E 89

The South Canterbury District Health Board

Annual Plan 2016-17

Which incorporates

Statement of Intent 2016-2020

Statement of Performance Expectations 2016-2017

Enhancing the health and independence of the people of South Canterbury

www.scdhb.health.nz

Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

07 OCT 2016

Mr Murray Cleverley
Chairperson
South Canterbury District Health Board
Private Bag 911
Timaru 7940

murray@businessclass.org.nz

Dear Mr Cleverley

South Canterbury District Health Board 2016/17 Annual Plan

This letter is to advise you I have approved and signed South Canterbury District Health Board's (DHB's) 2016/17 Annual Plan for three years.

I wish to emphasise how important Annual Plans are to ensure appropriate accountability arrangements are in place. I appreciate the significant work that is involved in preparing your Annual Plan and thank you for your effort.

The Government is committed to improving the health of New Zealanders and continues to make significant investments in health services, including for electives initiatives. In Budget 2016 Vote Health received an additional $2.2 billion over four years, demonstrating the Government's on-going commitment to protecting and growing our public health services.

As you are aware, the refresh of the New Zealand Health Strategy is now complete and the Strategy provides DHBs and the wider sector with a clear strategic direction for delivery of health services to New Zealanders. I note that you have committed to the Health Strategy and its themes in your 2016/17 Annual Plan and I look forward to seeing your progress throughout the year. In order to ensure that the Strategy is informing DHB planning, and in order to ensure value and high performance throughout the health sector, I am considering changes to streamline annual plans in the future and you will be engaged in this process.

Living Within our Means

In order to assist the Government to remain in surplus in 2016/17, DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of DHBs' operation and service delivery. Additionally, improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6818 Facsimile 64 4 817 6518

I am pleased to see that your DHB is planning a surplus for 2016/17 and for the following three years. I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result for 2016/17.

National Health Targets

Your Annual Plan includes positive actions that will support health target performance for your population. However, as you know, I am concerned about the pace of improvement in relation to the *faster cancer treatment* health target and remind you that this needs to be a particular focus of your service delivery, as does the *improved access to elective surgery* health target given the additional investment made in this area.

As you are aware, the *raising healthy kids* health target was launched at the beginning of July 2016 and will see 95 percent of obese children identified in the B4 School Check programme offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions by December 2017. I am pleased to note that your Annual Plan shows a clear plan for achievement of the target and I look forward to hearing of the progress made in your district.

System Integration including Shifting Services

As you are aware, DHBs are expected to continue focussing on integrated healthcare and to shift services closer to home in 2016/17, in line with one of the core Health Strategy themes of providing services and care closer to home. The ability of DHBs to shift services is varied based on local need, context and scalability and can range from co-locating outpatient clinics in the community, through to redesign of services.

I understand that South Canterbury DHB has committed to review and then implement an improved Care Plus programme, develop a primary care strategy, and ensure all general practices meet the Foundation Standards. I look forward to being advised of your progress with this throughout the year. If this activity triggers the service change protocols you will need to follow the normal service change process.

Cross-government Initiatives and Collaboration

Delivery of Better Public Services continues to be a key focus for the Government. Of the ten whole-of-government key result areas, the health service is leading the following areas:

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

In addition to these areas, the health service has a significant role in supporting and contributing to other cross-agency work that will have significant impacts on health outcomes, such as Reducing Unintended Teenage Pregnancy (as a sub-focus of the Better Public Service Result One), Whānau Ora, the Children's Action Plan, Healthy Families New Zealand and Youth Mental Health.

I note that you have included a clear focus and appropriate actions to demonstrate that you are working as one team to deliver on these priorities within your 2016/17 Annual Plan.

Annual Plan Approval

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health. Please ensure that you advise the Ministry as early as possible of any proposals for service change

that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2016/17 Annual Plan. I look forward to seeing your achievements, in particular in relation to IT programmes, mental health and the New Zealand Health Strategy.

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

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

cc Mr Nigel Trainor
Chief Executive
South Canterbury District Health Board
Private Bag 911
Timaru 7940

ntrainor@scdhb.health.nz

Contents

CHAPTER 1: INTRODUCTION AND STRATEGIC INTENTIONS

1.1 Executive Summary

In our 2016/17 Annual Plan we continue to achieve fiscal sustainability, maintain high levels of access to services across the continuum of services and high quality standards. This is evidenced by consistent achievement through accreditation and certification processes, as well as maintaining low staff vacancy and turnover rates. We enjoy high confidence from our community and achievement in most of the indicators which DHBs are measured against including the national Health Targets. We are continuing to work actively locally, regionally and nationally to ensure that this performance is maintained and improved and to deliver clinically led integrated health and disability services for our population.

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

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

- Meeting the requirements of the refreshed Health Strategy and revised Health of Older People Strategy;
- Reducing inequalities in the delivery of health services;
- Maintaining and enhancing the level of access to health and disability services our community enjoys given population changes, the Population Based Funding Formula review and consequent changes to funding in 2016/17;
- Strengthening clinical leadership and accountability;
- Continuing to improve the quality and safety of the services we both fund and deliver;
- Delivering integrated health services to support seamless patient journeys;
- Supporting our health workforce and ensuring a sustainable workforce for the future;
- Industrial settlements during 2016/17;
- Achieving greater productivity and efficiency gains to enable reinvestment in the South Canterbury health system; and
- Ensuring our facilities are fit for purpose and support integrated models of care.

To ensure the DHB is well placed to meet these challenges the DHB's management structure is being reviewed to strengthen clinical leadership and accountability and ready the organisation to meet the Government health priorities as set out in the refreshed Health Strategy and Roadmap of Actions. The DHB's Health Service Plan is being revised and along with the South Island Regional Health Services Plan, the SCDHB Workforce Development Plan and the Facility Master Plan, will underpin the delivery of integrated health services in South Canterbury.

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

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

As requested SCDHB's Statement of Intent is updated for 2016-2020 and will outline how the DHB will manage its resources and prioritise activity over the next four years. This along with the DHB's Statement of Performance Expectations has been incorporated into this document.

1.2 DHB Scope of Operations

SCDHB is one of 20 District Health Boards (DHBs) established under the Health and Disability Act 2000 and is the Government's funder and provider of public health services for the 59,210 people who reside in the South Canterbury District.

SCDHB objectives are to improve, promote and protect the health, wellbeing and independence of our population and to ensure the delivery of effective and efficient health care for our population. Our mission statement is "Enhancing the health and independence of the people of South Canterbury" and to achieve this we work with our consumers, our communities, health and disability service providers and other agencies to ensure the quality, safety and coordination of health and disability services for our population.

1.3 Funding and Provision of Services

DHBs are allocated funding on a national Population Based Funding Formula and the recent review is implemented in the 2016/17 DHB funding envelopes. South Canterbury has a stable population (neither growing nor declining significantly) but slowly reducing as a national share of population. We have one of the highest of population over 65 years, which will continue to place unique pressures on us. South Canterbury will receive a 2.5% increase in funding in 2016/17 including transition funding of $2.14M. This is the lowest percentage increase allocated to DHBs which has resulted in the requirement to seek further efficiencies in our resource allocation to ensure we are able to plan and deliver against a fiscally sustainable plan.

SCDHB will work actively with NZ Health Partnerships to deliver efficiencies across a range of services and is committed to engaging in initiatives that contribute to this objective; however, this plan assumes that any initiative will deliver a net gain financially.

In 2016/17 we will earn $7.69M from other sources such as Accident Compensation Corporation, interest income, sale of goods and other commercial activities such as laundry and Talbot Park.

The DHB will engage with clinical leadership to plan and implement service development which reflects our strategic direction. We will monitor performance of all health services we fund for the people of South Canterbury including Secondary Services, Primary and Community Services, Non-Government organisations or other DHBs through inter district flows.

The DHB continues to face cost pressures from demand within Secondary Services and Primary and Community Services and also faces significant risk in Inter District Flows and in increased demand for Disability Support Services for older people (aged related residential care and home and community support services).

DHBs have been advised that Annual Plans should be prepared using the planning assumption that funding increases in outer years will be of the same nominal value as that contained in the 2016/17 funding envelope. While that assumption places significant pressure on the DHB to continue to live within its means, this Annual Plan has been prepared on that basis.

Primary and Community Services provide the Primary Health Organisation (PHO) function for the SCDHB as well as providing the DHB's community services. The DHB's Primary Care Alliance is now in place and providing the forum for the development of integrated health services and will enable further progress in integrating services into the community.

Secondary Services includes the services provided by Timaru Hospital and Talbot Park (an aged residential care hospital and psychogeriatric level facility for older people which the SCDHB has made the decision to close when alternative age related residential beds become available in South Canterbury). Timaru Hospital provides 24-hour 7-day-a-week, acute medical and surgical services, maternity, neo-natal and paediatric services, mental health services Assessment, Treatment and Rehabilitation (AT&R) services. It also provides a range of tertiary services through visiting clinicians and outreach services.

Services to be funded and provided by Primary and Community Services and Secondary Services in 2016/17 are set out in the DHB's Summary Production Plan which is Appendix 8.5 to this Annual Plan.

SCDHB is committed to maintaining the same range of services and level of access to services, and to ensuring continued emphasis on improving the quality and safety of these services, all the while balancing this against ensuring efficiency and productivity gains are maximised. We have no plans to exit or significantly alter any primary or secondary services and will work with South Island DHBs towards achieving equitable access to services across the South Island.

South Canterbury's Public Health Plan for 2016/17, has been developed by Public and Community Health (Canterbury DHB) in conjunction with South Canterbury DHB. South Canterbury DHB Prevention/Early Detection/Intervention Performance Targets for 2016-17 are attached as Appendix 8.6 to this Annual Plan. Joint planning with other health promotion providers in South Canterbury enables a whole of system approach to developing integrated models of care i.e. to include public health and health promotion in the development of all models of care and to ensure our investment in health promotion is coordinated and contributing to achieving improved outcomes for our population.

1.4 Purchasing of Services

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

1.5 Treaty of Waitangi

DHB's responsibilities to Māori
Through our Māori Consultation Framework which is used by our Iwi/Māori Health Relationship Partners and our organisation we will ensure Māori participation and partnership in health planning, service design, development and delivery, and in the protection of Māori wellbeing. Our Māori Health Plan for 2016/17 includes national and local Māori health priorities. We are committed to our statutory obligations to Māori under the NZ Public Health & Disability Act and we are advised by our Māori Health Advisory Committee.

Investment in Māori Services
As an agent of the Crown we are committed to the principles of the Treaty of Waitangi and we will continue to maintain our investment in Māori Provider services and in mainstream services provided for Māori in 2016/17.

1.6 Population Projections 2016/17

SCDHB's catchment is South Canterbury, bounded by the Rangitata and Waitaki Rivers in the north and south and the Southern Alps in the west. South Canterbury's population of 59,210 is 1.26% of the total New Zealand resident population. An estimated 21.7% of our resident population is aged 65 years or older. This is one of the highest percentage of over 65 years in any DHB.

It is estimated that 4,960 (8.4%) of our population are Māori, up from 6% in 2006. This is expected to continue to increase during 2016/17. Despite this, South Canterbury still has the lowest proportion of Māori of any DHB. Our Māori population are much younger than our total population. The Ngai Tahu Iwi through their Runaka at Arowhenua and Waihao are the mana whenua of South Canterbury. Approximately 40% of the local Māori population affiliate with Ngai Tahu. South Canterbury has also seen increased proportions of Pacific and Asian ethnicities.

The health status of South Cantabrians appears to be similar to or slightly better than that of New Zealanders in general. The health status of Māori in South Canterbury is better than New Zealand Māori, although their health status remains below that of non-Māori.

The average household income is relatively low in South Canterbury, as are poverty and household overcrowding rates. The New Zealand deprivation index 2013 shows that Māori in South Canterbury have higher levels of socioeconomic deprivation than non-Māori. Overall, the South Canterbury population is relatively less deprived than the total New Zealand population.

1.7 Setting Our Strategic Direction

Strategic context

New Zealand's health system is generally performing well against international benchmarks. However, an aging population and a growing burden of long-term conditions is driving increased demand for health services, while financial and workforce constraints limit capacity.

Alongside these health sector drivers, there is growing acknowledgement of the social determinants of health and conversely, the role good health plays in social outcomes. Health outcomes for our communities are interlinked with issues of education, employment, housing and justice, and services will increasingly be asked to take a broader view of wellbeing.

These pressures mean health services cannot continue to be provided in the same way. While hospitals continue to be a setting for highly specialised care, we need to move away from the traditional health model.

There are clear opportunities that are supporting evolution in our health sector through aspects such as shifts towards earlier intervention, investment in preventative care, home and community based care, and new technology and information systems. Further change towards integrating and better connecting services, not only across the health sector, but inter-sectorally, is needed to achieve better health outcomes within available resources.

1.8 National Direction

Acknowledging these challenges and opportunities, New Zealand's long term vision for health services is articulated through the New Zealand Health Strategy. The Strategy intends to support New Zealander's to 'live well, stay well, get well' and sets out five themes to give focus for change in health services:

- People powered: understanding people's needs and partnering with them to design services; empowering people to be more involved in their health and wellbeing; building health literacy and supporting people's navigation of the system;
- Closer to home: more integrated health services and better connections with wider public services; investment early in life; care closer to home; focus on wellness and prevention;
- Value and high performance: focus on outcomes, equity, people's experience, best-value use of resources; strong performance measurement; culture of improvement; transparent use of information to share learning; use of investment approaches to address health and social issues[1];
- One team: operating as a team in a high trust system; flexible use of the health and disability workforce; leadership and workforce development; strengthening the role of consumers/communities; linking with researchers; and
- Smart system: information reliable, accurate and available at point of care; data and systems that improve evidence-based decision making and clinical audit; standardised technology.

More specifically, health services are guided by a range of population or condition specific strategies, including 'He Korowai Oranga' (Māori Health Strategy), 'Ala Mo'ui (Pathways to Pacific Health and Wellbeing), Health of Older People Strategy (currently being updated), Primary Care Health Strategy, 'Rising to the Challenge' (Mental Health and Addiction Service Development Plan – to be updated in 2016), Palliative Care Strategy, Cancer Strategy and Diabetes Strategy.

[1] *In line with the Productivity Commission's report More Effective Social Services (2015), an investment approach takes into account the long-term impact of an initiative on government spending and quality of life when making funding decisions.*

In supporting people to 'live well, stay well, get well'[2], DHBs are expected to commit to Government priorities to provide better public services. In particular, 'better, sooner, more convenient health services', but the health sector also contributes to the achievement of other Government priorities, including a number of Better Public Service results areas, and the building of a more productive economy.

Alongside these longer-term commitments, the Minister of Health's annual Letter of Expectation signals annual priorities for the health sector. In 2016/17 the focus is on:

- New Zealand Health Strategy: DHBs need to be focused on the critical areas to drive change that are identified in the Strategy;
- Living within our means: DHBs must continue to consider where efficiency gains can be made and look to improvements through national, regional and sub-regional initiatives;
- Working across government: cross-agency work to support vulnerable families and improve outcomes for children and young people is a priority, along with health's contribution to Better Public Service results;
- National health targets: while health target performance has improved, this needs to remain a focus for DHBs, particularly the Faster Cancer Treatment target;
- Tackling obesity: DHBs are expected to deliver on the new health target to address childhood obesity and show leadership in working to reduce the incidence of obesity;
- Shifting and integrating services: DHBs need to continue to work with primary care to move services closer to home and achieve better co-ordinated health and social services; and
- Health information systems: DHBs need to complete current national and regional IT investments and DHB, PHO and primary care input is sought into the co-design process of the Health IT Programme 2015-2020.

1.9 Regional Direction

In delivering its commitment to better public services and better, sooner, more convenient health services the Government also has clear expectations of increased integration and regional collaboration between health service providers (and other social service agencies).

The Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern DHBs form the South Island Alliance - together providing services for slightly over one million people, or 24 percent of the New Zealand population.

While each DHB is individually responsible for the provision of services to its own population, we recognise that working regionally enables us to better address our shared challenges. The South Island Alliance improves the systems within which, health services are provided by the individual South Island DHBs. Now entering its sixth year, the Alliance has proven to be a successful model for the South Island, bringing clinicians, managers, CEOs, primary care, aged residential care and consumers together to work towards a shared vision of *best for people, best for system.* The model has become embedded in the culture of the South Island health system with regional and sub-regional activity 'business as usual'.

The Alliance outcomes framework defines what success looks like for South Island health services, and outcome measures will be implemented this year to track if we are heading in the right direction. The *South Island Health Services Plan* outlines the agreed regional activity to be implemented through our seven priority service areas: Cancer, Child Health, Health of Older People, Mental Health and Addiction, Information Services, Support Services, and Quality and Safety Service Level Alliances. In addition to this, regional work streams will focus on: cardiac services, elective surgery, palliative care, public health, stroke, major trauma services and hepatitis C. Workforce planning, through the South Island Workforce Development Hub and regional asset planning, will contribute to improved delivery in all service areas.

All South Island DHBs are involved in the service level alliances and work streams. Each DHB's commitment in terms of the regional direction is outlined in their Annual Plan. Activity planned and prioritised in the coming

[2] *In the Ministry of Health's Statement of Intent this is articulated as: New Zealanders live longer, healthier, more independent lives and the health system is cost-effective and supports a productive economy.*

year is in line with the direction of the draft New Zealand Health Strategy and the priorities expressed by the Minister of Health.

1.10 Local Direction

Local health services must sustainably cope with the increasing demand for services and design pathways to manage the flow of people. Each DHB has local alliances through which they partner with primary care and other local stakeholders to drive local health service integration. These local alliances support health services to deliver care in the most appropriate setting and reduce demand by supporting people to remain independent.

While many of the challenges are similar, each DHB must address the particular needs of their community given the demographics, infrastructure and geographic features that make up its district. We support working towards alignment and collaboration where possible, but recognise there needs to be flexibility to enable local solutions for local communities.

Local Priorities

SCDHB's key priorities are:

- Promotion of healthy lifestyle choices in our local population and targeted prevention (including childhood obesity);
- Identification and early interventions for "at risk" populations;
- Management of Long Term Conditions which focuses on self-management strategies;
- Integration of our primary and secondary services to support seamless patient flow;
- Clinically and financially sustainable primary and secondary services;
- Development of child and youth services;
- Coordinated services for older people and embedding of Health of Older Persons Project changes;
- Strengthening clinical leadership and accountability;
- Meeting national Health Targets and Service Level Outcome Measures;
- Engaging with the Ministry on the work programme of the former National Health Committee once the programme is finalised;
- Maintaining and enhancing the quality and safety of health services;
- Development of a sustainable local workforce;
- Design and development of facilities which meet building compliance standards and supports delivery of services; and
- Implementation of an IT infrastructure which supports clinical practice.

During 2016/17 the SCDHB will continue to build on progress made to date on a number of initiatives to support and facilitate the ongoing development of integrated models of care. These include the continued development of ambulatory care to further facilitate integration between primary and secondary care. The SCDHB will also continue to implement regional IT projects in accordance with the South Island Alliance IT Plan.

Primary and Community Services is an integral part of the health service development in South Canterbury and participates strongly in the governance, management and delivery of health services. A key focus for 2016/17 will be developing and strengthening our Primary Care Alliance and the implementation of the new System Level Outcome Measures Framework.

In 2016/17 we will continue to focus on child and youth health, long term conditions, and coordinated services for older people. This includes embedding changes from the Centre of Excellence for Health of Older Persons Services project implemented over the 2014 to 2016 period. The development of integrated service models for child and youth services also continues across primary and secondary health services working with all other agencies providing health, community support and social services for children and youth and their families. The Integrated Child and Youth Alliance established in 2014/15 have identified a number of priorities and continues work to address these supported by cross agency collaboration.

Progress continues on facility redesign and development of the Front of Hospital Project.

The SCDHB has made the decision to close Talbot Park, its age related residential care facility. This will occur when adequate hospital and hospital dementia beds become available in South Canterbury.

The SCDHB Clinical Board, which provides primary and secondary governance, leads the DHB's development of clinical governance and quality and safety improvement for the DHB. Quality and safety improvement initiatives are being pursued at a local level and we continue to actively participate in the South Island Quality and Safety Service Level Alliance.

1.11 Signatories

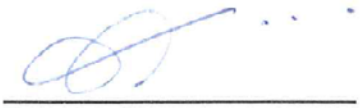
1.11 Signatories

AGREEMENT DATED THIS 07 **DAY OF** October **2016**

(Made under section 38 of the New Zealand Public Health and Disability Act 2000, Section 149C of the Crown Entities Act 2004 as amended by the Crown Entities Amendment Act 2013 and Section 139 of the CE Act).

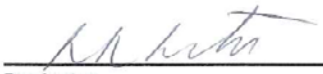
BETWEEN

Honourable Jonathan Coleman
Minister of Health



Murray Cleverley
Chairman of the Board

Nigel Trainor
Chief Executive Officer



Ron Luxton
Deputy Chairman of the Board

8

South Canterbury District Health Board Annual Plan 2016/17

1.12 Measuring Our Progress

How will we know if we are making a difference?

DHBs are expected to deliver against the national health system outcomes: 'All New Zealanders lead longer, healthier and more independent lives' and 'The health system is cost effective and supports a productive economy' and to their objectives under the New Zealand Public Health and Disability Act to 'improve, promote and protect the health of people and communities'.

As part of this accountability, DHBs need to demonstrate whether they are succeeding in achieving these goals and improving the health and wellbeing of their populations. There is no single indicator that can demonstrate the impact of the work DHBs do. Instead, we have chosen a mix of population health and service performance indicators that we believe are important to our stakeholders and that together, provide an insight into how well the health system and the DHB is performing.

In developing our strategic framework, the South Island DHBs identified three shared high-level outcome goals where collectively we can influence change and deliver on the expectations of Government, our communities and our patients, by making a positive change in the health of our populations.

Alongside these outcome goals are a number of associated outcome indicators, which will demonstrate success over time. These are long-term indicators and, as such, the aim is for a measurable change in health status over time, rather than a fixed target.

Outcome Goal 1: People are healthier and take greater responsibility for their own health

- ✓ A reduction in smoking rates
- ✓ A reduction in obesity rates

Outcome Goal 2: People stay well, in their own homes and communities

- ✓ A reduction in the rate of acute admissions to hospital
- ✓ An increase in the proportion of people living in their own homes

Outcome Goal 3: People with complex illnesses have improved health outcomes

- ✓ A reduction in the rate of acute readmissions to hospital
- ✓ A reduction in rate of avoidable mortality

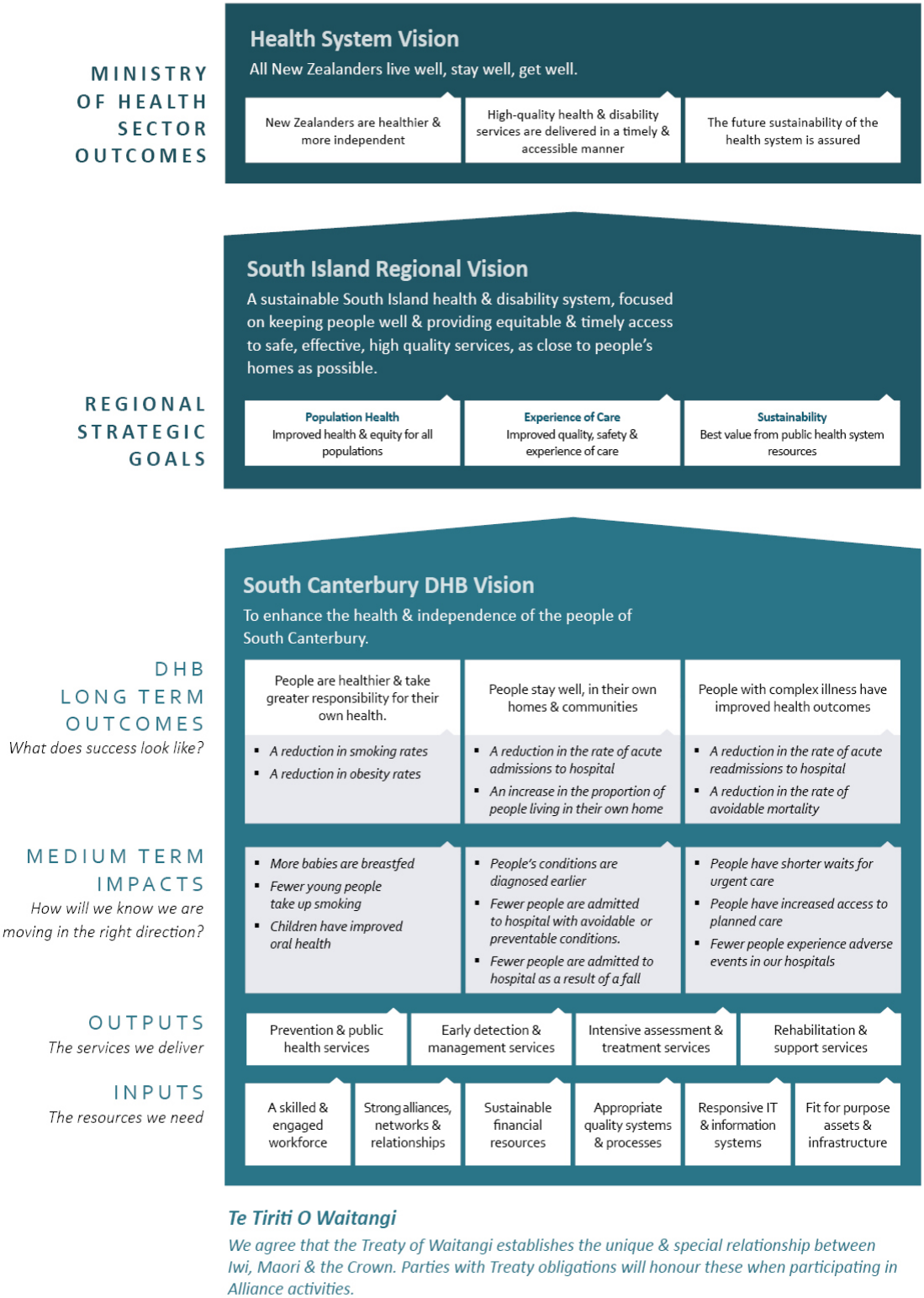
The South Island DHBs have also identified a core set of associated medium-term indicators. As change will be evident over a shorter period of time, these indicators have been identified as the headline or main measures of performance. Each DHB has set local targets in order to evaluate their performance over the next four years and determine whether they are moving in the right direction. These impact indicators will sit alongside each DHB's Statement of Performance Expectations and be reported against in the DHB's Annual Report at the end of every year.

The outcome and impact indicators were specifically chosen from existing data sources and reporting frameworks. This approach enables regular monitoring and comparison, without placing additional reporting burden on the DHBs or other providers.

As part of their obligations DHBs must also work towards achieving equity and to promote this, the targets for each of the impact indicators are the same across all ethnic groups.

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

Overarching intervention logic



Te Tiriti O Waitangi

We agree that the Treaty of Waitangi establishes the unique & special relationship between Iwi, Maori & the Crown. Parties with Treaty obligations will honour these when participating in Alliance activities.

STRATEGIC OUTCOME GOAL 1.

People are healthier and take greater responsibility for their own health

Why is this outcome a priority?

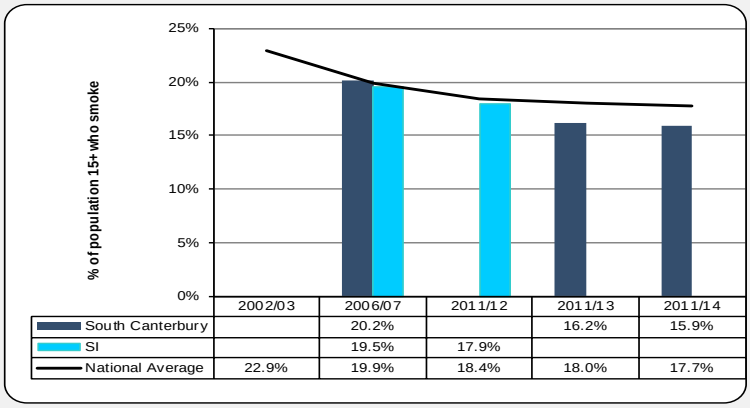
New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major causes of poor health and account for a significant number of presentations in primary care and hospital and specialist services. The likelihood of developing long-term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

Tobacco smoking, inactivity, poor nutrition and rising obesity rates are major contributors to a number of the most prevalent long-term conditions. These are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing. Public health and prevention services that support people to make healthy choices will help to decrease future demand for care and treatment and improve the quality of life and health status of our population.

Overarching Outcome Indicators

SMOKING

Percentage of the population (15+) who smoke



	2002/03	2006/07	2011/12	2011/13	2011/14
South Canterbury		20.2%		16.2%	15.9%
SI		19.5%	17.9%		
National Average	22.9%	19.9%	18.4%	18.0%	17.7%

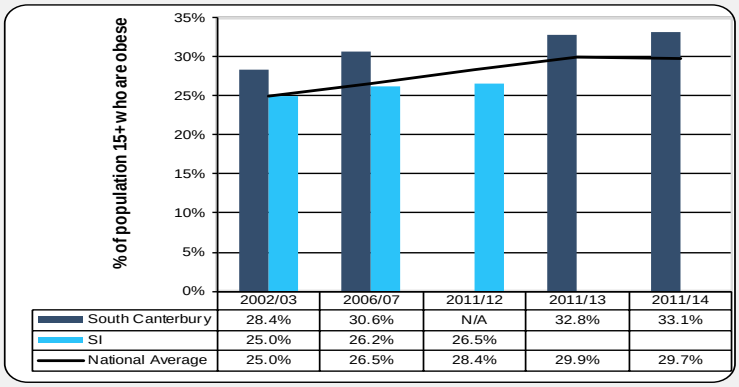
Tobacco smoking kills an estimated 5,000 people in NZ every year. Smoking is also a major contributor to preventable illness and long-term conditions, such as cancer, respiratory disease, heart disease and stroke and a risk factor for six of the eight leading causes of death worldwide. In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, meaning less money for necessities such as nutrition, education and health.

Supporting people to say 'no' to smoking is our foremost opportunity to not only improve overall health outcomes, but also to reduce inequalities in the health of our population.

Data Source: National Health Survey[3]

OBESITY

Percentage of the population (15+) who are obese



	2002/03	2006/07	2011/12	2011/13	2011/14
South Canterbury	28.4%	30.6%	N/A	32.8%	33.1%
SI	25.0%	26.2%	26.5%		
National Average	25.0%	26.5%	28.4%	29.9%	29.7%

There has been a rise in obesity rates in New Zealand in recent decades.
This has significant implications for rates of cardiovascular and respiratory disease, diabetes and some cancers, as well as poor psychosocial outcomes and reduced life expectancy.

Supporting our population to achieve healthier body weights through improved nutrition and physical activity levels is fundamental to improving their health and wellbeing and to preventing and better managing long-term conditions and disability at all ages.

Data Source: National Health Survey[4]

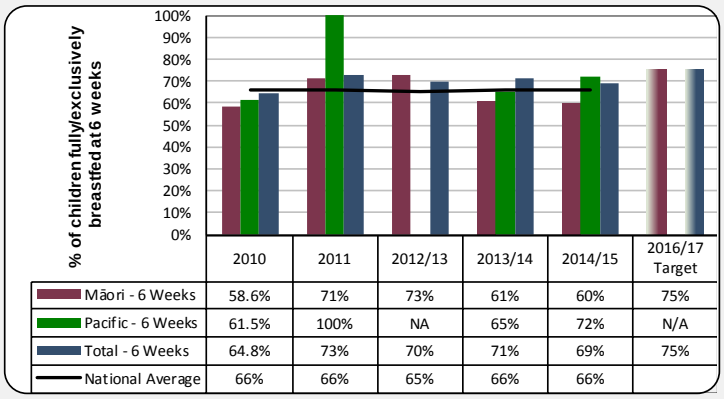
[3] *The NZ Health Survey was completed by the Ministry of Health in 2002/03, 2006/07, 2011/12 and 2011/13 and 2011/14. However, the 2011/12, 2012/13 and 2013/14 surveys were combined in order to provide results for smaller DHBs – hence the different time periods presented. Results are unavailable by ethnicity. The 2013 Census results (while not directly comparable) indicate rates for Māori, while improving, are twice that of the total population.*

[4] *The NZ Health Survey defines 'Obese' as having a Body Mass Index (BMI) of >30 or >32 for Māori and Pacific people.*

Intermediate Impact Indicators – Main Measures of Performance

BREASTFEEDING

Percentage of 6-week-old babies exclusively or fully breastfed



	2010	2011	2012/13	2013/14	2014/15	2016/17 Target
Māori - 6 Weeks	58.6%	71%	73%	61%	60%	75%
Pacific - 6 Weeks	61.5%	100%	NA	65%	72%	N/A
Total - 6 Weeks	64.8%	73%	70%	71%	69%	75%
National Average	66%	66%	65%	66%	66%	

2016/17	2017/18	2018/19	2019/20
Target 75%	75%	75%	75%

Breastfeeding helps lay the foundations for a healthy life, contributing positively to infant health and wellbeing and potentially reducing the likelihood of obesity later in life.

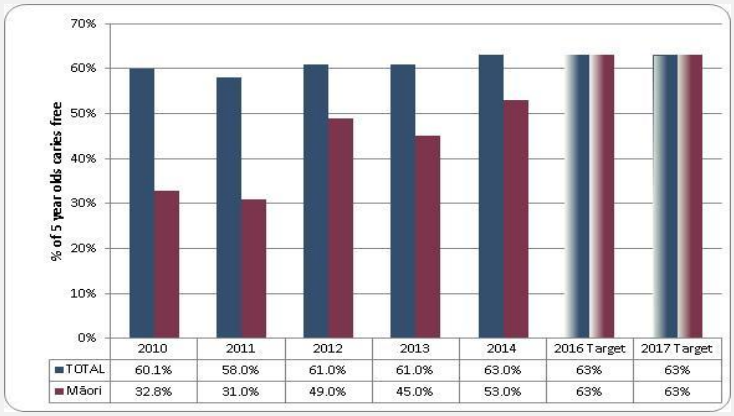
Breastfeeding also contributes to the wider wellbeing of mothers and bonding between mother and baby.

An increase in breastfeeding rates is seen as a proxy indictor of the success of health promotion and engagement activity, appropriate access to support services and a change in both social and environmental factors influencing behaviour and supporting healthier lifestyle choices.

Data Source: Ministry of Health

ORAL HEALTH

Percentage of 5-year-olds carries free (no holes or fillings)



	2010	2011	2012	2013	2014	2016 Target	2017 Target
TOTAL	60.1%	58.0%	61.0%	61.0%	63.0%	63%	63%
Māori	32.8%	31.0%	49.0%	45.0%	53.0%	63%	63%

	2018	2019	2020
Target	63%	63%	63%

Oral health is an integral component of lifelong health and impacts a person's self-esteem and quality of life.

Good oral health not only reduces unnecessary hospital admissions, but also signals a reduction in a number of risk factors, such as poor diet, which then has lasting benefits in terms of improved nutrition and health outcomes.

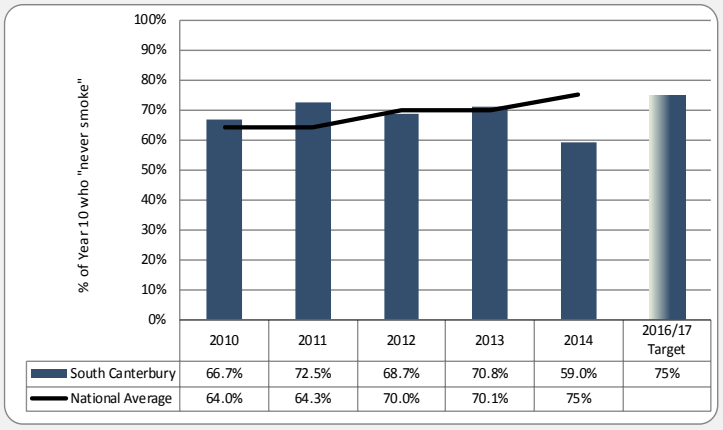
Māori and Pacific children are more likely to have decayed, missing or filled teeth. As such, improved oral health is also a proxy indicator of equity of access and the effectiveness of services in targeting those most at risk.

The target for this measure has been set to maintain the total population rate while placing particular emphasis on improving the rates for Māori and Pacific children.

Data Source: Ministry of Health Oral Health Team

SMOKING

Percentage of year-10-students who have 'never smoked'



	2010	2011	2012	2013	2014	2016/17 Target
South Canterbury	66.7%	72.5%	68.7%	70.8%	59.0%	75%
National Average	64.0%	64.3%	70.0%	70.1%	75%	

2016/17	2017/18	2018/19	22019/20
Target 75%	75%	75%	75%

Most smokers begin smoking before 15 years of age, with the highest prevalence of smoking amongst younger people. Reducing smoking prevalence across the total population is therefore largely dependent on preventing young people from taking up smoking.

A reduction in the uptake of smoking by young people is seen as a proxy indicator of the success of health promotion and engagement activity and a change in the social and environmental factors that influence risk behaviours and support healthier lifestyles.

Because Māori and Pacific have higher smoking rates, reducing the uptake amongst Māori and Pacific youth provides significant opportunities to improve long-term health outcomes for these populations.

Data Source: National Year 10 ASH Snapshot Survey

STRATEGIC OUTCOME GOAL 2.

People stay well in their own homes and communities

Why is this outcome a priority?

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

General practice can deliver services sooner and closer to home and through early detection, diagnosis and treatment, deliver improved health outcomes. The general practice team is also vital as a point of continuity, particularly in terms of improving the management of care for people with long-term conditions and reducing the likelihood of acute exacerbations of those conditions resulting in complications of injury and illness.

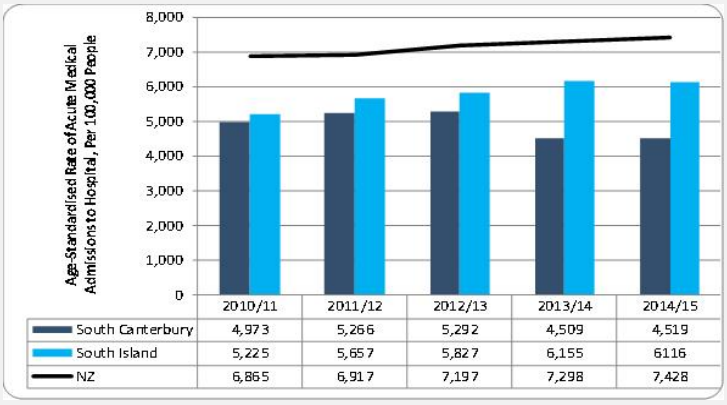
Health services also play an important role in supporting people to regain their functionality after illness and to remain healthy and independent. Supporting general practice are a range of other health professionals including midwives, community nurses, social workers, allied and personal health providers and pharmacists. These providers also have prevention, early intervention and restorative perspectives and link people with other social services that can further support them to stay well and out of hospital.

Even where returning to full health is not possible, access to responsive, needs-based pain management and palliative services (closer to home and families) can help to improve the quality of people's lives.

Overarching Outcome Indicators

ACUTE HOSPTIAL ADMISSIONS

Rate of acute (urgent) medical admissions to hospital (age standardised, per 100,000)



	2010/11	2011/12	2012/13	2013/14	2014/15
South Canterbury	4,973	5,266	5,292	4,509	4,519
South Island	5,225	5,657	5,827	6,155	6116
NZ	6,865	6,917	7,197	7,298	7,428

Long-term conditions (cardiovascular and respiratory disease, diabetes and mental illness) have a significant impact on the quality of a person's life.

However, with the right approach, people can live healthier lives and avoid the deterioration of their condition that leads to acute illness, hospital admission, complications and death.

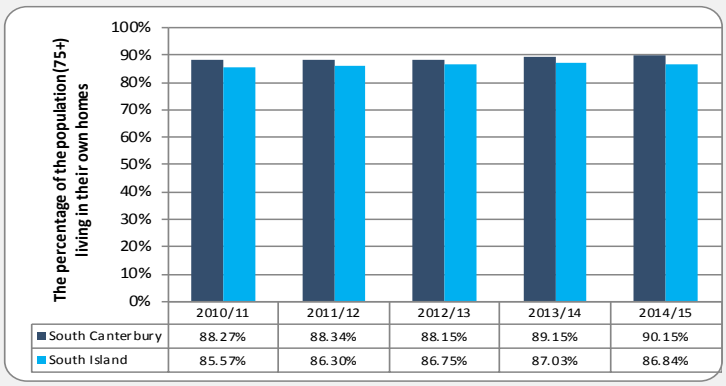
Lower acute admission rates can be used as a proxy indicator of improved conditions management. They can also be used to indicate the accessibility of timely and effective care and treatment in the community.

Reducing acute admissions also has a positive effect by enabling more efficient use of specialist resources that would otherwise be taken up by reacting to demand for urgent care.

Data Source: National Minimum Data Set

PEOPLE LIVING AT HOME

Percentage of the population (75+) living in their own home



	2010/11	2011/12	2012/13	2013/14	2014/15
South Canterbury	88.27%	88.34%	88.15%	89.15%	90.15%
South Island	85.57%	86.30%	86.75%	87.03%	86.84%

While living in Aged Related Residential Care (ARRC) is appropriate for a small proportion of our population, studies have shown a higher level of satisfaction and better long-term outcomes where people remain in their own homes and are positively connected to their communities.

Living in ARRC is also a more expensive option, and resources could be better spent providing appropriate levels of home-based support to help people stay well in their own homes.

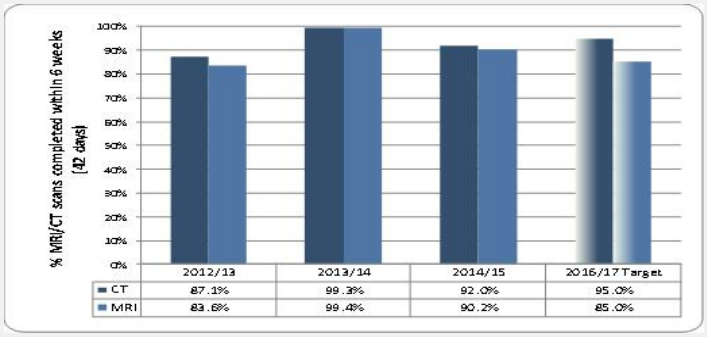
An increase in the proportion of older people supported in their own homes can be used as a proxy indicator of how well the health system is managing age-related and long-term conditions and responding to the needs of our older population.

Data Source: SIAPO Client Claims Payment System

Intermediate Impact Indicators – Main Measures of Performance

EARLIER DIAGNOSIS

Percentage of people waiting no more than six weeks for their CT or MRI Scan



	2016/17	2017/18	2018/19	2019/20
CT Target	95%	95%	95%	95%
MRI Target	85%	85%	85%	85%

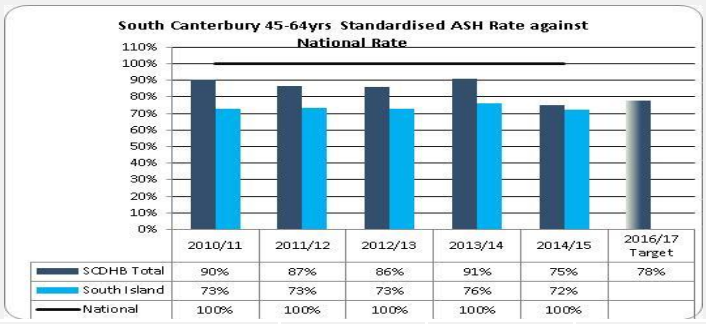
Diagnostics are an important part of the healthcare system and timely access, by improving clinical decision making, enables early and appropriate intervention, improving quality of care and outcomes for our population.

Timely access to diagnostics can be seen as a proxy indicator of system effectiveness where effective use of resources is needed to minimise wait times while meeting increasing demand.

Data Source: Individual DHB Patient Management Systems

AVOIDABLE HOSPTIAL ADMISSIONS

Ratio of actual vs. expected avoidable hospital admissions for the population aged under 75 (per 100,000)



2016/17	2017/18	2018/19	2019/20
78%	78%	78%	78%

Given the increasing prevalence of chronic conditions effective primary care provision is central to ensuring the long-term sustainability of our health system.

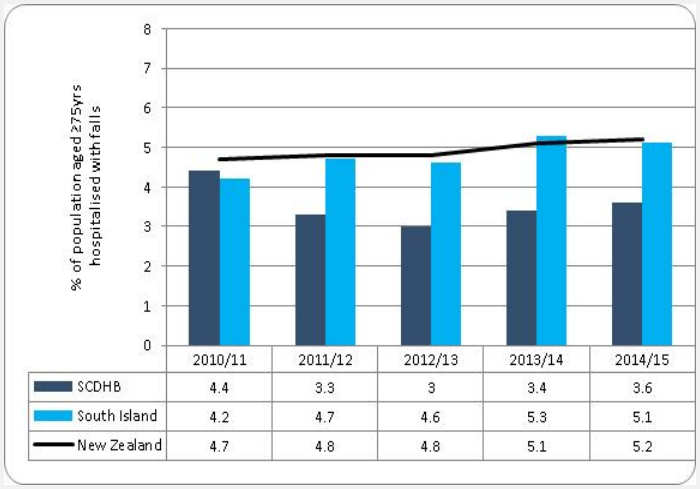
Keeping people well and supported to better manage their long-term conditions by providing appropriate and coordinated primary care, should result in fewer hospital admissions - not only improving health outcomes for our population but also reducing unnecessary pressure on our hospital services.

Lower avoidable admission rates are therefore seen as a proxy indicator of the accessibility and quality of primary care services and mark a more integrated health system.

Data Source: Ministry of Health Performance Reporting SI1[5]

FALLS PREVENTION

Percentage of the population (75+) admitted to hospital as a result of a fall



Approximately 22,000 New Zealanders (aged over 75) are hospitalised annually as a result of injury due to falls. Compared to people who do not fall, these people experience prolonged hospital stay, loss of confidence and independence, and an increased risk of institutional care.

With an ageing population, a focus on reducing falls will help people to stay well and independent and will reduce the demand on acute and aged residential care services.

Solutions to reducing falls span both the health and social service sectors and include appropriate medications use, improved physical activity and nutrition, appropriate support and a reduction in personal and environmental hazards.

Lower falls rates can therefore be seen as a proxy indicator of the responsiveness of the whole of the health system to the needs of our older population as well as a measure of the quality of the individual services being provided.

Data Source: National Minimum Data Set

[5] *This indicator is based on the national performance indicator SI1 and covers hospitalisations for 26 conditions which are considered preventable including: asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. The target is set to maintain performance below the national rate, which reflects less people presenting. There is currently a definition issue with regards to the use of self-identified vs. prioritised ethnicity and while this has no impact on total population result it has significant implications for Māori and Pacific breakdowns against this measure. The DHB continues to communicate with the Ministry around resolving this issue.*

STRATEGIC OUTCOME GOAL 3.

People with complex illness have improved health outcomes

Why is this outcome a priority?

For people who do need a higher level of intervention, timely access to quality specialist care and treatment is crucial in supporting recovery or slowing the progression of illness. This leads to improved health outcomes with restored functionality and a better quality of life.

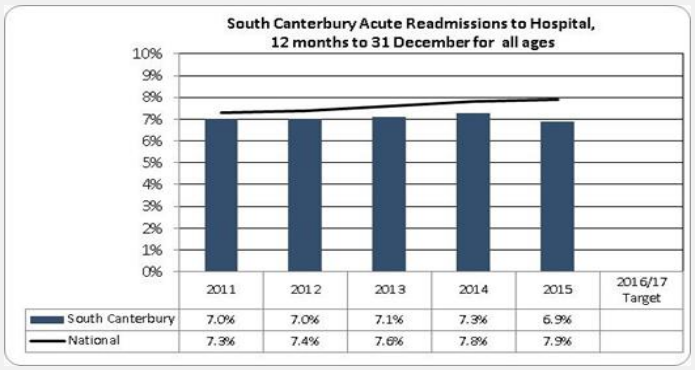
As providers of hospital and specialist services, DHBs are operating under growing demand and workforce pressures. At the same time, Government is concerned that patients wait too long for specialist assessments, cancer treatment and elective surgery. Shorter waiting lists and wait times are seen as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

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

Overarching Outcome Indicators

ACUTE READMISSIONS

Standardised rate of acute readmissions to hospital within 28 days of discharge



2016/17	2017/18	2018/19	2019/20
Target			

Unplanned hospital readmissions are largely (though not always) related to the care provided to the patient.

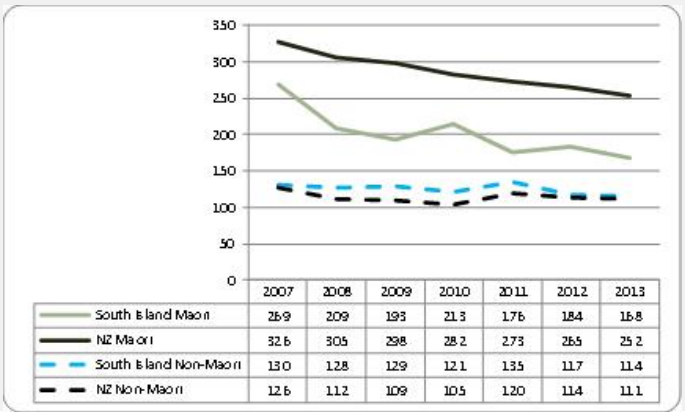
As well as reducing public confidence and driving unnecessary costs - patients are more likely to experience negative longer-term outcomes and a loss of confidence in the system.

Because the key factors in reducing acute readmissions include safety and quality processes, effective treatment and appropriate support on discharge – they are a useful maker of the quality of care being provided and the level of integration between services.

Data Source: Ministry of Health Performance Data OS8[6]

AVOIDABLE MORTALITY

Rate of all-cause mortality for people aged under 65 (age standardised, per 100,000)



Timely and effective diagnosis and treatment are crucial factors in improving survival rates for complex illnesses such as cancer and cardiovascular disease. Early detection increases treatment options and the chances of survival.

Premature mortality (death before age 65) is largely preventable through lifestyle change, intervention and safe and effective treatment. By detecting people at risk and improving the treatment and management of their condition, the serious impacts and complications of a number of complex illnesses can be reduced.

A reduction in avoidable mortality rates can be used as a proxy indicator of responsive specialist care and improved access to treatment for people with complex illness.

Data Source: National Mortality Collection - 2010 Update.[7]

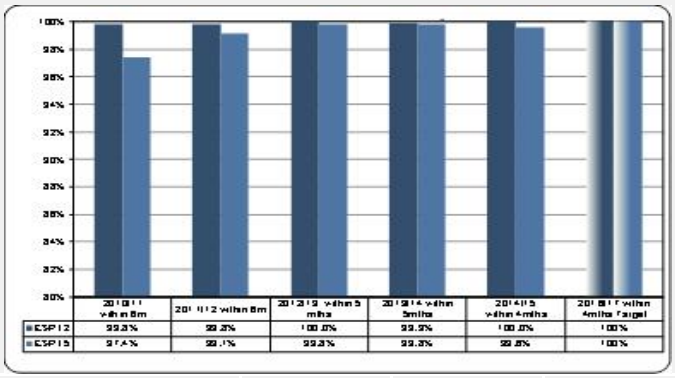
[6] *This indicator is based on the national performance indicator OS8.*

[7] *National Mortality Collection data is released four years in arrears and the data presented was released in 2014.*

Intermediate Impact Indicators – Main Measures of Performance

WAITS FOR URGENT CARE

Percentage of people presenting at ED who are admitted, discharged or transferred within six hours



	2016/17	2017/18	2018/19	2019/20
Target	95%	95%	95%	95%

Emergency Departments (EDs) are important components of our health system and a barometer of the health of the hospital and the wider system.

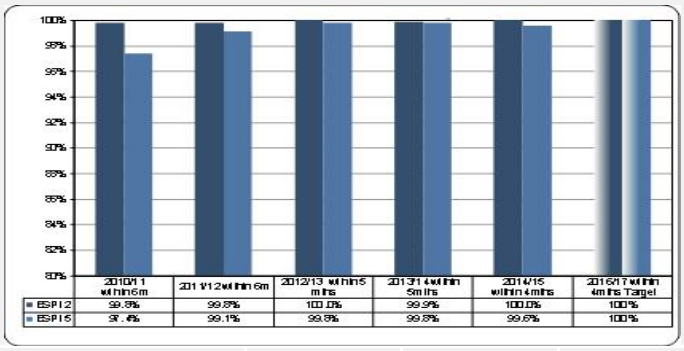
Long waits in ED are linked to overcrowding, longer hospital stays and negative outcomes for patients. Enhanced performance will not only improve patient outcomes by providing early intervention and treatment but will improve public confidence and trust in health services.

Solutions to reducing ED wait times span not only the hospital but the whole health system. In this sense, this indicator is a marker of how responsive the whole system is to the urgent care needs of the population.

Data Source: Individual DHB Patient Management Systems[8]

ACCESS TO PLANNED CARE

Percentage of people receiving their specialist assessment (ESPI 2) or agreed treatment (ESPI 5) in under four months



	2016/17	2017/18	2018/19	2019/20
Target	100%	100%	100%	100%

Planned services (including specialist assessment and elective surgery) are an important part of the healthcare system and improve people's quality of life by reducing pain or discomfort and improving independence and wellbeing.

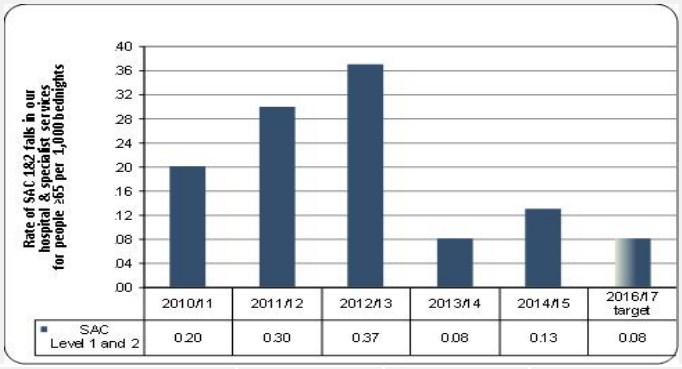
Timely access to assessment and treatment is considered a measure of health system effectiveness and improves health outcomes by slowing the progression of disease and maximising people's functional capacity.

Improved performance against this measure requires effective use of resources so wait times are minimised, while a year-on-year increase in volumes is delivered. In this sense, this indicator is a marker of how responsive the system is to the needs of the population.

Data Source: Ministry of Health Quickplace Data Warehouse[9]

ADVERSE EVENTS

Rate of SAC Level 1 & 2 falls in hospital (per 1,000 inpatient bed-days)



	2016/17	2017/18	2018/19	2019/20
Target	0.08	0.08	0.08	0.08

Adverse events in hospital, as well as causing avoidable harm to patients, reduces public confidence and drives unnecessary costs. Fewer adverse events provide an indication of the quality of services and systems, and improve outcomes for patients in our services.

The rate of falls is particularly important, as patients are more likely to have a prolonged hospital stay, loss of confidence, conditioning and independence, and an increased risk of institutional care.

Achievement against this measure is also seen as a proxy indicator of the engagement of staff and clinical leaders in improving processes and championing quality.

Data Source: Individual DHB Quality Systems[10]

---

[8] *This indicator is based on the national DHB Health Target 'Shorter Stays in ED' introduced in 2009 – in line with the health target reporting the annual results presented are those from the final quarter of the year.*

[9] *The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance and DHB are provided with individual performance reports from the Ministry of Health on a monthly basis. In line with the ESPIs target reporting the annual results presented are those from the final quarter of the year.*

[10] *The Severity Assessment Code (SAC) is a numerical score given to an incident based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with both the highest consequence and likelihood.*

CHAPTER 2: DELIVERING ON PRIORITIES AND TARGETS

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

When planning investment and activity within the health system, DHBs must consider the role they play in the achievement of the vision and goals of Government – reflected in the annual Minister's Letter of Expectations attached as appendix 8.1.

In setting expectations for 2016/17, Government has been clear that the public health system must continue to deliver *'better, sooner, more convenient'* health care and lift health outcomes for patients within constrained funding increases.

This chapter of the Annual Plan describes the actions that SCDHB is taking to effectively and efficiently deliver health services to its local population.

The South Island Alliance Health Services Plan (SIHSP) is a framework for the collaborative activities of the South Island Alliance, comprising the five South Island District Health Boards. The SIHSP draws from national strategies and key priorities and is interwoven into each of our South Island DHB Annual Plans. This Alliance approach helps to use resources to maximum effect across a large physical area, to address the challenges we face in the South Island.

This section of the Plan should be read in conjunction with the South Island Regional Services Health Plan 2016-19. SCDHB remains committed to actively participating in service level alliance and work stream activity and 'line of sight' is evident in our plan through local activity reflecting regional priorities and intent.

2.1 Health Targets

South Canterbury DHB's commitment to deliver against the six national Health Targets

	**Shorter Stays in Emergency Departments** 95 percent of patients will be admitted, discharged, or transferred from an emergency department within six hours.
	**Improved Access to Elective Surgery** The volume of elective surgery will be increased by an average of 4000 discharges per year. ***South Canterbury District Health Board's contribution*** 3,175 elective surgical discharges will be delivered in 2016/17.
	**Faster Cancer Treatment** 85 percent 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.
	**Increased Immunisation** 95 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.
	**Better Help for Smokers to Quit** 90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months. 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.
	***Childhood Obesity*** ***Government expectation*** By December 2017 95 percent 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.

The DHB will support national Health Promotion Agency activities around the Health Targets.

2.2 New Zealand Health Strategy

New Zealand's long term vision for health services is articulated through the New Zealand Health Strategy. The revised Strategy will provide the sector with a clear strategic direction and road map for the delivery of more integrated health services to New Zealanders into the future supporting them to 'live well, stay well, get well'. It sets out five themes to give focus for change in health services:

- People powered;
- Closer to home;
- Value and high performance;
- One team, and
- Smart system.

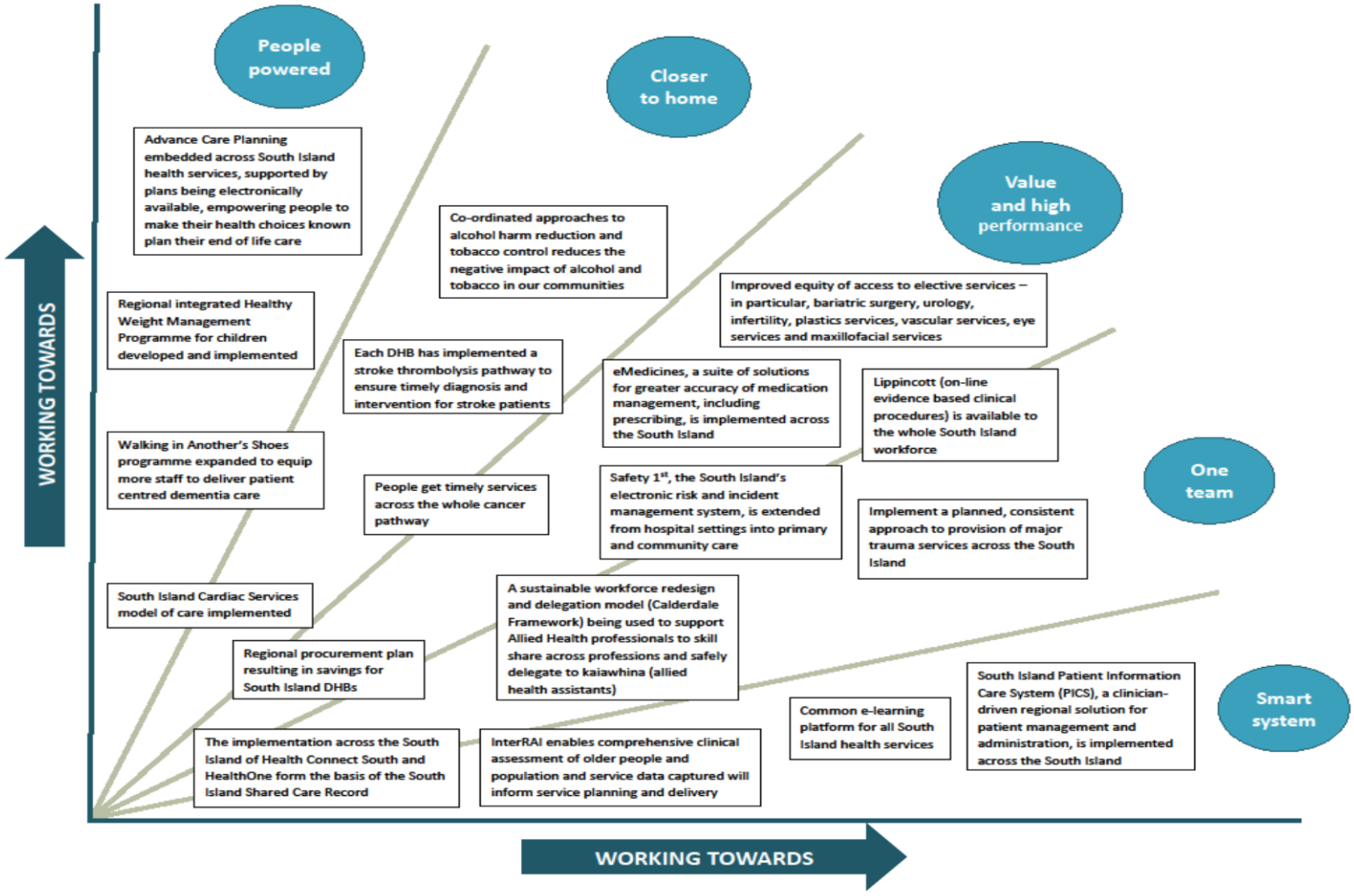
SCDHB is committed to the implementation of this Strategy locally and in delivering appropriate actions in line with the strategy roadmap. As such, on completion of the DHB's management re-structure the Board and staff will develop a vision for the SCDHB which not only reflects the New Zealand Health Strategy's vision statement but also outlines what each of the five themes means in our local community, what the DHB aspires to provide in each of these areas, and a strategic direction which will take us towards realising our vision.

The following existing planning priorities for 2016/17 are also a focus in the Strategy themes and the Roadmap of Actions. Further detail relating to planned actions to progress these priorities can be found under the relevant service headings in this document and have been referenced as per the following table.

Strategy Planning Priority	Page Ref.
• Obesity	32
• Long-term Conditions	30
• Service Configuration including Shifting Services	45
• Information Technology	60

Similar to the draft Health Strategy's Roadmap of Actions, the following diagram indicates how a small selection of the South Island Alliance's activities support the themes identified in the draft New Zealand Health Strategy. SCDHB will continue to be an active member of these Alliance activities.

Figure


People powered
Closer to home
Value and high performance
One team
Smart system
WORKING TOWARDS
WORKING TOWARDS
Advance Care Planning embedded across South Island health services, supported by plans being electronically available, empowering people to make their health choices known plan their end of life care
Co-ordinated approaches to alcohol harm reduction and tobacco control reduces the negative impact of alcohol and tobacco in our communities
Improved equity of access to elective services – in particular, bariatric surgery, urology, infertility, plastics services, vascular services, eye services and maxillofacial services
Regional integrated Healthy Weight Management Programme for children developed and implemented
Each DHB has implemented a stroke thrombolysis pathway to ensure timely diagnosis and intervention for stroke patients
eMedicines, a suite of solutions for greater accuracy of medication management, including prescribing, is implemented across the South Island
Lippincott (on-line evidence based clinical procedures) is available to the whole South Island workforce
Walking in Another's Shoes programme expanded to equip more staff to deliver patient centred dementia care
People get timely services across the whole cancer pathway
Safety 1st, the South Island's electronic risk and incident management system, is extended from hospital settings into primary and community care
Implement a planned, consistent approach to provision of major trauma services across the South Island
South Island Cardiac Services model of care implemented
A sustainable workforce redesign and delegation model (Calderdale Framework) being used to support Allied Health professionals to skill share across professions and safely delegate to kaiawhina (allied health assistants)
Regional procurement plan resulting in savings for South Island DHBs
South Island Patient Information Care System (PICS), a clinician-driven regional solution for patient management and administration, is implemented across the South Island
Common e-learning platform for all South Island health services
The implementation across the South Island of Health Connect South and HealthOne form the basis of the South Island Shared Care Record
InterRAI enables comprehensive clinical assessment of older people and population and service data captured will inform service planning and delivery

2.3 Maternal, Child and Youth Health

There is an important link between healthy social and emotional development during childhood and later health and wellbeing in adult life including the individual's learning outcomes and adulthood achievements. To have healthy adults we need to have healthy children.

The SCDHB Child and Youth Health Alliance with its cross agency approach continues to provide leadership in the development and provision of services and programmes which meet the health and wellbeing needs of children and youth across the full continuum of care through the life course, from before birth to transition to adulthood. This includes the Maternity Safety and Quality Programme, the Well Child/Tamariki Ora Project Plan, and the Family Violence Intervention Programme.

The Alliance's vision is the provision of innovative "Child, Youth and Family/Whānau centred models of healthcare, which are integrated, holistic, supportive and responsive to wellbeing with seamless interagency collaboration across South Canterbury services". The Alliance work streams continue to make satisfactory progress against selected priorities. This includes information sharing which has assisted in cementing our collaborative approach and has included improved access to electronic information for clinicians and others working with children and youth, as well as ensuring endorsed health information is available to the public through the Aoraki HealthInfo site. Alliance meetings routinely include presentations of available services and programmes increasing partner's knowledge of what is available across the sectors and how to access this. The aim during 2016/17 is to introduce a generic electronic referral form potentially utilising the Electronic Referral Management System for use in referring to Non-Government Organisations (NGOs).

The community nursing outreach service is now established. This has strengthened the interface between primary, community and secondary paediatrics services with the community paediatric nurse attending weekly paediatric unit clinical review meetings to discuss patient progress and receive and triage new referrals. Being part of this wider group also supports interdisciplinary community care planning through a process of physical and psychosocial health assessment. The focus during 2016/17 will move to promoting this community service to referrers. The group involved in addressing the needs of vulnerable children have agreed to focus on the 0-3 age group and how to effectively wrap support services around these children and their families.

The DHB remains actively involved in the South Island Alliance for Child Health and will continue to use the New Zealand Child and Youth Epidemiology Service annual reports to monitor the health status of its local child and youth population. SCDHB is not currently involved in any Social Sector Trials.

2.3.1 Maternity Quality and Safety Programme

Current context snapshot

The aim of the SCDHB Maternity Quality and Safety Programme (MQSP) is the collaborative review, monitoring and improvement of the SCDHB maternity services by professional and community stakeholders, to ensure the highest possible safety and best possible outcomes for women and babies living in South Canterbury. The Ministry of Health and the National Maternity Monitoring Group (NMMG) assessment of the SCDHB Maternity Quality and Safety Programme stage of development as at 30/06/2015 was that SCDHB best fits the criteria of 'Established' programme.

The Maternity Service Quality and Safety Steering Group remains active with an annual report produced outlining achievement against the Maternity Service Quality and Safety Plan. The key focus over the last year has been to increase the breadth of consumer input and feedback to include 'high needs' and rural cohorts by expanding the consumer feedback options for women including the introduction of visiting rural and urban 'listening posts'. These will continue into 2016/17 and new work will commence to improve the information provided about maternity services on the SCDHB website. This will enhance consumer engagement by providing the ability for consumers to feedback on their experiences.

The DHB will support the Health Promotion Agency through alcohol screening, brief intervention and the provision of routine and consistent advice to women of child bearing age about alcohol and pregnancy.

Women in South Canterbury do tend to register with a Lead Maternity Carer (LMC). The latest result available to the DHB (2013) shows that 98.1% of women registered with a LMC by the end of trimester two and the DHB is committed to maintaining achievement against the 95% target for women registering during their pregnancy. Where a woman does present in labour and South Canterbury is not her DHB of domicile then immediate care is provided and registration with a LMC facilitated.

The DHB delivers a pregnancy and parenting programme with one on one pregnancy/parenting education provided to women identified as 'high needs' or where numbers justified, for cohorts such as teen mums.
Work began in 2015/16 to ensure that women with gestational diabetes were diagnosed and management was provided based on evidence based guidance. The national guidelines for the management of gestational diabetes are reflected in the DHB clinical protocol and work will continue into 2016/17 to make sure that processes are in place to fully support this by establishing a model of care for the management of gestational diabetes involving primary care providers, LMCs and secondary care specialists.

Work also began in 2015/16 on the development of maternal mental health pathways with an integrated working group established. This work will continue into 2016/17.

The DHB maintains a Breast Feeding Plan which is refreshed annually. Continued promotion of current initiatives such as peer counsellors and 'The Big Latch On' event assists the DHB to achieve increased breast feeding rates and progress towards our target of 65% of babies being fed breast milk at six months of age (our result for 2014/2015 was 63.1%).

During 2015/16 the DHB initiated a review of its current Maternity Model of Care to ensure compliance against Section 88 of the Public Health and Disability Act and this work will continue into 2016/17. The DHB's maternity service also implemented the Maternity Clinical Information System (BadgerNET).

The DHB remains committed to achieving the target of having 98% of new-borns enrolled with general practice, Well Child/Tamariki Ora and community oral health services within three months. Compliance to this target is expected to improve once a national electronic referral document is available via BadgerNET.

Local focus for 2016/17

In addition to the operational requirements of the Maternity Quality and Safety Programme each DHB must identify, plan for and deliver three to five maternity quality and safety improvement projects over the term of the contract. The following areas have been chosen in consultation with community stakeholders and been approved by the MQSP Steering Group:

- Maternal Mental health pathways;
- Diabetes in pregnancy; and
- Consumer engagement.

The DHB will also complete implementation of its revised Maternity Services Model of Care during 2016/17.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Provide an integrated approach to the care of pregnant women with mental illness throughout their pregnancy and post-natal period.	Create and implement women-centred integrated maternal mental health pathways.	Pathways are implemented and survey of practitioners shows awareness and utilisation of these by June 2017. Audit shows that pregnant women are screened at least twice; once each in the ante and post-natal periods by June 2017.
Manage those women with gestational diabetes in line with the 2014 Clinical Practice Guideline - Screening, Diagnosis and Management of Gestational Diabetes.	Establish a pathway that reflects collaborative work processes and information flow between practitioners with women at the centre.	Pathway developed by September 2016. Audit of the pathway for adoption into routine practice by health practitioners completed by June 2017.
	Develop clear information to	Information strategy developed by

Action Plan 2016/17		
Objective	**Action**	**Evidence**
	inform women on gestational diabetes screening, diagnosis, management and follow up.	June 2017.
Continue to engage with our community including the consumer's valued opinions in how we shape our service going forward.	Progress the development of a maternal health section on the SCDHB website.	Monitoring and usage of the website data shows increasing use by June 2017.
Comply with Section 88 of the Public Health and Disability Act.	Implement a revised DHB Maternity Services Model of Care.	Revised Model of Care in place by December 2016.

2.3.2 Increased Immunisation

Current context snapshot

The SCDHB Immunisation Steering Group remains in-place and it is intended to revamp this group's terms of reference to align their role with the DHB's direction and to revitalise existing immunisation programmes such as the HPV programme to reflect agreed outcomes from the Ministry of Health Workshop held in 2014. Participation in regional and national forums will also be supported. As in previous years the DHB participates in the Immunisation Week campaign with profiling occurring across a variety of community settings utilising local community personalities. The associated Communication Plan includes the use of promotional materials such as posters along with media messaging with a focus during 2016/17 of expanding this to social media to raise public awareness especially in relation to the benefits of HPV vaccinations. A report will be submitted to the Ministry of Health early 2017 as required.

A new-born enrolment form (which includes the triple enrolment requirements) is in place and parents receive information on provider enrolments which will occur in line with completion of this form. The DHB also continues to work with primary care partners to monitor and increase new born enrolment rates to general practice, Well Child/Tamariki (WCTO) Ora and child oral health services to achieve the target set out in the Indicators for the Well Child/Tamariki Ora Quality Improvement Framework. The immunisation coordinator liaises closely with our WCTO providers, Plunket and AWS, facilitating access to parenting groups. Close contact is also maintained with practice nurses in general practice to increase coverage and an outreach service is also in place for hard to reach families. Vulnerable babies and young children are protected from whooping cough through effective cocooning with the established vaccination programme for Boostrix continuing to be funded and promoted.

Immunisation status is screened on presentation to hospital and if not current the parent/carer is advised to return to their General Practitioner (GP) when their chid is well to have this administered. This includes presentations to the emergency department and during day surgery pre-admission as part of history taking, on admission to the paediatric ward and as part of the patient assessment in outpatients. Work will continue into 2016/17 with the Immunisation Steering Group working with hospital services to support those children transferring into our district who are not registered with a general practice. The immunisation outreach service continues to improve coverage rates.

The 2015/16 Q2 result showed that 92.1 percent of eight month olds had received their primary course of immunisation on time and 93.5 percent of two year olds are fully immunised. There is regular public health nursing contact with play groups and subsequent liaison with the immunisation coordinator. This has been especially important in rural areas especially in view of their higher transient populations associated with local industry. Another recent enabler has been establishing a close linkage with the local migrant coordinator who is filling a key role in relaying information to our migrant communities.

Immunisation status against the four-year-old milestone is checked at the B4 School Check with the end of 2015/16 Q2 result for 2015/16 sitting at 90 percent.

A school based programme for HPV immunisation was commenced in 2013 by the Public Health Nursing service. It continues to support the rate of coverage for this vaccine whereby all three doses are provided to young women 12 - 18 in the district. South Canterbury continues to experience a high decline rate for this school based vaccination programme. In an effort to increase HPV vaccination coverage, the DHB continues to focus on raising awareness with both young women and their parents of the benefits of engaging in the HPV vaccination programme. This currently occurs through school based clinics and health education. Recent initiatives have included distributing HealthInfo cards with key words to assist web based information access. The DHB also facilitated a parents evening at a local primary school to improve parental knowledge of the HPV vaccine with the aim to improve informed consent and ultimately increased immunisation update.

Influenza and Pneumovax vaccination programmes continue for identified eligible populations with general practices utilising established recall systems to support timely vaccinations.

Local focus for 2016/17

The Immunisation Steering Group's focus will work on reviewing and revitalising their existing vaccination programmes with a specific focus on initiating appropriate vaccinations during pregnancy. South Canterbury's high decline rate for HPV vaccination will be specifically targeted in an attempt to reduce this decline rate to a more acceptable level as well as collaborating with hospital services to support those children and their families transferring into the community to engage with general practice to ensure immunisations are administered as per the immunisation schedule.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Ensure an effective infrastructure for the delivery of immunisation programmes to the community of South Canterbury.	Review the SCDHB Immunisation Steering Group's Terms of Reference to ensure they include the full scope of immunisation programmes and associated national targets including eight months, 24 months, four years and HPV.	SCDHB Immunisation Steering Group Terms of Reference reviewed by September 2016.
Reduce the rate of declines for immunisation programmes.	Empower the Immunisation Steering Group to develop and implement a Communication Plan for the promotion of immunisation programmes.	Childhood schedule immunisation targets for eight months, two years, five year and HPV met by June 2017.
Increase the uptake of immunisation during pregnancy.	Develop information strategies to promote immunisation programmes such as Boostrix / Flu during the ante-natal phase of pregnancy as part of the Immunisation Week focus.	All prescribers are prescribing Boostrix with 540 doses administered in 2016/17.
	Broaden settings for opportunistic vaccinations during pregnancy.	Vaccination of pregnant women during pregnancy reviewed by Immunisation Steering Group by June 2017 and additional staff trained if indicated.
Comply with target expectations for eight months, two years and five year immunisations and three doses of HPV vaccinations.	Complete implementation of the Immunisation Recovery Plan developed in 2016.	Childhood schedule immunisation targets for eight months, two years, five year and HPV are met by June 2017.
Link all children with relevant health services at first point of first contact with a focus on new	Instigate entry to all required services for all families on first contact utilising the support of	An increase in South Canterbury domicile children who are enrolled with a GP by June 2017.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
comers to South Canterbury.	the local Migrant Coordinator where relevant.	
Strengthen links with the Ministry of Education to help increase HPV immunisation rates.	Collaborate with the Ministry of Education and the Principals Association to establish a shared plan for HPV screening and education for the 2017 school year.	Shared plan agreed by September 2016.

2.3.3 Well Child /Tamariki Ora Quality Improvement Framework Project Plan

Current context snapshot

SCDHB has participated in the development of the South Island-wide Te Wai Pounamu South Island Well Child/ Tamariki Ora Quality Improvement coordination process including development of the shared Quality Improvement Framework Project Plan. The South Island DHBs and South Island Alliance have agreed that they will work together regionally and this plan highlights the quality activity associated with the WCTO quality improvement framework that will occur across the South Island region. Implementation of the plan will require a collaborative effort across the South Island with a strengths based approach encompassing every child, parent, family and whānau with cross sector collaboration and interagency involvement an integral facet to this quality improvement framework to promote integrative and consistent service provision.

The DHB continues to perform well in its coverage of the B4 School Check programme for both total and 'high needs' populations and will maintain this level of achievement.

Local focus for 2016/17

Each DHB is required to create an implementation plan that will highlight the quality indicators that their DHB have identified as a priority to address. These plans will be reviewed annually to ensure regional priorities are aligned to local strategic direction and to enable key stakeholders have been consulted and feedback incorporated. SCDHB has selected the following three indicators:

- Children are enrolled with oral health services;
- Mothers are smokefree at two weeks post-natal;
- Infants receive all WCTO core contacts in their first year; and
- Improve the timeliness of referrals and handover process between the LMC and WCTO.

In addition, the DHB will complete the Action Plan for WCTO services commenced in 2016/17.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Improve child oral health enrolment rates.	Embed the local multi-enrolment process for those families moving into South Canterbury.	95% of children are enrolled with child oral health services by June 2017.
Improve maternal smokefree rates at two weeks postpartum.	Refer to Smoking Cessation section of this plan.	95% of mothers are smokefree at two weeks post-natal by June 2017.
Ensure all infants receive their core contacts in their first year.	Work with local provider to identify those children not receiving their core contacts and the barriers to this occurring.	95% of infants receive all WCTO core contacts in their first year by June 2017.
Improve the timeliness of referrals and handover process between the LMC and WCTO.	Complete the WCTO services Action Plan through a district wide advisory group to oversee and	98% of families/whānau are referred to a WCTO provider by their LMC.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Increasing WCTO enrolment and reducing the differences between population groups in the South Canterbury region.	facilitate the improved integration, coverage and coordination of WCTO services in the South Canterbury area.	All action points closed out by June 2017.

2.3.4 Supporting Vulnerable Children

Current context snapshot

The Children's Action Plan provides the framework to achieve the fundamental changes contained in the White Paper for Vulnerable Children. The SCDHB has actively engaged in the implementation of the refreshed Children's Action Plan 2015 however has not yet been scheduled to establish a Children's Team.

The SCDHB Family Violence Intervention Programme (FVIP) Steering Group remains active. A Memorandum of Understanding (MOU) with Police and Child Youth and Family Service, including schedules 1 & 2, is in place and the MOU Governance Group meet quarterly. The last FVIP self-assessment score for child abuse and neglect was 93 and the DHB will work to sustain this result which comfortably meets the revised target of 80/100. FVIP core and refresher training is in place, as is a screening audit programme and schedule. This core training has been extended beyond mandatory areas. The DHB monitors and reports both hospitalisation and deaths from assault, neglect or maltreatment of children aged 0 – 14 years.

The Child Protection Advisory Group meets regularly to review reports of concern. A number of programmes including the Shaken Baby Prevention Programme and the Vulnerable Pregnant Women's Programme continue.

Gateway assessments are in place. CYFS funding is available for referral for mild to moderate mental health conditions for children and youth with referral occurring to the appropriate local NGO. The MoH has been unable to secure a local provider for managing behavioural problems so those identified as needing this intervention are referred out of district.

The National Child Alert System has been implemented and will be maintained. Work continues on expanding access to e-Prosafe, the regional web-based application for child protection and family violence.

The DHB is committed to meeting the requirements of the Vulnerable Children's Act. The DHB Child Protection Policy and associated processes, such as procedures for the identification and reporting of child abuse and neglect, have been reviewed to ensure that it meets all the requirements of the Vulnerable Children's Bill including updating provider contracts to include the requirement to have a Child Protection Policy.

SCDHB supports the development and implementation of plans and procedures by the 20 DHBs for recruiting workers in the children's workforce regarding safety checking. The DHB has implemented safety checking of all new core workers since 1 July 2015 with this process scheduled for use with non-core children's workers from 1 July 2016. The DHB ensures that safety checking information is available for provision to the Director General of Health (s39) to meet the requirements in the Vulnerable Children's legislation.

Local focus for 2016/17

The DHB will continue to monitor national progress on this initiative including the development of a new Vulnerable Children's Plan for 2016 as required by the Vulnerable Children's Act 2014. On implementation of a Children's Team the DHB will actively support the Vulnerable Children's Hub and the Vulnerable Kids Information System (ViKI). Once available it will also develop a plan to ensure all relevant staff meet the children's workforce core competencies. Monitoring of staff completing the Shaken Baby Programme training will be introduced. In addition to all new employees in our core children's workforce being screened in accordance with the requirements of the Vulnerable Children's Act, the checking of the existing core children's workforce will be phased in over the next three years.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Comply with statutory regulations regarding safety vetting of new and existing core workers.	Provide training to line managers regarding responsibilities. Complete planning regarding existing core worker vetting.	Training completed and all new core and existing workers vetted in accordance with regulations.
Reduce the incidence of 'Shaken Baby' syndrome in our community.	Deliver training to relevant staff within the Maternal, Child and Youth Health Services on the Shaken Baby Syndrome	Staff training register in place with regular monitoring by December 2016.

2.3.5 Reducing Rheumatic Fever

Current context snapshot

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

South Canterbury has not had a reported case of rheumatic fever in over 10 years. The SCDHB will notify any cases to Medical Officer of Health, Community and Public Health within seven days of hospital admission and will deliver on actions specified in the South Island Rheumatic Fever Prevention Plan.

Local focus for 2016/17

Should a new case of rheumatic fever be identified in the district, a case review will occur and the Ministry provided with a quarterly report on actions taken and lessons learned. Also note action under Primary Care.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Ensure that patients with a history of rheumatic fever receive appropriate follow up monitoring and treatment.	Develop an Aoraki HealthPathway and provide education to guide general practice in the management of those patients with a history of rheumatic fever transferring into the district and presenting in primary care.	Patients with a history of rheumatic fever receive monthly antibiotics not more than five days after their due date. Annual audit of rheumatic fever secondary prophylaxis coverage reported to the Ministry in Q4 2016/17.

2.3.6 Prime Minister's Youth Mental Health Project

Current context snapshot

The health sector's response to the Prime Minister's Youth Mental Health Project is to improve services for young people who seek help for mild to moderate illness. There is a focus on making primary health care more youth friendly, improving wait times and follow up care, improving referral pathways within the youth mental health system, and providing education programmes to tackle teenagers' drug and alcohol misuse. The DHB remains an active member of the district's Youth Sector Network and participated in the partnership approach to the development of an Action Plan in response to the Investing in Youth surveys and hui.

When developing youth services, it is crucial that services not only deliver positive outcomes but also positive relationships with health providers. These two key aspects ultimately lead to a change of behaviour, encouraging youth to seek healthcare in a timelier manner which will carry on through to adulthood.

The DHB continues to provide or fund a number of services for youth including a free community youth clinic, free sexual health for those under 25 years and youth health clinics in seven secondary schools and five alternative education settings. Home, Education and employment, Eating, Activities with peers, Drugs, Sexual activity, Suicide and Depression, Safety (HEEADSSS) assessments are available in the community youth clinic and alternative education setting.

South Canterbury does not have any decile one, two or three secondary schools, however chooses to provide health clinics in nine of ten secondary schools. The DHB is funded for and provides school based nursing services in all five alternative education settings including the Teen Parent Unit. The number of alternative education sites has reduced from the previous year as a number have amalgamated. The Youth Health Care in Secondary Schools Framework assessment has been completed in all alternate education settings and the Plan, Do, Study, Act (PDSA) cycle continues to be employed to guide service improvement activity in these areas.

A tracking system of youth engaged in alternative education has been established to track youth as they transfer between settings. There has also been increased liaison with the Gateway assessment coordinator which has facilitated information sharing and reduced duplication in HEEADSSS assessments. This has further been enhanced through shared access to this database to assist youth health nurses in supporting youth to re-engage with their general practitioner.

Work continues with primary care to improve the coordination of referrals from the HEEADSSS assessment, continuing to link young people back to their general practice or assisting them to enrol with a general practice.

Youth continue to experience good access rates and waiting times for mental health and addiction services. Local youth have access on referral to a mental health brief intervention service, the Adventure Development Programme, and youth alcohol and drug addiction services. The Strengths Recovery Model of Care is employed within SCDHB mental health and addiction services and Relapse Prevention Plans are in place as indicated. Follow-up in primary care on discharge is supported by ensuring that youth are engaged with a GP and the provision of a follow-up care plan supporting youth in the community on discharge, transitioning them to independence.

The local Māori health provider, Arowhenua Whānau Services also provides mental health and addiction services for youth which are culturally competent and meet the needs of local Māori. No further initiatives are planned in this area.

The DHB also holds a contract with the YMCA to deliver the Non-Participating Youth Programme. The aim of this programme is to provide physical activity opportunities and develop a health conscience with the 'at risk' youth in South Canterbury and to link these young people to further sporting opportunities in the community.

Local focus for 2016/17

The main focus for the DHB is continued local intersectoral collaboration with the local Youth Sector Forum and in partnership implementing the Youth Sector Network Action Plan. This plan aims to equip youth with life skills and to increase their resiliency to cope with life's stresses. It covers the following six foci

- Increasing parental awareness of the issues impacting on youth in South Canterbury;
- Improving youth friendliness of services accessed by youth in South Canterbury;
- Engaging youth to participate in volunteering as a way to enrich life's experience;
- Relaying youth relevant information and promoting activities to improve youth wellbeing in a way that is receptive by youth in South Canterbury;
- Providing opportunities for those working with youth to network and share information and advice on issues; and
- Supporting the voice of youth in local government activity.

The DHB will also continue to work with local alternate education providers to progress scheduled access to youth clinics at each site and to promote the availability of all local youth health services to avoid dependency on the public health nurse working in these facilities.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Provide access to nurse health clinics for those youth engaged in alternative education.	Complete the establishment of scheduled youth clinics within each of the alternative education providers.	Scheduled clinics with allocated appointments are in place in all alternative education settings by December 2016.
Expand youth engaged in alternative education settings awareness of the options for accessing health advice and services in the community.	Develop and implement a Youth Health Communication Plan.	Communication Plan fully implemented by December 2016.

2.3.7 Reducing Unintended Teenage Pregnancy

Current context snapshot

New Zealand Child and Youth Epidemiology statistics report that during 2006–2010, teenage birth rates for South Canterbury were not significantly different from the New Zealand rate however rates were higher for Māori than for European women. SCDHB has already completed significant work and is well resourced against this priority, including having a nurse practitioner working within the scope of sexual and youth health.

The DHB funds free GP sexual health visits for those between the ages of 14 - 25 years (up to four consultations a year and no more than two in a month), with an additional subsidy where treatment is indicated. These consultations cover both general sexual health issues and contraception. There is also a local Family Planning Clinic with referrals made from health practitioners as required.

The DHB funds a community based drop-in youth health clinic which is led by a nurse practitioner and runs four to five times a month with an average of 20 contacts a month. Consultations include contraceptive advice and prescriptions.

The same nurse practitioner also runs a drop-in sexual health clinic where contraception advice is available two evenings a week. On average 22 under 25 year olds are seen per month.

A 0.5 FTE registered nurse is funded to work with our five alternative education settings (including the teen parents' unit) to provide nurse led health clinics and provides contraceptive advice including distributing condoms and facilitates contraceptive prescriptions through referral to the youth clinic.

Public health nurses provide sexual health education in schools, where invited to do so, as part of the school year curriculum and work with the district's secondary schools to provide contraception advice and interventions as agreed by the individual school Boards through secondary school based health clinics.

The emergency contraceptive pill is available free through a numbers of avenues including GPs, school based health clinics where Board approval has been given, alternative education settings, and the youth health clinic. It can also be purchased from selected pharmacies.

First and second trimester terminations are referred to Canterbury District Health Board.

Local focus for 2016/17

The focus for the coming year will be on ensuring consistency around the administration of the emergency contraceptive pill, increasing the range and provision of contractive advice across high schools, ensuring suitable clinical supervision is in place for those public health nurses providing sexual health and contraceptive advice in school based health clinics. During 2016/17 the Primary Care Interim Alliance will consider the provision of intra-uterine devices, the use of Jadell implants and access to early medical abortion in reducing teenage pregnancy. Data matching will also be completed to identify demographic locations where a concentrated effort in prevention and early intervention is specifically indicated. Both of these will inform further planning against this priority for 2017/18.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Ensure consistent screening and advice in the provision of the emergency contraceptive pill.	Develop an Aoraki HealthPathway which sets out standardised screening questions and advice when administering the emergency contraceptive pill.	Aoraki HealthPathway on the emergency contraceptive pill agreed by March 2017.
Increase the suite of contraception provided in local secondary school settings.	Approach all South Canterbury high school Boards to discuss broadening the availability of contraception through school based health clinics.	All high school Boards visited by June 2017.
Support the clinical practice of those public health nurses providing contraceptive advice and provision in secondary school based clinics.	Arrange regular practice audit for all relevant public health nursing staff.	Practice audit occurring for all relevant public health nursing staff by June 2017.
Ensure youth friendly easily accessible advice on contraception is readily available for all youth in South Canterbury.	Highlight youth friendly information on contraception on the DHB HealthInfo site and work with other community partners such as the SC Youth website to disseminate this information.	HealthInfo information available by December 2016.

2.4 Long-term Conditions Prevention and Management

2.4.1 Integrated Long-term Conditions Steering Group

Current context snapshot

During 2015/16 SCDHB combined its Integrated Diabetes Services Group and Respiratory Services Group to form the DHB Integrated Long-term Conditions Steering Group. A variety of analysis tools which enable risk stratification to identify 'at risk' cohorts within our population continue to be utilised. These include health needs analysis, population and health profiles along with disease prevalence, current trends of health data e.g. health management data provided by the MoH, hospital admissions, non-admitted health services utilisation, as well as benchmarking with other populations etc.

The DHB has a Strategic Framework for the Prevention and Management of Long-term Conditions which guides its approach to service planning and delivery. A graphical depiction of the framework designed to be used across the DHB provides an effective visual tool for use with patients, staff and other stakeholders. Clinically a multi-condition rehabilitation approach to the management of all long term conditions continues to be employed, which empowers patients to actively manage their own long-term condition. The DHB continues to deliver group programmes both for those with established long-term conditions, as well as those identified as 'high risk'. Staff continue to utilise the Flinders tool and have completed training to undertake predictive risk assessments. The Aoraki HealthPathway for Sleep Apnoea, introduced during 2013/14, was evaluated for effectiveness during 2015/16 and has resulted in reviewed referral practices between secondary and tertiary services. Also reviewed in 2015, the Primary Physiotherapy Intervention Programme for osteoarthritis was deemed to be effective in the early intervention of joint problems and will continue to be funded.

Local focus for 2016/17

During 2016/17 the DHB will focus on further development of its Model of Care guidance documents, namely heart failure along with improving timeliness for patients requiring services and equipment through roll out of recent initiatives such as the Calderdale Framework and HealthOne.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Provide contemporary management of those patients with established heart failure.	Complete the development of a Model of Care for Heart Failure.	Model of Care approved by the Integrated Long-term Conditions Steering Group by December 2016.
Provide nursing and allied health support to patients which are community facing and integrated with primary Care.	Refocus the services delivered by clinical nurse specialists and allied health practitioners to those patients with an established long-term condition.	Improved service alignment with primary care evident by June 2017.
Share patient health information with all who are involved in the patient's care experience.	Utilise health One to provide a shared Care Plan to ED and St John ambulance for patients considered 'high risk' or 'frequent flyers'.	Shared Care Plan available by June 2017.
Increase workforce productivity whilst ensuring safe, effective and productive patient centred care.	Incorporate the Calderdale Framework into the long-term conditions team practice and functions.	Calderdale Framework introduced by December 2016.
	Incorporate the Calderdale Framework into primary care practice nurse practice and functions.	Calderdale Framework introduced and 'early adopters' supported by June 2017.

2.4.2 Keeping Healthy

Current context snapshot

SCDHB will continue to work closely with Community and Public Health, who is contracted to provide health promotion and prevention services for the district, along with local territorial authorities and other government agencies and community organisations. To this end we will continue to coordinate and support the South Canterbury Tobacco Control Group, the South Canterbury Breastfeeding Group, the South Canterbury Health Promotion Forum, and the South Canterbury Healthy Living Group and respective planned activity. Refer to appendix 8.6 for the SCDHB Prevention/Early Detection/Intervention Performance Targets 2016 – 17 Matrix.

South Canterbury has not been selected as one of the 10 Healthy Families NZ communities.

During 2015/16 in line with national activity work has commenced on the development of a DHB Food and Beverage Policy. This policy is aligned to the National DHB Food and Beverage Environment Network/MoH partnership and replaces the existing Nutrition Policy. It incorporates direction regarding the supply of sugar sweetened beverages on DHB premises in an aim to reduce consumption of sugar sweetened beverages by SCDHB staff, patients and their families. This policy is expected to provide a template for the community to support businesses in the district to adopt a similar stance. Sugar sweetened beverages have been removed from hospital based vending machines.

Local focus for 2016/17

Obesity is a major risk factor in the development of long term conditions. A key focus for reducing obesity in the local population during 2016/17 will be raising awareness of the impact of sugary drinks on weight gain, the promotion of healthy alternatives and instituting a ban on the purchase or supply of all sugary drinks on DHB premises.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Reduce the consumption of sugar sweetened beverages by SCDHB staff, patients and their families.	Through the SCDHB Workplace Health4You programme: Hold staff workshops to raise awareness of the health risks associated with the consumption of sugar sweetened beverages and promote healthy alternatives.	Workshops completed by December 2016.
Support businesses in the district in their development of a Food and Beverage Policy in line with national guidelines.	Provide the SCDHB Food and Beverage Policy as a guideline for adoption by local businesses.	Policy available for local businesses by June 2017.

2.4.3 Childhood Obesity

Current context snapshot

The DHB is committed to the national Childhood Obesity Plan, and addressing childhood obesity in its district, and in achieving the new childhood obesity Health Target. It will do so by focusing on realising an integrated system that contributes to maintaining and improving health outcomes for children and their families.

The DHB will continue to support WAVE initiatives during 2016/17. WAVE stands for "and Vitality in Education" and has been in place since 2006. It is a health promotion initiative that works collaboratively between education, health and Sport Canterbury and works across education providers including early childhood education settings to help create and support healthy environments. This programme maintains good engagement rates across the district with oversight provided by the South Canterbury WAVE Education steering and working groups. The WAVE Resource Centre has a range of resources that education settings can borrow free of charge to support the implementation of nutrition and physical activities.

Children and young people spend more time at education settings than any other environment when away from home, and consume an average of 32% of their daily energy intake whilst there. Promoting healthy food and beverages at education settings and setting events, helps to support the development of positive lifelong eating habits.

Initiatives in place under the WAVE banner to address the emerging trend of child obesity include secondary schools implementing physical activity actions following on from their physical activity surveys. An example of this is organising lunchtime walking groups, yoga groups and dance groups. A number of early education centres are reviewing and updating their nutrition policies, attending oral health development workshops which include healthy eating, and utilising the WAVE Resource Centre nutrition resources in their teaching programmes. Another example is a school updating its canteen menu, whilst other schools continue to support edible gardens.

There is a strong correlation between being physically active as a student and being physically active in adulthood. Along with increasing awareness and knowledge of the importance of being physically active and providing resources and guidelines to encourage physical activity opportunities, initiatives have included incorporating traditional Māori games into South Canterbury secondary schools, leading to an annual Ki O Rahi Tournament. Other reported initiatives include Active Transport Plans which aim to increase the number of students walking or cycling to school. The WAVE programme continues to identify ways of making it easier for the educational settings to connect with and involve communities including physical activity and sport organisations and clubs.

The DHB also holds a contract with Sports Canterbury to provide 0.7 FTE with the aim of enabling targeted communities to become more active through sport and physical activity, by growing participation and building the capability of schools and sport organisations. The community sport advisor is currently working with primary schools and communities working alongside the WAVE facilitators to assist schools to become

physically active and in adopting a whole school health promotion approach. Support includes assistance in developing and maintaining a Physical Education and Community Sport Plan, coordinating and delivering a teacher training package for the SportStart resource as well Physical Activity Leader training to students and teachers. Other activity includes working with Kiwi Sport coordinators, supporting schools to build strong relationships with sport clubs and coordinating the Jump Jam Extravaganza.

Local focus for 2016/17

In response to the new health target the DHB will develop a Childhood Obesity Action Plan and a health pathway for those children assessed as obese including those identified as meeting this threshold at their B4 School Check. This will require working with other providers such as our Māori Health provider, Arowhenua Whānau Services, Plunket, primary care and community dieticians to design a clear referral pathway for intervention. Training opportunities will also be explored on how to have the conversation with the parents of children accessed as obese.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Employ a collaborative approach through the Child and Youth Health Alliance to reduce the incidence of childhood obesity in South Canterbury.	Develop a Childhood Obesity Action Plan for the SCDHB.	Draft document prepared and consulted on by September 2016. Finalised Action Plan agreed and communicated to all key stakeholders by December 2016. Monitoring mechanisms and progress reports against planned action and performance against the Health Target received by the Child and Youth Health Alliance by March 2017.
Provide a clear pathway for referral and service delivery for those children assessed as obese.	Develop an integrated Aoraki HealthPathway for the management of children assessed as obese or clinically obese.	Aoraki HealthPathways in place by March 2017.
Equip clinical staff working with children assessed as obese on how to raise this topic of conversation with parents/carers.	Train staff in motivational interviewing and how to effectively raise sensitive issues.	Training completed for DHB public health nursing and paediatric staff along with practice nurses by June 2017.

2.4.4 Better Help for Smokers to Quit

Current context snapshot

2015/16 Q2 results showed 97.8 percent of hospitalised smokers and 86.6 percent of smokers seen in primary care, received advice and help to quit smoking. 2013 Census results show that the incidence of smoking in South Canterbury had reduced to 16.2 percent compared with 21.2 percent in 2006. The DHB is actively engaged in working towards the Government's aspirational goal of a Smoke-free NZ by 2025 with a smoking prevalence of <5% across all ethnicities, and will support the ASH NZ national campaign 'Stoptober' later this year.

The hospital target has been consistently met and the DHB will work to ensure sustainability. This continues to be achieved by incorporating ABC as part of the initial inpatient clinical assessment. Success in achievement is supported by direct ABC delivery training of all clinical staff.

The DHB Primary Care service will continue to directly target persistent underperforming general practices by providing support including assistance with patient prompt and decision support tools. The Karo data management system provides reports on practice status and population profile breakdown so that progress against the target can be regularly monitored. This allows practices with high Māori populations to be targeted for specialist support. The DHB is able to demonstrate the sustained effectiveness of its smoke

cessation strategies by capturing and analysing data relating to abstinence including through CO_2 validation quarterly. The target of over 30% of patients validated as smoke-free at three months has been achieved.

The DHB will also continue to run community based smoking cessation clinics at five sites within South Canterbury and continue to work with three mental health NGOs to provide onsite cessation support.

During 2015/16 the ABC model was extended to include community mental health and monitoring has commenced.

All pregnant women who identify as smokers continue to be referred to the SCDHB smoking cessation team. Inclusion of a smoking cessation worker in the antenatal clinic continues to have a positive impact. The DHB continues to work with Community and Public Health to develop localised health promotion focused on smoke-free pregnancy.

Local focus for 2016/17

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Increase the number of women smoke-free at conception.	Develop an integrated pathway with multiple points of contact to support women to a state of optimal health prior to pregnancy.	Integrated Aoraki HealthPathway available by June 2017.
Prioritise youth and young adults to reduce smoking initiation and increase quit attempts in primary care.	Develop a model for the delivery, monitoring and recording of 'ABC' in youth education settings.	Model developed and implemented that includes informing general practices of outcomes by June 2017.
Increase the number of children living in smoke-free homes.	Provide information packs to parents on how to ensure a smoke-free home.	Monitor B4SC data on a quarterly basis for smoke-free home status. Ongoing.
	Train and support staff to have effective conversations about how to ensure children live in a smoke-free home.	Training is provided and prompt cards are available to assist staff by June 2017.

2.4.5 Diabetes Care Improvement Package

Current context snapshot

SCDHB continues to provide an integrated approach to the management of people in South Canterbury with diabetes primarily being managed in the primary care setting except where specialist input is required. Persons at risk of diabetes are primarily identified through their general practice or Cardiovascular Disease Risk Assessment (CVDRA) and general practices are encouraged to utilise the Dr Info patient dashboards to monitor care components allowing prompt recall and to complete self-audits on diabetes management. The DHB remains committed to maintaining the desired HbA1c range for its diabetic patients. 79 percent of patients who had a diabetes annual review between December 2014 – December 2015 had a HbA1c ≤ 64mmols. Monitoring reports are also available on BMI indicating obesity and management through the use of statins. Quarterly Karo data management reports are utilised for general practice management as these provide a 'live' picture of a patients' status. Specialist support continues to be provided to general practices by clinical nurse specialists.

The DHB Integrated Diabetes Model of Care, which was developed with consumer input, covers the entire health continuum from prevention to end of life and has a key focus on empowering patients to self-manage their condition. A consumer continues to sit on the newly combined Long-term Conditions Steering Group to provide a consumer's perspective on diabetes services. The encounter programme, foot care programme for diabetics, conversation maps and pre-long-term condition lifestyle group education, are all scheduled to continue during 2016/17.

The DHB continues to provide specialist support to general practices through access to clinical nurse specialists – diabetes, and tracks the effectiveness of the Diabetes Care Improvement Package through monitoring the HbA1c of those patients.

The 20 Quality Standards for Diabetes Care contained in the Quality Standards for Diabetes Care Toolkit 2014 have been implemented with an audit having been completed to identify service gaps and opportunities for improvement which has informed our service planning. The only gap identified through this audit process was the lack of psychological support available to diabetic patients. This need has been addressed through the primary care brief intervention referral pathway.

With the introduction of Pharmac funding continuous insulin pumps, the DHB continues to promote the use of this intervention for those Type 1 adults and children who meet the clinical threshold. The DHB will continue to embed associated processes and provide ongoing monitoring sessions as set down by Pharmac.

The DHB continues to focus on reducing the incidence of complications due to poorly controlled diabetes through monitoring programmes such as the monitoring of diabetic retinopathy.

Local focus for 2016/17

The DHB will focus during 2016/17 on embedding its partnership approach to managing and monitoring service delivery for diabetes management across primary and secondary services including ensuring compliance against best practice guidelines such as the Diabetic Retinal Screening, Grading and Management Guidance. It will also continue to utilise the Diabetes Atlas of Variation annually to identify possible gaps in service delivery. The planned focus for improvement in clinical practice is in standardising the DHB's approach to insulin initiation.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Ensure a collaborative integrated approach to the planning of diabetes services within South Canterbury, employing identified opportunities for innovation to improve service delivery.	Provide an annual high level overview report to the Primary Care Interim Alliance to inform a partnership approach to service planning.	Annual Report received by the Primary Care Interim Alliance by June 2017.
Identify areas of diabetes management where South Canterbury's performance is below the national average.	Utilise national benchmarking data to inform the Long-term Conditions Steering Group of areas of diabetes management requiring improvement or inequity in access to treatment and services.	Annual presentation to the Long-term Steering Group on the Health Quality and Safety Commission's Atlas of Variation for Diabetes Management and development of an associated Action Plan by December 2016.
Move the initiation of insulin pumps to a sustainable framework.	Standardise the approach to initiation and management of insulin pumps including extending carbohydrate counting skills across the inter-disciplinary team.	Training completed by relevant staff by June 2017.
Reduce diabetes related visual impairment through effective screening for diabetic retinal disease and monitoring of diabetic retinopathy.	Complete implementation of the Diabetic Retinal Screening, Grading and Management Guidance.	Diabetic Retinal Screening reports are received by the Long-term Condition Steering Group. Ongoing.

2.4.6 Cardiovascular Disease (CVD)

Current context snapshot

The DHB continues to make steady progress towards achieving this performance target with established scheduled recall, monitoring and reporting systems in place along with health messaging. Target for the percentage who had their cardiovascular risk assessed in the last five years was met at the end of 2015/16 Q2 at 89.8 percent and the DHB will work to sustain this performance with the Primary Care Interim Alliance providing oversight and accountability for meeting this target. This result has been assisted through direct clinical nurse specialist support to general practices, along with incorporating practices such as the use of virtual CVDRAs and by creating a competitive environment through the provision of league tables so that practices can measure performance against other practices and peers. The utilisation of Dr Info has also assisted in improved results through the functionality of tools such as the patient dashboard which identifies patients requiring CVDRA. Data from Karo provides information on risk level, cholesterol level, statin usage, smoking status, as well as prescribing of ACE inhibitors, aspirin and beta blockers. GPs access and use this information to manage those patients at risk of CVD. During 2015/16 the DHB focused on preventing the progression of cardiovascular disease for those people identified at high risk and developed a pathway for those people with a CVDRA ≥15% to attend the pre-long-term conditions lifestyle programme. The Long-term Conditions Steering Group now receives reporting on the current cardiovascular risk for the population based on the risk profile captured from the population in South Canterbury who have completed a CVDRA in the proceeding 12-month period.

Local focus for 2016/17

The DHB's focus during 2016/17 will be on increasing engagement rates of Māori and Pacific people in CVDRA screening through a partnership approach with our local Māori Health provider and Fale Pasifika. CVDRA coverage has been selected as a contributory measure for the System Level Outcome Measures Framework for the DHB.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Increase CVDRA coverage for the local Māori population.	Expand the current concept of health hui to provide coverage for rural areas.	Two health hui on the need for cardiovascular disease risk assessment are held by June 2017. 90% of Māori men aged 35 – 44 years have had their CVD risk recorded within the past five years by June 2017.
Increase CVDRA coverage for the local Pacific population.	Partner with Fale Pasifika to promote CVDRA.	One hui on the need for cardiovascular disease risk assessment is held by June 2017.

2.4.7 Rising to the Challenge Plan

Current context snapshot

SCDHB continues to respond to The Mental Health and Addiction Service Development Plan 2012 – 2017, 'Rising to the Challenge' and has addressed most of its key actions. The Key Performance Indicator (KPI) project also continues to drive better clinical outcomes resulting in the local population continuing to experience high access rates and low waiting times for mental health and addiction services. The Choice and Partnership Approach (CAPA) is utilised across secondary services with referrals managed through a single point of entry. The DHB has implemented their Co-existing Problems Plan with staff trained using the 'Let's Get Real' Skills Competency Framework. The Alcohol and Drug Outcome Measure (ADOM) has been introduced within the Alcohol and Other Drug Service with required reporting occurring.

During 2015/16 the inpatient unit was refurbished including the seclusion suite. Staff also under went refresher training on the use of sensory modulation and mindfulness to be utilised as de-escalation tools to reduce the use of seclusion. The inpatient unit has incorporated a 'level of observation' tool for all patients.

This tool identifies patients' risks and is completed on entry to the inpatient unit and reviewed in conjunction with the patient, family and the multi-disciplinary team throughout the inpatient stay.

SCDHB has an active Suicide Prevention Plan 2015-2017 which was updated and submitted in 2015 and includes access to training across key sectors to support people to identify when others may be at risk of suicide and provides guidance on referral pathways. The DHB's Suicide Response (Postvention) Plan, which demonstrates a cross agency collaborative response to suicide clusters/contagion, has also been reviewed to reflect the MoH toolkit and is an appendix to the Suicide Prevention Plan.

The DHB enjoys a good relationship with local Police and an Interface Agreement has been developed and agreed. Both services enjoy an 'open door' policy and there is a 'walk in' process for Police to the adult inpatient unit. The TACT team response to attending patients in custody is assessed as timely.

The DHB delivers e-therapy programmes for depression, anxiety and addiction and has improved the mental health of older people through relapse prevention planning, joint consultations between primary care and specialist services and managing addictions in the older person. In line with the regional direction, the DHB has implemented the Maudsley family based eating disorder programme.

A staff e-learning resource on identifying 'at risk' children and when to refer has also been developed in 2015 along with supportive resources for parents. Work in this area will continue into 2016/17.Other recent staff educational opportunities include an Infant, Child, Adolescent, Mental Health Service (ICAMHS) education programme focusing on infant mental health.

Evidence based group therapies have been trialled e.g. dialectical behavioural, cognitive behavioural and 'mindfulness' therapies. Staff implemented a group therapy programme for long-term clients on physical health, wellbeing and readiness for employment. A review process was completed that assessed the effectiveness of this programme and informed its future going forward.

During 2015/16 the DHB reviewed the admission to discharge process flow, updating supervision templates and process to support staff in their caseload management. The delivery and integration of specialist mental health services within primary care has been enhanced both through regular attendance by the Clinical Director Mental Health and Older Person services at General Practice Connect Forums, as well as extending discharge planning meeting attendance to include primary care and NGOs. This has strengthened relationships and improved access to specialist knowledge and advice.

The DHB currently contracts a position with Plunket to provide post-natal depression support along with funding for families. The DHB also continues to engage in the regional development of youth forensic services which utilises the 'hub and spoke' approach. SCDHB is actively participating in the development of local initiatives derived from the Youth Crime Action Plan including looking at alternatives to custodial sentences for youth.

During 2015/16 the service developed a pathway for 'Supporting Parents Healthy Children' based on the Ministry of Health Children of Parents with Mental Illness and Addictions (COPMIA) Guidelines and expanded the scope of the current outreach clinics to include ICAMHS.

The DHB continues to actively engage and participate in the South Island Alliance for Mental Health Services, implementing agreed actions as per the South Island Regional Health Services Plan. The DHB will meet the mental health ring fence expectations.

Local Focus 2016/17

The DHB will focus on ensuring all key actions form the Mental Health and Addiction Service Development Plan 2012 – 2017, 'Rising to the Challenge' have been fully completed and are embedded within the service. The DHB remains committed to working with the Ministry in the shift to planned outcome and commissioning frameworks.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Use current resources effectively (Ref. Rising to the Challenge 1.1.3)	Gather data regarding the effectiveness of accessing detoxification beds in other regions and the high rate of relapse.	Proposal for detoxification beds prepared by December 2016.
	Initiate education group work with the NGO Emerge Aotearoa on mental health and addiction services.	Report on group achievements prepared by June 2017.
Build infrastructure for integration between primary and secondary services (Ref. Rising to the Challenge 2.2.3)	Initiate six weekly visits to GP services by psychiatrists and the Community Mental Health Team (CMHT).	Quarterly report on activity and outcomes. Ongoing.
Deliver increased access for adults with high prevalence conditions while increasing service integration and effectiveness (Ref. Rising to the Challenge 6.6.2)	Develop treatment plan for CMHT & Alcohol and Other Drugs (AOD).	Visibility of strengths with clear links to treatment plans and HoNOS evident by June 2017.
Support and strengthen our workforce (Ref. Rising to the Challenge 8.8.2)	Identify core skills for treatment of delivery for inclusion into an induction package	All new employees receive Treatment Information Booklets by June 2017.
Work to prevent suicide in South Canterbury.	Continue to implement the SCDHB Suicide Prevention Plan 2015 – 17.	Actions included in the SCDHB Suicide Prevention Plan 2015 – 17 completed by June 2017.

2.5 System Integration

2.5.1 Cancer Services

Current context snapshot

The SCDHB and the Southern Cancer Network (SCN) will work collaboratively to support each other and other stakeholders to improve services and outcomes for all cancer patients across the South Island.

The DHB Oncology Model of Care maps the journey for those patients in South Canterbury requiring oncology care. This model guides the patient journey from the point that a referral is made with a high suspicion of cancer, through diagnosis, to treatment, coordinating care and making sure assessments, diagnostic tests and treatment all occur in a timely, responsive and seamless manner. There is a steering group made up of clinicians and managers from both South Canterbury and Canterbury DHBs who provide an operational oversight group and who will continue to address opportunities for improvement and resolve issues as they arise. SCDHB remains an active member of the Southern Cancer Network with active participation in SCN projects. It is also a member of the South Canterbury Cancer Control Network providing support in the development of the local Cancer Plan.

The DHB is committed to improving the functionally and coverage of multi-disciplinary meetings (MDMs) and that planned activity is aligned to regionally agreed priorities. SCDHB is part of the hub and spoke model of care with CDHB oncology. Locally MDMs continue to be coordinated by the Cancer Nurse Coordinator and supported by improved information technology with connectivity issues addressed as they occur. Work continues to scope the requirements for best practice MDM sessions including patient-attended telehealth sessions including any need for relocation of the current MDM video conferencing room. MOSAIQ has been

fully implemented and integrated into practice. The DHB works to ensure services were delivered in line with National Tumour Standards for Head and Neck, Thyroid, and Colorectal. During 2015/16 the DHB participated in the regional audit of the National Standard for Gynaecology and will develop and implement an action plan based on this over the going year.

The DHB is committed to ensuring equity for Māori and as such will use resources such as the Framework for Equity of Health Care for Māori. In addition to providing marae based information as part of the DHB Māori Health Plan, it is planned during 2016/17 to hold a Hui on men's health which will include how to identify prostate related concerns and the importance of presenting to the GP for prostrate assessment. This hui will include input from both the health professional and consumer perspective. It is also committed to implementing the Cancer Health Information Strategy and to support implementation of Budget 2014 initiatives including implementing supportive care services for cancer patients. In line with this the oncology team now includes a social worker.

During 2015/16 the DHB explored the feasibility of, and prepared a business case for, implementing nurse led oncology follow-up clinics to reduce follow-up consultation demand in the visiting specialist clinics and a business case has been prepared.

In order to improve outcomes for men with prostate cancer the DHB has also commenced the implementation of guidance documents on referral for specialist review and active surveillance for men with localised, low risk prostate cancer. The DHB will continue to work with its contracted urology provider to complete implementation of this guidance and to ensure that the necessary referral pathways are in place and reflected within Aoraki HealthPathways.

Local focus for 2016/17

During 2016/17 the DHB will focus on completion of implementation of initiatives relating to guidance on specialist review and the use of active surveillance for men with low grade prostate cancer, and through capacity management reducing the number of follow up visits requiring direct specialist input. The DHB will implement an action plan following the regional audit against the National Tumour Standard for Gynaecology and continue to engage with the SCN in their planned activity.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Increase access to onsite specialist oncology services.	Complete implementation of nurse led oncology follow-up clinics to reduce follow-up consultation demand in the visiting specialist clinics.	Monthly nurse led clinics run in conjunction with visiting oncology services by June 2017.
Improve outcomes for men with prostate cancer.	Work with the contracted provider to implement national guidance documents on referral for specialist review and active surveillance for men with localised, low risk prostate cancer.	National guidance localised once these documents are published with localised referral pathways in place by December 2016.
Meet the National Tumour Standard for Gynaecology.	Develop and implement the Action Plan based on the National Tumour Standard for Gynaecology regional audit.	Action Plan against the National Tumour Standard for Gynaecology developed and completed by March 2017.
Meet the National Tumour Standard for Lung Cancer.	Participate in the National Tumour Standard for Lung Cancer regional audit.	Action plan against the National Tumour Standard for Lung Cancer developed and completed by June 2017.

Faster Cancer Treatment (FCT)

Current context snapshot

SCDHB and SCN will work collaboratively to support the delivery of the FCT targets and implement robust processes for ongoing delivery.

SCDHB continues to achieve 100 percent of patients' ready-for-treatment waiting less than four weeks for radiotherapy or chemotherapy. The DHB is committed to meeting the Health Target of 85 percent of patients receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer, and a need to be seen within two weeks. The DHB continues to work towards meeting this target with the Q2 result for the DHB 70.6 percent. The DHB continues to correctly identify the cohort for the target. Data is sourced from internal and external databases for cross referencing. Patients identified for the FCT pathway are tracked to ensure that unnecessary breaches do not occur. Where there are identified bottlenecks then these are analysed and alternate options occur. The DHB is also committed to meeting the DHB Performance Expectations for Faster Cancer Treatment (PP30).

In order to raise awareness amongst general practice on the FCT target and referral guidelines, contained in the Aoraki HealthPathways, education was delivered by the oncology nursing team during 2015.

Focus for 2016/17

The DHB will continue to analyse outliers where the target of 62 days is not met to identify and seek solutions. The DHB will also continue to work collaboratively with the SCN on a regional approach to health pathways for specific cancer presentations.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Provide timely access to high quality services for patients along the cancer pathway leading to better outcomes for patients and a better experience of care for patients and their families.	Conduct fortnightly review of outliers to the 62-day Faster Cancer Treatment target.	Progressive improvement each quarter against the target of 85 percent of patients receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.

2.5.2 Stroke Services

Current context snapshot

SCDHB's Stroke Steering Group remains active and membership on the South Island Stroke work stream continues with participation in regionally agreed actions as per the South Island Regional Services Plan. The DHB continues to provide a service that is consistent with the New Zealand Clinical Guidelines for Stroke Management and advice provided by the National Clinical Stroke Network. An Acute Stroke Thrombolysis Guideline is in place, with each case fully audited. The DHB has shown consistent performance against the target of 6% of potentially eligible patients with an ischaemic stroke receiving thrombolysis, (noting that small variance in numbers can result in significant fluctuations in results). Work continues in partnership with St John Ambulance Service and the ED to ensure the pathway is consistently followed. Admission to the DHB Acute Stroke Pathway is supported by fast tracked admission to the Assessment, Treatment and Rehabilitation (AT&R) Unit i.e. within 24 hours for 80 percent of cases. This allows a seamless transition between the acute and rehabilitation phases of care and where the patient remains under the care of a lead stroke physician.

Data is submitted to the National Stroke Register. Australasian Rehabilitation Outcomes Centre (AROC) training, data submission and benchmarking occurs in the rehabilitation unit as does training in the Functional Independence Measure (FIMS) assessment tool. St John Ambulance Service has in place protocols for both FAST Assessment for Stroke and ABCD2 Assessment for Transient Ischemic Attack (TIA). Emergency department staff have also been trained in the use of the ABCD2 assessment tool. Stroke Thrombolysis Guidelines have been implemented as has an audit of our Acute Stroke Pathway – Admission to Discharge,

with audit findings informing the development of an action plan to improve performance of thrombolysis delivery. Post-acute stroke rehabilitation continues and is supported by the 'Admission to Discharge' document in the rehabilitation unit during the inpatient stay. As part of post discharge rehabilitation planning, an excel spreadsheet has been introduced to allow tracking of patients' progress and reassessments. Audit regarding post-acute stroke rehabilitation plans, including access to integrated stroke rehabilitation services and transition back to the community, has also been completed.

A strong relationship is maintained with the Stroke Foundation with facilitated access for the public to their information resources including early detection of stroke (FAST assessment for stroke).

Local focus for 2016/17

Audit of the use of the ABCD2 assessment tool by emergency department clinicians will occur during 2016/17. Action plans will also be developed and implemented following audits of our Acute Stroke Pathway and post-acute stroke rehabilitation planning.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Improve health outcomes for people who experience a TIA.	Audit use of the ABCD2 protocol for the assessment of TIAs in the emergency department.	Audit report with findings and recommendations received by March 2017. Action plan based on the audit findings to improve thrombolysis delivery developed by June 2017.
Improve health outcomes for people who experience stroke.	Implement the action plan developed following the audit of the Acute Stroke Pathway – Admission to Discharge.	Action plan developed to address any identified barriers to thrombolysis fully implemented by June 2017. ≥6% of potentially eligible patients with an ischaemic stroke receives thrombolysis. Ongoing. 80% of stroke patients presenting with stroke are admitted to an organised stroke service with a demonstrated stroke pathway. Ongoing.
Provide patients who have had a stroke with timely access to integrated stroke rehabilitation services.	Develop and implement an action plan following the audit of the number of patients with comprehensive post-acute rehabilitation plans.	Action plan developed to address any identified barriers to effective post-acute rehabilitation by December 2016. Action plan fully implemented by June 2017. 80% of stroke patients discharged from the stroke service will have a comprehensive post-acute rehabilitation plan by June 2017. 80% of people admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission by June 2017.
Ensure appropriate clinical follow up and support occurs for people who have experienced a stroke.	Attendance at Stroke Club meetings by the clinical nurse specialist.	Report prepared biannually outlining any identified issues or themes for use in future service planning.

2.5.3 Cardiac Services

Current context snapshot

The DHB continues to work towards achieving the Acute Coronary Syndrome (ACS) indicator targets. As at the end of Q2 2015/16 81 percent (target 70%) of high risk patients had received an angiogram within three days of admissions. Performance against indicator two; (percentage of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI and Cath/PCI registry data collection within 30 days) has been more variable over the quarter with a result of 75.7 percent (target 95%) and monthly results ranging from 58.3 – 100 percent. The importance of registration continues to be promoted with clinicians. Note – in both of these measures the small numbers of patients cause significant fluctuation in results over the quarterly reporting periods.

The DHB continues to actively engage in the South Island regional work stream for cardiac services. Specialist cardiology services are provided on a visiting basis from Canterbury District Health Board (CDHB) and during 2015 were increased to three per month. This has improved access to specialist cardiology services ensuring FSA waiting times are met. These are supported by cardiac Clinical Nurse Specialist (CNS) clinics which are run concurrently.

The introduction of the required Accelerated Chest Pain Pathway (ACPP) for suspected acute ischaemic heart disease as per a Ministerial directive has occurred, with the validity of the document being tested against patients presenting to our emergency department so that required changes can be made to ensure that this meets the needs of our local population.

The DHB has completed the required cardiac training stock-take and participated in the regional approach to standardising educational training for registered nurses working with patients with a cardiac condition to improve the efficiency and effectiveness of clinical education and training to meet the needs of current and future health professionals.

The DHB has also worked at ensuring optimal management of patients with heart failure and has implemented agreed protocols for the management of heart failure. A primary and secondary working group developed a health pathway for primary care for the management of heart failure. A Frusemide Patient Action Plan was developed for patients to be able to titrate medication and reduce hospital admissions.

The DHB is able to provide some cardiac diagnostics on site such as echocardiograms and exercise tolerance tests. SCDHB also has an ACS pathway which includes use of the risk stratification assessment tool.

Local focus for 2016/17

The DHB will continue to work with CDHB, its Inter District Flow (IDF) provider, to meet the national target for angiography rate of 34.7 per 10,000. It will also revise its approach to rehabilitation post cardiac event and increase its provision of nurse led clinics to support outpatient cardiology services. The Accelerated Chest Pain Pathway introduced during 2015/16 will be further embedded into practice.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Improve the provision of cardiac services to the people of South Canterbury through improved patient flow ensuring that door to catheter target is met.	Engage in combined CDHB/ SCDHB meetings to develop agreed standard operating procedures for cardiology referrals resulting in clear responsibilities between SCDHB Medical Services and CDHB Cardiology Services.	70% of the local eligible population receive their angiogram within three days. Agreed action plan developed to address issues identified with ANZAC QI data.
Provide evidence based care to those with suspected acute ischaemic heart disease through use of the ACPP.	Audit those patients presenting to the ED with suspected acute ischaemic heart disease to ensure compliance against the ACPP.	Audit tool developed by September 2016. Audit tool trialled by December 2016.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
		Audit tool updated and fully implemented by March 2017. Audit reports prepared and available for monitoring review by June 2017.
Train relevant staff on data registry data collection to ensure that ANZACS QI and Cath/PCI registry data collection is completed in a timely manner.	Deliver a training session on data registry, data collection requirements, to the next intake of junior medical officers.	Training delivered to all junior medical officers by December 2016.
Provide a comprehensive programme of rehabilitation with a focus on self-management from post cardiac event to living with a long term condition.	Integrate the current Cardiac Rehabilitation Programme into the Long-term Conditions Programme standardising advice and support.	Long-term Conditions Programme updated by March 2017.
Increase the provision of follow ups post cardiology FSA for cardiac services through nurse led clinics.	Increase nurse led clinics from 1-2 per month to 3 per month running at the same time as cardiology clinics.	Patient contacts meet price volume schedule. Ongoing.

2.5.4 Health of Older Persons

Current context snapshot

Around 12,860 people aged 65 years and over are projected to live in South Canterbury during 2016/17. This is 21.7 percent of the local population. The DHB maintains its membership on the South Island Health of Older Persons Service Level Alliance and is committed to its ongoing participation in the development and implementation of work plan activity for 2016/17.

Most of these older people live independently at home. SCDHB's restorative approach to providing services for older people supports its philosophy of 'Ageing in Place'. The DHB continues to participate in the Aoraki Positive Ageing Forum and related activity.

SCDHB's Centre of Excellence for Health of Older Person's Services commenced two years ago and had the primary aim of system integration. This project is nearing completion and has resulted in significant service improvement with progress against implementation of recommendations monitored by the Disability Services Advisory Committee and Board.

System integration continues in partnership with aged related residential care and home based support service providers, St John ambulance services and the hospital, and has been facilitated through our Health of Older Person Alliance and Health of Older Person's Centre of Excellence project. Examples of recent service improvements include:

- St John referring directly to the Falls Prevention Programme;
- Community geriatrician working with age related residential care providers and general practice following discharge which includes ability for Age Related Residential Care providers to seek advice etc. direct from the geriatrician in the first 10 days following discharge; and
- Needs Assessment Service Coordination working closely with general practice to ensure seamless service delivery; and
- Wrap around services, now called Home First embedded with referral pathways established for both hospital, including ED, and primary care.

The DHB has an Aged Related Cognitive Impairment Pathway which reflects best practice and is supported by the Walking in Another Shoes (WiAS) training programme. This pathway is reviewed at regular intervals to

ensure it reflects contemporary practice. A number of measures are in place to monitor the effectiveness of the Aoraki HealthPathway for Cognitive Impairment including:

- Use of the Aoraki HealthPathway for Cognitive Impairment;
- The number of clients referred to Alzheimers South Canterbury for consultations; and
- The number of clients supported in the community through the Community First Dementia Programme which also has a focus on carer support in home based and community support services.

There is ready access to a geriatrician with ongoing clinical support provided to primary, secondary and aged care staff in diagnosing and caring for the older person. Early recognition and intervention of dementia in primary care has been enhanced through delivery of training to general practice on the SCDHB Cognitive Impairment HealthPathway. The DHB will continue to engage in the South Island regional approach to implementing the 'New Zealand Framework for Dementia Care' including attendance at planned workshops.

During 2015/16 the DHB implemented an Aoraki HealthPathway for Fragility Fractures that guides GPs, with direct access to DXA scans through a funded contract with a local provider and 60 Aclasta treatments which are funded per annum. During 2016/17 the Primary Care Alliance will review the current model of care for Aclasta provision. The community has a very effective falls prevention programme running and there is information for the public available on the Aoraki HealthInfo site relating to falls prevention. Further information relating to the DHB's integrated Combined Falls Steering Committee and falls assessment and care planning is available under the Quality and Safety section of this Plan.

All age related care providers have completed InterRAI training with DHB support. Timeframes for the completion of InterRAI first assessments within the target timeframe in home and community support settings continue to be monitored and show satisfactory results. The target timeframe from assessment to providing a package of care is also monitored and met. All long-term chronic funding clients admitted to an aged residential care facility are assessed using the InterRAI Home Care assessment tool. Appropriate care planning is monitored in aged residential care through a quarterly report generated from InterRAI on residents who have had a second InterRAI assessment completed 230 days after admission. The DHB continues to participate in the development of a national approach to benchmark and compare our performance with other DHBs.

A single point of entry for referrals has been implemented which supports the coordination of health assessments. A wrap around service is in place for older people. The DHB remains committed to support in-between travel and cost of travel (IBT) to home and community support service agreements using funding allocated to DHBs to ensure implementation. Work continues on the implementation of rapid response and improved transition of discharge to the community through referral pathways.

The DHB has also developed resources to support advance care planning and the use of advance directives in the district including training for staff in primary, secondary and aged care settings and promotion of the Conversations that Count campaign.

Established vaccination programmes such as the flu vaccination and pneumonia immunisation for ≥65 yrs. will continue to be promoted utilising Dr Info patient dashboards and audit tool to identify eligible persons.

Local focus for 2016/17

During 2016/17 the DHB will review its processes to ensure that the right patient information, including medication chart, prescriptions, discharge summary and Advance Care Plans are communicated between providers including hospital services, aged residential care and home and community support providers, general practice and pharmacies and the patient's family.

The final phase of the Centre of Excellence for Health of Older Persons Plan will be completed with the establishment of a community multidisciplinary team and implementing performance measures to evaluate the impact of the implementation of the Centre of Excellence plan.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Improve communication of patient information between providers so that all relevant patient information is available in order to provide effective care.	Complete South Island pilot of the Community Electronic Referral Form.	Pilot completed December 2016.
Improve coordination for those older persons requiring more complex management through an integrated approach across primary and secondary care.	Establish a multi-disciplinary team which includes and fully integrates staff within general practice and community pharmacy to employ a 'one stop shop' approach to assessment, management and referral practices.	Multi-disciplinary team in place with respective pathways established by June 2017.
Provide effective integrated management in the collaborative care of those accessing health of older persons' services.	Continue to implement a restorative model of care across health of older persons' services.	A restorative model of care for the provision of health of older persons' services. Ongoing
Evaluate the effectiveness of the Heath of Older Persons Centre of Excellence (system integration) project.	Implement a suite of performance measures and analyse the impact of action taken on system integration.	Monitoring in place and reporting to the Disability Services Advisory Committee by June 2017.

2.5.5 Service Configuration

Shifting Services into the Community

Current context snapshot

Providing improved integration of health services for the population of South Canterbury continues to require the ongoing strengthening and effective coordination of primary and community care, to become the first point of access for a wider range of publicly funded services.

SCDHB has already achieved a substantive shift in providing services closer to home. Clinical pathways have been localised and included in the Aoraki HealthPathways. Work on this project continues and a review process is now in place which sees these documents updated two yearly. These local clinical pathways support the introduction of integrated models of care within the DHB and GPs have access to community radiology in accordance with the guidance document 'National Access Criteria for Community Referred Diagnostics Guideline' released in 2014, as health pathways are implemented to support access.

SCDHB is not planning any new initiatives to manage acute demand as the measures already in place, including the development of models of integrated primary/secondary services and other service development initiatives, have already resulted in acute demand reducing. SCDHB does not have any acute demand issues causing delays in provision of acute services or putting pressure on services. Inpatient acute demand has continued to trend down over the last five years and inappropriate emergency department presentations are managed through our Joint Primary Secondary Emergency Department Service Group. Wrap around services for older people and the implementation of the DHBs Concept Plan is resulting in care and support for older people presenting at the emergency department avoiding admissions and ensuring older people are accessing appropriate services in the community. In addition, SCDHB Specialist Health of Older Persons (HOP) Services are working with general practice and aged residential care providers to avoid unnecessary acute admission and re-admission.

The following activity has previously been shifted from secondary to primary care:

- 300 steroid injections for musculoskeletal conditions;
- 20 Aclasta infusions for osteoporosis;
- 40 nerve conduction studies for carpal tunnel and other identified specific conditions;

- Insertion of replacement Mirena™ devices for menorrhagia;
- 150 DXA (Dual energy X-ray absorptiometry) scans provided in the community, (avoiding travel to Christchurch);
- Local delivery of treatment work-up including oximetry for sleep apnoea, (previously provided in Christchurch);
- Intravenous antibiotic therapy for cellulitis; and
- Dispensing of clozapine.

The following activity has been shifted from primary to community.

- INR monitoring.

General practice currently has direct access to:

- Colonoscopy and CTC;
- Vasectomy (contracted provider);
- CT imaging on recommendation from specialist or radiologist; and
- DXA scans.

Local focus for 2016/17

Work continues to identify where services can be appropriately and efficiently moved from secondary to primary services and to recognise opportunities where primary care could directly access diagnostic services where the threshold in the relevant Aoraki HealthPathway is reached. There is no intention to shift further services in 2016/17.

Primary Care

Current context snapshot

South Canterbury is unique in that it has no PHO making South Canterbury the only DHB where primary and community services are a division of the DHB. This structure facilitates improved integration and collaboration across the DHB which is supported by a single Clinical Board providing clinical leadership and overview across all primary and secondary services. In 2015 the DHB reviewed the current primary care alliance process in consultation with primary care and in December 2015 the Primary Care Interim Alliance was established. This Alliance has been involved in the development of the Annual Plan and a letter of support for the Plan is attached as appendix 8.2.

The rural funding process between SCDHB and the rural contracted providers within the South Canterbury region has now been formalised for the distribution of Rural Primary Care Funding.

Development of both the Aoraki HealthPathways and HealthInfo providing DHB endorsed patient information continues. The Electronic Referral Management System (ERMS) is now well embedded and most general practices have adopted the option of Dr Info to assist with clinical management.

All practices and pharmacies that requested access to Health Connect South now have this functionality. HealthOne was introduced in 2015 and this has increased sharing of information between community pharmacies, general practice and the hospital. During 2016 the DHB implemented the dynamic patient summary in HealthOne to share patient care plans e.g. Advance Care Plans.

Patients who are diagnosed as having a life limiting illness or condition are now supported in general practice to develop and agree an Advance Care Plan that is accessible to health professionals that may be involved in providing care to that person. This process involved agreement to a standard form, education and consultation with all providers, including aged care. There is now an Advance Care Planning pathway in place to guide staff.

During 2015/16 all general practices and pharmacies were supported to implement free general practice visits, including after hours and prescription co-payments for children less than 13 years of age.

During 2015, an Aoraki HealthPathway which encompasses the management of fragility fractures was introduced. This health pathway facilitates general practitioners to directly access DXA scans. Monitoring both the usage of DXA scans for this purpose and HealthPathway 'hits' is in place. The DHB will continue to explore data collection opportunities to evaluate effectiveness.

Pharmacists' services in the community are a critical part of the NZ health system. Community pharmacists are the experts in medicines management and their services could be better integrated with the wider health system. Consumers need to be at the heart of everything we do. Contracts need to support the delivery of services across primary care and the community and deliver on key government strategies such as the NZ Health Strategy, Implementing Medicines NZ, and the Pharmacy Action Plan. In addition to the national contract SDHB funds 220 places for INR monitoring and supports two pharmacy depots and an afterhours pharmacy to deliver after hours' services.

The DHB has already undertaken considerable work with local community pharmacies and now has access to reliable data on the Community Pharmacy Long-term Condition Programme. The infrastructure is now also in place to allow more meaningful medicines reconciliation on admission to hospital through use of the HealthOne framework and polypharmacy review in general practice is now supported through ready access to the DHB geriatrician. On receipt of the national Community Pharmacy Services Agreement guidance document, the Primary Care Alliance will formulate a plan to effect further service enhancements including establishing Service Level Agreements with local community pharmacies.

DHB's remains supported by a team of Primary and Community Services clinical nurse and allied health specialists and there is effective liaison between general practitioners and hospital specialists with immediate access to specialist advice as required.

Local focus for 2016/17

A major focus of the DHB during 2016/17 will be supporting the Primary Care Interim Alliance to maturity and embedding its oversight role for primary care. The DHB continues to support people with high health needs due to chronic conditions, acute medical or mental health needs, or terminal illness, through the Care Plus Programme with 87% of eligible people currently enrolled. Review of this programme will continue to ensure its delivery is in line with the national direction. Additional initiatives within primary care will be:

- The development of a local Primary Care Strategy once the national document is released;
- Implementation of the National Patient Enrolment service which will link to NHI and eSam for funding purposes; and
- Implementation of e-pharmacy primary care services and supporting Foundation Standards as a minimum in all general practices along with reaching the target for general practices engaged in Cornerstone Accreditation.

The DHB will continue to work with appropriate stakeholders, designing local pharmacist services that cost effectively match supply and demand as the national contract provides provision for. The DHB will continue to participate in national work towards different contracts for the provision of community pharmacist is services by working with consumers and a range of other stakeholders to develop service options. This will include local engagement with consumers and other stakeholders on potential options for pharmacist service delivery.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Support people with high health needs due to chronic conditions, acute medical or mental health needs, or terminal illness to access the Care Plus Programme.	Review the Care Plus programme to ensure those eligible have support to improve their chronic care management, reduce inequalities, and reduce the cost of services for those high-need patients.	Review of Care Plus completed by the Primary Care Alliance by March 2017. Care Plus is delivered in line with the national direction with 90% of eligible people enrolled in the programme by June 2017.
Provide clear direction for the development of primary care in South Canterbury.	Develop a local Primary Care Strategy.	Strategy document approved by the SCDHB Board and published by December 2016.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Confirm the Primary Care Alliance structure beyond its interim phase.	Review the existing interim Primary Care Alliance structure with a view to reflecting the broader primary care setting.	An Alliance structure which reflects a broader primary care sector is in place by March 2017.
Keep general practice at the forefront of safe, high quality primary healthcare delivery in South Canterbury.	Support the introduction of Foundation Standards Certification to Primary Care.	All practices have achieved Foundation Standards Certification or Cornerstone Accreditation by June 2017.
Improve operational effectiveness in general practice through a quality improvement framework providing assurance that practices are meeting a nationally consistent standard.	Support and encourage the introduction of Cornerstone Accreditation.	25 % of general practices have engaged in preparing for or have achieved Cornerstone Accreditation by June 2017.
Provide a single source of truth for all national enrolment and identity data.	Embed the use of the National Patient Enrolment Service into all general practices.	All general practices utilising the National Patient Enrolment Service by September 2016.
Reduce errors in medication prescribing and improve treatment information sharing between health providers.	Embed the use of the e-pharmacy into all general practices.	All general practices utilising e-pharmacy by December 2016.
Ensure that those in the community at 'end of life' have access to appropriate primary care palliative services.	Review the skill mix of the primary care and community workforce.	Review completed and a transition plan developed by September 2016.
Ensure all health partners involved in a patient's care are aware of the patient's future care plan.	Create electronic ACPs in the shared environment of HealthOne for view by other health care providers.	Electronic ACPs available by December 2016.
Improve health information sharing between health partners.	Embed the use of HealthOne into all general practices.	All general practices utilising health One by September 2016.
Improve the quality of primary care prescriptions and patient experience relating to medication management.	Roll our e-pharmacy across all South Canterbury general practices and pharmacies.	All general practices and pharmacies are utilising e-pharmacy by June 2017.
Improve the quality of INR monitoring in community pharmacies.	Benchmark local pharmacies performance to each other against a local target and against national delivery.	Monitoring on 'tests on time' and 'days in range' is within target with reports to the Primary Care Interim Alliance by March 2017.
Family Violence screening occurs in all health settings.	Develop an Aoraki HealthPathways which includes screening questions and referral pathways for support, when disclosures occur along with a process for submitting a 'Report of Concern' for suspected or actual child abuse or neglect.	Aoraki HealthPathway is in place by June 2017.
	Provide appropriate professional development to support family violence screening across the broader primary care setting.	Introductory session on the new pathway for general practitioners and practice nurse and nurse practitioners delivered by June 2017.

System Level Measures Framework

Current context snapshot

During 2015/16 the DHB transitioned from the existing Primary Care Performance Programme (PPP) to the Integrated Performance Incentive Framework (IPIF) and commenced monitoring against the first five indicators introduced. Results of monitoring have resulted in service improvements such as the development of an Aoraki HealthPathway for 'Hard to Reach' women who have declined a cervical smear.

Local focus for 2016/17

The Ministry of Health has worked closely with the sector to co-develop a suite of System Level Measures for the health sector to show how the health system is performing and the value the country is receiving from it.
The following four System Level Measures will be introduced for 2016/17:

- Ambulatory Sensitive Hospitalisations (ASH) rates per 100,000 for 0-4 year olds
- Acute hospital bed days per capita (i.e., using health resources effectively)
- Patient experience of care (i.e. person-centred care)
- Amenable mortality rates (i.e. prevention and early detection).

Two further System Level Measures will be developed during 2016/17:

- Number of babies who live in a smoke-free household at six weeks post-natal (i.e. healthy start)
- Youth access to and utilisation of youth appropriate health services (i.e. teens make good choices about their health and wellbeing).

As well as a system wide view of performance, we need the ability to measure outcomes for each of our system's component parts. The DHB is committed to working with the Primary Care Interim Alliance to jointly develop an agreed Improvement Plan to meet the agreed improvement milestones for each System Level Measure.

The system level measures to be introduced in 2016/17 rely on the contributions of a wider group of providers, expanding the 'one team' approach. The DHB's Primary Care Alliance will drive implementation of the Improvement Plan.
An additional focus for 2016/17 is progressing access to patient e-portals.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Implement the System Level Measures Framework.	Jointly develop with all stakeholders an agreed Improvement Plan to meet jointly agreed milestones for each System Level Measure.	Improvement Plan submitted to the Ministry on behalf of the district alliance by 20 October 2016.
Partner with patients to provide coordinated care and improve patient self-management.	Support general practices to introduce processes to enable the introduction of a 'patient portal'.	All practices that request access have an Implementation Plan approved by September 2016. Practices with an Implementation Plan have at least 100 patients using the portal by 31 March 2017.

2.5.6 Emergency Care

Current context snapshot

The 2015/16 Q2 result showed 96.1 percent of patients were admitted, discharged, or transferred from the emergency department within six hours. This target has been consistently met and the DHB will focus on sustaining this level of performance. During 2015/16 monitoring mechanisms for the 21 mandatory measures, as defined in 'A Quality Framework and Suite of Quality Measures for the Emergency Department Phase of Acute Patient Care in New Zealand March 2014', were introduced with regular reporting occurring to the Emergency Department Operational Group. A review of patient flow was completed in conjunction with the Health Round Table which included facility design, triage process and staff responsibilities and provided the opportunity for three non-mandatory measures: an audit of staff triaging practice to standardise approach, an audit of discharge summary completion to ensure a consistent standard and an audit of pain relief administration resulting in the development of a standing order for analgesia. These measures have provided the service with data on which to implement learnings for service improvement.

Local focus for 2016/17

The emergency department's focus during 2016/17 will continue to be the implementation of the 'Front of House' project which will see input into facility design detail, further review of processes to improve patient flow in line with facility re-design and aligning staffing levels to support the changes made. The DHB is committed to providing Health Target performance by ethnicity from Q1 2016/17.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Provide a contemporary emergency department facility which optimises efficient and effective patient flow and meets the current and future needs of the South Canterbury community.	Participate in the design detail phase of the facility upgrade of the hospital emergency department.	Design plans are approved by December 2017. Achievement against Emergency Department Quality Improvement Framework performance measures 48 and 49.
	Further review and consult on process flows that impact on the efficient functioning of the emergency department.	Further documented process flows are approved and communicated by June 2017. Additional patient journey time-stamp audits commenced by December 2016. Achievement against Emergency Department Quality Improvement Framework performance measure 4.
Align human resource support to efficiently and effectively support the upgraded emergency department facility.	Complete the SMO job sizing for emergency physicians.	New roster pattern in place by June 2017. Achievement against Emergency Department Quality Improvement Framework performance measure 50.
	Review the nursing roster pattern to ensure optimal coverage and ensure staff health.	New roster pattern in place by June 2017. Achievement against Emergency Department Quality Improvement Framework performance measure 50.

2.5.7 Whānau Ora

Current context snapshot

The DHB remains committed to focusing on achieving progress towards Whānau Ora and health equity within the five health priorities: mental health, asthma, oral health, obesity and smoking cessation. Progress is evaluated through the following measures:

- Mental health – reduced rate of Māori committed to compulsory treatment relative to non-Māori;
- Tobacco – 95 percent of all pregnant Māori women smoke free at two weeks post-natal;
- Asthma – reduced asthma and wheeze admission rates for Māori children (ASH 0-4 years)
- Oral health – increase in the number of children who are caries free at age five; and
- Obesity – by December 2017, 95 percent of obese Māori children identified in B4 School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

SCDHB funds the local Māori health provider, Arowhenua Whānau Services (AWS) for the provision of health services to local Māori. In the past, participation with Te Herenga Hauora o Te Waka o Aoraki (Te Herenga) has been a mechanism to ensure consistent support across the South Island DHBs to the Te Waipounamu Whānau Ora provider collective – Waka Ora. With the new commissioning agent starting up in 2014 the Te Herenga forum is also providing the opportunity for the South Island DHBs to engage with Te Putahitanga to discuss collaborative planning & funding for Whānau Ora specific initiatives.

Local focus for 2016/17

South Canterbury DHB will actively participate in the process for implementation of the Whānau Ora Information System with our local Māori Health provider, Arowhenua Whānau Services once available. SCDHB has also agreed to support Arowhenua Whānau Services to develop their service model to encompass a broader Whānau Ora approach for the whānau they are working with, whilst keeping focused on the hauora aspects of whānau care and support. For additional specific actions to address inequity in health outcomes for Māori refer to the SCDHB Māori Health Plan.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Increase engagement and collaboration with the South Island Commissioning Agency, Te Putahitanga.	Work with and identify a least one project with Te Putahitanga that can advance the Whānau Ora approach across Te Waipounamu.	Progress against identified project demonstrated by June 2017.
Decrease health disparities in health outcomes for our local Māori population.	Support the development of a Māori Model of Care that effectively coordinates broader service delivery for Whānau.	Māori Model of Care in place by June 2017.
Ensure adequate information technology support to aid Whānau Ora.	Support the implementation of the Whānau Ora Information System at AWS.	Whānau Ora Information System implemented once available.

2.5.8 Improve Access to Diagnostics

Current context snapshot

General practitioners have direct access to a number of diagnostics including a comprehensive suite of flat films, direct access to ultrasound and CT and CTC as per Aoraki HealthPathway guidance. Referral processes are supported through e-referrals. Results for 2015/16 Q2 show 95.1 percent of patients receive their CT scan within six weeks and 90.6 percent their MRI within six weeks.

The DHB continues to work with both regional and national clinical groups to contribute to the development of improvement programmes. It has an active project plan for the National Radiology Service Improvement Initiative. Recent service improvement activity has focused on improving referral pathways for general

practice access to bring it in line with the Ministry of Health National Criteria for Community Radiology e.g. hi-tech imaging.

General practitioners also have direct access to respiratory and cardiac diagnostics, nerve conduction studies, DXA scans and colonoscopy.

Results for colonoscopy waiting times for the 2015 calendar year ranged from 70% to 100% (average 83.9%), of people receiving their urgent diagnostic colonoscopy within two weeks, 23% - 52.4% (average 40%) a diagnostic colonoscopy within six weeks and 24.5% - 48.6% (average 36.6%) surveillance or follow up colonoscopy within 12 weeks of planned date. Patients are triaged using the National Referral for Direct Access to Outpatient Colonoscopy and CT colonography is used to full capacity. Aoraki HealthPathways for Colorectal Symptoms and Bowel Screening are in place. Whilst the national Endoscopy QIP has disestablished the local Endoscopy User Group continues to work within these principles. In order to address timeliness against targets the DHB has scheduled additional endoscopy sessions to meet the backlog of surveillance and non-urgent procedures. The service has also transitioned to a single generic waiting list for colonoscopy to ensure equity in access.

Local focus for 2016/17

The DHB will focus on improving its timeliness of non-urgent and surveillance colonoscopy during 2016/17 along with its preparation for IANZ Accreditation of its radiology service.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Increase the timeliness of non-urgent and surveillance colonoscopy.	Increase resourced capacity for non-urgent and surveillance colonoscopy through the appointment of an additional general surgeon.	Progressive improvement each quarter against the target of 70% of people accepted for a non-urgent diagnostic colonoscopy receives their procedure within six weeks. Progressive improvement each quarter against the target of 70% of people accepted for a surveillance colonoscopy receives their procedure within twelve weeks.
Meet contemporary radiology practice standards.	Prepare for IANZ Accreditation of DHB radiology services.	Processes reviewed and documentation completed in readiness for IANZ audit by June 2017.

2.5.9 Elective Services

Current context snapshot

The DHB is committed to delivering the expected number of health target discharges. 3,175 elective surgical discharges will be delivered by the SCDHB in 2016/17. This volume includes 'arranged' and elective discharges within prescribed treatment groups. SCDHB maintains its commitment to sustain current volumes of service delivery and to treat patients in accordance with assigned clinical priority and waiting time. It also continues to work with other South Island DHBs to deliver on the South Island Regional Services Plan activity relating to elective services for the region and continues to engage actively in the South Island regional work stream for elective services.

The SI DHBs have agreed that each DHB plans to deliver its share of the additional regional surgical discharges as set out in the Electives funding advice, namely: NMDHB (72), WCDHB (17), CDHB (219), SCDHB (30), SDHB (137). SI Total (475). The SI DHBs have agreed that they will seek collegial support to deliver the volumes if

that is required. The expectation for SCDHB of 30 elective surgical discharges is included in the total health target of 3,175 elective surgical discharges as mentioned above.

Development of Aoraki HealthPathways continues and provides guidance for referral. There are well established processes for monitoring and reporting on Elective Services Performance Indicators (ESPI). Achievement in this continues to be aided by the use of national, or nationally agreed CPAC tools and sound production planning. New national prioritisation tools introduced to date continue to be monitored to ensure compliance in practice by all clinicians. The DHB remains committed to meeting the four-month target for FSA and commitment to treatment, with processes now embedded and regular monitoring and evaluation occurring.

The Early Recovery After Surgery (ERAS) programme continues in general surgery with a standardised patient pathway for patients undergoing colorectal surgery developed utilising this framework. The DHB will continue to implement the National Patient Flow System as phases are developed.

Work was undertaken in 2015/16 to review dental clinic scheduling and composition which has resulted in a reduction in unnecessary follow ups. Work has also commenced on localising pathways to inform general practice on secondary dental service referral requirements and this work will be completed in 2016/17. The DHB continues to work with the DHB Hospital Oral Health Group to review all aspects of hospital services to ensure equitable access to services.

Work was undertaken in 2015/16 to improve waiting times ensuring timely access for children requiring dental interventions under general anaesthetic. Close monitoring will continue to ensure that improvement is sustained.

With the retirement of local speciality clinicians, alternative models of care have been explored and selected to ensure that services will continue to be delivered locally to the people of South Canterbury. In 2015/16 arrangements were made for urology services to be provided by a private provider who is supported by the introduction of DHB based urology nurses. SCDHB has purchased and re-branded the 'South Canterbury Eye Clinic' with an ophthalmologist appointed and scheduled to start in August. Work has commenced on developing a clinical pathway to CDHB for maxillofacial and dental treatments along with local treatment protocols to reduce unnecessary IDF out of district.

Local focus for 2016/17

The focus for the coming year will be on bedding down new models of care in urology, ophthalmology and maxillofacial and dental services.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Provide a local urology service.	Embed local protocols for urology acute presentations and elective surgery follow up care.	All required protocols in place for clinician guidance by September 2016.
Provide an ophthalmology service which meets the needs of the local community.	Select and implement an ophthalmology model of care for SCDHB.	Preferred option in place by December 2016.
Provide a maxillofacial and hospital dental service which is delivered locally where possible.	Embed the maxillofacial pathway for transfer of patients to CDHB.	Transfer protocol in place by September 2016.
	Develop management protocols for acute maxillofacial presentations.	Protocols for acute management agreed and published by September 2016.
	Complete development of local protocols for acute dental presentations.	Local protocols agreed and published by September 2016.
	Complete localising dental health	All Aoraki HealthPathways for

Action Plan 2016/17		
Objective	**Action**	**Evidence**
	pathways to inform general practice on secondary dental service referral requirements.	dental conditions localised, agreed and published by December 2016.

2.6 Regional Service Delivery

2.6.1 Reducing Hepatitis

Current context snapshot

Hepatitis clinics providing treatment for hepatitis B and C are currently run from secondary services. The DHB is working with the Hepatitis Foundation who holds the contract for supporting people across the South Island with hepatitis B.

Local focus for 2017/18

SCDHB will work regionally with the Ministry through the South Island Alliance to further develop a regional hepatitis C service for those people at risk of or with established hepatitis C disease within the region. This involves a model of care which includes an agreed clinical pathway.

2.6.2 Major Trauma

Current context snapshot

In response to the National Trauma Programme Implementation Plan, SCDHB worked regionally to develop and implement a formal South Island Region Major Trauma Plan which ensures more patients survive major trauma and recover with a good quality of life. The DHB has a clinical lead aligned to this initiative that represents SCDHB at regional and national work stream activity, networks and forums. They are supported by a nurse coordinator who is responsible for coordinating a training programme targeted at SCDHB staff and liaising with the IT team so that the DHB contributes to the regional reports on major trauma using the agreed national minimum dataset and contributes to the National Major Trauma Registry. They will also liaise with clinicians regarding trauma patients, providing assistance in coordinating their care.

Local focus for 2016/17

During 2016/17 the DHB will embed established processes such as major trauma protocols and standards of clinical care at Timaru Hospital, specifically:

- Review of all SCDHB trauma management guidelines and protocols;
- Delivery of a localised training programme; and
- Establish a local Major Trauma Review Group to review DHB performance to national quality markers, and ensuring local consistency with regional and national protocols including inter hospital transfer protocol and retrieval 'destination' policy.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Provide local oversight of major trauma care presentations and management.	Establish a local Major Trauma Review Group.	Regional reports National Major Trauma Registry of entries and national minimum datasets are reviewed by the Major Trauma Review Group by June 2017.
Implement regionally agreed protocols for major trauma management.	Review all existing protocols relating to trauma and update to reflect regionally agreed standards of clinical care delivery.	Protocols updated by June 2017.
Equip staff to effectively receive	Develop a training plan for use for	Training plan developed by June

Action Plan 2016/17		
Objective	**Action**	**Evidence**
and manage those patients experiencing major trauma.	those staff dealing with patients who have experienced major trauma.	2017. Relevant staff complete training during 2017/18.

2.6.3 Spinal Cord Impairment Action Plan

Current context snapshot

Canterbury DHB is our regional provider of spinal services and regional management and transport protocols are in place to safely ready patients for transfer from our acute services when acute spinal cord injuries present. In line with the New Zealand Spinal Cord Impairment Action Plan 2014-2019, SCDHB worked in partnership with its regional provider, Canterbury DHB Spinal Unit and St John Ambulance during 2015/16 to implement agreed nationally directed destination and referral processes for acute spinal cord injuries ensuring the local protocol was updated to reflect a regional response.

Local focus for 2016/17

The DHB will continue to raise staff awareness of the agreed regional clinical pathway for the transfer of acute spinal cord injuries to ensure safe transfer of those patients experiencing spinal cord injury to the regional spinal unit.

CHAPTER 3: STEWARDSHIP

3.1 Workforce

3.1.1 Managing our Workforce within Fiscal Constraints

Current context snapshot

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

Local Focus for 2016/17

South Canterbury DHB is participating in the creation of pay structures and conditions to support DHB business and workforce objectives with particular emphasis on the regional administrative workforce and national medical workforce.

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

We will continue to support and advance the work which was initiated by Health Benefits Limited (HBL) and now the responsibility of the 20 DHBs in the form of NZ Health Partnerships, in regards to governance and engagement, funding planning and programmes which will improve efficiency and contain costs.

SCDHB will specifically continue to support the national programmes, National Oracle Solution (NOS), National Infrastructure Platform (NIP) and initiatives relating to banking and insurance and national procurement.

South Canterbury DHB Workforce (December 2015)

Average age - 48 years		
Gender Mix	**Female** **Male**	82.00% 18.00%
Largest Ethnic Group	**NZ European**	62.00%
Hours of work	**Full time** **Part time/casual**	32.30% 67.70%

Professional Grouping	Contracted FTE
Allied Health	96.6
Nursing	295.50
Medical	63.00
Support	43.90
Management and Admin	110.80
Total	**609.80**

3.1.2 Strengthening our Workforce

Current context snapshot

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

The aging population and aging workforce continue to influence our planning and strategy development with more than 40% of staff 50 years old or older. Our Director of Nursing and Midwifery (DONM) also chairs the Nursing project group 'Sustaining the Workforce' which provides recommendations in regards to improved utilisation of nurses, encourages the active contribution of older nurses as long as possible, and is developing guidelines for nurse leaders to handle health concerns.

Our DHB will support South Island regional plans to expand the role of nurse practitioners, clinical nurse specialists with particular focus on palliative care and to support the training of sonographers and increasing the number of medical physicists to meet identified South Island need.

The DHB will continue to implement the supported actions of the Allied Health Review.

Local Focus for 2016/17

SCDHB will continue to support the goals of our South Island Workforce Development Hub and will participate in the various national and regional initiatives using the Workforce Intelligence and Planning Framework as the basis.

We will strengthen professional leadership and ensure that capability frameworks and leadership development fit with the national domains.

We will also update our workforce profile data and test the workforce development planning tool locally.

South Canterbury DHB will implement medical community based attachments to optimise the capacity and capability of interns meeting the new requirements of the Medical Council.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Test a national workforce development planning tool.	Participate in the development of the business case and test the tool using local information.	National workforce planning tool testing completed by June 2017.
Create and implement a community attachment which meets the requirements of the Medical Council.	Create and implement the community mental health attachment with at least one PGY2 intern per quarter.	Four rotations completed by June 2017.
Implement the supported findings of the Allied Health and Clinical Nurse Specialist Reviews.	Implement approved Allied Health and Clinical Nurse Specialist Review Action Plans.	Approved actions completed by June 2017.
Improve access to professional learning opportunities.	In line with regional activity provide a common e-learning platform for all DHB staff.	Common e-learning platform is available to all DHB health workforce staff by June 2017.
	Increase the number of regional e-learning packages available.	Regional e-learning packages are available. Ongoing.
Increase Māori and Pacifica participation in the Health Workforce.	Identify ways to increase the participation of Māori and Pacifica in the workforce and develop an agreed action plan jointly with GM Māori Health and relevant stakeholders.	Action Plan completed and participation rate increased by 10% by June 2017.
Build general leadership/management capability using regional leadership/management frameworks.	Develop standard induction programme for key managers and gateways to further development in partnership with the staff development unit.	Programme developed and gateways identified by June 2017.

3.1.3 Organisation Health

Current context snapshot

SCDHB will build on the positive organisation culture as reflected in previous results.

Local Focus for 2016/17

During 2016/17 the follow up actions of the staff survey will be embedded and further areas for improvement identified. Senior managers will give direction and focus to various projects and engage with staff.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Enhance organisation culture and employee engagement.	Embed actions of completed staff survey.	Actions completed and embedded by December 2016.

3.1.4 Health4You

Current context snapshot

The DHB is continuing the pro-active approach to employee health through its Healthy Workplace Programme by providing a variety of initiatives to empower staff to understand and improve their health. The targeted areas are improved nutrition, encouraging physical activity and workplace resilience. The subsidised gym memberships with our providers will continue as will the free flu vaccination programme for staff.

Local Focus for 2016/17

In the 2016/17 year we will continue with our holistic approach to health which includes activities encouraging leadership development, team building and employee resilience.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Adopt a holistic approach to employee health.	Continue the SCDHB Healthy Workplace Programme.	Programme delivered according to timeframes.

3.1.5 Health and Safety

Current context snapshot

SCDHB has adopted a best practice approach to health and safety which is reflected in our ongoing participation in the ACC Workplace Safety Management Practices Programme (WSMP). We benefit from specialised advice and co-ordinated injury prevention and claims management through ACC's Employer Centric Services programme. We maintain a safe and healthy environment by complying with all relevant legislation, regulations and codes of practice and are active, consultative and committed to all areas of health and safety management in the workplace.

Local Focus for 2016/17

During 2016/17 we will continue to ensure that our policies, procedures and practice align with the legislation changes. Our focus will be intelligence-led risk analysis and incorporating health and safety in facility design, procedures and practice.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Improve communication and empower representatives and other employees to carry out their role effectively.	Review our defined 'work groups'. Improve communication channels using electronic and printed forums.	Improved engagement measured by staff survey and number of pro-active improvements relating to health and safety initiated by staff.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Improve our health and safety system and transition all documentation to one accessible electronic source.	Identify any health and safety system gaps and complete transition of all documentation.	One electronic information source accessed by all and meeting regulatory requirements by June 2017.

3.1.6 Care Capacity Demand Management and Trendcare

Current context snapshot

SCDHB participates in the Care Capacity Demand Management (CCDM) programme supported by the Safe Staffing Health Workplace Unit and in partnership with the unions. The CCDM programme is designed to assist the matching of service demand with service capacity to ensure the right number and skill mix of staff meet patient needs. Trendcare, a technology system to measure patient acuity has been successfully implemented and provides data to support the CCDM programme. In addition, a 'capacity at a glance' (CaaG) and a variance indicator board were implemented in 2016/17. A CCDM Council and coordinator role continues to drive the effective implementation of the programme throughout the organisation and reporting has been established.

Local Focus for 2016/17

The DHB's main focus for 2016/17 will be to review its nursing model of care in generalist services. It will also continue to embed the CCDM programme with a focus on improving the match between demand and capacity utilising the PDCA cycle and further developing the CaaG screen to include 'Patient Status at a Glance' information. The DHB will also explore the benefits of utilising Trendcare for the allied health workforce.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Provide a nursing service in generalist areas which is contemporary and reflects best practice principles.	Review the nursing model of care for medical, surgical and AT&R inpatient services.	Model of nursing care agreed and implemented by June 2017.
Achieve the best match between patient demand and nursing capacity within inpatient services.	Implement the 2016/17 CCDM Work Plan.	Monthly reports received by the CCDM Council with updates provided to the Clinical Board and Hospital Advisory Committee by June 2017.
Improve the productivity of the allied health workforce and match staff skills to service need.	Establish a project group to implement Trendcare for allied health.	Trendcare reports available on allied health workforce activity by June 2017.

3.1.7 Workforce Development

Current context snapshot

SCDHB remains actively engaged in national activity with Health Workforce NZ (HWNZ) and regional activity through the South Island Workforce Development Hub involving the regional workforce development director and regional service planning process.

While necessary to develop support for our aging workforce it is equally important that more local young people are effectively engaged and attracted to health careers with a focus on undergraduate qualifications. To address this, SCDHB continues to run the Incubator Programme in High Schools and participates in career events as well as targeting year ten students by participating in the Work Inspiration Project. We also continue to create paid work experience for students who are participating in tertiary health education.

During 2015/16 the DHB participated in the South Island Workforce Development Hub Calderdale Framework training and developed a SCDHB pilot project for the implementation of the Framework.

The capability of healthcare assistants has been enhanced through the Healthcare Assistants Training Programme implemented in 2015/16. We continue to work in partnership to have both the CPIT midwifery cohort and the Otago Polytechnic nursing cohort locally.

We support the principles of equal opportunity and therefore promote career opportunities for Māori and Pacific Island youth and continue to actively engage with the Kia Ora Hauora Māori Health Careers Programme locally. SCDHB will continue the partnership with Māori stakeholders and be guided by Te Waipounamu Māori Health Workforce and other national plans. In order to enhance opportunities Māori and Pacific Island nursing graduates' applications are all put forward for interview at the short listing stage of selection for the Nurse Entry to Practice Programme.

SCDHB continues to engage with staff in career planning.

Local Focus for 2016/17

During 2016/17 the DHB will continue to build on the work completed in previous years especially in relation to supporting the unregulated workforce, the transition of core training requirements to the regional e-learning approach and continuing to attract youth to the health sector. The DHB will continue to support the regional implementation of the Calderdale Framework by evaluating the pilot implemented during 2015/16.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Increase workforce productivity whilst ensuring safe, effective and productive patient centred care through a review of staff skills, roles and service design.	Evaluate the implementation of the regional Calderdale Framework.	Evaluation report received by Clinical Board by June 2017.
Maximise gains for the DHB education delivery post e-learning implementation of HealthLearn, the regional e-learning platform.	Identify core training suitable for online delivery and transition to the regional e-learning platform.	Core education is available online to DHB staff 24 hours seven days a week by June 2017.
Equip new clinical leaders to fulfil all expectations of their leadership role.	Evaluate the DHB clinical leadership induction programme.	Evaluation completed and report prepared with recommendations for programme modified based on feedback by June 2017.

3.2 Information Technology

3.2.1 Building Capability

Current context snapshot

SCDHB is committed to working regionally as part of the South Island Information Systems Service Level Alliance (SIISSLA) to invest in new information systems. The South Island is to review, and change the way healthcare is delivered to consumers enabling a sustainable and integrated service to be provided over the coming years. This goal is to improve support for community services, better access by GPs, to DHB clinical and patient information and to provide greater integration and visibility across the continuum of care for both care teams and users of the health service.

Local focus 2016/17

This plan has an emphasis on clinical systems and supports the National Health IT Plan by developing, implementing and maintaining appropriate information systems aligned to both its Regional Service Plan and Annual Plan. Explicit approval for each of these items is required before proceeding.

SCDHB Share of Regional/National Projects

$000s	2015/16	2016/17	2017/18	2018/19	2019/20
Advance Care Plan	-	6	-	-	-
After hours cover	-	-	-	-	-
Base Alliance Contributions	-	-	-	-	-
Clinical Work Flow Suite	125	-	-	-	-
Data Architecture	-	-	-	-	-
E-Learning	21	22	-	-	-
Electrocardiogram	-	46	-	-	-
E-Medications	-	-	-	-	-
E-Medication Reconciliations	-	51	48	-	-
E-Ordering Laboratory	-	-	64	-	-
E-Ordering Radiology	-	75	-	-	-
E-Pharmacy	-	51	48	-	-
E-Prescription Repository	-	9	-	-	-
E-Referrals - Stages 1 and 2	-	-	-	-	-
E-Referrals - Stage 3	-	106	-	-	-
Growth Charts	4	2	-	-	-
Health Connect South (HCS)	-	-	-	-	-
HCS - Mobility	-	-	-	-	-
HCS - Soprano Medical Templates and Transcription	-	-	-	-	-
HealthOne	148	-	-	-	-
Jira Licences	-	-	-	-	-
Lippincott's nursing procedures	-	-	-	-	-
Multi-Disciplinary Meeting (MDM)	-	12	-	-	-
Mental Health Module	34	8	-	-	-
Metriq	-	-	-	-	-
Pace ART	-	-	-	-	-
Patient Track	-	216	-	-	-
Problem Lists	-	12	-	-	-
Provider Index	-	18	-	-	-
Proximity Auditing (HCS)	-	-	-	-	-
Regional Network Security	-	-	-	-	-
RL6 Solution	-	8	-	-	-
Silhouette	-	3	-	-	-
South Island PICS	485	615	1,133	691	46
National Oracle Solution (NOS)				950	
	817	1,259	1,293	1,641	46

3.2.2 Information Communication Technology

Current context snapshot

During the 2015/16 year SCDHB has continued to progress a programme of local, regional and national initiatives to improve information systems integration and functionality within the DHB environment. This includes virtualising servers to support disaster recovery initiatives and prepare for the National Infrastructure Platform (NIP) change, implementation of HealthOne and e-sign-off for laboratory results.

Local focus 2016/17

Patient Information Care System (PICS) - The National Health IT Board (NHITB) is driving the development of regional information systems including the integration of patient administration with clinical systems.

National Oracle Solution – SCDHB is awaiting further information on the programme going forward.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
FMIS - Replace existing Sun Financial System with Oracle.	Work with national and regional teams to plan implementation once Oracle v12 is ready and in place.	New financial system will be in place for procurement, accounts receivable, accounts payable, month end processes and reporting; provisional timeframe March 2018.

3.2.3 Clinical Technology/Communication

Current context snapshot

During the 2015/16 year SCDHB have implemented a number of system improvements to support clinical practice including HealthOne, and
e-sign-off.

Local focus 2016/17

During 2016/17 the DHB will continue to implement programmes to support safe medication management, clinical information sharing and the e-Learning platform for staff.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
e-Ordering	Implement electronic ordering for radiology and laboratory tests.	This will be completed in two parts, with radiology by June 2017; labs by June 2018.
e-Learning	Implement the regional e-Learning platform led by the South Island Regional Training Hub.	Access to the training hub for all staff by June 2017. Interface to update HR records is working and in place by Dec 2017.
Regional Data Warehouse	Agree a technical solution to enable the implementation of a regional data warehouse for all South Island DHBs.	Data warehouse is set up in support of PICS and being used by all DHBs in the South Island Region 2015-2018.

3.3 Quality and Safety

3.3.1 Safety Markers

Current context snapshot

The DHB continued to achieve a high level of engagement during 2015/16 against the four key focus areas of the Patient Safety Campaign – 'Open for Better Care' and the DHB will continue to engage with these Health, Quality and Safety Commission work programmes.

The DHB continues to build capability in quality and safety through the use of improvement science methodology. A train-the-trainer approach has been employed and is being rolled out across the organisation. At SCDHB, quality and risk activities, including the safety marker work, is supported centrally, and managed within the specific clinical area wherever possible. For example, the safe surgery work is being led by the service manager, surgical service, clinical director anaesthetics, and the charge nurse manager of theatre, and is supported by a quality and risk nurse coordinator. Alternatively, where a topic impacts upon a number of services, or across the organisation as a whole, such as with falls, the management is provided by the quality and risk team, with a team of representatives from across the organisation supporting. This model promotes ownership within specific services, and also a clear vision of all improvement activities centrally.

SCDHB takes the view that quality, both assurance of current performance, and improvement activity, is everyone's responsibility, hence the emphasis on ownership within the clinical areas. The SCDHB view is that organisational improvement is best achieved through centralised trained quality and improvement staff working to support activities across the services delivered. The quality team is also active in educating staff across the organisation and providing them tools so they can undertake their own improvement and quality focused activity. Regular quality reports are received by the Hospital Advisory Committee, Audit and Assurance Committee and the Board.

SCDHB continues to work hard to ensure engagement is maintained with national and regional activity by managing and allocating this resource as new requirements are identified.

The Integrated South Canterbury Combined Falls Steering Committee is delivering on its work plan and continues to lead change and integration activities across the DHB and local community. The QSM result for falls in the 2015/16 year continues to show strong performance in the number of older patients assessed for falls risk on admission to hospital but was more variable when it came to an individualised care plan being developed. The DHB is committed to improving its performance in the later area, and to sustaining its performance in providing risk assessments. The DHB will continue to utilise falls data collected and root cause analysis/case review investigations to identify further opportunities for falls reduction and harm minimisation. The DHB also aims to consolidate the reduced number of SAC 1 or 2 falls reported and are committed to sustaining this result through falls and related harm prevention activity.

The DHB is also committed to sustain and further improve its compliance with Good Hand Hygiene Practice and is working under the oversight of the Infection Control Committee. A pool of nursing staff, including quality improvement practitioners and the infection control nurse, has been trained to complete audits. The current number of trained auditors allows us to audit the required number of hand hygiene moments per period. Should audit numbers drop, further auditors will be identified and trained as per national process. This team is active in the promotion of good hand hygiene and contributes to the distribution of national infection control messaging to staff, patients and visitors. With the target increased to 80 percent compliance, the DHB is well placed to improve on its compliance level, having already reached the target in repeated QSM periods. Education is targeted to areas and staffing groups where performance does not meet the expected standard.

With the change to the surgical safety QSM requirements coming into place in July 2016, the DHB will work with the HQSC and its regional colleagues to ensure that targets are achieved. The DHB is currently engaged in cohort three of the safety work being led by HQSC. Whilst working with this new marker we will continue to monitor and record the previous QSM which has been retired. As with all other DHB's engaged in the process we will be working towards ensuring the checklist is in a paperless form ensuring this is used as a teamwork and communication tool rather than an audit tool. A recent visit to the DHB from HQSC has found that Timaru Hospital stood out with the work they are doing on communication and teamwork initiatives (briefing and debriefing) in the operating theatre.

The DHB performs well against the surgical site infection marker with Q2 2015/16 results showing 100 percent (target 100%) of patients receiving hip and knee replacement surgery received antibiotic cover in the required timeframe of 0 – 60 minutes before "knife to skin", 95 percent (target 95%) of cases receiving 2g or more of cefazolin or cefuroxime 1.5g and 100 percent having had the appropriate skin preparation. No new initiatives are planned at this stage for this QSM however action will be taken should results indicate the need. The DHB will continue to develop its infection management systems and is committed to sustaining performance against these quality safety markers and adherence to the clinical standards specified by the Surgical Site Infection Programme for all hip and knee surgery. Current performance against the skin antisepsis in surgery sits at a 100 percent and the DHB will work to maintain this result. The DHB will commit to meeting infection control expectations in accordance with the Operational Policy Framework – Section 9.8. and the continued development of infection management systems at our local DHB level.

The DHB is committed to working with contracted providers, the Ministry of Health, ACC and HQSC to encourage clinicians to complete treatment injury claim forms for pressure injuries with a grade greater than one, to provide a more accurate picture of the incidence of pressure injuries occurring while patients are in our

care. This is supported through the ACC coordinator role located at the hospital. Treatment injury claims are also identified on entry to district nursing services at the time of referral.

The DHB has well established processes relating to the prevention and management of pressure injuries based on evidence-based prevention approaches. These include risk assessment, classification of pressure injuries and use of pressure relieving devices. Staff are well supported to upskill in the area of identifying and grading pressure injuries through an e-learning package.

The incidence of pressure injury is reported through Safety1st (electronic incident reporting system) and monitored through the Patient Safety and System Improvement Committee. All pressure injuries graded above three are reported to the HQSC as serious adverse events. The DHB will continue to engage with the national quality group to set expectations and share learnings.

The DHB commits to surveying the experience of care patients received using the national core survey, at least quarterly. The DHB has continued to be rated at the upper end of the national average for each of the four domains of the National Patient Experience Survey. The DHB is taking part in the 'Cemplicity' run review of those not completing surveys. The DHB is continuing in its efforts to increase the number of electronic responses and to increase the number of e-mail addresses captured on patient admission forms.

Community input continues to be sought and incorporated into the DHB's Quality Account. The focus of the Quality Account remains one of providing answers to questions posed by our community and producing the document in a way that is accessible and they find easy to read. This resulted in the 'DHB Family' remaining the central point for the 2014/15 version with data, recent initiatives and patient stories provided around the appropriate family member demographic. This document will include the data as outlined in the Quality Account guidance such as adverse events, QSM data and health targets.

Speciality morbidity/mortality data is collected and reviews occur with reporting of recommendations being made to the Clinical Board where appropriate. The DHB continues to support national mortality review committees through submission of data and local activity such as the Child and Youth Mortality Review Group. Mortality Review Committee Annual Reports are reviewed by relevant groups to identify potential risk for the organisation and improvement opportunities.

SCDHB continues to hold the chair of the National Quality Managers group and has close links with the Health Quality and Safety Commission and is a member of the South Island Quality and Safety Service Level Alliance.

Local Focus for 2016/17

The DHB will continue work to improve its performance against the QSMs, including using the WHO Surgical Safety Check List as a communication tool rather than as an audit tool, in preparation for the revised marker planned for in this area for 2016/17. During 2016/17 it will work with primary care to introduce a Primary Care Patient Experience Survey and reporting system. Whilst DHBs hold contracts with general practices this initiative is funded directly by MoH for a three-year period and as such has no DHB financial implications.

Electronic medicine reconciliation has been deferred till 2017/18 as per the South Island Alliance Work Plan. In the interim the current paper-based process will continue for patients on admission to medical, surgical, intensive care and assessment, treatment and rehabilitation units to allow any discrepancies to be reconciled. Regular monitoring will continue against this indicator.

Following on from the success of the South Canterbury Falls Prevention Group the DHB will establish an integrated steering group for the prevention of pressure injuries.

SCDHB will continue to look at how it engages with consumers. Initial discussions on a consumer council have been held with the Senior Leadership Team, and the supporting documentation for such a group has been drafted should this be the decision taken. SCDHB is committed to finding the best and most effective communication methods with its community, such as through the consumer chaired Clinical Board, having consumer representatives on significant project groups and committees, and through attending community events where DHB activities (e.g. Quality Accounts) can be discussed with those attending.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Improve falls care planning for older patients when they have been assessed as having a falls risk.	Utilise QSM and related falls data to recommend and support improvement activity to increase the rate of older at risk patients being given an individualised care plan.	90% of older patients are given a falls risk assessment. Ongoing. 98% of older patients assessed as at risk of falling have an individualised care plan to address the risk. Ongoing.
Achieve the revised national target of 80% compliance with Good Hand Hygiene practice.	Utilise QSM data to identify areas / staff groups needing improvement and provide focused training and support with improvement processes. Present and discuss QSM data at relevant fora.	80% compliance with good hand hygiene practice. Ongoing.
Move the WHO Surgical Safety Checklist away from being an audit tool towards it being used as intended, as a teamwork and communication tool.	Work with the Health Quality and Safety Commission through a regional network approach to roll out a teamwork and communication quality improvement bundle including a paperless surgical checklist and briefing and debriefing process for each theatre list.	All three parts (sign in, time out, sign out) of the surgical safety checklist are used in 100 percent of surgical procedures, with levels of team engagement with the checklist at five or above, as measured by the 7-point Likert scale, 95 percent of the time.
Implement electronic medicine reconciliation.	Complete project aligned to national and regional work.	SCDHB has been deferred till 2017/18.
Gather patient and family experience information as a basis for identifying improvement opportunities.	Use the Patient Experience Survey (and guidance) alongside other local survey and feedback information to better focus improvement programmes.	Review of data from: • Patient Experience Survey • Complaints and compliment processes • Local surveys Ongoing.
Produce a consumer focused and consumer friendly Quality Account.	The Quality Account content will be drawn from: • National requirements (SAE and Health Targets); • Community and consumer feedback; • Annual Plan initiatives; • Service Work Plans; and • Previous editions of the Quality Account. Consumer feedback and input will be actively sort through attendance at community events, normal feedback mechanisms, and the feedback options contained within the current Quality Account.	The Quality Account process will be monitored by the Clinical Board including the usefulness and readability of the Quality Account being informed by review of feedback information.
Partner with our local community in health service design and delivery.	Establish a Consumer Council for the DHB.	SCDHB Consumer Council in place by June 2017.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Assess the patients experience in the primary care setting.	Implement the Health Quality and Safety Commission Primary Care Patient Satisfaction Survey once available.	Survey results utilised to identify opportunities for improvement initiatives once survey available.
Reduce the incidence of pressure injuries in South Canterbury across acute, residential and community settings.	Establish a forum to discuss, plan and support pressure injury prevention initiatives, strategies, research and policy, and to build partnerships, and promote coordinated and collaborative actions across all sectors of healthcare and the local community.	An integrated Pressure Injury Prevention Steering Group is established by December 2016.

3.3.2 Clinical Governance

Current context snapshot

There is an integrated Clinical Board which provides clinical leadership across the whole DHB and oversight of all clinical committees. The establishment of the Primary Care Interim Alliance has provided the necessary linkage mechanism for ensuring robust primary care input into Clinical Board discussions and decisions. During 2015/16 the DHB reviewed its membership of the EQUiP 5 Accreditation Programme and a decision was made to cease membership of this programme. With the withdrawal for Accreditation Certification has now become the interim framework for continuous quality improvement for the Hospital site and the Clinical Board actively manages the response process for this.

The DHB will meet expectations relating to capability and leadership in accordance with Operational Policy Framework Sections 9.3 and 9.4.6. The SCDHB Training and Development Plan includes a clinical leadership component focused on training clinical leaders in effective management practices e.g. understanding leadership. Individual training packages are developed for existing and emerging clinical leaders. The chief medical officer and clinical directors are supported with personal development plans specifically relating to leadership e.g. completion of health service management papers. During 2015/16 joint senior leadership team/senior medical officer workshop were held on Distributed Leadership with clinical leadership remaining a focus for strategic planning. Use of funding received from Health Workforce New Zealand (HWNZ) for post graduate nursing training is prioritised towards clinical leadership.

Clinical leadership covers both primary and secondary services and forms part of the senior leadership team with attendance of two of the four clinical leaders essential for a meeting quorum to be reached. Opportunities to improve knowledge and skills are made available for identified emerging leaders with inclusion on clinical project groups and DHB clinical committees.

Six clinical directors work in partnership with service managers in the management of clinical services including human resource management, production planning, CAPEX expenditure and implementation of new initiatives across services including the roll out of clinical IT systems to support medications management.

In line with the regional approach NZ Lippincott nursing procedures are now available online to support contemporary evidence based nursing practice.

Local Focus for 2016/17

During 2016/17 the DHB will continue to focus on the development of clinical leaders (see section on workforce development) and on agreeing and implementing an alternative quality improvement framework for the DHB.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Ensure the DHB has a framework in place to support continuous quality improvement across the entire DHB.	Explore options available as a replacement for 'Equip 5' Accreditation.	Paper to the DHB Board outlining findings and recommendations submitted by December 2016.

3.3.3 Risk Management

Current context snapshot

SCDHB's Risk Management policy functions as the framework to support the risk management programme within the DHB. It reflects the Risk Management Principles and Guidelines AS/NZS ISO 31000:2009. During 2015/6 the DHB has been working with Safety 1st the RL6 regional system to develop the risk module to better integrate risk management processes with incident and consumer feedback information.

Local Focus for 2016/17

The focus for this year is a full review of the Risk Management system and supporting documentation.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Develop a more dynamic and proactive risk management system.	Review the Risk Management policy and associated processes within the DHB.	Updated Risk Management policy and associated procedures are approved by December 2016. Quarterly Risk Management reports are received by Senior Leadership Team and Audit and Assurance Committees for risk activity including the identification, treatment and elimination/minimisation of risks within the Risk Register. Ongoing.

3.3.4 Compliance with Legislation

Current context snapshot

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

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

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

3.4 Facility Management

Current context snapshot

SCDHB completed work on the Gardens Block and Kensington facilities and commenced construction of the Records Building storage; along with an update to their Facility Master Plan for the district to determine the

scope of work required to maintain the hospital site for the next 15 years during 2015/16. Approval for the business case was attained from the SCDHB Board with the investment proposal covering the following:

- A new IL2 and IL4 building that accommodates:
  - Emergency department clinical floor space with new isolation facility and new ambulance bay – IL4
  - Outpatient Department – emergency operating theatre capability – IL2

- Redevelopment of the 'Front of Hospital' services:
  - X-Ray room between ED and outpatients
  - Medical day stay – including chemotherapy in existing cafeteria
  - Cafeteria in front foyer
  - Emergency department.

Local focus 2016/17

During 2016/17 work on the 'Front of Hospital' will commence, with projected completion estimated to be 26-30 months.

Action Plan 2016/17		
Objective	**Action**	**Evidence**
Front of Hospital	Implementation of the business case.	• Project manager/architect appointed June 2016. • Detailed designs and Resource Consent October 2016. • Contractor procurement December 2016. • Construction commences March 2017.

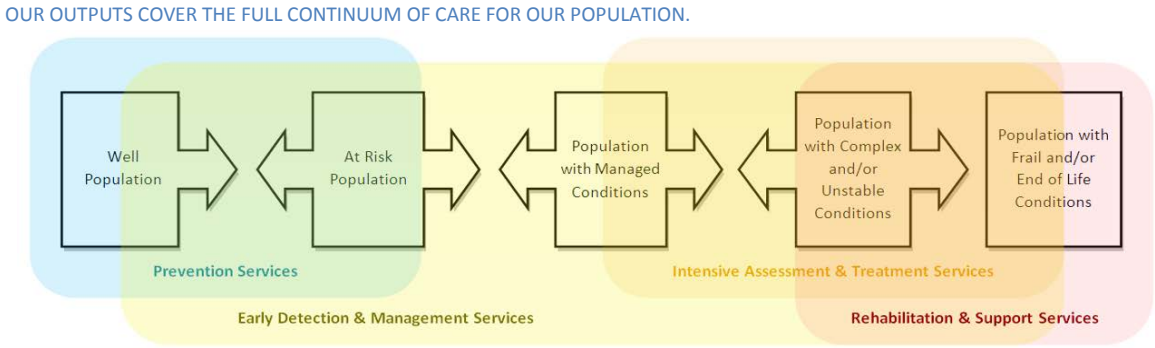
CHAPTER 4: STATEMENT OF PERFORMANCE EXPECTATIONS

4.1 How will we measure our performance?

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

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

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



One of the functions of this document is to demonstrate how we will evaluate the effectiveness of the decisions we make on behalf of our population. Over the longer term we do this by measuring our performance against a set of desired impacts and outcomes which are outlined in the strategic direction section (Chapter 1) of this document and highlighted in the intervention logic on page 10.

In the more immediate term, we evaluate our performance by providing a forecast of our planned outputs (what services we will fund and provide in the coming year). We then report actual performance against this forecast in our end of year Annual Report.[11]

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

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

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

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

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

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

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

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

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

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

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

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

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

Where does the money go?
The table at Page 83 provides a summary of the 2016/17 budgeted financial expectations by output class.

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

Output Class
4.2 Prevention Services

Output class description
Preventative health services promote and protect the health of the whole population, or identifiable sub-populations, and address individual behaviours by targeting population-wide changes to physical and social environments that engage, influence and support people to make healthier choices. These services include

education programmes and services to raise awareness of risk behaviours and healthy choices, the use of legislation and policy to protect the public from toxic environmental risks and communicable diseases, and individual health protection services such as immunisation and screening programmes that support early intervention to modify lifestyles and maintain good health.

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

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

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

Output Subsets: Short Term Performance Measures 2016/17

Health Promotion and Education Services These services inform people about risks and support them to be healthy. Success is measured by greater awareness and engagement, reinforced by programmes that support people to maintain wellness, change personal behaviours and make healthier choices.	**Notes**	**Actual 2012/13**	**Actual 2013/14**	**Actual 2014/15**	**Target /Est. Delivery 2016/17**
Percentage of babies breast-fed (exclusive and full) in the district at 6 weeks of age	C, Q [1]	70%	70%	74% (Published March 2015)	≥ 75%
Percentage of babies breast-fed (exclusive and full) in the district at 3 months of age	C, Q [1]	56%	56%	56.9%	≥ 60%
Percentage of babies being fed breast milk at 6 months of age	C, Q [1]	25%	27%	63.1%	≥ 65%
No. of people in South Canterbury accessing smoking cessation programmes	V [2]	873	548	574	≥ 500
Percentage of people who receive brief intervention to quit smoking in the hospital setting	C	98.8%	99.2%	98.9%	≥ 95%
Percentage of PHO enrolled patients who smoke who have been offered help to quit smoking by a health care practitioner in the last 15 months.	C	NEW	NEW	NEW	≥ 90%
No. of Green Prescription referrals	V [3]	385	414	427	≥ 557
Percentage of education settings engaged with WAVE	C [4]	99%	99.1%	99.1%	100%
Family Violence Intervention Programme Evaluation Audit score of hospital responsiveness	Q [5]	90	94	93	≥91

to child abuse above the national benchmark score of 80					
Family Violence Intervention Programme Evaluation Audit score of hospital responsiveness to partner abuse above the national benchmark score of 80	Q [5]	92	90	91	≥91

[1] The proportion of women breastfeeding is seen as a measure of service quality, demonstrating the effectiveness of consistent, collective health promotion messages delivered during the antenatal period and the value of breast feeding support during the post-natal period. Data for 2014 has been sourced from the WCTO QIF reports. Prior to this data was sourced from Plunket via the Ministry of Health and excluded data from Arowhenua Whānau Services. The indicator for six months changed in 2014/15 from babies being breast fed (exclusive or full) to being fed breast (i.e. now includes partial).

[2] These volumes relate to DHB funded programmes targeted at people with specialised needs. Others will be referred to programmes such as Quitline.

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

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

[5] The Family Violence Intervention Programme audits compliance against the National Guidelines for Partner and Child Abuse and contract specifications for this service. The expected level of compliance increased to 80 in 2015.

Population Based Screening These services are mostly funded and provided through the National Screening Unit and help identify people at risk of illness earlier. They include breast and cervical screening. The DHB's role is to encourage uptake, as indicated by high coverage rates.	**Notes**	**Actual 2012/13**	**Actual 2013/14**	**Actual 2014/15**	**Target /Est. Delivery 2016/17**
Percentage of enrolled women aged 25 – 69 years who have had a cervical screen in the last three years	T [6]	76.1%	78.7%	75.8%	≥ 80%
Percentage of Māori enrolled women aged 25 – 69 years who have had a cervical screen in the last three years	T [6]	70%	50.7%	48.8%	≥ 80%
Percentage of enrolled women aged 50 – 69 years who have had breast screening mammography as part of the national mammography screening programme in the last two years	T [6]	84.3% (45 – 69 years)	82.9% (45 – 69 years)	79.1%	≥70%
Percentage of Māori enrolled women aged 50 – 69 years who have had breast screening mammography as part of the national mammography screening programme in the last two years	T [6]	77.6% (45 – 69 years)	82.9% (45 – 69 years)	73.6%	≥ 70%
Percentage of eligible population provided with a B4 School Check	C [7]	>100%	112%	108%	≥ 90%
Percentage of eligible 'high needs' population provided with a B4 School Check	C [7]	>100%	119%	110%	≥ 90%
Percentage of obese children identified in the B4 School Check programme offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	Q, C [8]	NEW	NEW	NEW	95% (by December 2017)

[6] These national screening programmes screen women for signs of breast and cervical cancer to enable early treatment to reduce the rate of associated mortality. Result for cervical screening is based on NCSP. All results for mammography are taken from Breast Screen Aotearoa data. The age band for this indicator was changed to 50 – 69 years in 2014/15.

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

[8] This Health Target was implemented from 1 July 2016.

Immunisation These services reduce the transmission and impact of vaccine-preventable diseases including unnecessary hospitalisations. The DHB works with primary care and allied health professionals to improve the provision of immunisations across all age groups both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service.	**Notes**	**Actual 2012/13**	**Actual 2013/14**	**Actual 2014/15**	**Target/ Est Delivery 2016/17**
Percentage of 8 months old fully immunised on time	T, C	88%	92%	91.9%	≥ 95%
Percentage of 2 year olds fully immunised on time. Ref PP21	T, C	94%	97%	95.3%	≥ 95%
Percentage of 5 year olds fully immunised on time. Ref PP21	T, C	82%	89%	92%	95%
Percentage of the eligible population receiving the flu vaccination	C	68%	68.7%	67.3%	≥ 70%
No. ≥ 65 year olds immunised for pneumonia	C [9]	391	223	517	≥300
Percentage of eligible girls fully immunised with three doses of HPV vaccine. Ref PP21	C [10]	NEW	NEW	NEW	70% for dose 3

[9] This vaccine is expected to last 5 years.

[10] The measure is based on young women 12 - 18 who have been provided with all three doses. The school based programme commenced in 2013. The timing of this measure is a calendar year. This measure was altered in 2015/16 to focus on the percentage of eligible girls fully immunised.

Output Class

4.3 Early Detection and Management

Output class description

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

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

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

Why is this output class significant for us?

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

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

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

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

Output Subsets: Short Term Performance Measures 2016/17

Primary Health Care These services are offered in local community settings by a primary care team including general practitioners (GPs), registered nurses, nurse practitioners and other primary healthcare professionals, aimed at improving, maintaining or restoring people's health. High levels of enrolment with general practice are indicative of engagement, accessibility and responsiveness of primary care services.	**Notes**	**Actual 2012/13**	**Actual 2013/14**	**Actual 2014/15**	**Target/ Est. Delivery 2016/17**
No. people in the district enrolled with a Primary Care Provider	V	56,272	56,807	57,142	≥ 57,500
Percentage of eligible people enrolled in the Care Plus Programme	C [1]	81.46%	84%	86%	≥ 86%
Avoidable Hospital Admission (ASH) 0 – 4 years (Total) rate. Refer SI1.	Q [2]	53%	56%	61%	TBC
Avoidable Hospital Admission (ASH) 45 - 64 years (Total) rate. Refer SI1.	Q [2]	86%	91%	75%	80%

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

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

Long-term Conditions Programme These services are targeted at people with high needs due to long-term conditions and aim to reduce deterioration, crises and complications. Success is demonstrated through identification of need, regular monitoring and outcomes that demonstrate good conditions management. A focus on early intervention, self-management strategies and additional services available in the community will help to reduce the negative impact of long-term conditions and the need for hospital admission.	**Notes**	**Actual 2012/13**	**Actual 2013/14**	**Actual 2014/15**	**Target/ Est. Delivery 2016/17**
No. of patients who have completed the Multi-Condition Rehabilitation Programme	V[3]	NEW	55	76	≥75
No. of patients enrolled in the Diabetes Encounter Programme	V[4]	NEW	188	162	≥ 150
Percentage of the eligible population who have had their cardiovascular (CVD) risk assessed in the last 5 years. Ref PP20	C[5]	64.4%	81.2%	87.7%	≥ 90%

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

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

[5] This refers to CVD risk assessments undertaken in primary care.

Oral Health These services are provided by registered oral health professionals to help people maintain healthy teeth and gums. High enrolment indicates engagement, while timely examination and treatment indicates a well-functioning, efficient service.	**Notes**	**Actual 2012**	**Actual 2013**	**Actual 2014**	**Target/ Est. Delivery 2016**
Percentage of children under five years enrolled in DHB funded dental services. Refer PP13	C	76.7%	70.9%	69.8%	≥ 95%
Percentage of adolescents accessing DHB funded oral health services. Refer PP12	C	88.6%	88.7%	86%	≥ 91%
Percentage of children caries free at five years of age. Refer PP11	C	60.18%	61%	63%	≥ 65%
Oral Health Decayed, Missing and Filled Teeth score at year eight. Refer PP10	C	1.20	1.08	1.07	≤ 0.85
Percentage of enrolled preschool and primary school children overdue for their scheduled examination. Ref PP13	T	9%	10%	13%	≤ 9%

Pharmacy As Long-term Conditions (LTC) become prevalent, demand for pharmaceuticals will likely increase. The LTC service has been introduced to provide a greater hands-on role of community patient's pharmaceutical management. To improve service quality in the hospital setting we have also introduced medicines interventions monitoring along with medicines reconciliation to reduce the number of New Zealanders harmed each year by medication errors in our hospital.	**Notes**	**Actual 2012/13**	**Actual 2013/14**	**Actual 2014/15**	**Target/ Est. Delivery 2016/17**
Percentage of medicines reconciliations completed	Q[6]	NEW	27.2% (Oct 2013 – Jun 2014)	10.7%	50%
No. people enrolled in the Community Pharmacy INR Monitoring Programme	V	NEW	NEW	NEW	220
Percentage of people enrolled in the Community Pharmacy INR Monitoring Programme with results in the control range	Q	NEW	NEW	NEW	70%
Percentage of Community Pharmacy INR Monitoring Programme testing completed on time	T	NEW	NEW	NEW	85%

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

Community Referred Tests and Diagnostic Services These are services to which a health professional may refer a person to help diagnose a health condition, or as part of treatment. They are provided by personnel such as laboratory technicians, and radiographers. To improve performance, we will target improved primary care access to diagnostics without the need for a hospital appointment to improve clinical referral processes and decision making. Community referred laboratory tests are demand driven.	**Notes**	**Actual 2012/13**	**Actual 2013/14**	**Annual 2014/15**	**Target/ Est. Delivery 2016/17**
No. community referred laboratory tests	V[7]	252,873	282,429	286,241	Est.350,000
No. community referred radiology examinations	V[8]	10,067	10,564	10,455	Est. 10,500
Percentage of accepted referrals for a MRI scan receive their scan within six weeks. Refer PP29	T	84%	99.4%	90.2%	85%
Percentage of accepted referrals for a CT scan receive their scan within six weeks. Refer PP29	T	87%	99.3%	92%	95%
Percentage of people accepted for an urgent diagnostic colonoscopy who receive their procedure within 14 calendar days. Refer PP29	T	NEW	73%	87.5%	85%

Percentage of people accepted for a non-urgent diagnostic colonoscopy who receive their procedure within six weeks. Refer PP29	T	NEW	31.9%	52.4%	70%
Percentage of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks beyond the planned date. Refer PP29	T	NEW	NEW	35.8%	70%

[7] This volume is demand driven.
[8] This volume is demand driven.

Output Class

4.4 Intensive Assessment and Treatment Services

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

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

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

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

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

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

Output Subsets: Short Term Performance Measures 2016/17

Acute Services These are medical or surgical services for illnesses that have an abrupt onset or progress rapidly creating an urgent need for care. For more complex acute conditions, hospital based services include emergency services, acute medical and surgical services and intensive care services. Productivity measures such as length of stay are balanced with outcome measures such as readmission rates to indicate the quality of service provision.	**Notes**	**Actual 2012/13**	**Actual 2013/14**	**Actual 2014/15**	**Target/ Est. Delivery 2016/17**
No. of patients seen at ED that are not admitted	V	12,821	12,481	12,894	≤12,500
Percentage of patients discharged or transferred from ED within 6 hours	T	96.4%	96.2%	97.1%	≥95%
No. of acute medical/surgical patients discharged from Timaru Hospital	V[1]	6,527	6,637	6,625	≤7,000
Standardised length of stay for acute patients. Refer OS3	T[2]	4.73 (2012)	4.18 (Mar-14)	4.03 (March 2015)	≤2.35
Percentage of patients requiring radiation or chemotherapy who receive this treatment within four weeks	T	100%	100%	100%	100%
Percentage of patients who receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	T	NEW	NEW	62.5%	85%
Percentage of older patients assessed for the risk of falling	Q[3]	96% (Dec.-13)	98%	99% (March 2015)	90%
Percentage of older patients assessed as at risk of falling who received an individualised care plan that addressed these risks	Q[3]	93% (Dec-13)	89%	94% (March 2015)	98%
Number of falls in the hospital categorised as a SAC 1 or 2	Q[3]	16	3	5	≤5
Percentage of complaints responded to within 23 working days	Q	65%	75%	79%	100%
Percentage of compliant moments of hand hygiene	Q[4]	72% (Dec.-13)	74%	84% (March 2015)	80%
Hospital acquired blood stream infection rate	Q[4]	0.8	0.4	0	0.5
Percentage of ICU central line insertions fully compliant with bundle	Q[5]	100% (Dec-13)	92%	100%	90%
Number of central line acquired bacteraemia	Q	2	0	0	0

[1] This target now includes ED technical admissions.

[2] Productivity measures like length of stay are balanced with outcome measures such as readmission rates to indicate the quality of service provision. The target includes day cases.

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

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

[5] This is a HQSC Safety Marker.

Elective Services These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. This includes surgery and specialist assessments. National Elective Services Patient Flow Indicators (ESPIs) are indicative of a successful and responsive service, addressing population need.	**Notes**	**Actual 2012/13**	**Actual 2013/14**	**Actual 2014/15**	**Target/ Est. Delivery 2016/17**
Total no. of elective First Specialist Assessments (FSA)	V	8,558	9,428	9,313	≥9,349
No. non-contact secondary services surgical FSAs	V, T[5]	714	779	766	≥800
No. non-contact secondary services medical FSAs	V, T[5]	368	503	511	≥503
No. of Cost Weight Deliveries (CWDs)	V	3,690	3,775	3,788	3,600
No. of surgical discharges (incl. cardiology and dental)	V[6]	3,064	3,001	3,050	2,885
No. Health Target inpatient surgical discharges	V[6]	2,790	2,740	2,761	3,175
Standardised length of stay for elective patients. Refer OS3.	T[7]	3.77	3.4 (March14)	3.27 (March 2015)	1.55
Did Not Attend (DNA) rate for medical/surgical	Q	3.1%	2.8%	2.5%	≤3.3%
Percentage of hip and knee replacement patients who receive cefazolin ≥2g or cefuroxime ≥1.5g as surgical prophylaxis	Q[8]	NEW	NEW	95%	95%
Percentage of hip and knee replacement patients who receive prophylactic antibiotics 0 – 60 minutes before incision	Q, T[8]	NEW	NEW	95%	95%

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

[6] The definition for these measures was amended for the 2015/16 year to include surgical discharges regardless of whether they are discharged from a surgical or medical speciality and includes both elective and arranged admissions. Results for previous years relate to elective surgical discharges solely.

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

[8] This is a HQSC Safety Marker.

Maternity Services These services are provided to women and their families through pre-conception, pregnancy, childbirth and for the first months of a baby's life. These services are provided in home, community and hospital settings by a range of health professionals, including midwives, GPs and obstetricians and include: specialist obstetric, lactation, anaesthetic, paediatric and radiology services. We will monitor volumes in this area to determine access and responsiveness of services.	**Notes**	**Actual 2012/13**	**Actual 2013/14**	**Actual 2014/15**	**Target/ Est. Delivery 2016/17**
No. deliveries in the SCDHB Maternity Unit	V[9]	621	635	582	≤600
Percentage of births delivered by Caesarean	Q	26.5%	24.4%	25%	≤24%

Section					
Post-natal average length of stay	T	2.5 days	2.26 days	2.36 days	≥2.5days
Baby Friendly Hospital Accreditation is maintained	Q[10]	Yes	Yes	Yes	Yes

[9] Result indicates no. of babies born

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

Assessment, Treatment and Rehabilitation Services (AT and R) These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered from a specialist inpatient unit, outpatient clinic and also in the home environment.	**Notes**	**Actual 2012/13**	**Actual 2013/14**	**Actual 2014/15**	**Target/ Est. Delivery 2016/17**
No. of ATR bed days utilised > 65years	V	3,528	3,111	3,672	≤3,900
No. of ATR bed days utilised <65years	V	457	383	252	288.91
No. of ATR bed days utilised - psycho-geriatric	V	602	568	243	≤200
No. of ATR outpatient attendances	V	358	234	138	≥155
No. of ATR domiciliary visits	V	2,288	2,216	1,804	≥960

Specialist Mental Health Services These are services for the most severely affected by mental illness or addictions. They include assessment, diagnosis, treatment, rehabilitation and crisis response when needed. Utilisation and wait times are monitored to ensure service levels are maintained and to demonstrate responsiveness to need.	**Notes**	**Actual 2012/13**	**Actual 2013/14**	**Actual 2014/15**	**Target/ Est. Delivery 2016/17**
Percentage of young people (aged 0 – 19) who have accessed specialist mental health services. Ref PP6	C	5.29% (March 2013)	6.4% (March 2014)	5.9% (March 2015)	6.2%
Percentage of people (aged 20 – 64) who have accessed specialist mental health services. Ref PP6	C	3.58% (March 2013)	4.37% (March 2014)	4.19% (March 2015)	4.4%
Percentage of people (aged) who have accessed specialist mental health services. Ref. PP6	C	0.45% (March 2013)	0.38% (March 2014)	2.4% (March 2015)	1%
Percentage of people 0 – 19 referred for non-urgent mental health services seen within three weeks. Refer PP8	T[11]	79.2%	89.4% (March 2014)	85.7% (March 2015)	80%
Percentage of people 0 – 19 referred for non-urgent mental health services seen within eight weeks. Refer PP8	T[11]	94.5%	95.5% (March2014)	96.4% (March 2015)	95%
Percentage of people 0 – 19 referred for non-urgent addiction services seen within three weeks. Refer PP8	T[12]	100%	89% (March-2014)	96.7% (March 2015)	80%
Percentage of people 0 – 19 referred for non-urgent addiction services seen within eight	T[12]	100%	98.3% (March-	100% (March	95%

weeks. Refer PP8			2014)	2015)	
Percentage of child and youth with a transition (discharge) plan. Ref PP7	C[13]	NEW	NEW	94.6% (March 2015)	95%

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

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

[13] A transition (discharge) plan is a plan on discharge which includes relapse prevention and ensuring integration within community resources.

Output Class

4.5 Rehabilitation and Support Services

Output class description

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

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

Why is this output class significant for us?

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

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

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

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

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

Output Subsets: SHORT TERM PERFORMANCE MEASURES 2016/17

Palliative Care These are services that improve the quality of life of patients and their families facing life-threatening illness, through the prevention and relief of suffering by means of early intervention, assessment, treatment of pain and other supports.	**Notes**	**Actual 2012/13**	**Actual 2013/14**	**Actual 2014/15**	**Target/ Est. Delivery 2016/17**
No. clients accessing a South Canterbury Hospice bed	V	115	152	155	≥150

Needs Assessment and Support These are services that determine a person's eligibility and need for publicly funded support and the best mix of supports based on the person's strengths, resources and goals. The supports are delivered by an integrated team in the person's own home or community. The delivery of assessments and the use of evidence-based tools indicate quality, equity of access and responsiveness.	**Notes**	**Actual 2012/13**	**Actual 2013/14**	**Actual 2014/15**	**Target/ Est. Delivery 2016/17**
Percentage of InterRAI first assessments completed within target timeframe	T[1]	92%	91%	90%	90%

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

Home and Community Support These are services designed to support people to continue living in their own homes and to restore functional independence. They may be short or longer-term in nature. An increase in the number of people being supported is indicative of increased capacity in the system, and success is measured against decreased or delayed entry into residential or hospital services.	**Notes**	**Actual 2012/13**	**Actual 2013/14**	**Actual 2014/15**	**Target/ Est. Delivery 2016/17**
No. people (total) supported by Home Based Support Services	V[2]	965	971	1,022	1,000
No. high and complex dementia patients supported by Home Based Support Services	V[2]	15	25	18	20

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

4.6 2016/17 Budgeted Financial Expectations by Output Class

REVENUE		TOTAL $'000
Prevention		3,477
Early detection and management		43,035
Intensive assessment and treatment		107,858
Support and rehabilitation		37,321
Grand Total		**191,691**
EXPENDITURE		**TOTAL $'000**
Prevention		3,460
Early detection and management		42,827
Intensive assessment and treatment		106,928
Support and rehabilitation		37,154
Grand Total		**190,369**
Surplus/(Deficit)		**1,322**

CHAPTER 5: FINANCIAL PERFORMANCE

Forecast financial statements (for current and four following years)

- Measures and standards necessary to assess DHB financial performance
- Significant assumptions
- Additional information to reflect the operations and position of the DHB.

South Canterbury District Health Board	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Consolidated Financial Performance	Audited Actual	Forecast	Plan	Plan	Plan	Plan
2016/2017						
MOH Revenue	179,914	177,562	181,524	185,025	188,560	192,097
Patient Related Revenue	2,044	1,742	1,940	1,455	1,455	1,455
Other Revenue	2,224	2,087	2,331	2,342	2,364	2,386
IDF Inflow Revenue	3,709	4,113	4,354	4,397	4,441	4,485
TOTAL OPERATING REVENUE	187,891	185,504	190,149	193,219	196,820	200,423
Employee Benefit Costs	65,000	62,579	64,910	63,692	63,291	64,240
Treatment Related Costs	19,838	20,866	19,584	19,718	19,939	20,181
External Service Providers	64,328	58,435	62,630	65,496	67,628	68,301
IDF Expenditure	24,507	30,068	27,748	29,364	31,166	32,757
Non Treatment Related Costs	9,507	8,229	8,501	7,508	7,204	7,302
TOTAL OPERATING EXPENDITURE	183,180	180,177	183,373	185,777	189,228	192,782
NET RESULT BEFORE INTEREST DEPRECIATION	4,711	5,327	6,776	7,443	7,592	7,641
Interest expense	316	442	412	416	420	424
Interest Received	(1,827)	(1,475)	(1,542)	(1,320)	(1,320)	(1,320)
Depreciation	3,882	4,190	4,242	4,902	5,047	5,092
NET RESULT BEFORE NON OPERATING ITEMS	2,371	3,157	3,112	3,998	4,147	4,196
Donations						
Profit & (Loss) on Asset sales						
Capital Charge Expense	2,160	2,111	2,342	2,345	2,345	2,345
NET RESULT	**180**	**59**	**1,322**	**1,100**	**1,100**	**1,100**

South Canterbury District Health Board	1-Jul-14 Opening Balance	2014/15 Audited Actual	2015/16 Forecast	2016/17 Plan	2017/18 Plan	2018/19 Plan	2019/20 Plan
Consolidated Financial Position							
2016/2017							
Opening Equity	28,921	28,885	28,680	29,721	30,545	31,347	32,171
Operating Result for Period		180	59	1,322	1,100	1,100	1,100
TOTAL PUBLIC EQUITY							
Current Assets							
Cash & Bank	3	3	3	3	3	3	3
HBL Treasury Function	22,484	16,471	21,784	18,763	15,862	12,159	10,698
Short Term Investments	12,778	15,778	-	-	-	-	-
Debtors & Other Receivables	5,067	5,879	5,869	5,245	5,546	5,557	5,558
Stock	920	864	850	900	900	900	900
Total Current Assets	41,252	38,995	28,506	24,911	22,311	18,619	17,159
Current Laibilities							
Overdraft							
Creditors and Accruals	11,114	7,978	9,498	8,232	9,227	8,103	7,666
GST	1,191	1,088	1,100	1,200	1,212	1,212	1,212
Employee Entitlements	12,273	14,609	14,718	14,198	14,331	14,382	14,382
Short Term Loans	12,947	13,013	235	235	238	238	238
Total Current Liabilities	37,525	36,688	25,551	23,865	25,008	23,935	23,498
Working Capital	3,727	2,307	2,955	1,046	(2,697)	(5,316)	(6,339)
Non Current Assets							
Fixed Assets	32,342	33,691	32,913	34,476	38,176	40,360	42,486
Intangibles	704	768	656	2,051	3,006	4,274	3,995
Term Investments	298	734	13,777	13,769	13,769	13,769	13,769
Total Non Current Assets	33,344	35,193	47,346	50,296	54,951	58,403	60,250
Non Current Liabilities							
Employee Entitlements	6,970	7,357	7,447	7,447	7,521	7,554	7,554
Term Loans	1180	1,258	14,174	14,174	14,188	14,186	14,186
Total Non Current Liabilities	8,150	8,615	21,621	21,621	21,709	21,740	21,740
NET ASSETS	28,921	28,885	28,680	29,721	30,545	31,347	32,171

South Canterbury District Health Board		2014/15 Audited Actual	2015/16 Forecast	2016/17 Plan	2017/18 Plan	2018/19 Plan	2019/20 Plan
Statement of Changes in Equity							
2016/2017							
Total Equity at start of period		28,921	28,885	28,680	29,721	30,544	31,347
Net Surplus/ (Deficit) for year		180	59	1,322	1,100	1,100	1,100
Capital Movements							
Repayment to Crown		(216)	(216)	(216)	(216)	(216)	(216)
Other Movements			(48)	(65)	(60)	(81)	(61)
Total Equity at end of period		**28,885**	**28,680**	**29,721**	**30,545**	**31,347**	**32,171**

CASHFLOW & BANK	1-Jul-14 Opening Balance	2014/15 Audited Actual	2015/16 Forecast	2016/17 Plan	2017/18 Plan	2018/19 Plan	2019/20 Plan
2016/2017							
Total Receipts		186,740	187,897	191,691	194,539	198,141	201,745
Total payments		(185,472)	(178,992)	(186,512)	(189,349)	(195,336)	(201,131)
CASH FLOW FROM OPERATING ACTIVITIES		1,268	8,905	5,179	5,190	2,805	614
CASH FLOW FROM INVESTING ACTIVITIES		(6,892)	(2,989)	(7,572)	(7,459)	(5,873)	(1,435)
CASH FLOW FROM FINANCING ACTIVITIES		(389)	(603)	(628)	(632)	(636)	(640)
NET CASH FLOW		(6,013)	5,313	(3,021)	(2,901)	(3,704)	(1,461)
Plus: Cash (Opening)		22,487	16,474	21,787	18,766	15,865	12,162
YTD Net cash movements		(6,013)	5,313	(3,021)	(2,901)	(3,704)	(1,461)
Cash (Closing)	**22,487**	**16,474**	**21,787**	**18,766**	**15,865**	**12,162**	**10,701**

5.1 Fiscal Sustainability - Planned Net Results

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

The accumulated Mental Health surplus (forecast to be $0.5M at 30 June 2016) will be spent to continue funding Mental Health services in 2016/17.

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

SCDHB has also maintained an internal ring fence for Primary Health; this is due to our structure of covering the role of the PHO within the DHB. As at 31 January 2016 the DHB had $0.2M of equity that was ring fenced for Primary. This plan includes expenditure of $0.2M of ring fence primary funding which will be utilised on primary care initiatives during 2016/17.

A full revaluation of the DHB land and buildings was completed as at June 2014. This revaluation allowed for the works on Kensington, the Gardens Block and a large number of IS projects. A full revaluation is next due to be completed in June 2016.

The plan includes productivity and efficiency savings. Savings are generated through local, regional and national initiatives.

The Government Rules of Sourcing requires all DHBs to submit an Annual Procurement Plan (APP) detailing planned procurement activities (contract opportunities) to MBIE by 01 October 2016. This is a 12 month forward view with all APPs being consolidated and published on www.procurement.govt.nz to give suppliers advance notice of potential contact opportunities.

Where work is being derived from PHARMAC, MBIE or Health Partnerships on behalf of DHBs these procurements do not need to be included in individual APPs.

5.2 Cost and Volume Assumptions

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

- The community pharmaceutical budget is included as per forecast at $16.986M for 2016/17;
- NGOs will on average receive 1% increase in 2016/17;
- Primary care will receive an increase of 1.0% on first contact services and on average 1% across other services;
- The Ministry continues to provide the "good performance" advance of one month's revenue (about $10M);
- Net Inter District Flows will be $23.443M out to other DHBs, this is made up of an inflow of $4.305M and an outflow of $27.748M;
- Except for demand and continued refinement of needs based prioritisation within service lines, there are no changes to the nature, mix or volume of services planned to be funded or provided by SCDHB;
- If there are any services devolved by the Ministry of Health to SCDHB they will be devolved in a fiscally neutral manner;
- Employee costs have been calculated using employment agreement settlements where these exist. The assumption used in 2016/17 is a 1.7% settlement and in 2017/18 a 1.7% settlement;
- Any increase in volumes from demographic increase delivered by the SCDHB Provider will be absorbed by the current FTE as an efficiency saving;
- New Zealand Health Partners Limited (NZHPL) - Provision has been made for operational costs as advised by NZHPL. Cost savings have been incorporated into the Forecast Income Statements; these will be achieved via national, regional and local projects;
- The expectation is that any approved unbudgeted operational expenditure will be offset by extractable operational efficiencies, either directly attributable to the business cases or through other savings initiatives to compensate. Unbudgeted capital contributions may be incurred if the business cases are compelling to justify the investment;
- Health Quality and Safety Commission – there has been provision for the operational costs and capital expenditure associated with e-Pharmacy and e-Medicines reconciliation systems. However, these are subject to business cases, the rationale for this, is given the tight fiscal environment health is operating within, any proposal for enhancements should be compelling and deliver adequate extractable gains;
- The updates to various cost lines from the introduction of the revised supply and purchasing model have been included; and
- The MBIE Government Rules of Sourcing (Rules) became mandatory for the public health sector on 1 February 2015. South Canterbury DHB will continue to comply with the requirements set out in the Rules to the greatest extent that is practicable.

5.3 Efficiency Targets

During 2015/16 SCDHB has been working at containing the cost growth and reviewing the revenue from other activities to ensure that in 2016/17 the DHB can continue to live within the funding available while maintaining service delivery. The allowance for cost growth in our funding envelope from the Ministry of Health this year, as mentioned above, is 1%. When recognising industrial settlement pressures, step increases, and inflationary and other cost and quality pressures, the only way SCDHB is able to provide a break even financial forecast is by planning for the delivery of financial efficiency gains. In undertaking the planning, the following areas have been identified as areas for which gains have been incorporated into the plan:

- A full annual review of the commercial laundry prices will lead to a price increase of at least 1%. These are will be implemented with a minimum net gain to SCDHB of $11k;
- Review of management structure and function $500k;
- Allied Health and CNS service provision review $112k;
- Radiology contract review and renewal to a capped model $160k;
- ED/ICU Nursing shift rostering change $20k;
- IDF flow review and implementation of pathways $50k;

- Electronic drug treatment parameters in Medchart to reduce antibiotic costs $60k;
- Pharmacy stock waste reduction $76k;
- Review of dental services $50k;
- Contract services review $150k;
- Cessation of accreditation $17k;
- Recruitment medium review $10k;
- SIPP Platform reduction in line rental and calling costs $50k;
- Third party supply of goods ensuring all costs associated with procurement are passed on $40k;
- International patient billing $10k;
- HR & Payroll practices stationery savings $6k;
- Inventory management harmonisation of consumable supplies, including review of implants $150k;
- Laundry production efficiencies $117k;
- Implant review $100k;
- Electrical bio medical proposal $32k;
- TaaS AOG contract $2k;
- Changes within the provider, line by line review will continue to hold costs;
- SCDHB will continue to work with healthAlliance and Pharmac as part of the interim national procurement to obtain 'quick wins' from procurement, establish category management and aid in the development of a national pharmaceutical schedule;
- The food and household contracts are up for renewal in 2016/17 with National Food being revisited as part of the process to determine if this is a viable option;
- SCDHB is actively working with the other South Island DHBs to implement regional IS solutions. In the next three years SCDHB will complete implementation of electronic medicine management and e-referrals, with the other South Island DHBs. Development of a new Patient Information Care System is due for implementation at SCDHB in 2018. These collaborative projects will enable improvements to be made to the patient journey and change the way health care is delivered to consumers enabling a sustainable and integrated service to be provided over the coming years; and
- Procurement savings from national collaboration with healthAlliance assumes a saving of $68k in 2016/17.

Summary of Key Actions

	The incremental Financial Performance impacts from DHB and Regional Actions (Refer to AP Guidelines Living within our means) South Canterbury DHB			Incremental amount 2016/17 Plan ***	 2017/18 Plan	 2018/19 Plan	 2019/20 Plan	Alignment to Statement of Financial	
	Please briefly describe the action*	Initiative category (from drop down) **: a) Manage cost growth b) Purchase / Productivity Improvement c) Service reconfiguration	Please briefly describe the deliverable	$'000's	$'000's	$'000's	$'000's	Revenue / Expense Category ****	Risk Rating (Low / Medium / High)
1	Example - Action ABC	Select from drop down list						Select Major Rev / Exp Group: Personnel / Outsourced / Clinical Supplies etc	
2	Laundry Price Review	Manage cost growth - Key actions may include to limit the rate of cost growth through proactive management of employment relations settlements, improved/innovative use of a suitably skilled workforce, collective procurement and increased shared services	Full annual review of the commercial laundry prices will lead to a price increase of at least 1% when implemented a net gain to SCDHB of $11k;	- 11	- 11	- 11	- 11	Other Non Govt Revenue	Med
3	Review Management structure and function	Manage cost growth - Key actions may include to limit the rate of cost growth through proactive management of employment relations settlements, improved/innovative use of a suitably skilled workforce, collective procurement and increased shared services	To strengthen our clinical and professional leadership and integrate services across the whole DHB.	- 500	- 500	- 500	- 500	Admin Staff - Senior Management	Low
4	Allied Health & CNS service provision review	Manage cost growth - Key actions may include to limit the rate of cost growth through proactive management of employment relations settlements, improved/innovative use of a suitably skilled workforce, collective procurement and increased shared services	Review of vacant positions to determine who delivers services within a changing model	- 112	- 112	- 112	- 112	Nursing Staff	Low
5	Radiology contract review	Manage cost growth - Key actions may include to limit the rate of cost growth through proactive management of employment relations settlements, improved/innovative use of a suitably skilled workforce, collective procurement and increased shared services	Move contract model from a fee for service to a capped capacity contact with minimum saving to SCDHB of 10% to the 2014/15 actual spend.	- 160	- 160	- 160	- 160	Diagnostic Sevices	Med
6	ED/ICU nursing shift rostering	Purchasing / Productivity Improvement	Management of change proposal to permanently alter the nurse roster shift time from 12 hours to 8 hour shift in ED and Critical Care Unit	- 20	- 20	- 20	- 20	Nursing Staff	Low
7	IDF review of outpatient dental	Manage cost growth - Key actions may include to limit the rate of cost growth through proactive management of employment relations settlements, improved/innovative use of a suitably skilled workforce, collective procurement and increased shared services	Review of Dental IDFs to see what can be treated with protocols in ED and local dentists	- 50	- 50	- 50	- 50	Dental IDFs	Med
8	Electronic drug treatment parameters	Manage cost growth - Key actions may include to limit the rate of cost growth through proactive management of employment relations settlements, improved/innovative use of a suitably skilled workforce, collective procurement and increased shared services	To implement an automatic system to end courses of medication by default according to accepted protocols, and also to implement further protocols. This will reduce patient harm and avoid unneccesary cost.	- 10	- 10	- 10	- 10	Drugs	Low
9	Pharmacy reduction of waste/excessive stock holdings	Manage cost growth - Key actions may include to limit the rate of cost growth through proactive management of employment relations settlements, improved/innovative use of a suitably skilled workforce, collective procurement and increased shared services	Review of pharmacy stock levels and reporting to enable better stock management and rotation	- 76	- 50	- 50	- 50	Drugs	High
10	Review dental services	Manage cost growth - Key actions may include to limit the rate of cost growth through proactive management of employment relations settlements, improved/innovative use of a suitably skilled workforce, collective procurement and increased shared services	Expenditure Review	- 50	- 50	- 50	- 50	Adolescent dental benefit	Med
11	Contract other review	Manage cost growth - Key actions may include to limit the rate of cost growth through proactive management of employment relations settlements, improved/innovative use of a suitably skilled workforce, collective procurement and increased shared services	Remove budget balances relating to other year initiatives from 2016/17 budget to ensure correct provision made for other services	- 150	- 100	- 100	- 100	Other Services	Low
12	Stop Accreditation	Manage cost growth - Key actions may include to limit the rate of cost growth through proactive management of employment relations settlements, improved/innovative use of a suitably skilled workforce, collective procurement and increased shared services	Non renew the contract for Accreditation activity at the next review as is a voluntary process	- 17	- 17	- 17	- 17	Audit Fees External	Low
13	Recruitment Medium Advertising Review	Manage cost growth - Key actions may include to limit the rate of cost growth through proactive management of employment relations settlements, improved/innovative use of a suitably skilled workforce, collective procurement and increased shared services	Enhance the value of investment and reduce cost	- 10	- 10	- 10	- 10	Recruitment costs general	Low
14	SIPP platform Introduction	Manage cost growth - Key actions may include to limit the rate of cost growth through proactive management of employment relations settlements, improved/innovative use of a suitably skilled workforce, collective procurement and increased shared services	Cost savings for telephone line rental and calling costs.	- 50	- 50	- 50	- 50	Telephone line rental & tolls	Low
15	Overseas Patient Revenue	Manage cost growth - Key actions may include to limit the rate of cost growth through proactive management of employment relations settlements, improved/innovative use of a suitably skilled workforce, collective procurement and increased shared services	To ensure all overseas patients are billed appropriately for patient services rendered	- 10	- 10	- 10	- 10	Non Government overseas patient revenue	Med
16	Third party supply of goods	Purchasing / Productivity Improvement	The cost of all third party goods is invoiced, including freight, restocking and handling fees	- 40	- 40	- 40	- 40	Freight / Other Non Govt Revenue	Low
17	HR & payroll practices	Purchasing / Productivity Improvement	Improved workforce management across the DHB including a full Roster to Pay electronic solution, this is about supporting Managers to manage the workforce and extract tangible savings	- 7	- 7	- 7	- 7	Stationery	Low
18	Inventory management	Purchasing / Productivity Improvement	Introduction of fully integrated product catalogue with contract management	- 50	- 50	- 50	- 50	Medical Supplies	Low
19	Laundry production efficiencies	Purchasing / Productivity Improvement	• Increase customer base • Gain efficiencies around production to reduce energy costs	- 117	- 117	- 117	- 117	Non clinical services revenue / Energy	Low
20	Implants - hip review	Purchasing / Productivity Improvement	put in place systems to support the use of hip replacement implants according to the existing department protocols for patients	- 100	- 100	- 100	- 100	Implants & Prosthesis	Med
21	Electrical proposal re biomedical equipment	Purchasing / Productivity Improvement	Reduce contractor spend through employment of DHB electrician.	- 32	- 32	- 32	- 32	Outsourced Maintenance	Low
22	TaaS AOG contract	Purchasing / Productivity Improvement	Taas MOU savings on current provider costs	- 2	- 2	- 2	- 2	Telephone line rental & tolls	Low
			TOTAL	- 1,574	- 1,498	- 1,498	- 1,498		

5.4 Financial Risks in 2015/16

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

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

SCDHB's increase in December 2015 funding package from the Funding Envelope in 2015/16 is $2.839m. Additional funding announced in May 2016 for contribution to demographic and cost pressures $0.856m and Pharmaceutical Investment $0.556 takes the total increase in funding to $4.251m.

The range of pressures that the South Canterbury Health System is experiencing can be described into the interdependent categories below

- Cost Pressures in Hospital and Specialist Services
- Cost Pressures in NGO Sector
- Reserve Funds for Future Year to Support DHB Capital Investment in Medium Term or/and Provide an Organisational Operational Contingency
- Strategic Investment to progress Integrated System Approach regionally and nationally
- Investment for Improved Outcomes in Specific Population Groups e.g. Child and Youth, Maori or Mental Health Service Clients

The allocation of resources is pragmatic given the information available at this time and reflects prioritisation in line with DHB funding responsibilities and the Minister's Letter of Expectation. The following principles have been used to guide the proposed allocation of funding in 2016/17 year:

- Meet planned organisational consolidated position (surplus).
- Contribute to ability to effectively manage Provider and Funder cost pressures. DHBs are required to maintain core services for the local population and ensure continued elective growth consistent with the Government Policy. DHBs are expected to meet the demographic needs of an ageing and growing population within the funding provided.
- Ensure that improved outcomes in specific population groups e.g. Child and Youth, Maori or Mental Health Service Clients will be secured through any new investment.
- Allocate strategic investment to progress integrated system approach.
- Capital reserves and contingency only considered in the context of affordability.

In order to offset planned deficits in the Provider Arm, whilst service reconfiguration is undertaken to lower the cost base, the Funder is required to achieve significant surpluses. In 2016/17 the planned Funder surplus is $4.075 million. This presents a significant challenge for the Funder.

The intent of this approach is to facilitate the focus on 'models of service', with further integration of Primary and Secondary services and other sector partners.

The key risks associated with achievement of this surplus include

- Achievement of planned deficits in the Provider Arm.
- Growth in Inter District Flows.
- Growth in Health of Older People.
- Containment of growth in pharmaceuticals, these have been reduced compared to 2015/16 levels:
- Personnel costs
    - Salary/Wage Settlements –SMO, RMO and PSA MECAs negotiations outcomes are unknown, IEA review and job sizing to be undertaken.
    - Retirement of Senior Medical Officers;
- Land and Building Revaluations –the impact of the June 2016 valuations is at this time unknown and have not been factored into the financials;
- Implementation of efficiency initiatives;
- Facility seismic strengthening remains a risk until this FOH project is complete. Infrastructure upgrades and replacement also present significant risk.

5.5 Fixed Assets

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

SCDHB is well within its banking covenants.

Disposal of Land
SCDHB will ensure that disposal of land transferred to, or vested in it pursuant to the Health Sector (Transfers) Act (1993) will be subject to approval by the Minister of Health. The DHB will ensure that the relevant protection mechanisms that address the Crown's governance obligations in relation to Māori sites of significance and that the requirements of section 40 of the Public Works Act are addressed. Any such disposals will be planned in accordance with s42 (2) of the NZPHD Act 2000. No land disposals have been planned in 2016/17 and out years.

Front of Hospital Redevelopment
SCDHB has completed a single stage business case for the redevelopment of parts of Timaru Hospital site; and is now redeveloping the ED and ambulatory services areas only at a budgeted cost of $9.9M.

5.6 Capital Expenditure

Capital expenditure is provided in three components:

1. General Capital Expenditure

It should be noted that any delays in 2015/16 capital expenditure may be carried forward into 2016/17.

General

$000s	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	Total
Buildings , Plant & Equipment excl Clinical	205	406	412	418	425	431	437	444	451	457	4,403
Clinical Equipment	1,564	1,624	1,648	1,673	1,698	1,724	1,750	1,776	1,802	1,829	18,542
IT/IS - devices/hardware	166	203	206	209	212	215	219	222	225	229	2,226
Vehicles	200	203	206	209	212	215	219	222	225	229	2,341
Contingency	265										515
Total General	2,400	2,436	2,473	2,510	2,547	2,585	2,624	2,664	2,704	2,744	28,026

2. Special Capital Projects

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

Special Capital Projects

$000s	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	Total
Infrastructure	200	200	200	200	200	200	200	200	200		2,000
Facility & Seismic - Kensington											830
Facility & Seismic - Gardens											3,200
Facility & Seismic - FOH		9,880									9,880
Records Building											455
Radiology	500	400									900
Central Sterilising Unit	375										375
Environmental Upgrades	450	450									900
Energy Centre Upgrades	450										900
HRIS - Workforce Management	355										355
FMIS - Interim solution pre FPSC											151
Total Special	2,330	10,930	200	200	200	200	200	200	200		19,946

3. Regional/National Projects

These are regional / national projects that have been agreed. Explicit approval for each of these items is required before proceeding (detailed in Chapter 3).

5.7 Method of Capital Prioritisation

SCDHB funds capital expenditure for its Provider Arm only.

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

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

5.8 Funding Source

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

5.9 Debt and Equity

SCDHB has no additional borrowing facility or equity requirements during the three years of this financial plan.

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

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

Schedule of Debt and Equity Movements

$000s	2015/16 Forecast	2016/17 Plan	2017/18 Plan	2018/19 Plan
New Debt Drawdown - DMO	0	0	0	0
Debt Repayment DMO	0	0	0	0
Equity Movements FRS3 Depreciation funding repayment	-216	-216	-216	-216
- Net Result	-216	-216	-216	-216

Changes in Lenders, Limits and Borrowing Arrangements

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

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

CHAPTER 6: SERVICE CONFIGURATION

Service Coverage – Nil issues

Service Changes – Nil changes

CHAPTER 7: DHB PERFORMANCE EXPECTATIONS

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

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

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

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

Performance measure	2016/17 Performance expectation/target			
			Māori	Total
PP6: Improving the health status of people with severe mental illness through improved access.	Age 0-19		6.2%	6.2%
	Age 20-64		4.4%	4.4%
	Age 65+			1%
PP7: Improving mental health services using transition (discharge) planning and employment.	Long term clients		Provide a report as specified in the measure definition.	
	Child and youth with a Transition (discharge) Plan		At least 95% of clients discharged will have a Transition (discharge) Plan.	
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds.	Mental Health Provider Arm			
	Age	<= 3 weeks	<=8 weeks	
	0-19	80%	95%	
	Addictions (Provider Arm and NGO)			
	Age	<= 3 weeks	<=8 weeks	
	0-19	80%	95%	
PP10: Oral Health-Mean DMFT score at Year 8.	Ratio year 1		0.85	
	Ratio year 2		0.82	
PP11: Children caries-free at five years of age.	Ratio year 1		65%	
	Ratio year 2		66%	
PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years).	% year 1		>91%	
	% year 2		>91%	
PP13: Improving the number of children enrolled in DHB funded dental services.	0-4 years - % year 1		95%	
	0-4 years - % year 2		95%	
	Children not examined 0-12 years % year 1.		5%	
	Children not examined 0-12 years % year 2.		5%	

Performance measure	2016/17 Performance expectation/target	
PP20: improved management for long-term conditions (CVD, acute heart health, diabetes and stroke) Focus area 1: Long-term conditions.	Report on delivery of the actions and milestones identified in the Annual Plan.	
Focus area 2: Diabetes services	Reporting on implementation of actions in the diabetes plan "Living Well with Diabetes".	Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1c indicator)
Focus area 3: Cardiovascular (CVD) health	Indicator 1: 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.	90%
	Indicator 2: 90 percent of 'eligible Māori men in the PHO aged 35 – 44 years' who have had their cardiovascular risk assessed in the last five years.	90%
	Report on delivery of the actions and milestones identified in the Annual Plan.	
Focus area 4: Acute heart service	70 percent of high-risk patients will receive an angiogram within three days of admission ('Day of admission' being 'Day 0') by ethnicity.	70%
	Over 95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days.	≥95%
	Over 95 percent of patients undergoing cardiac surgery at the five regional cardiac surgery centres will have completion of Cardiac Surgery registry data collection with 30 days of discharge.	≥95%
	Report on deliverable for acute heart services identified in the Annual Plan and actions and progress in quality improvement initiatives to support the improvement of agreed indicators as reported in ANZACS-QI.	
Focus area 5: Stroke Services.	6 percent of potentially eligible stroke patients thrombolysed.	6%
	80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway.	80%
	80 percent of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are	80%

Performance measure	2016/17 Performance expectation/target	
	transferred within seven days of acute admission.	
	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP21: Immunisation coverage.	Percentage of two year olds fully immunised.	≥95%
	Percentage of five year olds fully immunised.	95%
	Percentage of eligible girls fully immunised - HPV vaccine.	70%
PP22: Improving system integration and SLM.	Report on delivery of the actions and milestones identified in the Annual Plan. SLM measures – A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17.	
PP23: Improving Wrap Around Services – Health of Older People.	Report on delivery of the actions and milestones identified in the Annual Plan.	
	The percent of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care plan.	95%
	Percentage of people in aged residential care by facility and by DHB who have a subsequent InterRAI long term care facility (LTCF) assessment completed within 230 days of the previous assessment.	Demonstrate an improvement on current performance.
	The percentage of LTCF clients admitted to an Aged Residential Care (ARC) facility who had been assessed using an interRAI Home Care assessment tool in the six months prior to that first long term care facility (LTCF) assessment.	85%

Performance measure	2016/17 Performance expectation/target	
PP25: Prime Minister's Youth Mental Health Project.	Initiative 1: School Based Health Services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities. 1. Provide quarterly quantitative reports on the implementation of SBHS, as per the template provided. 2. Provide quarterly narrative progress reports on 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. 1. Provide quarterly narrative progress reports (as part of PP26 Primary Mental Health reporting) with actions undertaken in that quarter to improve and strengthen youth primary mental health (12-19 year olds with mild to moderate mental health and/or addiction issues) to achieve the following outcomes: • early identification of mental health and/or addiction issues; • better access to timely and appropriate treatment and follow up; and • equitable access for Māori, Pacific and low decile youth populations. 2. Provide quantitative reports using the template provided under PP26. Initiative 5: Improve the responsiveness of primary care to youth. 1. Provide quarterly narrative reports with actions undertaken in that quarter to ensure the high performance of the youth SLAT(s) (or equivalent) in our local alliancing arrangements. 2. Provide quarterly narrative reports with actions the youth SLAT has undertaken in that quarter to improve the health of the DHB's youth population (for the 12-19-year age group at a minimum) by addressing identified gaps in responsiveness, access, service provision, clinical and financial sustainability for primary and community services for the young people, as per our SLAT(s) work programme.	
PP26: The Mental Health & Addiction Service Development Plan.	Provide reports as specified for each focus area: • Primary Mental Health • District Suicide Prevention and Postvention • Improving Crisis Response Services • Improve outcomes for children • Improving employment and physical health needs of people with low prevalence conditions	
PP27: Supporting vulnerable children.	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP28: Reducing rheumatic fever.	Provide a progress report against DHBs' Rheumatic Fever Prevention Plan.	
	Hospitalisation rates (per 100,000 DHB total population) for acute rheumatic fever.	0.2
	Report on progress in following-up known risk factors and system failure points in cases of both first episode and recurrent acute rheumatic fever.	
PP29: Improving waiting times	1. Coronary angiography – 95 percent of accepted referrals for elective coronary	95%

Performance measure	2016/17 Performance expectation/target	
for diagnostic services.	angiography will receive their procedure within three months (90 days).	
	2. CT and MRI – 95 percent of accepted referrals for CT scans, and 85 percent of accepted referrals for MRI scans will receive their scan within six weeks (42 days).	CT – 95% MRI – 85%
	3. Diagnostic colonoscopy a. 85 percent of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), and 100 percent within 30 days.	85% within 14 days 100% within 30 days
	b. 70 percent of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100 percent within 90 days.	70% within 42 days 100% within 90 days
	Surveillance colonoscopy c. 70 percent of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100 percent within 120 days.	70% within 84 days 100% within 120 days
PP30: Faster cancer treatment.	Part A: Faster cancer treatment – 31-day indicator	85 percent of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.
	Part B: Shorter waits for cancer treatment – radiotherapy and chemotherapy	All patients ready-for-treatment receive treatment within four weeks from decision-to-treat.
PP31: Better help for smokers to quit in public hospitals	95 percent 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.	95%
SI1: Ambulatory sensitive (avoidable) hospital admissions. (Service Level Measure age group 0 – 4 years).	Age 0 – 4	A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement

Performance measure	2016/17 Performance expectation/target	
		milestones, will be provided at the end of quarter one 2016/17 via measure PP22.
	Age 45 – 64	2,950
SI2: Delivery of Regional Service Plans.	Provision of a single progress report on behalf of the region agreed by all DHBs within that region.	
SI3: Ensuring delivery of Service Coverage.	Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage (as identified by the DHB or by the Ministry).	
SI4: Standardised Intervention Rates (SIRs).	Major joint replacement	An intervention rate of 21.0 per 10,000 of population.
	Cataract procedures	An intervention rate of 27.0 per 10,000.
	Cardiac surgery	A target intervention rate of 6.5 per 10,000 of population. DHBs with rates of 6.5 per 10,000 or above in previous years are required to maintain this rate.
	Percutaneous revascularization	A target rate of at least 12.5 per 10,000 of population.
	Coronary angiography services	A target rate of at least 34.7 per 10,000 of population.
SI5: Delivery of Whānau Ora	Performance expectations are met across all the measures associated with the five priority areas: • Mental health • Asthma • Oral health • Obesity • Tobacco And narrative reports cover all areas indicated.	
SI7: Service Level Measure - total acute hospital bed days per capita	A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22.	
SI8: Service Level Measure - patient experience of care	Hospital	Provide a report each quarter as specified in the measure definition. A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter on 2016/17 via measure PP22.

Performance measure	2016/17 Performance expectation/target	
	Primary care	A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter on 2016/17 via measure PP22.
S19: Service Level Measure - amendable mortality	A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter on 2016/17 via measure PP22.	
OS3: Inpatient Length of Stay	Elective LOS	1.55 days
	Acute LOS	2.35 days
OS8: Reducing Acute Readmissions to Hospital	Total population	TBA
	75 plus	TBA
OS10: 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 identity data.	New NHI registration in error. Greater than 1.5 percent and less than or equal to 6 percent.	>1.5% - ≤6%
	Recording of non-specific ethnicity. Greater than 0.5 percent and less than or equal to 2 percent.	>0.5% - ≤2%
	Update of specific ethnicity value in existing NHI record with a non-specific value. Greater than 0.5 percent and less than or equal to 2 percent.	>0.5% - ≤2%
	Validated addresses unknown. Greater than 76% and less than or equal to 85%.	>76% - ≤85%
	Invalid NHI data updates causing identity confusion.	No confirmed target
Focus area 2: Improving the quality of data submitted to National Collections.	NBRS links to NNPAC and NMDS Greater than or equal to 97 percent and less than 99.5 percent.	≥97% - <99.5%
	National collections file load success. Greater than or equal to 98 percent and less than 99.5 percent.	≥98% - <99.5%
	Assessment of data reported to the NMDS Greater than or equal to 75 percent	≥75%
	NNPAC timeliness Greater than or equal to 95 percent and less than 98 percent.	≥95% - <98%
Output 1: Mental health output delivery against plan	Volume delivery for specialist mental health and addiction services is within: a) five percent variance (+/-) of planned volumes for services measured by FTE, b) five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and c) actual expenditure on the delivery of programmes or places is	

Performance measure	2016/17 Performance expectation/target
	within 5% (+/-) of the year-to-date plan.
Developmental measure DV6: SLM youth access to and utilisation of youth appropriate health services.	No performance target/expectation
Developmental measure DV7: SLM number of babies who live in a smokefree household at six weeks post-natal.	No performance target/expectation

CHAPTER 8: APPENDICES

8.1 The Ministers 'Letter of Expectations'

Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

22 DEC 2015

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

Dear Mr Cleverley Murray

Letter of Expectations for DHBs and Subsidiary Entities 2016/17

The Government is committed to improving the health of New Zealanders and continues to invest in key health services. In Budget 2015 Vote Health received an additional $400 million the largest share of new funding, demonstrating the Government's on-going commitment to protecting and growing our public health services.

Refreshed New Zealand Health Strategy

It is important that the health sector has a clear and unified direction. The refreshed New Zealand Health Strategy will provide DHBs and the wider sector with this direction, and sets a clear view of the future we want for our health system to ensure that all New Zealanders live well, stay well and get well.

While the Strategy is not yet finalised, DHBs need to be focussed on the critical areas to drive change that come out of the refreshed strategy. The draft covers five themes – people-powered, closer to home, value and high performance, one team, and smart system. The Strategy is supported by a Roadmap of Actions, which sets the direction for the next five years. I am aware that DHBs are already progressing work under some of the themes. I expect that this work will continue and, where possible, be accelerated over the coming year. If you are thinking about new initiatives, these should have a clear link to one or more of the five themes and the outcomes should be able to be clearly linked to the intent of the draft Strategy.

I thank you for your involvement to date in this work and finalised planning expectations will be provided to DHBs in the new year.

Living Within our Means

While the global economic environment continues to be challenging, DHB funding has been increased by around $3 billion over the last seven years. While the health system could always use more resources, DHBs need to budget and operate within allocated funding and must have detailed plans to improve year-on-year financial performance. Your DHB's financial performance is currently tracking better than your plan for 2015/16. I appreciate the effort you have put into delivering a better result and I trust that you will continue to consider where your DHB can make efficiency gains. You and your Board must monitor and hold your Chief Executive accountable against these expectations as keeping to budget allows investment into new and more health initiatives.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6818 Facsimile 64 4 817 6518

Improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs. With the establishment of NZ Health Partnerships Ltd, consistent with the shareholders' agreement, I expect all DHBs to work together to ensure successful implementation of the current programmes and to identify, develop and implement future opportunities.

Working Across Government

Right now, a key focus of Government is vulnerable families. DHBs are already working closely with other social sector organisations to achieve sector goals in relation to the Government's Better Public Services initiatives, and other initiatives, such as Whānau Ora, Social Sector Trials, Prime Minister's Youth Mental Health Project and Healthy Housing. I expect DHBs to continue supporting cross-agency work that delivers outcomes for children and young people. I also expect that DHBs will keep me and the Ministry of Health informed of work they are undertaking with other sector agencies.

In line with this, the cross-government work programme on the Better Public Service Result One: Reducing long-term welfare dependence, is being expanded to include a focus on reducing unintended teenage pregnancies. I expect DHBs to commit to help deliver on this sub-focus in their 2016/17 annual plans.

National Health Targets

All of the national health targets are very important for driving overall hospital performance, and have resulted in major improvements in the health outcomes of New Zealanders. Health target performance continues to improve, but DHBs must remain focussed on achieving and improving performance against the targets, particularly the Faster Cancer Treatment target.

I remain concerned about the overall pace of progress on the Faster Cancer Treatment health target. South Canterbury DHB has shown limited improvement since the target was introduced and remains some way off both the current years goal of 85 percent and the increased goal of 90 percent by June 2017. Faster cancer treatment is a significant priority for the Government with almost $83 million invested over the last seven years to deliver better, faster cancer care. Please ensure delivery of this health target is a priority for your DHB.

Tackling Obesity

A key focus area for 2016/17 will be actions to reduce the incidence of obesity. The Childhood Obesity package of initiatives aims to prevent and manage obesity in children and young people up to 18 years of age, and includes a number of cross-agency activities. The core of the plan is the new childhood obesity health target, which is: by December 2017, 95 percent of obese children identified in the B4 School Check programme will be referred to a health professional for clinical assessment and other interventions.

I expect all DHBs to continue to show leadership in this area and to deliver on the new health target, and to identify other appropriate activities they can undertake to help reduce the incidence of obesity.

Shifting and Integrating Services

Integrating primary care with other parts of the health service is vital for better management of long-term conditions, mental health, an aging population and patients in general. The pathways to achieve better co-ordinated health and social services need to be developed and supported by clinical leaders in both community and hospital settings. I expect DHBs to continue to move services closer to home in 2016/17, and DHBs need to have clear evidence of how they plan to do this.

Health IT Programme 2015-2020

Health information systems have a crucial role to play to make the health system more sustainable, and to improve productivity, efficiency, and health outcomes. The Health IT Programme 2015–2020 begins with a design phase over the next nine months and I expect

DHB, PHO and primary care representatives to be part of the co-design process. Meanwhile, DHBs will need to complete current regional and national IT investments, such as the foundation programmes currently under way.

Please note that all DHBs must refresh their statements of intent (SOIs) for tabling in 2016/17 to reflect the key priority areas outlined above, and a health equity focus, and build these SOIs into their annual plans.

Keep in mind that the Budget 2016 process will clarify the priorities outlined in this letter and other Government priorities, and more information will be provided when available. Please share this letter with your clinical leaders and local primary care networks

Finally, please note that the provisions of the Enduring Letter of Expectations continue to apply. The letter can be accessed on the State Services Commission's website.

I would like to thank you, your staff, and your Board for your continued commitment to delivering quality health care to your population. I look forward to seeing your achievements throughout 2016/17.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

8.2 Primary Care Letter of Support

Primary Care Interim Alliance
C/- Primary & Community Services
South Canterbury District Health Board
Private Bag 911
Timaru 7940

24 May 2016

To Whom it May Concern

APPROVAL OF SOUTH CANTERBURY DISTRICT HEALTH BOARD ANNUAL PLAN 2016-2017

Members of the Primary Care Interim Alliance (PCIA) hereby advise that we have been consulted and confirm that we support the SCDHB Annual Plan 2016-2017 as it currently stands.

Signed by the members of the PCIA:

Allison Ross
PN Dee Street Medical Centre

Dagmar Crosby
GP Wood Street Surgery

Michelle Baldwin
Practice Manager Aoraki Medical & Hassall Street Surgery

Bruce Small
Chief Primary Care Medical Officer, SCDHB

Jane Brosnahan
Director of Nursing & Midwifery, SCDHB

Sharon Hansen
NP Temuka Health Care

Bryan Moore
GP Temuka Family Practice

John Fanning
GP Timaru Medical Centre

Tim Gardner
GP High Country Health

Carleen Craw-Thomson
Practice Manager
Dee Street Medical Centre

Kim Carter
PN Wood Street Surgery

8.3 Statement of Significant Accounting Policies

For the Year Ended 30 June 2016

8.3.1 Reporting Entity

South Canterbury District Health Board (SCDHB) is a Health Board established by the New Zealand Public Health and Disability Act 2000. SCDHB is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. SCDHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004 as amended by the Crown Entities Amendment Act 2013. The DHB's ultimate parent is the New Zealand Crown.

The group consists of the ultimate parent, South Canterbury District Health Board, and its subsidiary, South Canterbury Eye Clinic Limited.

SCDHB has designated itself as a public benefit entity (PBE) for financial reporting purposes.

SCDHB's activities involve delivering health and disability services and mental health services in a variety of ways to the community.

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

8.3.2 Reporting period

The financial statements for the DHB are for the year ended 30 June 2016, and were approved by the Board on 28th October 2016.

8.3.3 Statement of Compliance

The financial statements have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes the requirement to comply with Generally Accepted Accounting Practice in New Zealand (NZGAAP).

These financial statements have been prepared in accordance with Tier 1 PBE Accounting Standards and comply with those standards.

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

8.3.4 Basis of Preparation

The financial statements are prepared on a going concern basis, using historical costs, except that land and buildings are stated at their fair value. Accounting policies have been applied consistently throughout the period.

The financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand dollars.

The preparation of the financial statements in conformity with PBE accounting standards requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, revenue and expenses. Further details are given in the Accounting Policies for 'Critical accounting estimates and assumptions' and 'Critical judgements in applying accounting policies'.

8.3.5 Basis for Consolidation

SCDHB is required under the Crown Entities Act 2004 (the "Act") to prepare consolidated financial statements in relation to the group for each financial year. The consolidated financial statements are prepared by adding together like items of assets, liabilities, equity, revenue, and expenses in the group on a line-by-line basis. All intragroup balances, transactions, revenues, and expenses are eliminated on consolidation.

8.3.6 Subsidiaries

SCDHB consolidates in the group financial statements all entities where the DHB has the capacity to control their financing and operating policies so as to obtain benefits from the subsidiary. This power exists where the DHB controls the majority voting power on the governing body or where such policies have been irreversibly predetermined by the DHB or where the determination of such policies is unable to materially affect the level of potential ownership benefits that arise from the activities of the subsidiary.

The DHB will recognise goodwill where there is an excess of the consideration transferred over the net identifiable assets acquired and liabilities assumed. This difference reflects the goodwill to be recognised by the DHB. If the consideration transferred is lower than the net fair value of the DHB's interest in the identifiable assets acquired and liabilities assumed, the difference will be recognised immediately in the surplus or deficit.

The investment in subsidiaries is carried at cost in the DHB's parent entity financial statements. Information on the subsidiaries is separately disclosed in the notes to the financial statements.

8.3.7 Accounting Policies

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

1. Revenue

Crown Funding

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

Goods Sold and Services Rendered

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

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

Revenue relating to Service Contracts

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

Interest Revenue

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

Donated or Subsidised Assets

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

Where a physical asset is acquired for nil or nominal consideration the fair value of the asset received is recognised as revenue in the Statement of Comprehensive Revenue and Expenses. The fair value of donated assets is determined as follows:

- For new assets, fair value is usually determined by reference to the retail price of the same or similar assets at the time the asset was received.
- For used assets, fair value is usually determined by reference to market information for assets of a similar type, condition and age.

2. Expenditure

Interest expense

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

Capital Charge

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

Borrowing Costs

Borrowings costs are recognised as an expense in the financial year in which they are incurred.

3. Leases

Finance leases

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

Operating leases

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

4. Financial Instruments

Financial Assets

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

Available-for-sale financial assets are stated at fair value, with any resultant gain or loss, expected for impairment losses, recognised directly in equity. When these assets are derecognised, the cumulative gain or loss previously recognised directly in equity is recognised in the Statement of Comprehensive Revenue and Expenses.

Loans and receivables

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

5. Cash and Cash Equivalents

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

6. Trade and Other Receivables

Trade and other receivables are recorded at their face value, less any provision for impairment.

The receivable is considered impaired when there is evidence that SCDHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.
Bad debts are written off during the period in which they are identified.

7. Investments

Bank Term Deposits

Investments in bank term deposits are measured at the amount invested.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

Equity investments

SCDHB's investment in Health Benefits Limited is stated at cost less impairment losses.

SCDHB'S investment in the South Canterbury Eye Clinic is stated at cost.

8. Inventories

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

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

Any write down from cost to current replacement cost, or reversal of such a write down, is recognised in surplus or deficit in the period of the write down.

9. Property, Plant and Equipment

Classes of Property, Plant and Equipment

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

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

Owned assets

Land is measured at fair value and buildings are measured at fair value less accumulated depreciation. Except for the assets vested from the hospital and health service (see below), all other asset classes are stated at cost, less accumulated depreciation and impairment costs.

Fixed assets vested from the Hospital and Health Service

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

10. Revaluation of Land and Buildings

Land and Buildings are revalued with sufficient regularity, and at least every five years, to ensure that the carrying amount at balance date is not materially different to fair value. Fair value is determined by an independent registered valuer and based upon market evidence land and net replacement cost for buildings. If there is evidence supporting a material difference, then the asset class will be revalued. Revaluation movements are accounted for on a class-of-asset basis. The results of any revaluing are credited or debited to an asset revaluation reserve for that class of asset. Where this results in a debit balance in the asset revaluation reserve, this balance is expensed in the Statement of Comprehensive Revenue and Expenses. Any subsequent increase on revaluation that off-sets a previous decrease in value recognised in the Statement of Comprehensive Revenue and Expenses will be recognised first in the Statement of Comprehensive Revenue and Expenses up to the amount previously expensed, and then credited to the revaluation reserve for that class of asset.

11. Additions to Fixed Assets

The cost of an item of property, plant and equipment is recognised as an asset when it is probable that future economic benefits or service potential associated with the item will flow to SCDHB and the cost of the item can be measured reliably.

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

In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at date of acquisition.

Costs incurred subsequent to initial acquisition are capitalised only it is probable that future economic benefits or service potential associated with the item will flow to SCDHB and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

12. Disposal of Fixed Assets

When a fixed asset is disposed of, any gain or loss is recognised in the Statement of Comprehensive Revenue and Expenses and is calculated as the difference between the sale price and the carrying value of the fixed asset. When revalued assets are sold, the amounts included in the revaluation reserves in respect of those assets are transferred to general funds.

13. Depreciation of Fixed Assets

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

Buildings	33 to 65 years	1.5 – 3.0%
Building Fit-outs	3.5 to 20 years	5 – 28.6%

Plant and Equipment	2 to 10 years	10 – 50%
Motor Vehicles	3 to 5 years	20 – 33.3%

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

14. Intangible Assets

Software

Computer software that is acquired by SCDHB is stated at cost less accumulated amortisation and impairment losses.

Acquired computer software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include software development employee costs and, if applicable, an appropriate portion of relevant overheads.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred.

Costs associated with development and maintenance of SCDHB's website are recognised as an expense when incurred.

Amortisation

Amortisation is charged to the Surplus or Deficit on a straight-line basis over the estimated useful lives of intangible assets from the date they are available for use. The estimated useful lives are as follows:

Software	2 to 10 years	10-50%

15. Impairment of Property, Plant and Equipment and Intangible Assets

SCDHB does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Non-cash-generating Assets

Property, plant and equipment and intangible assets held at cost that have a finite useful life are reviewed at each balance date to determine whether there is any indication of impairment. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using an approach based on either a depreciated replacement cost approach, restoration cost approach or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information.

If the recoverable amount of an asset is less than its carrying amount, the asset is regarded as impaired and the carrying amount is written down to its recoverable amount and an impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss is recognised in the surplus or deficit.

16. Payables

Short term payables are recorded at their face value.

17. Borrowings

Borrowings are recognised initially at fair value plus transaction costs. Subsequent to initial recognition, all borrowings are stated at amortised cost with any difference between cost and redemption value

being recognised in the surplus or deficit over the period of the borrowings on an effective interest basis.

Borrowings are classified as current liabilities unless SCDHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

18. Employee Entitlements

Short term employee entitlements

Employee entitlements that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date and annual leave earned to but not yet taken at balance date.

Entitlements for retirement gratuities, senior doctor conference and sabbatical leave, long service leave, sick leave and senior doctor costs that are expected to be settled within 12 months after balance date are calculated on an actuarial basis.

Long term employee entitlements

Employee benefits that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as retirement gratuities, senior doctor conference and sabbatical leave, long service leave, sick leave, and senior doctor study costs are calculated on an actuarial basis.

The actuarial calculations are based on:

- likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement and contractual entitlement information, and
- assumptions of discount rates, salary escalation rates, resignation rates and (for sabbatical leave) the take up rate.

Superannuation Schemes

Defined contribution schemes

Obligations for contributions to Kiwisaver, the Government Superannuation Fund and the State Sector Retirement Savings Scheme are accounted for as defined contribution superannuation schemes and are recognised as an expense in the surplus or deficit as incurred.

Defined benefit schemes

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

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

19 Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that an outflow of future economic benefits will be required to settle the obligation and a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a pre-tax discount rate that reflects current market assessments of the time value of

money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense and included in "finance costs".

Restructuring

A provision for restructuring is recognised when an approved detailed formal plan for the restructuring has either been announced publicly to those affected, or for which implementation has already commenced.

Onerous contracts

A provision for onerous contracts is recognised when the expected benefits or service potential to be derived from a contract are lower than the unavoidable cost of meeting the obligations under the contract.

The provision is measured at the present value of the lower of the expected cost of terminating the contract and the expected net cost of continuing with the contract.

20. Equity

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

- General Funds (contributed capital);
- Accumulated surplus/(deficit);
- Equity from donated assets; and
- Property revaluation reserves

Property revaluation reserves

These reserves relate to the revaluation of land and buildings to fair value.

21. Goods and Services Tax

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

The net amount of GST recoverable from, or payable to, the IRD is included as part of the receivables or payables in the Statement of Financial Position.

The net GST paid to, or received from, the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the Statement of Cash Flows.

Commitments and contingencies are disclosed exclusive of GST.

22. Taxation

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

23. Budget Figures

The budget figures are those approved by the Board and published in its Annual Plan, which is the external accountability document prepared by SCDHB under the Crown Entities Act 2004. The budget figures have been prepared in accordance with generally accepted accounting practice and are consistent with the accounting policies adopted by the Board for the preparation of the financial statements.

24. Cost Allocation

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

25. Critical Accounting Estimates and Assumptions

In preparing these financial statements, SCDHB has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amount of the assets and liabilities within the next financial year are discussed below.

Estimating the fair value of land and buildings

Land and buildings were revalued, by a registered valuer, as at 30 June 2016 to fair value. SCDHB have relied upon this valuation and the assumptions made by the valuer in determining the fair value of land and buildings. The significant assumptions applied in determining the fair value of land and buildings are disclosed in note 7.

Estimating useful lives and residual values of property, plant and equipment

At each balance date, the useful lives and residual values of property, plant and equipment are reviewed. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires a number of factors to be considered such as the physical condition of the asset, expected period of use of the asset by SCDHB and expected disposal proceeds from the future sale of the asset.

An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit and the carrying amount of the asset in the Statement of Financial Position. SCDHB minimises the risk of this uncertainty by:

- Physical inspection of assets;
- Asset replacement programs.

SCDHB has not made significant changes to past assumptions concerning useful lives and residual values.

Employee entitlements

SCDHB has relied upon actuarial assessment for retirement gratuities, long service leave and some other employee entitlements.

26. Critical Judgements in Applying Accounting Policies

Management has exercised the following critical judgements in applying accounting policies.

Leases classification

Determining whether a lease agreement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to SCDHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the Statement of Financial Position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

SCDHB has exercised its judgement on the appropriate classification of the lease for the MRI scanner and has determined it to be a finance lease.

27. Changes in Accounting Policies

With the acquisition of a further subsidiary during the year, SCDHB has prepared consolidated financial statements.

There have been no other changes in accounting policies during the financial year.

8.4 Glossary of Terms

ABC	Ask about and document every person's smoking status, give brief advice to stop every person who smokes, and strongly encourage every person who smokes to use cessation support (a combination of behavioral support and stop-smoking medicine works best) and offer to help them access it.
ABCD2	Transient Ischemic Attack (TIA) assessment – age, blood pressure, clinical symptoms, diabetes and duration.
ACP	Advance Care Plan
ACCP	Accelerated Chest Pain Pathway
ACS	Acute Coronary Syndrome
ADOM	Alcohol and Drug Outcome Measure
ANZACS - QI	A web-based system to support clinical quality improvement in secondary care cardiology practice and to better understand the relevant population health profile within regions and nationally.
AOD	Alcohol and Other Drug
APP	Annual Procurement Plan
AROC	Australasian Rehabilitation Outcomes Centre
ARRC	Age Related Residential Care
ASH	Ambulatory Sensitive Hospitalisation
ASH NZ	Action on Smoking and Health NZ
ATLAS	The Atlas of Healthcare Variation displays easy-to-use maps, graphs, tables and commentaries that highlight variations by geographic area in the provision and use of specific health services and health outcomes.
ATR	Assessment, Treatment and Rehabilitation Services
AWS	Arowhenua Whānau Services
B4SC	Before School Check
BadgerNet	Specialist perinatal management software
BMI	Body Mass Index
CaaG	Capacity at a glance
CAP	Children's Action Plan
CAPA	Choice And Partnership Approach
CAPEX	Capital Expenditure
Cost Weighted Discharge (CWD)	A national method of measuring dissimilar outputs in a common way. E.g. a hip replacement is 4.008 case weights and an appendix removal is 1.044 case weights. I.e. a hip replacement is considered to use about four times the resources (or cost) than an appendectomy.
CCDM	Care Capacity Demand Management
CD	Clinical Director
CEO	Chief Executive Officer
CMHT	Community Mental Health Team
CNM	Charge Nurse Manager
CNS	Clinical Nurse Specialist
COPMIA	Children of Parents with Mental Health & Addictions
CPAC	Clinical Prioritisation Assessment Criteria
CPIT	Canterbury Polytechnic Institute of Technology
Crown Entity	A generic term for a diverse range of entities within one of the five categories referred to in section 7(1) of the Crown Entities Act 2004, namely: statutory entities, Crown entity companies, Crown entity subsidiaries, school boards of trustees, and tertiary education institutions. Crown entities are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister(s); they are included in the annual financial statements of the Government.
CT	Computed Tomography
CTC	Computed Tomography Colonoscopy
CVD	Cardiovascular Disease
CVDRA	Cardiovascular Disease Risk Assessment
CYFS	Child Youth and Family Services

DHB	District Health Board
DMFT	Decayed, Missing, Filled Teeth
DMO	Debt Management Office
DNA	Did Not Attend
DONM	Director of Nursing and Midwifery
Dr Info	Dr Info is an electronic software programme which pulls and collates information allowing general practice access at the point of service to real-time health information from a number of data sources.
DXA	A scan which measures bone density and is typically used to diagnose and monitor osteoporosis.
ED	Emergency department
Encounter Programme	An intensive 12 week programme to assist either newly diagnosed Type 2 diabetics, Type 2 diabetics starting on insulin therapy and patients who have not attended their Diabetes Annual Review and are considered at high risk of complications from diabetes due to poor metabolic control, to better self-manage lifestyle and medication requirements and to allow for a better quality of life and improved metabolic control.
ERAS	Early Recovery After Surgery
ERMS	Electronic Referral Management System
eSam	New address validation web services which uses data from NZ Post, Land Information NZ, Statistics NZ, and the Ministry of Health to provide accurate and standardised address and geospatial data.
ESPI	Elective Services Patient Flow Indicator
FAST	Sudden signs of stroke – face dropping, arm weakness, speech difficulty, time to call 111.
FIMS	Functional Interdependence Measure
FMIS	Financial Management Information Systems
FSA	First Specialist Assessment
FTE	Full Time Equivalent, e.g., two people each working 20 hours per week = 1 FTE.
FVIP	Family Violence Intervention Programme
GM	General Manager
GP	General Practitioner
GST	Goods and Services Tax
HbA1c	Haemoglobin A1c, often abbreviated HbA1c, is a form of haemoglobin (a blood pigment that carries oxygen) that is bound to glucose. The blood test for HbA1c level is routinely performed in people with type 1 and type 2 diabetes mellitus.
HBL	Health Benefits Limited
HCS	Health Connect South
HEEADSSS	Home, Education & employment, Eating, Activities with peers, Drugs, Sexual activity, Suicide & Depression, Safety.
NHITB	National Health Information Technology Board
HOP	Health of Older Persons
HONOS	Health of the Nation Outcome Scale
NMMG	National Maternity Monitoring Group
HPV	Human Papilloma Virus
HQSC	Health Quality & Safety Commission
HR	Human Resources
HRIS	Human Resource Information System
HWNZ	Health Workforce New Zealand
IANZ	The International Academy of New Zealand
ICAMHS	Infant Child Adolescent Mental Health Services
ICU	Intensive Care Unit
IDF	Inter-District Flows. Patients who live in one district receiving services in another district.
IL	Importance Level
Impact indicators	Impact indicators are attributed to agency (DHBs) outputs in a credible way. Impact indicators represent near-term results expected from the goods and services you deliver; can often be measured soon after delivery, promoting timely decisions; and may reveal specific ways in which

	managers can remedy performance shortfalls.
INR	The test used to monitor the effects of warfarin is called the International Normalised Ratio, or INR. It is a blood test that checks how long it takes for blood to clot.
Intervention logic model	A framework for describing the relationships between resources, activities and results. It provides a common approach for integrating planning, implementation, evaluation and reporting. Intervention logic also focuses on being accountable for what matters – impacts and outcomes.
InterRAI	Clinical assessment tool used in Older Persons Care.
IPIF	Integrated Performance Incentive Framework
IT	Information Technology
Karo	Karo Data Management designs easy tools for PHOs and health providers to manage primary health data and fulfil reporting obligations. Then we turn that data into meaningful information you can use to evaluate and improve your services to provide the best possible care for your patients and communities.
KPI	Key Performance Indicator
"Living within our means"	Providing the expected level of outputs within a break even budget or National Health Board (NHB) agreed deficit step toward break even by a specific time.
LMC	Lead Maternity Carer
LOS	Length of Stay
LTC	Long Term Condition
MBIE	Ministry Business Innovation & Employment
MDMs	Multi-Disciplinary Meetings
MECA	Multi Employment Collective Agreement
MOH	Ministry of Health
MOSAIQ	MOSAIQ is a complete patient information management system that centralizes radiation oncology, particle therapy and medical oncology patient data into a single user interface, accessible by multi-disciplinary teams across multiple locations.
MOU	Memorandum of Understanding
MQSP	Maternity Quality and Safety Programme
MRI	Magnetic Resonance Imaging
NBRS	National Booking Reporting System
NCSP	National Cervical Screening Programme
NGO	Non-Government Organisation
NHC	National Health Committee
NHI	National Health Index
NHITB	National Health Information Technology Board
NIP	National Infrastructure Platform
NMDS	National Minimum Data Set
NNPAC	National Non-Admitted Patient Collection
NOS	National Oracle Software
NZD	New Zealand Dollar
NZGAAP	New Zealand Generally Accepted Accounting Practice
NZIAS	New Zealand Institute Accountancy Standards
Outcome	Outcomes are the impacts on or the consequences for, the community of the outputs or activities of government. In common usage, however, the term 'outcomes' is often used more generally to mean results, regardless of whether they are produced by government action or other means. An intermediate outcome is expected to lead to an end outcome, but, in itself, is not the desired result. An end outcome is the final result desired from delivering outputs. An output may have more than one end outcome; or several outputs may contribute to a single end outcome. A state or condition of society, the economy or the environment and includes a change in that state or condition. (Public Finance Act 1989).
Output classes	An aggregation of outputs, or groups of similar outputs. (Public Finance Act 1989) Outputs can be grouped if they are of a similar nature. The output classes selected in your non-financial measures must also be reflected in your financial measures (s 142 (2) (b) Crown Entities Act 2004).
PBE	Public Benefit Entity

PCI	Percutaneous Coronary Intervention
PDCA	Plan, Do, Check, Act cycle
Performance measure	Selected measures must align with the DHBs Regional Service Plan and Annual Plan. Four or five key outcomes with associated outputs for non-financial forecast service performance are considered adequate. Appropriate measures should be selected and should consider quality, quantity, effectiveness and timeliness.
PHO	Primary Health Organisation
PICS	Patient Information Care System
PPP	Primary Performance Programme
Quality Accounts	A Quality Account is a report about the quality of services delivered by a healthcare provider.
QIP	Quality Improvement Programme
QSM	Quality Safety Marker
Regional collaboration	Regional collaboration refers to DHBs across geographical 'regions' for the purposes of planning and delivering services (clinical and non-clinical) together. Four regions exist. SCDHB is part of the Southern Region.
Ring-fence	Can be used for the designated purpose only.
RL6	Supplier of the DHB's electronic Incident Management System 'Safety 1st,
SAC	Severity Assessment Code
SBHS	School Based Health Services
SCDHB	South Canterbury District Health Board
SAE	Serious Adverse Event
Secondary	Second level health services to which the public need referral, e.g., hospital-based services except for emergency services.
SCN	Southern Cancer Network
SI	South Island
SIAPO	South Island Alliance Programme Office
SIISSLA	South Island Information Service, Service Level Alliance
SIHSP	South Island Health Service Plan
SLAT	Service Level Alliance Team
Strengths Recovery Approach	A strengths approach is a specific method of working with and resolving the problems experienced by a person presenting to mental health services.
TIA	Transient Ischemic Attack
VC	Video conferencing
WiAS	Walking in another's Shoes – Dementia Education Programme.
WAVE	Wellbeing and Vitality in Education: SCDHBs Intersectoral Child and Youth Health Project.
WCTO	Well Child/Tamariki Ora
WHO	World Health Organisation
WSMP	Workplace Safety Management Programme

8.5 Summary Production Plan

PU Code	PU Description	Unit of Measure	15/16 Target	15/16 Price	15/16 Total	16/17 Target	16/17 Price	16/17 Total
AH01001	Dietetics	Contact	1,174.00	149.17	175,124	1,174.00	151.30	177,629
AH01001	Community Dietitian Other	Contact	381	149.17	56,833	381	151.30	57,646
AH01001	Community Dietitian - Māori	Contact	95	149.17	14,171	95	151.30	14,374
AH01001	Community Dietitian - Community Education	FTE	0.2	102,696.07	20,539	0.2	103,723.03	20,745
AH01003	Occupational Therapy	Contact	3,067.00	183.45	562,652	3,067.00	162.27	497,670
AH01005	Physiotherapy	Attendance	8,137.00	97.90	796,576	8,137.00	102.94	837,625
AH01006	Podiatry	Contact	912.00	169.24	154,348	912.00	191.95	175,060
AH01007	Social Work	Contact	645.00	167.11	107,786	645.00	175.87	113,438
AH01008	Speech Therapy	Contact	373.00	161.50	60,240	373.00	164.46	61,343
C01011	Public Health Optometrist Assessments	Test	300	41.22	12,367	300	41.64	12,491
C01013	B4 Schools	Client	1	187,608.26	187,608	1	189,484.35	189,484
CO1016	Well Child (Public Health Nursing)	Client	1	662,907.22	662,907	1	669,536.29	669,536
COCH0027	School Based Health Services	Client	1	60,778.06	60,778	1	61,385.85	61,386
COCH0023	Immunisation Coordination	Service	1	53,587.80	53,588	1	53,587.80	53,588
COOC0050	National Immunisation register system development	Service	1	67,752.12	67,752	1	67,752.12	67,752
COPL0002	Palliative Clinical Care	Other	1	45,677.44	45,677	1	46,134.22	46,134
COPL0002	Palliative Care	Service	1	231,779.53	231,780	1	234,097.32	234,097
CS01001	Radiology DEXA scans	Scans	390	144.46	56,341	390	145.91	56,904
CS01001	Community Radiology	Relative Value Unit	10,564.00	72.13	761,959	10,564.00	68.70	725,790
CS04003	Community referred tests - audiology	Test	1,575.00	168.81	265,876	1,575.00	173.75	273,663
D01001	Inpatient Dental treatment	Cost Weighted Discharge	75.00	4,751.58	356,368	75.00	4,824.67	361,850
D01002	Outpatient Dental treatment	Attendance	978.00	243.34	237,985	978.00	242.14	236,816
DOM101	Community Services - professional nursing services	Contact	32,200	101.69	3,274,448	32,200	101.96	3,283,108
DOM101	Domiciliary Nursing	Visit	750	101.69	76,268	750	101.96	76,470
DOM102	Community Services - home oxygen	Client	60	576.72	34,603	60	584.08	35,045
DOM103	Community Services - stomal services	Client	250	2,212.89	553,223	250	2,241.13	560,284
DOM104	Community Services - continence service	Client	470	425.64	200,053	470	431.08	202,606
DOM105	Community Services - Home help	Hour	1,300	27.39	35,608	1,300	33.29	43,274
DOM106	Community Services - meals on wheels	Meal	16,812	4.25	71,524	13,000	5.07	65,867

PU Code	PU Description	Unit of Measure	15/16 Target	15/16 Price	15/16 Total	16/17 Target	16/17 Price	16/17 Total
DOM107	Community Services - personal care	Hour	200	34.40	6,880	200	34.84	6,967
ED04001	Emergency Dept - Level 4	Attendance	12,481.00	298.65	3,727,489	12,481.00	333.90	4,167,398
M00001	General Internal Medical Services - Inpatient Services (DRGs)	Cost Weighted Discharge	2,270.00	4,751.58	10,786,077	2,458.00	4,824.67	11,859,035
M00002	General Medicine - 1st attendance	Attendance	977.00	466.51	455,782	977.00	472.47	461,599
M00010	Medical Non-Contact First Specialist Assessment	Written Plan of Care	503.00	193.57	97,368	503.00	171.40	86,215
M00003	General Medicine - Subsequent attendance	Attendance	2,082.00	266.46	554,763	2,082.00	258.58	538,357
MSO2001	Blood transfusions - any health specialty	Attendance	153.00	1,075.17	164,501	153.00	1,068.02	163,406
M050001	Emergency Medicine	Cost Weighted Discharge	400.00	4,751.58	1,900,630	400.00	4,824.67	1,929,867
M10002	Cardiology - 1st attendance	Attendance	138.00	465.69	64,266	138.00	469.30	64,763
M10003	Cardiology - Subsequent attendance	Attendance	263.00	279.16	73,419	263.00	267.58	70,374
M10004	Cardiac Education and Management	FTE	0.40	102,695.65	41,078	0.40	103,722.60	41,489
M10004	Cardiac Education and Management	FTE	1.0	102,695.65	102,696	1.0	103,722.60	103,723
M15002	Dermatology - 1st attendance	Attendance	80.00	293.24	23,459	80.00	271.32	21,706
M15003	Dermatology - Subsequent attendance	Attendance	210.00	230.12	48,324	210.00	213.54	44,843
M20006	Diabetes Education and Care	Client	270.00	304.97	82,342	270.00	256.10	69,148
M20006	Diabetes	Other	1	76,129.07	76,129	1	76,890.36	76,890
M20007	Diabetes - Fundus Screening	Procedure	1,000.00	93.99	93,992	1,000.00	81.27	81,266
MSO2006	ERCP - Any Health Specialty	Procedure	3.00	1,819.58	5,459	3.00	2,700.80	8,102
MSO2007	Colonoscopy - any health specialty	Procedure	780.00	1,189.84	928,075	780.00	1,217.09	949,333
MSO2005	Gastroscopy - any health specialty	Procedure	342.00	1,057.44	361,645	342.00	1,013.19	346,512
M45002	Neurology - 1st attendance	Attendance	40.00	513.68	20,547	40.00	549.97	21,999
M45003	Neurology - Subsequent attendance	Attendance	5.00	349.68	1,748	5.00	341.54	1,708
M50020	Oncology - 1st attendance	Attendance	40.00	624.87	24,995	40.00	619.06	24,762
M50021	Oncology - Subsequent attendance	Attendance	1,019.00	363.82	370,735	1,019.00	344.79	351,337
MSO2009	IV Chemotherapy	Attendance	1,143.83	43.96	50,283	1,150.00	44.40	51,060
MSO2009	IV Chemotherapy	Attendance	6.17	488.00	3,011	0	488.30	0
M55001	Paediatric Medical Service (Inpatient)	Cost Weighted Discharge	219.00	4,751.58	1,040,595	219.00	4,824.67	1,056,602
M55002	Paediatric Medical Outpatient - 1st attendance	Attendance	452.00	513.31	232,018	452.00	573.86	259,385
M55003	Paediatric Medical Outpatient - Subsequent attendance	Attendance	1,148.00	341.26	391,769	1,148.00	336.34	386,115
M55005	Paediatric Community Programme	Service	1.00	30,000.00	30,000	1.00	30,000.00	30,000

PU Code	PU Description	Unit of Measure	15/16 Target	15/16 Price	15/16 Total	16/17 Target	16/17 Price	16/17 Total
M60002	Renal Medicine - 1st attendance	Attendance	26.00	525.27	13,657	26.00	525.21	13,656
M60003	Renal Medicine - Subsequent attendance	Attendance	174.00	328.08	57,087	174.00	310.64	54,052
M65004	Respiratory Education and Management	FTE	0.20	102,695.65	20,539	0.20	103,722.60	20,745
M65004	Respiratory Education and Management	FTE	1.0	102,695.65	102,696	1.0	103,722.60	103,723
MSO2003	Respiratory - Bronchoscopy	Procedure	20.00	1,383.81	27,676	20.00	1,341.17	26,823
MS01001	Nurse Led Outpatient Clinics Cardiac	Attendance	60.00	191.58	11,495	60.00	197.26	11,835
MS01001	Nurse Led Outpatient Clinics Orthopaedic	Attendance	650.00	191.58	124,526	650.00	197.26	128,216
MS01001	Nurse Led Outpatient Clinics Hepatitis C	Attendance	140.00	191.58	26,821	140.00	197.26	27,616
MS01001	Nurse Led Outpatient Clinics Enuresis	Attendance	102.00	191.58	19,541	102.00	197.26	20,120
OT02001	Coroner Deaths not requiring Post Mortem	Case	45.00	42.57	1,916	45.00	43.12	1,940
PC0001	Pain Specialist assessment	Attendance	120.00	670.75	80,491	120.00	693.12	83,174
PC0003	Pain Specialist Appointment - Follow-up	Attendance	1,380.00	440.65	608,099	1,380.00	377.31	520,687
SH01001	Sexual Health - First Contact	Contact	330	201.74	66,575	330	204.32	67,424
SH01002	Sexual Health - Follow Up	Contact	350	152.27	53,295	350	154.22	53,975
SH01004	Medical Management of Sexual Abuse	Service	1.00	5,817.90	5,818	1.00	5,876.08	5,876
S00001	General Surgery - Inpatient Services (DRGs)	Cost Weighted Discharge	2,397.88	4,751.58	11,393,708	2,143.46	4,824.67	10,341,484
S00002	General Surgery - 1st attendance	Attendance	1,928.00	343.72	662,695	1,859.00	326.73	607,391
S05001	Anaesthesia Services - Inpatient Services (DRGs)	Cost Weighted Discharge	44.50	4,751.58	211,445	102.41	4,824.67	494,094
MSO2016	Skin Lesion	Cost Weighted Discharge	7.62	4,751.58	36,207	18.98	4,824.67	91,572
S00011	Surgical Non-Contact First Specialist Assessment	Written Plan of Care	800.00	193.57	154,859	800.00	171.40	137,122
S00003	General Surgery - Subsequent attendance	Attendance	3,000.00	280.07	840,197	2,710.00	251.56	681,715
S00008	Minor Operations	Procedure	50.00	367.50	18,375	50.00	383.24	19,162
S25001	Ear, Nose and Throat - Inpatient Services (DRGs)	Cost Weighted Discharge	242.85	4,751.58	1,153,912	249.55	4,824.67	1,203,973
S25002	Ear Nose and Throat - 1st attendance	Attendance	650.00	333.00	216,452	650.00	309.05	200,880
S25003	Ear Nose and Throat - Subsequent attendance	Attendance	1,190.00	239.65	285,184	1,190.00	226.98	270,110
S30001	Gynaecology - Inpatient Services (DRGs)	Cost Weighted Discharge	333.52	4,751.58	1,584,746	356.52	4,824.67	1,720,091
S30002	Gynaecology - 1st attendance	Attendance	433.00	396.40	171,642	433.00	397.55	172,138
S30003	Gynaecology - Subsequent attendance	Attendance	1,062.00	280.24	297,619	1,062.00	269.42	286,129
S40001	Ophthalmology - Inpatient Services (DRGs)	Cost Weighted Discharge	142.00	4,751.58	674,724	142.00	4,824.67	685,103
S40002	Ophthalmology - 1st attendance	Attendance	740.00	229.28	169,669	740.00	217.87	161,226

PU Code	PU Description	Unit of Measure	15/16 Target	15/16 Price	15/16 Total	16/17 Target	16/17 Price	16/17 Total
S40003	Ophthalmology - Subsequent attendance	Attendance	2,800.00	175.13	490,370	2,800.00	165.46	463,296
S40008	Minor Eye Procedures	Procedure	180.00	234.92	42,285	250.00	285.50	71,375
S40005	Eye - Argon Laser	Procedure	200.00	244.30	48,860	200.00	232.29	46,458
S40007	Avastin treatments	Procedure	400.00	328.12	131,248	450.00	331.40	149,131
S40006	Alcon Ocuscan Treatments	Service	1.00	906.44	906	0	0	0
S40006	Ophthalmology Technician	FTE	0.50	123,678.24	61,839	0	0	0
S45001	Orthopaedics - Inpatient Services (DRGs)	Cost Weighted Discharge	1,580.00	4,751.58	7,507,490	1,652.36	4,824.67	7,972,089
S45002	Orthopaedics - 1st attendance	Attendance	1,164.00	320.70	373,292	1,164.00	308.20	358,742
S45003	Orthopaedics - Subsequent attendance	Attendance	2,693.00	239.22	644,219	2,693.00	227.01	611,342
S55002	Paediatric Surgery Outpatient - 1st attendance	Attendance	32.00	282.99	9,056	32.00	277.61	8,883
S55003	Paediatric Surgery Outpatient - subsequent attendance	Attendance	80.00	255.58	20,447	80.00	270.99	21,679
S60002	Plastics (incl Burns and Maxillofacial) - 1st attendance	Attendance	39.00	279.75	10,910	39.00	258.23	10,071
S60003	Plastics (incl Burns and Maxillofacial) - Subsequent attendance	Attendance	55.00	203.74	11,205	55.00	184.21	10,132
MSO2004	Cystoscopy - any health specialty	Procedure	300.00	445.88	133,763	225.00	500.39	112,588
S70006	Urology - Lithotripsy	Procedure	19.00	5,339.05	101,442	19.00	4,325.75	82,189
S70007	Urodynamics	Procedure	40.00	499.07	19,963	40.00	528.96	21,158
W01011	Pregnancy and Parenting Education	Course	16.00	2,093.07	33,489	16.00	2,114.00	33,824
W10 01	Maternity inpatient (DRGs)	Cost Weighted Discharge	650.00	4,751.58	3,088,524	650.00	4,824.67	3,136,034
W03010	Breastfeeding clinic / lactation clinic	FTE	1.00	101,015.24	101,015	1.00	102,025.39	102,025
WO1007	Antenatal Consultations - Non Specialist	Contact	76.00	144.28	10,965	76.00	160.80	12,221
WO1008	Postnatal Consultations - Non Specialist	Contact	6.00	144.28	866	6.00	152.56	915
WO1021	DHB Primary Maternity Ultrasound	Procedure	1,400.00	50.00	70,000	1,400.00	50.50	70,700
WO3002	Secondary Obstetric Outpatients - First Attendance	Attendance	320.00	326.27	104,406	320.00	333.19	106,621
WO3003	Secondary Obstetric Outpatients - Followup Attendance	Attendance	1,030.00	318.78	328,340	1,030.00	273.39	281,591
W06003	Specialist neonates	Cost Weighted Discharge	70.00	4,751.58	332,610	70.00	4,824.67	337,727
M65010	Tobacco Control	FTE	0.80	91,439.40	73,151.52	0.80	92,627.58	74,102.06
RM00111	Tobacco Control	FTE	2	90,951.40	181,903	2	90,951.40	181,903
RM00111	Tobacco Control Clinical Lead	Other	1.0	22,120.00	22,120	1.0	22,120.00	22,120
COOC0070	Family Violence Project Coordination	Service	1.00	120,000.00	120,000	1.00	120,000.00	120,000
CS03001	Hospital Dispensing of Pharmaceuticals	Item Dispensed	1,880.00	8.05	15,134	1,880.00	8.15	15,327

PU Code	PU Description	Unit of Measure	15/16 Target	15/16 Price	15/16 Total	16/17 Target	16/17 Price	16/17 Total
MHD74C	Community Alcohol & Drug Services	Other Clinical FTE	3.60	131,890.78	474,807	3.60	133,209.68	479,555
MHF80C	Community Forensic Service	Clinical FTE	0.50	61,825.96	30,913	0.50	62,444.22	31,222
MHW67D	Family and Whanau advisory service	FTE	0.40	93,757.10	37,503	0.40	94,694.67	37,878
MHK61E	Kaumatua roles - Cultural	FTE	2.00	99,690.77	199,382	2.00	100,687.68	201,375
MHD69	Methadone Treatment – General Practitioner	Case	21.00	2,530.89	53,149	21.00	2,556.20	53,680
MHD70	Methadone Treatment – Specialist	Case	68.00	3,708.89	252,205	68.00	3,745.98	254,727
MHFF	Individual Primary Care Support	FTE	1.00	21,671.35	21,671	1.00	21,671.35	21,671
MHO98	Older People Inpatient Beds	Available Bed Day	200.00	796.27	159,254	200.00	804.23	160,846
MHWF	Workforce Development	Programme	1.00	174,353.85	174,354	0	174,353.85	0
MHA01	Acute 24 Hour Clinical Intervention (inpatient)	Available bed day	1,954.00	827.83	1,617,577	1,954.00	836.11	1,633,753
MHA03	Adult Crisis Respite	Occupied bed day	1.00	52,786.21	52,786	1.00	52,786.21	52,786
MHA07	Subacute Extended Care - Inpatient beds	Available bed day	250.00	539.38	134,846	250.00	544.78	136,195
MHA09A	Community Clinical Mental Health Service	FTE	1.20	283,505.63	340,207	1.20	286,340.69	343,609
MHA09C	Community Clinical Mental Health Service	FTE	16.10	132,866.14	2,139,145	16.10	134,194.80	2,160,536
MHA09D	Adult Community Support Services	FTE	3.00	85,473.76	256,421	3.00	86,328.50	258,986
MHA22D	Vocational Support Services	FTE	1.00	21,994.25	21,994	1.00	21,994.25	21,994
MHC36F	Peer support service-Adults	FTE	0.80	111,145.94	88,917	0.80	112,257.40	89,806
MHI44A	Infant, child, adolescent & youth community mental health services	FTE	0.45	316,893.13	142,602	0.45	320,062.06	144,028
MHI44C	Infant, child, adolescent & youth community mental health services	FTE	6.05	111,793.80	676,352	6.05	112,911.74	683,116
MHI44C	Infant, child, adolescent & youth community mental health services	FTE	0.20	137,912.49	27,582	0.20	139,291.62	27,858
MHDI48C	Child, adolescent and youth alcohol & drug community services	FTE	1.00	123,756.52	123,757	1.00	124,994.08	124,994
MHIY87	Forensic Youth Worker	FTE	0.70	130,793.00	91,555	0.70	124,994.08	87,496
HOP214	ATR Inpatient	Bed Day	3,900.00	815.15	3,179,072	3,900.00	793.16	3,093,311
HOP215	ATR Outpatient – Clinics	Attendance	155.00	207.27	32,126	155.00	202.68	31,415
HOP216	ATR Outpatient - Day Hospital & Day Programmes	Day Attendance	10.00	236.09	2,361	10.00	191.28	1,913
HOP217	ATR Outpatient – domiciliary assessments & education sessions	Visit	960.00	209.26	200,888	960.00	178.62	171,479

PU Code	PU Description	Unit of Measure	15/16 Target	15/16 Price	15/16 Total	16/17 Target	16/17 Price	16/17 Total
DOM110	Orthotics	Contacts	900.00	65.02	58,521	900.00	65.67	59,106
	Dementia Educator	Other	0.50	100,890.00	50,445	0.50	100,890.00	50,445
AH01003	Driving Assessments	Client	12.00	183.45	2,201	12.00	162.27	1,947
M50021	Oncology Nurse	FTE	2.00	102,696.07	205,392	2.00	103,723.03	207,446
M50021	Cancer Nurse Coordinator	FTE	1.00	100,610.00	100,610	1.00	100,000.00	100,000
ADJ119	Adult cancer services - psychological and social support	Other	0	0	0	1.00	49,548.00	49,548
M00008	Multi Disciplinary Meetings	Programme	1.00	30,000.00	30,000	1.00	30,000.00	30,000
COPL0002	Specialist Palliative care	Programme	1.00	31,761.78	31,762	1.00	32,079.40	32,079
DSS221	ASD Coordinator	FTE	0.70	75,000.00	52,500	0.70	75,000.00	52,500
UNHS-40	New Born Hearing screening	Programme	1.00	44,758.46	44,758	1.00	58,472.44	58,472
WO8001	Maternity Quality & Safety	Programme	1.00	68,609.98	68,610	1.00	69,634.00	69,634
C01008	LCYMRC	Programme	1.00	9,300.20	9,300	1.00	9,300.20	9,300
MEOU0075	Patient flow improvement project	Service	1.00	15,302.00	15,302	1.00	7,129.00	7,129
MEOU0071	Patient flow improvement - GP Liaison	Service	1.00	32,965.72	32,966	1.00	33,295.37	33,295
PCT001	Pharmaceutical Cancer Treatments & Community Drugs	Item Dispensed	1.00	1,562,326.00	1,562,326	1.00	1,562,326.00	1,562,326
DO1013	Dental Projects (Lease Woollcombe)	Service	1	29,875.18	29,875	1	29,875.18	29,875
PHOM0008	Primary and Community Services	Other	1	814,366.79	814,367	1	822,510.45	822,510
D01001	Inpatient Dental treatment	Cost Weighted Discharge	1.48	4,751.58	7,035.66	0.99	4,824.67	4,782
S00001	General Surgery - Inpatient Services (DRGs)	Cost Weighted Discharge	10.93	4,751.58	51,931.40	33.69	4,824.67	162,547
S30001	Gynaecology - Inpatient Services (DRGs)	Cost Weighted Discharge	2.62	4,751.58	12,425.37	1.22	4,824.67	5,902
S40001	Ophthalmology - Inpatient Services (DRGs)	Cost Weighted Discharge	5.52	4,751.58	26,232.50	0	4,824.67	0-
S45001	Orthopaedics - Inpatient Services (DRGs)	Cost Weighted Discharge	1.53	4,751.58	7,276.09	12.27	4,824.67	59,206
MSO2016	Skin Lesion	Cost Weighted Discharge	0	4,751.58	0	1.06	4,824.67	5,118
HOP235	ATR Inpatient – Mental Health service(s) for Elderly	Bed Day	6.17	756.62	4,668.51	0	766.28	0
ADJ111	Offer Adjuster	Other	1	2,028,985.00	2,028,985.00	1	1,953,193.00	1,953,193
DSS207	Residential Long Stay - Non Aged	Other	1	3,597,914.00	3,597,914.00	1	3,597,914.00	3,597,914
					$83,513,365			**$84,400,439**

8.6 SCDHB Prevention/Early Intervention Performance Targets

Appendix 4 South Canterbury DHB Prevention/Early Detection/Intervention Performance Targets 2016-17

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

	Community	Education	Workplaces	Primary Care	Secondary care	Impact targets
Nutrition & physical activity		95% of all settings have active WAVE settings plans CPH 2 new settings develop school travel plans CPH 6 schools supported to sustain travel plans	Establishment of a new workplace physical activity event SCDHB/ SC	557 patients referred to Green Prescription 22%GRx referrals Diabetes related. SC 8 Wellness programmes delivered to 120 patients	30 new referrals to GRx from secondary care SC/SS	F&V consumption targets BF targets
	6 sessions / week averaging 20 students / SC Kiwisport Non participating Youth SCDHB/ SC	13 primary schools engaged from targeted communities SC 17 primary schools engaged in supported communities		2 Face to Face clinics catering for 140 GRx patients SC		PA targets
				95% obese children identified in B4 School Check offered referral for clinical assessment & family based nutrition, activity & lifestyle interventions. PCS		
Tobacco (Ministry Health Target Indicator)	Stop Smoking Services delivered enrolled to 72-90 clients CPH All referrals contacted within 3 working days	Smokefree reflected in 5 settings plans CPH	3 workplaces engage in a HP process that includes smokefree initiatives and other workplaces receive smokefree advice and support as requested CPH	≥500 people in South Canterbury access smoking cessation programmes PCS	95% of smokers using hospital services are offered advice & support to quit to quit SS	75% of Year 10 students have never smoked.
	3 events or settings where young people, Māori and 18-35 age group frequent are supported with a smokefree/Auahi Kore message CPH All SFEA complaints processed in specified times CPH			90% of PHO enrolled patients who smoke offered help to quit PCS	90% of pregnant women who smoke upon registration are offered advice & support to quit SS	

	Community	Education	Workplaces	Primary Care	Secondary care	Impact targets
	Support the Stoptober campaign CPH 3 tobacco CPOs CPH At least 1 presentation held to communicate Smokefree 2025 to key leaders/sectors/orgs CPH/			≥90% Māori, Pacific & pregnant women receive ABC in primary care PCS	≥95% Māori, Pacific & pregnant women receive ABC in Hospital SS	
Alcohol	Alcohol harm reduction strategy piloted in one sports club *CPH* 2 community alcohol accord agreements are maintained CPH Inter-agency monitoring of high-risk premises and events as appropriate CPH 3 alcohol CPOs CPH	Working with four Schools to develop or review their alcohol policies. CPH				
Skin cancer prevention	At least 2 major events / activities are supported to be SunSmart CSNZ	All ECE's have up to date resources / policies/ procedures New online curriculum resource promoted to all primary schools 100% of all primary schools SunSmart Accredited by March 2016 CSNZ Alongside WAVE team develop reaccreditation process & sustainability of SunSmart messages with schools			*(Note: Not a SCDHB target. The impact of skin cancer prevention programmes on the reduction in Melanoma and non-malignant skin cancer rates is not known for many years to come. Therefore, short term outcomes are the focus.)*	
Oral health (Ministry Policy Priority Indicator)	All high risk families referred to oral health promoter contacted & offered one on one oral health support. CPH	5 ECE settings engaged in oral health promotion activities / initiatives as able CPH		85% children (Māori & Total) aged 0-4yrs are enrolled with dental services SCDHB-SDS		caries-free at 5 yrs – ≥64% DMFT 12 years – ≤1.05 ≥91%

	Community	Education	Workplaces	Primary Care	Secondary care	Impact targets
	All well child and midwives provided with consistent oral health advice and support CPH					Adolescent utilisation of DHB dental services
Fall prevention (Ministry Policy Priority Indicator)	Stay On Your Feet Classes - 150 people 65+ years attending 10 community classes SC			270 patients referred to falls prevention (FP) programmes SCDHB/ SC 90 FP patients receive Face to Face support with Health Professional SC	90% of older patients admitted to hospital are assessed for risk of falling *SS*	>75yrs hospitalised for falls per year
Breastfeeding)	Media coverage of breastfeeding issues (at least 4 articles) SCDHB/BFAG Maintain S.C. Breastfeeding Community Policy reflecting intentions of BFCI, across all health and community breastfeeding services (including Māori & Pacific providers) SCDHB/ BFAG 5% increase in Peer Support Programme referrals SS/ SCDHB/ Plunket 2 Breastfeeding education workshops for community service workers and primary care nurses SCDHB/BFAG		Establish 'Welcome Here Project' in 20 new workplaces and have 100% renewal of present accreditees as required. BFAG Maintain staff Breastfeeding Room at Timaru Hospital SS		Maternity Unit maintains BHFI accreditation SS "BF welcome here" certification for SCDHB Secondary Service (included in BFHI) SS Maintain accurate Breastfeeding stats at discharge SS	6 wk breastfeeding targets ≥75% 3 mth breastfeeding targets ≥60% 6 mth breastfeeding targets ≥65%
Communicable diseases	All notifiable diseases followed up and outbreaks investigated according to CD protocols CPH	Infection control procedures reviewed in 10 ECECs CPH Sneezesafe delivered to education settings in Autumn 2016 (numbers to be confirmed) CPH		70% of eligible girls are fully immunised with three doses HPV vaccine PCS 95% 8 months old and >95% 2 year olds are fully immunised. 95% 4yr olds fully immunised by age 5yrs PCS	Staff influenza vaccination target - ≥ 2016 total of immunisations delivered to SCDHB staff SS	95% 8 month olds fully immunised targets

	Community	Education	Workplaces	Primary Care	Secondary care	Impact targets
(Immunisation – Ministry Health Target Indicator)				≥70% of eligible population receive the flu vaccine PCS 540 doses of Boostrix are administered 2016/17 PCS ≥ 300 of >65yrs immunised for pneumonia. PCS		
Physical environment	Improved quality of drinking water according to annual survey & gradings CPH All Council plans and notified resources consents reviewed for public health issues, with submissions as required CPH Provide timely input into TLA District Annual Plans and other policy proposals as appropriate CPH Shipping inspections and exotic mosquito trapping completed according to protocols CPH					
Screening (Cardio-vascular - Ministry Health Target indicator)	≥90% of eligible & high needs population provided with a B4 School Check PHNS / PCS	100% of students attending Alternative Education settings > 1 term have a completed HEEADSSS assessment. PCS		Cervical screening target ≥80% of eligible women within 3 years PCS Breast screening target ≥70% seen 50-69yrs by ethnicity PCS CVD screening target - ≥90% PCS	Universal Newborn Hearing Screening offered to 100% eligible babies SS	90% eligible populations CVD risk assessed in last 5 yrs Long term decrease in prevalence of CVD and stroke

	Community		Education		Workplaces		Primary Care		Secondary care		Impact targets
General	Public health information & education resources provided to South Canterbury and recorded in database	CPH	Active WAVE website visits increased WAVE Resource Centre usage increases	CPH	3 workplaces engaged in a health promotion process.	CPH					
	Media releases or articles on public health average at least one per week	CPH/SCDHB Comms	10 district-wide professional development Health workshops for teachers	CPH							
			Minimum 8 Hauora Education Hui	PCS							
Mental health (Ministry Policy Priority Indicator)	**Events** Provide representation on and support to the Ka Toi Māori o Aoraki FLAVA festival committee and festival. For Mid and South Canterbury (Inter-school Māori Visual and Performing Arts Festival) – 50 % (25) of South Canterbury Schools participate in the event. Organise local World Suicide Prevention Day (Sept 10) event each year, with local media coverage Organise event for WHO World Health Day 2017 – focus is Depression and Suicide Prevention Support Men's Health & Movember activities Support Mental Health Awareness week **Community Education** Provide 10 community gatekeeper training education sessions Rural Communities Provide 5 community	CPH/SCDHB SCDHB	Offer to provide suicide prevention education for school staff Provide suicide prevention training in Polytech for trades/construction and other high risk student groups, and provide gatekeeper training for polytech staff	SCDHB	Establish Suicide Prevention gatekeeper training programme in 20 new SC workplaces	SCDHB	Provide 2 suicide prevention presentations to GPs and practice nurse	SCDHB	Provide 10 suicide prevention presentations to SC DHB staff Provide revised, updated suicide risk assessment and management training to Mental Health Services (MHS) staff Work with ED to scope implementation of MOH new ED guidelines	SCDHB	At least 80% of all staff members in each NGO have received suicide prevention training within last 2 years At least 80% of all MHS staff have received suicide prevention training within last 2 years At least 75% of GPs have attended a suicide prevention presentation within last 2 years At least 20 new workplaces enrolled in suicide prevention

	Community	Education	Workplaces	Primary Care	Secondary care	Impact targets
	gatekeeper training education sessions with rural focus, in rural SC **NGOs education** Provide 10 education sessions for local NGOs					workplace programme