. Consideration of these changes is crucial to the planning of future health services in South Canterbury.

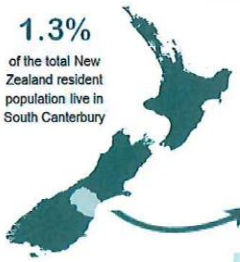
**55,626 residents**

**3.2%** increase in the number of residents in South Canterbury since 2006.


**20.4%** of our population are aged 65 years or older.

**7.2 %** of our population are **Māori**

**1.3%** of the total New Zealand resident population live in South Canterbury



**79%** of our population live in the Timaru District.

**7%** live in the Mackenzie District.

**14%** live in the Waimate District.

**16.2%** of those aged 15 years or older are regular smokers, down from 21.2% in 2006.

**16.2%**

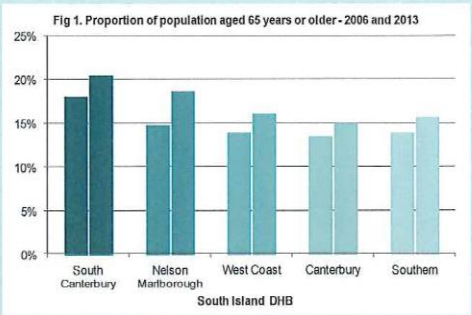
2% decrease in the number of families with dependent children.

1.3% increase in the number of one parent families with dependent children.

### Our Aging Population

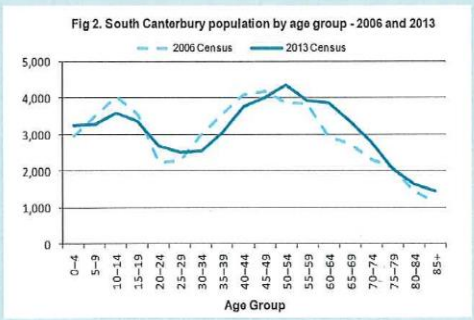
South Canterbury's resident population has increased by 3.2% since 2006. We are continuing to see our older residents making up a greater proportion of our population. 20.4% of our population are now aged 65 years or older. This is the highest proportion of any DHB in the country.

Figure 1 illustrates our aging population in comparison to other South Island DHBs:




There has been a decrease in the number of younger people in South Canterbury since 2006. Whilst there has been an increase of 291 children aged 0-4 years, there has been a decrease of 864 young people aged between 5-19 years. There are now 2.1% fewer families with dependent children in South Canterbury than in 2006.

Figure 2 illustrates the makeup of our population by age group:

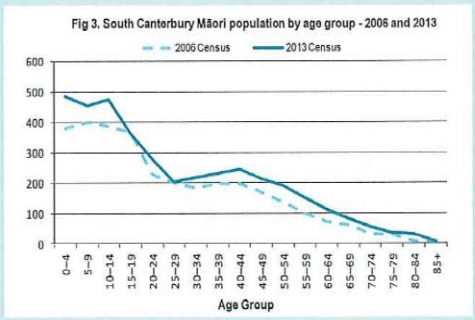



### What We Do Not Know

***Updated population projections and estimates***

The current Statistics New Zealand population projections are still based on the 2006 Census results. Projections based on the 2013 Census results will not be made available until December 2014. The current Statistics New Zealand population estimates (which our funding is based on) are also still based on the 2006 Census results. Updated population estimates will be made available in August 2014.

### Ethnicity




South Canterbury's population has become more diverse since 2006. 7.2% of our population are Māori, up from 6% in 2006. Despite this, South Canterbury still has the lowest proportion of Māori of any South Island DHB. As Figure 3 demonstrates, our Māori population are much younger than our total population. 38% of South Canterbury Māori identify as Ngāi Tahu/Kāi Tahu.

South Canterbury has also seen increased proportions of Pacific and Asian ethnicities. 1.1% of our population identify as Pacific ethnicity, up from 0.8% in 2006. 2.5% of our population identify as an Asian ethnicity, up from 1.5% in 2006.

Data source: Statistics New Zealand, Census of Population and Dwellings, 2013

## 1.7 Strategic Context

Populations are ageing, long-term conditions are becoming more prevalent and the needs of vulnerable populations are escalating. As people's conditions become more complex, the care required is more costly in terms of time, resources and dollars.

Although DHBs may differ in size, structure and approach, they all have a common goal: to improve the health and wellbeing of their populations by delivering high quality and accessible health care. With increasing demand for services, workforce shortages and rising costs, this is increasingly challenging and the health system faces an unsustainable future.

To ensure the sustainability of the health system, DHBs need to shift their population's health needs away from the complex end of the continuum of care and support more people to stay healthy and well.

In 2010 the National Health Board released *Trends in Service Design and New Models of Care*. This document provided a summary of international responses to the same pressures and challenges facing the New Zealand health sector, to help guide DHB service planning.[4]

International direction emphasises that an aligned, 'whole of system' approach is required to ensure service sustainability, quality and safety while making the best use of limited resources. This entails four major shifts in service delivery:

1. Early intervention, targeted prevention and self management and a shift to more home-based care;
2. A more connected system and integrated services, with more services provided in community settings;
3. Regional collaboration clusters and clinical networks, with more regional service provision; and
4. Managed specialisation, with a shift to consolidate the number of tertiary centre/hubs.

Hospitals continue to be a key support and a setting for highly specialised care, with the importance of timely and accessible care being paramount. However, less-complex care (traditionally provided in hospital settings) is increasingly being provided in the community.

The focus is shifting towards supporting people to better manage their own health and to stay well, with the support of connected and integrated clinical networks and multidisciplinary teams.

## 1.8 National Direction

These international shifts are consistent with the changes being driven across the New Zealand health system to meet the Government's commitment to providing *'better, sooner, more convenient health services'.*[5]

At the highest level DHBs are guided by the New Zealand Health Strategy, Disability Strategy, and Māori Health Strategy (He Korowai Oranga) and by the requirements of the New Zealand Public Health and Disability Act - with the ultimate health sector outcomes being that:

- All New Zealanders lead longer, healthier and more independent lives; and
- The health system is cost effective and supports a productive economy.

DHBs are expected to contribute to meeting health sector outcomes and Government commitments by: increasing access to services and reducing waiting times; improving quality, patient safety and performance; and providing better value for money**.**

Alongside these longer-term national strategies and commitments; the Minister of Health's 'Letter of Expectations' also signals annual priorities for the health sector – most specifically with regards to the delivery of better public services and the delivery of the six national health targets.

The South Canterbury District Health Board is committed to making continued progress against national priorities and health targets and activity planned over the coming year to deliver on national expectations is outlined in Chapter 2 of this document.

[4] *Trends in Service Design and New Models of Care: A Review, 2010, Ministry of Health, www.nationalhealthboard.govt.nz.*

[5] *John Key, National Party Health Discussion Paper 2007.*

## 1.9 Regional Direction

In delivering its commitment to '*better, sooner, more convenient health services*' the Government also has clear expectations of increased regional collaboration and alignment between DHBs.

The South Island Alliance was established in 2011 to formalise the partnership between the five South Island DHBs. In 2013 it was agreed to further develop the approach with a framework that ensures all regional activity aligns to agreed goals. The '*best for patients, best for system*' framework has become '*Best for People, Best for System'* supporting a focus on the whole population. The shared vision has also been revised to include disability to ensure key population groups are identified within the framework.

**Our regional vision is a sustainable South Island health and disability system focused on keeping people well and providing equitable and timely access to safe, effective, high-quality services, as close to people's homes as possible.**

While each DHB is individually responsible for the provision of services to its own population, working regionally enables them to better address their shared challenges and support improved patient care and more efficient use of resources. The South Island DHBs are committed through the Alliance to make the best use of all available resources, strengthen clinical and financial sustainability and increase access to services for the South Island population.

Canterbury, Nelson Marlborough, West Coast, South Canterbury and Southern DHBs form the South Island Alliance - together providing services for 1,004,380 people (23.7%) of the total NZ population.

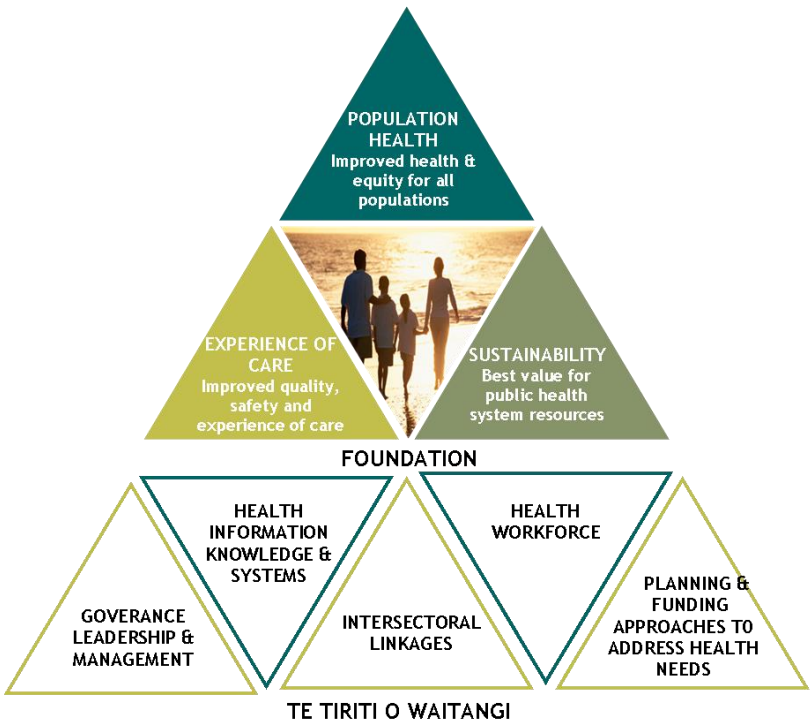
The success of the Alliance relies on improving patient flow and the coordination of health services across the South Island by aligning patient pathways, introducing more flexible workforce models and improving patient information systems to better connect the services and clinical teams involved in a patient's care.

Closely aligned to the national direction the shared outcome goals of the South Island Alliance are:

- Improved health and equity for all populations;
- Improved quality safety and experience of care; and
- Best value for public health system resources.

To help ensure success, regional activity is implemented through service level alliances and workstreams based around priority service areas. The work is clinically led, with multidisciplinary representation from community and primary care, as well as hospital and specialist services and consumers involvement.

Seven service areas have been prioritised: Cancer, Child Health, Health of Older People, Mental Health, Information Services, Support Services and Quality and Safety.




Regional activity will also focus on: cardiac, elective surgery, neurosurgery, public health, stroke and major trauma services. Regional asset planning and workforce planning, through the South Island Regional Training Hub, will contribute to improved delivery in all service areas.

All South Island DHBs are involved in the majority of the service level alliances and work streams and lead at least one priority area. Each DHB's commitment in terms of the regional direction is outlined in Chapter 2 of this document. The Regional Health Services Plan is available from the South Island Alliance website: www.sialliance.health.nz.

## 1.10 Local Direction

In reviewing the South Canterbury Health Service Plan for the SCDHB our initial five priorities have been extended to seven service priorities:

- Promotion of healthy lifestyle choices in our local population and targeted prevention;
- Identification and early interventions for "at risk" populations;
- Management of Long Term Conditions which focuses on self-management strategies;
- Integration of services to support seamless patient flows;
- Sustainable secondary services;
- Development of child and youth services; and
- Coordinated services for older people.

During 2014/15 the SCDHB will continue to build on progress to date and will undertake a number of initiatives to support and facilitate the ongoing development of integrated models of care. This will include revising Allied Health and Clinical Nurse Specialist roles to ensure alignment with integrated models of care and developing an ambulatory model of care to facilitate integration between primary and secondary care. The SCDHB will also continue to implement regional IT projects in accordance with the South Island Alliance IT Plan and Aoraki HealthPathways. Our DHB structure with Primary and Community Services as part of the DHB continues to support and facilitate the integration of services. Primary and Community Services is an integral part of the health service development in South Canterbury and participates strongly in the governance, management and delivery of health services.

Integrated service development in 2014/15 will focus on child and youth health, long term conditions, and coordinated services for older people including the implementation of the recommendations of the Centre of Excellence for Health of Older Peoples services completed in 2013. The development of integrated service models for child and youth services is being undertaken across primary and secondary health services and includes work with all other agencies providing services for children and youth.

The SCDHB Clinical Board which covers primary and secondary governance is leading the DHB's development of clinical governance and quality and safety improvement for the DHB. Quality and safety improvement initiatives are being pursued at a local level and we are actively participating in the South Island Quality and Safety Service Level Alliance.

## 1.11 Signatories

**AGREEMENT DATED THIS DAY OF 2014**

(Made under section 39 (1) of the New Zealand Public Health and Disability Act 2000)

**BETWEEN**

_____
**Honourable Tony Ryall**
**Minister of Health**

_____
**Murray Cleverley**
**Chairman of the Board**

_____
**Nigel Trainor**
**Chief Executive Officer**

_____
**Ron Luxton**
**Deputy Chairman of the Board**

## 1.12 Improving Health Outcomes for our Population

### What are we trying to achieve?

DHBs are expected to deliver against the national health sector outcomes: "*All New Zealanders lead longer, healthier and more independent lives*" and '*The health system is cost effective and supports a productive economy*' and to meet Government commitments to deliver '*better, sooner, more convenient health services*'.

As part of this accountability DHBs need to demonstrate whether they are succeeding in meeting those commitments and in improving the health and wellbeing of their populations. There is no single measure that can demonstrate the impact of the work DHBs do, so a mix of population health and service access indicators are used as proxies to demonstrate improvements in the health status of the population and the effectiveness of the health system.

In developing its strategic framework, the South Island DHBs identified three strategic regional outcome goals. To achieve these goals they have agreed a number of key strategies which will be achieved through the delivery of regional initiatives and the collective activity of all five South Island DHBs. A comprehensive indicator set is currently under development, to sit alongside the regional strategic framework and enable evaluation of regional activity.

While the regional framework is developed, the South Island DHBs have identified four collective outcomes where individual DHB performance will contribute to regional success - along with a core set of associated outcomes indicators, which will demonstrate whether they are making a positive change in the health of their populations. These are long-term outcome indicators (5-10 years in the life of the health system) and as such, the aim is for a measurable change in health status over time, rather than a fixed target.

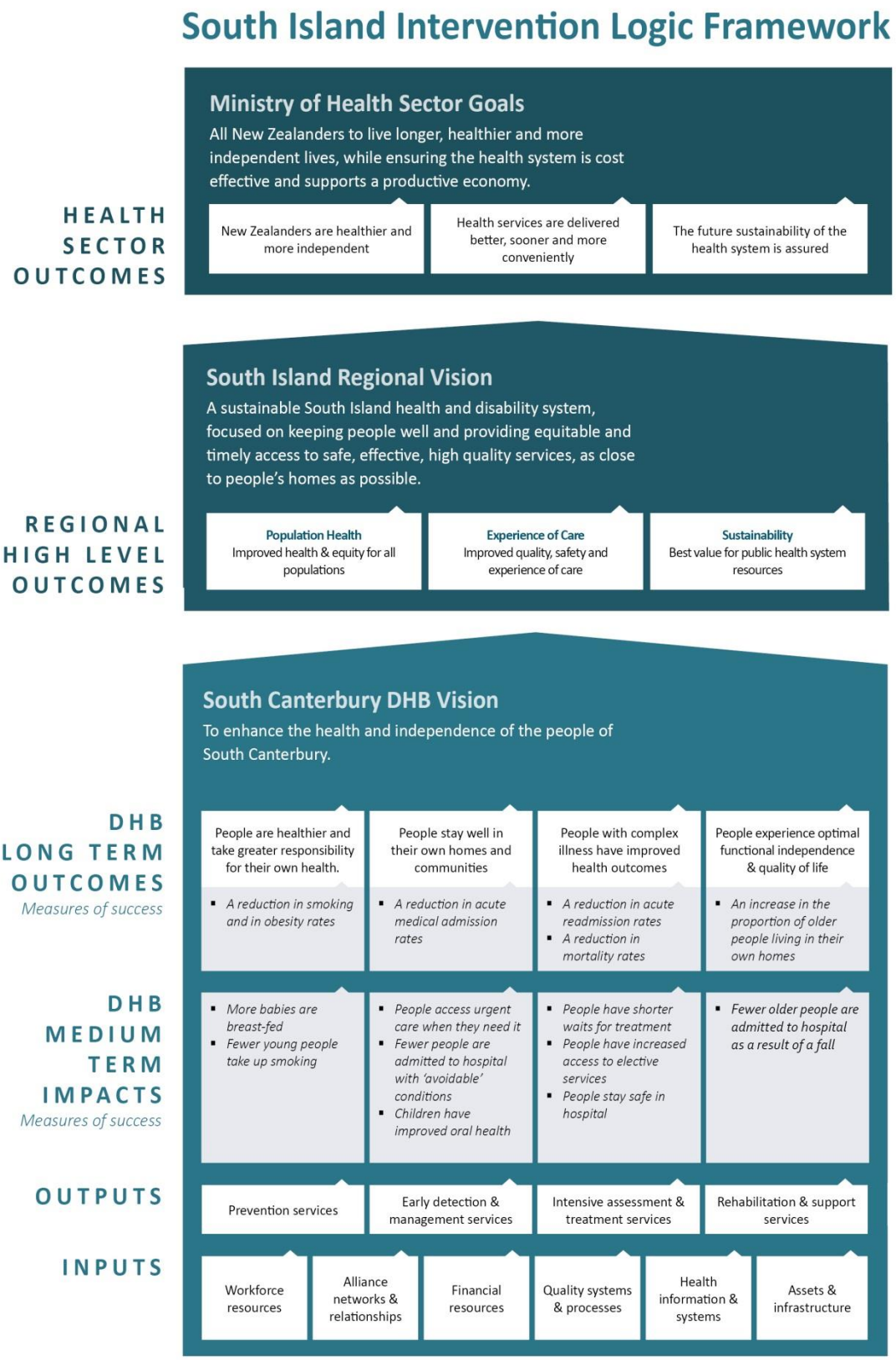
- **Outcome 1: People are healthier and take greater responsibility for their own health.**
  - A reduction in smoking rates.
  - A reduction in obesity rates.
- **Outcome 2: People stay well in their own homes and communities.**
  - A reduction in acute medical admission rates.
- **Outcome 2: People with complex illnesses have improved health outcomes.**
  - A reduction in acute readmission rates.
  - A reduction in all cause mortality rates.
- **Outcome 3: People experience optimal functional independence and quality of life.**
  - An increase in the proportion of the population over 75 living in their own homes.

Each of the South Island DHBs has also identified a set of associated medium-term (3-5 years) indicators of performance. Because change will be evident over a shorter period of time, these impact measures have been identified as the 'headline' or 'main' measures of performance and each DHB has set local targets in their Annual Plans to evaluate their performance over the next three years.

### South Island Intervention Logic Framework

The following intervention logic diagram demonstrates the value chain: how the services that an individual DHB chooses to fund or provide (outputs) will have an impact on the health of their population and result in the achievement of desired longer-term regional outcomes and the expectations and priorities of Government.

**Figure 2: South Island Intervention Logic Diagram**



## STRATEGIC OUTCOME GOAL 1

### People are healthier and take greater responsibility for their own health

***Why is this outcome a priority?***

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major causes of poor health and account for a significant number of presentations in primary care and admissions to hospital and specialist services. We are more likely to develop long-term conditions as we age, and with an ageing population, the burden of long-term conditions will increase. The World Health Organisation (WHO) estimates more than 70% of all health funding is spent on long-term conditions. Long-term conditions are also more prevalent amongst Māori and Pacific Islanders and are closely associated with significant disparities in health outcomes across population groups.

Tobacco smoking, inactivity, poor nutrition and rising obesity rates are major and common contributors to a number of the most prevalent long-term conditions.

These are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing. Supporting people to make healthy choices will enable our population to attain a higher quality of life and to avoid, delay or reduce the impact of long-term conditions.

**OUTCOME MEASURES LONG TERM (5-10 YEARS)**

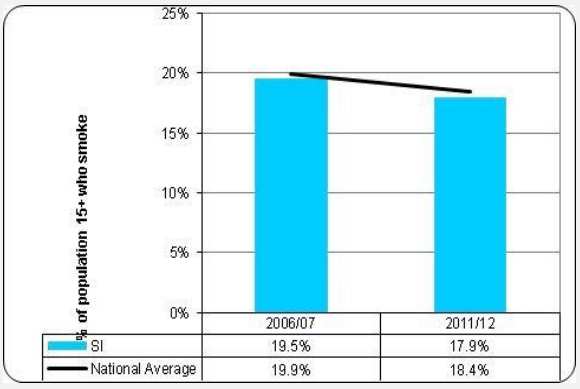
We will know we are succeeding when there is:

A reduction in smoking rates.

- *Tobacco smoking kills an estimated 5,000 people in NZ every year, including deaths due to second-hand smoke exposure. Smoking is also a major contributor to preventable illness and long-term conditions, such as cancer, respiratory disease, heart disease and stroke.*
- *In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, meaning less money is available for necessities such as nutrition, education and health. Supporting our population to say 'no' to tobacco smoking is our foremost opportunity to reduce inequalities and target improvements in the health of our population.*

*Data sourced from national NZ Health Survey.*[6]

Outcome Measure: The percentage of the population (15+) who smoke.

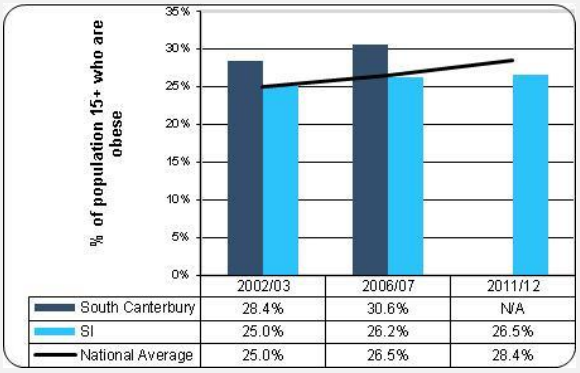



A reduction in obesity rates.

- *There has been a rise in obesity rates in NZ in recent decades, and the 2011/12 NZ Health Survey found that one in ten children (10%) and three in ten adults (28%) are obese. This has significant implications for rates of cardiovascular disease, diabetes, respiratory disease and some cancers, as well as poor psychosocial outcomes and reduced life expectancy.*
- *Supporting our population to maintain healthier body weights through improved nutrition and increased physical activity levels is fundamental to improving their health and wellbeing and to preventing and better managing long-term conditions and disability at all ages.*

*Data sourced from national NZ Health Survey.6*

Outcome Measure: The percentage of the population (15+) who are obese.




[6] *The NZ Health Survey was completed by the Ministry of Health in 2003/04, 2006/07 and 2011/12. Results by region and district are subject to MoH availability. 'Obese' is defined as having a Body Mass Index (BMI) of >30.0, or >32.0 for Māori or Pacific people.*

## IMPACT MEASURES MEDIUM TERM (3-5 YRS)

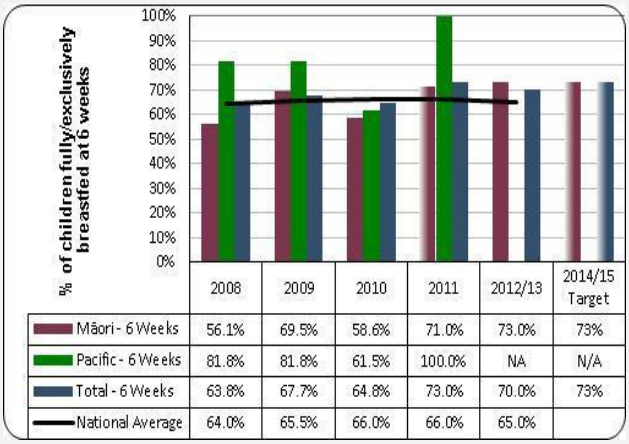
Over the next three years, we seek to make a positive impact on the health and wellbeing of the South Canterbury population and contribute to achieving the longer-term outcomes we seek. The following headlines indicators will be used to evaluate the effectiveness and quality of the services the DHB funds and provides:

More babies are breastfed.

- *Breastfeeding helps lay the foundations for a healthy life, contributing positively to infant health and wellbeing and potentially reducing the likelihood of obesity later in life. Breastfeeding also contributes to the wider wellbeing of mothers.*
- *Although breastfeeding is natural, it sometimes doesn't come naturally, so it's important that mothers have access to appropriate support and advice.*
- *An increase in breastfeeding rates is seen as a proxy measure of successful health promotion and engagement, access to support services and a change in social and environmental factors that influence behaviour and support healthier lifestyles.*

*Data sourced from Plunket via the Ministry of Health.*[7]

The percentage of babies fully/exclusively breastfed at 6 weeks.



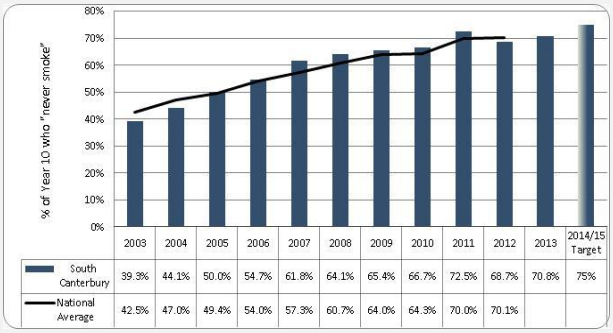

| | 2008 | 2009 | 2010 | 2011 | 2012/13 | 2014/15 Target |
|---|---|---|---|---|---|---|
| Māori - 6 Weeks | 56.1% | 69.5% | 58.6% | 71.0% | 73.0% | 73% |
| Pacific - 6 Weeks | 81.8% | 81.8% | 61.5% | 100.0% | NA | N/A |
| Total - 6 Weeks | 63.8% | 67.7% | 64.8% | 73.0% | 70.0% | 73% |
| National Average | 64.0% | 65.5% | 66.0% | 66.0% | 65.0% | |

Fewer young people take up tobacco smoking.

- *Most smokers begin smoking by 18 years of age, and the highest prevalence of smoking is amongst younger people. Reducing smoking prevalence is therefore largely dependent on preventing young people from taking up smoking.*
- *A reduction in the uptake of smoking is seen as a proxy measure of successful health promotion and engagement and a change in the social and environmental factors that influence risk behaviours and support healthier lifestyles.*

*Data sourced from national Year 10 ASH Survey.*[8]

The percentage of 'never smokers' among Year 10 students.




| | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014/15 Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| South Canterbury | 39.3% | 44.1% | 50.0% | 54.7% | 61.8% | 64.1% | 65.4% | 66.7% | 72.5% | 68.7% | 70.8% | 75% |
| National Average | 42.5% | 47.0% | 49.4% | 54.0% | 57.3% | 60.7% | 64.0% | 64.3% | 70.0% | 70.1% | | |

## STRATEGIC OUTCOME GOAL 2

### People stay well in their own homes and communities

#### *Why is this outcome a priority?*

For most people, their general practice team is their first point of contact with health services. General practice can deliver services sooner and closer to home and prevent disease through education, screening, early detection, diagnosis and timely provision of treatment. The general practice team is also vital as a point of continuity and effective coordination across the continuum of care, particularly in terms of improving the management of care for people with long-term conditions and reducing the exacerbations of those conditions and the complications of injury and illness.

Supporting general practice are a range of other health professionals including midwives, community nurses, social workers, personal health providers and pharmacists. These providers have prevention and early intervention perspectives that link people with other health and social services and support them to stay well.

When people are supported to stay well in the community, they need fewer hospital-level or long-stay interventions. This is not only a better health outcome for our population, but it reduces the rate of acute hospital admissions and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and achieve better health outcomes for lower cost than countries with systems that focus on specialist level care.

[7] *The 2011 result is only for the second half of the 2011 year (i.e. July to December) due to MoH data availability.*

[8] *The ASH survey is run by Action on Smoking and Health and provides an annual point prevalence data set: www.ash.org.nz.*

## OUTCOME MEASURES LONG TERM (5-10 YEARS)

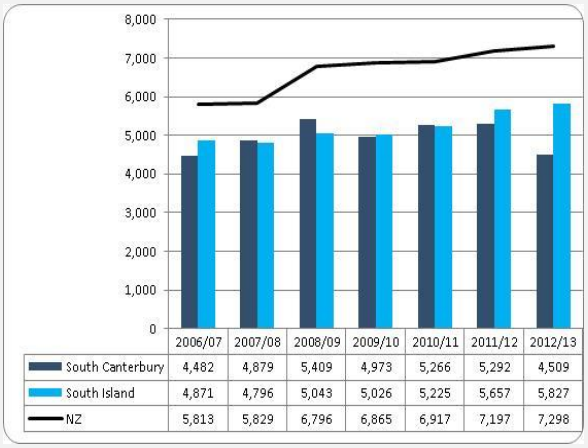
We will know we are succeeding when there is:

A reduction in acute medical admissions.

- *The impact long-term conditions have on quality of life and demand growth is significant. By improving the management of long-term conditions, people can live more stable, healthier lives, and avoid deterioration that leads to acute illness, hospital admission, complications and death.*
- *Reducing acute hospital admissions also has a positive effect on productivity in hospital and specialist services - enabling more efficient use of resources that would otherwise be taken up by a reactive response to demand for urgent care.*
- *Acute medical admissions can be used as a proxy measure of improved conditions management by indicating that fewer people are experiencing an escalation of their condition leading to an urgent (acute) or complex intervention. They can also be used to indicate access to appropriate and effective care and treatment in the community.*

*Data sourced from National Minimum Data Set.*

Outcome Measure: The rate of acute medical admissions to hospital (age-standardised, per 100,000).




| | 2006/07 | 2007/08 | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2012/13 |
|---|---|---|---|---|---|---|---|
| South Canterbury | 4,482 | 4,879 | 5,409 | 4,973 | 5,266 | 5,292 | 4,509 |
| South Island | 4,871 | 4,796 | 5,043 | 5,026 | 5,225 | 5,657 | 5,827 |
| NZ | 5,813 | 5,829 | 6,796 | 6,865 | 6,917 | 7,197 | 7,298 |

## IMPACT MEASURES MEDIUM TERM (3-5 YRS)

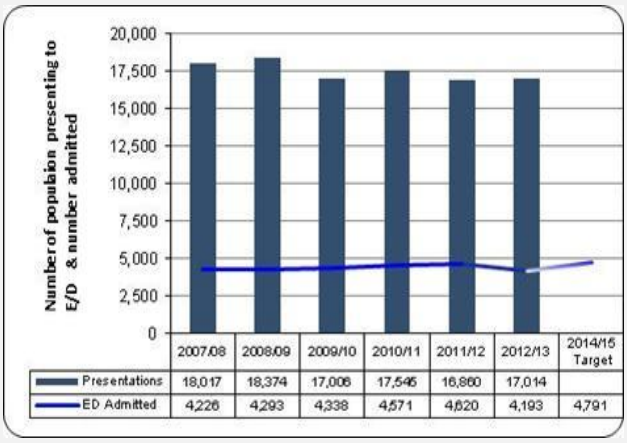
Over the next three years, we seek to make a positive impact on the health and wellbeing of the South Canterbury population and contribute to achieving the longer-term outcomes we seek. The following headlines indicators will be used to evaluate the effectiveness and quality of the services the DHB funds and provides:

People access urgent care when they need it.

- *Supporting people to seek early intervention and providing alternative urgent care pathways will ensure people are able to access the right treatment and support when they need it, which is not necessarily in hospital Emergency Departments.*
- *Early and appropriate intervention will not only improve health outcomes for our population, but will also reduce unnecessary pressure on our hospitals.*
- *A reduction in the proportion of the population presenting to the Emergency Department (ED) and an increase in the number admitted can be seen as a proxy measure of the availability and uptake of alternative community options to more appropriately manage and support people. A higher percentage of admissions for those who present to ED indicate that people are attending ED appropriately and that those who could be attended to in primary and community care systems are using the correct pathways of health care.*

*Data sourced from individual DHBs.*[9]

The percentage of the population presenting at ED and number admitted.




| | 2007/08 | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2014/15 Target |
|---|---|---|---|---|---|---|---|
| Presentations | 18,017 | 18,374 | 17,006 | 17,545 | 16,860 | 17,014 | |
| ED Admitted | 4,226 | 4,293 | 4,338 | 4,571 | 4,620 | 4,193 | 4,791 |

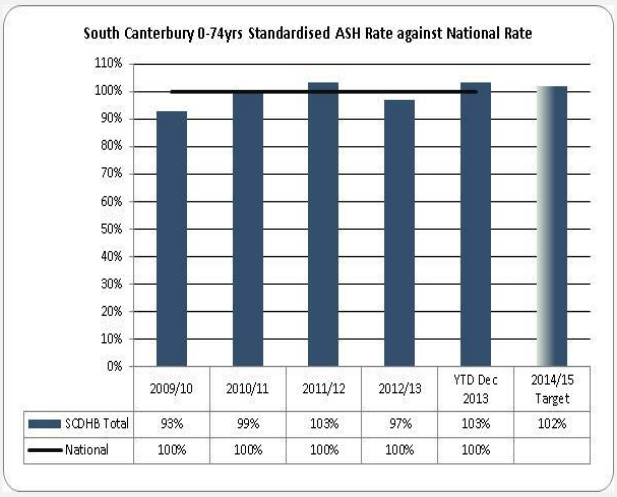
[9] *'Presenting' and 'Admitted' are defined by the Ministry of Health national ED health target.*

Fewer people are admitted to hospital with conditions considered 'avoidable' or 'preventable'.

- *A number of admissions to hospital are for conditions which are seen as preventable through appropriate early intervention and a reduction in risk factors.*
- *These admissions provide an indication of the quality of early detection, intervention and disease management services. A reduction would indicate improvements in care and would also free up hospital resources for more complex and urgent cases.*
- *The key factors in reducing avoidable admissions include improving integration between primary and secondary services, access to diagnostics and the management of long-term conditions. Achievement against this measure is therefore seen as a proxy measure of a more unified health system, as well as a measure of the quality of services being provided.*

*Data sourced from the Ministry of Health.* [10]

The rate of avoidable hospital admissions per 100,000 population (<75).




| | 2009/10 | 2010/11 | 2011/12 | 2012/13 | YTD Dec 2013 | 2014/15 Target |
|---|---|---|---|---|---|---|
| SCDHB Total | 93% | 99% | 103% | 97% | 103% | 102% |
| National | 100% | 100% | 100% | 100% | 100% | |

Children have improved oral health.

- *Oral health is an integral component of lifelong health and impacts a person's comfort in eating and ability to maintain good nutrition, self esteem and quality of life.*
- *Good oral health not only reduces unnecessary complications and hospital admissions, but also signals a reduction in a number of risk factors, such as poor diet, which has lasting benefits in terms of improved nutrition - helping to keep people well.*
- *Māori and Pacific children are more likely to have decayed, missing or filled teeth. As such, improved oral health is also a proxy measure of equity of access and the effectiveness of services in targeting those at risk.*

*Data sourced from Ministry of Health.*

The percentage of children caries-free at age 5 (no holes or fillings).


| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2014 Target | 2015 Target |
|---|---|---|---|---|---|---|---|---|---|
| TOTAL | 50.9% | 59.3% | 59.8% | 64.1% | 60.1% | 58.0% | 61.0% | 62% | 68% |
| Māori | 43.5% | 25.0% | 40.4% | 44.4% | 32.8% | 31.0% | 49.0% | 62% | 68% |

## STRATEGIC OUTCOME GOAL 3

### People with complex illness have improved health outcomes

#### *Why is this outcome a priority?*

For those people who do need a higher level of intervention, timely access to high quality complex care and treatment is crucial in supporting people to recover or in slowing the progression of illness and improving health outcomes by restoring functionality and improving the quality of life.

As providers of hospital and specialist services, DHBs are operating under increasing demand and workforce pressures. At the same time Government is concerned that patients wait too long for diagnostic tests, cancer treatment and elective surgery. Shorter waiting lists and wait times are indicative of a well functioning system that matches capacity with demand by managing the flow of patients through services and reducing demand by moving the point of intervention earlier in the path of illness.

This goal reflects the importance of ensuring that hospital and specialist services are sustainable and that the South Island has the capacity to provide for the complex needs of its population now and into the future. It also reflects the importance of the quality of treatment. Adverse events, unnecessary waits or ineffective treatment can cause harm, resulting in longer hospital stays, readmissions and unnecessary complications that have a negative impact of the health of our population.

[10] *This measure is based on the national DHB performance indicator SI1 and covers hospitalisations for 26 identified conditions including asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. It is defined as the standardised rate per 100,000 population, and the target is set to maintain performance at below 95% of the national rate.*

## OUTCOME MEASURES LONG TERM (5-10 YEARS)

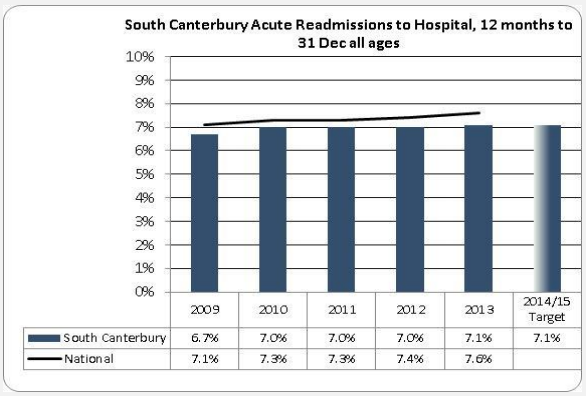
We will know we are succeeding when there is:

A reduction in acute readmissions.

- *An unplanned acute hospital readmission may often (though not always) occur as a result of the care provided to the patient by the health system.*
- *Acute readmissions can be prevented through improved patient safety and quality processes and improved patient flow and service integration - ensuring that people receive more effective treatment, experience fewer adverse events and are better supported on discharge from hospital.*
- *Reducing acute readmissions can therefore be used as a proxy measure of the effectiveness of service provision and the quality of care provided.*
- *They also serve as a counter-measure to balance improvements in productivity and reductions in the length of stay and provide an indication of the integration between services to appropriately support people on discharge.*

*Data sourced from Ministry of Health.*

Outcome Measure: The rate of acute readmissions to hospital within 28 days of discharge.



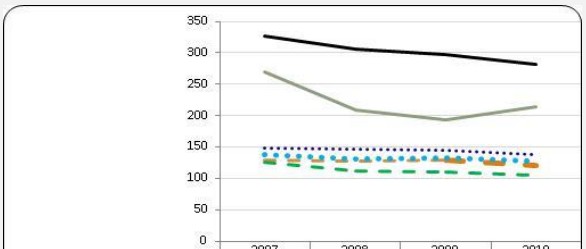

| | 2009 | 2010 | 2011 | 2012 | 2013 | 2014/15 Target |
|---|---|---|---|---|---|---|
| South Canterbury | 6.7% | 7.0% | 7.0% | 7.0% | 7.1% | 7.1% |
| National | 7.1% | 7.3% | 7.3% | 7.4% | 7.6% | |

A reduction in mortality rates.

- *Timely and effective diagnosis and treatment are crucial to improving survival rates for complex illnesses such as cancer and cardiovascular disease. Early detection increases the options for treatment and the chances of survival.*
- *Premature mortality (under 65) is largely preventable with lifestyle change, earlier intervention and safe and effective treatment. By detecting people at risk and improving the treatment and management of their condition the more harmful impacts and complications of a number of complex illnesses can be reduced.*
- *A reduction in mortality rates can be used as a proxy measure of responsive specialist care and improved access to treatment for people with complex illness.*

*Data sourced from MoH mortality collection.*

Outcome Measure: The rate of all cause mortality for people aged under 65 (age standardised per 100,000).




| | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|
| South Island Maori | 269 | 209 | 193 | 213 |
| NZ Maori | 326 | 305 | 298 | 282 |
| South Island Non-Maori | 130 | 128 | 129 | 121 |
| NZ Non-Maori | 126 | 112 | 109 | 105 |
| South Island Total | 137 | 131 | 132 | 127 |
| NZ Total | 149 | 146 | 144 | 138 |

## IMPACT MEASURES MEDIUM TERM (3-5 YRS)

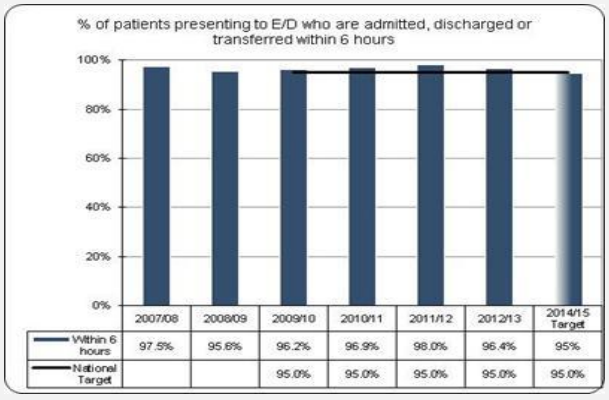
Over the next three years, we seek to make a positive impact on the health and wellbeing of the South Canterbury population and contribute to achieving the longer-term outcomes we seek. The following headlines indicators will be used to evaluate the effectiveness and quality of the services the DHB funds and provides:

*People have shorter waits for treatment.*

- *Emergency Departments (EDs) are important components of our health system and a barometer of the health of the hospital and the wider system.*
- *Long waits in ED are linked to overcrowding, negative outcomes, longer hospital stays and compromised standards of privacy and dignity for patients. Enhanced performance will not only improve outcomes by providing early intervention and treatment but will improve public confidence and trust in health services.*
- *Solutions to reducing ED wait times need to address the underlying causes of delay, and therefore span not only the hospital but the whole health system. In this sense, this indicator is indicative of how responsive the system is to the urgent care needs of the population.*

*Data sourced from individual DHBs.*[11]

The percentage of patients presenting in ED who are admitted, discharged or transferred within six hours.




| | 2007/08 | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2014/15 Target |
|---|---|---|---|---|---|---|---|
| Within 6 hours | 97.5% | 95.6% | 96.2% | 96.9% | 98.0% | 96.4% | 95% |
| National Target | | | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% |

[11] *This measure is based on the national DHB health target 'Shorter stays in Emergency Departments' introduced in 2009/10.*

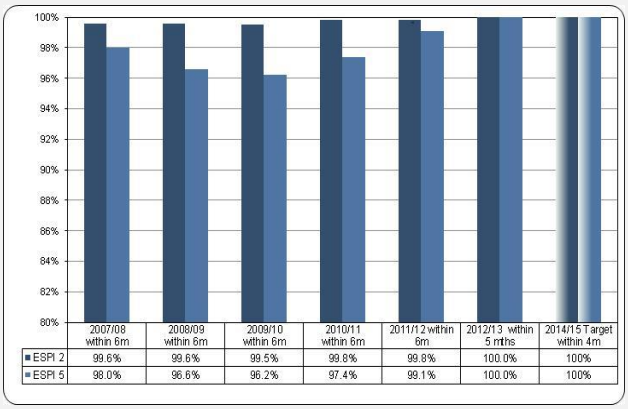
*People have increased access to elective services.*

- *Elective (non-urgent) services are an important part of the healthcare system: these services improve the patient's quality of life by reducing pain or discomfort and improving independence and wellbeing.*
- *Timely access to services and treatment is considered a measure of health system effectiveness and improves health outcomes by slowing the progression of disease and maximising people's functional capacity.*
- *Improved performance against this measure requires effective use of resources so wait times are minimised, while a year-on-year increase in volumes is delivered. In this sense, this indicator is indicative of how responsive the system is to the needs of the population.*

*Data sourced from Ministry of Health.*[12]

The time people wait from referral to First Specialist Assessment (ESPI 2).

The time people wait from commitment to treat until treatment (ESPI 5).

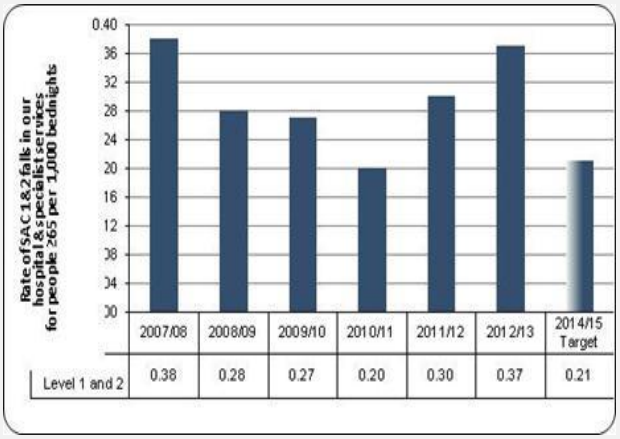



*People stay safe in hospital.*

- *Adverse events in hospital, as well as causing avoidable harm to patients, reduce public confidence and drive unnecessary costs. Fewer adverse events provide an indication of the quality of services and systems and improve outcomes for patients in our services.*
- *The rate of falls is particularly important, as these patients are more likely to have a prolonged hospital stay, loss of confidence and independence and an increased risk of institutional care.*
- *A key factor in reducing adverse events is the engagement of staff and clinical leaders in improving processes and championing change. Achievement against this measure is therefore also seen as a proxy indicator of an engaged and capable workforce with the capacity and capability to improve service delivery.*

*Data sourced from individual DHBs.*[13]

The rate of SAC level 1 and 2 falls in South Canterbury Hospitals.




## STRATEGIC OUTCOME GOAL 4

### People experience optimal functional independence and quality of life

***Why is this outcome a priority?***

As well as providing early intervention and treatment, health services play an important role in supporting people to regain their functionality after illness and to remain healthy and independent. There are also a number of services or interventions that focus on patient care such as pain management or palliative services to improve the quality of life.

With an ageing population, the South Island will require a strong base of primary care and community support, including home-based support, respite and residential care. These services support people to recover and rehabilitate in the community, giving them a greater chance of returning to a state of good health or slowing the progression of disease. Even where returning to full health is not possible, access to responsive, needs-based services helps people to maximise function with the least restriction and dependence. This is not only a better health outcome for our population, but it reduces the rate of acute hospital admissions and frees up health resources across the system.

[12] *The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance and DHBs receive summary reports from the Ministry of Health on a monthly basis. National average performance data is not made available. Historical data is against a six month target, while the target reduces to 5 months for 2013/14 and 4 months from January 2015.*

[13] *The Severity Assessment Code (SAC) is a numerical score given to an incident, based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with highest consequence and likelihood. Data reported is per 1,000 inpatient bed days.*

## OUTCOME MEASURES LONG TERM (5-10 YEARS)

We will know we are succeeding when there is:

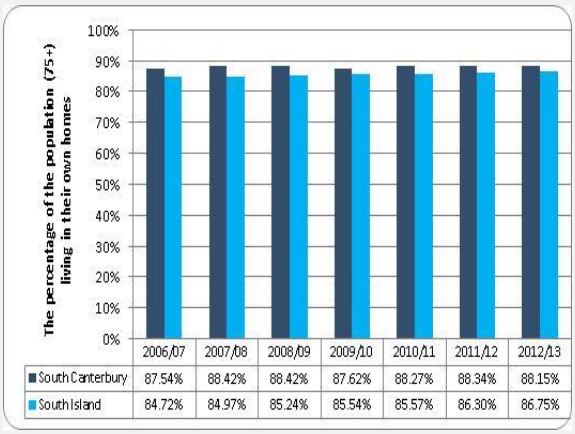
An increase in the proportion of the population living in their own home.

- *While living in Aged Related Residential Care (ARRC) is appropriate for a small proportion of our population, evaluation of older people's services have shown a higher level of satisfaction and better long-term outcomes where people remain in their own homes and positively connected to their communities.*
- *Living in ARRC facilities is also a more expensive option, and resources could be better spent providing appropriate levels of Home-Based Support Service (HBSS) to people to stay well in their own homes.*
- *An increase in the proportion of people supported in their own home can be used as a proxy measure of how well the system is managing age-related long-term conditions and responding to the needs of our older population.*

*Data sourced from Client Claims Payments provided by SIAPO.*

Statistics NZ projections for the 75+ population were higher prior to the 2013 census results have evidenced.

Outcome Measure: The percentage of the population (75+) living in their own homes.




| | 2006/07 | 2007/08 | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2012/13 |
|---|---|---|---|---|---|---|---|
| South Canterbury | 87.54% | 88.42% | 88.42% | 87.62% | 88.27% | 88.34% | 88.15% |
| South Island | 84.72% | 84.97% | 85.24% | 85.54% | 85.57% | 86.30% | 86.75% |

## IMPACT MEASURES MEDIUM TERM (3-5 YRS)

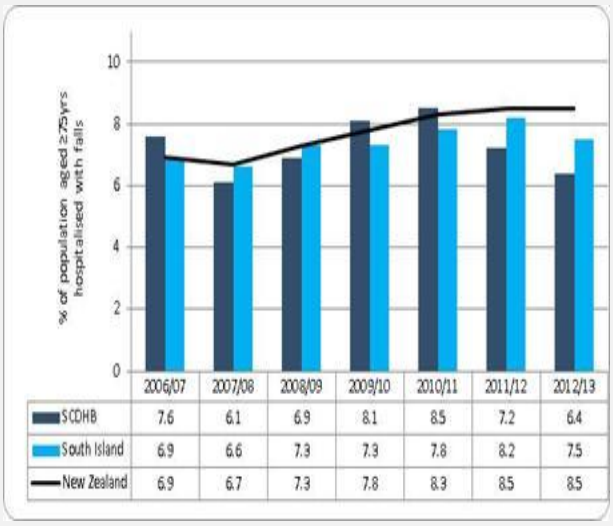
Over the next three years, we seek to make a positive impact on the health and wellbeing of the South Canterbury population and contribute to achieving the longer-term outcomes we seek. The following headlines indicators will be used to evaluate the effectiveness and quality of the services the DHB funds and provides:

Fewer people are admitted to hospital as a result of a fall.

- *Around 22,000 New Zealanders (75+) are hospitalised annually as a result of injury due to falls. Compared to people who do not fall, those who do experience prolonged hospital stay, loss of confidence and independence and an increased risk of institutional care.*
- *With an ageing population, a focus on reducing falls will help people to stay well and independent and will reduce the relative demand on acute and aged residential care services.*
- *The solutions to reducing falls address various health issues and associated risk factors including: medications use, lack of physical activity, poor nutrition, osteoporosis, impaired vision and environmental hazards.*
- *A reduction in falls can therefore be seen as a proxy measure for improved health service provision for older people.*

*Data sourced from National Minimum Data Set.*

The percentage of the population (75+) admitted to hospital as a result of a fall.




| | 2006/07 | 2007/08 | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2012/13 |
|---|---|---|---|---|---|---|---|
| SCDHB | 7.6 | 6.1 | 6.9 | 8.1 | 8.5 | 7.2 | 6.4 |
| South Island | 6.9 | 6.6 | 7.3 | 7.3 | 7.8 | 8.2 | 7.5 |
| New Zealand | 6.9 | 6.7 | 7.3 | 7.8 | 8.3 | 8.5 | 8.5 |

# CHAPTER 2: DELIVERING ON PRIORITIES & TARGETS

**Minister's priorities and health targets – how will we contribute?**

When planning investment and activity within the health system, DHBs must consider the role they play in the achievement of the vision and goals of Government – reflected in the annual Minister's Letter of Expectations attached at appendix 1.

In setting expectations for 2014/15, Government has been clear that the public health system must continue to deliver *'better, sooner, more convenient'* health care and lift health outcomes for patients within constrained funding increases.

In summary, the Minister's 2014/15 priorities are:

- *Better public services – in particular, increased infant immunisation, reduced incidence of rheumatic fever, and reduced assaults on children*
- *Care closer to home;*
- *Health of older people;*
- *Regional and national collaboration; and*
- *Living within our means.*

DHBs are also expected to deliver against the six national health targets:

- *Shorter stays in emergency departments;*
- *Improved access to elective surgery;*
- *Faster cancer treatments;*
- *Increased immunisation;*
- *Better help for smokers to quit; and*
- *More heart and diabetes checks.*

This chapter of the Annual Plan describes the actions that SCDHB is taking to effectively and efficiently deliver on the overarching goal of '*Better Sooner More Convenient'* health services for all New Zealanders and have been clustered to reflect the national health targets, Government's Better Public Services and the requirement for increased system integration.

The South Island Alliance Health Services Plan (SIHSP) is a framework for the collaborative activities of the South Island Alliance, comprising the five South Island District Health Boards. The SIHSP draws from national strategies and key priorities and is interwoven into each of our South Island DHB Annual Plans. This Alliance approach helps to use our resources to maximum effect across a large physical area, to address the challenges we face in the South Island. In addition to the nationally driven priorities: elective services, cancer services, cardiac services, mental health and addictions, stroke services, health of older people, major trauma, information technology and workforce we have also identified regional priorities to deliver improved public health services: child health services, quality and safety and support services . In addition to these, there are a number of other smaller, but significant, regional initiatives that are continuing to develop (neurosurgery, bariatric surgery, and fertility services). Where activity occurs in partnership with the South Island Alliance's South Island Health Service Plan 2014 – 17 actions these are presented to demonstrate clear alignment or 'line of sight' between regional priorities and local activity.

## 2.1 Health Targets


### Increased Immunisation Health Target

**Government Expectation**

90 percent of eight month olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2014 and 95 percent by December 2014.

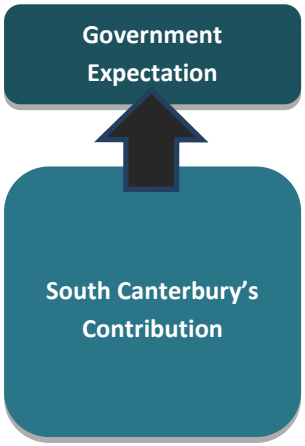
**South Canterbury's Contribution**

The SCDHB Immunisation Steering Group remains active. Processes for the transfer of care from the LMC to the GP and WCTO are in place. Immunisation status is screened on presentation to hospital with referral as required. The immunisation outreach service continues to improve coverage rates. The 2013/14 Q3 result showed that 94 percent of eight month olds had received their primary course of immunisation on time. The focus for 2014/15 will be implementing the multiple provider enrolment form (which includes the triple enrolment requirements) and working with primary care partners to monitor and increase new born enrolment rates to general practice, well child/tamariki ora and child oral health services to achieve the target set out in the Indicators for the Well Child/Tamariki Ora Quality Improvement Framework.

***South Canterbury DHB's Key Local Initiatives 2014/15***

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Complete timely enrolment of all newborns with general practice, well child/ tamariki ora and child oral health service providers. | | Develop and implement a multiple enrolment form to be completed at birth. | • Develop and print a multiple enrolment form for referral to multiple child health providers. Q1<br>• Work with primary care partners to implement the multiple enrolment form. Q1<br>• Continue to monitor newborn enrolment rates- Ongoing<br>• Audit compliance with completion of the multiple enrolment form at birth. Q4 | • Multiple enrolment form is completed at birth and prior to discharge from the Maternity Unit.<br>• 88% of newborns are enrolled with a general practice by three months and referred by the LMC to WCTO by December 2014 and 98% by June 2016.<br>• 86% of preschool children are enrolled with oral health services by December 2014 and 95% by June 2016. |

## More Heart and Diabetes Checks Health Target




90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.

The DHB continues to make steady progress towards achieving this target with established recall, monitoring and reporting systems along with health messaging. The 2013/14 Q3 result showed 78.1 percent had their cardiovascular risk assessed in the last five years. There has been a four – five percent improvement quarter on quarter and it is expected that the DHB will reach the health target of 90 percent by Q2. This has been brought about by a greater acceptance of practices of virtual CVDRA's than before following repeated visits to reinforce their importance and creating a competitive environment through the provision of league tables so that practices can measure performance against other practices and peers. The DHB will focus on utilising Dr Info which will be funded as an alternative to Best Practice Intelligence if desired during 2014/15 to improve this result further.

### *South Canterbury DHB's Key Local Initiatives 2014/15*

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Increase cardiovascular risk assessment coverage in South Canterbury. | In partnership with general practices. | Introduce Dr Info to assist in CVDRA coverage. | • Utilise Dr Info audit programme practice data to complete virtual CVD checks. Q1<br>• Generate patient re-call letters for outstanding patients who are eligible but unable to be completed through the virtual process. Q2 - 3 | 90 percent of the eligible South Canterbury population will have had their cardiovascular risk assessed in the last five years. |


## Shorter Stays in Emergency Departments Health Target

**Government Expectation**

95 percent of patients will be admitted, discharged, or transferred from an Emergency Department within six hours.

**South Canterbury's Contribution**

The 2013/14 Q3 result showed 96.9 percent of patients were admitted, discharged, or transferred from the Emergency Department within six hours. This target has been consistently met for 10 consecutive quarters and the DHBs will focus on sustaining this level of performance. The emergency department's focus during 2014/15 will be the phased implementation of a quality framework for the ED phase of acute care.

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Improve the emergency department's phase of acute care by measuring and monitoring data by ethnicity, observing trends and making improvements where required based on the needs of population groups. | Staged approach to implementing 'A Quality Framework and Suite of Quality Measures for the Emergency Department Phase of Acute Patient Care in New Zealand March 2014'. | Implement a quality framework for the ED phase of acute care inline with the recently published document 'A Quality Framework and Suite of Quality Measures for the Emergency Department Phase of Acute Patient Care in New Zealand March 2014'. | • Draft a quality framework document for the emergency department. Q1<br>• Introduce the 21 mandatory measures as defined in 'A Quality Framework and Suite of Quality Measures for the Emergency Department Phase of Acute Patient Care in New Zealand March 2014'. Q1<br>• Analyse and act on the results of mandatory measures. Q3<br>• Consider the inclusion of additional non-mandatory measures to provide a comprehensive approach to quality improvement within emergency department acute patient care. Q3 | • An approved Emergency Department Quality Improvement Framework document is available for reference.<br>• Quarterly reporting against mandatory and selected non-mandatory quality measures to the Emergency Department Operational Group. |

## Better Help for Smokers to Quit Health Target

**Government Expectation**

95 percent of hospitalised patients who smoke and are seen by a health practitioner in public hospitals and 90 percent of enrolled patients who smoke and are seen by a health practitioner in general practice are offered brief advice and support to quit smoking. Progress towards 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with a lead maternity carer being offered brief advice and support to quit smoking.

**South Canterbury's Contribution**

2013/14 Q3 results showed 98.1 percent of hospitalised smokers and 90.2 percent of smokers seen in primary care received advice and help to quit smoking. The DHB will continue to support the South Canterbury Smokefree Group and coordinate the development of the local Tobacco Control Plan. The DHB is actively engaging in working towards the Government's aspirational goal of a Smokefree NZ by 2025 with a smoking prevalence of <5% across all ethnicities and will support the ASH NZ national campaign 'Stoptober' later this year. The hospital target has been met for 11 consecutive quarters and the DHB will work to sustain this level of performance. This has been achieved by incorporating ABC as part of the initial inpatient clinical assessment. Success in achievement is supported by a robust education programme on ABC delivery.

No new initiatives are planned for the hospital setting with the focus during 2014/15 targeted towards improvement in primary care.

### *South Canterbury DHB's Key Local Initiatives 2014/15*

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Increase the percentage of smokers seen in primary care receiving advice and support to quit smoking. | In partnership with general practice. | Utilise the resourced two FTE primary care smokefree facilitators and designated GP clinical champion (which is part of the role of the Primary Care CMO 0.4FTE role) to increase direct targeting of persistent underperforming general practices by providing one on one support. | • Two FTE smokefree facilitators continue to work with specific practices and undertake cessation support clinics in five rural practices. Q1-Q4<br>• Continue to offer training to all practice personnel not already engaged and support new practice personnel including assistance with patient prompt and decision support tools. Q1-4<br>• Run Dr Info audits across | 90 percent of enrolled patients who smoke and are seen by a health practitioner in general practice are offered brief advice and support to quit smoking. |

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| | | | practice registers to identify known smokers requiring brief advice. Q1 | |
| | SCDHB Smokefree Programme. | Continue to run community based smoking cessation clinics at five sites within South Canterbury. | 15 rural clinics held Q1, 2, 3, & 4 | A minimum of 60 clinics are held annually. |
| Increase the percentage of pregnant women offered advice and support to quit. | SCDHB Smokefree Programme. | All women confirmed as pregnant and who identify as smokers will be referred to the SCDHB smoking cessation team. | • Complete Maternity Booking Form on registration which includes a mandatory smoking status field prompting the LMC (for obstetricians this will be a DHB Continuity of Care Midwife) to deliver ABC and forward form to Maternity Services. Q1<br>• Forward contact details from the Maternity Booking Form for women identified as smokers to the primary care smokefree facilitator. Q1<br>• Report number of referrals received. Q2 & 4 | 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy or booking with a lead maternity carer are offered advice and support to quit. |


## Improved Access to Elective Surgery Health Target

**Government Expectation**

The volume of elective surgery will be increased by at least 4,000 discharges per year.

**South Canterbury's Contribution**

2,634 elective surgical discharges will be delivered by the SCDHB in 2014/15. For regional and local initiatives relating to elective services refer to page 37.


## Faster Cancer Treatment Health Target

**Government Expectation**

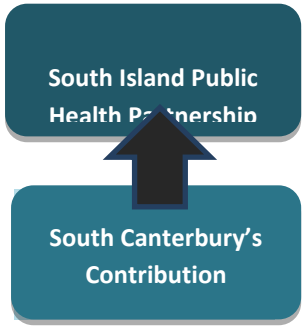
85% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment (or other management) by July 2016.

**South Canterbury's Contribution**

2013/14 Q3 result showed 100 percent of patients ready-for-treatment waited less than four weeks for radiotherapy or chemotherapy. This target has been consistently met for 12 consecutive quarters and the DHB will work at sustaining this result with the focus shifting to transitioning to achieving the health target of 85% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment (or other management) from the 1 October 2014. Implementation of the revised Oncology Model of Care will assist in meeting this health target. Further detail relating to this action point and other regional and local initiatives to meeting the Faster Cancer Treatment timeframes can be found on page 40 - 41.

## 2.2 Better Public Services

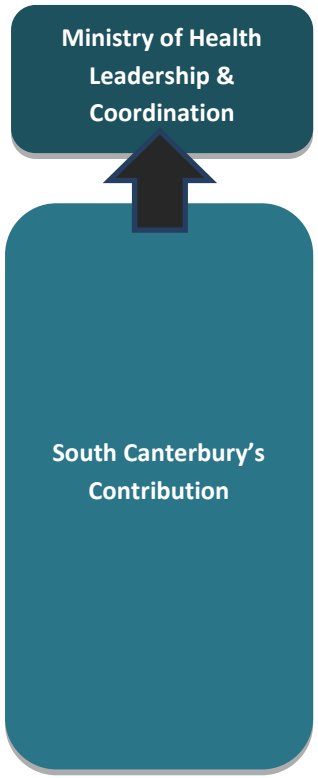
### 2.2.1 Reducing Rheumatic Fever




The region has developed the South Island Rheumatic Fever Prevention Plan which will be implemented via the SIHSP. The South Island Public Health Partnership continues to provide a surveillance function for Rheumatic Fever and plays a facilitative role in ensuring each DHB has mechanisms in place to ensure the Rheumatic Fever Prevention and Management Plan is being implemented as intended. The partnership also has a Communicable Diseases protocol Group. Refer PP28.

South Canterbury has not had a reported case of rheumatic fever in the last 10 years. The SCDHB will notify any cases to Community and Public Health and will deliver on actions specified in the South Island Rheumatic Fever Prevention Plan. Should a new case of rheumatic fever be identified in the district a case review will occur and the Ministry provided with a quarterly report on actions taken and lessons learned. There are no other new local initiatives planned for 2014/15.

### 2.2.2 Prime Minister's Youth Mental Health Project




The health sectors response to the Prime Minister's Youth Mental Health Project is to improve services for young people who seek help for mild to moderate illness with a focus on making primary health care more youth friendly, improving wait times and follow up care, improving referral pathways within the youth mental health system and providing education programmes to tackle teenagers' drug and alcohol misuse. Refer PP25.

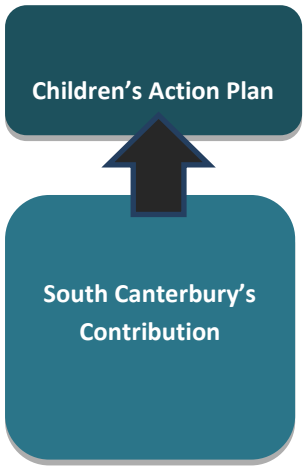
SCDHB provides or funds a number of services for youth including a free community youth clinic, free sexual health for those under 25 years and youth health clinics in seven secondary schools and nine alternative education settings, with HEEADSSS assessments available in the community youth clinic and alternative education setting. Work will continue with primary care to improve the coordination of referrals from the HEEADSSS assessment, continuing to link young people back to their general practice or assisting them to enrol with a general practice. Local youth have access on referral to a mental health brief intervention service, The Adventure Development Programme and youth alcohol and drug addiction services. The Strengths Recovery Model of Care is employed within SCDHB mental health and addiction services and Relapse Prevention Plans are in place as indicated. Follow-up in primary care on discharge is supported by ensuring that youth are engaged with a GP and provision of a follow-up care plan. The focus during 2014/15 will continue to be on supporting youth in the community on discharge, transitioning to independence. The local Māori health provider, Arowhenau Whānau Services also provides mental health and addiction services for youth which are culturally-competent and meet the needs of local Māori. No further initiatives are planned in this area. 2013 results show 82.9 percent of 0 – 19 year olds accessed mental health services within three weeks and a further 10.7 percent within eight weeks. Results for 2013 also show that 81 percent of 0 – 19 year olds accessed addiction services within three weeks and a further 9.5 percent within eight weeks. The SCDHB WAVE programme continues with good engagement rates across the district. Participation continues in the National Mental Health & Addiction Key Performance Indicators Project. The DHB also continues to work regionally on the implementation of the regional youth forensic service, utilising the 'hub and spoke' approach (refer to the section on mental health pg. 48). This will remain a focus for 2014/15. The other main focus for the DHB is continued local intersectoral collaboration and specifically in its participation in the South Canterbury Intersectoral Youth Project.

### *South Canterbury DHB's Key Local Initiatives 2014/15*

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Meet the health and wellbeing needs of children and youth in South Canterbury across the full continuum of care; through the life course from before birth to transition to adulthood. | SCDHB Integrated Child and Youth Model of Care. | Establish an integrated Child and Youth Services Steering Group which includes representation from primary, secondary and NGO services to provide leadership in the development and oversight of the provision of child and youth services. | • Finalise Integrated Child and Youth Services Steering Group membership and Terms of Reference. Q1<br>• Hold Integrated Child and Youth Services Steering Group inaugural meeting. Q2<br>• Approve Youth Services Working Group membership and Terms of Reference. Q2<br>• Hold Youth Services Working Group planning meeting. Q2 | Approved Terms of Reference, meeting minutes and action plan. |
| Increase the community support for mental health and addiction service users in the discharge and post discharge phases of treatment with particular emphasis on relapse prevention. | In partnership with the Ministry of Social Development.<br>The project is a collaboration between CAMHS (a South Canterbury DHB provider arm service) and Adventure Development Ltd (an SCDHB funded NGO). | Implement and evaluate the multi agency contract service for youth support and discharge from mental health and addiction services. | • Activate contracted positions. Q1<br>• Evaluate service delivery. Q4 | 25 young people are supported in the community and transition back to independence. |
| Improve access to a broad range of services and agencies for youth in South Canterbury including those relating to health and social support. | South Canterbury Youth Intersectoral Project Steering Group. | Contribute to the execution of the South Canterbury Youth Intersectoral Project Steering Group and work stream implementation plans. | • Share education opportunities with other agencies – Ongoing.<br>• Survey providers training and support needs. Q1<br>• Facilitate closer working relationships and understanding between youth service providers through use of a common language to ensure appropriate referral to | |

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| | | | mental health services - Ongoing.<br>• Utilise the completed stocktake of youth services to produce and distribute information on eligibility criteria and how to be referred to or access available youth services. Q1 | |
| Improve the health of youth by providing school based health services that are effective for youth. | Ministry of Health Care in Secondary Schools: A Framework for CQI. | Complete the self assessment check lists contained in the Ministry of Health Care in Secondary Schools: A Framework for CQI and develop an action plan to address areas of non or partial compliance against quality indicators. | • Complete WAVE Programme self assessment. Q1<br>• Complete Youth Health clinic self assessment. Q2<br>• Complete educational settings self assessments. Q3 | Services meet Secondary Schools: A Framework for CQI expectations with improvement demonstrated on baseline for:<br>Youth participation, accessibility, youth trained staff, partnership with schools and the community, commitment to the Treaty of Waitangi, supporting quality holistic care and health promotion. |
| Improve mental health service delivery to meet the needs of young people in South Canterbury. | Evaluation of services established in South Canterbury funded by the DHB. | Provide funding to evaluate:<br>• Brief intervention services for youth<br>• Addiction services for youth. | Complete evaluations and identify any actions required. Q4 | The evaluation report is received by the SCDHB. |

### 2.2.3 Children's Action Plan




The Children's Action Plan provides the framework to achieve the fundamental changes contained in the White Paper for Vulnerable Children. It has 10 main areas of focus: 1. Vulnerable Children's Bill, 2. Reporting child abuse, 3. Multidisciplinary Children's Teams, 4. Child Abuse Prevention Orders, 5. Vetting & screening of staff, 6. Information system for vulnerable children, 7. Evidence based programmes, 8. Care giver selection and support, 9. Cross agency approach, 10. Mentorship of vulnerable children. Ref PP27.

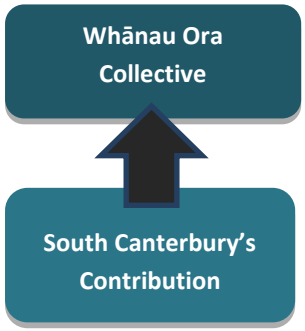
The SCDHB Family Violence Intervention Programme (FVIP) Steering Group remains active with a strategic plan for the FVIP in place for 2012 – 15. The Child Protection Advisory Group meets regularly to review reports of concern. FVIP core and refresher training is in place as is a screening audit programme and schedule. It is intended to expand this core training beyond mandatory areas in 2014/15. A number of programmes have been successfully implemented including the Shaken Baby Prevention Programme and the Vulnerable Pregnant Women's Programme. A MOU with Police and CYFS including Schedules 1 & 2 is in place and the MOU Governance Group meet quarterly. Gateway assessments are in place. The National Child Alert System was implemented in 2013/14. The 2013/14 FVIP self assessment score for child abuse and neglect was 96 and the DHB will work to sustain this result. The DHB's main focus during 2014/15 will be responding to the Children's Action Plan.

***South Canterbury DHB's Key Local Initiatives 2014/15***

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Wrap every support around those vulnerable children who are at risk of neglect and abuse. | SCDHB Integrated Child and Youth Model of Care Steering Group. | Participate in the local implementation of the Children's Action Plan once timing known. | Prepare for the roll out of a local Children's Team. Timeframe TBA | |
| Increase the opportunity for early identification and reporting of child abuse and neglect. | SCDHB Integrated Child and Youth Model of Care Steering Group. | Develop and implement a DHB Child Protection Policy and associated process that meet all the requirements of the Vulnerable Children's Bill. | Child Protection Policy developed, published electronically and implemented. Q1 | Compliance with section 17 of the Vulnerable Children's Bill is evident. |
| Reduce the risk of harm to children by requiring people employed or engaged in work that involves regular or overnight contact with children to be safety checked. | SCDHB Integrated Child and Youth Model of Care Steering Group. | Introduce standard safety checks for all new employees working with children. | Develop and implement a DHB policy and associated process for the vetting and screening of new staff employed to work with children. Q4 | Compliance with section 31 of the Vulnerable Children's Bill is evident. |
| Increase the opportunity for early intervention for 'at risk' women and children. | SCDHB Family Violence Invention Programme (FVIP) Steering Group. | Expand SCDHB's FVIP staff training programme to clinical services other than the | • Deliver training to dental therapy staff. Q1<br>• Deliver training to | • 100% of staff receive training in mandatory areas. |

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| | | mandatory areas of coverage. | registered medical officers on entry to the DHB. Q2<br>• Deliver training to surgical services staff. Q3<br>• Deliver training to clinical nurse specialists. Q4 | • 30% of staff receive training in selected optional areas. |

### 2.2.4 Whānau Ora




SCDHB will continue to work with Arowhenua Whānau Services to develop their capacity and strategic engagement with the regional Whānau Ora project under the umbrella of He Oranga Pounamu's Programme of Action. Refer S15.

SCDHB is the only government agency funding the local Maori health provider, Arowhenua Whānau Services (AWS). The DHB continues to participate in Te Herega Hauora with the South Island General Managers Māori Health to collectively support the Te Waipaunamu Ora Project - Waka Ora. During 2014/15 the DHB will review the contract with AWS to ensure it supports Whānau Ora Collective initiatives.

***South Canterbury DHB's Key Local Initiatives 2014/15***

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Engage in the He Oranga Pounamu's Programme of Action. | SCDHB contract management and monitoring system. | Review the AWS contract to ensure it supports Whānau Ora Collective initiatives. | • Review contract against Collective initiatives and re-draft. Q1<br>• Circulate Contract for consultation. Q2<br>• Finalise Contract. Q3<br>• Agree and sign Contract. Q4 | A reduction in disparity in health outcomes results for Māori compared to the total population. Refer SCDHB Māori Health Plan 2014/15. |

## 2.3 System Integration

### 2.3.1 Long Term Conditions

**South Canterbury's Contribution**

SCDHB has a Framework for Chronic Conditions which will be reviewed during 2014/15 with a focus on adopting a multi-condition rehabilitation approach and predictive risk assessment. SCDHB continues to use a variety of analysis tools which enable risk stratification to identify 'at risk' cohorts within our population. These include health needs analysis, population and health profiles along with disease prevalence, current trends of health data e.g. health management data provided by the MOH, hospital admissions, non-admitted health services utilisation as well as benchmarking with other populations etc. The DHB remains committed to maintaining current activity relating to long term condition prevention and management as well as continuing to commit the DICP funding for people with diabetes. Integrated models of care for diabetes and respiratory are overseen by respective steering groups and are underpinned by related Aoraki HealthPathways and LTC programmes e.g. the multi-condition rehabilitation programme, encounter programme, foot care programme for diabetics, pre-diabetes lifestyle group education, and the SWIM programme. Along with further development of Aoraki HealthPathways these programmes will all continue into 2014/15. Planned workstream projects for integrated diabetes services include the development of a patient held Care Plan and use of the ATLAS clinical indicators for diabetes. It is intended during 2014/15 to replace the Virtual Diabetes Register with an alternate approach to monitoring and analysis of glycaemic control. National Quality Standards for Diabetes Management will also be considered once approved and published. Refer to the section on Primary Care page 45 for initiatives relating to the SCDHB Integrated Respiratory Services Model of Care.

***South Canterbury DHB's Key Local Initiatives 2014/15***

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Provide a contemporary strategic framework for the prevention and management of long term conditions. | | Review SCDHB's Strategic Framework for the Prevention and Management of Long Term Conditions 2009. | • Draft Framework. Q1<br>• Consult on Framework. Q2<br>• Approve Framework by SLT. Q4 | |
| Employ a multi condition rehabilitation approach to the management of all long term conditions. | | Develop a holistic approach to the management of people with a diagnosed long term condition which identifies other health related needs and knowledge gaps. | • Develop a holistic predictive risk assessment tool to identify the optimal patient pathway. Q1<br>• Introduce an interdisciplinary team approach to care planning and delivery utilising a predictive risk approach and incorporating self management. Q2<br>• Evaluate the revised approach. Q4 | Partners in health scores post intervention indicate an improvement in self management and knowledge. |

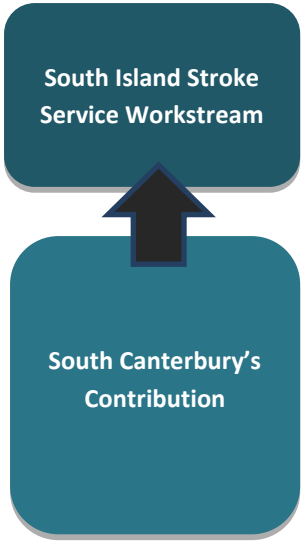
| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Empower patients to actively manage their own long-term condition. | | Continue provision of the Multi-condition Rehabilitation (MCR) Programme utilising the Flinders tool to complete predictive risk assessment. | Ongoing. | • 65patients enrolled in the MRC Programme.<br>• 75 percent of patients who commence the MCR Programme complete the full 12 sessions. |

### Diabetes Care Improvement Package

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Provide an integrated approach to the management of people in South Canterbury with diabetes primarily being managed in the primary care setting except where specialist input is required. | The SCDHB Integrated Diabetes Services Steering Group. | Continue provision of the Encounter Programme. | Ongoing. | Number enrolled on the Encounter Programme over 12 months. |
| | | Continue access to the Foot Care Programme. | Ongoing. | Number of completed foot assessments for diabetes. |
| | | Utilise the ATLAS Diabetes Clinical Indicator set. | • Assure accuracy of data collection & submission. Q1<br>• Present data reports to key clinical groups. Q2<br>• Identify and agree three priority areas for action. Q3<br>• Agree actions for inclusion in 2015/16 DCIP. Q4 | Dataset identified and being captured in a format presentable for analysis. |
| | | Develop and trial a patient held Diabetes Care Plan for use across primary and secondary care services. | • Identify and review existing resources. Q1<br>• Draft Care Plan. Q2<br>• Consult on and update Care Plan. Q3<br>• Finalise and approve Care Plan for pilot. Q4 | 30 patients pilot the patient held Diabetes Care Plan. |
| | | Review and localise Diabetes HealthPathways. | • Review CDHB HealthPathways and identify required amendments. Q2<br>• Approve amendments and publish. Q3 | All Diabetes Management Aoraki HealthPathway completed. |

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Track Diabetes Care Improvement Package effectiveness through monitoring the HbA1c of those patients engaged in either the Encounter or Pre-diabetes Programme. | Planning and development will occur in collaboration with Medlab. | Develop a database and regular data updating system to capture the patient's most recent HbA1c result. | • Agree structure and process. Q1<br>• Implement database. Q2 | HbA1c reporting available at the individual's level is compared to that individual's ideal range. |
| Identify persons at risk of diabetes or other LTC through GP practice or CVDRA. | In partnership with general practice. | Provide pre-diabetes group education and information programme which includes other LTCs utilising a multidisciplinary approach. | • Ongoing | A minimum of six pre-diabetes programmes are held per annum. |

### 2.3.2 Stroke Services




This workstream has been formed to: "support the implementation of organised stroke services locally and regionally across the South Island and thereby encourage consistency and sustainability in the provision and delivery of acute and rehabilitation stroke services. Organised stroke services have been shown to improve the health outcomes of those who have a transient ischaemic attack (TIA) or stroke."[14] The workstream's key focus areas for 2014/15 are: 1. Equitable access to acute stroke services for the South Island population; 2. Integrated stroke rehabilitation services for the South Island population and 3. Workforce planning and development.

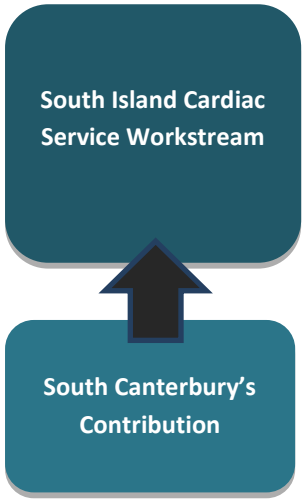
SCDHB's Stroke Steering Group remains active. Thrombolysis Pathway and an Acute Stroke Pathway which cover admission to discharge are both established and are inline with the South island Stroke Workstream recommendations. Admission to the DHB Acute Stroke Pathway is monitored (Refer PP20) and work continues to ensure the integrity of data collected and reported. A DHB Stroke Register is also maintained. AROC training, data submission and benchmarking occurs in the rehabilitation unit as does training in the FIMS assessment tool. St Johns Ambulance Service has in place protocols for both FAST Assessment for Stroke and ABCD2 Assessment for TIA. The focus for 2014/15 will be on expanding the use of the ABCD2 protocol in the emergency department, implementation of the recently released Stroke Thrombolysis Guideline, audit of our Acute Stroke Pathway and post acute rehabilitation including transition back to the community. SCDHB will contribute data relating to timely transfer of patients presenting with acute stroke to an in-patient rehabilitation service as part of the regional reporting programme.

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Improve health outcomes for people who experience a TIA or | South Island Stroke Services Workstream and SCDHB Stroke | Implement the ABCD2 protocol for the assessment of TIAs in | Train emergency department staff in the use of the ABCD2 | ≥ 6% of potentially eligible patients with an ischaemic |

[14] *South Island Regional Health Services Plan 2014 - 2017*

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| stroke. | Working Group - Implementation of the NZ Guidelines 2010 for Stroke Management. | the Emergency Department. | assessment tool for TIA and implement. Q1 | stroke receive thrombolysis. Refer PP20 Focus area 4.<br>Baseline: Q2 2013/14 -5.3% |
| | | Implement the Acute Stroke Thrombolysis Guideline "Time is Brain'. | • Implement a care plan for thrombolysis for insertion in the Acute Stroke Pathway - Admission to Discharge. Q1<br>• Continue to train staff on the Acute Stroke Thrombolysis Guideline and implement. Q2 | |
| Provide patients who have a stroke with timely access to integrated stroke rehabilitation services. | | Audit the revised Acute Stroke Pathway – Admission to Discharge<br>Audit compliance on the use of the AROC tool. | • Draft data collection tools and trial. Q1<br>• Train staff in the completion of the data collection tools and implement. Q2<br>• Complete a six month audit and present findings. Q4 | • 80% of stroke patients presenting with stroke are admitted to an organised stroke service with a demonstrated stroke pathway. Refer PP20 Focus area 4.<br>Baseline: Q2 2013/13 -67%<br>• 80% of stroke patients have an AROC completed. |
| | | Audit the number of patients with comprehensive post acute rehabilitation plans including transition back to the community. | • Develop a post acute rehabilitation plan format to cover the patient's care across the continuum including the transition back to the community. Q3<br>• Review the format of the post acute rehabilitation care plan at three months post implementation. Q4<br>• Complete audit of patients discharged from stroke services. Q4 | • 80% of stroke patients discharged from the stroke service will have **a** comprehensive post acute rehabilitation plan.<br>• Proportion of people with acute stroke who are transferred to in-patient rehabilitation service.<br>• 60% of people with acute stroke who are transferred to in-patient rehabilitation service who are transferred within 10 days of acute stroke admission. |

### 2.3.3 Cardiac Services




This workstream has been formed to: "provide regional leadership across the South Island cardiac continuum of care through: a supported and planned approach of coordination and collaboration across the delivery of service, reducing inequalities in access to cardiology services across the South Island, enhancing the quality of cardiac health services across the South Island, utilising common referral, prioritisation and condition management tools and ensuring the sustainable management of cardiac services in the South Island."[15] The workstream's key focus areas for 2014/15 are: 1. Meeting national indicators; 2. Equity of access; 3. Health Pathways; 4. Chest Pain Pathway; 5. Guidelines for the arranged transporting of cardiac patients; 6. Guidelines for the transporting/retrieving of emergency/acute cardiac patients; and 7. Minimum facilities guidelines.

SCDHB has an ACS pathway which includes use of the risk stratification assessment tool. An ACS transfer protocol is also in place to assure timely transfer to our tertiary provider. The DHB is able to provide some cardiac diagnostics such as echocardiograms and exercise tolerance tests. The DHB will continue to work with CDHB, its IDF provider to meet the national target for angiography of 34.7 per 10,000. SCDHB is actively involved in the review of cardiology services in the South Island. Our focus for 2014/15 will be embedding the ANZACS-QI and engaging in the regional activity relating to ACS and regional cardiac thoracic services.

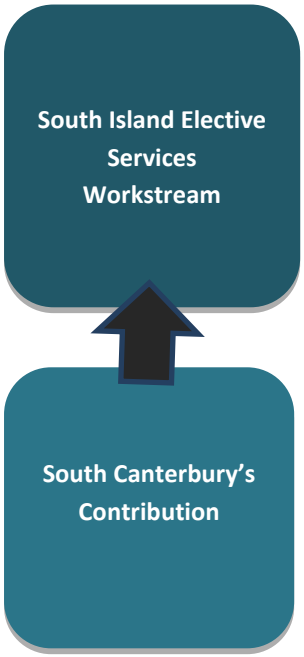
***South Canterbury DHB's Key Local Initiatives 2014/15***

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Improve outcomes for people with suspected Acute Coronary Syndrome. | South Island Cardiac Workstream. | Embed the ANZACS-QI Register introduced in May 2014. | • Continue data submission. Q2<br>• Review baseline performance data against target. Q3<br>• Identify key actions to improve performance. Q4 | • 70% of high-risk patients will receive an angiogram within three days of admission. Refer PP20 Focus area 3.<br>• ≥95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 30 days. Refer PP20 Focus area 3. |
| Support the Ministry of Health plans to introduce 'Accelerated | National Cardiac Network | Finalise SCDHB's ACPP ensuring that this includes the key | • Finalise and publish ACPP. | The introduction of a structured accelerated clinical assessment |

[15] *South Island Regional Health Services Plan 2014 - 2017*

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| chest pain pathways' (ACPP) for suspected acute ischaemic heart disease into the Regional Service Frameworks. | South Island Cardiac Services Workstream. | intervention components included in the national framework. | Q1<br>• Introduce audits against the ACPP. Q3 | pathway has a genuine real-life positive impact on hospital length of stay and other key outcomes of patients presenting to hospital. |
| | Health Research Council and National Health Board collaborative to conduct a pilot study of accelerated diagnostic pathway implementation strategies. | Participate as a pilot site in research relating to accelerated chest pain assessment processes. | • Allocate nurse support for the implementation of this research pilot. Q4<br>• Key clinical stakeholder participation in research pilot. Q4 | |

### 2.3.4 Elective Services




This workstream has been formed to: "explore elective service delivery across the South Island focussing on population need and projections and options to support clinically and financially sustainable service delivery into the future, support the South Island DHBs to achieve the Government elective services waiting time targets, gain a better understanding of the resources (facility and workforce) and the use of production planning across the South Island, undertake analysis of secondary and tertiary referral services and identify the capacity and capability of these services across the South Island. The outcome of the analysis will inform and support future configuration and delivery of elective health services across the South Island and understand the variability of delivery of elective services across the five DHBs of the South Island."[16] The workstream's key focus areas for 2014/15 are 1. Regional equity of access; 2. Regional/sub regional (clinical and business process) collaboration; 3. Integrated whole of system care with the patient at the centre; and 4. Best sustainable use of South Island health system resources.

SCDHB maintains its commitment to sustain current volumes of service delivery and to treat patients in accordance with assigned clinical priority and waiting time. There are well established processes for monitoring and reporting on Elective Services Performance Indicators (ESPI). Achievement in this is aided by the use of national, or nationally agreed CPAC tools and sound production planning. The DHB is tracking towards meeting the expectation that patients will wait no longer than four months for their FSA and patients given a commitment are treated within four months by December 2014. This will remain a focus during 2014/15. The Productive Operating Theatre Programme has been substantially implemented over the last two years and the underlying principles will continue to be embedded. The Early Recovery After Surgery (ERAS) programme for orthopaedics will continue into 2014/15 as will implementing the Aoraki HealthPathways for direct access to elective surgery for tonsillectomy and grommets agreed in 2013/14.

[16] *South ISLAND Regional Health Services Plan 2014 -2017*

### *South Canterbury DHB's Key Local Initiatives 2014/15*

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Provide direct access to two ENT procedures for Primary Care. | SCDHB Elective Services Operational Group. | Embed Aoraki HealthPathways for direct referral for two ENT procedures. | • Determine criteria for direct access. Q1<br>• Draft and consult on an AHP for Direct Access to selected ENT procedures. Q2<br>• Finalise and publish an AHP for Direct Access to selected ENT procedures. Q3<br>• Inform GPs of the Financial Sustainable Threshold for access – Ongoing. | |
| Ensure no patient waits longer than four months for a first specialist assessment and treatment. | Elective Services Performance Indicators. | Reduce the wait time for FSA and treatment by December 2014. | Reduce wait time to four months. Q2 | Compliance demonstrated against ESPI 2 and 5. |
| Support patients to recover from surgery and leave hospital sooner by minimising the stress response on the body during surgery. | SCDHB ERAS Project Group.<br><br>ERAS Orthopaedic Project Plan.<br><br>National Orthopaedic ERAS Collaborative. | Continue the Early Recovery After Surgery approach project for the orthopaedic service. | • Review participant satisfaction with pre-joint surgery education programme. Q1<br>• Review content of pre-joint surgery education programme based on participant feedback and best practise. Q3<br>• Enhance the pathway between the acute surgery unit and the AT&R unit for those patients with a fractured neck of femur through the development of a Fractured Neck of Femur Care Map. Q2<br>• Continue to collect, analyse and act on data utilising the | • Average length of stay for hip and knee joint replacement is ≤ 4 days.<br>• Average length of stay for fractured neck of femur is 7 days.<br>• 100% of South Canterbury patients receiving total hip replacement, total knee replacement and fractured neck of femur surgery are managed according to ERAS principles by November 2014.<br>• Elective Services Productivity and Workforce Programme: National Orthopaedic ERAS Collaborative reporting. |

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| | | | PDSA model to minimise the cause of day of surgery cancellations – Ongoing.<br>• Enhance the ERAS dashboard to reflect ERAS compliance metrics and provide staff with 'status at a glance' – Ongoing. | |

### 2.3.5 Improved Access to Diagnostics

**South Canterbury's Contribution**

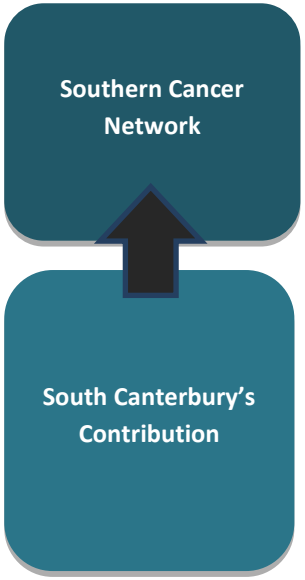
General practitioners have direct access to a number of diagnostics including a comprehensive suite of flat films, direct access to ultrasound, respiratory and cardiac diagnostics, CT and MRI as per AHP guidance, nerve conduction studies, DXA scans and colonoscopy. There has been access to a local MRI since March 2013. 2014 February results show 99.4 percent of patients receive their CT scan within six weeks and 96 percent their MRI within six weeks. Results for colonoscopy waiting times for the same period showed 66.7 percent of people received their urgent diagnostic colonoscopy within two weeks, 22.4 percent a diagnostic colonoscopy within six weeks and 10.6 percent surveillance or follow up colonoscopy within 12 weeks of planned date. The Provation endoscopy software programme was implemented in early 2014. The DHB's focus for 2014/15 will be to manage colonoscopy waiting times to within national targets. MRI/CT and Endoscopy Action Plans have recently been submitted to the Ministry of Health. Detail relating to the National Patient Flow initiative is contained within Chapter 5 Stewardship - Clinical technology/communication page 101.

***South Canterbury DHB's Key Local Initiatives 2014/15***

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Ensure patients have equitable access to timely endoscopy procedures. | SCDHB Endoscopy User Group.<br><br>Colonoscopy Action Plan. | Reduce waiting times for colonoscopy to meet compliance with Ministry of Health guidelines. | • Implement a generic endoscopy waiting list. Q1<br>• Implement the National Referral Criteria for Direct Access to Colonoscopy for colonoscopy. Q1<br>• Approve and publish the Aoraki HealthPathway for Colorectal Symptoms. Q1<br>• Approve and publish the Aoraki HealthPathway for Bowel Screening. Q1 | Monthly National Booking Referral System Diagnostic Reporting. Refer PP29.<br>• 75% of people accepted for an urgent diagnostic colonoscopy receive their procedure within two weeks (14 days).<br>• 60% of people accepted for a diagnostic colonoscopy receive their procedure within six weeks (42 days).<br>• 60% of people waiting for a |

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| | | | | surveillance or follow up colonoscopy wait no longer than 12 weeks (84 days) beyond the planned date. |
| Facilitate safe, patient-focused endoscopy services that are efficient, accountable and sustainable. | SCDHB Endoscopy User Group. | Continue to meet criteria National Endoscopy QIP – Global Rating Scale (GRS). | • Continue to submit endoscopy data via the GRS productivity tool – Ongoing.<br>• Complete QIP self assessment survey and action plan and submit six monthly. Q2 & Q4 | • Report from QI National Endoscopy Team received six monthly post GRS survey. |

### 2.3.6 Cancer Services




The Southern Cancer Network was formed to: "provide a framework that supports the linkages between the South Island DHB's, DHB specialist service providers, NGOs, PHOs, and consumers, coordinate implementation of the cancer control action plan across the South Island, provide a formal structure that supports improvement in coordination of population programmes for prevention and screening and the quality of treatment and provide support to families and patients on the pathway of cancer care."[17] The Alliance's key focus areas for 2014/15 are 1. South Island Faster Cancer Treatment; 2. Improving waiting times for diagnostic services – Colonoscopy; 3. South Island Cancer Service Coordination and Quality Improvement; and 4. South Island Clinical Cancer Information System (SICCIS).

The SCDHB/CDHB Oncology Services Steering Group remains active and is nearing the completion of redesigning an Oncology Model of Care for South Canterbury. The health target of 100 percent of patients' ready-for-treatment waited less than four weeks for radiotherapy or chemotherapy is consistently met by the DHB. MDM's have been introduced and will continue to be enhanced during 2014/15. The DHB has established data collection and submission processes for national FCT monitoring. The Endoscopy QIP has been implemented with regular submission of data occurring alongside self assessment against the framework's domains. Local initiatives during 2014/15 will concentrate on the implementation of MOSAIQ, reviewing the oncology nursing service provision so that it fully supports the redesigned Oncology Model of Care and in working towards achieving the new health target of 85% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment (or other management) by July 2016. It is expected that maintenance of existing initiatives along side those included in the following action plan will provide the necessary structure to support achievement of this target.

[17] *South Island Regional Health Services Plan 2014 - 2017*

*South Canterbury DHB's Key Local Initiatives 2014/15*

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Provide an integrated seamless oncology service which focuses on the patient, delivers services as close to home as possible and supports patient choice in decision making. | SCDHB/CDHB Oncology Services Steering Group. | Implement the revised Oncology Model of Care. | • Finalise process flows for patient journey, clinical pathway and administrative pathway. Q1<br>• Present process flows to the wider consultation group. Q2<br>• Implement agreed oncology pathway communicated to key stakeholders and fully implemented. Q3<br>• Monitor progress against the Oncology Steering Group Action Plan and FCT results - Ongoing. | Monthly FCT Reporting. Refer PP30.<br>• 62 day indicator – 85% of patients referred with a high suspicion of cancer receive their first treatment (or other management) within 62 days.<br>• 31 day indicator – <10 percent of the records submitted by the DHB are declined.<br>• 100 percent of patients' ready-for-treatment wait less than four weeks for radiotherapy or chemotherapy. |
| | Southern Cancer Network. | Implement the MOSAIQ programme. | • Train staff in the use of MOSAIQ and 'go live'. Q1<br>• Check data integrity and take corrective action if required. Q2 | |
| | Southern Cancer Network. | Review local implementation of MDMs. | • Design local MDM processes in collaboration with CDHB which meets patient and clinician need in a secondary care setting i.e. inclusion of CNS presentations. Q1<br>• Trial proposed MDM processes using a PDSA approach. Q2<br>• Evaluate trialled processes and agree finalised structure. Q4 | Refer Improving Waiting Times – Cancer Multidisciplinary Meetings PP24. |

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| | | Review SCDHB Oncology Nursing Service Provision. | • Complete orientation of new staff to CNS positions. Q1<br>• Draft revised Oncology Nursing Care Delivery Model. Q2<br>• Implement revised Care Delivery Model. Q3 | |
| Assist the patient journey from the point that a referral is made with a high suspicion of cancer, through diagnosis to treatment, coordinating care and making sure assessments, diagnostic tests and treatment all occur in a timely, responsive and seamless manner. | Southern Cancer Network | Continue to actively support the Cancer Nurse Coordination role. | • Implement recommendations from the first year report on the South Island implementation of the roles. Q4<br>• Support the Cancer Nurse Coordinator to attend national and regional training and mentoring forums. Q1 – Q4<br>• Continue to embed the single point of contact communication link between the CNC and CDHB Oncology Services. Q1 | CNC professional development attendance records. |
| Ensure patients receive timely, good quality care along the cancer management pathway. | • Ministry of Health roll out of approved tumour standards documents.<br>• Southern Cancer Network Regional Tumour Standards Audit Project. | Deliver services inline with national tumour standards for: Head & Neck, Thyroid and Colorectal. | • Audit current services against published national tumour standards utilising the SCN modified audit tool. Q1<br>• Review audit results and make required service improvements. Q2 & Q3<br>• Review relevant Aoraki HealthPathways to reflect any service improvements. Q4 | Monthly FCT Reporting. Refer PP30.<br>• 62 day indicator – 85% of patients referred with a high suspicion of cancer receive their first treatment (or other management) within 62 days.<br>• 31 day indicator – <10 % of the records submitted by the DHB are declined. |

### 2.3.7 Primary Care

**South Canterbury's Contribution**

The DHB also has an annual decision making process involving consultation with rural GPs to decide how rural funding should be utilised for the year. A plan for distribution of rural funding will be developed by the end of Q4 and be implemented by the end of Q1 2015/16. Development of the Aoraki HealthPathways continues and has recently been supplemented with a Health Infoline which provides DHB endorsed patient information. Activity in this area will continue into 2014/15. The Electronic Referral Management System (ERMS) introduced in 2013/14 is now embedded. Population screening remains a major focus for Primary Care resulting in improved results. Triple enrolment for new-borns is in place and the NIR administration sits within the DHB. Established vaccination programmes such as the flu vaccination and pneumonia immunisation for ≥65 yrs will continue with increased promotion. General practitioners have direct access to colonoscopy, vasectomy and a number of radiological diagnostics as per Aoraki HealthPathways. A number of services have already been transferred to primary care including, nerve conduction studies, DXA scans, aclasta infusions, replacement Mirena™, steroid injections, ECG clinic and sleep apnoea clinic . The DHB does not intend to shift any further hospital based services into the community during 2014/15. Integrated respiratory services workstream projects such as the South Canterbury Air Quality Collaborative, access to respiratory diagnostics, long-term community oxygen therapy and evaluation of the recently established Sleep Apnoea Aoraki HealthPathway will be completed in 2014/15. The primary physiotherapy intervention programme for osteoarthritis will continue to be funded during 2014/15 and an Aoraki HealthPathway for fragility fractures will be introduced. The Community Pharmacy Services Agreement is in place. General practice remains supported by a team of Primary and Community Services clinical nurse and allied health specialists and there is effective liaison between general practitioners and hospital specialists with immediate access to specialist advice as required. There continues to be a good response to the use of non-contact FSAs. The current Primary Performance Programme (PPP) will be replaced by the introduction of the Integrated Performance & Incentive Framework and this will be a focus for the DHB during 2014/15. The Palliative Care Aoraki HealthPathway will also continue to be enhanced. The Integrated Child & Youth Steering Group referenced under the Prime Minister's Youth Mental Health Project will have the mandate to function as a youth specific Service Level Alliance Team, as required for the Youth Mental Health Project and for System Integration: Primary Care.

***South Canterbury DHB's Key Local Initiatives 2014/15***

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Increase the uptake of the flu vaccination by those ≥ 65yrs. | SCDHB Immunisation Steering Group. | Promote the annual flu vaccination programme targeting those patients who are ≥ 65years. | • Develop a Communication Plan containing key messages and opportunities for delivery. Q2<br>• Implement key communication strategies. Q3<br>• Evaluate for any improvement in uptake. Q4 | ≥ 70 percent of the eligible population receive the flu vaccination. |
| Protect those patients who | SCDHB Immunisation Steering | Develop an Aoraki | • Consult with CDHB Cancer | |

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| have received treatment which has compromised immunity against communicable diseases. | Group. | HealthPathway for Vaccination following Cancer Treatment. | Centre to identify requirements. Q1<br>• Draft an Aoraki HealthPathway for vaccination post cancer treatment. Q2<br>• Finalise Aoraki HealthPathway and implement. Q3 | |
| Increase access to sleep apnoea assessment. | SCDHB Integrated Respiratory Services Steering Group – Sleep Apnoea Workstream. | Evaluate service provision for sleep apnoea assessment introduced in 2013/14. | Evaluate the pathway 12 month post implementation. Q4 | 276 local clinic assessments completed. |
| Intervene earlier to delay or remove the need for joint replacement. | SCDHB contract with the South Canterbury Physiotherapist Group. | Continue provision of the Primary Physiotherapy Intervention Group (PPIG) introduced in 2013/14. | Evaluate PPIG programme 12 month post implementation. Q2 | • 54 of patients enrolled in the PPIG Programme.<br>• 80 percent of patients who commence the PPIG Programme complete the full 12 sessions. |
| Standardise access and delivery of respiratory diagnostics. | SCDHB Integrated Respiratory Services Steering Group – Respiratory Diagnostics Workstream. | Complete the Access to Respiratory Diagnostics Project commenced in 2013/14. | • Approve Aoraki HealthPathways for respiratory diagnostics. Q1<br>• Launch Aoraki HealthPathways for respiratory diagnostics. Q2 | |
| Streamline the pathway for long-term oxygen therapy and improve patient support. | SCDHB Integrated Respiratory Services Steering Group – Long-term Community Oxygen Therapy. | Introduce the re-designed patient pathway for long-term community oxygen therapy. | • Approve Aoraki HealthPathway for long-term oxygen therapy. Q1<br>• Deliver key stakeholder presentations on new patient pathway. Q2<br>• Evaluate patient experience. Q3<br>• Audit service against Service Specification for Long-term Oxygen Therapy. Q4 | Compliance with Service Specification for Long-term Oxygen Therapy. |

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Deliver high quality secondary preventative care for fragility suffers to prevent future fractures. | South Island Health of Older Persons Service Level Alliance. | Implement a health pathway for the management of people identified as having fragility fractures. | • Review provision of Aclasta. Q1<br>• Develop and launch an Aoraki HealthPathway for Prevention of Fragility Fractures. Q2<br>• Establish a reporting system to capture fracture information in women over 50 years of age. Q4 | • Number of women over 50 years of age who have had a DXA scan following their first fracture.<br>• Number of women who are over 50 years and have had their first fracture. |
| Decrease variation in palliative care management in South Canterbury. | Palliative Care Implementation Committee. | Embed Palliative Patient Score (PPS) methodology across the district so that the integrated health team are using the same clinical tools. | • Complete staff training in primary, secondary, community, residential and hospice settings. Q1<br>• Implement the PPS tool. Q2<br>• Audit use of the PPS tool for patients referred to the palliative team. Q3 | The PPS tool is used consistently for palliative care patients across the sector. |
| Replace the existing Primary Care Performance Programme (PPP). | National Health Board. | Transition from the existing PPP to the Integrated Performance Incentive Framework (IPIF). | Implement the IPIF) inline with national roll out. Q1 | A comprehensive suite of primary care performance measures is available for monitoring and analysis within the DHB. |

### 2.3.8 Health of Older People


This Alliance was formed to: "lead the development of disability support services for older people across the South Island through: developing sustainable models of care and systems for the delivery of quality health services for older people and providing expertise and guidance around delivery of service to the South Island population over 65."[18] The Alliance's key focus areas for 2014/15 are: 1. Dementia Services – implementing the New Zealand framework for dementia care in the South Island; 2. Develop the primary care workforce and improve timeliness of diagnosis through delivery of dementia awareness and responsiveness education programmes; 3. Restorative Model of Care; 4. Comprehensive Clinical Assessment (InterRAI) – use of a standardised assessment tool designed for older people to facilitate a system wide approach to common assessment across the continuum; 4. Falls Prevention and Fracture Liaison Service; and 5. Advance Care Planning.

SCDHB's restorative approach to providing services for older people supports its philosophy of 'Ageing in Place'. Wrap around services for older people includes both urban and rural home based support services. The DHB is committed to adding CCP to home based support service agreements for the 2014/15 year and will continue to commit the additional funding received in 2013/14 to these services. An Aged Related Cognitive Impairment Pathway has been agreed and is supported by WIAS training. The DHB will continue to progress its Dementia Action Plan which was updated in 2014. Age related care providers have engaged with InterRAI and the DHB will support training rolled out during 2014/15 inline with the national training schedule. Falls prevention remains a priority for the DHB and a Combined Community/Health Falls Prevention Steering Group was formed in 2013/14 (See Stewardship – Quality & Safety for further detail). There is ready access to a geriatrician for advice and this clinical expert resource will be maintained during 2014/15 to provide education for health professionals on the care of the elderly. Registered nurses receive support to attend gerontology courses as these are available. Elder abuse and neglect policy and procedures are in place inline with national guidelines. The DHB's initiatives during 2014/15 will concentrate on developing and implementing an Aoraki HealthPathway for Fragility (see the section on Primary Care for detail), progressing the implementation of advance care planning (see the section on Quality and Safety for detail) and implementing recommendations from the Centre of Excellence for Health of Older Persons Concept Paper approved in 2014, including : a single point of entry for referrals, wrap around services, establishment of a community multidisciplinary team, rapid response and discharge management. The South Island Health of Older Persons Service Level Alliance is developing quality indicators from the InterRAI data which all SI DHBs will report and use for quality improvement initiatives.

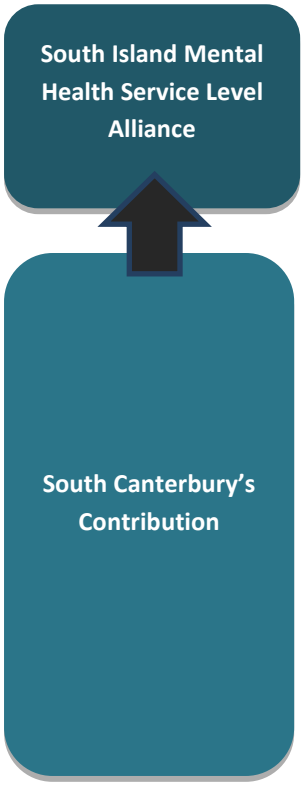
***South Canterbury DHB's Key Local Initiatives 2014/15***

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Increase staff knowledge and competency in caring for the older person including early diagnosis of dementia. | South Island Health of Older Persons Service Level Alliance. | Utilise local expertise in Health of Older People Services to up-skill primary and secondary care clinicians in contemporary treatment practices when diagnosing and caring for the older person. | • Deliver training to aged care providers. Q2<br>• Update session delivered to GP Forum. Q3<br>• Deliver CME session to secondary care clinicians. Q4 | Four training sessions are delivered during 2014/15. |

[18] *South Island Regional Health Services Plan 2014 - 2017*

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Support the uptake of InterRAI training by aged related residential care facilities. | South Island Health of Older Persons Service Level Alliance. | Continue to support the implementation of the national training schedule for the roll-out of Clinical Care Assessments in aged related care facilities in South Canterbury. | Ongoing. | All aged residential facilities in the DHB area are fully compliant by July 2015. |
| Develop and improve dementia care and resources available in South Canterbury. | National Framework for Dementia - SCDHB Dementia Action Plan. | Maintain a dementia pathway which reflects the intentions of the National Dementia Care Pathway Framework. | • Review Cognitive Impairment Pathway to ensure continued best practice. Q4<br>• Continue participation in the South Island WIAS Programme – Ongoing.<br>• Work with Alzheimers South Canterbury to increase access to clinics and education programmes for both clients and carers – Ongoing. | Reports on progress against the Dementia Action Plan received at each SCDHB DSAC meeting. |
| Delivery of priority areas within the Concept Plan for health services to older people within South Canterbury. | SCDHB Centre of Excellence for Older Persons Steering Group.<br>Centre of Excellence Project Plans. | Implement prioritised recommendations based on Steering Group planning from the Centre of Excellence Concept Plan developed in 2013/14. | • Implement a single point of entry for Health of the Older Person community referrals. Q2<br>• Further development of wrap around services for older persons – Ongoing.<br>• Establish a community multi-disciplinary team. Q4<br>• Continue implementation of rapid response. Q1<br>• Improved transition of discharge to the community through improved referrals pathways to community services. Q4 | • ≤10.1 percent of acute readmissions to hospital for those over 75 years of age. Refer OS8.<br>• Report on wrap around services for older people. Refer PP24. |

### 2.3.9 Mental Health Service Development Plan




This Alliance has been formed to: "provide advice, guidance and direction to the South Island mental health sector through: best integration of funding and population requirements for the South Island and providing service provision across the continuum of primary, community, secondary and tertiary services".[19] The Alliance's key focus areas for 2014/15 are: 1. Improved access to the range of eating disorder services; 2. Improved adult forensic service capacity and responsiveness through the national forensic network; 3. Improved youth forensic service capacity and responsiveness; 4. Improved perinatal and maternal mental health service residential options as part of a service continuum; and 5. Improved mental health and addiction service capacity for people with high and complex needs.

SCDHB continues to respond to The Mental Health and Addiction Service Development Plan 2012 – 2017 – 'Rising to the Challenge'. The Key Performance Indicator (KPI) project continues to drive better clinical outcomes with the introduction of the Alcohol and Drug Outcome Measure (ADOM) scheduled for 2014/15. The Choice and Partnership Approach (CAPA) is utilised across secondary services with referrals managed through a single point of entry. SCDHB has an active Suicide Prevention Plan 2013-2016 which includes access to training across key sectors to support people to identify when others maybe at risk of suicide and provides guidance on referral pathways. The DHB's Suicide Response (Postvention) Plan which demonstrates a cross agency collaborative response to suicide clusters/contagion will be reviewed after the release of the MOH tool kit. This tool kit contains guidance for DHB's on suicide prevention and postvention and is currently under development. The DHB continues to implement their Co-existing Problems Plan. Staff are trained using the 'Lets Get Real' Skills Competency Framework. Inline with the regional direction the DHB will continue to introduce the Maudsley family based eating disorder programme and localise the maternal depression pathway during 2014/15. The DHB currently contracts a position with Plunket to provide post natal depression support along with funding for families. The DHB continues to engage in the regional development of youth forensic services which utilises the 'hub and spoke' approach. SCDHB is participating in the development of local initiatives derived from the Youth Crime Action Plan. In response to 'Rising to the Challenge' the DHB will implement programmes for COPMIA, e-therapy programmes for depression, anxiety and addiction and focus on improving the mental health of older people, specifically relapse prevention planning, joint clinical consultations between primary care and specialist services and managing addictions in the older person. The DHB will meet the mental health ring fence expectations.

***South Canterbury DHB's Key Local Initiatives 2014/15***

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Provide timely and equitable access to eating disorder services for the children and youth in South Canterbury. | South Island Mental Health Service Level Alliance. | Deliver the Maudsley family based eating disorders programme for children and youth locally. | • Make programme available locally. Q1<br>• Commence trainer attendance at monthly peer review meetings. Q1 | • Number of children and youth offered the Maudsley family based therapy programme.<br>• Number of children and youth who successfully complete the Maudsley family based therapy |

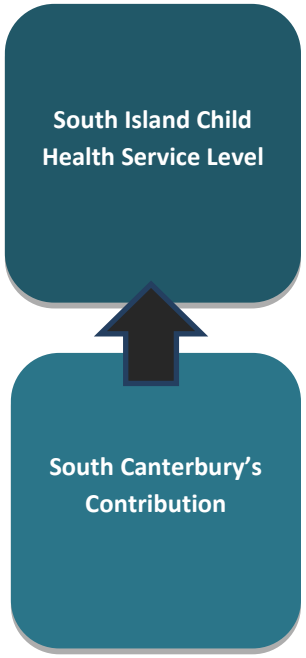
[19] *South Island Regional Health Services Plan 2014 - 2017*

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| | | | | programme. |
| Provide a youth-focused forensic mental health service that is non-stigmatising and culturally appropriate for young people involved with the justice system within South Canterbury. | South Island Mental Health Service Level Alliance. | Continue to implement the regional 'hub and spoke' approach to youth forensic services. | • Complete Service Framework – Youth Justice Service. Q1<br>• Participate in the development of a South Canterbury intersectoral action plan as outlined by the YOT Governance Group - Ongoing. | • Service Framework audits are undertaken with 85% compliance.<br>• Regular attendance at monthly YOT meetings. |
| Support women with a history of depression throughout their pregnancy and during the post natal period. | South Island Mental Health Service Level Alliance. | Localise the regional pathway for maternal depression. | • Approve and publish the Aoraki HealthPathway for Maternal Depression. Q1 | |
| Increase resilience and improve outcomes for children of parents with mental illness or addictions. (Ref. Rising to the Challenge 4.15). | South Island Mental Health Service Level Alliance.<br><br>Mental Health and Addiction Service Development Plan Rising to the Challenge 2012 – 2017. | Implement a group-based psycho-education programme that provides the children of parents with mental health and addiction issues (COPMIA) with information, peer support and tools to promote resilience, self-esteem and coping strategies. | • Screen adults entering mental health and addiction services to identify children who may require further supportive interventions – Ongoing<br>• Localise a COPMIA programme which reflects the South Island Mental Health Service Level Alliance selected direction. Q4 | Mental Health & Addiction Service Development Plan reporting. Refer PP26. |
| Improve specialist service performance using national performance indicators and service user feedback. (Ref. Rising to the Challenge 1.8). | Mental Health and Addiction Service Development Plan Rising to the Challenge 2012 – 2017. | Continue the KPI Project for Mental Health Services. | • Collect, analyse and report KPI data – Ongoing.<br>• Analyse data and report on National Consumer Survey data – Ongoing.<br>• Implement ADOM training and data collection. Q1<br>• Modify Ajexus IT system to enable reporting. Q1 | • ADOM outcome measures available for three monthly case reviews.<br>• Mental Health & Addiction Service Development Plan reporting. Refer PP26. |
| Provide services in ways that are efficient as well as effective. | Mental Health and Addiction Service Development Plan | Implement e-therapy options for clients for; depression, | • Implement programmes. Q1 | • Number of people offered e-therapy for depression, |

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| (Ref. Rising to the Challenge 1.10). | Rising to the Challenge 2012 – 2017. | anxiety and addiction. | | anxiety and addiction.<br>• Number of people who successfully complete e-therapy programmes for depression, anxiety and addiction.<br>• Mental Health & Addiction Service Development Plan reporting. Refer PP26. |
| Work to prevent suicide among people known to mental health and addiction services. (Ref. Rising to the Challenge 3.9). | Mental Health and Addiction Service Development Plan Rising to the Challenge 2012 – 2017. | Update South Canterbury DHB's Suicide Response (Postvention) Plan. | • Review the localised plan against nationally developed tool kit for suicide prevention and postvention which includes an update of the SCDHB Suicide Response Plan using a cross agency collaboration approach to reduce instances of suicide clusters. Q1<br>• Advise changes in the Suicide Response Plan to key stakeholders. Q2<br>• Continue the Suicide Prevention Coordinator position – Ongoing.<br>• Continue Gatekeeper training – Ongoing. | • Monitor instances of suicide clusters or contagion with an aim for this to be zero.<br>• Mental Health & Addiction Service Development Plan reporting. Refer PP26. |
| Promote wellness planning in the older population. (Ref. Rising to the Challenge 7.2). | Mental Health and Addiction Service Development Plan Rising to the Challenge 2012 – 2017. | Introduce relapse prevention planning into the psycho-geriatric service alongside EPOA and ACP. | • Train staff working with psycho-geriatric patients in relapse prevention planning. Q1<br>• Implement Relapse Prevention Plans. Q2 | • 95% of psycho-geriatric patients will have a Relapse Prevention Plan.<br>• Mental Health & Addiction Service Development Plan reporting. Refer PP26. |
| Enhance the delivery and integration of specialist mental health and addiction services | Mental Health and Addiction Service Development Plan Rising to the Challenge 2012 – | Review current service delivery interface with primary care. | Continue consult liaison between psycho geriatrician, psycho geriatric CNSs and | • Joint patient consultations.<br>• Joint case review of complex cases. |

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| within primary care and health services for older people. (Ref. Rising to the Challenge 7.4). | 2017. | | primary care clinicians – Ongoing. | • Mental Health & Addiction Service Development Plan reporting. Refer PP26. |
| Ensure addiction services are responsive to the needs of older people. (Ref. Rising to the Challenge 7.5). | Mental Health and Addiction Service Development Plan Rising to the Challenge 2012 – 2017. | Deliver education to Aged Related Residential Care (ARRC) providers in the management of the older person with addiction issues. | • Design a training programme for staff in ARRC. Q3<br>• Offer training programme to ARRC. Q4<br>• Develop a resource kit on Health of Older Persons Addictions Management and make available to ARRC. Q4 | • ARRC facilities have access to a training programme and resource kit on Health of Older Persons Addictions Management for use with their residents with addictions.<br>• Mental Health & Addiction Service Development Plan reporting. Refer PP26. |
| Enhance the responsiveness and flexibility of specialist mental health services for older people. (Ref. Rising to the Challenge 7.6). | Mental Health and Addiction Service Development Plan Rising to the Challenge 2012 – 2017. | Input Health of Older Person data into PRIMHD to support development of mental health services for those over 65 years. | • Continue psycho geriatric community assessments – Ongoing.<br>• Train staff to input own community assessment activity into Ajexus. Q2 | • Health of Older Persons Psycho geriatric Services data included in PRIMHD reporting.<br>• Mental Health & Addiction Service Development Plan reporting. Refer PP26. |
| Ensure that decisions Youth Aid make as to whether a warning, alternate action or pre-family group conferencing consultation are underpinned by knowledge from CYF, health and education ensuring a coordinated response, resulting in a reduction in offending, re-offending and victimisation rates. | Youth Crime Action Plan 2013-2023. | Participate in the development and implementation of the district Pre-Family Group Conferencing Consultation Model. | • Client information is submitted to Youth Aid - on request - Ongoing.<br>• Attendance at client interagency meeting to review information agencies hold and contribute to decisions made - Ongoing. | The Government's Better Public Services target of reducing youth crime by 25 percent by 2017. |
| Work with other local agencies to address identified local youth crime problems. | Youth Crime Action Plan 2013-2023. | Participate in the review of the local Youth Offending Team (YOT). | • Continue membership of the reviewed YOT through attendance by the youth forensic key worker. Q1 | The Government's Better Public Services target of reducing youth crime by 25 percent by 2017. |

### 2.3.10 Maternal and Child Health




This Alliance was formed to: "improve the health outcomes for children and young people of the South Island through: transforming healthcare services and supporting clinical decision making and the shifting of activities close to home and communities that children and young people live in, working in partnership and linking with national, regional and local teams/groups to make strategic health care decisions using a "whole-of-system" approach, supporting collaboration and integration across the South Island DHBs and inter-sectorial groups/organisations (education, social welfare) to make the best of health resources and balancing a focus on the highest priority needs in our communities, while ensuring appropriate care across all our populations." [20] The Alliance's key focus areas for 2014/15 are: 1. Growing up healthy – responding to national strategies for improving children's health outcomes and prevention of child abuse; 2. Young persons health – responding to the Prime Minister's Youth Mental Health Project; and 3. Access to Child Health Services – supporting innovation, good practice and equity based on the Children's Commissioner Compass Report 2013.

SCDHB's Integrated Child and Youth Steering Group continues to develop its Integrated Model of Care for Child and Youth and in 2014/15 will direct its attention to establishing a community paediatric nursing service and strengthening psychological support for children and youth with high needs and their families. There is an active Maternity Services Quality & Safety Steering Group. An annual report is produced outlining achievement against the Maternity Services Quality & Safety Plan. During 2014/15 there will be an effort to improve both consumer feedback options along with the quality of information provided to women throughout their pregnancy. The DHB's maternity service actively engages in the Maternity Clinical Indicator Programme. There is an established public health nursing service which provides a wide range of services including a school based HPV programme. South Canterbury performs well against most Well Child Tamariki Ora (WCTO) Quality Improvement Indicators. It has developed a WCTO Quality Improvement Plan, selecting an area for action against each of the domains of access, outcomes and quality. The main initiative for the DHB's maternity service during 2014/15 is the implementation of BadgerNET.

***South Canterbury DHB's Key Local Initiatives 2014/15***

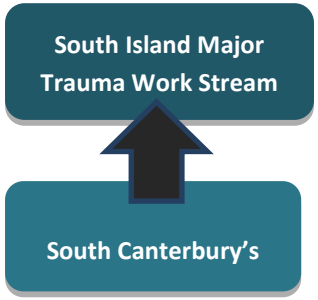
| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Meet the health and wellbeing needs of children and youth in South Canterbury across the full continuum of care; through the life course from before birth to transition to adulthood. | SCDHB Integrated Child and Youth Model of Care. | Establish an integrated Child and Youth Services Steering Group which includes representation from primary, secondary and NGO services to provide leadership in the development and oversight of the provision of child and youth services. | • Finalise Integrated Child and Youth Services Steering Group membership and Terms of Reference. Q1<br>• Hold Integrated Child and Youth Services Steering Group inaugural meeting. Q2<br>• Approve Child Services Working Group membership and Terms of Reference. Q2 | Approved: Terms of Reference, meeting minutes and action plan. |

[20] *South Island Regional Health Services Plan 2014 - 2017*

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| | | | • Hold Child Services Working Group planning meeting. Q2 | |
| Engage with the local community of maternity consumers to inform quality improvement and service provision. | Maternity Services Quality & Safety Steering Group – Maternity Services Quality & Safety Plan. | Increase the percent of maternity service consumers being surveyed on their experience of/satisfaction with maternity service in South Canterbury by implementing alternative options for gaining user feedback. | • Redesign consumer feedback form and test with consumers. Q1<br>• Provide paper feedback form with pre-paid envelope to all women on discharge from maternity services. Q1<br>• Provide a link on SCDHB website to a Maternity Services Survey Monkey. Q1<br>• Explore options for and agree a way forward for establishing a consumer forum. Q2 | • 100% of South Canterbury maternity service consumers are provided with an opportunity to give formal feedback at any stage of their maternity journey/experience.<br>• The rate of consumer feedback will increase from 6-7% of the birthing population to at least 35% in the first year of the new approach. |
| Deliver appropriate information to women on how to maintain a healthy pregnancy and how to access local services. | Maternity Services Quality & Safety Steering Group – Maternity Services Quality & Safety Plan. | Complete the suite of healthy pregnancy packages available to women in South Canterbury by developing second and third trimester information packs. | • Determine the key information requirements for each pack. Q1<br>• Trial the packs with a consumer focus group. Q2<br>• Provide packs to all pregnant women. Q2 | Consumer feedback indicates satisfaction with information packs available. |
| Diagnose and manage women with gestational diabetes based on evidence based guidance. | Ministry of Health. | Review existing protocol to ensure it reflects the national guidance document on gestational diabetes once released. | • Review the Aoraki HealthPathway for Gestational Diabetes. Q4 | |
| Provide a complete managed service solution for live patient data management for maternity and neonatal critical care. | Ministry of Health national roll out.<br><br>South Island IT SLA. | Implement the BadgerNet system in the maternity service. | • Deliver staff training. Q1<br>• Launch system. Q2<br>• Provide maternity service providers with regular updates on progress – Ongoing. | Reporting structure Version 1.<br>Interface with other systems as per national timeframes. |

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Provide a paediatric outreach nursing service which supports children and their families and is provided in the child's home. | Child & Youth Steering Group – Integrated Child & Youth Model of Care. | Implement a paediatric outreach service within the community district nursing service team to support children and young people and their families in the community. | • Finalise entry criteria. Q1<br>• Finalise referral pathway. Q2<br>• Allocate nursing resource to position. Q3 | |
| Provide psychological support for children and their families. | Child & Youth Steering Group – Integrated Child & Youth Model of Care. | Improve access to psychology support for high needs child and youth and their families. | • Finalise entry criteria. Q1<br>• Finalise referral pathway. Q2 | |
| Increase the number of core contacts for 0-12 month for Māori infants. | WCTO Quality Improvement Framework. | Continue to recall infants prior to the due date for their core contact utilising a personalised approach based on mother's choice. | Monitor the effectiveness of the recall system implemented in 2013/14 and utilise the PDSA approach to gain further improvement if required. Q1 | 86% of Māori infants have received their core contacts in their first year of life by December 2014 |
| Increase the number of Māori mothers who are smokefree at two weeks post natal. | WCTO Quality Improvement Framework. | Utilise BadgerNET to capture smoking status at two weeks post-natal. | • Develop a process for capturing data for inputting into BadgerNET. Q1<br>• Develop a BadgerNET reporting function to provide smoking status by ethnicity. Q2<br>• Continue smokefree cessation and support – Ongoing. | 86% of Māori mothers are smokefree at two weeks post natal by December 2014. |
| Increase the number of children with a 'lift the lip' score of 2-6 referred. | WCTO Quality Improvement Framework. | Provide LTL assessment to all children at the B4SC and lower the referral threshold to dental therapy for all children with a score of >1. | Monitor effectiveness of the Ministry of Health Before School monthly performance against target report – Ongoing. | 86% of children with a 'lift the lip' score of 2-6 are referred by December 2014. |
| Improve the timeliness of LMC registration for women choosing an obstetrician as their LMC. | | Consolidate the process introduced in 2014 for the registration of women who choose an obstetrician as their LMC. | • Women who choose an obstetrician as their LMC receive their initial ante-natal assessment by a Continuity of Care Midwife and are registered at eight weeks. | 80% of women register with an LMC by week 12 of their pregnancy. |

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| | | | Q1<br>• LMC Midwives continue to register women on initial assessment at six – seven weeks. Q1 | |




The South Island Alliance will establish a Major Trauma Workstream in 2014/15. The key focus areas of this workstream are; 1. South Island Region Major Trauma Plan; 2. NZ Major Trauma Minimum Dataset; 3. NZ Major Trauma Registry; and 4. Clinical Leadership.

South Canterbury DHB will contribute to the regional reports on major trauma using the agreed national minimum dataset and contribute to the National Major Trauma Registry.

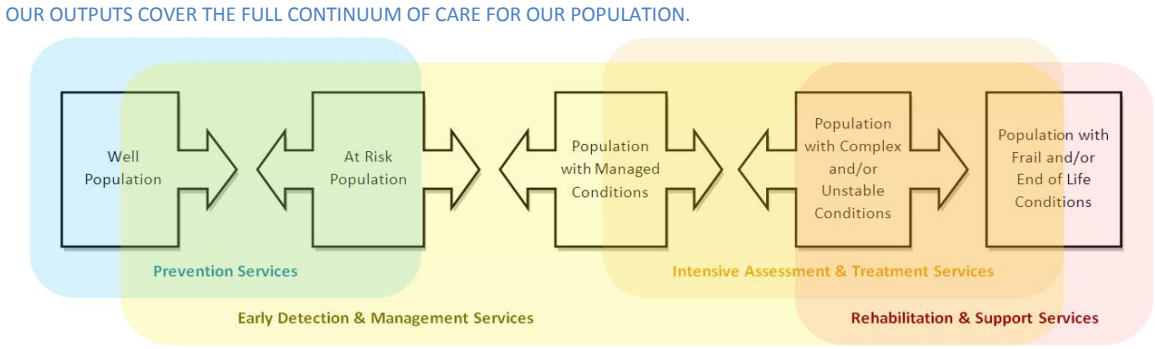
# CHAPTER 3: STATEMENT OF PERFORMANCE EXPECTATIONS

## 3.1 How will we measure our performance?

Over the long term, we aim to make positive changes in the health status of our population. As the major funder and provider of health and disability services in South Canterbury, the decisions we make about which services will be delivered have a significant impact on our population and, if coordinated and planned well, will improve the efficiency and effectiveness of the whole South Canterbury health system.

Understanding the dynamics of our population and the drivers of demand is fundamental when determining which services to fund for our population and at which level. Just as fundamental is our ability to assess whether the services we are purchasing and providing are making a measurable difference in the health and wellbeing of our population.

**Figure 3: Scope of DHB operations – output classes against the continuum of care.**




One of the functions of this document is to demonstrate how we will evaluate the effectiveness of the decisions we make on behalf of our population. Over the longer term we do this by measuring our performance against a set of desired outcomes which are outlined in the strategic direction section (Chapter 1) of this document and highlighted in the intervention logic on page 12.

In the more immediate term, we evaluate our performance by providing a forecast of our planned outputs (what services we will fund and provide in the coming year). These are also outlined in Chapter 1. We then report actual performance against this forecast in our end of year Annual Report.[21]

In order to present a representative picture of performance, outputs have been grouped into four *'output classes'* ; Prevention Services; Early Detection and Management; Intensive Assessment and Treatment Services; and Rehabilitation and Support Services that are a logical fit with the stages of the continuum of care and are applicable to all DHBs.

Identifying a set of appropriate measures for each class is difficult. We cannot simply measure *'volumes'*. The number of services delivered or the number of people who receive a service is often less important than whether *'the right person'* or *'enough'* of the right people received the service, and whether the service was delivered *'at the right time'*.

In order to best demonstrate this we have chosen to present our forecast of service performance expectations using a mix of measures which focus on four key elements of performance:

- Quantity (V) – to demonstrate volumes of services delivered;
- Quality (Q) – to demonstrate safety, effectiveness and acceptability;
- Timeliness (T) – to demonstrate responsive access to services; and
- Coverage (C) – to demonstrate the scope and scale of services provided.

[21] *SCDHB Annual Reports can be found at www.scdhb.health.nz*

All of these help us to evaluate different aspects of our performance and against which we have set targets to demonstrate the standard expected.

The output measures chosen cover the activities with the potential to make the greatest contribution to the wellbeing of our population in the shorter term and to the health outcomes we are seeking over the longer term. They also cover areas where we are developing new services and expect to see a change in activity levels or settings in the coming year – and therefore reflect a reasonable picture of activity across the whole of the South Canterbury health system.

To ensure the quality of services provided, the DHB invests in programmes that are evidence-based or evidence-informed where research shows definite gains and positive outcomes such as Green Prescription, ABC smoking cessation, and InterRAI assessments. This provides the DHB with greater assurance that these are 'the right services', allowing us to focus on monitoring implementation and whether the right people have access at the right time and in the right place.

***Setting targets***

Wherever possible, we have included baseline data to support evaluation of our performance at the end of the year, and the most recently published national averages to give context in terms of what we are trying to achieve.

In setting performance targets, we have considered the changing demographics of our population, increasing demand for health services and the assumption that funding will be limited. Targets tend to reflect the objective of maintaining performance levels against increasing demand growth but reducing waiting times and delays in treatment to demonstrate increased productivity and capacity.

Targets that demonstrate growth in service activity or the establishment of new services tend to be based in primary and community settings (closer to people's own homes) and are set against programmes that will support people to stay well and reduce demand for hospital and residential care.

Our targets also reflect our commitment to reducing inequalities between population groups, and hence some measures appropriately reflect a specific focus on high needs groups.

Some selected measures are new and as such have no baseline data. A number of the output measures also relate to South Canterbury specific services for which there is no national comparison or national average available. It is also important to note a significant proportion of the services funded/provided by the DHB are driven by demand. Estimated service volumes have been provided to give the reader context in terms of the use of resource and capacity across the South Canterbury system, however these estimated volumes are not seen as targets and are not set as such. They are provided for information to give context to the picture of performance. Some data is provided to the DHB by external parties and is provided by calendar and not financial year, where this occurs this has been noted. Where measures are also included in Chapter 7 'DHB Performance Expectations' which sets out the Ministry of Health's Performance Monitoring Framework these are referenced as such. The following abbreviations are used: PP – Policy Priorities, SI – System Integration, and OS – Ownership.

***Where does the money go?***

The table at Page 70 provides a summary of the 2014/15 budgeted financial expectations by output class.

Over time, we anticipate it will be possible to use this output class framework to demonstrate changes in allocation of resources and activity from one end of the continuum of care to the other.

## Output Class

## 3.2 Prevention Services

***Output class description***

Preventative health services promote and protect the health of the whole population, or identifiable sub-populations, and address individual behaviours by targeting population-wide changes to physical and social environments that engage, influence and support people to make healthier choices. These services include education programmes and services to raise awareness of risk behaviours and healthy choices, the use of legislation and policy to protect the public from toxic environmental risks and communicable diseases, and individual health protection services such as immunisation and screening programmes that support early intervention to modify lifestyles and maintain good health.

These services are the domain of many organisations across the region including: the Ministry of Health; Community and Public Health (the public health unit of Canterbury DHB which provides services for the South Canterbury region); primary care and general practice; a significant array of private and non-government organisations; and local and regional government. Services are provided with a mix of public and private funding.

***Why is this output class significant for the DHB?***

By improving environments and raising awareness, these services support people to make healthier choices, reducing the major risk factors that contribute to long-term conditions and delaying or reducing the impact of these conditions. Services are often designed to disseminate consistent messages to large numbers of people and can be cost-effective. High need and at-risk population groups are also more likely to engage in risky behaviours and to live in environments less conducive to making healthier choices. Prevention services are therefore also our foremost opportunity to target improvements in the health of high need populations and to reduce inequalities in health status and health outcomes.

Successful provision of these services will reduce risk factors such as smoking and improve positive behaviours such as breastfeeding, healthier diets and regular exercise – which will improve the overall health and wellbeing of our population. The effect of these outputs is demonstrated in the medium term impact and long term outcome measures included in Chapter 1.

### Output Subsets: SHORT TERM PERFORMANCE MEASURES 2014/15

| **Health Promotion and Education Services**<br>These services inform people about risks and support them to be healthy. Success is measured by greater awareness and engagement, reinforced by programmes that support people to maintain wellness, change personal behaviours and make healthier choices. | **Notes** | **Actual 2011/12** | **Actual 2012/13** | **Target/Est. Delivery 2014/15** | **2012/13 National Average** |
|---|---|---|---|---|---|
| Percentage of babies breast-fed (exclusive and full) in the district at 6 weeks of age | C,Q [1] | 73% (2011) | 70% | ≥ 73% | 65% |
| Percentage of babies breast-fed (exclusive and full) in the district at 3 months of age | C,Q [1] | 54% (2011) | 56% | ≥ 58% | 55% |
| Percentage of babies breast-fed (exclusive and full) in the district at 6 months of age | C,Q [1] | 26% (2011) | 25% | ≥ 28% | 24% |
| No. of people in South Canterbury accessing smoking cessation programmes | V [2] | 1205 | 873 | ≥ 500 | - |
| Percentage of people who receive brief invention to quit smoking in the hospital setting | C | 96% | 98.8% | ≥ 95% | 95.8% |
| Percentage of people who receive brief invention to quit smoking in the primary care setting | C | 35.4% | 76% | ≥ 90% | 56.9% |
| No. of Green Prescription referrals | V [3] | 360 | 385 | ≥ 520 | - |
| Percentage of education settings engaged with | C [4] | ≥99% | 99% | ≥ 99% | - |

| | | | | | |
|---|---|---|---|---|---|
| WAVE | | | | | |
| Family Violence Intervention Programme Evaluation Audit score of hospital responsiveness to child abuse above the national benchmark score of 70 | Q [5] | 91 | 96 | ≥91 | - |
| Family Violence Intervention Programme Evaluation Audit score of hospital responsiveness to partner abuse above the national benchmark score of 70 | Q [5] | 92 | 92 | ≥92 | - |

[1] The proportion of women breastfeeding is seen as a measure of service quality, demonstrating the effectiveness of consistent, collective health promotion messages delivered during the antenatal period and the value of breast feeding support during the post natal period. Data is sourced from Plunket via the Ministry of Health. Results exclude data from Arowhenua Whānau Services.

[2] These volumes relate to DHB funded programmes and the target for 2014/15 is targeted at people with specialised needs. Others will be referred to programmes such as Quitline.

[3] The Green Prescription initiative is a way to improve the health of New Zealanders. This service is provided on referral to Sport Canterbury for adults and focuses on sustaining physical activity to improve health outcomes.

[4] WAVE stands for "Well-being and Vitality in Education". It is a health promotion initiative that works collaboratively between education, health and Sport Canterbury and works across all levels of education to help create and support healthy environments.

[5] The Family Violence Intervention Programme audits compliance against the National Guidelines for Partner and Child Abuse and contract specifications for this service.

| **Population Based Screening**<br>These services are mostly funded and provided through the National Screening Unit and help identify people at risk of illness earlier. They include breast and cervical screening. The DHB's role is to encourage uptake, as indicated by high coverage rates. | **Notes** | **Actual 2011/12** | **Actual 2012/13** | **Target/Est. Delivery 2014/15** | **2012/13 National Average** |
|---|---|---|---|---|---|
| Percentage of enrolled women aged 25 – 69 years who have had a cervical screen in the last three years | T [6] | 75.8% | 76.1% | ≥ 80% | 76.72% |
| Percentage of Māori enrolled women aged 20 – 69 years who have had a cervical screen in the last three years | T [6] | 66.25% | 69.50% | ≥ 80% | |
| Percentage of enrolled women aged 45 – 69 years who have had breast screening mammography as part of the national mammography screening programme in the last two years | T [6] | 81.4% (50 – 69 years) | 84.3% (45 – 69 years) | ≥70% | 71.93% (45 – 69 years) |
| Percentage of Māori enrolled women aged 45 – 69 years who have had breast screening mammography as part of the national mammography screening programme in the last two years | T [6] | 80% (50 – 69 years) | 77.6% (45-69 years) | ≥ 70% | 64.74% (45 – 69 years) |
| No. of B4 School Checks completed | V [7] | 652 | 816 | ≥ 613 | - |
| Percentage of eligible population provided with a B4 School Check | C [7] | 95.58% | 100% | ≥ 90% | |
| No. of 'high needs' B4 School Checks completed | V [7] | 74 | 87 | ≥ 62 | - |
| Percentage of eligible 'high needs' population provided with a B4 School Check | C [7] | 100% | 100% | ≥ 90% | |

[6] These national screening programmes screen women for signs of breast and cervical cancer to enable early treatment to reduce the rate of associated mortality. Result for cervical screening total population is based on NCSP data, whereas results for the Māori population are taken from the Primary Performance Programme where the age band is 20 – 69 years. The age band for data reporting from the National Cervical Screening Programme changed in 2012 from 50-69 to 45-69. All results for mammography are taken from Breast Screen Aotearoa data.

[7] The B4 School Check is the final core Well Child/Tamariki Ora check, which children receive at age four. It is free and includes vision, hearing, oral health, height and weight. The check allows health concerns to be identified and addressed early in a child's development.

| **Immunisation**<br>These services reduce the transmission and impact of vaccine-preventable diseases including unnecessary hospitalisations. The DHB works with primary care and allied health professionals to improve the provision of immunisations across all age groups both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service. | **Notes** | **Actual 2011/12** | **Actual 2012/13** | **Target/Est Delivery 2014/15** | **2012/13 National Average** |
|---|---|---|---|---|---|
| Percentage of 8 months old fully immunised on time | T,C | 92% | 88% | ≥ 95% | 90.1% |
| Percentage of 2 years old fully immunised on time. Ref PP21. | T,C | 94% | 94% | ≥ 95% | 92% |
| Percentage of the eligible population receiving the flu vaccination | C | 66.79% | 68% | ≥ 70% | |
| No. ≥ 65 year olds immunised for pneumonia | C [8] | 736 | 391 | ≥180 | - |
| No. of HPV vaccinations completed for consenting adolescents through the school based programme. | V [9] | NEW | 130 (2013) | 115 (2014) | - |

[8] This immunisation programme commenced in 2011. The planned volumes for the first two years of this programme were set at 850/year to address the back log and then reducing to 180/year ongoing. The vaccine is expected to last 5 years.

[9] The measure is based on young women 12 - 18 who have been provided with all three doses through the school based programme commenced in 2013. The timing of this measure is a calendar year.

## Output Class

## 3.3 Early Detection and Management

***Output class description***

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

These services are by nature more generalist, usually accessible from multiple providers and a number of different locations. They include general practice, primary and community services, personal and mental health services, Māori and Pacific health services, pharmacy services, community radiology and diagnostic services and child oral health services.

Some of these services are demand-driven, such as pharmaceuticals and laboratory tests, and services are provided with a mix of public and private funding and may include co-payments for general practice services and pharmaceuticals.

***Why is this output class significant for us?***

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

By promoting regular engagement with health services, we support people to maintain good health through earlier diagnosis and treatment, which provides an opportunity to intervene in less invasive and more cost-effective ways associated with better long-term outcomes. These services also support people to better manage their long-term conditions and avoid complications, acute illness and crises. The integration of services to meet Government expectations for 'better, sooner, more convenient health services' presents a unique opportunity to reduce inefficiencies across the health system and provide access to a wider range of publicly funded services closer to home.

Providing flexible and responsive services in the community, without the need for a hospital appointment, will support people to stay well and reduce the overall rate of admissions, particularly acute emergency and avoidable hospital admissions. Reducing the diversion of critical resources into managing acute demand will have a major impact in freeing up hospital and specialist services for more complex and planned interventions.

The effect of these outputs is demonstrated in the medium term impact and long term outcome measures included in Chapter 1.

## Output Subsets: SHORT TERM PERFORMANCE MEASURES 2014/15

| **Primary Health Care**<br>These services are offered in local community settings by a primary care team including general practitioners (GPs), registered nurses, nurse practitioners and other primary healthcare professionals, aimed at improving, maintaining or restoring people's health. High levels of enrolment with general practice are indicative of engagement, accessibility and responsiveness of primary care services. | **Notes** | **Actual 2011/12** | **Actual 2012/13** | **Target/ Est. Delivery 2014/15** | **2012/13 National Average** |
|---|---|---|---|---|---|
| No. people in the district enrolled with a Primary Care Provider | V | 55,995 | 56,272 | ≥ 56,000 | - |
| Percentage of eligible people enrolled in the Care Plus Programme | C [1] | 83.5% | 81.46% | ≥ 82% | - |
| No. Aoraki HealthPathways in place | Q [2] | 139 | 265 | 500 | - |
| Percentage of newborns enrolled with a GP within three months of birth | T | NEW | NEW | 88% by December 2014 | - |
| Avoidable Hospital Admission (ASH) 0 – 74 years (Total) rate. Refer SI1. | Q [3] | 103% | 97% | 102% | |

[1] Care Plus aims to improve chronic care management, reduce inequalities, improve primary health care teamwork and reduce the cost of services for high-need primary health users.

[2] Aoraki HealthPathways website contains clinical pathways which provide general practice with information on referrals, specialist advice, diagnostic tools, GP procedure subsidies and patient handouts.

[3] Some admissions to hospital are seen as preventable through appropriate early intervention. These admissions provide an indication of the access and effectiveness of primary care and an improved integration between primary and secondary services.

| **Long Term Conditions Programme**<br>These services are targeted at people with high need due to long-term conditions and aim to reduce deterioration, crises and complications. Success is demonstrated through identification of need, regular monitoring and outcomes that demonstrate good conditions management. A focus on early intervention, self-management strategies and additional services available in the community will help to reduce the negative impact of long-term conditions and the need for hospital admission. | **Notes** | **Actual 2011/12** | **Actual 2012/13** | **Target/ Est. Delivery 2014/15** | **2012/13 National Average** |
|---|---|---|---|---|---|
| No. of patients who have completed the Multi-condition Rehabilitation Programme | V[4] | NEW | NEW | ≥ 70% | - |
| No. of patients enrolled in the Diabetes Encounter Programme | V[5] | NEW | NEW | ≥ 150 | - |
| Percentage of the eligible population who have had their cardiovascular risk checked in the last 5 years | C[6] | 44.1% | 64.4% | ≥ 90% | 67.1% |

[4] The multi-condition rehabilitation programme provides a rehabilitation programme for persons with a wide range of long term conditions including cardiac, diabetes and respiratory.

[5] The Diabetes Encounter Project works with newly diagnosed diabetics, those commencing insulin in the community or those persons within general practice, with known diabetes whom are not engaged with primary care, therefore have either poor glycaemic control, or unknown glycaemic control. The patient receives intensive input in a planned way from their GP, Practice Nurse and the Clinical Nurse Specialist Diabetes. The aim of this input is to get good glycaemic control within a short time frame.

[6] This refers to CVD risk assessments undertaken in primary care in line with the expectations of the PHO Performance Programme and the 'More heart and diabetes checks' health target.

| **Oral Health**<br>These services are provided by registered oral health professionals to help people maintain healthy teeth and gums. High enrolment indicates engagement, while timely examination and treatment indicates a well functioning, efficient service. | **Notes** | **Actual 2011** | **Actual 2012** | **Target/Est. Delivery 2014/15** | **2012/13 National Average** |
|---|---|---|---|---|---|
| Percentage of children under five years enrolled in DHB funded dental services. Refer PP13. | C | 76.7% | 76.7% | ≥ 83% | 63% |
| Percentage of adolescents accessing DHB funded oral health services. Refer PP12. | C | 91.4% | 88.6% | ≥ 91% | 71.6% |
| Percentage of children caries free at five years of age. Refer PP11. | C | 58% | 60.18% | ≥ 62% | 60% |
| Oral Health Decayed, Missing and Filled Teeth score at year eight. Refer PP10. | C | 1.29 | 1.20 | ≤ 1.1 | 1.20 |
| Percentage of enrolled preschool and primary school children overdue for their scheduled examination | T | 6% | 9% | ≤ 10% | - |

| **Pharmacy**<br>As Long Term Conditions (LTC) become prevalent, demand for pharmaceuticals will likely increase. The LTC service has been introduced to provide a greater hands on role of community patient's pharmaceutical management. To improve service quality in the hospital setting we have also introduced medicines interventions monitoring along with medicines reconciliation to reduce the number of New Zealanders harmed each year by medication errors in our hospital. | **Notes** | **Actual 2011/12** | **Actual 2012/13** | **Target/Est. Delivery 2014/15** | **2012/13 National Average** |
|---|---|---|---|---|---|
| No. of medicines reconciliations completed | Q[7] | NEW | NEW | 40% | - |

[7] Medicine reconciliation is about obtaining the most accurate list of patient medicines, allergies and adverse drug reactions and comparing this with the prescribed medicines and documented allergies and adverse drug reactions. Any discrepancies are then documented and reconciled. Prioritised inpatients have medicine reconciliation completed within 24 hours of admission. Prioritised patients are patients on medical, ICU, surgical and AT&R wards. The target is 30% by Q2 and 40% by year end.

| **Community Referred Tests & Diagnostic Services**<br>These are services to which a health professional may refer a person to help diagnose a health condition, or as part of treatment. They are provided by personnel such as laboratory technicians, and radiographers. To improve performance, we will target improved primary care access to diagnostics without the need for a hospital appointment to improve clinical referral processes and decision making. Community referred laboratory tests are demand driven. | **Notes** | **Actual 2011/12** | **Actual 2012/13** | **Target/ Est. Delivery 2014/15** | **Current National Average** |
|---|---|---|---|---|---|
| No. community referred laboratory tests | V[8] | 215,695 | 252,873 | Est. 245,000 | - |
| No. community referred radiology examinations | V[9] | 11,249 | 10,067 | Est. 10,500 | - |
| Percentage of accepted referrals for a MRI scan receive their scan within six weeks. Refer PP29. | T | NEW | 84% | 80% | 52% |
| Percentage of accepted referrals for a CT scan receive their scan within six weeks. Refer PP29. | T | NEW | 87% | 90% | 79% |
| Percentage of people accepted for an urgent diagnostic colonoscopy who receive their procedure within two weeks. Refer PP29. | T | NEW | NEW | 75% | - |
| Percentage of people accepted for a diagnostic colonoscopy who receive their procedure within six weeks. Refer PP29. | T | NEW | NEW | 60% | - |
| Percentage of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks beyond the planned date. Refer PP29. | T | NEW | NEW | 60% | |

[8] This volume is demand driven.

[9] This volume is demand driven.

## Output Class

### 3.4 Intensive Assessment and Treatment Services

***Output class description***

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

We provide an extensive range of intensive treatment and complex specialist services for our population and we also fund some intensive assessment and treatment services for our population that are provided by other DHBs. A proportion of these services are driven by demand which we must meet, such as acute and maternity services. However, others are planned services for which provision and access are determined by capacity, clinical triage, national service coverage agreements and treatment thresholds.

***Why is this output class significant for us?***

Equitable, timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention (e.g. removal of an obstructed gallbladder so that the patient does not have repeat attacks of abdominal pain) or through corrective action (e.g. major joint replacements). Responsive services and timely treatment support improvements across the whole system and give people confidence that complex intervention is available when needed. People are then able to establish more stable lives, resulting in improved public confidence in the health system.

As an owner and provider of these services, we are also concerned with the quality of the services being provided. Quality improvement in service delivery, systems and processes will improve patient safety, reduce the number of events causing injury or harm and provide improved outcomes for people in our services. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services. Appropriate and quality service provision will reduce readmission rates and better support people to recover from complex illness and / or maximise their quality of life.

Government has set clear expectations for the delivery of elective surgical volumes, a reduction in waiting times for treatments and increased clinical leadership to improve the quality of care. In meeting these expectations, we are introducing innovative clinically led service delivery models and reducing waiting time within our hospital services.

The effect of these outputs is demonstrated in the medium term impact and long term outcome measures included in Chapter 1.

## Output Subsets: SHORT TERM PERFORMANCE MEASURES 2014/15

| **Acute Services**<br>These are medical or surgical services for illnesses that have an abrupt onset or progress rapidly creating an urgent need for care. For more complex acute conditions, hospital based services include emergency services, acute medical and surgical services and intensive care services. Productivity measures such as length of stay are balanced with outcome measures such as readmission rates to indicate the quality of service provision. | **Notes** | **Actual 2011/12** | **Actual 2012/13** | **Target/ Est. Delivery 2014/15** | **2012/13 National Average** |
|---|---|---|---|---|---|
| No. of patients seen at ED that are not admitted | V | 10,926 | 12,821 | ≤10,705 | - |
| Percentage of patients discharged or | T | 96.5% | 96.4% | ≥95% | 93.5% |

| | | | | | |
|---|---|---|---|---|---|
| transferred from ED within 6 hours | | | | | |
| No. of acute medical/surgical patients discharged from Timaru Hospital | V | 6,885 | 6,527 | ≤6,200 | - |
| Standardised length of stay for acute patients. Refer OS3. | T[1] | NEW | 4.73 (2012) | ≤4.32 | - |
| Standardised readmission rate. Refer OS8. | Q[1] | 10.38 | 10.37 | ≤7.1% | 10.32%) |
| Percentage of patients requiring radiation or chemotherapy who receive this treatment within four weeks | T | 100% | 100% | 100% | 100% |
| Percentage of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment (or other management) by July 2016 | T | NEW | NEW | 85% | |
| Percentage of older patients assessed for the risk of falling | Q[2] | NEW | 96% (Dec. 2013) | 90% | 87% (Dec. 2013) |
| Percentage of older patients assessed as at risk of falling who received an individualised care plan that addressed these risks | Q[2] | NEW | 93% (Dec. 2013) | 90% | 80% (Dec. 2013) |
| Number of falls in the hospital categorised as a SAC 1 or 2 | Q[2] | 14 | 16 | ≤9 | - |
| Percentage of complaints responded to within 23 working days | Q | 81% | 65% | 90% | - |
| Percentage of compliant moments of hand hygiene | Q[3] | NEW | 72% (Dec. 2013) | 70% | 71% (Dec. 2013) |
| Hospital acquired blood stream infection rate | Q[3] | 0.8 | 0.8 | 0.6 | - |
| Percentage of ICU central line insertions fully compliant with bundle | Q[4] | NEW | 100% (Dec. 2013) | 90% | 93% (Dec. 2013) |
| Number of central line acquired bacteraemia | Q | NEW | 2 | 0 | - |
| Percentage of operations where all three parts of the surgical safety checklist were used | Q[4] | NEW | 92% (Dec. 2013) | 90% | 89% (Dec. 2013) |

[1] Productivity measures like length of stay are balanced with outcome measures such as readmission rates to indicate the quality of service provision.

[2] Measures relating to falls assessment and falls prevention plans are HQSC Safety Markers. SAC refers to the Severity Assessment Code assigned to an adverse event based of the degree of harm caused and the likelihood of the reoccurrence of a similar event.

[3] Hand Hygiene is one of the HQSC Safety Markers. A low incidence of hospital acquired infections can be reflective of effective infection control procedures. This measure is per 1,000 inpatient bed days.

[4] This is a HQSC Safety Marker.

| **Elective Services**<br>These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. This includes surgery and specialist assessments. National Elective Services Patient Flow Indicators (ESPIs) are indicative of a successful and responsive service, addressing population need. | **Notes** | **Actual 2011/12** | **Actual 2012/13** | **Target/ Est. Delivery 2014/15** | **2012/13 National Average** |
|---|---|---|---|---|---|
| Total no. of elective First Specialist Assessments (FSA) | V | 8,539 | 8,558 | ≥9,165 | - |
| No. non contact secondary services surgical FSAs | V, T[5] | 584 | 714 | ≥700 | - |

| | | | | | |
|---|---|---|---|---|---|
| No. non contact secondary services medical FSAs | V, T[5] | 274 | 368 | ≥560 | - |
| No. of Cost Weight Deliveries CWDs | V | 3,663 | 3,690 | ≥3,595 | - |
| No. of elective surgical discharges (incl. cardiology & dental) | V | 3,039 | 3,064 | ≥2,887 | - |
| No. Health Target surgical elective discharges | V[6] | 2,730 | 2,790 | ≥2,634 | - |
| Standardised length of stay for elective patients. Refer OS8. | T[7] | NEW | 3.77 | ≤3. 40 | - |
| Elective theatre time utilisation | Q[8] | 84.4% | 83.3% | ≥85% | - |
| Did Not Attend (DNA) rate for medical/surgical | Q | 3.3% | 3.1% | ≤3.3% | - |

[5] Non-contact FSAs are those where specialist advice and assessment is provided without the need for a hospital appointment, increasing capacity across the system, reducing wait time for patients and taking waste and duplication out of the system.

[6] This number counts elective surgery volumes based on the national health target definition (excludes cardiology and dental volumes).

[7] Productivity measures like length of stay are balanced with outcome measures such as readmission rates to indicate the quality of service provision.

[8] This is the sum of occupancy time for all patients in an elective session, calculated as a percentage of the scheduled session duration.

| **Maternity Services**<br>These services are provided to women and their families through pre-conception, pregnancy, childbirth and for the first months of a baby's life. These services are provided in home, community and hospital settings by a range of health professionals, including midwives, GPs and obstetricians and include: specialist obstetric, lactation, anaesthetic, paediatric and radiology services. We will monitor volumes in this area to determine access and responsiveness of services. | **Notes** | **Actual 2011/12** | **Actual 2012/13** | **Target/Est. Delivery 2014/15** | **2012/13 National Average** |
|---|---|---|---|---|---|
| No. deliveries in the SCDHB Maternity Unit | V[9] | 544 | 621 | ≤550 | - |
| Percentage of births delivered by Caesarean Section | Q | 23.6% | 26.5% | ≤23% | - |
| Post natal average length of stay | T | 2.5days | 2.5 days | ≥2.5days | - |
| Baby Friendly Hospital Accreditation is maintained | Q[10] | Yes | Yes | Yes | - |

[9] Result indicates no. of babies born

[10] The Baby Friendly Hospital Initiative is a worldwide programme of the World Health Organisation and UNICEF. It was established in 1992 to encourage maternity hospitals to deliver a high standard of care and implement best practice in relation to infant feeding for pregnant women and mothers and babies. An assessment and accreditation process recognises those that have achieved the required standard.

| **Assessment, Treatment and Rehabilitation Services (AT&R)**<br>These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered from a specialist inpatient unit, outpatient clinic and also in the home environment. | **Notes** | **Actual 2011/12** | **Actual 2012/13** | **Target/ Est. Delivery 2014/15** | **2012/13 National Average** |
|---|---|---|---|---|---|
| No. of ATR bed days utilised > 65years | V | 4,559 | 3,528 | ≤4,000 | - |
| No. of ATR bed days utilised <65years | V | 435 | 457 | 288.91 | - |
| No. of ATR bed days utilised - psycho-geriatric | V | 471 | 602 | ≤650 | - |
| No. of AT&R outpatient attendances | V | 546 | 358 | ≥450 | - |
| No. of AT&R domiciliary visits | V | 2,774 | 2,288 | ≥2,700 | - |

| **Specialist Mental Health Services**<br>These are services for the most severely affected by mental illness or addictions. They include assessment, diagnosis, treatment, rehabilitation and crisis response when needed. Utilisation and wait times are monitored to ensure service levels are maintained and to demonstrate responsiveness to need. | **Notes** | **Actual 2011/12** | **Actual 2012/13** | **Target/ Est. Delivery 2014/15** | **2012/13 National Average** |
|---|---|---|---|---|---|
| Percentage of young people (aged 0 – 19) who have accessed specialist mental health services. Ref PP6 | C | 4.7% (Mar-12) | 5.29% | 5% | 3.0% (Mar – 12) |
| Percentage of people (aged 20 – 64) who have accessed specialist mental health services. Ref PP6 | | 3.8% (Mar-12) | 3.58% | 3.6% | 3.5% (Mar-12) |
| Percentage of people (aged 65+) who have accessed specialist mental health services. Ref. PP6 | C | 0.6% (Mar-12) | 0.45% | 1% | 2.2% (Mar-12) |
| Percentage of people 0 – 19 referred for non-urgent mental health services seen within three weeks. Refer PP8. | T[11] | 80.8% (Sept 12) | 79.2% | 80% | 76% |
| Percentage of people 0 – 19 referred for non-urgent mental health services seen within eight weeks. Refer PP8. | T[11] | 91.2% (Sept 12) | 94.5% | 95% | 93% |
| Percentage of people 0 – 19 referred for non-urgent addiction services seen within three weeks. Refer PP8. | T[12] | 74.4% (Sept 12) | 100% | 80% | 72.8% |
| Percentage of people 0 – 19 referred for non-urgent addiction services seen within eight weeks. Refer PP8. | T[12] | 97.4% (Sept 12) | 100% | 95% | 87.8% |
| Percentage of child and youth with a transition (discharge) plan. Ref PP7. | C[13] | NEW | NEW | 95% | - |

[11] Results reflect the total for provider arm performance only.

[12] Results reflect the total for provider and NGO performance.

[13] Relapse prevention/resiliency planning helps to minimise the impact of mental illness, improving outcomes for clients. Clients with enduring serious mental illness are expected to have an up-to-date plan identifying early warning signs and what action to take. This result excludes those with addictions only.

## Output Class

## 3.5 Rehabilitation and Support Services

***Output class description***

Rehabilitation and support services provide people with the support and assistance they need to maintain or regain maximum functional independence, either temporarily while they recover from illness or disability, or over the rest of their lives. These services are delivered following a clinical 'needs assessment' process and include: domestic support, personal care, community nursing, community services provided in people's own homes and places of residence, day care, respite and residential care services. Services are mostly for older people, mental health clients and for personal health clients with complex health conditions.

Support services also include palliative care services for people who have end-stage conditions. It is important that they and their families are appropriately supported, so that the person is able to live comfortably, have their needs met in a holistic and respectful way and die with appropriate end of life care irrespective of the setting where this occurs. Delivery of these services is likely to include coordination with many other organisations and agencies and may include public, private and part-funding arrangements.

***Why is this output class significant for us?***

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

In preventing deterioration and acute illness or crisis, these services have a major impact on the sustainability of hospital and specialist services and on the wider health system in general by reducing acute demand, unnecessary ED presentations and the need for more complex intervention. These services also support the flow of patients and improved recovery after an acute illness or hospital admission – helping to reduce readmission rates and supporting people to recover from complex illness and / or maximise their quality of life.

Living in ARRC has been associated with a more rapid functional decline than 'ageing in place' and is a more expensive option. Resources can be better utilised providing appropriate levels of support to people to help them stay in their own homes and to moderate the need for residential care and hospital level services.

We have taken a 'restorative' approach and have introduced individual packages of care to better meet people's needs, including complex care packages for people assessed as eligible for ARRC who would rather stay in their own homes. With an ageing population, it is vital we monitor the effectiveness of these services, and we use the InterRAI (International Residential Assessment Instrument) tool to ensure people receive equitable access to clinically appropriate support services that best meet their needs.

The effect of these outputs is demonstrated in the medium term impact and long term outcome measures included in Chapter 1.

## Output Subsets: SHORT TERM PERFORMANCE MEASURES 2014/15

| **Palliative Care**<br>These are services that improve the quality of life of patients and their families facing life-threatening illness, through the prevention and relief of suffering by means of early intervention, assessment, treatment of pain and other supports. | **Notes** | **Actual 2011/12** | **Actual 2012/13** | **Target/Est. Delivery 2014/15** | **2012/13 National Average** |
|---|---|---|---|---|---|
| No. of clients receiving palliative care in the home | V | NEW | 98 | est. 150 | - |
| No. clients accessing a South Canterbury Hospice bed | V | 144 | 115 | ≥150 | - |

| **Needs Assessment & Support**<br>These are services that determine a person's eligibility and need for publicly funded support and the best mix of supports based on the person's strengths, resources and goals. The supports are delivered by an integrated team in the person's own home or community. The delivery of assessments and the use of evidence-based tools indicate quality, equity of access and responsiveness. | **Notes** | **Actual 2011/12** | **Actual 2012/13** | **Target/Est. Delivery 2014/15** | **2012/13 National Average** |
|---|---|---|---|---|---|
| Percentage of InterRAI first assessments completed within target timeframe | T[1] | 85% | 92% | 90% | - |
| Percentage of InterRAI reviews completed within target timeframe | T[1] | NEW | 91.5% | 85% | - |

[1] InterRAI is a comprehensive clinical assessment tool that has been rolled out nationally to ensure consistency of assessments.

| **Home & Community Support**<br>These are services designed to support people to continue living in their own homes and to restore functional independence. They may be short or longer-term in nature. An increase in the number of people being supported is indicative of increased capacity in the system, and success is measured against decreased or delayed entry into residential or hospital services. | **Notes** | **Actual 2011/12** | **Actual 2012/13** | **Target/Est. Delivery 2014/15** | **2012/13 National Average** |
|---|---|---|---|---|---|
| No. people (total) supported by Home Based Support Services | V[2] | 981 | 965 | 1000 | - |
| No. high and complex dementia patients supported by Home Based Support Services | V[2] | NEW | 15 | 20 | - |
| No. of domiciliary district nursing visits delivered | V[3] | 41,397 | 33,345 | 32,087 | - |
| Readmission rate for patients ≥ 75 years | Q | 12.8% (Sept-12) | 13.8% | 10.1% | 9.7% (Sept-12) |

[2] Home Based Support Services are services delivered in the person's home to assist them to remain at home.

[3] The reduction in domiciliary district nursing visits is as a result of data integrity.

| **Residential Care Services**<br>These services are provided to meet the needs of a person who has been assessed as requiring long-term residential care in a hospital or rest home indefinitely. With an ageing population, a decrease in the number of subsidised bed days is seen as indicative of more people being successfully supported to continue living in their own homes and is balanced against the level of home-based support. | **Notes** | **Actual 2011/12** | **Actual 2012/13** | **Target/Est. Delivery 2014/15** | **2012/13 National Average** |
|---|---|---|---|---|---|
| No. subsidised residential care bed days | V[4] | 177,221 | 173,205 | est. 184,601 | - |

[4] This volume is demand driven.

| **Respite & Day Care**<br>These services provide people with a break from a routine or regimented programme so that crisis can be averted or so that a specific health need can be addressed. Services are provided by specialised organisations and are usually short-term in nature. They may also include support and respite for families, caregivers and others affected. Services are expected to increase over time, as more people are supported to remain in their own homes. | **Notes** | **Actual 2011/12** | **Actual 2012/13** | **Target/Est. Delivery 2014/15** | **2012/13 National Average** |
|---|---|---|---|---|---|
| No. people accessing day care | V | 187 | 147 | ≥150 | - |
| No. people accessing dementia day care | V | NEW | 13 | ≥14 | - |
| Percentage of respite bed days utilised | C | 85% | 97% | ≥95 | - |
| Percentage of dementia respite bed days utilised | C | 94% | 99% | ≥90 | - |

## 3.6 2014/15 Budgeted Financial Expectations by Output Class

| REVENUE | TOTAL $'000 |
|---|---|
| Prevention | 3,517 |
| Early detection and management | 39,861 |
| Intensive assessment and treatment | 108,745 |
| Support and rehabilitation | 31,044 |
| **Grand Total** | **183,167** |
| | |
| **EXPENDITURE** | **TOTAL $'000** |
| Prevention | 3,517 |
| Early detection and management | 40,161 |
| Intensive assessment and treatment | 108,428 |
| Support and rehabilitation | 30,993 |
| **Grand Total** | **183,099** |
| | |
| **Surplus/(Deficit)** | **68** |

# CHAPTER 4: FINANCIAL PERFORMANCE

- Forecast financial statements (for current and 3 following years)
- Measures and standards necessary to assess DHB financial performance
- Significant assumptions
- Additional information to reflect the operations and position of the DHB.

**SOUTH CANTERBURY DISTRICT HEALTH BOARD**
**CONSOLIDATED - SCDHB**
**ANNUAL PLAN 2014/15** **000'S**

| Statement of Forecast Comprehensive Income | 2012/13 Actual | 2013/14 Forecast | 2014/15 Plan | 2015/16 Plan | 2016/17 Plan | 2017/18 Plan |
|---|---|---|---|---|---|---|
| Revenue | 176,425 | 179,500 | 181,554 | 184,044 | 187,203 | 189,819 |
| Finance Income | 1,530 | 1,636 | 1,613 | 1,623 | 1,633 | 1,522 |
| | 177,955 | 181,136 | 183,167 | 185,667 | 188,836 | 191,341 |
| Personnel Costs | 56,777 | 59,075 | 62,385 | 63,007 | 63,636 | 64,270 |
| Outsourced Personnel & Other Services | 9,248 | 10,630 | 8,532 | 8,616 | 8,700 | 8,785 |
| Clinical Supplies | 10,310 | 11,258 | 10,569 | 10,633 | 10,698 | 10,764 |
| Infrastructure & Non Clinical Expenses | 9,973 | 9,869 | 8,775 | 8,823 | 8,876 | 8,930 |
| Payments to Non DHB Health Providers | 60,121 | 59,434 | 61,007 | 62,438 | 64,502 | 65,980 |
| IDF Outflows | 25,349 | 24,334 | 25,807 | 25,972 | 26,138 | 26,305 |
| Financing Charges | 2,346 | 2,364 | 2,304 | 2,318 | 2,332 | 2,346 |
| Depreciation | 3,095 | 3,686 | 3,720 | 3,743 | 3,766 | 3,788 |
| Total Expenses | 177,219 | 180,650 | 183,099 | 185,550 | 188,647 | 191,169 |
| **OPERATING SURPLUS (DEFICIT)** | 736 | 486 | 68 | 118 | 188 | 172 |
| **NON RECURRING ITEMS** | | | | | | |
| **TOTAL SURPLUS (DEFICIT)** | 736 | 486 | 68 | 118 | 188 | 172 |

**SOUTH CANTERBURY DISTRICT HEALTH BOARD**
**CONSOLIDATED - SCDHB**
**ANNUAL PLAN 2014/15** **000'S**

| Statement of Forecast Comprehensive Income | 2010/11 Actual | 2011/12 Forecast | 2012/13 Plan | 2013/14 Plan | 2014/15 Plan | 2017/18 Plan |
|---|---|---|---|---|---|---|
| **SURPLUS (DEFICIT)** | **736** | **486** | **68** | **118** | **188** | **172** |
| **Other comprehensive income** | **0** | **0** | **0** | **0** | **0** | **0** |
| **TOTAL COMPREHENSIVE SURPLUS (DEFICIT)** | **736** | **486** | **68** | **118** | **188** | **172** |

**SOUTH CANTERBURY DISTRICT HEALTH BOARD**

**CONSOLIDATED - SCDHB**

**ANNUAL PLAN 2014/15** **000'S**

| Statement of Forecast Cash Flows | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|---|---|
| | Actual | Forecast | Plan | Plan | Plan | Plan |
| **Cash Flow From Operating** | | | | | | |
| Receipts - Interest | | | | | | |
| Receipts - Other | 176,490 | 179,890 | 181,555 | 184,045 | 187,204 | 189,699 |
| **Total Receipts** | 176,490 | 179,890 | 181,555 | 184,045 | 187,204 | 189,699 |
| Payments - Interest | 321 | 319 | 324 | 320 | 320 | 320 |
| Payments - Other | 169,617 | 176,806 | 182,993 | 185,782 | 186,374 | 178,635 |
| **Total Payments** | 169,938 | 177,125 | 183,317 | 186,102 | 186,694 | 178,955 |
| **Net Cash From Operating** | 6,552 | 2,765 | (1,762) | (2,057) | 510 | 10,744 |
| **Cash Flow From Investing** | | | | | | |
| Decrease in Investments | | | | | | |
| Interest Received | 1,530 | 1,633 | 1,613 | 1,623 | 1,633 | 1,643 |
| Sale of Fixed Assets | 0 | 0 | 0 | 0 | 0 | 0 |
| Investment Receipts - Other | | | | | | |
| Total Receipts | 1,530 | 1,633 | 1,613 | 1,623 | 1,633 | 1,643 |
| Capital Expenditure | 5,069 | 2,783 | 9,457 | 2,911 | 10,616 | 12,601 |
| Investments including Restricted and Trust Funds Assets | 0 | 0 | 0 | 0 | 0 | 0 |
| Investment Payments - Other | 555 | 0 | 0 | 0 | 0 | 0 |
| Total Payments | 5,624 | 2,783 | 9,457 | 2,911 | 10,616 | 12,601 |
| **Net Cash From Investing** | (4,094) | (1,150) | (7,844) | (1,288) | (8,983) | (10,958) |
| **Cash Flow From Financing** | | | | | | |
| Equity Injections (Repayment) | 0 | 0 | 0 | 0 | 0 | 0 |
| New Debt (Repayment) | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Equity Movement | 216 | 216 | 216 | 216 | 216 | 216 |
| Other Non Current Liability Movement | 3,454 | 0 | 0 | 0 | 0 | 0 |
| **Net Cash From Financing** | 3,670 | 216 | 216 | 216 | 216 | 216 |
| **Overall Increase/(Decrease)** | **6,128** | **1,831** | **(9,390)** | **(3,129)** | **(8,257)** | **2** |
| Add: Opening Cash Balance | 13,194 | 19,322 | 21,153 | 11,763 | 8,634 | 377 |
| **Closing Cash** | 19,322 | 21,153 | 11,763 | 8,634 | 377 | 379 |

**SOUTH CANTERBURY DISTRICT HEALTH BOARD**
**CONSOLIDATED - SCDHB**
**ANNUAL PLAN 2014/15** **000'S**

| Statement of Forecast Financial Position | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|---|---|
| | Actual | Forecast | Plan | Plan | Plan | Plan |
| **EQUITY** | | | | | | |
| General Funds | 5,477 | 4,222 | 4,006 | 3,790 | 3,574 | 3,358 |
| Retained Earnings | 10,552 | 10,986 | 11,054 | 11,172 | 11,359 | 11,532 |
| Revaluation Reserve | 9,246 | 9,246 | 9,246 | 9,246 | 9,246 | 9,246 |
| Other Reserves - Donated Assets and Special Funds | 860 | 1,961 | 1,859 | 1,859 | 1,859 | 1,859 |
| **TOTAL EQUITY** | 26,135 | 26,415 | 26,165 | 26,067 | 26,038 | 25,995 |
| **ASSETS** | | | | | | |
| **Current Assets** | | | | | | |
| Cash and Cash Equivalents | 19,322 | 21,153 | 11,763 | 8,634 | 377 | 379 |
| Financial Assets | 0 | 0 | 0 | 0 | 0 | 0 |
| Debtors & Other Receivables | 4,839 | 4,760 | 4,610 | 4,610 | 4,610 | 4,581 |
| Other Current Assets | 920 | 972 | 970 | 971 | 970 | 1,000 |
| **Total Current Assets** | 25,081 | 26,885 | 17,343 | 14,215 | 5,957 | 5,960 |
| **Add Non Current Assets** | 45,146 | 44,209 | 52,087 | 54,163 | 62,149 | 61,255 |
| **Total Non Current Assets** | 45,146 | 44,209 | 52,087 | 54,163 | 62,149 | 61,255 |
| **TOTAL ASSETS** | **70,227** | **71,094** | **69,430** | **68,378** | **68,106** | **67,215** |
| **LIABILITIES** | | | | | | |
| **Current Liabilities** | | | | | | |
| Bank Overdraft | 0 | 0 | 0 | 0 | 0 | 0 |
| Creditors & Other Payables | 12,100 | 2,429 | 11,929 | 10,788 | 10,546 | 10,573 |
| Borrow ings | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Current Liabilities | 11,380 | 21,807 | 10,817 | 11,004 | 11,003 | 10,128 |
| **Total Current Liabilities** | 23,480 | 24,236 | 22,746 | 21,792 | 21,549 | 20,701 |
| **Non Current Liabilities** | | | | | | |
| Employee Entitlements | 6,485 | 6,485 | 6,560 | 6,560 | 6,560 | 6,560 |
| Term loans | 14,127 | 13,958 | 13,959 | 13,959 | 13,959 | 13,959 |
| **Total Non Current Liabilities** | 20,612 | 20,443 | 20,519 | 20,519 | 20,519 | 20,519 |
| **TOTAL LIABILITIES** | **44,092** | **44,679** | **43,265** | **42,311** | **42,068** | **41,220** |
| **NET ASSETS** | 26,135 | 26,415 | 26,165 | 26,067 | 26,038 | 25,995 |

**SOUTH CANTERBURY DISTRICT HEALTH BOARD**
**CONSOLIDATED - SCDHB**
**ANNUAL PLAN 2014/15** **000'S**

| Statement of Forecast Changes in Equity | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|---|---|
| | Actual | Forecast | Plan | Plan | Plan | Plan |
| **Equity at Beginning of the Period** | (25,598) | (26,135) | (26,415) | (26,165) | (26,067) | (26,038) |
| **Net Surplus (Deficit) for the Period** | | | | | | |
| Net Surplus (Deficit) for the Period | (736) | (486) | (68) | (117) | (189) | (172) |
| **OTHER MOVEMENTS** | | | | | | |
| Movement in Revaluation Reserve | 0 | 0 | 0 | 0 | 0 | 0 |
| Movement in Special Funds | 0 | (1,101) | 0 | 0 | 0 | 0 |
| Movement in Equity - Other | 199 | 1,307 | 318 | 215 | 217 | 215 |
| **Total Other Movements** | 199 | 206 | 318 | 215 | 217 | 215 |
| **Equity at End of the Period** | (26,135) | (26,415) | (26,165) | (26,067) | (26,038) | (25,995) |

**SOUTH CANTERBURY DISTRICT HEALTH BOARD**
**FUNDER**
**ANNUAL PLAN 2014/15** **000'S**

| Prospective Income Statement | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|---|---|
| | Actual | Forecast | Plan | Plan | Plan | Plan |
| **Revenue** | | | | | | |
| **MOH Funding** | | | | | | |
| Excluding Mental Health Services | 152,229 | 150,551 | 151,987 | 154,337 | 156,686 | 159,035 |
| Mental Health Services | 11,173 | 11,359 | 11,738 | 11,809 | 11,882 | 11,954 |
| MoH Funding Sub-Contracts | 0 | 6,758 | 6,437 | 6,437 | 6,437 | 6,437 |
| **Inter District Flows - Inflows** | | | | | | |
| Excluding Mental Health Services | 3,866 | 3,474 | 3,263 | 3,283 | 3,303 | 3,323 |
| Mental Health Services | 486 | 483 | 446 | 449 | 451 | 454 |
| **Other Income** | | 15 | 23 | 23 | 22 | 22 |
| **Total Revenue** | 167,754 | 172,640 | 173,894 | 176,338 | 178,782 | 181,226 |
| **Expenditure** | | | | | | |
| **Personal Health** | | | | | | |
| Provider - Personal Health | 63,636 | 67,011 | 66,130 | 66,505 | 66,488 | 67,143 |
| Pharmaceuticals | 17,028 | 16,285 | 16,765 | 16,867 | 16,970 | 17,074 |
| Laboratories | 2,674 | 2,684 | 2,368 | 2,382 | 2,397 | 2,412 |
| General Practioners | 11,353 | 10,966 | 11,392 | 11,461 | 11,472 | 11,542 |
| Dental | 1,191 | 1,141 | 1,314 | 1,322 | 1,330 | 1,338 |
| Maternity | 707 | 69 | 35 | 35 | 35 | 36 |
| Pallative Care | 1,078 | 1,166 | 1,177 | 1,184 | 1,191 | 1,199 |
| Other Funder Services | 2,066 | 2,259 | 2,314 | 3,303 | 4,982 | 6,011 |
| IDF Outflows | 22,020 | 21,323 | 22,939 | 23,079 | 23,220 | 23,361 |
| **Total Personal Health** | 121,753 | 122,904 | 124,434 | 126,140 | 128,087 | 130,115 |
| **Mental Health** | | | | | | |
| Provider - Mental Health | 7,435 | 7,644 | 7,719 | 7,766 | 7,813 | 7,861 |
| Expenditure | 2,984 | 2,958 | 3,527 | 3,549 | 3,570 | 3,592 |
| IDF Outflows | 1,322 | 1,197 | 987 | 993 | 999 | 1,005 |
| **Total Mental Health** | 11,741 | 11,799 | 12,233 | 12,308 | 12,383 | 12,458 |
| **Disability Support** | | | | | | |
| Provider - DSS | 7,364 | 7,090 | 7,339 | 7,412 | 7,487 | 7,561 |
| Expenditure | 20,551 | 21,303 | 21,464 | 21,679 | 21,895 | 22,114 |
| DSS IDF Outflows | 2,007 | 1,814 | 1,881 | 1,900 | 1,919 | 1,938 |
| **Total Disability Support** | 29,922 | 30,207 | 30,684 | 30,991 | 31,301 | 31,614 |
| **Maori Health** | | | | | | |
| Expenditure | 489 | 593 | 651 | 655 | 659 | 663 |
| **Public Health** | | | | | | |
| Provider - Public Health | 244 | 367 | 333 | 335 | 337 | 339 |
| **Governance & Funder Administration** | | | | | | |
| Governance & Funder Admin | 3,139 | 3,286 | 3,566 | 3,588 | 3,610 | 3,632 |
| **Total Expenditure** | 167,288 | 169,156 | 171,901 | 174,016 | 176,376 | 178,821 |
| **Total Results** | | | | | | |
| Total Revenue | 167,754 | 172,640 | 173,894 | 176,338 | 178,782 | 181,226 |
| Total Expenditure | 167,288 | 169,156 | 171,901 | 174,016 | 176,376 | 178,821 |
| **Net Surplus (Deficit)** | 466 | 3,484 | 1,993 | 2,322 | 2,406 | 2,405 |

**SOUTH CANTERBURY DISTRICT HEALTH BOARD**
**PROVIDER**
**ANNUAL PLAN 2014/15** **000'S**

| Prospective Income Statement | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|---|---|
| | Actual | Forecast | Plan | Plan | Plan | Plan |
| **Income** | | | | | | |
| Internal Revenue | 78,679 | 82,102 | 81,521 | 82,018 | 82,126 | 82,905 |
| Internal Revenue DSS | | | | | | |
| Government and Agencies Income | 2,912 | 2,694 | 2,957 | 2,975 | 2,993 | 3,011 |
| Other Income | 7,289 | 5,802 | 6,316 | 6,355 | 7,061 | 7,104 |
| **Total Income** | 88,880 | 90,598 | 90,794 | 91,348 | 92,180 | 93,020 |
| **Expenditure** | | | | | | |
| Personnel | 56,442 | 58,839 | 61,956 | 62,576 | 63,201 | 63,833 |
| Outsourced Services | 8,922 | 10,231 | 8,084 | 8,165 | 8,246 | 8,329 |
| Clinical Supplies | 10,310 | 11,258 | 10,569 | 10,633 | 10,698 | 10,764 |
| Infrastructure | 8,715 | 8,333 | 7,406 | 7,445 | 7,491 | 7,536 |
| Financing Charges | 985 | 1,014 | 984 | 990 | 996 | 1,002 |
| Depreciation | 3,095 | 3,686 | 3,720 | 3,743 | 3,766 | 3,788 |
| **Total Expenditure** | 88,469 | 93,361 | 92,719 | 93,552 | 94,398 | 95,253 |
| **Operating Result** | 411 | (2,763) | (1,925) | (2,204) | (2,218) | (2,232) |

**SOUTH CANTERBURY DISTRICT HEALTH BOARD**
**GOVERNANCE & FUNDER ADMINISTRATION**
**ANNUAL PLAN 2014/15** **000'S**

| Prospective Income Statement | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|---|---|
| | Actual | Forecast | Plan | Plan | Plan | Plan |
| **INCOME** | | | | | | |
| Internal Revenue | 3,139 | 3,286 | 3,566 | 3,588 | 3,610 | 3,632 |
| Other Revenue | 0 | 0 | 0 | 0 | 0 | 0 |
| **TOTAL INCOME** | 3,139 | 3,286 | 3,566 | 3,588 | 3,610 | 3,632 |
| **EXPENDITURE** | | | | | | |
| Personnel Costs | 335 | 236 | 429 | 432 | 434 | 437 |
| Outsourced Services | 326 | 399 | 448 | 451 | 453 | 456 |
| Other Operating | 1,258 | 1,536 | 1,369 | 1,377 | 1,386 | 1,394 |
| Financing Charges | 1,361 | 1,350 | 1,320 | 1,328 | 1,336 | 1,344 |
| Depreciation | 0 | 0 | 0 | 0 | 0 | 0 |
| **TOTAL EXPENDITURE** | 3,280 | 3,521 | 3,566 | 3,588 | 3,610 | 3,632 |
| **NET SURPLUS/(DEFICIT)** | (141) | (235) | 0 | 0 | 0 | 0 |

## 4.1 Planned Net Results

SCDHB has more than a ten-year history of achieving or bettering its financial plans. It plans to utilise retained Mental Health surpluses in the next two years, and to utilise ring fence Primary & Community equity (as allowed by the agreement reached with the Ministry of Health on the disestablishment of Aoraki Primary Health Organisation) in the next three years, this is included in the planned surplus for each year.

The accumulated Mental Health surplus (Forecast to be $0.4M @ 30 June 2014) will be spent to continue funding Mental Health services in 2014/15 and 2015/16.

To the extent SCDHB achieves a surplus in any one year it may then plan to run an off-setting deficit in the subsequent years.

SCDHB has also maintained an internal ring fence for Primary Health; this is due to our structure of covering the role of the PHO within the DHB. As at 31 January 2014 the DHB had $0.450M of equity that was ring fenced for Primary. This plan includes expenditure of $0.3M of ring fence primary funding which will be utilised on Primary Care initiatives during 2014/15.

The DHB will review for accounting purposes the valuation of its land and buildings in May 2014. A provision for an increase in capital charge and depreciation impacts in the financial forecasts should the revaluation result in a 10% increase in value of land and buildings , along with the inclusion of works on Kensington, the Gardens Block and a large number of IS initiatives have been allowed for. A full revaluation was last completed in June 2013.

The plan includes productivity and efficiency savings. Savings are generated through local, regional and national initiatives, including working with Health Benefits Limited (HBL). HBL are targeting a number of savings from their programs and some of these will be offset by investment required in the short term, but overall SCDHB has a target of net overall gain.

## 4.2 Cost and Volume Assumptions

The following assumptions have been utilised in the development of financial forecasts, and the management actions being put in place to deliver against the plan:

- The community pharmaceutical budget stays within $16.8M for 2014/15;
- NGOs will on average receive 0.61% increase in 2014/15;
- Primary care will receive an increase of 1.0% on first contact services and on average 0.61% across other services;
- The Ministry continues to provide the “good performance” advance of one month’s revenue (about $10M);
- Net Inter District Flows will be $22.1M out to other DHBs, this is made up of an inflow of $3.7M and an outflow of $25.8M;
- Except for demand and continued refinement of needs based prioritisation within service lines, there are no changes to the nature, mix or volume of services planned to be funded or provided by SCDHB;
- If there are any services devolved by the Ministry of Health to SCDHB they will be devolved in a fiscally neutral manner;
- Employee costs have been calculated using employment agreement settlements where these exist. The assumption used in 2015/16 is a 1.0% settlement and in 2016/17 a 1.0% settlement;
- Any increase in volumes from demographic increase delivered by the SCDHB Provider will be absorbed by the current FTE as an efficiency saving;
- Health Benefits Limited - Provision has been made for the operational costs of Health Benefits Limited and provision of $44K has been made to purchase “b” class shares in Health Benefits Ltd as a contribution for the Finance, Procurement and Supply Chain business case. No other cost

provision has been made at this stage. Cost savings have been incorporated into the Forecast Income Statements; these will be achieved via national, regional and local projects.

The expectation is that any approved unbudgeted operational expenditure will be offset by extractable operational efficiencies, either directly attributable to the business cases or through other savings initiatives Health Benefits Limited initiate to compensate. Unbudgeted capital contributions may be incurred if the business cases are compelling to justify the investment.

- Health Quality & Safety Commission – there has been provision for the maternity system operational costs and capital expenditure associated with medicines management system. However, these are subject to business cases, the rationale for this, is given the tight fiscal environment health is operating within; any proposal for enhancements should be compelling and deliver adequate extractable gains.
- The updates to various cost lines from the introduction of the in-house MRI have been included.
- SCDHB has provisioned funding for initiatives that are yet to be announced in the 2014/15 budget process.

## 4.3 Efficiency Targets

During 2013/14 SCDHB has been working at containing the cost growth and reviewing the revenue from other activities to ensure that in 2014/15 the DHB can continue to live within the funding available while maintaining service delivery. The allowance for cost growth in our funding envelope from the Ministry of Health this year, as mentioned above, is 0.61%. When recognising industrial settlement pressures, step increases, and inflationary and other cost and quality pressures, the only way SCDHB is able to provide a break even financial forecast is by planning for the delivery of financial efficiency gains. In undertaking the planning the following areas have been identified as areas for which gains have been incorporated into the plan:

- A full annual review of the commercial laundry prices will lead to a price increase of 1%. These are being implemented and the net gain to SCDHB will be $13,000;
- Interest rates are favourable, therefore a net gain on budget of $125K has been included in the plan;
- Changes within the provider, line by line review will continue to hold costs;
- SCDHB will continue to work with HBL and Pharmac as part of the interim national procurement to obtain 'quick wins' from procurement, establish category management and aid in the development of a national pharmaceutical schedule; this will be in advance of the full establishment of the standard financial management information system for all DHBs;
- The food and household contracts expires in Oct 2014. HBL have advised these will be rolled forward for a further 12 months. No further savings are anticipated;
- SCDHB will continue to actively work with HBL on the Linen and Laundry business case to help refine options for savings across the sector;
- Work with HBL to progress the detailed business case for the national infrastructure programme scheduled to be released in July. It is anticipated that this will be cost neutral from a DHB's perspective;
- SCDHB is actively working with the other South Island DHBs to implement regional IS solutions, this has seen the development of the first shared Clinical Information System, shared PACS and a shared Radiology Information System. In the next three years SCDHB will implement Electronic Medicine Management, e-referrals, e-Maternity and a Self-care Portal with the other South Island DHBs, with the development of a new Patient Administration System for implementation at SCDHB in 2018. These collaborative projects will over time save the DHBs expenditure but will also enable improvements to be made to the patient journey and change the way health care is delivered to consumers enabling a sustainable and integrated service to be provided over the coming years;
- Procurement savings from local, national and regional collaboration with HBL, Southern DHB and regional DHBs, assumes a saving of an additional $78K in 2014/15; and
- SCDHB will also actively work with HBL on the back office function solution and supports the business case currently being developed by HBL; however the planning assumption is that any

investment required by HBL will be at least offset by additional savings over and above the efficiencies explicitly included above.

| Summary of Key Actions | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | | |
| | | Plan | Plan | Plan | Plan | | |
| KEY ACTIONS - with brief description* | DELIVERABLES - timing | | | | | Specify linkage to Financial Performance Forecasts ** | DHB's assessment (high/medium/low) and reasons for risk of non implementation |
| Centre of Excellence Health of Older Persons Project | Implementation of recommendations from Cente of Excellence concept plan | 107 | | | | Additional investment to support development service delivery for ageing population | Medium |
| Child and Youth Integrated Model of Care | Integrated Model of Care | 50 | | | | Improved coordination in the delivery of services to Children and Youth | Low |
| Laundry Service Review | Efficienies following laundry operation review | (13) | (13) | (13) | (13) | -Increase in commercial customer pricing<br>-Reduction in costs and wastage | Medium |
| Replacement of Legacy Patient Administration System (PAS) | CORE PAS developed and delivered to Model Community by Orion, SCDHB implementation 2018 | 235 | 214 | 290 | 2,238 | As per Regional Business Case approved by NHITB | Medium |
| eMedicines Reconciliation (eMR) with eDischarge Summary | Implement eMR following on from ePA, ePM Q4 2014/15 | 1,079 | 356 | - | - | Includes all eMedicines programmes, ePrescribing and Administration management, ePharmacy, eReferrals, eMaternity, eMed reconciliation, eLabs/ordering | Low |
| Regional Clinical Workstation (CWS) and Clinical Data Repository (CDR) | Implement regional solution 2014/15 | 29 | - | - | - | Deploy the Regional HCS Mental Health module, Portal Upgrade, deployment of CWS across the rest of the region. | Medium |
| National Patient Flow | To implement the National Patient Flow project which will track and report on the patient journey | 52 | - | - | - | Phase 1 National Data Collection (Referrals to First Specialist Assessment) live 1 July 2014. Project scoping, requirements gathering for Phase 2 commenced | Low |
| Self-Care Portal | To implement a Self Care Patient Portal that helps patients be involved in their care | 90 | - | - | - | Reviewing portals available including Regional concept | High - Regional proof of concept for technical solution will take 6 months to develop pilot. Parameters/governance around this will require consultation |
| | **TOTAL** | 1,629 | 557 | 277 | 2,225 | | |

## 4.4 Financial Risks in 2014/15

All DHBs face pressure from additional expenditure which must be managed within the allocated funding. These have been described more fully in earlier sections of the plan.

Management of expenditure pressure will require considerable restraint, and focused exploration of productivity improvements.

SCDHB will manage staff numbers to appropriate levels and implement changes to service configuration. Efforts will be prioritised within DHB's service priorities and demographics.

On top of these risks there are a number of specific risks to the financial projections contained in this plan. They include:

- Industrial Settlements – The majority of Industrial Agreements will be settled in the 2013/14 financial year within financial parameters and the total cost, including progression already provided for in existing agreements will be managed within a combination of funding or additional efficiencies or productivity gains. The NZNO MECA expiring in February 2015 may pose a challenge for it represents a large component of our workforce and employee expectations tend to mirror the improvement in the national economy.
- Inter District Flows – The Funding Envelope identified the level expected for Inter District Flows. This is based on historical patterns and the updated price.
- Asset Revaluations – A provision has been made for a 10% increase in the revaluation of land and buildings, along with the work to be carried out on Kensington and the Gardens Block the consequential flow on impact for depreciation and capital charge has not been included.

- Demand Pressures – The plan is based on delivering to the agreed price volume schedules. There are risks on both the Funder and Provider side of the Annual Plan. Specifically the risks are:
  - HBL costs/savings/timings around workstreams;
  - National Costing Collection & Pricing Programme (NCCP) related work including an overall review of PBFF over next 18 months including secondary and tertiary adjusters by the Ministry of Health;
  - Talbot Park revenue and costs;
  - Employee entitlement valuations;
  - Land and Building revaluations;
  - 2013 census population base changes; and
  - Changes in depreciation and capital charge as a result of site redevelopment work.
- The HBL Indicative Case(s) for Change will require investment from the sector, this is significant across the various programmes and at this stage SCDHB has planned for a net cost in 2014/15 and then a net gain in the following two years. There is a risk on the timing of the investment vs. gain in any one financial year, particularly where business cases are compelling across the sector but may disadvantage individual DHBs.
- The Facility Master Plan is currently being updated to determine scope of work required to maintain the hospital site for 15-20 years. Related seismic strengthening remains a risk until this work is complete. The plan allows for the interim capital expenditure of $3.9M for the strengthening and refurbishment of the Gardens Block due to be completed in 2014/15. The outcome of Facility Master Plan review could identify that $16M currently earmarked for this work is not sufficient, or the work may need to happen in conjunction with a major facility redevelopment.
- Procurement and Supplies – The plan assumes supplies costs are tightly controlled and savings delivered by national, regional and district based procurement initiatives. Exchange rates and other supplier cost pressures are a risk to these assumptions.
- Information Systems Strategic Plan – SCDHB will continue to support the regional and national initiatives to replace and develop systems. The funding included in the capital expenditure section of the plan is indicative of the projects that will be completed under the regional plan with the major focus on the replacement of the patient administration system.

## 4.5 Fixed Assets

The Board considers the appropriateness of the valuation of its land and buildings each year in June. No impact on capital charge, as a result of any requirement to adopt a new valuation, has been provided in either income or expenditure.

SCDHB is well within its banking covenants.

**Disposal of Land**
SCDHB will ensure that disposal of land transferred to, or vested in it pursuant to the Health Sector (Transfers) Act (1993) will be subject to approval by the Minister of Health. The DHB will ensure that the relevant protection mechanisms that address the Crown's governance obligations in relation to Māori sites of significance and that the requirements of section 40 of the Public Works Act are addressed. Any such disposals will be [planned in accordance with s42 (2) of the NZPHD Act 2000. No land disposals have been planned in 2014/15 and out years.

**Business Cases**
SCDHB is completing a single stage business case for the redevelopment of parts of Timaru Hospital. The business case follows the approval by the Capital Investment Committee of the Strategic Assessment. The business case will be completed in the 2014/15 financial year.

## 4.6 Capital Expenditure

Capital expenditure is provided in two components:

- General Capital Expenditure

It should be noted that any delays in 2013/14 capital expenditure will be carried forward into 2014/15.

| $000s | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|---|
| Buildings , Plant & Equipment excl Clinical | 1,701 | 1,735 | 1,770 | 1,805 | 1,841 |
| Clinical Equipment | - | - | - | - | - |
| IT/IS | 117 | 118 | 119 | 121 | 122 |
| Vehicles | 200 | 200 | 200 | 200 | 200 |
| Total General | 2,018 | 2,053 | 2,089 | 2,126 | 2,163 |

- 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 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|---|
| Infrastructure | 200 | 200 | 200 | 200 | 200 |
| ISSP | 1,101 | 2,454 | 246 | 246 | 1,927 |
| Facility & Seismic Aprroved | | 3,900 | | | |
| Facility & Seismic Unaprroved | | | 8,000 | 8,100 | |
| Radiology | | 900 | | | |
| Total Special | 1,301 | 7,454 | 8,446 | 8,546 | 2,127 |
| Total Capex | 3,319 | 9,508 | 10,525 | 10,651 | 4,258 |

## 4.7 Method of Capital Prioritisation

SCDHB funds capital expenditure for its Provider Arm only.

SCDHB sets the capital budget, which is informed by the budgeting process, including a bottom-up list of requests.

The capital budget is compiled from prioritised bottom-up requests and management knowledge. Prioritisation is based on clinical, quality or compliance driven need or financial justification to which various thresholds/hurdles apply depending on the nature and quantum of the proposed investment.

## 4.8 Funding Source

All capital expenditure will be from internally generated funds or existing debt facilities already in place with the Crown Health Financing Agency.

## 4.9 Debt and Equity

SCDHB has no additional borrowing facility or equity requirements during the three years of this financial plan, unless the Facility Master Plan is advanced due to the seismic strengthening work not being able to proceed due to the building being occupied.

The DHB plans to draw down against existing facilities to meet its requirements for the Capital Plan.

To minimise its funding costs SCDHB will maintain a high debt-to-equity ratio while remaining within its banking covenants and maintaining flexibility in its ability to drawdown debt.

**Schedule of Debt and Equity Movements**

| $000s | 2013/14 Forecast | 2014/15 Plan | 2015/16 Plan | 2016/17 Plan |
|---|---|---|---|---|
| New Debt Drawdown<br>- DMO | 0 | 0 | 0 | 0 |
| Debt Repayment<br>DMO | 0 | 0 | 0 | 0 |
| Equity Movements<br>FRS3 Depreciation funding repayment | (200) | (200) | (200) | (200) |
| - Net Result | (200) | (200) | (200) | (200) |

**Changes in Lenders, Limits and Borrowing Arrangements**
All debt facilities except overdraft are with the Debt Management Office (DMO). The DMO advised on 14 November 2007 that it waived the requirement on the DHB to comply with financial covenants and annual ratio compliance certificates. There have been no other changes to arrangements and none are planned.

SCDHB joined the HBL Banking and Treasury arrangements during 2012/13 and continues to be a party to this arrangement. Where the DHB can attain a preferential rate for term deposits outside this arrangement it has retained the right to do so.

## 4.10 Statement of Significant Accounting Policies

### 4.10.1 Reporting Entity

SCDHB is a Health Board established by the New Zealand Public Health and Disability Act 2000. SCDHB is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. SCDHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993 and the Crown Entities Act 2004 as amended by the Crown Entities Amendment Act 2013.

SCDHB is a public benefit entity, as defined under NZIAS 1.

SCDHB's activities involve delivering Health and Disability Services and Mental Health Services in a variety of ways to the community.

In addition, funds administered on behalf of patients have been reported as a note to the financial statements.

### 4.10.2 Reporting period

The reporting period for these prospective financial statements is for the year ended 30 June 2015.

### 4.10.3 Statement of Compliance

The financial statements have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZGAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZIFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

These are SCDHB's first full NZIFRS prospective financial statements and NZIFRS 1 has been applied.

These Prospective Financial Statements have been authorised for issue by the Board of SCDHB. The Board and management are responsible for ensuring that the Prospective Financial Statements are prepared using appropriate assumptions and that all disclosure requirements have been met.

### 4.10.4 Basis of Preparation

The prospective financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand. The financial statements are prepared on the historical cost basis except that land and buildings are stated at their fair value.

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

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

The Prospective Financial Statements include actual audited financial results for the year ended 30 June 2013.

These prospective financial statements have been prepared in compliance with FRS-42: Prospective Financial Statements.

### 4.10.5 Accounting Policies

The following particular accounting policies which materially affect the measurement of financial results and financial position have been applied consistently in preparing these Prospective Financial Statements:

1. Goods and Services Tax

   All items in the financial statements are exclusive of goods and services tax (GST) with the exception of receivables and payables, which are stated with GST included. Where GST is irrecoverable as an input tax it is recognised as part of the related asset or expense.

2. Taxation

   SCDHB is exempt from income tax as it is a public authority.

3. Donations and Bequest Funds

   Donations and bequests to SCDHB are dealt with by the Aoraki Foundation through the Health Endowment Fund.

4. Trade and Other Receivables

   Trade and other receivables are initially recognised at fair value and subsequently stated at amortised cost less impairment losses. Bad debts are written off during the period in which they are identified.

5. Inventories

   Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis is measured at the lower of cost and current replacement cost.

   The cost of purchased inventory held for distribution is determined using the weighted average cost formula.

   Any write down from cost to current replacement cost, or reversal of such a write down, is recognised in the statement of financial performance.

6. Cash and Cash Equivalents

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

7. Property, Plant and Equipment

***Classes of Property, Plant and Equipment***

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

- freehold land;
- freehold buildings;
- plant, equipment and vehicles;
- fixture and fittings; and
- work in progress.

***Owned Assets***

Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses. The cost of self-constructed assets includes the cost of materials, direct labour, the initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads. Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to SCDHB. All other costs are recognised in the statement of financial performance as an expense as incurred.

When an asset is acquired for nil or nominal consideration the asset will be recognised initially at fair value, where fair value can be reliably determined, with the fair value of the asset received, less costs incurred to acquire the asset, also recognised as revenue in the Statement of Financial Performance.

***Fixed assets vested from the Hospital and Health Service***

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Health South Canterbury Limited (a Hospital and Health Service) vested in South Canterbury DHB on 1 January 2001. Accordingly, assets were transferred to South Canterbury DHB at their net book values as recorded in the books of the Hospital and Health Service. In effecting this transfer, the Board has recognised the cost and accumulated depreciation amounts from the records of the Hospital and Health Service. The vested assets will continue to be depreciated over their remaining useful lives.

8. Revaluation of Land and Buildings

Land was revalued as at 31 January 2014 to fair value and buildings were revalued as at 31 January 2014 to fair value. Fair value is determined by an independent registered valuation advisor and based upon market evidence for land and net replacement cost for buildings. Land and Buildings are revalued with sufficient regularity, and at least every five years, to ensure that the carrying amount at balance date is not materially different to fair value. Consideration of the current valuations to determine that they have not materially changed is conducted in January each year. The results of revaluing are credited or debited to an asset revaluation reserve for that class of asset. Where this results in a debit balance in the asset revaluation reserve, this balance is expensed in the statement of financial performance. Any subsequent increase on revaluation that off-sets a previous decrease in value recognised in the statement of financial performance will be recognised first in the statement of financial performance up to the amount previously expensed, and then credited to the revaluation reserve for that class of asset.

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

9. Disposal of Fixed Assets

When a fixed asset is disposed of, any gain or loss is recognised in the Statement of Financial Performance and is calculated as the difference between the sale price and the carrying value of the fixed asset.

10. Depreciation of Fixed Assets

Depreciation is provided on a straight line basis on all fixed assets, other than freehold land, at rates which will write-off the cost (or revaluation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

| | | |
|---|---|---|
| Buildings | 33 to 65 years | 1.5 – 3.0% |
| Building Fit-outs | 3.5 to 20 years | 5 – 28.6% |
| Plant and Equipment | 2 to 10 years | 10 – 50% |
| Motor Vehicles | 3 to 5 years | 20 – 33.3% |

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

11. Leases

***Finance Leases***

Leases which effectively transfer to SCDHB substantially all the risks and benefits incident to ownership of the leased items are classified as finance leases. These are capitalised at the lower of the fair value of the asset or the present value of the minimum lease payments. The leased assets and corresponding lease liabilities are recognised in the Statement of Financial Position. The leased assets are depreciated over the period SCDHB is expected to benefit from their use.

***Operating Leases***

Leases where the lessor effectively retains substantially all the risks and benefits of ownership of the leased items are classified as operating leases. Payments under these leases are recognised as expenses in the periods in which they are incurred.

12. Intangible Assets

***Software***

Computer software that is acquired by SCDHB is stated at cost less accumulated amortisation and impairment losses. Subsequent expenditure on intangible assets is capitalised only when it increases the service potential or future economic benefits embodied in the specific asset to which it relates. All other expenditure is expensed as incurred.

***Amortisation***

Amortisation is charged to the statement of financial performance on a straight-line basis over the estimated useful lives of intangible assets unless such lives are indefinite. Intangible assets with an indefinite useful life are tested for impairment at each balance sheet date. Other intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

| | | |
|---|---|---|
| Software | 2 to 10 years | 50-10% |

13. Impairment

The carrying amounts of SCDHB's assets are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.

For intangible assets that have an indefinite useful life and intangible assets that are not yet available for use, the recoverable amount is estimated at each balance sheet date and was estimated at the date of transition.

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the statement of financial performance.

An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset.

A provision for impairment of receivables is established when there is objective evidence that SCDHB will not be able to collect all amounts due according to the original terms of receivables. The amount of the provision is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted using the effective interest method. Receivables with a short duration are not discounted.

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. Value in use is calculated differently depending on whether an asset generates cash or not. For an asset that does not generate largely independent cash inflows, the recoverable amount is determined for the cash-generating unit to which the asset belongs.

Impairment gains and losses, for items of property, plant and equipment that are revalued on a class of assets basis, are also recognised on a class basis.

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through the statement of financial performance.

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

14. Investments in Equity Securities

SCDHB's investments in equity securities are classified as available-for-sale financial assets and are stated at fair value, with any resultant gain or loss, expect for impairment losses, recognised directly in equity. When these assets are derecognised, the cumulative gain or loss previously recognised directly in equity is recognised in the statement of financial performance.

15. Employee Benefits

Long Service Leave, Sick Leave, Sabbatical Leave, Medical Education Leave and Retirement Gratuities

SCDHB's net obligation in respect of long service leave, sick leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The entitlement is calculated by discounting the obligation to its present value. The discount rate is the market yield on relevant New Zealand government bonds at the balance sheet date.

***Annual Leave***

Annual leave is a short-term obligation and is calculated on an actual basis at the amount SCDHB expects to pay. SCDHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates.

***Superannuation Schemes***

*Defined contribution schemes*

Obligations for contributions to defined contribution superannuation schemes are recognised as an expense in the statement of financial performance as incurred.

***Defined benefit schemes***

SCDHB belongs to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme, the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme.

16. Revenue

***Crown Funding***

The majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.

***Goods Sold and Services Rendered***

Revenue from goods sold is recognised when SCDHB has transferred to the buyer the significant risks and rewards of ownership of the goods and SCDHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to SCDHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by SCDHB.

***Revenue relating to Service Contracts***

SCDHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or SCDHB, with the agreement of the Ministry of Health, may be required to expend it on specific services in subsequent years. The amount unexpended is recognised as a liability.

***Interest Revenue***

Interest income is accrued using the effective interest rate method. The effective interest rate exactly discounts estimated future cash receipts through the expected life of the financial asset to that asset's net carrying amount. The method applies this rate to the principle outstanding to determine the interest income each period.

***Donated or Subsidised Assets***

Where a physical asset is acquired for nil or nominal consideration the fair value of the asset received is recognised as revenue in the Statement of Financial Performance.

17. Interest Expenditure

Interest expense is accrued using the effective interest rate method. The effective interest rate exactly discounts estimated future cash payments through the expected life of the financial liability to that liability's net carrying amount. The method applies this rate to the principle outstanding to determine the interest expense each period.

18. Cost Allocation

SCDHB has arrived at the net cost of service for each significant activity using the following cost allocation system. Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity/usage information. The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers, such as actual usage, staff numbers and floor area.

19. Interest-bearing borrowings

Interest-bearing borrowings are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest-bearing borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the statement of financial performance over the period of the borrowings on an effective interest basis.

20. Trade and Other Payables

    Trade and other payables are stated at amortised cost using the effective interest rate.

21. Other Liabilities and Provisions

    Other liabilities and provisions are recorded at the best estimate of the expenditure required to settle the obligation. Liabilities and provisions to be settled beyond 12 months are recorded at their present value.

22. Financial Instruments

    ***Financial Assets***

    Financial assets held for trading and financial assets designated at fair value through profit and loss are recorded at fair value with any realised and unrealised gains or losses recognised in the Statement of Financial Performance. A financial asset is designated at fair value through profit and loss if acquired principally for the purpose of selling in the short term. It may also be designated into this category if the accounting treatment results in more relevant information because it either significantly reduces an accounting mismatch with related liabilities or is part of a group of financial assets that is managed and evaluated to fair value basis. Gains or losses from interest, foreign exchange and fair value movements are separately reported in the Statement of Financial Performance.

    ***Loans and receivables***

    Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. Loans and receivables are recognised initially at fair value plus transaction costs and subsequently measured at amortised cost using the effective interest rate method. Loans and receivables issued with duration less than 12 months are recognised at their nominal value, unless the effect of discounting is material. Allowances for estimated recoverable amounts are recognised when there is objective evidence that the asset is impaired. Interest, impairment losses and foreign exchange gains and losses are recognised in the Statement of Financial Performance.

23. Standards issued but not yet effective.

    None.

24. Changes in Accounting Policies

    SCDHB has adopted New Zealand equivalents to International Financial Reporting Standards (NZ IFRS) with effect from 1 July 2006.

These prospective financial statements have been prepared in accordance with NZIFRS.

# CHAPTER 5: STEWARDSHIP

## 5.1 Quality & Safety

The DHB continues its commitment to embedding and integrating its clinical governance structures, allowing time for the combined Clinical Board to bed in and become known within the organisation. Following the completion of a review of the activities of the Clinical Board reporting committees, structures will be further developed.

At a national level, we will continue to engage with the Health, Quality and Safety Commission work programmes and priorities (with a particular focus on the Patient Safety Campaign work, and developments in capturing patient experience).

With a view to clinical governance SCDHB will continue to actively participate in the activities of the South Island Service Level Alliance for Quality and Safety. This Alliance was "formed to lead advice and make recommendations to support and coordinate improvements in safety and quality in health care for the South Island DHBs; identify and monitor initiatives that support improvements in national health and safety indicators; report on safety and quality, including performance against national indicators; and share knowledge about and advocate for safety and quality".[22] The Alliance's key focus areas for 2014 - 2017 are: 1.Open for Better Care (Patient Safety Campaign); 2.Incident Management; 3.Quality Systems and Indicator Framework; 4.Consumer Participation.

SCDHB continues to hold the chair of the National Quality Managers group and has close links with the Health Quality and Safety Commission, with membership on bodies such as the Patient Safety Campaign Advisory Group.

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Prevent falls and reduce harm from falls in South Canterbury. | Health Quality & Safety Commission's Open for Better Care - Patient Safety Programme.<br>SCDHB's Community Falls Steering Group. | Continue to focus on and improve processes around falls prevention. | • Roll out successful piloted improvement projects completed in 2012/13 across the DHB – Ongoing.<br>• Implement the Community Falls Prevention Action Plan developed in 2013 – Ongoing.<br>• Continue to engage with the national and regional approaches to falls reduction – Ongoing. | • HQSC Quality Safety Marker – 90% of older patients are given a falls risk assessment.<br>• No. of falls in the hospital categorised as a SAC 1 or 2 is ≤9.<br>• Percentage of the population admitted to hospital as a result of a fall is <6% |

[22] *South Island Regional Health Services Plan 2014 - 2017*

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Improve hand hygiene practices in order to reduce healthcare associated infections. | Health Quality & Safety Commission's Open for Better Care - Patient Safety Programme.<br>SCDHB's Infection Control Committee. | Continue to audit and educate clinical hospital staff in hand hygiene. | • Audit to the national schedule – Ongoing.<br>• Target education to least well performing staff groups as identified by audit data – Ongoing.<br>• Continue to engage with national patient safety campaign specifically the HAI topic – Ongoing. | HQSC Quality Safety Marker – 80% compliance with good hand hygiene practice. |
| Reduce preventable harm resulting from surgical site infections. | Health Quality & Safety Commission's Open for Better Care - Patient Safety Programme.<br>SCDHB's Infection Control Committee. | Commit to meeting infection control expectations in accordance with the Operation Policy Framework – Section 9.8 | Continue to engage with the national data warehouse through submission of data. | Surgical site infection programme national surveillance data warehouse information. |
| Use the World Health Surgical Safety Checklist to enhance the surgical team's communication. | Health Quality & Safety Commission's Open for Better Care - Patient Safety Programme.<br>Quality & Risk and Clinical Board Work Plans. | Continue to maintain the current level of performance in use of the World Health Organisation Surgical Safety Checklist. | Submit data to the national quality and safety marker programme – Ongoing. | HQSC Quality Safety Marker – All three parts of the surgical safety checklist are used 90% of the time. |
| Utilise effective antibiotic prophylaxis in lower limb joint replacements. | Health Quality & Safety Commission's Open for Better Care - Patient Safety Programme.<br>SCDHB's Infection Control Committee. | Implement the use of cephazolin prophylactically for hip and knee replacements. | Submit data to the national quality and safety marker programme for lower limb joint replacement. Q1 | HQSC Quality Safety Marker - 95% of hip and knee replacement patients receive cephazolin ≥ 2g as surgical prophylaxis. |
| Utilise appropriate skin preparation in lower limb joint replacements. | Health Quality & Safety Commission's Open for Better Care - Patient Safety Programme.<br>SCDHB's Infection Control | Implement standardised skin preparation for hip and knee replacements. | Submit data to the national quality and safety marker programme for lower limb joint replacement. Q1 | HQSC Quality Safety Marker - 100% of hip and knee replacement patients have appropriate skin preparation. |

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| | Committee. | | | |
| Prevent harm caused by surgery by improving communication and feedback within teams. | Health Quality & Safety Commission's Open for Better Care - Patient Safety Programme. | Implement suggested interventions as identified and proposed by the HQSC pilot project. | Continue to perform 'Time Out' prior to surgical procedures and audit compliance via the Health Quality & Safety Commission Quality and Safety Marker data submission. Q1, Q2, Q3, Q4 | HQSC Quality and Safety Marker for peri-operative harm. |
| Preventing harm due to medication errors. | Health Quality & Safety Commission's Open for Better Care - Patient Safety Programme.<br>The South Island DHB's are committed to implementing the IS SLA 2014-15 workplan. Milestones are detailed in the 2014-15 SIHSP. | Continue to commit resources to support the current ePrescribing and eMedicines installation within agreed priority areas. | As per timeframes in the joint work programme with the NHITB for an electronic system to access patient medication information. | Improved electronic medication management. |
| Capture people's health care experiences to identify how we can use that information to develop new ideas, measure change and report back to consumers. | Health Quality & Safety Commission Project.<br>Quality & Risk and Clinical Board Work Plans. | Implement the national Consumer Satisfaction Survey. | • Online survey goes live. Q1<br>• Access dashboard data to identify improvement opportunities. Q2 | National Consumer Satisfaction Survey data and information. |
| Give an account of the quality of SCDHB services to the community of South Canterbury. | Health Quality & Safety Commission Project.<br>Quality & Risk and Clinical Board Work Plans. | To further develop the SCDHB Quality Account format to meet agreed national standardised requirements. | • Draft Quality Account. Q1<br>• Finalise and approve Quality Account. Q2<br>• Publish Quality Account. Q3 | |
| Improve the level and effectiveness of organisational communication. | Improving Communication Project.<br>Clinical Board Work Plan. | Develop communication guidance and strategies that will enhance intra-organisational and community-wide communication. | • Produce Communication Guideline. Q1<br>• Implement guide and associated templates. Q2 – Q4 | |

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Reinforce the adoption and use of Improvement Science. | Quality and Risk Work Plan.<br>Clinical Board Work Plan. | Standardise tool and language to encourage improvement activity. | • Roll out Good Ideas Initiative. Q1<br>• Familiarise and educate staff in standardised language. Q3 | |
| Implement Advance Care Planning (ACP). | Clinical Board Work Plan. | Ensure that clinicians are provided with training and guidance regarding ACP in the NZ context, including the principles and associated legislation to ensure consistency of practice. | • Refine the clinical champion role. Q1<br>• Visit practices to up-skill GPs and practice nurses around the initiation of the conversation regarding ACP. Q3 | |

## 5.2 Risk Management

SCDHB's Risk Management Policy functions as the framework to support the risk management programme within the DHB: it reflects the Risk Management Principles and Guidelines AS/NZS ISO 31000:2009. The DHB will explore ways it can continue to strengthen its risk management processes specifically in relation to hierarchy of risk, (including service level risk) and expanding its risk identification to capture those involving the potential risk of patient harm.

## 5.3 Compliance with Legislation

South Canterbury District Health Board (SCDHB) is a Health Board established by the New Zealand Public Health and Disability Act 2000. SCDHB is a crown entity in terms of the Crown Entities Act 2004 and Amendment Act 2013, owned by the Crown and domiciled in New Zealand. SCDHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993 and the Crown Entities Act 2004 and Amendment Act 2013.

As required by the DHB Operating Policy Framework the SCDHB will comply with all relevant legislation and regulation in all activities and will meet the requirements of the Crown Entities Act 2004 and Amendment Act 2013.

The DHB secondary services Provider arm and Talbot Park both hold current certification.

## 5.4 Managing our Workforce within Fiscal Restraints

SCDHB supports and actively participates in national collective bargaining to ensure sector, organisational and professional needs are considered and remuneration and other terms and conditions are developed within fiscal constraints which in turn leads to performance improvement, productivity enhancement and effective employee engagement.

We will continue to participate in workforce profiling and the development of strategies and actions in relation to vulnerable workforces. Some medical specialties, sonographers, orthotists and mental health roles have been identified in this regard.

SCDHB will continue to support national/regional initiatives to improve the recruitment, deployment and retention of staff and support the use of common technology, coordination of HR processes and development of key HR metrics which will inform business planning processes.

We support the development and implementation of a Leadership and Management Framework and will evaluate the benefit of joining the Health Workforce Curriculum Partnership with education and training providers.

We will continue to support and advance the work of HBL as it identifies new service delivery models, technology, processes and policies which will improve efficiency and contain costs.

Finance, Procurement and Supply Chain Shared Services teams have developed detailed operating models, shared policies and over arching agreements and are engaging with DHBs in the implementation phases. SCDHB will continue to support the Food and Laundry, National Infrastructure Platform and HRMIS projects as they continue to develop.

## 5.5 Strengthening our Workforce

We are committed to a workforce strategy which provides a healthy environment, supportive work culture and ensures that every employee has the capacity and capability to deliver to current and future health care needs of our community.

SCDHB will continue to work with our Regional Training Hub Director and will participate in the various national initiatives to deliver workforce plans which will reflect core baseline data, utilise service demand forecasting and meet workforce requirements regarding hard to staff positions.

To strengthen professional leadership across allied and technical professions we will participate in the regional allied health professional leadership/educator advanced practice roles project and evaluate the establishment of an allied health professional forum.

The aging population and aging workforce are issues which drive our planning and strategy development with more than 40% of staff 50 years old or older. In view of this we have progressed a project to determine the factors which affect the retention, productivity and motivation of the older workforce. Our DONMAH also chairs the Nursing project group 'Sustaining the Workforce' which will provide recommendations in regard to improved utilisation of nurses and encourage the active contribution of older nurses as long as possible.

## 5.6 Safe and Competent Workforce

**Children's Worker Safety Checking**

SCDHB will support the development and implementation of plans and procedures by the 20 DHBs for recruiting workers in the children's workforce regarding safety checking. New employees in our core children's workforce will be screened in accordance with the requirements of the Vulnerable Children's Bill from 1 July 2014 and the checking of the existing core children's workforce will be phased in over the following

three years. The DHB will ensure that safety checking information is available for provision to the Director General (s38) to meet the requirements in the Vulnerable Children's legislation.

## 5.7 Organisation Health

We want to ensure that we build on the positive organisation culture as reflected in our most recent staff survey which showed an overall improvement in relation to previous results. Senior managers will give direction and focus to various projects and engage with staff for further improvement.

## 5.8 Health 4 You

We are continuing the pro-active approach to employee health by providing a variety of initiatives to empower staff to understand and improve their health. The targeted areas are improved nutrition, encouraging physical activity and workplace resilience. The subsidised gym memberships and other free or low cost contracted activities such as the provision of fitness programmes delivered on site by local fitness providers will continue. In the 2014/15 year we will continue with our holistic approach and include activities with a social context e.g. team building and activities which build employee resilience.

## 5.9 Health and Safety

We maintain a safe and healthy environment by participating in the ACC Workplace Safety Management Practices Programme and are participating in ACC's Employer Centric Services programme to benefit from specialised advice and coordinated injury prevention and claims management. SCDHB will also strengthen the integration and collaboration of stakeholders relating to Health and Safety and apply the guidelines of good governance for managing health and safety risks.

## 5.10 Care Capacity and Demand Management

SCDHB joined the Care Capacity Demand Management (CCDM) programme supported by the Safe Staffing Health Workplace Unit and in partnership with the unions. The CCDM programme is designed to assist the matching of service demand with service capacity to ensure the right number and skill mix of staff meet patient needs. An information technology system to measure patient acuity has been successfully implemented which will provide the necessary data to support the CCDM programme.

***South Canterbury DHB Workforce (July 2013)***

| | | |
|---|---|---|
| **Average age** - 47 years | | |
| **Gender Mix** | **Female**<br>**Male** | 84.02%<br>15.98% |
| **Largest Ethnic Group** | **NZ European** | 63.40% |
| **Hours of work** | **Full time**<br>**Part time/casual** | 32.24%<br>67.76% |

| Professional Grouping | FTE |
|---|---|
| Allied Health | 100.45 |
| Nursing | 296.43 |
| Medical | 55.79 |
| Support | 44.56 |
| Management and Admin | 112.04 |
| **Total** | **609.27** |

## 5.11 Workforce Development

SCDHB remains actively engaged in national activity through Health Workforce NZ (HWNZ) and regional activity through participation in the South Island Regional Training Hub (SIRTH), refer appendix 8.5. SIRTH is one of four national training hubs established through a HWNZ initiative and "functions to create a training and education network within the region that facilitates the coordination and delivery of education and training to all health professionals".[23]

While necessary to develop support for our aging workforce it is equally important that more local young people are effectively engaged and attracted to health careers with a focus on undergraduate qualifications. To address this need SCDHB implemented the Incubator Programme at six High Schools and participated in career choice events. We are progressively increasing the number of schools participating in the programme and are creating paid work experience for students who are participating in tertiary health education.

It is also important that we ensure all health professional graduates are supported in their first year of practice and to facilitate this we will develop a Learning and Development Framework with particular emphasis on development of an Allied Health and Technical new graduate programme, transitioning to an interdisciplinary framework.

To enable the national understanding of the skill mix, competencies, education and training needs of the mental health workforce we will participate in the Te Pou and Matua Raki workforce stocktake of adult mental health and addiction services.

We support the principles of equal opportunity and therefore will be promoting career opportunities for Maori and Pacific Island youth and continue to actively engage with the Kia Ora Hauora Maori Health Careers Programme locally. SCDHB will continue the partnership with Maori stakeholders and be guided by Te Waipounamu Maori Health Workforce and other national plans.

SCDHB will support the development of a framework for the implementation of allied health assistant training and development and participate in the regional pilot for rehabilitation assistant training.

Following the stock take of qualifications/training of health care assistants and orderlies we will be working with individuals to facilitate the creation of potential career paths in conjunction with Careerforce. This work will also meet collective contractual agreement requirements.

SCDHB will continue to engage with staff by providing some career planning guidance to medical, nursing and allied health employees taking the 70/20/10 model of medical education funding into account.

The Health Workforce New Zealand supported pilot for our GP registrar training is continuing with one GPEP2 level registrar rotating at the teaching practices during 2014/15.

The new role of Associate Director of Allied Health has been established and implemented and is making a positive contribution to the development of the allied health workforce.

[23] *South Island Regional Health Services Plan 2014 - 2017*

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Develop a framework for the implementation of the Allied Health Assistant Training and Development Programme into the five regional South Island DHBs. | South Island Regional Training Hub. | Participate in the regional pilot for the rehabilitation assistant training programme. | • Review progress of the four SCDHB enrolled participants. Q1<br>• Review workload implications for verifiers. Q1<br>• Participate in the evaluation of the teaching/delivery and assessment of the Careerforce NZQA Level 3 Health Assistant Qualification. Q3 | • Four SCDHB allied health assistants complete the training programme. |
| Strengthen professional leadership across allied and technical professions. | SCDHB Learning and Development Framework.<br><br>South Island Regional Training Hub. | • Continue the development of allied health leadership.<br>• Participate in the regional allied health professional leadership / educator / advanced practice roles project. | • Evaluate establishment of the allied health professional forum. Q1<br>• Complete implementation of career planning for allied health. Q2<br>• Establish linkages with neighbouring DHBs to engage in training and development opportunities via videoconference for selected allied health and technical groups. Q4<br>• Provide SCDHB information to project leader regarding current SCDHB roles. Q1 | • Two annual allied health professional forums held in 2014/15.<br>• A career plan is completed for all post graduate training and development applications.<br>• A minimum of three professional groups have established links with neighbouring DHBs. |
| Meet collective contractual agreement requirements for Service and Food Workers relating to Orderly Services. | Human Resources Work Plan. | Implement a training programme for orderly services. | Assessment of prior learning completed and programme offered. Q4 | |
| Provide career advice, guidance and support to HWNZ funded trainees enabling career development. | Human Resources Work Plan. | Provide career guidance and develop a plan for all HWNZ funded RMOs. | • Provide support to enable RMOs to acquire the skills and qualifications needed for any given career pathway. Q2<br>• Provide workforce | Feedback from HWNZ funded RMOs.<br><br>Lists/links provided. |

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| | | | information, including future demand for specialty or skill, and potential future opportunities as an SMO. Q3<br>• Supply a list of courses available that are deemed appropriate for future career development. Q3<br>• Ensure access to training within chosen career pathway. Q4 | |
| Increase the number of Diabetes Nurse Prescribers nationally, contributing to improved services being offered for diabetes enabling healthcare to be delivered closer to home. | South Island Regional Training Hub. | Support the regional approach being taken to addressing key workforce requirements on diabetes nurse prescribers. | As per the South Island Regional Training Hub Workplan. | Contribution to HWNZ's priority to have 100+ diabetes nurse prescribers either in training or trained by July 2014. |
| Implement training requirements for GPEP2 registrars to train with doctors of other vocational scopes. | South Island Regional Training Hub. | Support the regional approach being taken to addressing key workforce requirements on GPEP 2 registrars. | As per the South Island Regional Training Hub Workplan. | GPEP2 registrars complete the equivalent of at least 120 days training alongside a doctor registered in a vocational scope other than general practice. |
| Increase the number of sonographers nationally to enable more timely delivery of healthcare services, and meet increased demand from demographic change and growth of sonography as a diagnostic tool. | South Island Regional Training Hub. | Support the regional approach being taken to addressing key workforce requirements of sonographers. | As per the South Island Regional Training Hub Workplan. | Contribution to HWNZ's priority to have an additional 300 FTE employees over the period to 2023. |
| Implement the new 70/20/10 funding criteria for post-entry training in medical disciplines. | HWNZ medical contract for post-entry training. | Support the growth of the medical workforce by aligning training funding to the 70/20/10 | Ongoing. | Model implemented by July 2015. |

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| | | model. | | |
| Increase the national understanding of the skill mix, competencies, education and training needs of the mental health workforce. | Te Pou and Matua Raki workforce stocktake of adult mental health and addiction services. | Participate in the Mental Health Workforce Stocktake. | Workforce census completed. Q2 | |
| Provide advice and recommendations to the South Island Executives Directors of Nursing with regard to better utilisation and retention of nurses. | South Island Regional Training Hub - Sustainable Nursing Project Group. | Lead the SIRTH Nursing Project - 'Sustaining the Workforce'. | • Develop a communication strategy valuing experienced nurses. Q1<br>• Provide SI DONs with recommended roster patterns to best retain nurses. Q2<br>• Develop an action plan based on the Position Statement published in 2013/14. Q4 | |
| Attract South Canterbury youth to choose a health career that meets the future health workforce needs. | SCDHB Workforce Development Plan. | Continue the Incubator Project. | Programme delivered to seven South Canterbury secondary schools from terms one to three in 2015. | Interest, motivation and action measured through standard student feedback and school leaving data for tertiary study. |
| Ensure all health professional graduates are supported in their first year of practice. | SCDHB Learning and Development Framework. | Development of an allied health and technical new graduate programme transitioning to an interdisciplinary framework. | • Review existing allied health induction programmes. Q1<br>• Develop new graduate programme guidelines for use across allied and technical professions. Q2<br>• Draft a generic framework for an interdisciplinary approach. Q3<br>• Implement approved interdisciplinary framework. Q4 | |

## 5.12 Building Capability

SCDHB has committed to working regionally as part of the South Island Information Systems Service Level Alliance (SIISSLA) to invest in new information systems. This plan has an emphasis on clinical systems and supports the National Health IT Plan by developing, implementing and maintaining appropriate information systems aligned to both its Regional Service Plan and Annual Plan.

SCDHB Share of Regional/National Projects

| $000s | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 + | Total |
|---|---|---|---|---|---|---|
| PAS(Patient Administration System) - Total | 205 | 235 | 214 | 290 | 2,238 | 3,183 |
| e-Pharmacy | - | 300 | | - | - | 300 |
| e-Prescribing & Administration | 6 | 401 | | | | 407 |
| e-Medicine Reconciliation | | 55 | - | | | 55 |
| e-Medicine Management | | | 356 | | | 356 |
| e-Referrals (DHB) | 124 | 5 | | | | 129 |
| Regional Shared Care Record (eSCRV) | - | 264 | 52 | - | | 316 |
| e-Maternity | - | 201 | - | | | 201 |
| IT - RL6 | - | 35 | | | | 35 |
| IT - eOrdering Shared Radiology/Labs | 117 | 117 | | | | 234 |
| IT - National Patient Flow | 17 | 52 | | | | 70 |
| IT - Clinical Workstation | 6 | 29 | | | | 35 |
| IT - Provation | - | 94 | - | | | 94 |
| IT - Mosaic | - | 20 | - | | | 20 |
| IT - Commuity ePrescribing | | 70 | | | | 70 |
| IT - Self-care Portal | | 90 | | | | 90 |
| IT - FPSC | 298 | 436 | | | | 734 |
| IT - Concept Projects/Unspecified | | | | | | 933 |
| | **774** | **2,404** | **622** | **290** | **2,238** | **7,261** |

There are a number of national projects which the SISSLA are awaiting further information in order to prioritise against the current programme of work. Therefore this Annual Plan does not include any assumptions on investment, operation costs and benefits for the following systems:

- HRMIS – national via HBL;
- National Infrastructure – national via HBL; and
- National Patient Flow.

***Regional***

The South Island is to review, and change the way health care is delivered to consumers enabling a sustainable and integrated service to be provided over the coming years. This goal is to improve support for community services, better access by GPs, to DHB clinical and patient information and to provide greater integration and visibility across the continuum of care for both care teams and users of the health service.

## 5.13 Information Communication Technology - Support information and data– Daptiv programme

**Patient Administration System (PAS)** - The National Health IT Board (NHITB) is driving the development of regional information systems including the integration of Patient Administration with clinical systems.

***South Canterbury DHB's Key Local Initiatives 2014/15***

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| Replace end of life PAS Systems and provide a future enabler to provide improved support for community services, to support better access by GP's to DHB clinical and patient information and to provide greater integration and visibility across the continuum of care for both care teams and users of the health service. | SIISSLA | CORE PAS developed and delivered to Model Community by Orion - Secondment of Staff member for 6 months to the Functionality Design Team. | Input into the design and functionality of the PAS. Q1/Q2 | • Delivery of core PAS 2015/16.<br>• SCDHB PAS 'go live' implementation August 2018. |
| SCDHB PAS contingency plans enacted to ensure continuity of current PAS until regional solution delivered. | Consultation with IT Department and SI DHBs around approaches to be taken. | • Document alternatives and make a recommendation.<br>• Implement recommendation and monitor. | 2015 contingency plan to be in place. Q1 | • Risk mitigated - ensuring adequate system/staffing in place to see SCDHB through to regional PAS implementation 2018. |

**Finance procurement & supply chain –** Support the programme's information requests and the procurement transition from 1 July 2015. Currently SCDHB is not scheduled to transform to the new Finance and Supply model until Q1 2016.

## 5.14 Clinical Technology/Communication

***South Canterbury DHB's Key Local Initiatives 2014/15***

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| ePrescribing and Administration (ePA). | Regional SIISSLA. | Implementing ePA into inpatient wards across SCDHB (incorporating NZULM & NZ Formulary when sources are available) with the aim of improving medication safety for patients. | • Device deployment to the wards. Q1<br>• Implementation of SDHB instance of ePrescribing at SCDHB. Q2/Q3 | • Reduction in errors and harm.<br>• Improved reporting for community practitioners, pharmacists and inpatients.<br>• Alignment of processes |

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| | | | | amongst stakeholder DHBs. |
| ePharmacy (ePM). | Regional SIISSLA, SDHB regional instance. | Implement ePharmacy into South Island DHB's using a single regional instance (incorporating NZULM & NZ Formulary when sources are available) to enable the management of medications. | SCDHB implementation. Q2/Q3 | • Appropriate use of resources.<br>• Reduced waste of resources.<br>• Decreased adverse events.<br>• Decreased avoidable mortality. |
| eMedicine Reconciliation (eMR). | Regional SIISSLA. | Implementing electronic Medication Reconciliation across South Island DHBs following ePA and ePM. | • eMR regional instance ready. Q3<br>• Implementation. Q4 | • Appropriate use of resources .<br>• Reduced waste of resources.<br>• Decreased adverse events.<br>• Decreased avoidable mortality. |
| Advance Care Planning template. | Regional SIISSLA. | Develop and implement a regional AdvanceCare Plan template accessible to all health care clinicians to support a person to make informed choice about their end of life plan. Plan to be accessible to Primary, Community Nursing, First Response (Ambulance) and Secondary Clinicians. | • Agree and decide on a regional ACP template and technical infrastructure. Q4<br>• DHB Business case development. Q4<br>• Progress with regional implementation. TBA | Improved patient health and better understanding of conditions. |
| Self-care portal. | Regional SIISSLA. | To prepare to implement a Self-Care Portal that helps patients be involved in their care. It also ensures clear communication resulting in a better patient experience and improved | • Business case incl Portal recommendation. Q1<br>• Real me sign up logistics. Q2<br>• Contact help/desk set up/how this is supported. Q2<br>• Consumer engagement. Q3<br>• Dependency on | • 25% patient uptake within 12 months of launch.<br>• Increased awareness and self-management of long term conditions. |

| Objective | Planning Approach | Action | Milestones/Timeframe | Measurable Deliverables |
|---|---|---|---|---|
| | | patient outcomes. | eSCRV for full patient view. Q3 | • Release of GP practice staff time. |
| Shared Care Record View (eSCRV). | Regional SIISSLA. | To implement a South Island solution that provides access to the patient record. | • Regional solution data quality issues to be resolved. Q2<br>• Business Case Implementation. Q4 | Increased patient care and productivity by having access to all regional information about the patient. |
| National Patient Flow – phase 1 data collection. | National Initiative following programme project. | To implement the National Patient Flow project which will track and report on the patient journey. | • Phase 1 National Data Collection (Referrals to First Specialist Assessment) live. Q1<br>• Engage in project scoping requirements for phase 2 as these become available. Q2 | • Improved quality and quantity of data collection.<br>• Improved patient planned care.<br>• Reduction in cancelled services. |
| eReferral – phase 2 | Regional SIISSLA. | Regional implementation of eReferrals (electronic referrals), including the use and maintenance of Electronic Request Management System (ERMS) and Orion Health's Referral Management System (RMS) in Health Connect South (HCS). | • Orion to develop a new Referral Management System "RMS". Q1<br>• Finalise 'referral product', business process and Implement. Q2 | • Electronic referrals with minimum paper output – reduced archiving space requirements.<br>• Productivity gains for staff.<br>• Readily available information on the patient journey through eSCRV for GPs. |

## 5.15 National Health Committee (NHC)

The South Island DHB's will work with the NHC via the Strategic Planning and Integration Team who will take on the role of the Regional Prioritisation Networks and work with NHC to understand the implications and resource requirements in supporting the following NHC initiatives:

- the burden of disease review programme by engaging with and providing advice on the burden of disease documents;
- the NHC work programme for sector referral round by referring technologies that are driving fast-growing expenditure to the NHC for prioritisation and assessment where appropriate;
- the NHC work programme for the development of recommendations and implementation strategies by providing expert clinical opinion to working and advisory groups on health technology assessments

where possible and by not introducing emerging technologies where the NHC has recommended that these technologies should not be introduced;
- the NHC identification of notional savings work programme by providing expert business opinion to working and advisory groups on health technology assessments where possible;
- the NHC health innovation partnership work programme by providing clinical research time to design and run field evaluations where possible; and
- the NHC development of regional prioritisation networks work programme by referring technologies that are driving fast-growing expenditure and that have not been prioritised for assessment at the national level, to the Regional Prioritisation Network where appropriate.

## 5.16 Health Promotion Agency (HPA)

The DHB will support the following HPA initiatives:

- national health promotion activities around the health targets;
- work undertaken by the HPA on preventing foetal alcohol spectrum disorder; and
- compliance with requirements of the Sale and Supply of Alcohol Act 2012, including enabling the Medical Officer of Health to comply with their specific responsibilities and duties outlined under the Act.

## 5.17 PHARMAC

The DHB will support the following PHARMAC initiatives:

- commencing its interim procurement role for hospital medical devices, including committing to implement new national medical device contracts, when appropriate; and
- progressing its hospital pharmaceuticals management function.

While hospital medical devices category and interim budget management establishment have been identified as a national entity priority initiative, the DHB and the Ministry do not expect this to have an impact on 2014/15 planning.

# CHAPTER 6: SERVICE CONFIGURATION

Service Coverage – Nil issues

Service Changes –

**Fertility Services:** CDHB, as lead DHB, have contracted this service to date for the South Canterbury population and SCDHB will participate in the regional approach for the provision of fertility services including the development and issuing of an RFP noting the existing provider contract is due for renewal December 2014. This will ensure equitable and consistent access to publicly funded, high quality fertility services across the South Island.

# CHAPTER 7: DHB PERFORMANCE EXPECTATIONS

The DHB monitoring framework aims to provide a rounded view of performance using a range of performance markers. Four dimensions are identified reflecting DHB functions as owners, funders and providers of health and disability services. The four identified dimensions of DHB performance cover:

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

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

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

| **Performance measure** | **2014/15 Performance expectation/target** | | |
|---|---|---|---|
| PP6: Improving the health status of people with severe mental illness through improved access. | Age 0-19 | | 5% |
| | Age 20-64 | | 3.6% |
| | Age 65+. | | 1% |
| PP7: Improving mental health services using transition (discharge) planning and employment. | Long term clients. | | Provide a report as specified. |
| | Child and youth with a transition (discharge) plan. | | At least 95% of clients discharged will have a transition (discharge) plan. |
| PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds. | Mental Health Provider Arm. | | |
| | Age | <= 3 weeks | <=8 weeks |
| | 0-19 | 80% | 95% |
| | Addictions (Provider Arm and NGO). | | |
| | Age | <= 3 weeks | <=8 weeks |
| | 0-19 | 80% | 95% |
| PP10: Oral Health- Mean DMFT score at Year 8. | Ratio year 1 | | 1.1 |
| | Ratio year 2 | | 1.1 |
| PP11: Children caries-free at five years of age. | Ratio year 1 | | 62% |
| | Ratio year 2 | | 68% |
| PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years). | % year 1 | | 91% |
| | % year 2 | | 91% |
| PP13: Improving the number of children enrolled in DHB funded dental services. | 0-4 years - % year 1. | | 83% |
| | 0-4 years - % year 2. | | 85% |
| | Children not examined 0-12 years. % year 1. | | 10% |
| | Children not examined 0-12 years. % year 2. | | 10% |

| Performance measure | 2014/15 Performance expectation/target | |
|---|---|---|
| PP18: Improving community support to maintain the independence of older people. | The % of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care plan. | >95% |
| PP20: improved management for long term conditions (CVD, diabetes and stroke):<br>Focus area 1: Long term conditions. | Report on delivery of the actions and milestones identified in the Annual Plan. | |
| Focus area 2: Diabetes Management (HbA1c) Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control. | Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control. | Improve or maintain proportion of patients with good or acceptable glycaemic control. |
| Focus area 3: Acute coronary syndrome services. | 70 percent of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0'). | ≥ 70% |
| | Over 95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days. | >95% |
| Focus area 4: Stroke Services. | 6 percent of potentially eligible stroke patients thrombolysed. | ≥6% |
| | 80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway. | ≥80% |
| PP21: Immunisation coverage (previous health target). | Percentage of two year olds fully immunised. | 95% |
| PP22: Improving system integration. | Report on delivery of the actions and milestones identified in the Annual Plan. | |
| PP23: Improving Wrap Around Services – Health of Older People. | Report on delivery of the actions and milestones identified in the Annual Plan. | |
| PP24: Improving Waiting Times – Cancer Multidisciplinary Meetings. | Report on delivery of the actions and milestones identified in the Annual Plan. | |
| PP25: Prime Minister's youth mental health project. | Provide quarterly narrative progress reports against the local alliance Service Level Agreement plan to implement named initiatives/actions to improve primary care responsiveness to youth. Include progress on named actions, milestones and measures. | |
| PP26: The Mental Health & Addiction Service Development Plan. | Report on the status of quarterly milestones for a minimum of eight actions to be completed in 2014/15 and for any actions which are in progress/ongoing in 2014/15. | |
| PP27: Delivery of the children's action plan. | Report on delivery of the actions and milestones identified in the Annual Plan. | |

| Performance measure | 2014/15 Performance expectation/target | |
|---|---|---|
| PP28: Reducing Rheumatic fever. | Provide a progress report against DHBs' rheumatic fever prevention plan. | |
| | Hospitalisation rates (per 100,000 DHB total population) for acute rheumatic fever are 40% lower than the average over the last 3 years. | 0.3 |
| PP29: Improving waiting times for diagnostic services. | 1. Coronary angiography – 90% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days). | ≥90% |
| | 2. CT and MRI – 90% of accepted referrals for CT scans, and 80% of accepted referrals for MRI scans will receive their scan within than 6 weeks (42 days). | CT – 90%<br>MRI – 80% |
| | 3. <u>Diagnostic colonoscopy:</u><br>a. 75% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 days); and<br>b. 60% of people accepted for a diagnostic colonoscopy will receive their procedure within six weeks (42 days). | 75%<br><br>60% |
| | <u>Surveillance colonoscopy:</u><br>c. 60% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date. | 60% |
| PP30: Faster cancer treatment (details of expectations to be confirmed). | Part A: Faster cancer treatment<br>- 62 day indicator<br>*This indicator will be included within PP30 for quarter one 2014/15 only*<br>*From quarter two 2014/15 this indicator will become a health target.* | 85% |
| | Part B: Faster cancer treatment<br>- 31 day indicator<br>*This indicator will be included within PP30 for all quarters of 2014/15.* | <10 percent of the records submitted by the DHB are declined. |
| | Part C: Shorter waits for cancer | All patients |

| Performance measure | 2014/15 Performance expectation/target | |
|---|---|---|
| | treatment<br>- radiotherapy and chemotherapy<br>*This indicator will be included within PP30 from quarter two 2014/15 (transitioning from health target.)* | ready for treatment receive treatment within four weeks form decision-to-treat. |
| SI1: Ambulatory sensitive (avoidable) hospital admissions. | Age 0-4 | ≤95% |
| | Age 45-64 | ≤107% |
| | Age 0-74 | ≤102% |
| SI2: Delivery of Regional Service Plans. | Provision of a single progress report on behalf of the region agreed by all DHBs within that region ( the report includes local DHB actions that support delivery of regional objectives. | |
| SI3: Ensuring delivery of Service Coverage | Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage. | |
| SI4: Standardised Intervention Rates (SIRs) | major joint replacement. | an intervention rate of 21.0 per 10,000 of population. |
| | cataract procedures. | an intervention rate of 27.0 per 10,000. |
| | cardiac surgery. | an intervention rate of 6.5 per 10,000 of population. |
| | percutaneous revascularization. | a target rate of at least 12.5 per 10,000 of population. |
| | coronary angiography services. | a target rate of at least 34.7 per 10,000 of population. |
| SI5: Delivery of Whānau Ora | Report progress on planned activities with providers to improve service delivery and develop mature providers. | |
| OS3: Inpatient Length of Stay. | Elective LOS. | 3.4 |
| | Acute LOS. | 4.32 |
| OS8: Reducing Acute Readmissions to Hospital. | total pop. | ≤7.1% |
| | 75 plus. | ≤10.1% |
| OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections:<br>Focus area 1: Improving the quality of identity data. | New NHI registration in error.<br>A. Greater than 2% and less than or equal to 4%.<br>B. Greater than 1% and less than or equal to 3%.<br>C. Greater than 1.5% and less than or equal to 6%. | Greater than 1.5% and less than or equal to 6%. |
| | Recording of non-specific ethnicity.<br>Greater than 0.5% and less than | Greater than 0.5% and less than or equal to |

| Performance measure | 2014/15 Performance expectation/target | |
|---|---|---|
| | or equal to 2%. | 2%. |
| | Update of specific ethnicity value in existing NHI record with a non-specific value.<br>Greater than 0.5% and less than or equal to 2%. | Greater than 0.5% and less than or equal to 2%. |
| | Validated addresses unknown.<br>Greater than 76% and less than or equal to 85%. | Greater than 76% and less than or equal to 85%. |
| | Invalid NHI data updates causing identity confusion.<br>% tbc | |
| Focus area 2: Improving the quality of data submitted to National Collections. | NBRS links to NNPAC and NMDS.<br>Greater than or equal to 97% and less than 99.5%. | Greater than or equal to 97% and less than 99.5%. |
| | National collections file load success.<br>Greater than or equal to 98% and less than 99.5%. | Greater than or equal to 98% and less than 99.5%. |
| | Standard vs edited descriptors.<br>Greater than or equal to 75% and less than 90%. | Greater than or equal to 75% and less than 90%. |
| | NNPAC timeliness.<br>Greater than or equal to 95% and less than 98%. | Greater than or equal to 95% and less than 98%. |
| Focus area 3: Improving the quality of the programme for Integration of mental health data (PRIMHD). | PRIMHD File Success Rate-<br>Greater than 95%. | >95% |
| | PRIMHD data quality. | Routine audits undertaken with appropriate actions where required. |
| Output 1: Mental health output delivery against plan. | Volume delivery for specialist Mental Health and Addiction services is within:<br>a) five percent variance (+/-) of planned volumes for services measured by FTE;<br>b) five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; and<br>c) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan. | |
| Developmental measure DV4: Improving patient experience. | No performance target set. | |

# CHAPTER 8: APPENDICES

## 8.1 Letter of Expectations

Office of Hon Tony Ryall
Minister of Health
Minister for State Owned Enterprises

30 JAN 2014

Dear

**Letter of Expectations for DHBs and subsidiary entities 2014/15**

Public and patient confidence in the health service continues to grow strongly. Thank you to your team. This achievement is built on the four objectives of the Government's health plan: *helping families stay healthy, better performance, best use of every dollar, and a strong and trusted workforce*. In the next year we expect continued strong focus on successful implementation.

New Zealand has come through the global financial crisis in much better shape than most other countries. That's because of this government's careful and prudent financial management. Our approach has been to protect the most vulnerable in our society, and rebuild the economy's capacity to create jobs, higher incomes and security.

Despite the toughest of times, we are providing better public services within careful funding increases. This government now invests an extra $2.5 billion a year more into the public health service. And this year's budget will again see more investment in Health.

**Better Public Services: Results for New Zealanders**

Of the Prime Minister's ten whole-of-government key result areas, DHBs are expected to actively engage and invest in increased infant immunisation, reduced incidence of rheumatic fever, and reduced assaults on children.

It is important Boards work closely with other social sector organisations and initiatives including Whanau Ora, Children's Action Plan and Youth Mental Health. The government values the contribution of NGOs and DHBs must work with them.

**National Health Targets**

The national health targets have proven very successful at driving major improvements for patients: more elective surgery, faster access to emergency and cancer care, and better prevention. DHBs will provide clear and specific plans for achieving all national health targets in their Annual Plans.

In particular further work is required to achieve the three preventive targets. You must demonstrate appropriate performance management arrangements for PHOs. Poor performance must be rectified and not ignored. You should again show your local primary care networks are involved in and explicitly endorse your target achievement plans.

Your DHB is expected to help patients by meeting our objectives of shorter waiting times for surgery, diagnostics, cardiac and cancer care.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6804 Facsimile 64 4 817 6504

**Care Closer to Home**

New Zealanders are living longer, more sedentary lives. This means more of us have chronic conditions like diabetes, asthma, dementia, cancer and mental health disorders. The sooner doctors and nurses can detect, treat or prevent these conditions, the better they can reduce the significant burden these conditions put on both patients and the health system.

A major strategy to do this is *clinical integration* – providing joined-up care across primary and secondary services. With resources and interventions flowing to where they are most effective. So patients get their care sooner and closer to home.

DHBs must focus strongly on service integration across the health system, including integrated family health centres, primary care direct referral for diagnostics, clinical pathways and sharing of patient controlled health records.

**Health of Older People**

Your DHB is expected to continue working with primary and community care to deliver integrated services for older people to support their continued safe, independent living at home; particularly important are avoiding a hospital admission and care after a hospital discharge. You should continue working with the Ministry to implement our commitments to improving home care, stroke services and dementia care pathways.

**Regional and National Collaboration**

DHBs are expected to make further progress on implementing Regional Service Plans including workforce, IT and capital objectives. DHBs are expected to strongly support the implementation of the key Health Benefits Ltd savings programmes. Further gains in quality, efficiency and cost control will also come from your work with Pharmac, Health Workforce NZ and the Health Quality and Safety Commission. The new patient satisfaction survey is one example.

Strong clinical leadership and engagement is important and remains essential.

**Living Within Our Means**

To support New Zealand's recovery your DHB must keep to budget. Your DHB must have detailed and effective plans to improve financial performance year on year. Equity and capital remain constrained. As agents of the Crown you and your Board must assure yourselves that you have in place the appropriate clinical and executive leadership to deliver on the government's objectives. You and your Board must monitor and hold your CEO accountable against these expectations.

**Appreciation**

Again, thank you for the considerable effort you and your team are making. This makes a real difference to the quality of life of many thousands of New Zealanders. Please share this letter with your clinical leaders and local primary care networks.

Yours sincerely

Tony Ryall

Tony Ryall
**Minister of Health**

Attached: PM's Key Result Areas and National Health Targets

## Appendix 1: Prime Minister's Key Result Areas and DHB Health Targets for 2014/15

### Prime Minister's Key Result Areas – Supporting Vulnerable Children

Increase immunisation rates

Increase infant immunisation rates so that 95 percent of eight-month-olds are fully immunised by December 2014 and this is maintained through to 30 June 2017.

Rheumatic Fever

Reduce the incidence of rheumatic fever by two thirds to 1.4 cases per 100,000 people by 2017.

Assist to reduce the number of assaults on children

By 2017, halt the rise in children experiencing physical abuse and reduce current numbers by 5%.

### National Health Targets for 2014/15

Shorter stays in Emergency Departments

95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.

Improved access to elective surgery

The volume of elective surgery will be increased by at least 4,000 discharges per year.

Shorter waits for cancer treatment / transitioning to Faster Cancer Treatment

All patients ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy.

Faster cancer treatment.

The 62-day faster cancer treatment indicator that is currently a developmental measure, will transition into a full policy priority accountability measure, and will become the next cancer health target during 2014/15. Further details including the health target definition, DHB performance expectations for 2014/15, and the process for transition will be provided at the end of February 2014.

Increased immunisation

90 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2014 and 95 percent by December 2014.

Better help for smokers to quit

95 percent of hospitalised patients who smoke and are seen by a health practitioner in public hospitals and 90 percent of enrolled patients who smoke and are seen by a health practitioner in General Practice are offered brief advice and support to quit smoking. Within the target a specialised identified group will include:

- progress towards 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit.

More heart and diabetes checks

90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.

## 8.2 Glossary of Terms

| | |
|---|---|
| **ABC** | Ask about and document every person's smoking status, give brief advice to stop every person who smokes, and strongly encourage every person who smokes to use cessation support (a combination of behavioral support and stop-smoking medicine works best) and offer to help them access it. |
| **ABCD2** | TIA assessment – age, blood pressure, clinical symptoms, diabetes and duration. |
| **ACC** | Accident Compensation Corporation |
| **ACP** | Advance Care Planning |
| **ACPP** | Accelerated Chest Pain Pathway |
| **ACS** | Acute Coronary Syndrome |
| **ADOM** | Alcohol and Drug Outcome Measure |
| **AHP** | Aoraki HealthPathways. Pathways, for the care and management of patients within South Canterbury that have been developed jointly by primary and secondary care clinicians. |
| **Ajexus** | Mental Health Information System Software |
| **ANZACS - QI** | A web-based system to support clinical quality improvement in secondary care cardiology practice and to better understand the relevant population health profile within regions and nationally. |
| **AOD** | Alcohol and Other Drug |
| **ARRC** | Age Related Residential Care |
| **ATLAS** | The Atlas of Healthcare Variation displays easy-to-use maps, graphs, tables and commentaries that highlight variations by geographic area in the provision and use of specific health services and health outcomes. |
| **ATR** | Assessment, Treatment & Rehabilitation Services |
| **AWS** | Arowhenua Whānau Services |
| **BadgerNet** | Specialist perinatal management software |
| **CAMHS** | Child and Adolescent Mental Health Services |
| **CAPA** | Choice And Partnership Approach |
| **CAPEX** | Capital Expenditure |
| **Caseweight** | A national method of measuring dissimilar outputs in a common way. E.g. a hip replacement is 4.008 case weights and an appendix removal is 1.044 case weights. I.e. a hip replacement is considered to use about four times the resources (or cost) than an appendectomy. |
| **CCDM** | Care Capacity Demand Management |
| **CCP** | Contribution to Cost Pressure |
| **CDHB** | Canterbury District Health Board |
| **CNC** | Cancer Nurse Coordinator |
| **CNS** | Clinical Nurse Specialist |
| **COPMIA** | Children of Parents with Mental Illness and Addictions |
| **CPAC** | Clinical Prioritisation Assessment Criteria |
| **Crown Entity** | A generic term for a diverse range of entities within one of the five categories referred to in section 7(1) of the Crown Entities Act 2004, namely: statutory entities, Crown entity companies, Crown entity subsidiaries, school boards of trustees, and tertiary education institutions. Crown entities are legally separate from the Crown and operate at arms length from the responsible or shareholding Minister(s); they are included in the annual financial statements of the Government. |
| **CT** | Computed Tomography |
| **CVD** | Cardiovascular Disease |
| **CWD** | Cost Weighted Discharge |
| **CYFS** | Child Youth and Family Services |
| **DCIP** | Diabetes Care Improvement Package |
| **DHB** | District Health Board |
| **DMFT** | Decayed, Missing, Filled Teeth |
| **DMO** | Debt Management Office |
| **DNA** | Did Not Attend |
| **DON** | Director of Nursing |
| **DONMAH** | Director of Nursing, Midwifery and Allied Health |

| | |
|---|---|
| **Dr Info** | Dr Info is an electronic soft ware programme which pulls and collates information allowing general practice access at the point of service to real-time health information from a number of data sources. |
| **DSAC** | Disability Services Advisory Committee |
| **DSS** | Disability Support Services |
| **DXA** | A scan which measures bone density and is typically used to diagnose and monitor osteoporosis. |
| **ECAN** | Environment Canterbury |
| **ECG** | Electrocardiogram |
| **ED** | Emergency Department |
| **eMR** | Electronic Medicines Reconciliation |
| **Encounter Programme** | An intensive 12 week programme to assist either newly diagnosed Type 2 diabetics, Type 2 diabetics starting on insulin therapy and patients who have not attended their Diabetes Annual Review and are considered at high risk of complications from diabetes due to poor metabolic control, to better self-manage lifestyle and medication requirements and to allow for a better quality of life and improved metabolic control. |
| **ENT** | Ear, Nose and Throat |
| **ePA** | ePrescribing and Administration |
| **ePM** | ePharmacy |
| **EPOA** | Enduring Power of Attorney |
| **ERAS** | Early Recovery After Surgery |
| **ESPI** | Elective Services Patient Flow Indicator |
| **eSURV** | Electronic Shared Care Record View |
| **ERMS** | Electronic Referral Management System |
| **FAST** | Sudden signs of stroke – face dropping, arm weakness, speech difficulty, time to call 111. |
| **FCT** | Faster Cancer Treatment |
| **FIM** | Functional Interdependence Measure |
| **FSA** | First Specialist Assessment |
| **FST** | Financial Sustainable Threshold |
| **FTE** | Full Time Equivalent, e.g., two people each working 20 hours per week = 1 FTE. |
| **FVIP** | Family Violence Intervention Programme |
| **Funder Arm** | The part of the DHB that funds (purchases) services from providers of health services, including the DHB's own Provider Arm. |
| **GP** | General Practitioner |
| **GST** | Goods and Services Tax |
| **HAI** | Hospital Acquired Infection |
| **HBL** | Health Benefits Limited |
| **HBSS** | Home Based Support Services |
| **HCS** | Health Connect South |
| **HEEADSSS** | Home, Education & employment, Eating, Activities with peers, Drugs, Sexual activity, Suicide & Depression, Safety. |
| | |
| **HPV** | Human Papilloma Virus |
| **HQSC** | Health Quality & Safety Commission |
| **HR** | Human Resources |
| **HRMIS** | Human Resource Management Information System |
| **HWNZ** | Health Workforce New Zealand |
| **IDF** | Inter-District Flows. Patients who live in one district receiving services in another district. |
| **Impact measures** | Impact measures are attributed to agency (DHBs) outputs in a credible way. Impact measures represent near-term results expected from the goods and services you deliver; can often be measured soon after delivery, promoting timely decisions; and may reveal specific ways in which managers can remedy performance shortfalls. |

| | |
|---|---|
| **Intervention logic model** | A framework for describing the relationships between resources, activities and results. It provides a common approach for integrating planning, implementation, evaluation and reporting. Intervention logic also focuses on being accountable for what matters – impacts and outcomes. |
| **InterRAI** | Clinical assessment tool used in Older Persons Care. |
| **ISSP** | Information Systems Strategic Plan |
| **IS** | Information Services |
| **IT** | Information Technology |
| **KPI** | Key Performance Indicator |
| **"Living within our means"** | Providing the expected level of outputs within a break even budget or National Health Board (NHB) agreed deficit step toward break even by a specific time. |
| **LMC** | Lead Maternity Carer |
| **LOS** | Length of Stay |
| **LTC** | Long Term Condition |
| **MCR** | Multi Condition Rehab. A 6 week long, twice weekly, rehabilitation programme for people with long term conditions such as diabetes, heart and respiratory conditions.<br>The focus of the programme is to teach people how to manage their conditions better themselves. |
| **MDMs** | Multi Disciplinary Meetings |
| **MOH** | Ministry of Health |
| **MOSAIQ** | MOSAIQ is a complete patient information management system that centralizes radiation oncology, particle therapy and medical oncology patient data into a single user interface, accessible by multi-disciplinary teams across multiple locations. |
| **MOU** | Memorandum of Understanding |
| **MRI** | Magnetic Resonance Imaging |
| **NCCP** | National Costing Collection and Pricing Programme |
| **NGO** | Non-Government Organisation |
| **NIR** | National Immunisation Register |
| **NZD** | New Zealand Dollar |
| **NZDep** | New Zealand Index of Deprivation |
| **NZGAAP** | New Zealand Generally Accepted Accounting Practice |
| **NZIFRS** | New Zealand International Financial Reporting Standards |
| **NZULM** | New Zealand Universal List of Medicines |
| **Outcome** | Outcomes are the impacts on or the consequences for, the community of the outputs or activities of government. In common usage, however, the term 'outcomes' is often used more generally to mean results, regardless of whether they are produced by government action or other means. An intermediate outcome is expected to lead to an end outcome, but, in itself, is not the desired result. An end outcome is the final result desired from delivering outputs. An output may have more than one end outcome; or several outputs may contribute to a single end outcome.<br>A state or condition of society, the economy or the environment and includes a change in that state or condition. (Public Finance Act 1989). |
| **Output classes** | An aggregation of outputs, or groups of similar outputs. (Public Finance Act 1989)<br>Outputs can be grouped if they are of a similar nature. The output classes selected in your non-financial measures must also be reflected in your financial measures (s 142 (2) (b) Crown Entities Act 2004). |
| **PACS** | Picture Archiving and Communication System. |
| **PAS** | Patient Administration System |
| **PBFF** | Population Based Funding Formula |
| **PCI** | Percutaneous Coronary Intervention |
| **PDSA** | Plan, Study, Do, Act. Using PDSA cycles enables you to test out changes before wholesale implementation and gives stakeholders the opportunity to see if the proposed change will work. |
| **Performance measure** | Selected measures must align with the DHBs Regional Service Plan and Annual Plan. Four or five key outcomes with associated outputs for non-financial forecast service performance are considered adequate. Appropriate measures should be selected and should consider quality, quantity, effectiveness and timeliness. |

| | |
|---|---|
| **PHO** | Primary Health Organisation |
| **PPIG** | Primary Physiotherapy Intervention Group. |
| **PPP** | Primary Performance Programme |
| **PPS** | Palliative Patient Score |
| **PRIMHD** | (pronounced 'primed') is a Ministry of Health single national mental health and addiction information collection of service activity and outcomes data for health consumers. |
| **Priorities** | Statements of medium term policy priorities. |
| **Quality Accounts** | A Quality Account is a report about the quality of services delivered by a healthcare provider. |
| **QIP** | Quality Improvement Programme |
| **Regional collaboration** | Regional collaboration refers to DHBs across geographical 'regions' for the purposes of planning and delivering services (clinical and non-clinical) together. Four regions exist. SCDHB is part of the Southern Region. |
| **Results** | Sometimes used as a synonym for 'Outcomes'; sometimes to denote the degree to which an organisation successfully delivers its outputs; and sometimes with both meanings at once. |
| **Ring-fence** | Can be used for the designated purpose only. |
| **RMO** | Registered Medical Officer |
| **RMS** | Orion Health's Referral Management System |
| **SAC** | Severity Assessment Code |
| **SCDHB** | South Canterbury District Health Board |
| **SCN** | Southern Cancer Network |
| **Secondary** | Second level health services to which the public need referral, e.g., hospital-based services except for emergency services. |
| **SI** | South Island |
| **SIA** | South Island Alliance |
| **SIAPO** | South Island Alliance Programme Office |
| **SICCIS** | South Island Cancer Coordination Information System |
| **SIISSLA** | South Island Information Service, Service Level Alliance |
| **SIHSP** | South Island Health Service Plan |
| **SIRTH** | South Island Regional Training Hub |
| **SLT** | Senior Leadership Team |
| **South Canterbury Air Quality Collaborative** | Collaboration between the SCDHB, Environment Canterbury (ECAN) and Local Territorial Authorities which assists in more effectively addressing the link between the causes, effects and solutions to local air quality issues. |
| **SUDI** | Sudden Unexpected Death of an Infant |
| **SSCL** | Surgical Safety Check List |
| **Strengths Recovery Approach** | A strengths approach is a specific method of working with and resolving the problems experienced by a person presenting to mental health services. |
| **SWIM** | Strength, Wellbeing, Independence and Movement. This is a subsidised swimming programme for clients who have a long term health or disability condition(s), would benefit from water therapy and land based exercise/activity options have been explored and are not suitable. |
| **TIA** | Transient Ischaemic Attack |
| **TPOT** | The Productive Operating Theatre |
| **Values** | The collectively shared principles that guide judgment about what is good and proper. The standards of integrity and conduct expected of public sector officials in concrete situations are often derived from a nation's core values which, in turn, tend to be drawn from social norms, democratic principles and professional ethos. |
| **Value for money** | The assessment of benefits relative to cost, in determining whether specific current or future investments/expenditures are the best use of available resource. |
| **WIAS** | Walking in another's Shoes – Dementia Education Programme. |
| **WAVE** | Wellbeing and Vitality in Education: SCDHBs Intersectoral Child and Youth Health Project. |
| **WCTO** | Well Child Tamariki Ora |
| **WHO** | World Health Organisation |
| **YOT** | Youth Offending Team |

## 8.3 2014/15 Production Plan

| PU Code | PU Description | Unit of Measure | 13/14 Target | 13/14 Price | 13/14 Total | 14/15 Target | 14/15 Price | 14/15 Total |
|---|---|---|---|---|---|---|---|---|
| AH01001 | Dietetics | Contact | 1,600 | 118.66 | 189,858 | 1,600 | 120.31 | 192,489 |
| AH01003 | Occupational Therapy | Contact | 2,100 | 149.74 | 314,452 | 2,100 | 151.81 | 318,809 |
| AH01005 | Physiotherapy | Attendance | 7,500 | 82.81 | 621,106 | 7,500 | 83.96 | 629,712 |
| AH01006 | Podiatry | Contact | 860 | 143.98 | 123,826 | 860 | 145.98 | 125,542 |
| AH01007 | Social Work | Contact | 620 | 167.79 | 104,027 | 620 | 170.11 | 105,468 |
| AH01008 | Speech Therapy | Contact | 280 | 159.09 | 44,544 | 280 | 161.29 | 45,161 |
| CS01001 | Community Radiology | Relative Value Unit | 10,500 | 69.44 | 729,149 | 10,500 | 71.42 | 749,899 |
| CS04003 | Community referred tests - audiology | Test | 1,500 | 176.81 | 265,217 | 1,500 | 181.84 | 272,764 |
| CO1016 | Well Child (Public Health Nursing) | Client | 1 | 658,888.00 | 658,888 | 1 | 662,907.22 | 662,907 |
| C01013 | B4 Schools | Client | 1 | 186,471.00 | 186,471 | 1 | 187,608.26 | 187,608 |
| COCH0027 | School Based Health Services | Client | 1 | 60,410.00 | 60,410 | 1 | 60,778.06 | 60,778 |
| COCH0023 | Immunisation Coordination | Service | 1 | 51,036.00 | 51,036 | 1 | 53,587.80 | 53,588 |
| CS01001 | Radiology DEXA scans | Scans | 190 | 143.59 | 27,282 | 190 | 144.46 | 27,448 |
| D01001 | Inpatient Dental treatment | Cost Weighted Discharge | 84.1 | 4,655.43 | 391,522 | 84.1 | 4,681.97 | 393,754 |
| D01002 | Outpatient Dental treatment | Attendance | 1,260 | 237.55 | 299,319 | 1,075 | 240.85 | 258,910 |
| DOM101 | Community Services - professional nursing services | Contact | 35,000 | 98.29 | 3,440,089 | 32,087 | 99.65 | 3,197,471 |
| DOM102 | Community Services - home oxygen | Client | 65 | 545.52 | 35,459 | 65 | 553.08 | 35,950 |
| DOM103 | Community Services - stomal services | Client | 230 | 2,093.20 | 481,435 | 230 | 2,122.20 | 488,106 |
| DOM104 | Community Services - continence service | Client | 495 | 402.62 | 199,297 | 495 | 408.20 | 202,058 |
| DOM105 | Community Services - Home help | Hour | 6,070 | 21.59 | 131,070 | 6,070 | 21.89 | 132,886 |
| DOM106 | Community Services - meals on wheels | Meal | 26,000 | 4.03 | 104,754 | 24,000 | 4.08 | 98,036 |
| DOM107 | Community Services - personal care | Hour | 500 | 27.12 | 13,559 | 500 | 27.49 | 13,747 |
| ED04001 | Emergency Dept - Level 4 | Attendance | 10,705 | 251.48 | 2,692,053 | 10,705 | 254.96 | 2,729,351 |
| M00001 | General Internal Medical Services - Inpatient Services (DRGs) | Cost Weighted Discharge | 2,470 | 4,655.43 | 11,500,030 | 2,470 | 4,681.97 | 11,565,596 |
| M00002 | General Medicine - 1st attendance | Attendance | 1,050 | 375.80 | 394,585 | 930 | 381.00 | 354,332 |
| M00010 | Medical Non-Contact First Specialist Assessment | Written Plan of Care | 440 | 151.34 | 66,587 | 560 | 150.00 | 84,000 |
| M00003 | General Medicine - Subsequent attendance | Attendance | 2,364 | 255.14 | 603,146 | 2,364 | 258.67 | 611,503 |

| PU Code | PU Description | Unit of Measure | 13/14 Target | 13/14 Price | 13/14 Total | 14/15 Target | 14/15 Price | 14/15 Total |
|---|---|---|---|---|---|---|---|---|
| M00006 | General medicine - blood transfusions | Attendance | 130 | 485.04 | 63,055 | 130 | 491.76 | 63,929 |
| ADJ111 | Offer Adjuster | P/D | 1 | 2,208,198.00 | 2,208,198 | 1 | 2,098,048 | 2,098,048 |
| M10002 | Cardiology - 1st attendance | Attendance | 150 | 433.31 | 64,996 | 150 | 439.31 | 65,897 |
| M10003 | Cardiology - Subsequent attendance | Attendance | 260 | 279.01 | 72,544 | 260 | 282.88 | 73,549 |
| M10004 | Cardiac Education and Management | FTE | 0.4 | 102,073.42 | 40,829 | 0.4 | 102,696.07 | 41,078 |
| AH01001 | Community Dietitian Other | Contact | 630 | 118.66 | | 410 | 120.31 | 49,325 |
| AH01001 | Community Dietitian - Māori | Contact | 210 | 118.66 | | 130 | 120.31 | 15,640 |
| AH01001 | Community Dietitian - Community Education | FTE | 0.2 | 102,073.42 | | 0.2 | 102,696.07 | 20,539 |
| M10004 | Cardiac Education and Management | FTE | 1.0 | 102,073.42 | 102,073 | 1.0 | 102,696.07 | 102,696 |
| M15002 | Dermatology - 1st attendance | Attendance | 56 | 243.71 | 13,648 | 70 | 247.08 | 17,296 |
| M15003 | Dermatology - Subsequent attendance | Attendance | 110 | 195.56 | 21,512 | 150 | 198.27 | 29,741 |
| M20006 | Diabetes Education and Care | Client | 350 | 288.47 | 100,966 | 350 | 292.47 | 102,365 |
| M20007 | Diabetes - Fundus Screening | Procedure | 1,000 | 105.91 | 105,914 | 1,000 | 107.38 | 107,382 |
| M25004 | Gastroenterology - ERCP | Procedure | 2 | 1,721.16 | 3,442 | 2 | 1,745.01 | 3,490 |
| M25005 | Gastroenterology - Colonoscopy | Procedure | 744 | 943.34 | 701,848 | 744 | 956.41 | 711,572 |
| M25006 | Gastroenterology - Gastroscopy | Procedure | 460 | 843.36 | 387,947 | 460 | 855.05 | 393,322 |
| M45002 | Neurology - 1st attendance | Attendance | 37 | 607.37 | 22,473 | 37 | 615.79 | 22,784 |
| M45003 | Neurology - Subsequent attendance | Attendance | 15 | 404.03 | 6,060 | 15 | 409.63 | 6,144 |
| M50020 | Oncology - 1st attendance | Attendance | 153 | 632.26 | 96,736 | 12 | 641.02 | 7,692 |
| M50021 | Oncology - Subsequent attendance | Attendance | 800 | 430.18 | 344,147 | 800 | 436.14 | 348,915 |
| MSO2009 | IV Chemotherapy | Attendance | 987.68 | 43.69 | 43,153 | 1,000.00 | 43.96 | 43,958 |
| MSO2009 | IV Chemotherapy | Attendance | 12.32 | 505.65 | 6,230 | - | 512.65 | - |
| M55001 | Paediatric Medical Service (Inpatient) | Cost Weighted Discharge | 220 | 4,655.43 | 1,024,195 | 220 | 4,681.97 | 1,030,034 |
| M55002 | Paediatric Medical Outpatient - 1st attendance | Attendance | 420 | 404.62 | 169,940 | 420 | 410.23 | 172,295 |
| M55003 | Paediatric Medical Outpatient - Subsequent attendance | Attendance | 950 | 269.00 | 255,554 | 950 | 272.73 | 259,095 |
| M55005 | Paediatric Community Programme | Service | 1 | 42,703.00 | 42,703 | 1 | 30,000.00 | 30,000 |
| M60002 | Renal Medicine - 1st attendance | Attendance | 20 | 515.79 | 10,316 | 20 | 522.93 | 10,459 |
| M60003 | Renal Medicine - Subsequent attendance | Attendance | 140 | 263.67 | 36,914 | 140 | 267.32 | 37,425 |

| PU Code | PU Description | Unit of Measure | 13/14 Target | 13/14 Price | 13/14 Total | 14/15 Target | 14/15 Price | 14/15 Total |
|---|---|---|---|---|---|---|---|---|
| M65004 | Respiratory Education and Management | FTE | 0.2 | 102,073.42 | 20,415 | 0.2 | 102,696.07 | 20,539 |
| M65004 | Respiratory Education and Management | FTE | 1.0 | 102,073.42 | 102,073 | 1.0 | 102,695.65 | 102,696 |
| MSO2003 | Respiratory - Bronchoscopy | Procedure | 18 | 1,252.73 | 22,549 | 18 | 1,270.09 | 22,862 |
| M80005 | Palliative Clinical Care | Other | 1 | 45,400.50 | 45,401 | 1 | 45,677.44 | 45,677 |
| M80005 | Palliative Care | Service | 1 | 230,374.25 | 230,374 | 1 | 231,779.53 | 231,780 |
| M90001 | Care and Review | Service | 30 | 55.34 | 1,660 | - | | - |
| MS01001 | Nurse Led Outpatient Clinics Cardiac | Attendance | 100 | 158.63 | 15,863 | 100 | 160.83 | 16,083 |
| MS01001 | Nurse Led Outpatient Clinics Orthopaedic | Attendance | 450 | 158.63 | 71,385 | 450 | 160.83 | 72,374 |
| MS01001 | Nurse Led Outpatient Clinics Hepatitis C | Attendance | 160 | 158.63 | 25,381 | 160 | 160.83 | 25,733 |
| MS01001 | Nurse Led Outpatient Clinics Enuresis | Attendance | 110 | 158.63 | 17,450 | 110 | 160.83 | 17,691 |
| OT02001 | Coroner Deaths not requiring Post Mortem | Case | 70 | 40.27 | 2,819 | 45 | 40.83 | 1,837 |
| PC0001 | Pain Specialist assessment | Attendance | 120 | 537.86 | 64,544 | 120 | 545.32 | 65,438 |
| PC0003 | Pain Specialist Appointment - Follow-up | Attendance | 1,380 | 347.35 | 479,345 | 1,380 | 352.16 | 485,986 |
| SH01001 | Sexual Health - First Contact | Contact | 330 | 191.13 | 63,074 | 330 | 193.78 | 63,948 |
| SH01002 | Sexual Health - Follow Up | Contact | 250 | 163.25 | 40,812 | 250 | 165.51 | 41,377 |
| SH01004 | Medical Management of Sexual Abuse | Service | 1 | 5,782.63 | 5,783 | 1 | 5,817.90 | 5,818 |
| S00001 | General Surgery - Inpatient Services (DRGs) | Cost Weighted Discharge | 2,562 | 4,655.43 | 11,927,212 | 2,562 | 4,681.97 | 11,995,214 |
| S00002 | General Surgery (incl Vascular Surgery) - 1st attendance | Attendance | 1,840 | 285.76 | 525,799 | 1,840 | 289.72 | 533,084 |
| S00011 | Surgical Non-Contact First Specialist Assessment | Written Plan of Care | 700 | 151.34 | 105,935 | 700 | 152.62 | 106,837 |
| S00003 | General Surgery (incl Vascular) - Subsequent attendance | Attendance | 3,700 | 225.90 | 835,825 | 3,700 | 229.03 | 847,405 |
| S00008 | Minor Operations | Procedure | 50 | 289.69 | 14,484 | 50 | 293.70 | 14,685 |
| S25001 | Ear, Nose and Throat - Inpatient Services (DRGs) | Cost Weighted Discharge | 270 | 4,655.43 | 1,254,732 | 285 | 4,681.97 | 1,336,188 |
| S25002 | Ear Nose and Throat - 1st attendance | Attendance | 650 | 295.92 | 192,347 | 650 | 300.02 | 195,012 |
| S25003 | Ear Nose and Throat - Subsequent attendance | Attendance | 1,190 | 193.46 | 230,220 | 1,190 | 196.14 | 233,410 |
| S30001 | Gynaecology - Inpatient Services (DRGs) | Cost Weighted Discharge | 477 | 4,655.43 | 2,220,640 | 477 | 4,681.97 | 2,233,301 |
| S30002 | Gynaecology - 1st attendance | Attendance | 467 | 370.36 | 172,958 | 467 | 375.49 | 175,354 |
| S30003 | Gynaecology - Subsequent attendance | Attendance | 1,230 | 284.25 | 349,629 | 1,230 | 288.19 | 354,474 |
| S30006 | Termination of Pregnancy - 1st trimester | Procedure | 3 | 965.93 | 2,898 | 3 | 979.31 | 2,938 |

| PU Code | PU Description | Unit of Measure | 13/14 Target | 13/14 Price | 13/14 Total | 14/15 Target | 14/15 Price | 14/15 Total |
|---|---|---|---|---|---|---|---|---|
| S40001 | Ophthalmology - Inpatient Services (DRGs) | Cost Weighted Discharge | 149 | 4,655.43 | 693,659 | 149 | 4,681.97 | 697,614 |
| S40002 | Ophthalmology - 1st attendance | Attendance | 740 | 188.46 | 139,458 | 740 | 191.07 | 141,390 |
| S40003 | Ophthalmology - Subsequent attendance | Attendance | 2,950 | 156.46 | 461,568 | 2,800 | 158.63 | 444,168 |
| S40008 | Minor Eye Procedures | Procedure | 100 | 222.21 | 22,221 | 180 | 225.29 | 40,552 |
| S40005 | Eye - Argon Laser | Procedure | 200 | 213.93 | 42,787 | 200 | 216.90 | 43,379 |
| S40007 | Avastin treatments | Procedure | 350 | 326.13 | 114,144 | 400 | 328.12 | 131,248 |
| S40006 | Alcon Ocuscan Treatments | Service | 1 | 900.63 | 901 | 1 | 906.44 | 906 |
| S40006 | Ophthalmology Technician | FTE | 0.5 | 122,928.37 | 61,464 | 0.5 | 123,678.24 | 61,839 |
| S45001 | Orthopaedics - Inpatient Services (DRGs) | Cost Weighted Discharge | 1,745 | 4,655.43 | 8,123,725 | 1,745 | 4,681.97 | 8,170,042 |
| S45002 | Orthopaedics - 1st attendance | Attendance | 1,250 | 275.62 | 344,523 | 1,250 | 279.44 | 349,296 |
| S45003 | Orthopaedics - Subsequent attendance | Attendance | 2,600 | 222.78 | 579,231 | 2,600 | 225.87 | 587,256 |
| S55002 | Paediatric Surgery Outpatient - 1st attendance | Attendance | 40 | 224.96 | 8,999 | 40 | 228.08 | 9,123 |
| S55003 | Paediatric Surgery Outpatient - subsequent attendance | Attendance | 80 | 287.36 | 22,989 | 80 | 291.35 | 23,308 |
| S60002 | Plastics (incl Burns and Maxillofacial) - 1st attendance | Attendance | 35 | 244.79 | 8,568 | 35 | 248.18 | 8,686 |
| S60003 | Plastics (incl Burns and Maxillofacial) - Subsequent attendance | Attendance | 80 | 231.49 | 18,520 | 80 | 234.70 | 18,776 |
| S70005 | Urology - Cystoscopy | Procedure | 232 | 477.61 | 110,805 | 232 | 484.22 | 112,340 |
| S70006 | Urology - Lithotripsy | Procedure | 19 | 5,050.26 | 95,955 | 19 | 5,120.23 | 97,284 |
| S70007 | Urodynamics | Procedure | 40 | 393.40 | 15,736 | 40 | 398.85 | 15,954 |
| W01002 | Pregnancy and Parenting Education | Course | 16 | 2,035.15 | 32,562 | 16 | 2,093.07 | 33,489 |
| W10 01 | Maternity inpatient (DRGs) | Cost Weighted Discharge | 600 | 4,655.43 | 2,793,258 | 600 | 4,681.97 | 2,809,184 |
| W03010 | Breastfeeding clinic / lactation clinic | FTE | 1.0 | 100,402.78 | 100,403 | 1.0 | 101,015.24 | 101,015 |
| W06003 | Specialist neonates | Cost Weighted Discharge | 96.89 | 4,655.43 | 451,065 | 96.89 | 4,681.97 | 453,636 |
| RM00111 | Tobacco Control | FTE | 2 | 90,885.00 | 181,770 | 2 | 90,951.40 | 181,903 |
| M65010 | Tobacco Control | FTE | 0.8 | 90,885.00 | 72,708 | 0.8 | 91,439.40 | 73,152 |
| RM00111 | Tobacco Control Clinical Lead | | 1.0 | 22,120.00 | 22,120 | 1.0 | 22,120.00 | 22,120 |
| COOC0050 | National Immunisation register system development | Service | 1 | 65,779.00 | 65,779 | 1 | 67,752.12 | 67,752 |
| COOC0070 | Family Violence Project Coordination | Service | 1 | 120,000.00 | 120,000 | 1 | 120,000.00 | 120,000 |
| CS03001 | Hospital Dispensing of Pharmaceuticals | Item Dispensed | 2,000 | 7.62 | 15,235 | 2,000 | 7.72 | 15,446 |

| PU Code | PU Description | Unit of Measure | 13/14 Target | 13/14 Price | 13/14 Total | 14/15 Target | 14/15 Price | 14/15 Total |
|---|---|---|---|---|---|---|---|---|
| MHD74C | Community Alcohol & Drug Services | Other Clinical FTE | 3.6 | 131,091.12 | 471,928 | 3.6 | 131,890.78 | 474,807 |
| MHF80C | Community Forensic Service | Clinical FTE | 0.5 | 61,451.11 | 30,726 | 0.5 | 61,825.96 | 30,913 |
| MHW67D | Family and Whanau advisory service | FTE | 0.4 | 93,188.65 | 37,275 | 0.4 | 93,757.10 | 37,503 |
| MHK61E | Kaumatua roles - Cultural | FTE | 2.0 | 99,086.35 | 198,173 | 2.0 | 99,690.77 | 199,382 |
| MHD69 | Methadone Treatment – General Practitioner | Case | 21 | 2,515.55 | 52,827 | 21 | 2,530.89 | 53,149 |
| MHD70 | Methadone Treatment – Specialist | Case | 68 | 3,686.41 | 250,676 | 68 | 3,708.89 | 252,205 |
| MHFF | Individual Primary Care Support | FTE | 1.0 | 21,539.95 | 21,540 | 1.0 | 21,671.35 | 21,671 |
| MHO98 | Older People Inpatient Beds | Available Bed Day | 650 | 791.44 | 514,436 | 650 | 796.27 | 517,574 |
| MHWF | Workforce Development | Programme | 1 | 173,296.74 | 173,297 | 1 | 174,353.85 | 174,354 |
| MHA01 | Acute 24 Hour Clinical Intervention (inpatient) | Available bed day | 2,000 | 822.81 | 1,645,619 | 2,000 | 827.83 | 1,655,657 |
| MHA03 | Adult Crisis Respite | Occupied bed day | 1 | 52,466.17 | 52,466 | 1 | 52,786.21 | 52,786 |
| MHA07 | Subacute Extended Care - Inpatient beds | Available bed day | 635 | 536.11 | 340,432 | 635 | 539.38 | 342,509 |
| MHA09A | Community Clinical Mental Health Service | FTE | 1.2 | 281,786.74 | 338,144 | 1.2 | 283,505.63 | 340,207 |
| MHA09C | Community Clinical Mental Health Service | FTE | 16.1 | 132,060.57 | 2,126,175 | 16.1 | 132,866.14 | 2,139,145 |
| MHA09D | Adult Community Support Services | FTE | 3.0 | 84,955.53 | 254,867 | 3.0 | 85,473.76 | 256,421 |
| MHA22D | Vocational Support Services | FTE | 1.0 | 21,860.90 | 21,861 | 1.0 | 21,994.25 | 21,994 |
| MHC36F | Peer support service-Adults | FTE | 0.8 | 110,472.06 | 88,378 | 0.8 | 111,145.94 | 88,917 |
| MHI44A | Infant, child, adolescent & youth community mental health services | FTE | 0.45 | 314,971.80 | 141,737 | 0.45 | 316,893.13 | 142,602 |
| MHI44C | Infant, child, adolescent & youth community mental health services | FTE | 6.05 | 111,115.99 | 672,252 | 6.05 | 111,793.80 | 676,352 |
| MHI44C | Infant, child, adolescent & youth community mental health services | FTE | 0.2 | 137,076.33 | 27,415 | 0.2 | 137,912.49 | 27,582 |
| MHDI48C | Child, adolescent and youth alcohol & drug community services | FTE | 1.0 | 123,006.18 | 123,006 | 1.0 | 123,756.52 | 123,757 |
| MHIY87 | Forensic Youth Worker | FTE | 0.7 | 130,000.00 | 91,000 | 0.7 | 130,793.00 | 91,555 |
| SUI01006 | Suicide Coordinator | FTE | 1.0 | 100,000.00 | 100,000 | 1.0 | 67,000.00 | 67,000 |
| HOP214 | ATR Inpatient | Bed Day | 4,000 | 681.79 | 2,727,141 | 4,000 | 691.23 | 2,764,926 |
| HOP215 | ATR Outpatient – Clinics | Attendance | 450 | 215.90 | 97,154 | 450 | 218.89 | 98,501 |
| HOP216 | ATR Outpatient - Day Hospital & Day Programmes | Day Attendance | 25 | 208.54 | 5,214 | 25 | 211.43 | 5,286 |
| HOP217 | ATR Outpatient – domiciliary assessments & education | Visit | 2,700 | 242.67 | 655,200 | 2,700 | 246.03 | 664,278 |

| PU Code | PU Description | Unit of Measure | 13/14 Target | 13/14 Price | 13/14 Total | 14/15 Target | 14/15 Price | 14/15 Total |
|---|---|---|---|---|---|---|---|---|
| DOM110 | Orthotics | Contacts | 900 | 64.63 | 58,166 | 900 | 65.02 | 58,521 |
| HOPR257 | Domiciliary Nursing | Visit | 1,900 | 70.45 | 133,856 | 1,500 | 70.88 | 106,320 |
| | Dementia Educator | Other | 1 | 50,445.00 | 50,445 | 1 | 50,445.00 | 50,445 |
| AH01003 | Driving Assessments | Client | 15 | 149.74 | 2,246 | 15 | 151.81 | 2,277 |
| C01011 | Public Health Optometrist Assessments | Test | 300 | 40.97 | 12,292 | 300 | 41.22 | 12,367 |
| M50021 | Oncology Nurse | FTE | 2.0 | 102,073.42 | 204,147 | 2.0 | 102,696.07 | 205,392 |
| M50026 | Cancer Nurse Coordinator | FTE | 1.0 | 100,000.00 | 100,000 | 1.0 | 100,610.00 | 100,610 |
| M00008 | Multi Disciplinary Meetings | Programme | 1.0 | 30,000.00 | 30,000 | 1.0 | 30,000.00 | 30,000 |
| COOC0013 | Liverpool Care Pathway | Other | 1 | 20,000.00 | 20,000 | - | | - |
| M80005 | Specialist Palliative care | Programme | 1 | 31,569.21 | 31,569 | 1 | 31,761.78 | 31,762 |
| DSS221 | ASD Coordinator | FTE | 0.7 | 82,324.67 | 57,627 | 0.7 | 75,000.00 | 52,500 |
| | Oncology Project | Other | 1 | 150,000.00 | 150,000 | 1 | 150,000.00 | 150,000 |
| AHSP-33 | Antenatal HIV screening | Programme | 1 | 39,276.46 | 39,276 | 1 | 39,669.22 | 39,669 |
| UNHS-40 | New Born Hearing screening | Programme | 1 | 44,051.00 | 44,051 | 1 | 44,051.00 | 44,051 |
| WO8001 | Maternity Quality & Safety | Programme | 1 | 68,194.00 | 68,194 | 1 | 68,609.98 | 68,610 |
| CO1008 | LCYMRC | Programme | 1 | 13,819.21 | 13,697 | 1 | 9,300.20 | 9,300 |
| MEOU0000 | Patient flow improvement project | Service | 1 | 15,472.00 | 15,472 | 1 | 15,411.00 | 15,411 |
| MEOU0071 | Patient flow improvement - GP Liaison | Service | 1 | 32,765.84 | 32,766 | 1 | 32,965.72 | 32,966 |
| MEOU0075 | Additional Funding for Elective Services (TPOT) | Service | 1 | 175,000.00 | 175,000 | - | | - |
| DO1013 | Dental Projects | Service | 1 | 29,694.05 | 29,694 | 1 | 29,875.18 | 29,875 |
| DSS207 | Residential Long Stay - non aged | Bed Day | 1 | 3,692,000.00 | 3,692,000 | 1 | 3,714,521.20 | 3,597,914 |
| PCT001 | Pharmaceutical Cancer Treatments & Community Drugs | Item Dispensed | 1 | 1,122,497.00 | 1,122,497 | 1 | 1,129,344.23 | 1,129,344 |
| PHOM0008 | Primary and Community Services | Other | 1 | 814,366.79 | 814,367 | 1 | 814,366.79 | 814,367 |
| RM00107 | Breastfeeding Support | Service | 1 | 5,000.00 | 5,000 | 1 | 5,000.00 | 5,000 |
| M20006 | Diabetes | Other | 1 | 75,667.50 | 75,668 | 1 | 76,129.07 | 76,129 |
| | | | | | **81,673,287** | | | **81,525,005** |

## 8.4 South Canterbury DHB Prevention/Early Detection/Intervention Performance Targets 2014-15

*CPH–Community & Public Health, SSC–Sport South Canterbury, PCS–SCDHB Primary & Community Services, SS–SCDHB Secondary Services, CSNZ-Cancer Society N.Z, SCDHB-South Canterbury District Health Board, SFSCC-Smokefree South Canterbury Committee*

| | Community | Education | Workplaces | Primary Care | Secondary care | Impact targets |
|---|---|---|---|---|---|---|
| **Nutrition & physical activity** | 100% Māori Community Action Project reporting for projects funded in 2014/15 year (3yr projects) PCS | 95% of all settings have active WAVE settings plans CPH | 5% increase in Sea 2 Sea participation PCS / SSC | 520 patients referred to Green Prescription programme<br>22%of GRx patient referrals to be Diabetes related. SSC<br>8 Wellness programmes delivered to 120 patients | 30 new referrals to GRx from secondary care SSC/SS | F&V consumption targets |
| | 6 sessions / week averaging 20 students / SC Kiwisport Non participating Youth SCDHB/ SSC | 15 primary schools engaged from targeted communities SSC | | 2 Face to Face clinics catering for 140 GRx patients SSC | | BF targets |
| | | 6 settings with travel plans CPH | | | | PA targets |
| **Tobacco (Ministry Health Target Indicator)** | AKP delivered to 72-90 clients CPH | Smokefree reflected in 5 settings plans CPH | 3 workplaces engage in a HP process that includes smokefree initiatives and other workplaces receive smokefree advice and support as requested CPH | Minimum1 Practice Nurse in every GP Practice is Quit Card trained. PCS | 95% of smokers using hospital services advised to quit SS | 75% of Year 10 students have never smoked. |
| | 3 events where young people and Māori frequent are supported with a smokefree/Auahi Kore message CPH | | | 90% enrolled patients who smoke and are seen in General Practice are provided with ABC PCS | SS | |
| | 3 tobacco CPOs CPH | | | 100% of GP Practices with a Practice Nurse Quit card trained PCS | 100% SCDHB new clinical staff ABC trained SS | |
| | All SFEA complaints processed in specified times CPH | | | | | |
| | Support the Stoptober campaign CPH | | | | | |
| | 1 event held to communicate Smokefree 2025 to key leaders/sectors/orgs CPH/ | | | Māori, Pacific and pregnant women are at least as likely to receive ABC as the general population in both Hospital setting and primary care SS/PCS | | |
| **Alcohol** | 2 community campaigns incorporating HPA campaigns and supporting responsible alcohol use CPH | Provide support to the upper SI SADD coordinator to ensure 10 active SADD groups CPH/ Upper SI SADD Coordinator | | | | |

| | Community | | Education | Workplaces | Primary Care | | Secondary care | Impact targets |
|---|---|---|---|---|---|---|---|---|
| | 2 community alcohol accord agreements are maintained | CPH | | | | | | |
| | Inter-agency monitoring of high-risk premises and events as appropriate | CPH | | | | | | |
| | 3 alcohol CPOs | CPH | | | | | | |
| **Oral health** (Ministry Policy Priority Indicator) | All high risk families referred to oral health promoter contacted & offered one on one oral health support. | CPH | 5 ECE settings engaged in oral health promotion activities / initiatives as able | CPH | | | | Caries-free at 5 – 62% DMFT & 12 years – 1.1<br><br>≥91% Adolescent utilisation of DHB dental services |
| | All South Canterbury Well Child Providers (Plunket, Tamariki Ora provider and PHN's) are provided with oral health promotion support. | CPH | | | | | | |
| | All SC midwives are provided with oral health promotion support | CPH | | | | | | |
| **Fall prevention** | Stay On Your Feet Classes - 150 people 65+ years attending 10 community classes | SSC | | | 300 patients referred to falls prevention (FP) programmes | PCS/ SSC | | >75yrs hospitalised for falls per year |
| (Ministry Policy Priority Indicator) | | | | | 80 FP patients receive Face to Face support with Health Professional | SSC | | |
| | | | | | 25 patients receive Face to Face support with volunteer | SSC | | |

| | Community | Education | Workplaces | Primary Care | Secondary care | Impact targets |
|---|---|---|---|---|---|---|
| **Breastfeeding** | Media coverage of breastfeeding issues (at least 4 articles) PCS/BFAG | | Establish 'Welcome Here Project' in 10 new workplaces and have 100% renewal of present accreditees as required. BFAG/ PCS | | Maternity Unit maintains BHFI accreditation SS | 6 wk breastfeeding targets ≥73% |
| (Ministry System Integration Indicator) | Maintain S.C. Breastfeeding Community Policy reflecting intentions of BFCI, across all health and community breastfeeding services (including Māori & Pacific providers) PCS/BFAG | | Maintain staff Breastfeeding Room at Timaru Hospital SS | | "BF welcome here" certification for SCDHB Secondary Services SS | 3 mth breastfeeding targets ≥58% |
| | 5% increase in Peer Support Programme referrals SS/PCS/ Plunket | | | | Maintain accurate Breastfeeding stat - discharge and handover SS/ Plunket | 6 mth breastfeeding targets ≥28% |
| | 2 Breastfeeding education workshops for community service workers and primary care nurses PCS/BFAG | | | | | |
| **Communicable diseases** | All notifiable diseases followed up and outbreaks investigated according to CD protocols CPH | Infection control procedures reviewed in 10 ECECs CPH | Awareness-raising campaigns target meat works and farming industry CPH | 115 HPV vaccinations completedin 20214 r for consenting adolescents through the school based programme PCS | Staff influenza vaccination target - 365 immunisations delivered to SCDHB staff SS | 95% 8 month olds fully immunised targets |
| (Immunisation – Ministry Health Target Indicator) | | | | 95% 8 month old and >95% 2 year olds are fully immunised. PCS | | |
| | | | | ≥70% of eligible population receive the flu vaccine PCS | | |
| | | | | ≥180 of >65yrs immunised for pneumonia. PCS | | |
| **Physical environment** | Improved quality of drinking water according to annual survey & gradings CPH | | | | | |
| | All Council plans and notified resources consents reviewed for public health issues, with submissions as required CPH | | | | | |

| | Community | | Education | | Workplaces | | Primary Care | | Secondary care | | Impact targets |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | ***Provide timely input into TLA District Annual Plans and other policy proposals as appropriate*** | **CPH** | | | | | | | | | |
| | **Shipping inspections and exotic mosquito trapping completed according to protocols** | **CPH** | | | | | | | | | |
| **Screening**<br><br>(Cardiovascular - Ministry Health Target indicator) | **≥680 B4 School Checks completed with a minimum of ≥65 high needs** | **PHNS / PCS** | **100% of students attending Alternative Education settings have a completed HEADSS assessment.** | ***PCS*** | | | **Cervical screening target ≥80% of eligible women within 3 years** | **PCS** | **Antenatal HIV Screening is offered to 100% pregnant women** | **SS** | **90% eligible populations CVD risk assessed in last 5 yrs**<br>**Long term decrease in prevalence of CVD and stroke** |
| | | | | | | | **Breast screening target ≥70% seen 45-69yrs by ethnicity** | **PCS** | **Universal Newborn Hearing Screening offered to 100% eligible babies** | **SS** | |
| | | | | | | | **CVD screening target - ≥90%** | **PCS** | | | |
| **General** | **Public health information & education resources provided to South Canterbury** | **CPH** | **Active WAVE website visits increased** | **CPH** | **3 workplaces engaged in a health promotion process.** | **CPH** | | | | | |
| | **Media releases or articles on public health average at least one per week** | **CPH/SCDHB Comms** | **10 district-wide professional development Health workshops for teachers** | **CPH** | | | | | | | |
| | **5 community youth events promote a range of health messages** | **CPH** | **Minimum 8 Hauora Education Hui** | **PCS** | | | | | | | |
| **Mental health** | **Provide representation on and support to the Ka Toi Māori o Aoraki FLAVA festival committee and festival. For Mid and South Canterbury (Inter-school Māori Visual and Performing Arts Festival) – 50 % (25) of South Canterbury Schools participate in the event.** | **CPH/PCS** | | | | | | | | | |

## 8.5 South Island Regional Training Hub Structure