South Canterbury
District Health Board

2020/21 ANNUAL PLAN

EVERY moment MATTERS

www.scdhb.health.nz

Annual Plan dated the 31st of July 2020.

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

Contents

MINISTER'S LETTER OF APPROVAL

Hon Chris Hipkins

MP for Remutaka
Minister of Education
Minister of Health
Minister of State Services
Leader of the House
Minister Responsible for Ministerial Services

25 September 2020

Ron Luxton
Chair
South Canterbury District Health Board
rjlux@xtra.co.nz

Dear Ron

South Canterbury District Health Board 2020/21 Annual Plan

This letter is to advise you that I have approved and signed South Canterbury District Health Board's (DHB's) 2020/21 Annual Plan (Plan) for three years.

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

I encourage you to continue discussions with your fellow Chairs about how you can share skills and expertise in order to ensure that your financial performance is consistent with the agreed plan. I particularly encourage you to ensure that your senior executives maintain the tight fiscal controls that will be necessary to sustain improvements in the out years. Your focus on strengthening financial management and performance, including through collaboration with your fellow Chairs, remains critical to creating a sustainable financial path.

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

Please note that approval of your Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health, including changes in FTE. I expect you to continue to engage with the Ministry of Health to ensure you have a strong rationale for any adjustment to planned FTE during the year. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan does not constitute approval of any capital business cases or requests for equity support that have not been approved through the normal process.

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

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

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

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

Ngā mihi nui

Hon Chris Hipkins
Minister of Health

cc Nigel Trainor
Chief Executive
South Canterbury District Health Board

MESSAGE FROM THE BOARD & CHIEF EXECUTIVE

Having a strong and equitable health system is fundamental for improving the health and wellbeing of our community.

"Ensuring equitable access for all is front of mind when designing our services and meeting future demand"

The South Canterbury District Health Board's Annual Plan for 2020/21 outlines the importance we place on the health and independence of people in South Canterbury.

Health care is not an isolated activity. It brings together organisations from across the social sector who, working in partnership with the person and family, make positive differences in people's lives.

Our community is more engaged with health than ever before, providing us with a real opportunity to shift our focus from illness to emphasising health, wellbeing and care.

Our 2020/21 Annual Plan outlines our approach to addressing the issues we, as a community face, such as an aging population and more complex illnesses that are requiring long-term care.

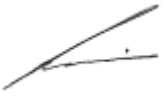
There is greater ethnic diversity and as a health provider the importance of ensuring equitable access for all is front of mind when designing our services and meeting our population's future demand.

We are casting an equity lens over all that we do to ensure that both local Māori and migrants moving into our community have the same level of access to services and that these services are delivered in such a way as to support their engagement.

Alongside equity we have an emphasis on preventing disease and maintaining good health. We know that lifestyle diseases resulting from obesity and inactivity continues to put the DHB under pressure. Increasing our promotion of healthy lifestyle choices, our screening programmes and early intervention models of care are helping reduce progression to established diseases.

However, we cannot do it alone. We need to engage with our community and our health partners to work collectively on maximising the years we spend in good health, particularly as we have New Zealand's highest proportion of people over 65 years.

What you will read in these pages is our commitment to enhancing the health and independence of the people of South Canterbury.



Ron Luxton, Chair, SCDHB

Nigel Trainor, CEO, SCDHB

MESSAGE FROM SCDHB CHAIR & CHAIR OF MAORI PARTNERSHIP BOARD

"Ko te pae tawhiti whaia kia tata, ko te pae tata whakamaua kia tina"

Seek out the possibilities in the distant horizons to draw them nearer, whilst managing the ones that have already been attained.

"Achieving health equity for Māori is a key priority for us"

He whakarato i kā tākata katoa ki te kōuka o kā ratoka hauora puta noa i tēnei takiwā, te wawata o Te Pōari Hauora o Waitaha ki te toka. He whakatutuki i te mana taurite hauora mō te Māori, tētahi aroka matua o Te Poari. Ka whakamana te pōari i te wairua me kā mātāpono o Te Tiriti o Waitangi. E whakapono hoki ana mātou, koia nei he tūāpapa ki te hauoratanga o te Māori i kā hāpōri.

The aspiration of the South Canterbury District Health Board, is to serve all people with good quality health services throughout this district. Achieving health equity for Māori is a key priority for us. Our commitment to this is to acknowledge the wairua and guiding principles of te Tiriti o Waitangi, which is our belief and pathway to good health for Māori in the community.

Ron Luxton, Chair
SCDHB

Karl Te Raki, Chair
Māori Health Advisory Committee (MHAC)

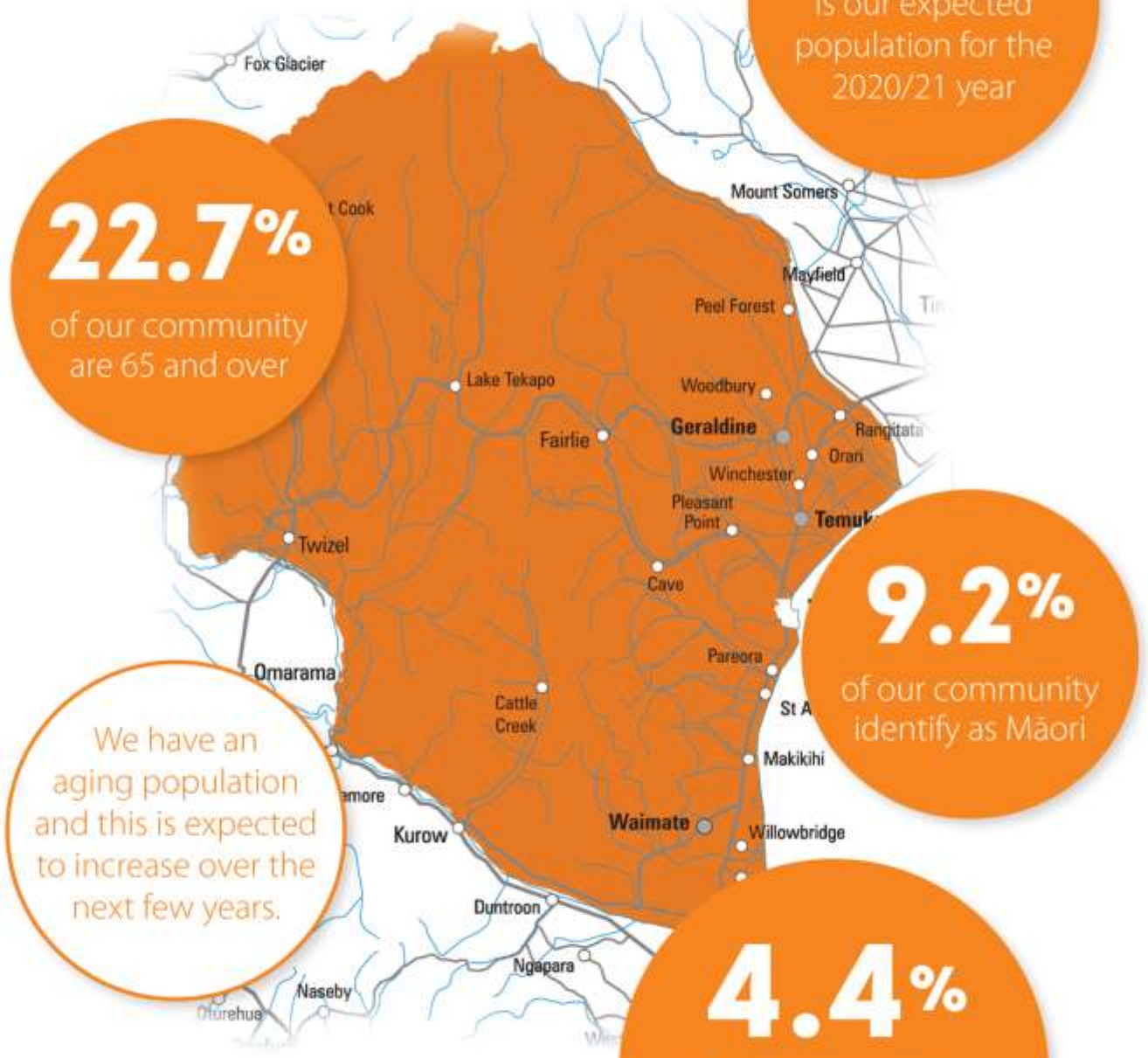
SECTION ONE: Overview of Strategic Priorities

OUR DHB 2020/21

South Canterbury is one of the five DHBs on the South Island. The DHB's area is the province of South Canterbury which covers a large geographical area. It consists of the Timaru, Mackenzie and Waimate district councils, and is bounded by the Rangitata and Waitaki rivers to the north and south, and Mt Cook to the west.

61,955
is our expected population for the 2020/21 year

22.7%
of our community are 65 and over



9.2%
of our community identify as Māori

We have an aging population and this is expected to increase over the next few years.

4.4%
Is the increase in our population over the last five years.
This will continue to rise.

Source: 2019 Stats NZ Population Projections (Ministry of Health)

At South Canterbury DHB we believe that every moment matters

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

- Section 2: Identifies our actions against agreed Government Planning Priorities including:
    - Improving child wellbeing
    - Improving mental wellbeing
    - Improving wellbeing through prevention
    - Better population health outcomes supported by a strong and equitable public health and disability system
    - Achieving health equity and wellbeing for Māori through the Māori Health Action Plan
    - Better population health outcomes supported by primary health care
    - Strong fiscal management

These priorities support the Government's overall priority of improving the wellbeing of New Zealanders and their families through:

- Support healthier, safer and more connected communities
- Make New Zealand the best place in the world to be a child
- Ensure everyone who is able to, is earning, learning, caring or volunteering

- Section 3: Notes our responsibility for ensuring service coverage for our population in accordance with the Service Coverage Schedule agreement.
- Section 4: Highlights how we build a support system around our services to ensure they can meet our commitments to key priorities and service coverage, including business management, infrastructure, workforce and IT strategies.
- Section 5: Outlines a framework for reporting to ensure we know how and when we have delivered on our commitments.

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

A strong health system is fundamental for improving the health of our population and eliminating health inequities. We need to listen to our community and gain a sound understanding of their needs as well as working alongside other government agencies and our community partners to reduce the impact of social determinants of health.

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

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

Furthermore, our annual plan commitments are guided by a number of national strategies, including: He Korowai Oranga Māori Health Strategy; New Zealand Health Strategy; Healthy Aging Strategy; Ola Manuia 2020 - 2025: Pacific Health and Wellbeing Action Plan.

The plan is reflective of the vision provided by the South Canterbury District Health Board in the Navigating Our Future document, and aligns with our strategic goals of:

- Productive partnerships
- Integrated person-centred services
- Valuing our people
- Health equity for all
- Fit for future

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

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

We need to ensure that our key focus areas align with what is expected of us from the Ministry of Health. Here we look at Government's planning priorities and ensure we perform against these priorities, including:

Child wellbeing

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

Improving mental wellbeing

Mental health, wellbeing and addiction are priority areas for the Government and the budget in 2019 reflected a transformative approach to these services. We need to all work together to build a whole of system approach to mental health, wellbeing and addiction services. Our plan reflects strengthening what we currently do and actively working with all partners to develop strong mental health, wellbeing and addiction services for our community.

Improving wellbeing through Prevention

Early intervention and prevention of illness and disease see us working in partnership with Community Public Health to reduce illness and hospitalisation. The focus continues to be on helping people in South Canterbury achieve better health and wellbeing outcomes enabling them to live well for longer.

Strong and equitable public health and disability system

Our aging population will bring an increased prevalence of chronic illnesses. Demand for services are likely to exceed capacity if we do not evolve our models of care to include a greater emphasis on prevention and self-management of established disease. We see ourselves as a centre of excellence for the health of older persons and our actions against the healthy aging priority will

enable us to demonstrate how our innovative Integrated Community Assessment Treatment Team model is decreasing presentations of those people aged over 75 years to the Emergency Department. During the 2020/21 year we will continue to promote distributive leadership including clinical in partnership with our unions. We will identify targeted areas for service planning and improvement through a system wide health needs assessment. A particular focus on Maori leadership and leading for Equity will be promoted through our Kaupapa Maori Navigate programme. We will review the medical model of care, led by the Chief Medical Officer and Clinical Directors including a specific assessment of the benefits and risks of introducing Registrars into some services.

- Better population health and outcomes supported by primary health care

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

- Achieving health equity and wellbeing for Māori

  In 2020/21 we will continue to build on the foundations and relationships formed with our Māori health service providers and iwi partners while raising cultural awareness and competency within the DHB. The mission in our Hauora Māori Health Strategic Plan 2017-2022 is about working towards a healthy Māori future and ensuring all services for Māori are appropriate and safe.

- Strong fiscal management

  As a DHB we need to design services that validate the person and their family at the centre of all that we do, all within a fiscally tight environment. Our aging population combined with chronic lifestyle diseases will continue to put the DHB under significant financial pressure. If we continue to deliver services as we currently do, we will simply be unable to meet this increasing demand. This is why we need to be smart about how we operate and we allocate funding to maximise health care services.

This is our plan to enhance the health and independence of the people of South Canterbury in the 2020/2021 year. By living our values of integrity, collaboration, accountability, respect, and excellence (ICARE) we can be confident to deliver on our vision, making every moment matter.

Signatories

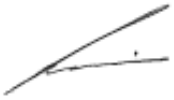
Agreement for the South Canterbury DHB 2020/21 Annual Plan

Between

Ron Luxton

Chair, SCDHB

Date: 31st of July 2020



Nigel Trainor

CEO, SCDHB

Date: 31st of July 2020

Honourable Chris Hipkins

Minister of Health

Date: 23rd of Sep 2020

SECTION TWO: Delivering on Priorities

2.1 Give practical effect to He Korowai Oranga – the Māori Health Strategy

Engagement and obligations as a Treaty partner				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
EOA: Ensure that Māori, as a Treaty partner, have input through the Māori Health Advisory Committee (MHAC). This committee comprises of Iwi representatives from mana whenua Te Rūnaka o Arowhenua, Te Rūnaka o Waihao and Ngā Maata Waka Te Aitarakihi. SCDHB seeks guidance in planning, advising and implementing strategies to improve Māori health outcomes and achieve health equities for Māori within the South Canterbury region. Establish regular meetings between the Chair of MHAC and Chair of SCDHB Board, Māori appointments to the Board, CEO, and SCDHB Director Māori Health. MHAC Board Chair minutes tabled at SCDHB Board meetings. SCDHB Board will meet with South Canterbury Māori community annually.	Evidence of meetings occurring between MHAC Chair, DHB Chair and iwi representatives. Q1-Q4: MHAC Chair minutes tabled at 100% of SCDHB Board meetings. Q3: SCDHB Board meet and consult with Māori community annually on the marae, through powhiri process.	Number of meetings and documented action plan to target health inequities for Māori in place.	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering
EOA: Provide cultural competency/cultural safety programmes for SCDHB staff that comprise of:	Q2: Development and implementation of cultural competency/cultural safety programmes.	Total number of SCDHB staff in attendance at cultural competency/cultural safety		

• Te Tiriti o Waitangi understanding the origins of Te Tiriti o Waitangi within this takiwa • Introduction to Te Reo Māori and whakaahua Māori • Tikanga best practice • Health inequities training including addressing institutional, personal racism, discrimination and bias • Impacts of colonisation • Cultural Self-Assessment		programme. 80% of participants indicate an increase in understanding of content presented at cultural competency/safety training sessions.		
EOA: SCDHB Board and Strategic Leadership Team (SLT) to complete cultural competency training/ te tiriti o waitangi training/cultural self-assessment and gain understanding of systemic racism or personal racism and bias.	Q4: Training scheduled and completed by SCDHB Board members and SLT team.	100% of Board/Executive Leadership team members trained. 100% indicate an increased understanding of TOW and drivers of health inequities/equity for Māori.		
EOA: Iwi/ Māori have input into decision making at all levels at a governance level from Māori Health Advisory Committee, at a strategic level through the SCDHB senior leadership team and at a service provision level through Arowhenua Whānau Services (AWS) SCDHB Māori staff hui/forum. SCDHB will be able to evidence these forums had input into the shaping of: • SCDHB Annual Plan (MHAC/AWS/Rūnaka). • Consultation hui at marae and in community (SCDHB/MHAC/AWS/Rūnaka). • Māori health workforce development (Nursing and Midwifery, Allied Health) (MHAC/AWS).	Q4: Evidence of Iwi /Māori participation in key organisational Strategy, planning and initiatives. Bi-monthly Māori staff hui/forum. Evidence of consultation with iwi Māori and the wider Māori community within South Canterbury.	Key organisation strategy, planning and initiatives, evidence a commitment to Te Tiriti o Waitangi and reducing health inequities for Iwi/Māori in South Canterbury.		

Māori Health Action Plan – Accelerate the spread and delivery of Kaupapa Māori services				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
EOA: Support South Canterbury kaupapa Māori health services through:			We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering
Collaboration between SCDHB and kaupapa Māori on equity focused initiatives.	Q4: Regular meetings held between SCDHB and kaupapa Māori health services to ensure collaboration on equity targeted initiatives.	Total number of equity focused projects between kaupapa Māori health providers and SCDHB.		
Incorporating kaupapa Māori services in delivery and training of cultural competency/safety programmes at SCDHB.	Q2: Include kaupapa Māori services in delivery of cultural competency/safety training to SCDHB staff.	Total number of cultural competency/safety programmes attended.		
Partner with kaupapa Māori services to engage with the community.	Q4: SCDHB to partner with kaupapa Māori services to engage with the Māori community.	Total number of community engagement events in partnership with Māori health providers.		
Increased awareness of kaupapa Māori health services, through orientation process of new SCDHB staff.	Q4: Kaupapa Māori health services have option of participating in cultural competency/safety training of SCDHB staff. Q4: SCDHB to include kaupapa Māori health services in orientation process for new staff.	Total number of SCDHB orientation days attended by kaupapa Māori services.		

Māori Health Action Plan – Shifting cultural and social norms

Activity	Milestone	Measure	System outcome	Government priority outcome
Refer to section: Engagement and Obligation as a Treaty Partner for information on building SCDHB staff in Te Tiriti o Waitangi.			We have health equity for Māori and other groups	Support healthier, safer and more connected communities
EOA: Deliver prevocational medical education on Māori Health for all medical staff.	Q4: SCDHB to develop cultural competency/safety programme in partnership with key stakeholders which will include rūnaka, Māori community, kaupapa Māori services, kaumatua and tertiary providers (University of Otago).	Total number of education sessions provided. Total number in attendance. 100% of participants indicate an increase in understanding of content presented at cultural competency/safety from training sessions.		

Māori Health Action Plan – Reducing health inequities - the burden of disease for Māori

Activity	Milestone	Measure	System outcome	Government priority outcome
EOA: Pilot a Hauora Direct event in collaboration with kaupapa Māori health service AWS (subject to funding being available). The purpose of this event will assist in identifying barriers of access and provide pathways for Māori, Pacifika and high need non-Māori to essential health services. Services may include stop smoking practitioner, oral health, health promotion, Primary Care enrolment, immunisations, health literacy education, community dietician, whānau ora navigator, vision and hearing, mental health and appointments set up to access smears and B4School check.	Q4: Pilot Hauora Direct event scheduled.	Total numbers in attendance, Hauora assessments completed and referrals sent.	We have health equity for Māori and other groups	Make New Zealand the best place in the world to be a child

EOA: Pilot hapūtanga wānanga: kaupapa Māori pregnancy and parenting programme (subject to funding being available). The programme will provide: • Mainstream and traditional Māori practices relating to pregnancy and birth. Hapū Wananga is open to all people and will provide education on stop smoking practitioner, oral health, health promotion, Primary Care enrolment, immunisations, health literacy education, whānau ora navigator and vision and hearing. • A safe environment for education to build health literacy and link immediate whānau and wider whānau to appropriate information, education, services and interventions.	Q4: Pilot hapū wānanga: kaupapa Māori pregnancy and parenting programme established.	Total numbers of Māori in attendance of Hauora Direct event.		
EOA: Pilot a 'Oral Health Programme' within Arowhenua Māori School and He Manu Hou bilingual early childhood centre, ensuring collaboration with kaupapa Māori Health Service, Community Public Health and Dental Service in delivery of the programme.	Q2: Pilot Oral Health Programme scheduled.	Total number of whānau, pepi and tamariki participating in programme.	We have health equity for Māori and other groups	Make New Zealand the best place in the world to be a child
EOA: Develop kaupapa Māori leadership programme in collaboration with the current Navigate Leadership Programme. • To deliver a kaupapa Māori leadership programme, for SCDHB Māori employees and community health sector. • Accelerate Māori leadership capability and capacity.	Q1: Development and implementation of Māori leadership programme.	Total number of Māori enrolled and completion of programme. 80% completion rate of programme.		

Develop a Māori workforce strategy with a focus on increasing Māori workforce and retention of Māori staff. • Increase Māori participation and retention in health workforces and ensure that Māori have equitable access to training opportunities. • Increase participation of Pacifika into the health workforce. • Build cultural competence across the whole health workforce. • Actions that facilitate healthy and culturally reinforcing working environments that support health equity. • Actions that support Māori and Pacifika into leadership and management roles. • Develop partnership with Kia Ora Hauora	Q4: Development of Māori workforce strategy.	Completed strategy in 2020 with a report of increase in recruitment and retention of Māori workforce in 2021.		

Māori Health Action Plan – Strengthening system settings

Activity	Milestone	Measure	System outcome	Government priority outcome
EOA: Engage with kaupapa Māori services and community agencies.	Q4: Meetings established.	Total number of meetings held between MHAC and kaupapa Māori health services.	We live longer in good health	Support healthier, safer and more connected communities
EOA: Hold community and stakeholder consultation Hui for planning and funding of Māori health services in South Canterbury.	Q1: Engage with stakeholders and Māori community for planning and funding initiatives.	Total number in attendance of planning and funding meetings.		

2.2 Improving sustainability

Improved out year planning processes				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
SCDHB will engage with an external provider to support the development of a long-term vision and strategy. Transforming how we operate is paramount in providing sustainable health care to our community. In the short-term, the following items need to be actioned to support our planning processes that will help inform our long-term vision: • Health needs assessment – the purpose of this assessment is to bring about change that will benefit our population. This will be an important part of our planning processes, informing both our strategic planning and funding decisions. • Data Quality – the quality of health care data impacts on decisions made about the care we provide to our community. Without quality data we cannot fully understand the population we serve and the health inequities that exist. Investing in data quality is an integral part of ensuring accurate and reliable data.	Q2: Development of a detailed logic map focusing on the next five years. Q1: Health needs assessment commenced. Q1: invest in regional data systems which will allow for the creation of a data warehouse/dashboard for SCDHB.	Completed logic map. Completed health needs assessment to inform planning processes. Data warehouse implemented	We have improved quality of life	Support healthier, safer and more connected communities

Savings plans – in-year gains				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
Savings have been identified in the following areas: • Review of Home Based Support Services to identify areas for improvement. • FTE's – manage vacant positions. • Catering and Cleaning Services.	Q1: Review of Home Based Support Services completed. Q1- Q4: Each month vacancies are managed between resignation and filling of these positions. Q2: RFP undertaken for the provision of Catering and Cleaning Services.	Outcome of review completed and implemented (savings to be confirmed in Q4). Savings identified ($200k). Implementation of RFP outcome implemented (savings to be confirmed in Q4).	We have improved quality of life	Support healthier, safer and more connected communities

Savings plans – out year gains				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
SCDHB will continue to embed identified savings from previous years, from internal structural changes, that have had a positive effect on our ability to maintain a surplus position in out years.				
Home Based Support Services	Q1: Commence implementation of the review findings. Q3: Implementation complete.	Review implemented with savings identified (savings to be confirmed in Q4).	We have improved quality of life	Support healthier, safer and more connected communities
Talbot Park - DHB Psychogeriatric Service move to new provider	Q1: Plan developed for the Psychogeriatric service to move to a new provider. Q2: Residents are moved in a planned way to the new provider.	All residents moved and supported at the new provider (savings to be confirmed in Q4).	We have improved quality of life	Support healthier, safer and more connected communities

Working with sector partners to support sustainable system improvements				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
EOA: Partner with Whānau Ora commissioning agency Te Putahitanga o Te Waipounamu to identifiy oppotinuties for alignment. Estabishing these partnerships ensures collaboration and investment in Whānau Ora initiatives for Māori and Pacific communities.	Q2: Establish partnerships with Whānau Ora commissioning agency Te Putahitanga o Te Waipounamu.	Partnership establish and initiatives identified and documented.	We have health equity for Māori and other groups	Support healthier, safer and more connected communities
EOA: Extend addiction access and choice to youth with a focus on improving engagement with Māori as the priority.	Q2: Adventure Development and Arowhenua Whānau Health Services will work in collaboration to improve access and choice for Māori Youth.	An increase in the number of youth accessing and engaging with Services.		
EOA: Partner with kaupapa Māori services to improve engagement with our Māori Community.	Q4: SCDHB to partner with kaupapa Māori services.	Total number of community engagement events in partnership with Māori health providers.		

2.3 Improving Child Wellbeing - improving maternal, child and youth wellbeing

Maternity and Midwifery Workforce				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
EOA: Continue to identify pipeline new graduate midwifery supply through quarterly meetings with local tertiary provider, Ara. This will provide transparency for employment planning and identification of Māori New Graduate Midwives as a priority for employment.	Q1-Q4: Quarterly meetings with tertiary provider established.	Evidence of regular meetings with transparency of student numbers and pipeline employment discussions.	We live longer in good health	Support healthier, safer and more connected communities
All new graduate midwives will be supported with the SCDHB midwifery new graduate programme.	Q1: Implementation of the new graduate programme, which is inclusive of supernumerary orientation, professional development and allocation of preceptor support.	Evaluation of new graduate programme completed by current graduate midwives.		
Progression of TrendCare Acuity Data within the maternity unit.	Q1-Q4: Development of reliable acuity data reflective of the inpatient activity.	Ability to use acuity data to progress FTE calculation.		
Implementation of a maternity CCDM local data council.	Q4: Monthly local data council meetings with resulting data transparency.	Evidence of documented LDC activity within the maternity unit.		
Variance response management is centrally managed by the Resource Unit. Deployment of health workforce in relation to maternity service acuity occurs, inclusive of Registered Nurse, Enrolled Nurse, Health Care Assistant deployment.	Q1: Variance response management occurring through central Resource Unit.	TrendCare reflects deployed resource according to variance.		
Breastfeeding professional development initiated for Registered Nurses in Paediatric Services.	Q2: Professional development to support Registered Nurse knowledge and skills.	Increase breastfeeding initiatives and support for women.		

Maternity and early years

Activity	Milestone	Measure	System outcome	Government priority outcome
Collaboration with South Island colleagues to plan a culturally supportive pregnancy and parenting programme, Haputanga Wānanga. This programme will be a Kaupapa model and give consumers a wider selection when deciding what programme they would like to be involved in.	Q2: Localise the pregnancy and parenting programme for SCDHB community. Q3: Education and communication on the new programme to the community. Q4: First programme held.	Number participating in the programme and feedback received.	We have improved quality of life	Support healthier, safer and more connected communities
Collaborate with Christchurch University, our Public Health Unit and local stakeholders to host a second "first 1000 days Hui". The purpose of the Hui assists to identify service improvement opportunities.	Q2: Hui completed and service improvement opportunities identified. Q3: Action plan developed Q4: Appropriate service improvements implemented.	Number attending Hui. Summary of service improvements implemented.		
Work with Community and Public Health to broaden the reach of safe sleep messaging.	Q1: Planning commenced with PHU. Q2: Actions identified.	Educational sessions held and number of attendees.		
EOA: Continue to focus on the actions set out in the SCDHB SUDI prevention plan. The plan addresses key modifiable risk factors which include: • Stopping smoking during pregnancy and postnatally. • Provision of safe sleep space • Sharing consistent safe sleep messages "PEPE" framework. ***Please refer to our SLM for more information and actions regarding Babies in Smokefree Households.***	Q1: Wahakura flax baskets available to Whānau. Q1: Provide educational sessions to the community to increase the awareness of SUDI risk factors.	No of attendees. SUDI plan to be provided to the Ministry as per the CFA requirement.		

EOA: Investigate where the inequities exist for people accessing the following services: community-based midwifery services, ultrasound scanning, pregnancy and parenting and Well Child Tamariki Ora Services.	Q1: Identify the equity gaps that may exist. Q2: Develop a plan to target the identified gaps. Q3: Implementation of the plan. Q4: Evaluation of the plan.	Equity gaps identified and plan developed to address gaps.		

Immunisation

Activity	Milestone	Measure	System outcome	Government priority outcome
The Outreach team will ensure that up to date information about immunisation is included in all pregnancy and parenting education.	Q2 & Q4: Reporting on immunisation rates.	SCDHB will meet or exceed the 95% target for the milestone ages of 8 months, 2 years and 5 years.	We have improved quality of life	Make New Zealand the best place in the world to be a child
The Immunisation team to expand their diverse culture knowledge to include incoming refugee populations. The team work closely with the South Canterbury Pasifika Health Provider to ensure immunisations are offered appropriately to all families.	Q2: The Immunisation Team to attend information sessions organised by the migrant centre about cultural, social and health matters relevant to the different cultures.			

School-Based Health Services				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
Continue to enhance and provide free sexual health consultations in Primary Care through the utilisation of flexible funding to support the Youth Sexual Health Programme.	Q1: Access eligibility and payment to general practice providers reviewed.	Full utilisation against allocated programme budget.	We live longer in good health	Support healthier, safer and more connected communities
Provide quantitative reports in quarter two and four on the implementation of school-based health services in decile one to five secondary schools, teen parent units and alternative education facilities.	Q2 & Q4: Quantitative reports.	CW12: Youth Mental Health Initiatives.		
Use the Youth Health Care in Secondary Schools framework as a tool to review our current high school clinics, and make changes if required.	Q2: Review current clinics. Q4: Implement changes.	Student feedback on clinics reported to SLAT.		
Provide quarterly narrative reports on the actions of the Service Level Alliance Team to improve health of the DHB's youth population.	Q1 – Q4: Reports submitted.	CW12: Youth Mental Health Initiatives.		
EOA: Expand access to School-based health services to two decile five high schools. This is for the provision of health and wellbeing assessments for all year nine students.	Q2 & Q4: Quantitative reports.	CW12: Youth Mental Health Initiatives.		

Family violence and sexual violence				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
EOA: Continue to improve support to staff to enable increased awareness and understanding of family violence and sexual violence.	Q1: Providing nationally approved VIP core training locally, that will enable new staff to access training. This will take place in partnership with our Māori Health team, who will be actively involved in preparing for and providing this training. Q4: Expand on the Clinical Nurse Manager dashboard reporting for designated services to include an audit of VIP routine enquiry. Q4: Team to participate in any new Council "Safer Communities" initiative, to strengthen links with other government and community organisations.	Intimate Partner Violence routine enquiry in the six designated services to meet the VIP programme expectation of >80%. 80% of children presenting to ED having a child protection assessment completed. Routine audits of designated services to report on compliance to understand areas for improvement. Programme Delphi audit score increase from 72-75.	We have improved quality of life	Support healthier, safer and more connected communities

2.4 Improving mental wellbeing

Mental Health and Addiction System Transformation				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
EOA: Review the roles of the Consumer and Family Advisor making sure there is robust support available.	Q1: Review position descriptions. Q2: Empower the consumer and family whānau voice through leadership opportunities. Q3: Facilitate the NGO funded, to provide Peer Support to maximise the roles.	Evidence of transformation and continuous quality improvement. Increased access to peer support.	We have improved quality of life	Support healthier, safer and more connected communities
EOA: To actively seek feedback from service users and family/whānau to enable service planning and implementation.	Q2: Increase the avenues for feedback from consumers and families / whānau. Q3: Introduce the opportunities for focus groups.	Actions implemented from feedback contribute to transformation and continuous quality improvement.	We have an improved quality of life	Support healthier, safer and more connected communities
EOA: Address the inequity for Māori by enabling effective feedback mechanisms.	Q2: Work in partnership with the provider of Māori services and establish regular hui with Māori consumers and whānau.	Feedback from Māori indicate improvement.	We have health equity for Māori	Support healthier, safer and more connected communities
Demonstrate leadership in promoting respect for the observance of the code of Health and Disability Services Consumers' Rights. Partner with the organisation responsible for the settlement of refugees.	Q1: Develop and maintain strong relationships with the organisation responsible for refugee settlement. Q2: Partner with other agencies to ensure a culturally sensitive approach to care.	Refugees are able to easily access the mental health services they need.	We have health equity for other groups	Support healthier, safer and more connected communities
Through greater consumer, family/whānau input and the development of peer led services there is improved support for consumers during episodes of distress or psychosis with a focus on providing cultural support 24/7 for Māori.	Q2: Continued commitment to Zero Seclusion with a focus on extending cultural support outside of core hours. Q2 & Q4: Reducing the rate of Māori under community treatment orders MH05 reporting.	Reduced rates of compulsory treatments and consumer rights upheld.	We have health equity for Māori and other groups	Support healthier, safer and more connected communities

To work in collaboration to enable a seamless, stepped care approach that eliminates barriers and enables ease of access.	Q1 – Q4: Waiting times MH03 and transition/discharge plans MH02. Q1 – Q4: Audits of Transition to Wellness plans. Q2: To increase and improve the liaison role. Q4: The South Canterbury Mental Health and Addiction Alliance will work together to the identified barriers eliminate barriers.	Increased positive feedback regarding how agencies work together ensuring a client and family/ whanau centred approach. Increased services.	We have an improved quality of life	Support healthier, safer and more connected communities
Continued commitment to ensure accurate and meaningful data is available to guide service delivery improvement.	Q1 – Q4: Reports to the Ministry. Q2 & Q4: Improved connection with the PRIMHD stakeholders' group.	PRIMHD Compliance remains over 95%.	We have health equity for Māori and other groups	Support healthier, safer and more connected communities
Work collaboratively with NGOs and other organisations to have a wellbeing focus that enables and encourages consumers to have improved physical and mental health. We will be passing on all cost pressure funding to ensure NGOs are sustainable and continue to work together to ensure improved wellbeing for our community.	Q2: Improve data collection across the complete spectrum of mental health and addiction to demonstrate physical health and wellbeing. Q3: Explore ways for stronger connection with community groups that promote physical activity and/or learning.	An improved wellbeing.	We live longer in good health	Support healthier, safer and more connected communities
Improve employment, education and training options for people with low prevalence conditions.	Q1: Improve data collection. Q2: Build strong relationships with employment workers and agencies.	More people in employment, education or volunteering.	We live longer in good health	Ensure everyone who is able to is earning, learning, caring or volunteering
EOA: Improve engagement strategies with Māori to improve outcomes.	Q2: Deliver an increased number of appointments at more appropriate locations.	Increased number of Māori engaged in Mental Health and Addiction services.	We have health equity for Māori and other groups	Support healthier, safer and more connected communities
Continue the implementation of Supporting Parents, Healthy Children.	Q2: Introduce systems to better demonstrate progress. Q4: Evaluate progress and plan next actions.	Families are supported at times of need.	We have an improved quality of life	Make New Zealand the best place in the world to be a child

Collaborate and work with the Ministry, the Mental Health and Wellbeing commission, the Suicide Prevention office and other leadership bodies and key partners to help drive transformation in line with He Ara Oranga. To include Primary care, Early intervention and prevention.	Q2: Progress report from SC Mental Health and Addiction Alliance against the SC Mental Health and Addiction Strategic Plan. Q4: The Alliance to develop a clear action plan developed for the next 12 months.	Progress in ensuring an integrated approach to mental health addiction and wellbeing.	We have an improved quality of life	Support healthier, safer and more connected communities
Make decisions and Implement changes to the Crisis Team.	Q2: Continue the work from 2019/20 to make a decision on the revised model of care. Q4: Implement changes.	An improved crisis approach.	We have an improved quality of life	Support healthier, safer and more connected communities
Commit to increase choice by broadening the types of mental health and addiction services across the full continuum of care.	Q1: Implement the new local initiative of E Korowai Tamariki Whakamana, Au te Whānau. Q4: Evaluate E Korowai Tamariki Whakamana Au te Whānau.	A collaborative approach for vulnerable children and their family/Whānau.	We have an improved quality of life	Make New Zealand the best place in the world to be a child
Commit to implementing actions from the Suicide Prevention Strategy - Every Life Matters.	Q1: Plan the implementation of the European Alliance Against Depression. Q3: Develop a pamphlet for distribution regarding availability of free counselling and group support services. Q4: Conduct mortality reviews of all local suicides. Q1 – Q4: Offer increased opportunities for community NGOs, faith-based groups, Rural Support Trust, schools and workplace training in mental health literacy and gatekeeper training.	Reduced number of suicides. Improved support for those bereaved by suicide.	We have an improved quality of life	Support healthier, safer and more connected communities

Encourage professional development of staff in the appropriate knowledge and skills to support people with mental health and addiction needs.	Q1: A focused and strengthen approach to the use of the Let's get Real framework. Q3: Increase the workforce numbers of people with lived experience.	A skilled workforce.	We have an improved quality of life	Support healthier, safer and more connected communities
Actively engage and contribute to the Forensic Framework Project.	Q1; Strengthen the interface with our Regional Services which will enable a regional approach and contribution to the Forensic Framework Project. Q3: Engage in forensic forums.	An improved integrated, culturally appropriate service.		

Mental health and addictions improvement activities

Activity	Milestone	Measure	System outcome	Government priority outcome
EOA: Commitment to Mental health and Addiction improvement activities with a continued focus on minimising restrictive care and improving transition plans ensuring specific cultural support is available and meets the needs of Māori.	Q1 – Q4: Reports to the Ministry. Q1 – Q4: Audits of Transition to Wellness plans. Q2: Continued commitment to Zero Seclusion with a focus on extending cultural support outside of core hours.	95% of clients have transition to wellness plans. Clients are able to access cultural support at any time.	We have health equity for Māori and other groups	Support healthier, safer and more connected communities

Addiction

Activity	Milestone	Measure	System outcome	Government priority outcome
EOA: Extend addiction access and choice to youth with a focus on improving engagement with Māori as the priority.	Q1: Adventure Development will implement changes to the contract to enable greater access. Q2: Adventure Development and Arowhenua Whānau Services will work in collaboration to improve access and choice for Māori Youth.	An increase in the number of youths accessing and engaging with services.	We have health equity for Māori and other groups	Support healthier, safer and more connected communities

Maternal mental health services				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
EOA: Provide support for women with a specific focus on Māori women requiring perinatal, antenatal and post-partum maternal mental health support.	Q1: Reform an advisory group to review the South Canterbury maternal mental health and wellbeing pathway. This group will include representatives from Māori, people with lived experience, Whānau representative and an Infant Child and Adolescent Clinician. Q2: Communication and education plan to be developed that will include all stakeholders that need to be aware of the maternal health and wellbeing services available to our community. Q3: Improved data collection to monitor and evaluate services available, including Māori accessing services. Q4: Collaborate and co-design with South Canterbury's Māori provider to expand the current services available for Māori woman.	Maternal mental health and wellbeing pathway reviewed. Communication and education plan developed. Improved data collection and equity gaps identified.	We have an improved quality of life	Make New Zealand the best place in the world to be a child

2.5 Improving wellbeing through prevention

Environmental sustainability				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
Undertake a review of the SCDHB energy needs with the view of replacing the current coal boilers with a more environmentally sustainable option.	Q1: External review of alternative energy options. Q4: Replacement of current coal Boilers.	Report submitted to SCDHB Board for approval of preferred option. New energy system in place.	We have improved quality of life	Support healthier, safer and more connected communities

Antimicrobial Resistance (AMR)				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
Assist clinical reasoning by introducing CRP testing into general practice to improve antibiotic prescribing practices.	Q1: Pilot CRP testing (Continuous Respiratory Pressure) point of contact in one large urban general practice with a diverse population profile.	Reduced general practice-based prescription of antibiotics.	We live longer in good health	Support healthier, safer and more connected communities
EOA: Expand medicine use reviews undertaken in primary care and aged residential care, completed by the community clinical pharmacist, to include antibiotic prescribing.	Q1: Expanded scope of reviews implemented.	Reduced general practice-based prescription of antibiotics. Report reviews undertaken by ethnicity.		
Enhance antimicrobial stewardship and governance across the DHB hospital and primary care providers by reviewing the current DHB Medicines and Therapeutics Committee scope and functions.	Q1: Terms of Reference and membership reviewed and approved by the Clinical Board. Q2: Work plan developed. Q4: Evaluation report submitted to the Clinical Board.	Approved Terms of Reference and workplan.		

Strengthen communication and education initiatives on AMR and stewardship for all prescribers, health care professionals and health care team members.	Q2: A process exists to evaluate compliance with prophylactic and therapeutic antimicrobial policies. This is linked to the Antimicrobial Stewardship Programme. Q3: Community Clinical Pharmacists will continue to work with staff in Aged Residential Care facilities to raise awareness to ensure prescription practices meet best practice requirements. Q4: Continue to provide educational updates for Primary Care practitioners on antimicrobial stewardship.	Documented adherence audits and chart reviews completed annually. Number of medication reviews undertaken by the Clinical Pharmacist. Primary Care educational forum attendance.		

Drinking water

Activity	Milestone	Measure	System outcome	Government priority outcome
Deliver and report on the drinking water activities and measures in the Ministry of Health Environmental Health exemplar.	Q4: 100% of network suppliers (serving 100+ people) receive compliance reports. Q2: Percentage of networked drinking water supplies compliant with the Health Act.	Receiving of compliance reports. Compliance with the Health Act.	We live longer in good health	Support healthier, safer and more connected communities
EOA: Provide technical advice and support on marae drinking water quality to local rūnanga via the ECan Tuia initiative and via the Drinking Water Assistance Programme on request.	Q2 & Q4: Report on advice/interactions.	Support/advice provided.		

Environmental and Border Health

Activity	Milestone	Measure	System outcome	Government priority outcome
Improve the quality and safety of our physical environment by undertaking compliance and enforcement activities relating to the Health Act 1956 and other environmental and border health legislation by delivering on the activities and reporting on the performance measures contained in the Ministry of Health Environmental and Border Health exemplar.	Q3: Border Health report. Q4: Reporting against all other exemplar measures.	All regulatory performance measures reported as required.	We live longer in good health	Support healthier, safer and more connected communities
EOA: Maintain relationships with local Rūnaka to support ongoing partnerships in addressing environmental health issues.	Q2 & Q4: Meetings have been held with Rūnaka representatives.	Number of contacts with Rūnaka representatives.		

Healthy food and drink

Activity	Milestone	Measure	System outcome	Government priority outcome
Refresh of SCDHB's Healthy Food and Drink Policy (using the recently endorsed West Coast policy).	Q1: Communication of the DHB Policy. Q4: Audit of current food and drink items provided.	DHB Healthy Food and Drink Policy implemented.	We live longer in good health	Support healthier, safer and more connected communities
Work regionally to agree consistent approach to health service provider contracts that stipulates the expectation providers will develop and implement a Healthy Food and Drink Policy, in line with the National Policy for Organisations.	Q2: Service provider contract clause agreed. Q4: Service provider contracts include Healthy Food and Drink Policy expectations.	Healthy Food and Drink Policies implemented by health provider organisations.		
EOA: Engage with providers to provide support and advice in developing their Policies, with a focus on our Māori service provider to target higher need populations.	Q4: Service provider contracts include Healthy Food and Drink Policy expectations.	Number and proportion of education providers adopting water-only and Healthy Food Policies.		
Track the number of provider contracts with a Healthy Food and Drink Policy.	Q2 & Q4: Monitoring reports on progress.	Reports submitted.		

Work with education providers in early learning settings, primary, intermediate and secondary schools to support the adoption of water-only and healthy food policies in line with the Healthy Active Learning Initiative.	Q2 & Q4: Monitoring reports on progress and adoption of policies by schools, kura and early learning services.	Reports submitted.		

Smokefree 2025

Activity	Milestone	Measure	System outcome	Government priority outcome
EOA: In partnership with Community and Public Health, collaborate with Smokefree South Canterbury to inform submissions on tobacco-related issues (including the proposed vaping legislation.	Q1: Collaboration on submissions on tobacco-related issues.	Number of submissions supported.	We live longer in good health.	Support healthier, safer and more connected communities.
Undertake compliance activities relating to the Smokefree Environments Act 1990, including delivering and reporting on the activities relating to the public health regulatory performance measures.	Q2 & Q4: Delivery of activities relating to the public health regulatory performance measures.	All regulatory performance measures reported six-monthly.		
EOA: Improve engagement with Māori Wāhine and remove barriers to accessing smoking cessation services and supports.	Q1: Introduce an incentive-based Māori Wāhine programme (Wāhine Toa Auahi Kore) targeting young Māori women aged 20 – 30 years.	Number enrolled in service and number CO validated at four weeks smokefree.		
Improve the home environment during pregnancy and increase the number of babies living in smokefree homes.	Q1: Expand the existing Pregnant Mamma incentivised programme to include all family members living in the household.	Number of household members participating in the programme. Number of CO validations of smokefree status.		
Continue to engage local businesses, educational providers and sports clubs to assist in supporting a smokefree culture and take smokefree services to where people work and study.	Q4: Engage two additional worksites to support staff to become smokefree. Q4: Engage one additional tertiary alternative educational setting to support an onsite drop-in smoking cessation clinic for staff and students.	Two additional workplaces included. One sports club on smokefree journey.		

	Q4: Approach at least one local high-profile sport club to start the journey to support members to become smokefree.	One additional tertiary organisation.		
Continue to work with DHB and non-government mental health services to minimise harm caused by cigarette smoking.	Q1-Q4: Continue to work in partnership with mental health providers to transition those clients currently smoking to the smoking cessation intervention of vaping.	Education sessions provided to mental health workforce on vaping.		
In partnership with Arowhenua Whanau Services, continue to deliver a wrap around Stop Smoking Service to the South Canterbury Community.	Q1: Develop a work plan for the service which includes scheduled initiatives such as the Pregnant Mama Programme, Maori Wāhine programme (Wāhine Toa Auahi Kore) and Co-validation success initiative.	Quarterly contract monitoring reports to the Ministry of Health.		

Breast Screening

Activity	Milestone	Measure	System outcome	Government priority outcome
EOA: Collaborate with ScreenSouth, Pacific Radiology Group and Arowhenua Whānau Services to deliver a joint breast/cervical screening clinic in Timaru.	Q4: One Joint clinic held locally with engagement and support of eligible wahine Māori and Pacific women to attend, provided by our Māori Health Provider, Arowhenua Whānau Services, Aoraki Migrant Centre and Fale Pacifica Support Workers.	70% of eligible women across all ethnicities receive breast screening every two years.	We have health equity for Māori and other groups	Support healthier, safer and more connected communities
EOA: Increase messaging promoting breast screening across a number of additional media platforms.	Q1: ScreenSouth will promote breast screening through Chinese and Korean newspapers which have a nationwide distribution.			

Cervical Screening

Activity	Milestone	Measure	System outcome	Government priority outcome
EOA: Explore the possibility with ScreenSouth, Pacific Radiology Group and Arowhenua Whānau Services to deliver a joint breast/cervical screening clinic in Timaru.	Q4: Options explored and joint clinic implemented if possible.	80% of eligible women across all ethnicities receive cervical screening every two years.	We have health equity for Māori and other groups	Support healthier, safer and more connected communities
EOA: Collaborate with ScreenSouth, Arowhenua Whānau Services and local industry with a high level of hard to reach eligible women including Māori to provide an onsite cervical screening clinic.	Q4: Industry site-based clinic held.			
EOA: ScreenSouth will continue to work with general practices across the screening pathway working with Primary Care on their PMS systems and processes to improve coverage, in particular mismatches and differences identified in the PHO Cervical Screening data match report.	Q4: PHO Cervical data match report provided.			
EOA: ScreenSouth will continue to provide support to practices to assist with identifying overdue priority group women and contacting them to offer an appointment for free.	Q4: Engagement of ScreenSouth with general practices.			

Reducing Alcohol Related Harm

Activity	Milestone	Measure	System outcome	Government priority outcome
Undertake compliance activities relating to the Sale and Supply of Alcohol Act 2012, including delivering and reporting on the activities relating to the public health regulatory performance measures.	Q2 & Q4: Delivering on compliance activities.	All regulatory performance measures reported six-monthly.	We live longer in good health	Support healthier, safer and more connected communities
Maintain and support intersectoral alcohol accords in South Canterbury.	Q2 & Q4: Supporting alcohol accords.	Number of active alcohol accords.		

Respond to an identified gap in youth resiliency by investing in the expansion of the YMCA current Resiliency Toolkit for Years 9 to 13 to include the development and delivery of a piloted programme in Year 7 and 8.	Q1: Programme developed, piloted in two educational settings and evaluated.	Documented evaluation report submitted to the Primary Care Alliance.		
EOA: Work in partnership with whānau to promote and enable the change needed to support a client receiving treatment and support with alcohol addiction/abuse issues.	Q1: Increase the cultural support available to whānau when a client is undergoing detox or rehab away from the family home. Q2: Increase the education available to whānau. Q3: Through improved engagement reduce the Do Not Attend rates.	Increased whānau contact and increased engagement.		

Sexual health

Activity	Milestone	Measure	System outcome	Government priority outcome
Continue to provide free sexual health consultations to youth and young people in South Canterbury. With changes to the Cervical Screening Programme age, eligibility extend under the programme to include 25-year olds so that young women remain eligible to have their first cervical screening smear under this programme.	Q1: SCDHB Primary Care Services Agreement with Primary Care providers, updated toreflect extended eligible population. Q1: Appropriate software updated toreflect extended eligible population.	Signed Primary Care Services Agreements with all general practice business owners. Monitoring of utilisation against Youth Sexual Health Programme budget.	We live longer in good health	Support healthier, safer and more connected communities
EOA: Appropriate contraception and health promotion information will be made available via the South Canterbury Community Health Information Centre	Q2 & Q4: Reporting period.	Number of resources provided.		

Communicable Diseases

Activity	Milestone	Measure	System outcome	Government priority outcome
EOA: Monitor and report communicable disease trends and outbreaks, including ethnicity breakdown where appropriate.	Q2 & Q4: Report to be submitted.	Number of reports sent to health professionals.	We live longer in good health	Support healthier, safer and more connected communities

EOA: Follow up communicable disease notifications to reduce disease spread, with a focus on a culturally appropriate response.	Q2 & Q4: Report to be submitted.	Number of notifications completed.		
EOA: Identify and control communicable disease outbreaks, with a focus on culturally appropriate response.	Q2 & Q4: Report to be submitted.	Number of outbreaks recorded.		
Improve public awareness and understanding of communicable disease prevention.	Q2 & Q4: Report to be submitted.	Number of media releases and other publicity.		
Communicate with Primary Care providers and advise them of current prevalence and trends of communicable diseases in the district.	Q1 – Q4: Monthly provision to primary care of local incidence and rates of communicable diseases.	Distribution of surveillance information.		

Cross Sectoral Collaboration including Health in All Policies

Activity	Milestone	Measure	System outcome	Government priority outcome
EOA: Work with rūnanga, education, and sports partners to deliver WAVE (Wellbeing and Vitality in Education).	Q2 & Q4: Report to be submitted.	Number of education settings with active health action plans.	We live longer in good health	Support healthier, safer and more connected communities
EOA: Develop DHB submissions related to policies impacting on our community's health.	Q2 & Q4: Report to be submitted.	Number of submissions.		
EOA: Work with Environment Canterbury and the Councils to improve health in our region, with a particular focus on air quality and warm housing.	Q2 & Q4: Report to be submitted.	Number of new or redeveloped joint initiatives agreed.		

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

Delivery of Whānau Ora				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
EOA: Partner with Whānau Ora commissioning agency Te Pūtahitanga o Te Waipounamu to identify opportunities for alignment. By establishing these partnerships, it is ensuring collaboration and investment in Whānau Ora initiatives for Māori and Pacifika communities.	Q2: Establish partnerships with Whānau Ora commissioning agency Te Pūtahitanga o Te Waipounamu. Q4: Schedule regular meetings.	Partnership established and initiatives identified and documented.	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering
EOA: Raise awareness and promote the NZ Certificate and Diploma in Whānau Ora to SCDHB staff.	Q2: Build relationships with Whānau Ora training providers. Q2: Promotion activities to SCDHB staff for the NZ Certificate and Diploma in Whānau Ora.	Total number of SCDHB staff enrolled in Whānau Ora certificate or Diploma course.		

Ola Manuia 2020 – 2025: Pacific Health Action Plan				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
EOA: Support delivery of the Pacific Health Action Plan once it has been agreed.	To be determined.	To be determined.	We have health equity for Māori and other groups	Support healthier, safer and more connected communities

Care Capacity Demand Management (CCDM)

Activity	Milestone	Measure	System outcome	Government priority outcome
Governance Ensure regular TrendCare steering group meetings are held, discussing key acuity data reflective of system activity. Build TrendCare steering group reporting system to the CCDM council as overall governance.	Q1-Q4: Quarterly TrendCare steering group meetings are held in January, April, July, October.	Evidence of meetings tabled at CCDM council meetings with acuity data discussed.	We live longer in good health	Support healthier, safer and more connected communities
Patient Acuity Data Socialise TrendCare business rules with operational staff to ensure data entered is within benchmark and reflects gold standard.	Q1-Q4: Hours per patient type within national benchmarks.	Evidence of continued improvement in acuity data across the business.		
Core Data Set Access and socialisation of the available data sets to inform local data council activity to be developed. 18 data measures are now displayed in a digital platform, Tableau. This applies to Nursing data.	Q2 & Q4: Local data councils consistently discussing Tableau CDS dashboards.	Evidence of LDC driven activity by CDS measures.		
Variance Response CaaG screens visible in all clinical areas, staff moving identify an opportunity to develop a regular framework to support moving to a different clinical area that they are unfamiliar.	Q4: Support the framework for working in a different clinical area.	Increased activity of RNs moving work environments according to variance.		
Staffing Methodology Process Nursing FTE calculation in a timely manner to fit with the 2020/21 budget cycles.	Q2 & Q4: Accurate timeline for Nursing FTE calculation process.	FTE calculations completed in advance of budget request deadlines.		
Undertake a SSHW recommended CCDM Standards Assessment to identify key opportunities to develop and build these into a workplan for the 2020/21 period.	Q4: Completion of standards assessment to be submitted to CCDM Council.	Operational workplan to progress CCDM related activity.		

Disability Action Plan

Activity	Milestone	Measure	System outcome	Government priority outcome
Commitment to working with the Ministry of Health to develop a local Disability Action plan. The purpose of this plan will be to improve access to quality health services and improve the health outcomes of disabled people. The focus will be on data, access and workforce.	Q4: Disability action plan developed.	Disability Action Plan completed.	We have improved quality of life	Support healthier, safer and more connected communities

Disability

Activity	Milestone	Measure	System outcome	Government priority outcome
Consumer led referral service improvement project addressing audit recommendations to improve how we identify and respond to the needs of people with disabilities.	Q2: Project developed to address high priority areas to improve referral processes for people with disabilities. Q4: Feasibility assessment completed for a specific Disability Plan to be developed in partnership with consumers, wider state services and clinicians.	Proportion of people with disabilities who are identified as part of the referral process. Service process improvements initiated as a result of changes to the referral process.	We have improved quality of life	Support healthier, safer and more connected communities
Work with National Emergency Management Planning agency to ensure SCDHB supports implementation of national alert systems (inclusive of people with disabilities).	Q1: Emergency management community communication process review. Q4: Audit of community communication processes during health led emergencies as part of our emergency planning processes with a focus on people with disabilities.	ERMS updated to include an alert for people with disabilities.		
Disability responsiveness online training programme promoted during staff orientation and induction and listed as “highly recommended” for all front-line staff as part of standard professional development processes.	Q1: Disability responsiveness course added to Learning Hub Highly recommended list. Q1: Monitoring of numbers of staff completing the package included in Learning Hub reporting to workforce governance group.	Disability responsiveness HealthLearn Package completion.		

Planned Care				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
Review and implement a more stream lined process to ensure there is a smooth transition from primary care referral though to the outpatient/inpatient journey including supporting consumers to navigate their health journey. This will take into account national consistency and local context.	Q1: Communications plan to promote the key steps along the Planned Care Journey for patients. Q3: Undertake a review of our current patient flow from Primary Care. Q3: Implementation plan developed. Q4: Plan implemented.	Brochure for patients to access in Primary Care. Posters for Outpatients and Preadmission waiting areas. areas. Final Process flow Report completed. Project plan completed. Completed implementation of agreed outcomes.	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering
EOA: Review health care needs of our Māori population and equity of access to secondary services to improve health outcomes.	Q2: Data review completed. Q4: Action plan on identified areas of need developed.	Report reviewed by Māori Health Advisory Committee. Report submitted to Community and Public health & Disability Support Advisory Committee.		
EOA: Review strategies to work with our affected community to improve DNA rates across Planned Care.	Q4: Identify and understand the reasons for the gaps between all deprivation groups.	Analysis of DNA rates for different groups. Plan developed to address the inequalities.		
EOA: Conduct a cultural assessment on the discharge process and implement one recommendation to improve the effectiveness for Māori and Pacific people.	Q1: Cultural assessment of discharge planning process completed. Q4: At least one recommended action implemented to improve experience for Māori and Pacific people at or following discharge.	Total numbers completed. Tangata Whaiora experience of care.		

Acute Demand				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
Continued development of an implementation plan for SNOMED coding.	Q4: Implementation plan developed.	Implementation plan completed.	We have improved quality of life	Support healthier, safer and more connected communities
EOA: Encourage cultural competency and recognise the diversity of the community we serve.	Q4: Make 'practice te reo Māori' cards available. ED staff are encouraged to use te reo in their interaction with patients presenting to the department.	Increased use of appropriate te reo within the emergency setting.	We have health equity for Māori and other groups	
Improved management of patients presenting to ED with cardiac chest pain.	Q3: Whole of hospital focus on managing the patient with cardiac chest pain. "One team' approach to the care of patients with cardiac chest pain ensuring they are treated by the right health professionals in the right place at the right time. Medical, including coronary care, and emergency department teams will work together to ensure the patient with chest pain is treated.	Reduction of patients admitted to inpatient units with chest pain.	We have improved quality of life	
SCDHB aim to maintain wait times exemplar ED access targets.	Q4: Improving pathways for women in South Canterbury District who are in their first trimester of pregnancy and experiencing concerns around bleeding. Interface closely with lead maternity carers (LMCs), primary care providers and secondary service providers to create a streamlined pathway with clear direction for all involved in the care of the pregnant woman. Pathways will remain patient and family-centric.	Decrease in presentations of women entering the secondary service for bleeding during the first trimester of pregnancy.		

Rural health				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
Ensure the viability of rural general practice in South Canterbury.	Q1: Engage providers in discussions relating to the utilisation of rural funding with a view to changing the local funding model. Q2: Provide feedback from consultation to inform the SCDHB Primary Care and Community Strategy.	A model for rural health primary care provision is included in the Primary Care and Community Strategy.	We live longer in good health	Support healthier, safer and more connected communities

Healthy Ageing				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
EOA: Align local DHB service specifications for home and community support services to the vision, principles, core component, measures and outcomes of the national framework and ensure the needs of Māori have been taken into account.	Q1: Collate baseline data related to outcomes of local Home based Provider Services. Q2: Introduce case-mix to inform the future delivery of HBP service. Q3: Modify the delivery of services to meet National Service Specifications. Q4: Evaluate initial outcomes.	Baseline established to be able to measure impact of changes. IT System in place to ensure case-mix is updated as required. Reduction in the number of overdue reviews by 30%. Report on learnings from the implementation phase.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities

To identify frail and vulnerable older people, with a focus on Māori and Pacific peoples, and put interventions in place to prevent the need for acute care and restore function	Q1-Q2: Establish pilot with primary care where the Geriatrician will work alongside the contracted GP in four Aged care facilities to reduce number of presentations to ED by offering alternatives to admissions and involvement of the Integrated Community Assessment Treatment Team. Q3: Review Q4: Report on outcomes	Establish baseline data regarding presentation from Aged Residential Care and the number of Residents in the pilot with Advanced Care Plan's. Implement nursing support package to meet gaps in knowledge and skills in Aged Residential Care. Reduce presentations to ED for those in pilot by 22% comparing to residents not part of the pilot from baseline data. 80% of Residents in pilot have an Advanced Care Plan.		
Work with ACC on the development of the community non-acute pathway to help older people to regain or maintain their ability to manage their day to day needs after an acute episode.	Q1: Define and educate staff on the new ACC pathway to improve discharge planning. Q3: Audit 10%of clients who have accessed the non-acute pathway. Q4: Report findings and recommendations.	Staff surveyed and report increased awareness of ACC pathway. Evidence of compliance with falls programme. Reduced presentations to ED for people over 65 years of age who are admitted to AT&R (to be reported by ethnicity)	We live longer in good health	Support healthier, safer and more connected communities
Work with ACC, HQSC and the MOH to promote and increase enrolment in strength and balance programmes and improvement of data driven osteoporosis management.	Q1: Falls register created. Q4: Evaluation of outcomes for those that have attended S&B programmes.	Number of falls that have occurred following completion of programme, resulting in presentation to ED.		
Facilitate equitable community services and education for people with dementia, plus their family/whanau/carers to enable them to live well.	Q1: Identify those people with cognitive impairment case mix 6a-7h.	Population profile created based on those individuals active within NASC.		

	Q2: Audit files against dementia pathway, match services offered against services accepted, against what was received. Q3: Present findings and recommendations. Q4: Recommended actions approved by the CPHDSAC committee.	Gaps within serviced delivery, challenges and barriers identified. Report on outcomes/findings based on survey of family/whanau carers. Cognitive impairment pathway updated.		
Build responsiveness to frailty in primary health care settings and improve links to all necessary supports, treatment and rehabilitation services.	Q1: Presentation to Primary Care regarding frailty. Q2: Create wellbeing clinic which focuses on screening, assessment and management of fragility, cognitive impairment, falls, and medication review within ICATT. Q4: Evaluation of Clinic.	Improved support in place. Clinic established and attendances recorded. Report on outcomes/findings.	We live longer in good health	Support healthier, safer and more connected communities

Improving Quality

Activity	Milestone	Measure	System outcome	Government priority outcome
Develop a system wide long-term conditions plan inclusive of diabetes and respiratory conditions.	Q1: Terms of Reference developed. Q4: Plan developed.	LTC Plan includes actions to address barriers to equity in outcomes for respiratory illness and diabetes.	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering
EOA: Review the Health Pathway for Gout with an equity lens and localise (if required).	Q4: Canterbury DHB Gout pathway reviewed.	All health professionals can access current Health Pathway for Gout.		
Review Service management of inpatient falls and monitor improvements through the falls committee.	Q2: Develop a falls committee action plan.	Action plan includes service level initiatives.		

To increase primary care understanding of rheumatology inclusive of Gout.	Q1: Hold a Rheumatology workshop as part of SCDHB Primary Care Symposium.	Number of symposium attendees.		
Consumer Council led review of consumer engagement QSM against SURE framework. Consumer Council workplan includes guidance to implementation of the Engagement quality marker.	Q3: HQSE Consumer Engagement QSM being monitored. Q1: Consumer Council workplan includes QSM implementation. Q4: Data loaded into QSM dashboard. Q4: Report provided to the Consumer Council.	Consumer Council minutes reflect report and monitoring. Workplan approved by the Board. HQSC QSM reporting. Consumer Council minutes.		
Improve postvention support through the introduction of access to a postvention pack and inclusion of whanau fully in development of the learnings from adverse events. The Suicide Prevention Coordinator will also be involved in adverse event investigations and there will be continued development of the recently established Suicide Mortality Group, learnings.	Q4: All Whanau fully involved.	Postvention support improved.		

New Zealand Cancer Action Plan 2019 - 2029

Activity	Milestone	Measure	System outcome	Government priority outcome
Work with the Te Aho o Te Kahu (National Cancer Control Agency) to implement and localise the NZ Cancer Action Plan.	Q2: Stocktake of the current activity the DHB undertakes in order to identify areas that need to be addressed to meet the NZ Cancer Action Plan. Q4: Following the stocktake a local action plan will then need to be developed to ensure alignment nationally.	Stocktake completed. Documented local action plan completed.	We live longer in good health	Ensure everyone who is able to, is earning, learning, caring or volunteering

EOA: Ensure equity of access to timely diagnosis and treatment for all patients on the Faster Cancer Treatment pathway to minimise breaches of the 31 day indicator and 62 day target.	Q1: The Faster Cancer Treatment team to commence an audit project to understand the reasons for the breaches. Q2: Findings translated into a work plan to minimise breaches in the future.	Findings report (due in October 2020). Workplan with agreed actions and outcomes for minimising breaches.		

Bowel Screening and colonoscopy wait times

Activity	Milestone	Measure	System outcome	Government priority outcome
To ensure that the colonoscopy wait times continue to be met and that this is sustainable for the DHB.	Q1: Endoscopy User Group continues to monitor progress and assess sustainability.	SS15 – to improve and maintain colonoscopy wait times.	We live longer in good health	Ensure everyone who is able to, is earning, learning, caring or volunteering
EOA: Ensure equity of access throughout the bowel screening pathway.	Working with the South Island Bowel Screening group to support implementation of the programme. In addition, working with our Māori Health providers, Arowhenua Whānau Services, to promote the programme.	Equitable participation in the Bowel screening programme by Māori, Pacifika and high deprivation population groups.		

Workforce

Activity	Milestone	Measure	System outcome	Government priority outcome
EOA: Develop a Health Literacy Plan inclusive of actions to improve the health literacy of non-clinical staff and working with Primary Care to meet health literacy education and training needs and health literacy education and training for health system volunteers.	Q4: Action plan developed.	Actions implemented.	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering
Maintain focus on health literacy development particularly for the non-clinical front-line workforce groups and inclusive of health sector volunteers.	Q1-Q4: Ongoing activities to enhance workforce health literacy will continue to be promoted and developed. Q1: Training needs analysis undertaken.	Staff uptake of online health literacy packages.		

	Q2: HealthLearn packages targeting health literacy being promoted for key workforce groups. Q2: Kōrero mai roll out completed as part of our deteriorating patient programme. Q1: Bridges Self-Management promotion continuing. Q2: Feasibility analysis conducted on developing a training programme for volunteers to be developed as health watchers.	Number of Services Implementing Kōrero mai. Staff enrolled in Bridges programme. SLT minutes.		
Roll out of Line Manager Essentials Training.	Q1: Develop materials and schedule accessible PD time for target staff. Q1: Ensure all staff being developed towards or occupying line management roles, have access to a programme of development and refresher on key management tasks.	80% of line managers participate in training.	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering
Implement a Mentor/Buddy system for Line Managers.	Q2: Implement a mentor system for all new Line Managers in order to provide the support of a colleague in their transition to their new role.	100% of new line managers have named mentor.	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering
EOA: Increase Māori participation in our workforce through supporting the Tumu Whakarae Position Statement in partnership with the Directors of Māori Health.	Q1: Structured interview templates aligned with recommendations from Kia Ora Hauora to ensure measurement of cultural fluency. Q4: Prioritise Māori staff inclusion on interview panels. Q4: Māori applicants meeting minimum requirements will automatically be progressed to interview stage for all externally advertised positions.	Recruitment policy and process align with the Tumu Whakarae Position Statement. Register established of Māori staff willing to participate in interview processes. Proportion of interviews with Māori interviewers increases. Māori representation in the workforce moves closer to our population.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities

EOA: Facilitate a close working relationship with Kia Ora Hauora for Māori Workforce Pipeline Development through creating strong links with South Canterbury Schools and supporting our youth to enrol and thrive once in the programme.	Q1: Kia Ora Hauora introduced to local schools.	Number of South Canterbury youth enrolled in Kia Ora Hauora Programme.		
EOA: Continue to support the development of a strategy to grow the South Island Māori health workforce and ensure that workforce is well supported and thrives. This is through our collaboration between the South Island DHBs facilitated by SIAPO (Workforce Hub) and Kōhatu, Centre for Hauora Māori in the University of Otago.	Q1: Evaluate report summarising key findings from the background review. Q4: Develop a description of initiatives, their implementation and evaluation.	Review published and shared. Initiatives implemented regionally.		
EOA: Develop and Run a Māori Specific Leadership Learning Programme as part of the SCDHB Navigate Programme.	Q1: Māori leadership Development programme implemented.	Participants report positive learning and experience by Q3		
Improve equitable funding for Nurse Practitioner professional development.	Targeted promotion of Professional Development opportunities for NPs and ongoing reporting of access (annually) to Workforce Governance Group.	Number of NPs in South Canterbury. PD funded activity undertaken by NPs.	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering
Improve access for Primary Care workforce to Professional Development Programmes.	Q1: Recruitment of LH advisor holding Primary Care Portfolio. Q1-Q4: Registered nurses on the pathway to nurse practitioner are supported through robust general practice supervision and mentorship by experienced nurse practitioners through regular Nurse Practitioner forum. Q1-Q4: Nurse Practitioner interns are provided with professional leadership opportunities such as membership of the Primary Care Alliance and opportunities to lead Primary Care Clinical Update sessions.	Portfolio holder in place. NP forum occurs quarterly. At least one intern occupies a professional leadership role.		

	Q1-Q4: Primary Care Nurse Practitioners encouraged and supported to access DHB led professional development activities. Q1 & Q4: RMOs are invited to Primary Care Clinical & Sector Update forums as well as the annual Primary Care symposium. Q1: Training calendar shared with Primary and Care providers as well as invitations extended to join the Learning Hub Facebook group to keep up to date with learning opportunities. Q2: Promotion of Calderdale CTI training with unregulated workforce.	Attendance at PD activities. RMO attendance increased. LH Facebook membership increases. Enrolments in CTI training increases.		
EOA: Facilitate a healthy and culturally reinforcing work environment including awareness of institutional racism and expand the reach and impact of the cultural context workshops.	Q1-Q4: Continue to grow attendance at Māori staff hui as a key mechanism to encourage professional development for this workforce group. Q3: Institutional racism included in cultural context workshops and orientation programme.	Māori staff enrolment in PD increases.	We have health equity for Maori and other groups	Support healthier, safer and more connected communities
EOA: Improve outcomes and independence for Māori and Pacific People.	Q4: Continue to offer Bridges Self-Management workshops. Q1: Kōrero mai process specifically reviewed to support Māori Whānau escalation of concerns.	Workshops run Q2 & Q4. Kōrero mai process review Q2.		

EOA: SCDHB intends to remain a Medical Council of New Zealand accredited prevocational medical training provider. We are the only DHB in the country that has achieved 100% CBA (Community-based Clinical Attachments) placements. We plan to continue this excellent record into the future. We will continue to ensure that high standards of medical practice, education and training inclusive of medical education on Māori health, are delivered for new graduates and PGY1 & 2s.	Q4: Maintain 100% Community Based Clinical Attachments (CBA) placements. Q4: RMO Orientation programme continues to incorporate Marae over-night stay and education on Māori Health, delivered through Arowhenua Marae. Q1-Q4: All RMOs offered Cultural safety, Treaty of Waitangi and te Reo Māori language development via onsite learning and external providers. Q1: RMOs included in Bi-monthly Māori staff hui/forums for Māori staff (inclusive of RMOs). Continue to run inter-disciplinary new graduate experiences including scenario/simulation training, ACLS and Tuesday Grand Rounds. Promotion of pastoral support and sign posting, implemented through the Learning Hub Advisors for all new graduates.	SCDHB remains a Medical Council of New Zealand accredited prevocational medical training provider. Prevocational specific measures include Noho at Arowhenua marae and twice monthly RMO teaching sessions. Increase Māori medical graduates employed at SCDHB Numbers of RMOs included in simulation activities		

We will continue to strengthen alliances with training bodies, professional colleges, responsible authorities & other societies by reinforcing our existing relationships with key people within the Medical Council, Immigration, Education Providers and neighbouring DHB's. We will attend any relevant information/training sessions held by the Medical Council or Immigration – Right skills, right place, and right time.	Q1: Ara – SCDHB partnership governance group established. Q2 & Q4: Maintain SCDHB presence at education fairs. Q4: Health & Wellbeing Level 3 Careerforce promotion for HCAs, AHAs and Orderlies. Q3: Maintain our in-house workforce pipe-line development programme in partnership with local secondary schools (our "Wish Programme").	Number of meetings annually Attendance at relevant Information/training sessions held by the Medical Council or Immigration. Number of Careerforce enrolments and graduates. Number of students enrolled in programme.		
EOA: The Consumer Council will provide governance for the development of a Health Literacy Plan inclusive of both staff and consumers and with specific attention to people with long term conditions and our Māori and Migrant consumer groups. Key objectives will include improved health literacy across high need segments of our community and targeted members of our health workforce, particularly our non-clinical staff and volunteers.	Q4: Develop a SCDHB wide Health Literacy Plan in partnership with consumers.	Plan in place.		
Maintain focus on health literacy development particularly for the non-clinical front-line workforce groups and inclusive of health sector volunteers.	Q1 – Q4: Ongoing activities to enhance workforce health literacy will continue to be promoted and developed. Q2: Training needs analysis undertaken Q1 and HealthLearn packages targeting health literacy being promoted for key workforce groups. Q2: Kōrero mai roll out completed as part of our deteriorating patient programme. Q1: Bridges Self-Management promotion continuing. Q2: Feasibility analysis conducted on developing a training programme for volunteers to be developed as health watchers.	Staff uptake of online health literacy packages. Number of Services implementing Kōrero mai. Staff enrolled in Bridges programme. SLT minutes.		

Data and Digital				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
Implementation of South Island PICS.	Q4: SI PICS roll out completed.	Implementation plan completed.	We have improved quality of life	Support healthier, safer and more connected communities
Roll out of eTriage within SCDHB.	Q4: eTriage Implemented**.**	eTriage implemented.		
EOA: Implementation of the National Bowel Screening Programme to support equity of access to services for our community.	Q1: Implementation by November 2020.	Go live date is achieved as part of the National Bowel Screening programme.		
Implementation of the National FPIM system.	Q3: FPIM implementation.	Implementation completed.		

Implementing the New Zealand Health Research Strategy				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
EOA: Maintain commitment to enable, support, and promote evidence-based practice through research activities in line with the NZ Health Research Strategy 2017-2027, at South Canterbury District Health Board. In particular, work on embedding the four guiding principles of research; excellence, transparency, partnership with Māori and collaboration. In the current year we will focus on Strategic Priority 2: Create a vibrant research environment in the health sector and Priority 3: Build and strengthen pathways for translating research findings into policy and practice. **Priority 2** - Strengthen the clinical research environment and health services research. • Continue to provide a point of contact, information and resources for staff wanting to undertake research, and connect them with research opportunities, agencies and pathways to support their work through our SCDHB library service. • Provide a point of contact and information to other institutions who want to collaborate with SCDHB in national and regional research activities. • Improve equity in Healthcare by promoting and supporting Māori health research activities. E.g. Tooth brushing study at Arowhenua School.	Q1: Tooth brushing study at Arowhenua school initiated.	Number of studies being initiated within SCDHB. Number of studies being supported by SCDHB staff.	We have health equity for Māori and other groups	Ensure everyone who is able to, is earning, learning, caring or volunteering

• Continue to provide staff with thetools and encouragement to actively participate and initiate research and look for research opportunities for SCDHB to contribute to an equitable Health system. **Priority 3**: Build and strengthen pathways for translating research findings into policy and practice Research based approach to increase Māori participation in the health workforce see workforce section on South Island DHBs facilitated by SIAPO (Workforce Hub) and Kōhatu, Centre for Hauora Māori in the University of Otago.	Q1-Q4: Maintain Support for Kōhatu project.	Number of recommended actions implemented.		
Clinical Research Policy review conducted to ensure it supports; • SCDHB to participate in regional networks (to supports staff locally to be engaged with research and innovation and build capacity and capability) and; • Clinical staff have a supportive framework to engage in research and innovation activities.	Q2: Policy Updated.	Number of staff participating in regional research and analytics networks.	We live longer in good health	Support healthier, safer and more connected communities
Progress summary report provided to Ministry of Health and SCDHB Board.	Q4: Report provided.	Board and Ministry of Health reports.		

Delivery of Regional Service Plan (RSP) priorities and relevant national service plans				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
HealthPathways is updated as required when new treatment/screening recommendations are implemented. This aids in keeping primary care services up to date on new treatments they can provide and that they are updated from a national perspective and include what other DHB's have implemented.	Q2 & Q4: Newly implemented treatment/screening recommendations are updated in HealthPathways.	Primary care services are kept informed on new treatments.	We live longer in good health	Support healthier, safer and more connected communities
Linking in with GP practices with the aid of reps from Maviret company to increase screening via GP practices and uptake of treatment delivery.	Q2: Establish relationships with GP practices through Maviret.	Increase in screening via GP's – numbers increase.		
Continual linking in with both Needle Exchange Timaru and Alcohol & Drug services to promote screening and referral to the Hepatitis clinic.	Q2 & Q4: Meetings are held with Needle Exchange Timaru and Alcohol and Drug Services.	Continual increase in referrals via NEXT/A&D.		
Project to be undertaken to link with Arowhenua Whānau services to promote HCV screening to the Māori population.	Q3: An HCV screening project with Arowhenua Whānau services is underway.	Increase in screening of Māori population.		
Lost to follow up patients – many have already been approached via phone/letter however further work needs to be done to catch those who are still lost to follow up.	Q3: Review, identify and contact those still lost to follow-up.	Increase in those lost to follow up return to the clinic/GPs.		
The WHO aims to eliminate HCV by 2030. With this in mind, the Hepatitis clinic treats all those patients already known about and new patients, to facilitate the aim of eliminating the virus as quickly as possible.	Q4: Increase the numbers of patients treated in the clinic.	HCV not detected in those treated over the year.		

2.7 Better Population Health Outcomes Supported by Primary Health Care

Primary health care integration				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
EOA: Assess and understand the needs of local population so that we are better placed to address barriers to access and equitable outcomes.	Q1: Establish a cross system data analysis capability. Q3: Utilise data analysis to inform planning for long term condition management.	Cross system data report available. Planned pilots for new programmes.	We have health equity for Māori and other groups	Support healthier, safer and more connected communities
Support all primary care providers in the event of an adverse weather event, pandemic or major incident by developing an Emergency Response Plan for Primary Care.	Q1: Emergency Response planning group established. Q3: Emergency Response Plan developed. Q4: Emergency Response exercise designed to test the Emergency Response Plan.	Primary Care Emergency Response Plan signed off and socialized.		
Implement a 'Choosing Wisely' campaign based on prescribing and dispensing.	Q1: Complete a stock take of current prescribing and dispensing instructions. Q2: Clarify for prescribers agreed protocols for dispensing guidance of prescriptions. Q4: Evaluate effectiveness of guidance through audit of adherence to and user feedback for selected medications.	Reduced prescribing and dispensing of paracetamol as an indicator drug (SCDHB highest volume prescribed and dispensed drug).		
Embrace technological enablers to support the patient as a key in managing their own health and Support the interface between the patient and their healthcare team.	Q2: Promote the benefits of engaging patients in the use of patient portals.	National reports for portal use indicate increasing adoption by practices and registration by enrolled patients.		
Embed telehealth initiatives as a result of the COVID-19 disruption.	Q1: Establish a process for capturing telehealth consultations and reporting on activity. Q2: Gain baseline benchmark data. Q3: Work with primary care providers to set realistic targets.	Telehealth consults as a percentage of total consultations.		

Enhance the gains made through COVID-19 response in relation to strengthening intersectoral relationships within the NGO and volunteer sector.	Q1: Scan other structures to identify different ways of working. Q2: Establish funding streams and infrastructure to support a South Canterbury network aligned with Caring Communities. Q3: Transition from Health Psychosocial led to a new infrastructure.	Formalised structure to the intersectoral NGO and volunteer leadership.		

Air Ambulance Centralised Tasking

Activity	Milestone	Measure	System outcome	Government priority outcome
The DHB remains committed to the 10 year plan to achieve a high functioning and integrated National Air Ambulance service and will participate through the National Ambulance Collaborative to achieve this. The DHB will support the implementation of changed Governance arrangements to include DHBs to effect improved partnership with MOH and ACC in all elements of leadership of the NASO work programme, and supports the development of a robust national process to scope the requirements of a national tasking service	Q4.	Status update report.	We live longer in good health	Support healthier, safer and more connected communities

Pharmacy				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
Continue to promote the uptake of influenza vaccination in Māori people over 65 years.	Q3 & Q4: Connect with Arowhenua Whānau Services and the Migrant Centre to promote the availability of free flu vaccinations to their kaumatua/elders through their general practice and or pharmacies.	75% of over 65-year olds have been immunised against influenza. To be reported by ethnicity.	We live longer in good health	Support healthier, safer and more connected communities
Ensure convenient access to vaccination in South Canterbury by supporting community pharmacies to deliver the flu vaccination.	Q1: Work with the DHB Learning Hub to provide access to the required intermediate level resuscitation training (NZ Resuscitation Councils resuscitation level 4) required as the minimum first aid requirement for pharmacist vaccinators.	No. of community pharmacists provided with intermediate level resuscitation training will be reported in operational reports. 75% of those people in South Canterbury eligible for a free flu vaccination are immunised against influenza.		
Build connectivity between general practice and community pharmacies by embedding IT enhancements initiated in our response to the COVID-19 disruption.	Q2: Promote and engage general practice and community pharmacies in the uptake of NZePS.	Two general practices sign up to NZePS.		

Long-term conditions including diabetes				
Activity	**Milestone**	**Measure**	**System outcome**	**Government priority outcome**
EOA: Improve renal monitoring – in all diabetes patients with a particular focus on Māori and Pacific populations.	All patients with Diabetes will be screened for renal impairment.	All patients with diabetes to have as minimum a yearly ACR and renal function test.	We have health equity for Māori and other groups	Support healthier, safer and more connected communities
EOA: Arowhenua Whānau Services is a free healthcare service providing a wide range of services to all Māori and non-Māori in the Arowhenua area. This service is easily accessible and is situated locally they provide a hub between primary and secondary care and are able to access CNS and other support services. Support chronic disease (diabetes) to our Māori populations. Two Diabetes Clinical Nurse Specialists are in the process of reviewing engagement with Arowhenua Whānau Services to enhance Māori participation in diabetes management and self-education programs (DMSE). We are also working towards strategic planning alongside Māori members of non-clinical to meet the cultural needs and expectations of our SCDHB Māori population.	Q4: Increasing the number of Māori accessing diabetes Clinical Nurse Specialist services by 5%.	Māori attending the clinic have improvement in their understanding and ability to self-manage their condition.		

Eligible people living with diabetes have access to the Diabetes Encounter Programme. This entitles people to 6 fully funded consults with their Primary Care team. Eligibility is a. Newly diagnosed b. Commencing insulin therapy c. Re-engagement. History of poorly controlled diabetes	Q3: Improvement in the number of people with an HbA1c at or below their individual target. Targets are set with the person with diabetes and their health provider.	SS12: Improved management for long term conditions.		
Clinical Nurse Specialist Diabetes team are attending MCRG providing information to support healthy lifestyle practice to reduce the risk of developing type 2 diabetes. For those people who already have a long-term condition such as diabetes, the information provided could support them to self-manage, to reduce their risk of complications and improve diabetes control. This program covers all rural outline areas.	Q2: Extend the programme to reach more people in rural areas.	Numbers participating in the programme increase by 5%.		
ICATT has been introduced and is used as a streamline referral system. This is to enable referrals from Primary Care for long term conditions including diabetes to improve the multi conditionally approach. These referrals are seen as outpatients or domiciliary visits, or in collaboration with Primary healthcare providers.	Q1: All target volumes for referrals are met.	Contract volumes.	We have improved quality of life.	Ensure everyone who is able to, is earning, learning, caring or volunteering.
In an effort to make the service more seamless, the team have recently updated the relevant Healthcare pathways in diabetes particularly as there is new screening and additional medications that can now be utilised.	Q3: Improving Primary care activity.	All Primary and Secondary care providers will now utilise the same healthcare pathways resulting in consistent and current evidence-based practice in the management of diabetes.		
Continue to improve integrity of Annual Diabetes Review data in South Canterbury.	Q1: Establish working group to explore options for obtaining valid data.	SS13 quarterly reporting.		

2.8 Financial Performance Summary

South Canterbury District Health Board **Consolidated Financial Performance 2020/2021**	2018/19 **Audited Actual**	2019/20 **Forecast**	2020/21 **Plan**	2021/22 **Plan**	2022/23 **Plan**	2023/24 **Plan**
Patient Care Revenue	205,217	222,496	225,678	235,652	245,507	255,788
Other Revenue	2,464	2,185	1,717	1,715	1,715	1,715
Finance Revenue	815	666	611	51	-	-
TOTAL OPERATING REVENUE	208,496	225,347	228,006	237,418	247,222	257,503
	-	-	-	-	-	-
Personnel Benefit Costs	82,686	74,524	77,449	79,877	80,463	82,315
Outsourced Services	10,779	10,267	9,188	10,268	10,454	10,689
Clinical Supplies	10,468	11,443	11,669	11,940	12,107	12,901
Infrastructure & Non-Clinical Supplies	10,978	10,067	11,241	11,121	10,783	11,583
Payments to Non DHB health providers	101,726	114,175	112,025	117,309	124,781	130,888
Depreciation and Ammortisation expenses	4,436	4,323	4,742	5,162	5,497	5,502
Finance Costs	4	-	-	-	-	-
Capital Charge	2,389	1,648	1,620	1,620	1,620	1,620
TOTAL OPERATING EXPENDITURE	223,466	226,447	227,934	237,297	245,705	255,498
SURPLUS/(DEFICIT)	**(14,970)**	**(1,100)**	**72**	**121**	**1,517**	**2,005**

South Canterbury District Health Board
Consolidated Financial Position
2020/2021

	2018/19 **Audited Actual**	2019/20 **Forecast**	2020/21 **Plan**	2021/22 **Plan**	2022/23 **Plan**	2023/24 **Plan**
Public Equity						
General Funds	16,480	16,300	16,049	15,798	15,545	15,293
Accumulated Surplus	(4,762)	(5,862)	(5,790)	(5,669)	(4,152)	(2,147)
Equity from Donated Assets	1,572	1,534	1,503	1,471	1,435	1,399
Revaluation Reserve	15,450	15,450	15,450	15,450	15,450	15,450
Total Equity	28,740	27,422	27,212	27,050	28,278	29,995
ASSETS						
Current Assets						
Cash and cash equivalents	7,673	8,145	2,181	2	2	4,099
Financial Assets	12,778	7,600	-	-	-	-
Debtors and other receivables	7,307	5,912	7,210	7,210	6,810	6,760
Inventories	1,242	1,188	1,200	1,200	1,100	1,100
Total Current Assets	29,000	22,845	10,591	8,412	7,912	11,959
Non Current Assets						
Financial Assets	201	5,379	201	201	201	50
Property, plant and equipment	40,958	43,096	56,109	61,820	66,243	64,083
Intangible Assets	787	803	5,120	5,896	6,447	6,998
Total Non Current Assets	41,946	49,278	61,430	67,917	72,891	71,131
TOTAL ASSETS	70,946	72,123	72,021	76,329	80,803	83,090
LIABILITIES						
Current Liabilities						

Bank Overdraft	-	-	-	3,432	3,036	-
Creditors and other payables	11,043	11,723	11,197	12,238	12,728	13,152
Employee Entitlements	23,585	25,545	25,993	25,993	26,692	27,143
Borrowings	-	-	-	-	-	-
Total Current Liabilities	34,628	37,268	37,190	41,663	42,456	40,295
Non Current Liabilities						
Finance Lease Liability	337	169	169	169	169	1,200
Term Loans	-	-	-	-	-	-
Employee Entitlements	7,241	7,264	7,450	7,450	9,900	11,600
Total Non Current Liabilities	7,578	7,433	7,619	7,619	10,069	12,800
TOTAL LIABILITIES	42,206	44,701	44,809	49,282	52,525	53,095
NET ASSETS	**28,740**	**27,422**	**27,212**	**27,047**	**28,278**	**29,995**

South Canterbury District Health Board
Statement of Changes in Equity
2020/2021

	1-Jul-18 Opening Balance	2018/19 Audited Actual	2019/20 Forecast	2020/21 Plan	2021/22 Plan	2022/23 Plan	2023/24 Plan
Total Equity at start of period		41,258	28,740	27,422	27,212	27,047	28,278
Net Surplus/ (Deficit) for year		(14,970)	(1,100)	72	121	1,517	2,005
Movement in Revaluation Reserve		2,667	-	-	-	-	-
Equity Injection Deficit Support		-	-	-	-	-	-
Capital Repaid		(217)	(217)	(217)	(217)	(217)	(217)
Other Movements		2	(1)	(65)	(69)	(69)	(71)
Total Equity at end of period		**28,740**	**27,422**	**27,212**	**27,047**	**28,278**	**29,995**

CASHFLOW & BANK
2020/2021

	1-Jul-18 Opening Balance	2018/19 Audited Actual	2019/20 Forecast	2020/21 Plan	2021/22 Plan	2022/23 Plan	2023/24 Plan
Total Receipts		208,635	221,472	227,395	237,565	247,816	258,493
Total payments		(203,593)	(214,908)	(209,166)	(236,701)	(240,973)	(248,553)
CASH FLOW FROM OPERATING ACTIVITIES		5,042	6,564	18,229	864	6,843	9,940
CASH FLOW FROM INVESTING ACTIVITIES		(5,223)	(5,875)	(24,410)	(20,692)	(6,664)	(3,024)
CASH FLOW FROM FINANCING ACTIVITIES		(457)	(217)	217	14,217	217	217
NET CASH FLOW		(638)	472	(5,964)	(5,611)	396	7,133
Plus: Cash (Opening)		8,311	7,673	8,145	2,181	(3,430)	(3,034)
YTD Net cash movements		(638)	472	(5,964)	(5,611)	396	7,133
Cash (Closing)	**8,311**	**7,673**	**8,145**	**2,181**	**(3,430)**	**(3,034)**	**4,099**

SECTION THREE: Service Configuration

3.1 Service Coverage

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

Responsibility for service coverage is shared between DHBs and the Ministry. DHBs are responsible for taking appropriate action to ensure that service coverage is delivered for their population, including populations that may have high or different needs such as Māori, Pacific and high-needs groups. South Canterbury DHB may, pursuant to section 25 of the New Zealand Public Health and Disability Act 2000, negotiate and enter into, or amend any current agreement for the provision or procurement of services.

South Canterbury DHB is not seeking any formal exemptions to the Service Coverage Schedule in 2020/21.

3.2 Service Change

Change	Description of the Change	Benefits of the change	Local, Regional, or National reason
***Home Based Support Services**	Review of the Home Based Support Services to identify areas for improvement.	Improve integration and increase efficiencies in the delivery of care across community services.	Local.
***Mental Health and Addiction**	Currently SCDHB specialist mental health and addition resources are organised into a traditional hub and spoke model, which directs flow into the mental health facility essentially creating comprehensive hospital-based services. Therefore, this change will involve transforming the service with emphasis on community-based services.	Balancing the emphasis of specialty, hospital and community based services to ensure mental health services in South Canterbury is designed to a contemporary model of care.	Local.
FTE changes	**Medical staff** Anaesthetic – increase of 2.57 FTE Orthopaedic – increase of 1 FTE. Medical Oncology – increase of 1.4 FTE. **Nursing Staff** Nursing/EN/HCA – increase of 7.72 FTE. **Allied Health** Allied Health – increase of 2.16 FTE.	 Increase in FTE due to job sizing of the Anaesthetic department. Increase to meet Orthopaedic demand due to the aging population in South Canterbury. Increase due to demand in Oncology services, this supports both a local and regional need to allow patients to receive services within South Canterbury. Additional staff based on CCDM to meet the increasing demand, complexity and acuity of patients. Increase to support the increasing complexity of patients both inpatient and community services, this is across Speech Language, Dietetics, Dental and Allied Assistants.	 Local Local. Local/Regional. Local. Local.

*Further discussions will take place with the Ministry of Health as the proposed service changes progress.

Note: There are no proposed service changes or local initiated reviews planned as a result of Covid-19.

SECTION FOUR: Stewardship

4.1 Managing our Business

Partnerships

The South Canterbury DHB works in partnership with a number of external public and private organisations to implement cross-agency programmes to 'support the health and independence of the people of South Canterbury'. In recognition of our significant role to play in future workforce development, we work closely with local High Schools, Ara Polytechnic and Otago University as well as Kia Ora Hauora to support health sector workforce training, here in South Canterbury.

Organisational performance management

South Canterbury DHB's performance is assessed using financial and non-financial metrics, which are measured and reported at operational, strategic and governance levels of the organisation. These are reported as appropriate.

Funding and financial management

South Canterbury DHB's key financial indicators are Statement of Financial Performance, Statement of Consolidated Financial Position and Statement of Changes and Equity. These are assessed against and reported through South Canterbury DHB's performance management process to operational, strategic and governance levels on a monthly basis. Further information about South Canterbury DHB's planned financial position for 2020/21 and out years is contained in the Financial Performance Summary section of this document and in Appendix 1: Statement of Performance Expectations.

Investment and asset management

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

Shared service arrangements and ownership interests

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

Risk management

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

Quality assurance and improvement

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

South Canterbury DHB will continue our clinical leadership programme to improve the use of clinical process and outcomes information in targeted services. This will leverage our CCDM and High-Performance High-Engagement (HPHE) focus on data and improvement.

A strong focus for South Canterbury DHB will be on enhanced consumer engagement and participation. We will develop a health literacy plan and will implement the HQSC Consumer Engagement QSM in partnership with our consumer council.

4.2. Building Capability

Capital and infrastructure development

The South Canterbury DHB is undertaking a refurbishment programme which includes some new buildings, this programme covers emergency, outpatients, day stay services, hospital reception, Café and all Wards in the Timaru Hospital. The Ministry has provided $2m towards the refurbishment of the Child and Maternity Ward. The refurbishment programme will involve a number of projects over the next three years with a total cost of approximately $25m, which will be funded by the DHB.

As part of minimising our carbon footprint, the DHB will be replacing the current coal boilers to a more efficient energy source. The Ministry has provided $4m towards this replacement.

Co-operative developments

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

4.3 Workforce

Below is a short summary of our organisational culture, leadership and workforce development initiatives. Further detail about the South Island regional approach to workforce is contained in the 2020/21 South Island Regional Service Plan.

For 2020/21 we continue to support our two overarching goals; to build SCDHB as a learning organisation and to build our community of learning professionals. We recognize the unique opportunity to embed our Learning culture and innovation mindset arising from our response to COVID-19. We have embarked on a programme of work (dubbed project Phoenix) which aims to discover together opportunities that have arisen in response to COVID-19 and develop a Healthcare Innovation and Improvement Plan for South Canterbury that will guide our organizational development activities for the current year and beyond.

We began a cultural development programme in 2016, which continues today. In 2018, we increased our investment in leadership development (through Navigate/Whakatere – our leadership learning programme), in strengthened partnerships, (particularly with our unions and consumers) and in support for a safe culture for patients and staff.

In the coming year we will expand on our focus on equity and cultural sensitivity and competence to reinforce our organisational culture reset efforts. We will be supporting the Tumu Whakarai Position Statement to increase Māori participation in our workforce.

We will continue to invest in leadership and in addition to our current offerings to develop individual and team leadership capability, we will offer a "line managers essentials" workshop to improve sharing and consistency of management practice and introduce a new model for Navigate (our leadership learning programme) which will be specifically targeting Māori leaders across health and the wider social services. This programme will be co-designed by our Director of Māori Health and delivered in partnership with our Māori community. Our commitment to strong union engagement through our Joint Consultation Committee and Bi-Partite forums will continue with transferred learnings from our new 'partnership group' (set up to support COVID related developments) and ongoing work with High-Performance High-Engagement (HPHE) activities in partnership with New Zealand Nurses Organisation, the

Public Service Association and E tu.

Referenced in section two of our Annual Plan are the workforce activities that SCDHB will undertake to meet the workforce commitments.

- *Building a diverse and capable workforce*
  South Canterbury DHB will continue to build on some significant changes to our orientation programme and ongoing development options for front-line staff to develop and maintain cultural competence to ensure our workforce is prepared to deliver equity and value in terms of health outcomes for our community. Specifically, we will review our recruitment policy and process to align with the Tumu Whakarae Position Statement and continue to provide cultural context workshops for all staff. We will partner with Kia Ora Hauora to target local Māori youth into health careers in addition to maintaining our WISH programme (schools experience programme in health careers) in partnership with schools. We will also extend our cultural supervision opportunities for new staff who identify as Māori to improve cultural connectedness for this key part of our workforce, building on existing bi-monthly Māori Workforce Hui.

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

  South Canterbury DHB will continue to drive scenario and simulation activities (within community and primary settings and in both clinical and non-clinical areas) as a key learning methodology for interdisciplinary team work capability development.

- *Health Literacy*
  South Canterbury DHB will develop a health literacy plan in partnership with the Consumer Council. This will be inclusive of continuing to build skills in health literacy practice among the health workforce across the health system. There will be continued focus on the "Choosing Wisely" programme across the health system with an emphasis on pharmaceuticals in the 2020/21 year.

  To enhance equity, we will offer education on institutional racism for all front-line staff and continue to offer tools training in 'difficult conversations' for clinical staff as well as high level communications skills development through our leadership learning (Navigate) programme. We will continue to support the deteriorating patient programme through embedding Kōrero mai and implementing shared goals of care.

4.4 Information Technology

Developing a local Information Technology (IT) Strategy is one of the DHB's strategic priorities as outlined in its strategic direction document and will be developed to align to the New Zealand Digital Health Strategy. SCDHB will work to improve the digital capabilities within the organisation and continue to actively engage in the roll out of the South Island IT Alliance work programme. Further detail is contained in Te Waipounamu - South Island Health Services Plan 2018-2021. In addition, the DHB will look to capture and build on the learnings post COVID-19 and investigate the utilisation of telehealth solutions between South Canterbury and tertiary care providers in neighbouring DHBs. Referenced in section two of our Annual Plan are the data and digital activities that SCDHB will undertake to meet the IT commitments.

SECTION FIVE: Performance Measures

5.1 2020/21 Performance measures

Performance measure		Expectation		
CW01	Children caries free at 5 years of age	Year 1	68%	
		Year 2	68%	
CW02	Oral health: Mean DMFT score at school year 8	Year 1	<0.73	
		Year 2	<0.73	
CW03	Improving the number of children enrolled and accessing the Community Oral health service	Children (0-4) enrolled (≥ 95 percent of pre-school children (aged 0-4 years of age) will be enrolled in the COHS)	Year 1	≥95%
			Year 2	≥95%
		Children (0-12) not examined according to planned recall (≤ 10 percent of pre-school and primary school children enrolled with the COHS will be overdue for their scheduled examinations with the COHS.)	Year 1	≤10%
			Year 2	≤10%
CW04	Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	Year 1	>85%	
		Year 2	>85%	
CW05	Immunisation coverage at eight months of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	95% of eight-month-olds fully immunised.		
		95% of five-year-olds have completed all age-appropriate immunisations due between birth and five year of age.		
		75% of girls and boys fully immunised – HPV vaccine.		
		75% of 65+ year olds immunised – flu vaccine.		
CW06	Child Health (Breastfeeding)	70% of infants are exclusively or fully breastfed at three months.		
CW07	Newborn enrolment with General Practice	The DHB has reached the "Total population" target for children enrolled with a general practice by 6 weeks of age (55%) and by 3 months of age (85%) and has delivered all the actions and milestones identified for the period in its annual plan and has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group, for both targets.		
CW08	Increased immunisation at two years	95% of two-year olds have completed all age-appropriate immunisations due between birth and age two years,		
CW09	Better help for smokers to quit (maternity)	90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.		
CW10	Raising healthy kids	95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.		
CW12	Youth mental health initiatives	Initiative 1: Report on implementation of school-based health services (SBHS) in decile one to four (and decile five after January		

		2020) secondary schools, teen parent units and alternative education facilities and actions undertaken to implement *Youth Health Care in Secondary Schools: A framework for continuous quality improvement* in each school (or group of schools) with SBHS.	
		Initiative 3: Youth Primary Mental Health.	
		Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population.	
MH01	Improving the health status of people with severe mental illness through improved access	Age (0-19) Māori, other & total	5%
		Age (20-64) Māori, other & total	5%
		Age (65+) Māori, other &total	2%
MH02	Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan.	
		95% of audited files meet accepted good practice.	
MH03	Shorter waits for non-urgent mental health and addiction services	Mental health provider arm	80% of people seen within 3 weeks.
			95% of people seen within 8 weeks.
		Addictions (Provider Arm and NGO)	80% of people seen within 3 weeks.
			95% of people seen within 8 weeks.
MH04	Rising to the Challenge: The Mental Health and Addiction Service Development Plan	Provide reports as specified.	
MH05	Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.	
MH06	Output delivery against plan	Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.	
MH07 (tbc)	Improving the health status of people with severe mental illness through improved acute inpatient post discharge community care	(expectation to be confirmed)	
PV01	Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall.	

PV02	Improving cervical Screening coverage	80% coverage for all ethnic groups and overall.		
SS01	Faster cancer treatment – 31-day indicator	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.		
SS02	Ensuring delivery of Regional Service Plans	Provide reports as specified.		
SS03	Ensuring delivery of Service Coverage	Provide reports as specified.		
SS04	Delivery of actions to improve Wrap Around Services for Older People	Provide reports as specified.		
SS05	Ambulatory Sensitive Hospitalisations (ASH adult)	00-04:		≤ 4,195
		45-64:		3,331/100,000
SS06	Better help for smokers to quit in public hospitals (previous health target)	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.		Only applies to specified DHBs
SS07	Planned Care Measures	Planned Care Measure 1: *Planned Care Interventions*		TBC
		Planned Care Measure 2: *Elective Service Patient Flow Indicators*	ESPI 1	100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less)
			ESPI 2	0% – no patients are waiting over four months for FSA
			ESPI 3	0% - zero patients in Active Review with a priority score above the actual Treatment Threshold (aTT)
			ESPI 5	0% - zero patients are waiting over 120 days for treatment
			ESPI 8	100% - all patients were prioritised using an approved

				national or nationally recognised prioritisation tool
		Planned Care Measure 3: *Diagnostics waiting times*	Coronary Angiography	95% of patients with accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)
			Computed Tomography (CT)	95% of patients with accepted referrals for CT scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).
			Magnetic Resonance Imaging (MRI)	90% of patients with accepted referrals for MRI scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).
		Planned Care Measure 4: *Ophthalmology Follow-up Waiting Times*	No patient will wait more than or equal to 50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service.	
		Planned Care Measure 5: *Cardiac Urgency Waiting Times* (Only the Five Cardiac units are required to report for this measure)	All patients (both acute and elective) will receive their cardiac surgery within the urgency timeframe based on their clinical urgency.	
		Planned Care Measure 6: *Acute Readmissions*	The proportion of patients who were acutely re-admitted post discharge	Base level: 9.8%

			improves from base levels.	
		Planned Care Measure 7: Did Not Attend Rates (DNA) for First Specialist Assessment (FSA) by Ethnicity (Developmental)	Note: There will not be a Target Rate identified for this measure. It will be developmental for establishing baseline rates in the 2020/21 year.	
SS08	Planned care three year plan	Provide reports as specified.		
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (causing duplication)	>1.5% and <= 6%
			Recording of non-specific ethnicity in new NHI registration	>0.5% and < or equal to 2%
			Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% and < or equal to 2%
			Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and < or equal to 85%
			Invalid NHI data updates	Still to be confirmed
		Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC and NMDS for FSA and planned inpatient procedures.	Greater than or equal to 90% and less than95 %
			National Collections completeness	Greater than or equal to 94.5% and less than 97.5 %
			Assessment of data reported to the NMDS	Greater than or equal to 75%
		Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)		Provide reports as specified
SS10	Shorter stays in Emergency Departments	95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.		

SS11	Faster Cancer Treatment (62 days)	90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.	
SS12	Engagement and obligations as a Treaty partner	Reports provided and obligations met as specified.	
SS13	Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	Focus Area 1: Long term conditions	Report on actions, milestones and measures to: Support people with LTC to self-manage and build health literacy.
		Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care.*
			Count of enrolled people aged 15-74 in the PHO who have completed a DAR in the previous 12 months.
			Ascertainment: target 95-105% and no inequity HbA1c<64mmols: target 60% and no inequity No HbA1c result: target 7-8% and no inequity
		Focus Area 3: Cardiovascular health	Provide reports as specified
		Focus Area 4: Acute heart service	**Indicator 1: Door to cath** - Door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram**.**
			Indicator 2a: Registry completion- >95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and **Indicator 2b:** ≥ 99% within 3 months.
			Indicator 3: ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (i.e. have had an echocardiogram or LVgram).
			Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator in the absence of a documented contraindication/intolerance ≥85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge

			- Aspirin*, a 2nd anti-platelet agent*, and an statin (3 classes) - ACEI/ARB if any of the following – LVEF ,50%, DM, HT, in-hospital HF (Killip Class II to IV) (4 classes), - Beta-blocker if LVEF<40% (5-classes). * An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.
			Indicator 5: Device registry completion ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS-QI Device PPM forms completed within 2 months of the procedure.
			Indicator 6: Device registry completion- ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device PPM (Indicator 5A) and ICD (Indicator 5B) forms within 2 months of the procedure.
		Focus Area 5: Stroke services Provide confirmation report according to the template provided	**Indicator 1** ASU: 80% of acute stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital
			Indicator 2 Reperfusion Thrombolysis /Stroke Clot Retrieval 12% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile, (Service provision 24/7)
			Indicator 3: In-patient rehabilitation: 80% patients admitted with acute stroke are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission
			Indicator 4: Community rehabilitation: 60% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.
SS15	Improving waiting times for Colonoscopy	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less 100% within 30 days or less.	

		70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less.
		70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less.
		95% of people who returned a positive FIT have a first offered diagnostic date that is within 45 working days or less of their FIT result being recorded in the NBSP IT system.
SS17	Delivery of Whānau ora	Appropriate progress identified in all areas of the measure deliverable.
SS18	Financial outyear planning & savings plan	Provide reports as specified.
SS19	Workforce outyear planning	Provide reports as specified.
PH01	Delivery of actions to improve SLMs	Provide reports as specified.
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers	All PHOs in the region have implemented, trained staff and audited the quality of ethnicity data using EDAT within the past three-year period and the current results from Stage 3 EDAT show a level of match in ethnicity data of greater than 90 percent.
PH03	Access to Care (PHO Enrolments)	The DHB has an enrolled Māori population of 95 percent or above
PH04	Primary health care: Better help for smokers to quit (primary care)	90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months
Annual plan actions – status update reports		Provide reports as specified.

APPENDIX 1: Statement of Performance Expectations

APPENDIX 2: System Level Measures Improvement Plan