



Otago
District Health Board
Pouari Hauora-ā-rohe ki Ōtāgo

OTAGO DISTRICT HEALTH BOARD

DISTRICT STRATEGIC PLAN
2005 - 2015

MIHI

Ka taki te titi
Ka taki te kaka
Ka taki ko ahau
Tihei Mauri Ora!

E kā iwi o te motu nei
E te iwi o tawahi
E te iwi o te Moana nui a Kiwa
Tēnā koutou, tēnā koutou, Mauri ora ki a tātou

The mutton bird cries
The Parrot cries
I also cry
Behold there is life

To the people of this land
To the people from overseas
To the people of the pacific
We greet you, may we all be well.

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FROM OUR CHAIRMAN

We can be rightfully proud of the range and quality of health and disability services that we fund and provide to the people that we serve. This is made possible by the high calibre of the health professionals delivering those services. We have had to meet many challenges in the past to shape the Otago District Health Board and the way we fund and provide health and disability services. We face challenges in the future to maintain and sustain access to the quality services that the people of Otago have come to expect.

One of our biggest challenges in the future is our level of funding. We are considered to be 'over funded' presently on a population based funding (PBF) formula, and we are required (and committed) to reach the Government's intended funding level for Otago over the next seven years. This means that our funding will grow more slowly in real terms than other DHB's and we will have to find ways to do things differently if we are to continue to fund and provide the current range and levels of services. Therefore, this strategic plan focuses primarily on sustainability rather than new investment. We have faced this sort of challenge before and I believe we have the people who can help us achieve what we need to do. Indeed, our progress to date in dealing with this 'over funded' position has been very encouraging as two years ago the deficit was \$32 million and now its \$20 million. Two years ago we were running a deficit of around \$10 million, and now we are forecasting a break even position. In that same time we have been able to sustain existing services despite finding economies in spending.

Our Otago Health Profile has provided us with a recent look at our health status and needs. We have an aging population which will increase the demand for health services in a significant way in about 15 year's time. We are aware of certain chronic diseases which cause death and disability and we will develop targeted programmes to prevent, detect, treat and manage the prevalent ones, and improve health outcomes for Māori and other high risk groups.

The health professional workforce environment is a global one. We will do all we can to attract and retain qualified staff, and we will look to strengthening our relationship with our key partners to do that. The people of Southland rely on us to provide their tertiary services, and we rely on them to provide the critical mass of patients to keep our clinicians skilled and up to date. The Southland District Health Board faces challenges similar to ours and we have resolved at Board level do all we can to meet these challenges together.

In acknowledging the various challenges we will face, we have set certain strategic goals to ensure that our population has every chance of being well and independent. Our key goals are to:

- Reduce Inequalities in Health
- Promote and Enhance Independence
- Reduce the Incidence and Impacts of Chronic Disease and Cancer
- Maintain and Enhance our Capability to Deliver Quality Health Services.

The Otago District Health Board is committed to doing all it can to achieve these goals through the various strategies and initiatives outlined in this District Strategic Plan.

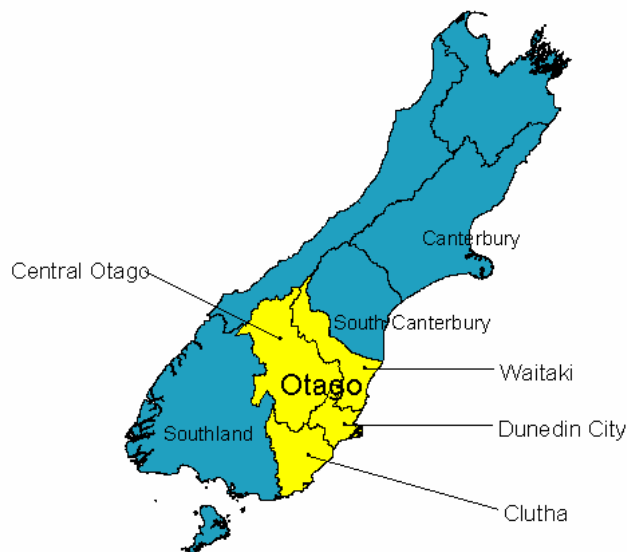
A handwritten signature in grey ink, appearing to read 'R. Thomson', followed by a long horizontal flourish.

Richard Thomson
Chairman

INTRODUCTION

Who Are We

The Otago District Health Board (Otago DHB) was formed in 2001¹ and is responsible for working co-operatively with health professionals and the community to improve the health and well-being of the people of Otago, and for Southland as well, for tertiary services.



Central Government funds the Otago DHB to both provide and contract for health and disability support services. In doing so, we are mindful of local requirements but we must take into account the Government's priorities and policies. Services are provided by public hospitals and related services (run by the Otago DHB) or by other independent providers, such as rural hospitals, general practitioners, pharmacists, midwives, disability support and mental health community services and so on. The Otago DHB covers Clutha, Waitaki, and Central Otago, including Wanaka (Queenstown is included in the Southland DHB area).

OUR VISION

Our vision is Working together to promote Wellness and Independence.

The Otago DHB, in seeking to fulfil this vision, recognises the importance of the Treaty of Waitangi and that existing services have been developed over many years by the efforts of many people, both members of the community and health care workers. We will build on their work to secure our vision.

¹ Through the New Zealand Public Health and Disability Act 2000

OUR VALUES

Our Values are:

- **Integrity**
Being honest and treating all people with respect and dignity, valuing individual and cultural differences and diversity.
- **Professionalism**
Acting with integrity and embracing the highest ethical standards and excellence.
- **Innovation**
Constantly seeking and striving for new ideas and solutions.
- **Teamwork**
Achieving success by working together and valuing each other's skills and contributions.
- **Responsibility**
Using and developing our capabilities to achieve outstanding results and taking accountability for our individual and collective actions.

Our Values define the expected behaviour of all staff and remind us of what behaviours are important to us as an organisation. They underpin the way we do things at Otago DHB and apply to all staff, defining how we as an organisation will behave as we go about achieving our Vision.

OUR STRUCTURE

The 'Board' governs the Otago DHB. Seven Board members are elected and four are appointed by the Minister of Health². The Board exercises its governance through formal meetings, routine and regular consultation and engagement with stakeholders and in so doing acknowledges the Crown's Treaty obligations to Māori. The Otago DHB, in accordance with the Act has three statutory committees:

- Community & Public Health Advisory Committee (CPHAC) advises the Board on the health needs of the Otago population and the priorities and funding required to address those needs;
- Hospital Advisory Committee (HAC) advises the Board on the financial and operating performance of Provider Arm³ of the Otago DHB, the Board's provider of hospital and health services (Dunedin and Wakari Hospitals), and on strategic issues relating to the provision of those services;
- Disability Support Advisory Committee (DSAC) advises the Board on the disability support needs of Otago people and advocates for those with disabilities.

OUR PRIORITIES

The Otago DHB needs to make choices about what health and disability support services it funds. These choices must be made within a fixed level of

² In accordance with New Zealand Public Health and Disability (NZPHD) Act 2000

³ Provider Arm includes Dunedin and Wakari Hospitals and their associated community services.

funding from Government to meet the priority needs of the people of Otago. Making a choice to fund one service and not another service is always difficult. The process to make choices must be consistent, open and understood by the public. Therefore, the values of the Otago DHB are underpinned by a set of principles which guide this decision-making process. These principles are:

- Equity of access to services - regardless of income or geographic location within the Otago DHB region.
- Equity of outcomes - giving priority to improving the health and well-being of those least well off.
- Value for money - obtaining the greatest health gain per dollar spent, where value for money is assessed utilising measures of health and independence gained and is also assessed "from a broad perspective" to avoid cost-shifting.
- Investing in the future - obtaining improvements in health and well-being in the future through current spending.
- Cultural appropriateness - sensitivity to the needs of Māori, sensitivity to the broader views of society and sensitivity to the needs of minority groups.
- Treaty of Waitangi - acknowledgement of the Otago DHB's responsibilities to the principles of the Treaty within the context of the NZPHD Act.
- Ensuring sustainable, quality services - ensuring funded services are economically viable and that accepted standards of clinical practice are achieved.

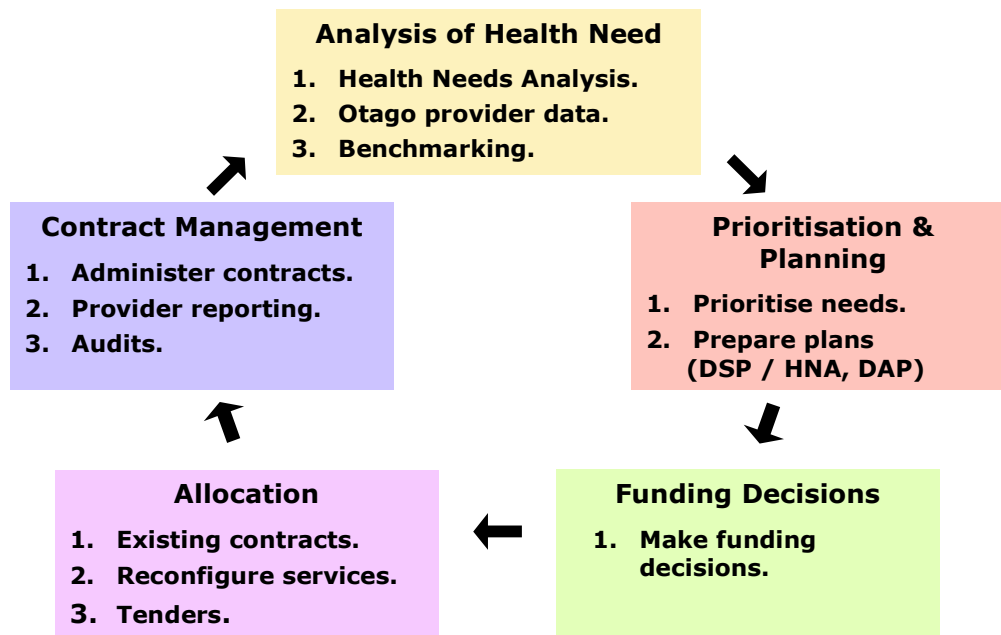
These prioritisation principles are used at various levels because:

- they are used at an early stage when identifying the key messages from the initial needs assessment process,
- they are used in developing the strategic objectives, and
- they are used in each annual planning process.

A document adopted by the Otago DHB in February 2004, *Prioritisation Policy: A Process Framework for Prioritisation* provides a prioritisation methodology for management to adopt when making planning and funding recommendations to the Board.

OUR DISTRICT STRATEGIC PLAN

The purpose of our District Strategic Plan (DSP) is to identify how we, the Otago District Health Board, will fulfil our vision and goals for the next five to ten years. To establish the goals we have analysed our current situation, identified our key issues, and developed our keys goals and strategies to deal with those issues. By its very nature, the DSP is a high level view of the direction we wish to take going into the future. The District Annual Plan details and budgets all of the activities we will undertake each year based on the direction contained in DSP. The DSP is reviewed and refined every three to four years, and this DSP is the Otago DHB's second since its inception. The planning cycle is illustrated below.



The consultation for the draft DSP was carried out over 12 September to 14 October 2005. The consultation was by way of a letter drop to all house holds, a mail-out to all likely stakeholders, and a series of public meetings throughout the region. Feedback was verbal, mailed and emailed. An analyst from SISSAL was engaged to analyse the feedback and recommend changes. As a result of the consultation a number of changes were made to the DSP the most significant of which included the following:

- Our key goals and strategies were changed slightly to better align them. In particular, Key Goal 3 has been reworded to include cancer.
- New sections have been added on Pacific People, Electives Services and Emergency Management.
- We have recognised the importance of prevention when discussing chronic disease management, and we have emphasised the need to deal with obesity and smoking in children and youth in particular.

OUR POPULATION

Relative to other DHBs, we are a very rural population as the projected data (2001 Census) shows the population distribution as follows: Wanaka ward of Queenstown Lakes District - 2.7%; Central Otago District - 8.5%; Clutha District - 10.1%; Waitaki District - 11.8%; and Dunedin City - 67.0%. The population of the Otago and Southland region is approximately 280,000 but 23% of the people reside in rural areas which are geographically widely dispersed when compared to rural New Zealand at 14%⁴.

We need to continue to ensure that rural people's access to health services is well provided for. This is about *maintaining and enhancing our capacity to deliver quality health services*.

⁴ 2001 Census Snapshot 10: Rural New Zealand published by Statistics New Zealand. 10 June 2002

The Otago DHB's 2004 population is 180,220⁵ and by ethnicity is - Māori 11,290; Pacific People 2,600 and Other Ethnicities 166,330. Our population is expected to change little overall in size over the next 15 years notwithstanding the expected growth in the Central Otago region. However, our population will grow older with substantial associated increases in per capita health costs. Looking toward 2021, Statistics NZ predicts that the Otago population is expected to decline only marginally (this is different to the national trend predicting an increase of approximately 11.4% by 2021).

The older population (over 50 years of age) is expected to increase considerably. By 2021, the 85 and older age group is expected to increase by 82%, whereas the age groups between 60 and 74 are predicted to increase by 45 to 55%. Small increases are expected in those age groups between 25 and 59. The 40 to 49 age groups are predicted to decrease by approximately 30% by 2021. The 10 to 19 age groups are expected to be reduced by approximately 20 to 30%.

We know older people are bigger users of health services and need to factor this into our planning for the future. This is about *promoting and enhancing independence*, and *maintaining and enhancing our capacity to deliver quality health services*.

For more information on our demographic profile, refer to our website www.otagodhb.govt.nz

OUR POPULATION'S HEALTH

District Health Boards (DHBs) are required by the New Zealand Public Health and Disability Act 2000 to improve, promote and protect the health of the people and communities in their region. The Act states that one of the functions of the DHBs is:

To regularly investigate, assess, and monitor the health status of its resident population, any factors that the DHB believes may adversely affect the health status of the population, and the need of that population for services (Clause 23 (1) (g)).

The main way of assessing the health status or profile of a population is through a Health Needs Assessment (HNA) process. In this way we can determine the health and independence profile of the Otago population as a snapshot in time.

Health Profile Process

To develop a meaningful health profile of Otago, given the relative small population in the South Island, a South Island regional approach was taken. Five of the six South Island DHBs collaborated to produce a generic report

⁵ Statistics New Zealand, reproduced by the Ministry of Health 2004

with quantitative regionalised data recorded. This process was co-ordinated by the South Island Shared Service Agency Limited (SISSAL). The emphasis on this process was to focus on national priority areas identified by the New Zealand Health Strategy (2000) and the New Zealand Disability Strategy (2001).

Health Profile Executive Summary

Compared to the New Zealand population overall, the Otago DHB population is somewhat disadvantaged demographically and socio-economically. The following health and healthcare issues stand out:

Poorer Measures in the Otago DHB than in New Zealand, Overall

Smoking. There are more smoking-attributable hospital admissions in the Otago DHB than on average for New Zealand but about the same smoking prevalence.

Cardiovascular Disease. There are more deaths in the Otago DHB from cardiovascular disease than for New Zealand overall, disease prevalence is similar, and hospitalisations are lower.

Self-inflicted Injuries. There are more deaths and hospital admissions in the Otago DHB than expected.

Better or Similar Measures in the Otago DHB than in New Zealand, Overall

Access to Health Services. There is better access to most types of health professional.

Cancer. Better than other regions.

Physical Activity. Similar to other regions.

Diabetes. Similar to other regions.

Chronic Respiratory Disease. Similar to other regions. Lower hospital admission rate for asthma.

Measures that may be important but data are insufficient to assess in the Otago DHB

Mental Health. There is not enough data on specific mental health disease prevalence but there is lower use of mental health services, especially community-based services.

Māori Health. The small numbers of Māori in the Otago DHB make estimates imprecise. The following results may be due to this imprecision:

- Better outcomes on hearing failure at 5 years among Otago DHB Māori.
- Diabetes – poorer health to start with but greater improvements through the Get Checked programme than for non-Māori in the Otago DHB.
- More lung cancer in male Māori in the Otago DHB.
- Less breast cancer among female Māori in the Otago DHB.
- Lower asthma admission rates for Māori children in the Otago DHB.
- Higher suicide rates for Māori than non-Māori in the Otago DHB.

This section of the DSP was informed by an independent summary report at **Appendix 1** and it needs to be read in conjunction with the full report on the *Otago Health Profile* which contains the detailed, referenced data. Refer to our website at www.otagodhb.govt.nz

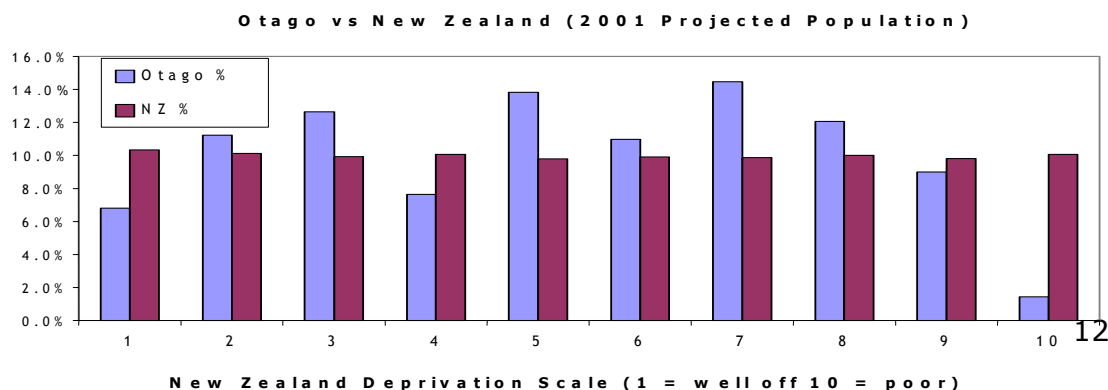
We want to continue to maintain the current range and levels of services, target certain chronic diseases and improve the health outcomes of Māori. This is about *reducing inequalities, and maintaining and enhancing our capability to deliver quality health services.*

OUR POPULATION'S WEALTH

There are many factors that can contribute to an individual's health status. The *New Zealand Health Strategy* emphasises that socioeconomic factors are major determinants of health and well-being. The Strategy also acknowledges that disease and poor health may have an impact on socioeconomic position and can be part of a complex feedback loop in which personal health status becomes a driver of persistent disadvantage. People with disabilities in particular are affected by a complex set of intersectoral factors. Health in old and middle age depends on past circumstances as well as present ones, and the effects of disadvantage may accumulate throughout a person's life. The report *Health of People in the South* (Health Funding Authority 1998) showed that socio-economically disadvantaged localities tend to have higher than average rates of premature death and hospitalisation for many causes. Socioeconomic factors, such as unemployment levels, poor housing standards and low income levels are also shown to have a detrimental effect on mental health. The sections below in this segment have been extracted from the *Otago Health Profile* which is available on our website at www.otagodhb.govt.nz.

Deprivation

The table below shows the deprivation profile for Otago in 2001, projected from the NZDep96 Index. Otago differed somewhat from the remainder of New Zealand. The most deprived (NZDep group 9 and 10) proportion of the population was only 10.4% (17,951) compared with the national figure of 19.9%. These groups were all located within Dunedin City. Clutha and Central Otago had deprivation ratings between 3 and 6. The distribution in the Waitaki District was rated as a 7, yet only 120 people were classified in deciles 8, 9 or 10.



It should be noted that the Otago DHB profile is better than the New Zealand and South Island profiles for the Māori population as analysis shows a downward trend toward the higher deciles. The distribution is comparatively even between the Māori and non-Māori population and across all the deciles.

The Dunedin City District is the only district in the Otago DHB that shows an upward trend for Māori from deciles 1 to 10. The above is even more accentuated for the Māori and Pacific people ethnicities. Dunedin City (\$14,500) has the second lowest median income of all Territorial Authorities in the South Island and, along with Waitaki (\$15,000) and Central Otago Districts (\$15,600), is significantly below the overall New Zealand level of \$18,500.

Income

Income has been claimed to be the most important modifiable determinant of health upon which many other determinants rest. A household's level of absolute income can have a material effect on the health of individuals in the household – through enabling people to pay for adequate food, appropriate housing and private health care. Otago DHB has a lower distribution of personal income than New Zealand as a whole. Otago has a higher percentage of the lowest categories, is comparable around the low/middle \$15-30,000 levels, and has a lower percentage earning greater than this.

Housing

Housing is a basic human need and has a large impact on people's wellbeing and quality of life. Issues related to housing crises, such as affordability problems, poor quality and household crowding, have many flow-on effects for people's health, education, community participation, community cohesion and safety. Poor quality and inappropriate housing can expose people to health problems. Nationally, Otago continued to rank highest for the third consecutive quarter at 37.3%. Dunedin has the lowest median weekly rent level of the eight largest cities (New Zealand City Councils' 2003).

Crowding

Crowding is an indicator of housing affordability. Crowded households are more likely than others to be located in socio-economically deprived neighbourhoods, be work-poor, and have lower incomes. Overcrowding is the aspect of housing most directly related to health outcomes. Living in crowded situations can contribute to poor health outcomes such as respiratory and infectious diseases (particularly meningococcal disease). The proportion of overcrowded households in Otago is less than half the New Zealand average. The Otago rate is similar to the combined South Island rate. There appears to be disparity between different ethnicities. Māori and Pacific people are both more than three times more likely to live in an overcrowded house, while Asian people are six times the DHB average. However, all ethnicities have a significantly lower rate than their respective national percentages.

Home Ownership

Owning a home seems to have direct health advantages. Home ownership rates are steadily declining in New Zealand. Otago DHB has a slightly higher proportion of residents owning their own home than New Zealand as a whole. Dunedin City has a relatively high rate of home ownership at 65.2% (New Zealand City Councils' 2003). There is a significant problem with sub-standard housing in Dunedin. Shannon et al (2003) state that there are a number of houses affected by poor solar aspect especially amongst the student and higher deprivation areas of the city. Another significant issue is old, cold, damp housing, most of which is un-insulated, some of which has inadequate and inefficient means of heating, and may even be incapable of being heated to 17C which is the temperature below which adverse health effects can be expected. The health risk due to low ambient temperatures is mostly confined to the very young and elderly age groups and includes risk of respiratory disease and cardiovascular strain.

Climate

With a cool climate, poor solar access, relatively poor population (by NZ standards) and an old mostly un-insulated housing stock, Dunedin could be surmised to be a health risk in terms of having indoor house temperatures below normally acceptable levels. A survey in June/July 2004⁶ of low income private rental housing in Dunedin 2004 found that two thirds of the 100 properties surveyed failed this standard.

We need to target resources earlier, at those more at risk of becoming high users of health services simply because of their socio-economic status. We also need to educate other stakeholders who have a direct influence on those factors which contribute to poor health. This is about *reducing inequalities, promoting and enhancing independence, and maintaining and enhancing our capacity to deliver quality health services.*

OUR FINANCES AND FORECAST

Our funding determines how much health service we provide. Otago DHB has reduced its deficit from \$11.2 million in 2002/03, to \$0.7 million in 2004/05, and by the end of 2005/06 year we expect to be at a break-even position. Nevertheless, under the current Population Based Funding (PBF) model, the Otago DHB is currently calculated to be over-funded relative to other District Health Boards by \$20.2 million. This over-funded position is to be recovered at a rate of \$3.15 million per year (i.e. 1% of 2004/05 base funding) commencing July 2005, resulting in Otago DHB reaching PBF equity after six years. It is important that financial projections for 2006/07 and beyond are sustainable to ensure we provide at least national levels of access if not

⁶Dunedin: Presbyterian Support Otago, 2005. Compiled by Dennis M. Povey and Ulrika Harris. It measured low income occupied private rental accommodation in Dunedin against a 'reasonable rental' standard, based on safety, soundness, habitability and value.

more, as we now do. Our summary forecast statements of financial performance for this DSP are indicated in **Appendix 4**.

In essence, we want to use our funding to maintain the current range and levels of services rather than reduce services. This is about *maintaining and enhancing our capacity to deliver quality health services* and *maintaining and enhancing our capacity to deliver quality health services*.

We have a well planned and managed process for prioritising our capital expenditure. We have learnt from previous experience that the procurement of new and the replacement of obsolete equipment must be routinely scheduled to avoid unnecessary expense and a reduction in services because of equipment failure. Our buildings are also maintained through a dedicated, routine maintenance plan. However, the configuration of services within the various buildings that we own needs to be reviewed. As well, some of our buildings are no longer suitable to deliver clinical services from.

We need to develop a longer term strategy to make the best use of available facilities to ensure we can continue to deliver the desired range and level of services. This is about *maintaining and enhancing our capacity to deliver quality health services*.

OUR RELATIONSHIP WITH MĀORI AND PACIFIC PEOPLES

Māori

Over time the Otago DHB believes it has developed a good working relationship with Māori, and it will continue to work with Kāi Tahu to implement the Memorandum of Understanding between the Otago DHB and Kā Papatipu Rūnaka ki Arai Te Uru.

The Otago DHB is working together with Iwi and Māori communities to improve Māori health outcomes and reduce Māori health inequalities by implementing Konohi Kai Hauora, the Otago DHB's Māori Health and Disability Strategic Plan. Konohi Kai Hauora, developed in partnership with Iwi and Māori, details how the Otago DHB will realise its objectives and accountabilities from the NZPHD Act 2000, He Korowai Oranga and Whakatātaka.

There are four goals that the Otago DHB, Iwi and Māori have set out in Konohi Kai Hauora, namely:

1. Improve the health of Māori to being at least as good as those of other New Zealanders.
2. Encourage collaboration between all sectors of the community to address Māori health and disability needs.
3. Improve access to health and disability services including;
 - a. Those culturally based and staffed; and

- b. Mainstream services that are sensitive and responsive to Māori health and disability needs.
- 4. Support Māori to develop local solutions and delivery models for the Otago Māori community.

An accountability framework and consultation calendar to ensure that the Otago DHB and all providers of services to Māori are accountable to Māori communities will continue to be developed. However, we recognise that the capacity of Iwi and the Māori community to meet the growing needs of consultation and representation across the sector will be an ongoing issue.

The Otago DHB will continue to fund a range of Māori health and disability services and is committed to further developing Māori health providers within the Otago Region and developing innovative mechanisms to ensure further developmental opportunities for providers of services to Māori within the Otago region. Nevertheless, because it is in mainstream services (both primary and secondary) that Māori receive most of their health care, we recognise the importance of improving the cultural appropriateness of these services. The Otago DHB is committed to maintaining and increasing the current level of expenditure for Māori health and targets for this will be set in our District Annual Plans.

Pacific Peoples

Otago has a small Pacific Peoples population and Pacific People are well assimilated into existing health systems in Otago. Pacific People's enrolment in PHOs is good, and the main provider for Pacific Peoples, the Otago Pacific People's Health Trust, has a close working relationship with the DHB. It is our intention to secure increased funding for this provider to enhance its services to Pacific People, and to maintain the current level of access that Pacific People have to services.

OUR ACCESS TO SERVICES

The people of Otago's access to health services is better than the average in New Zealand. Surgical service access is above the national average reflecting historical good access in Otago, and there is anecdotal evidence of lower rates of private service providers and lower than average private medical insurance. Whilst Dunedin Hospital Emergency Department attendances have declined slightly since 1999 they are still well above national average rates of attendance

We are proud of the level of services that we deliver but we know we will need to continue to do so within fixed resources. This is about *maintaining and enhancing our capacity to deliver quality health services.*

Despite a relatively low population growth, demand for primary, secondary and tertiary services continues to increase beyond funding levels.

The historical demand for hospital beds has been steadily rising which, if unchecked, will become well beyond our resources. This is about *maintaining and enhancing our capacity to deliver quality health services.*

Currently, our older people have better access to aged care services compared to average national rates, notably to residential and home based care. This level of access will not be sustainable into the future.

We will develop an Otago Older People's Health Strategy which will set out how we will meet the challenge of delivering the Government's Health of Older People Strategy, and at the same time living within our means. This is about *maintaining and enhancing our capacity to deliver quality health services*.

The Otago DHB undertook an extensive review of its mental health services in order to align them with the needs of the population and at the same time acknowledging the requirements of the Government's *Blueprint for Mental Health Services in New Zealand: How Things Need to Be*. Generally, the outcomes of our review provide for a realignment of the mix of services with an emphasis on the need for increasing those delivered in the community setting.

'Community for Mental Health Otago' is the strategy for the DHB to implement the agreed recommendations from our review of mental health services. This is about *reducing inequalities and maintaining and enhancing our capacity to deliver quality health services*.

OUR STAFF

We have a dedicated, hard working but 'aging' workforce that will need to be replaced with a newer workforce over time. We live in a global community particularly when it comes to the career opportunities for health professionals which are numerous within New Zealand and overseas. Recent legislation requires us to ensure our workforce meets high standards of competency and for staff to remain continually at the forefront of their chosen professions. We fully agree with this direction and the staff's aspirations to be as good as they can be. Union led professional groups are demanding better national pay and conditions. The work environment too is a major factor on staff satisfaction and retention. Best Human Resources practices and competent leadership of our staff at all levels are important to retaining staff. We have excellent relationships with our partner organisations with whom we share and train staff but who also have similar staffing issues. All of these factors pose challenges and opportunities in how we recruit and retain staff. We need a coordinated, rather than piecemeal, approach to building the strategic capability of our health workforce which is critical to the ongoing sustainability of the sector for this DHB and indeed for New Zealand and so we will continue to participate in national workforce planning activities.

We need to develop an Otago Workforce Strategy to provide for our forecast staffing requirements. This is about *reducing inequalities, promoting and enhancing independence, reducing the impacts and incidence of chronic disease, and maintaining and enhancing our capability to deliver quality health services*.

In the broader sense of our staffing capacity, we need to consider health professionals who deliver care but whom are not employed by the Otago DHB. We are aware of the difficulties that rural areas have in recruiting and training staff. We feel that the nursing workforce is one significant professional group for whom we see much scope to develop beyond the traditional boundaries and constraints to address certain staffing issues and models of care.

We will establish an Otago Nursing Strategic Plan to develop nursing across the continuum of care regardless of their practice setting. This is about *reducing inequalities, promoting and enhancing independence, reducing the impacts and incidence of chronic disease and cancer, and maintaining and enhancing our capability to deliver quality health services.*

OUR INNOVATIONS

We know we have a fixed level of funding over the foreseeable future which largely determines what we can afford to do. We also want to generally maintain the current range and levels of service. To do so we will have to be innovative. We have already signalled an intention to deliver laboratory services using one provider and combining with the Southland DHB, rather than using four providers⁷. Information and computer technology offers solutions which are new, faster and with improved quality assurance but sometimes at significant cost. We need to develop new and different ways to deliver health services to make our funding for them go as far as possible in order to maintain our level of services and access.

We believe we have the staff, contracted providers and other stakeholders to develop innovative solutions to sustain services and access. This is about *maintaining and enhancing our capacity to deliver quality health services.*

OUR UNIQUENESS IN OTAGO

Dunedin Hospital

Dunedin Hospital is a 400-bed facility that provides secondary services to the Otago region and tertiary services to the Otago and Southland regions. By other DHB tertiary hospital standards it is a small tertiary hospital and lacks the economies of scale that larger hospitals have. However, they are critical to provision of "life and limb" saving acute care. The private health sector in Dunedin is not very well developed. Not surprisingly, Dunedin Hospital is by far the main provider of elective services to the Otago community.

⁷ The initial proposal was not approved by the Commerce Commission and we will explore future options to progress this initiative.

Tertiary Educational Institutes

The University of Otago and Otago DHB have a mutually dependent relationship, working together to provide a teaching hospital producing clinical graduates for the country, and services for the people of Otago and Southland. The sharing of staff between the Otago DHB and the University Of Otago Division Of Health Sciences provides economies of scale and allows both organisations to deliver high quality services, teaching and research.

The University of Otago's Dunedin School of Medicine trains about 200 4th, 5th and 6th year medical students every year. The Dunedin School of Medicine graduates about 60 New Zealand resident doctors each year who are of strategic importance to the country's health workforce, as well as contributing to the training of many specialists (including General Practitioners), providing post-graduate courses and advancing medical knowledge through research. Students enrolled for other health professional degrees at the University of Otago, including Dentistry, Pharmacy, Physiotherapy, Medical Laboratory Science and Clinical Psychology also require clinical access to Dunedin Hospital services for essential clinical experience in their programs.

The Otago Polytechnic trains about 250 nurses per year, who also complete much of their practical training within the Otago DHB's services. It graduates about 60 nurses per year who are also of strategic importance to the country's health workforce.

We will consolidate and strengthen our relationship with our partners to enhance our collective roles as teaching and research institutions as well as service providers. This is about *maintaining and enhancing our capacity to deliver quality health services.*

Rural Health Sector

Otago has a large rural population and a rural health sector to deliver services. One of the features of the rural health sector is the rural hospitals. Except for the Dunstan Hospital facility, these are not owned by the DHB but are owned and operated by the rural communities. This has enabled those communities to have a sense of real ownership which in turn has led to innovation and local solutions to meet local needs.

The rural health services provide a vital role in the provision of healthcare throughout Otago which we will continue to support and enhance. This is about *reducing inequalities and maintaining and enhancing our capacity to deliver quality health services.*

OUR NEIGHBOURS AND PARTNERS

The people of Southland are our close neighbours in more than just geography. We deliver our tertiary services to the people of Southland, and that also helps sustain those services as our combined populations provide

the critical mass that clinicians need to retain their skills and expertise. In this regard such services are very much regional services.

We want to look for opportunities to collaborate more with the Southland DHB to enhance those clinical services and to share non-clinical services and make those more efficient to both DHBs. This is about *maintaining and enhancing our capacity to deliver quality health services*.

We also have and must continue to enhance our relationships with the other neighbouring DHBs, namely Canterbury DHB and South Canterbury DHB. Some of our patients are referred to Canterbury DHB for certain specialist services and vice versa. Because of Timaru Hospital's proximity to North Otago, some of our patients access hospital services there and of course some of their patients access our specialist services.

We work closely with the other South Island DHBs through our shared organisation SISSAL. SISSAL's work is directed by and for the benefit of all the South Island DHB's and in so doing unites us as partners. We believe that SISSAL will continue to provide an important service to the partner DHBs.

The Ministry of Health is the major stakeholder in the DHBs given that it is major funder and it directs national health policy for DHBs to implement. Our relationship with the Ministry of Health is a strong one based on good communication, and mutual trust and respect. It is one that we will strive to maintain and enhance.

There are other key partners who have a direct or indirect influence on the population's health. Partners such regional, district and city councils, various government agencies (Education, Welfare, Housing, Police), and non-government agencies need to be engaged by the DHB to coordinate and collaborate on matters of mutual interest. For example, one such matter is the *Healthy Eating Healthy Action* programme.

Otago, mainly through the University of Otago, has a good reputation for research and development. Such work informs the development of health services and health outcomes. We will continue to foster and support health related research.

OUR GOVERNMENT'S PRIORITIES

The Government has advised its health priorities through the Minister of Health in her 'Letter of Expectations' for 2005/06. This DHB has taken due cognisance of those expectations and will demonstrate how they are acknowledged and factored into the DHB's planning further in this document. The Government through the Ministry of Health has directed a range of

strategies⁸ to deal with the challenges New Zealand faces from those conditions that are the leading causes of death and disability which include:

- Cardiovascular disease (heart disease and strokes)
- Diabetes
- Cancer
- Depression
- Chronic Obstructive respiratory Disease
- Asthma
- Suicide and self harm.

The Government through the Ministry of Health largely directs the range and amounts of health services that the Otago DHB will provide through a specific arrangement called the Crown Funding Agreement. This ensures the all New Zealanders have equal access to essential services throughout the country. Therefore, the Government's priorities, strategies and funding arrangements with DHBs do limit how much significant change can be made to healthcare provision by DHBs. Nevertheless, there is still scope for improving and refining healthcare, and for innovations.

This DSP's goals and strategies take in to account the national strategies and policies. Everyday we see and treat people with mild, moderate or chronic disease, cancers and conditions throughout the region. We are always looking for improve how we do this through the national strategies and through our own innovations.

One of the more recent and, in our view, far reaching strategies is the Primary Health Care Strategy. In essence, this strategy is about reducing the barriers for people to access primary care so that they can get early detection of conditions, and get full and regular care and treatment to prevent the onset of serious and debilitating conditions. Primary Healthcare Organisations have been successfully established in Otago, with approximately 94% of the Otago resident community now registered with a PHO.

Much work is still needed to facilitate integration of primary care providers, enhance the team based approach to delivery of community care and move increasingly towards a 'wellness model'.

Elective services are one of the Governments many priority areas. Over recent years the Otago DHB's access to publicly funded elective services has been better than average. The Otago DHB will continue to maintain levels of access to elective volumes, review and address areas of comparative under provision, and prioritise patient need and treatment.

⁸ Refer to list contained in the References section of this DSP.

The NZ Disability Strategy was launched in 2001. One in five people have a disability⁹. People with disabilities enter the health sector at all entry points and with many different forms of disability and impairment. People with disabilities cannot and should not all be together for ease of identification and administration. This in part explains why this and other DHBs have struggled to implement the NZ Disability Strategy. We have a workplan towards implementing the NZ Disability Strategy which needs to be further developed.

We will refine and develop the workplan into an Otago Disability strategy. This is about *reducing inequalities*.

OUR KEY ISSUES

Taking into account our current situation and the likely impact that it will have on the future, we have identified a number of key issues that we will grapple with over the next five to ten years which are listed below. These form the basis of our strategic goals.

Primary Care Development

The development of PHOs within the Otago DHB has been very satisfactory to date, however, much work is still required to enable PHOs to realise the objectives and gains outlined in the Primary Healthcare Strategy. All Otago PHOs, with a total enrolment of 163,065 continue to show good progress. We have developed an initial Otago Primary Care Strategic Plan. We will consult, develop and promote this strategy further. The strategy aims to explore ways to encourage PHOs to broaden their range of services and deliver them in different ways to improve access, prevent, detect and manage chronic conditions, and to reduce dependency on hospital services. Therefore, the Otago DHB will continue to work closely with PHOs to facilitate development of PHO specific initiatives to ensure that progress is made toward implementing the Primary Health Care Strategy.

We have already started some initiatives as part of our overall strategy which have been signaled in the DAP 05/06. These include:

- Identifying best practice primary care models to encourage larger, more economical, multi-provider team-based practices capable of delivering a broader range of services to their community, consistent with the objectives of the Primary Care Strategy.
- Developing General Practitioners with Special Interest (GPSIs) to allow patients better access to certain treatment that is currently being delivered by secondary care but can be delivered through PHOs.
- Developing a model of care that will ensure that inappropriate ED attendances are instead referred to primary care.

We need to collaboratively develop our Otago Primary Care Strategy in order for PHOs to implement the NZ Primary Healthcare Strategy. This is about *reducing inequalities, promoting and enhancing independence, reducing the impacts and incidence of chronic disease and cancer, and maintaining and enhancing our capability to deliver quality health services.*

Management of Demand Driven Services

Despite a relatively low population growth, demand for primary, secondary and tertiary services continues to increase beyond funding levels. The Otago DHB is committed to ensuring access to elective surgery for all patients before they reach a state of unreasonable distress, ill health or incapacity. This commitment is to also ensure that patients do not wait longer than six months for first specialist assessment and that patients offered publicly funded treatment wait no longer than six months.

In primary care, the demand for pharmaceuticals in particular shows usage above national per capita rates. Whilst primary referred laboratory and pharmaceutical demand is not showing abnormal growth, national comparisons suggest that the Otago per capita rate is too high. We will pursue initiatives that will bring usage in to line with best practice.

Under PBF, Otago DHB is considered to be over-funded by an estimated \$20 million and \$10 million of that is for older person's Disability Support Services (DSS). We know that we have an ageing population, and we also know how difficult the aged care sector environment is for some providers to care for the older population. We will need to develop an Otago Older Person's Health Strategic Plan which will set out how we will meet the challenge of implementing the Government's Health of Older People Strategy, and at the same time living within our means. The types of initiatives we will consider will include those such as:

- A sector wide collaborative process to align residential care services to achieve equity of access.
- Ensuring there is a sustainable DSS workforce within Otago.
- Enhancing the provision of home based support services.
- Enhancing aged care specialist support to community and primary care providers.

This is about reducing inequalities, promoting and enhancing independence, reducing the impacts and incidence of chronic disease and cancer, and maintaining and enhancing our capability to deliver quality health services.

Financial Sustainability

The financial forecast in this DSP, at **Appendix 4**, will make it a challenge to continue to deliver the current range of services within agreed resources. Management of cost growth in all operational areas is essential. Indeed our main challenge is to maintain the current range and levels of services into the future under PBF. The predicted growth and impacts of chronic diseases and cancer pose a significant financial risk and service delivery to treat them will be difficult to sustain; refer to the next section on Management of Chronic Disease and Cancer.

This DHB has a number of facilities across various sites in Dunedin City from which it delivers health services and accommodates its corporate functions. The DHB also leases a number of premises around the city. The housing of

clinical services in many instances is beyond the current capacity of the allocated space to do so safely and efficiently. Our service delivery models need to keep up with best practice and technological advancements have changed how this is and should be done in some instances.

We need to develop our secondary and tertiary clinical services models within our available facilities to be as high quality, safe and efficient as possible. This is about *maintaining and enhancing our capacity to deliver quality health services*.

Chronic Disease and Cancer Prevention and Management

As already stated, *The New Zealand Health Strategy* clearly defines the significant challenges we face from those prevalent conditions that are the leading causes of death and disability. In Otago we currently strive to manage all of those but our priority will be:

- Cardiovascular disease (heart disease and strokes)
- Diabetes
- Chronic Obstructive Pulmonary Disease

Chronic disease and cancer prevention and management is about targeting health resources and effort to prevent the onset of those conditions as well as managing those with conditions which are already chronic. From research we know that those of lower socio-economic status are more susceptible to having poor health and developing chronic conditions. We consider that our implementation of the *Healthy Eating-Healthy Action: Oranga Kai-Oranga Pumau (HEHA) Implementation Plan: 2004-2010* is a vital component of proactively reducing the incidence and impacts of chronic disease and cancer. Two areas in particular that the DHB will concentrate effort are obesity and smoking with an emphasis on children and youth.

We need improve our population's health to avoid the onset of these conditions by ensuring that people are 'targeted' to get the right care, in the right place at the right time. This is about *reducing the incidence and impacts of chronic disease and cancer*.

Collaboration with Southland

Otago has always had a long standing relationship with Southland across all sectors of society, and the health sector is no exception. We provide many tertiary services to the people of Southland, and they are important to providing the critical mass of patients to sustain such services. Notwithstanding this, the Southland District Health Board (SDHB) faces similar challenges to us as a small DHB in trying to recruit and retain staff, live within PBF, and deliver services to a large geographically spread region. It makes much sense for us to collaborate with the SDHB to meet these challenges together and to seek operational and administrative efficiencies through economies of scale within a regional shared services approach. Collaboration with Southland DHB commenced formally in 2003, exploring back-office shared services. The areas focused on were primarily Human

Resources Management, Information Technology, Finance, Procurement and Planning & Funding Administration. More recently, public health and clinical services have been explored, together with embarking on a joint initiative for provision of laboratory services across Otago Southland.

We must continue to pursue common strategies of collaboration to the benefit of both DHBs. This is about *maintaining and enhancing our capacity to deliver quality health services*.

OUR KEY ASSUMPTIONS

Planning for the medium term, five to ten years, inherently is imprecise and requires some assumptions to be made. Our assumptions are listed below and are based on the best information available at the time this DSP was written. Our assumptions are:

- Population Based Funding remains the mechanism through which DHBs are funded.
- We will move to PBF equity over the next seven years during which time we will address the drivers and areas of over funding. In particular, we will align older people's residential care and support services to achieve equity of access.
- Capital expenditure will be funded from depreciation.
- Increasing rate of technological advancements, including information technology, will continue to change the care and treatment of patients. Certain advancements will be costly and will not be immediately available from the DHB.
- Patient and community pressure will increase as access to and the promotion of health information increases.
- Workforce issues will continue to be problematic as various professional groups strive to improve wages and conditions.
- Salary settlements will be in line with our planning assumptions. Our assumptions exclude any flow-on effects of the Provider Arm NZNO nursing settlement into NGOs and other groups. Our assumption is that pay parity/equity initiatives agreed to by Government resulting in increased costs will be funded through additional revenue.
- Efficiency improvements from the various Strategic Initiatives are planned to achieve savings of 1% of Provider Arm revenue over the period of the DSP.
- Other DHBs, and particularly our neighboring South Island DHBs, will conduct their operations in such a way so as not to impact negatively on Otago DHB operations, e.g. wage settlements significantly ahead of Otago DHB planning assumptions, major changes restricting elective Inter District Flows inflows, etc.
- Policy changes that increase access to health services, such as the recent changes to the Social Security Act, which result in cost increases will be funded.

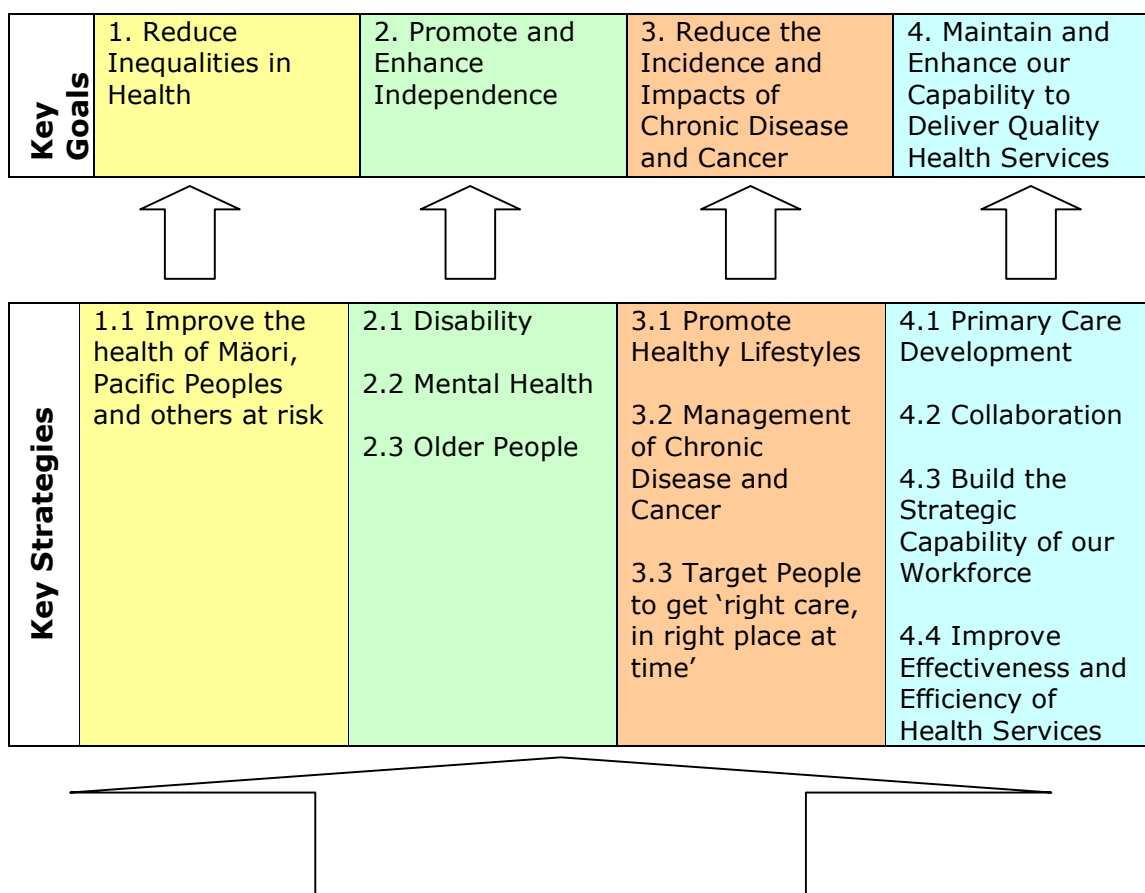
- The NZ\$ exchange rate with countries supplying medical consumables and capital equipment will remain at approximately current levels of US\$0.70.
- Our Key Goals, Strategies and Initiatives will continue to receive support by staff, primary care providers and the general public.

OUR KEY GOALS AND STRATEGIES

The Otago DHB has considered its current situation against demographic projections, financial forecasts, and service delivery aspirations for the next 5 to 10 years. Taking into account those factors which affect the achievement of our stated vision, we believe we will achieve it through our key goals, as follows:

1. **Reduce Inequalities in Health.** This goal is about improving the health status of the population, and particularly of those groups most at risk such as Māori, Pacific People and the lower socioeconomic group.
2. **Promote and Enhance Independence.** This goal recognises that the DHB's concern is more than just delivering health services. We do not want to create a dependency on services but rather encourage people to be about more independent in order to lead healthy and fulfilling lives.
3. **Reduce the Incidence and Impacts of Chronic Disease and Cancer.** There is strong evidence about the future onset of chronic disease and cancer. This goal is about targeting health resources and effort to prevent the onset of those conditions as well as managing those with conditions which are already advanced or chronic.
4. **Maintain and Enhance our Capability to Deliver Quality Health Services.** This DHB provides a full range of tertiary, secondary and primary health services to the population. The people of Otago's access to health services is better than the average in New Zealand. This goal is about keeping that level and access to health services.

These goals are long term which require strategies to support them which are in turn supported by various initiatives (projects, programmes and actions). Our Key Goals, Strategies and Supporting Initiatives are illustrated below, and are further detailed at **Appendix 2**. Our Medium Term Outcome Measures and Broad Targets for this DSP are listed at **Appendix 3**. Our District Annual Plans will detail how and when we will develop various initiatives to support the strategies to achieve our goals. The list of initiatives is not exhaustive and new initiatives will be identified and others will expire.



Key Initiatives (to support one or more of the Goals and Strategies)	
Encourage collaboration between all sectors of the community to address Māori health and disability needs	Support Māori to Develop Local Solutions and Delivery Models for the Otago Māori Community
Otago Older Person's Health Strategic Plan	Aging in Place
Implement the Review of Mental Health Services through 'Community For Mental Health'	Realignment of mental health services to achieve equity of access
Chronic Care Management programmes (CVD; COPD; diabetes initially)	Implement the NZ Cancer Control Strategy
Promote Healthy Lifestyles	Public Health Through Primary Care
Strengthen our Relationship with our Neighbors and Key Partners	Healthy Eating Healthy Action
Master Services and Site Plan	Efficiency Improvement Strategies
Otago Māori Health and Disability Strategic Plan	Otago Workforce Strategic Plan
Otago Disability Strategic Plan	Otago Primary Care Strategic Plan
Otago Nursing Strategic Plan	Otago Health of Older People Strategic Plan
Foster and Support Research	Innovative Technological Solutions
Integration of Primary and Secondary Care	Management of Demand Driven Services
Access to services	Embed Successful Acute Demand Management Programmes
Collaborative, Regional, Shared Clinical and Support Services with Southland DHB	

QUALITY IMPROVEMENT

We are committed to ensuring that services provided and contracted by the Otago DHB are safe, of good quality and comply with various legislative and quality standards.

Contracted Services

To support the Otago DHB's role to fund services that are safe, effective, efficient, accessible and responsive to consumer needs, we have in place a provider Quality Improvement Strategy. This strategy includes key actions to support an environment of quality assurance and improvement. These actions involve provider audit programmes with a particular focus on ensuring that services are delivered to the contract specifications. Further actions include enhanced consumer representation in quality improvement activities and review and development of possible incentives for good performance to be incorporated into provider funding agreements.

Provider Arm (DHB's Hospitals') Services

The Provider Arm's direction for improving quality and managing risk is detailed in its Quality Improvement and Risk Management Plan. The plan is based on the principles identified in the National Health Committee publication 'Safe Systems Supporting Safe Care'. The plan incorporates the Otago DHB strategic initiatives and actions identified in the Ministry of Health 'Improving Quality' action plan. Quality Improvement is celebrated through annual Quality Improvement Awards to recognise staff for their achievements in the area of quality improvement.

Otago DHB Provider Arm was awarded a three-year accreditation following a Quality Health NZ survey in October 2003 and a repeat certification audit and accreditation progress visit is scheduled for 2005-06.

Complaints and Incidents

We view complaints and incidents as an opportunity for continuous improvement. The Complaints Review and Incident Review committees oversee the investigation and management of complaints and incidents to ensure that they are correctly dealt with. Learning from complaints and incidents is shared through these committees and opportunities for improvement actioned by service based quality groups.

We will continue to strive for quality and safety in all our activities.
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RISK MANAGEMENT

This DSP's Key Issues effectively are our risks. Our Goals and Strategies direct how we will manage those risks. Generally, the main risk we envisage is a reduction in access and levels of service due to financial constraints under PBF. This DSP is about maintaining the current service levels and access within PBF. The key strategies and initiatives signalled in this plan to mitigate the risks include the following:

- Implement the Review of Mental Health Services through Community For Mental Health.
- Realignment of mental health services to achieve equity of access.
- Chronic Care Management programmes (initially CVD; COPD; diabetes).
- Efficiency Improvement Strategies.
- Master Services and Site Plan.
- Development of specific strategic plans:
 - ≈ Otago Workforce Strategic Plan
 - ≈ Otago Māori Health and Disability Strategic Plan
 - ≈ Otago Disability Strategic Plan
 - ≈ Otago Primary Care Strategic Plan
 - ≈ Otago Health of Older People Strategic Plan
 - ≈ Otago Nursing Strategic Plan.
- Management of Demand Driven Services.
- Collaborative, Regional, Shared Clinical and Support Services with Southland DHB.
- Innovative Technological Solutions.
- Promote Healthy Lifestyles.

This DHB has well developed systems and processes to identify, investigate, report, monitor and manage risks. The structures in which risk are managed involve individual service/department structures, clinical practice groups structures which report through the management chain, and specialist committees which report to the Quality Improvement and Risk Committee. These in turn report to the Board.

We believe our key goals and supporting strategies and initiatives mitigate the risks.

EMERGENCY MANAGEMENT

The recent threats of Y2K and SARs gave all DHBs cause to review and develop their emergency management processes. This DHB has invested considerable time and resource to its emergency management capability. The DHB conducts exercises for key staff in the management of emergencies and disasters, and does the same for its clinical responses to those, including external expert evaluation. The threat of the avian bird flu is another matter that this DHB is planning for alongside national agencies. This DHB is confident that it has well developed capability to respond to emergencies and will continue to exercise, evaluate and enhance that capability.

Whenever there is an emergency, stakeholders should rightfully expect the DHB to ensure that appropriate measures are taken to ensure that essential funded and contracted services continue to be provided. The Otago DHB has emergency governance and management structures which seek to:

- Develop plans to ensure continuity of service delivery in an emergency.

- Ensure that contracted service providers have plans that integrate with the DHB plan.
- Ensure that the plan(s) provides for primary, secondary, tertiary and public health service resilience in an emergency situation.
- Coordinate those plans with those of other agencies who may be involved in an emergency response.
- Gain participation of all DHB health providers in local regional and national emergency exercises.
- Jointly develop regional plans for health emergencies, and input by DHBs into National Health Emergency Plan development.

INFORMATION & TELECOMMUNICATIONS

We have established an Information Service Strategic Plan (ISSP) which provides our vision and direction for information and telecommunications into the future. Consistent with our vision, we want to provide and facilitate the highest quality electronic information to all users of our services with the overall aim of improving the clinical outcomes. We will continue to consolidate and enhance the clinical and administrative systems. We will also continue to actively participate in the Health Information Strategy NZ initiatives.

A recent initiative has been the deployment of a clinical information framework to the rural hospitals over the first quarter of 2005 thus improving clinical access to patient information throughout this DHB's region. We will continue to provide infrastructure and support for the rural hospitals, Southland DHB and South Canterbury DHB.

Our Information Steering Group is a governance body and its membership includes Secondary and Primary Care representatives. In our DAP 2005/06 we have signalled our intention to roll out certain systems and we are planning others that will be detailed in subsequent DAPs. These involve systems such as our Electronic Discharges programme and the electronic charting of drugs programme, and extending the connectivity between primary care and Dunedin Hospital. Our MHSmart¹⁰ was fully operational throughout the Otago DHB by March 2005. There are now well developed electronic clinical decision support systems which reduce some of the clinical risk in assessment and treatment which we will evaluate and consider. We will integrate patient and related information between primary and secondary care in order to enhance care and treatment, and to avoid duplication of effort.

The key component of our ISSP going forward is the intent to share clinical information between primary and secondary care clinicians at the point of care, as this offers much to improve care and treatment and reduce duplication of cost and effort. We also see that a key strategy to managing

¹⁰ MHSmart collects information on patients using the HONOS scales as an outcome measure to the degree of wellness of the client.

the costs of information and telecommunication technology is through collaborative arrangements with other DHBs.

We remain committed to ensuring that we use information and telecommunication technology wisely to enhance patient outcomes, quality and safety, and where possible reduce unnecessary costs. This is about *maintaining and enhancing our capacity to deliver quality health services.*

COMMUNITY CONSULTATION

This DHB has, and continues to recognise the need for regular consultation and communication with the community and is committed to doing so. The Otago DHB has in place a Consultation and Communications Strategy that outlines the key processes and protocols by which the Otago DHB engages the various communities of Otago. Each consultation project requires the development of a consultation plan outlining in detail the process by which consultation will be carried out. The foreseeable issues that we will specifically consult the community and our staff on are primary areas of service reconfiguration that we envisage are as follows:

- Implementation of the agreed outcomes from the Review of Mental Health services through 'Community for Mental Health'.
- Primary Care Development.
- Models for Delivery of Medical, Accident, Urgent and Emergency Services in Dunedin City.
- Referred Services Provision.
- Home Based Support Services Review.
- After hours care.

The Otago DHB has developed and continues to refine its website as an important and efficient communication and consultation tool. It is also an important tool for the dissemination of Board meeting material to the public, for recruitment, and for the provision of wider DHB information to the public. The website will be continue to be refreshed and modernised.

We believe that ongoing consultation with the community and our staff is essential to enabling the DHB to communicate, ensuring that the various stakeholders have a good understanding about the DSP's goals and strategies and the work that will follow to achieve them.

We will continue to consult with our staff and the community about any significant changes to health services within the region.

WORKING DIFFERENTLY

For many DHBs to maintain financial sustainability there is the prospect of service change/reduction/discontinuation. Our previous experience suggests that service reduction (as opposed to discontinuation) without reducing infrastructure will only yield marginal cost reduction, whereas total service discontinuation would allow associated overhead costs to be reduced and that these marginal cost savings are offset by waiting list increases, and reduced public confidence in health services. Any pressures that cause us to consider service reduction will be done so robustly. We do not contemplate service discontinuation but we do see the need to find different ways to do things.

The primary areas that we foresee the need to work differently and find new and better ways to provide care are:

- Primary Care Development.
- Model for Delivery of Medical, Accident, Urgent and Emergency Services in Dunedin City.
- Implementation of the agreed outcomes from the Review of Mental Health services through 'Community for Mental Health'.
- Provision of referred services (pharmaceuticals and laboratory testing).
- Provision of after-hours care throughout the region.
- Older people's health services.

This latter area is one that will prove to be a challenge to all DHBs and indeed most nations with aging populations. A lot of work has and is being done to find different and better ways to deliver care and support to older people. Our challenge is significant given the financial constraints that we must live within and the current way services are delivered. This DHB will develop an Otago Older People's Health Strategic Plan which will set out how we will meet the challenge of delivering the Government's Health of Older People Strategy, and at the same time living within our means.

APPENDICES

1. Summary Report on the *Health Profile of Otago*
2. Our Key Goals, Strategies and Supporting Initiatives
3. Our Medium Term Outcome Measures and Broad Targets
4. Summary Forecast Statements of Financial Performance

REFERENCES

The following Ministry of Health documents have informed this District Strategic Plan, and are available on the Ministry of Health website www.moh.govt.nz

- Planning Package. Planning Guidelines Component for Developing DHB Planning Documents. For 2005-2006.
- The New Zealand New Zealand Health Strategy.
- The Primary Health Care Strategy.
- He Korowai Oranga: Māori Health Strategy.
- The Health of Older People Strategy
- The New Zealand Disability Strategy. Also at www.odi.govt.nz/nzds/
- The New Zealand Positive Ageing Strategy.
- The New Zealand Cancer Control Strategy.
- The Pacific Health and Disability Action Plan.
- Blueprint for Mental Health Services in New Zealand: How Things Need to Be.
- Reduced Waiting Times for Public Hospital Elective Services. Government Strategy.
- A Difference in Communities: What's happening in The Primary Health Organisations.

The following documents are referred to in this District Strategic Plan, and are available on the Otago DHB website www.otagodhb.govt.nz

- District Annual Plan 2005/06-2007/08. Approved 14 July 2005. This includes a copy of Minister of Health's Letter. Letter of Expectations: DHB Planning for 2005/06.
- Otago Health Profile: Otago District Health Board.
- Review of Mental Health Services Provision in Otago and Strategic Recommendations for Future Development.
- Otago DHB Māori Health and Disability Strategic Plan.
- Prioritisation Policy: A Process Framework for Prioritisation
- Community Engagement. A Consultation and Communications Strategy for the Otago District Health Board.

OUR POPULATION'S HEALTH

Summary abstracted by Susan Dovey from the draft Health Profile document (June 2005) prepared by the South Island Shared Service Agency Ltd.

Executive Summary

Compared to the New Zealand population overall, the Otago DHB population is somewhat disadvantaged demographically and socio-economically. The following health and healthcare issues stand out:

Poorer Measures in the Otago DHB than in New Zealand, Overall

Smoking. There are more smoking-attributable hospital admissions in the Otago DHB than on average for New Zealand but about the same smoking prevalence.

Cardiovascular Disease. There are more deaths in the Otago DHB from cardiovascular disease than for New Zealand overall, disease prevalence is similar, and hospitalisations are lower.

Self-inflicted Injuries. There are more deaths and hospital admissions in the Otago DHB than expected.

Better or Similar Measures in the Otago DHB than in New Zealand, Overall

Access to Health Services. There is better access to most types of health professional.

Cancer. Better than other regions.

Physical Activity. Similar to other regions.

Diabetes. Similar to other regions.

Chronic Respiratory Disease. Similar to other regions. Lower hospital admission rate for asthma.

Measures that may be important but data are insufficient to assess in the Otago DHB

Mental Health. There is not enough data on specific mental health disease prevalence but lower use of mental health services, especially community-based services.

Māori Health. The small numbers of Māori in the Otago DHB make estimates imprecise. The following results may be due to this imprecision:

- Better outcomes on hearing failure at 5 years among Otago DHB Māori.
- Diabetes – poorer health to start with but greater improvements through the Get Checked programme than for non- Māori in the Otago DHB.
- More lung cancer in male Māori in the Otago DHB.
- Less breast cancer among female Māori in the Otago DHB.
- Lower asthma admission rates for Māori children in the Otago DHB.
- Higher suicide rates for Māori than non- Māori in the Otago DHB.

Health Status and Health Needs

The Otago District Health Board's (Otago DHB) 2004 population of 180,220 is expected to change little overall in size over the next 15 years but grow older – with substantial associated increases in per capita health costs.

The number of births to European women in the Otago DHB decreased 14.8% from 1996 to 2002, while for Māori women births increased 10.9%.

The Otago population has a slightly lower life expectancy (2.4 months less) than the New Zealand average. Life expectancy in Otago is expected to increase by about 4 years in the next 20 years.

Health status and healthcare needs are related to social deprivation, income, and housing. The Otago DHB has a relatively small population living in high deprivation areas (10.4% of the Otago DHB population vs 19.9% of the New Zealand population). Almost all high deprivation areas are in Dunedin city. Unemployment in the region was 4.6% in 2004 – above the national rate of 4.0%. Personal income of the Otago DHB population is lower than in New Zealand generally and there has been a recent steep decline in housing affordability in the region. Although levels of home ownership in the region are relatively high, there is a significant problem with old, cold, and damp housing in Dunedin.

Adult smoking prevalence in Otago is similar to New Zealand generally (22% in Otago and 24% in New Zealand) but may have increased between 1998 and 2000. A similar proportion of Year 10 female students in Otago and in New Zealand smoke (23.5% of Otago girls and 24.9% of New Zealand girls) but more boys smoke in Otago (18.9% of Otago boys and 16.4% of New Zealand boys). The Otago DHB covers about 4.4% of the New Zealand population and contributes 5.2% of the smoking attributable hospitalisations in New Zealand.

Otago children and adults have a similar level of physical activity to other New Zealanders.

According to data in the report, overall the Otago DHB population is somewhat disadvantaged demographically and socioeconomically and may therefore have higher health needs than other New Zealanders. Changing risky lifestyle behaviours such as smoking and physical activity will confer significant benefits to the health of Otago people.

Rates of Prevalent Diseases

Cardiovascular Disease (Heart Disease and Strokes)

Cardiovascular disease is a major problem for the Otago DHB population, accounting for 39% of deaths in the Otago DHB and 37% of deaths in New Zealand overall. Refer to below table.

Age-Standardised Cardiovascular Disease Mortality Rate (per 100,000) (including 95% CIs), by Ethnicity and Gender, Otago, South Island and New Zealand, 2000 to 2001				
Ethnicity	Gender	Otago	South Island	New Zealand
Māori	Male	1,151 (658,1869)	336 (270,413)	417 (391,445)
	Female	136	230 (174,299)	324 (302,347)
Non-Māori	Male	230 (212,250)	220 (212,228)	214 (210,218)
	Female	149 (138,161)	141 (136,146)	135 (132,137)
Total	Male	235 (216,255)	224 (216,232)	227 (223,231)
	Female	149 (138,161)	143 (138,172)	145 (142,148)

Source: Ministry of Health 2004b.

In 2000/2001 6% of all New Zealand deaths and 5% of all hospitalisations due to cardiovascular disease occurred in Otago. Compared to New Zealand generally, there were in the Otago DHB 17.6% more deaths per 100,000 from ischaemic heart disease (IHD), 20.0% more deaths from other heart disease, and 20.9% more deaths from stroke.

Heart disease and stroke prevalence overall in Otago is similar to the prevalence in New Zealand.

The socioeconomic gradient (with lowest rates in quintile 1 and highest in quintile 5) in cardiovascular disease mortality evident in the South Island and New Zealand is weaker in Otago. The socioeconomic gradient for stroke is particularly weak. However, a socioeconomic gradient in hospitalisation for cardiovascular disease is apparent in Otago to the same extent as in the South Island and New Zealand.

In Otago hospitalisation rates for acute myocardial infarction (AMI) and stroke are considerably lower than in the South Island and New Zealand.

Rates per 100,000 of mortality from stroke are slightly higher in Otago (males 45, females 47) than in the South Island (males 42, females 42) and in the whole of New Zealand (males 43, females 41). Rates of hospitalisation for stroke are however lower in Otago than in the South Island and New Zealand.

Diabetes

The 2003 prevalence of diabetes in Otago was estimated at 4,830 (2.7%) but expected to increase. Refer to below table.

Expected Number of People with known Diabetes in Otago			
Ethnic Group	2001	2002	2003
Māori	401	332	398
Pacific People	62	63	77
All Others	3,950	4,118	4,355
Total	4,414	4,513	4,830

Source: Otago Diabetes Model 2003, 2004

Diabetes accounts for a similar proportion of deaths in the Otago DHB and in New Zealand overall (3%).

In the 2003/2004 year there were 3,073 known hospital admissions in Otago for diabetes-related conditions. This represents about 1/3 of all people in Otago with diagnosed diabetes having a hospital admission – a conservative 7% needing hospital admission for reasons directly related to their diabetes – loss of glycaemic control, eye and vascular complications, and skin ulcerations.

120 admissions (29%) involved people with Type 1 diabetes although they comprise only 10% of all people with diabetes in the region. In particular, patients with Type 1 diabetes had 66% of the admissions for loss of glycaemic control, suggesting a need for more proactive primary care in this group.

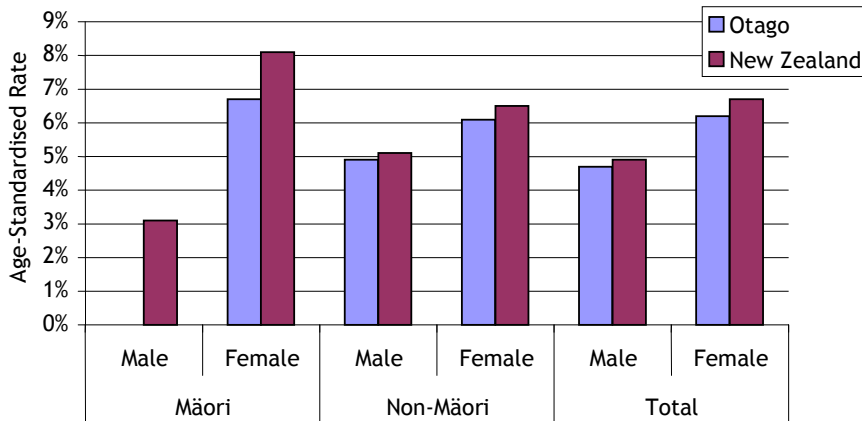
There has been an increasing uptake of free annual diabetes checks in Otago from an estimated 57% of people with diabetes having a free check in 2001, to 70% in 2002, and 72% in 2003. These rates were calculated using unvalidated population estimates as denominators so they are more useful for comparisons between years than as a measure of unmet need. Research to provide more robust estimates of diabetes prevalence in Otago is currently being undertaken in the Dunedin School of Medicine.

Among those receiving free diabetes checks, there was relative stability across 2001, 2002, and 2003 in the proportion with poor glycaemic control (28%, 27%, 27%), the proportion having retinal screening (83%, 82%, 83%), and the proportion who smoke (13%, 11%, 13%).

Cancer

Cancer is no greater health problem in Otago than in other parts of New Zealand and may be less of a problem. Refer to the chart below.

Age-Standardised Cancer Prevalence Rates by Ethnicity and Gender, Otago and New Zealand, 2002 to 2003



Source: Ministry of Health 2004b.

Cancer data in the report are inconsistent and need to be revisited:

- Table 14 (page 29) shows that cancer accounts for 27% of deaths in the Otago DHB and 42% of deaths in New Zealand overall (1999-2000). The New Zealand figure contrasts with the statement on page 49 that 27% of New Zealand deaths are due to cancer.
- There are conflicting data in the report about the uptake of breast cancer screening in Otago. Table 54 (page 60) shows 53% uptake by Māori women and 59% uptake by non-Māori: both these results are well below the 70% required in a successful screening programme. Page 213 states that 73% of all eligible women in Otago have been screened (success) but only 46% of Māori women.

If the comparative data is correct, compared to New Zealand generally, there are in the Otago DHB 21.3% more deaths per 100,000 from lung cancer, 23.0% more deaths from colorectal cancer, 16.7% more deaths from prostate cancer, and 20.0% more deaths from breast cancer: however, there were 86.9% **fewer** deaths from other cancers. The large difference between Otago DHB and New Zealand registered deaths from "other cancers" (12.6% of all deaths in Otago vs 27.8% of all deaths in New Zealand) probably indicates a coding problem that likely negates the above excess in Otago deaths from specific cancers.

Non-Māori males in Otago have a higher cancer hospitalisation rate than in the South Island or New Zealand more generally.

Although there is a deprivation gradient in cancer mortality in Otago as in the rest of New Zealand (lowest rates in the least deprived areas), there is no such gradient in cancer-related hospitalisation in Otago, as there is in the rest of New Zealand.

Males across all deprivation quintiles have a higher lung cancer mortality rate than females in Otago, the South Island, and New Zealand.

Across all ethnic groups breast cancer screening uptake is higher in Otago than nationally. Mortality from breast and cervical cancer in Otago is lower than nationally and unrelated to deprivation.

Cervical cancer registration, hospitalisation, and mortality in Otago do not vary by ethnicity or deprivation. Cervical cancer screening rates in Otago (76.3% screened, 90.8% enrolled in the screening programme) are higher in all age groups than screening rates in other South Island DHBs and in New Zealand overall.

Melanoma registration and mortality rates are lower in Otago than nationally but melanoma hospitalisation rates are higher.

It needs to be reiterated that the data about individual cancers is inconsistent and firm conclusions cannot be drawn from it.

Depression

There are no data in the report specifically about depression.

The rate of access to mental health services in Otago is 1.3% - below the overall target rate of 3% but above the South Island average of 0.9%.

Chronic Obstructive Respiratory Disease

There are no data in the report specifically about Chronic Obstructive Respiratory Disease.

Chronic respiratory disease (overall) accounts for a similar proportion of deaths in Otago and in New Zealand (6.8% of Otago deaths and 6.4% of New Zealand deaths).

Asthma

Child and youth asthma admission rates in Otago from 1988/89 to 2002/03 were lower than the New Zealand average for both age groups and declined over the time period.

Suicide and Self-Harm

Intentional self harm accounts for a similar proportion of deaths in the Otago DHB and in New Zealand overall (1.5% of Otago deaths and 1.8% of New Zealand deaths).

There are fewer suicide deaths overall and for youth in Otago than in other South Island DHBs.

Self-inflicted injuries made up a higher percentage of all injury fatalities in all South Island DHBs than in New Zealand overall (33% of injury fatalities in Otago vs 31% in New Zealand). Self-inflicted injuries make up 8% of injury-related hospital admissions in the Otago DHB.

Access to Health and Disability Services

The prevalence of having a usual healthcare provider, obtaining prescriptions, and accessing pharmacies in Otago is similar to that of New Zealand.

Compared to the whole of New Zealand, Otago has more optometrists per 100,000 population (11.0 vs 9.8), more dentists (134.0 vs 97.1), dietitians (9.9 vs 6.0), medical laboratory technologists (24.9 vs 18.8), medical radiation technologists (24.7 vs 19.7), occupational therapists (42.6 vs 21.5), physiotherapists (44.3 vs 29.2), and registered psychologists (26.9 vs 19.1).

63% of the Otago DHB population lives within 10km of a hospital and 92% within 50km. 86% of the population lives within 10km of a general practitioner and 86% lives within 10km of a pharmacy. 81% lives within 10km of a dentist.

The proportion of registered medical practitioners who are general practitioners is lower in Otago than nationally (29% vs 34%). The New Zealand Medical Association recommends 71.4 FTE per 100,000 population but in Otago and nationally there are more than this number (83.2 in Otago and 78.1 nationally). The rate of medical specialists per 100,000 in Otago is the third highest in the country.

Otago has the second highest per capita number of dispensed prescriptions in New Zealand (6.9 vs 6.0 overall for New Zealand) and the third highest pharmaceutical expenditure per capita (\$166.7 vs \$147.5 overall for New Zealand).

Otago has the third highest per capita expenditure on community-based laboratory use (\$43.43 vs \$39.71 overall for New Zealand).

The prevalence of accessing a general practitioner in Otago is similar to general practitioner access in New Zealand.

The prevalence of accessing complementary or alternative healthcare providers in Otago is lower than in New Zealand overall.

High private payments needed for oral health services limits access in Otago but the presence of the School of Dentistry in Dunedin probably secures better access than is available in most other parts of the country to oral health services for those with greatest need.

Hospital discharge rates have increased in Otago at about the same rate as in New Zealand overall. The standardised discharge ratio for acute medical discharges was consistently lower than expected, given the make-up of the Otago population. 'Acute medical discharge' is the only category with standardised discharge ratios that compare favourably with national discharges for all 5 years 1998-2003. Surgical discharge rates are higher than expected.

The overall day case percentage is similar to other South Island DHBs.

The number of people waiting for first specialist assessment decreased slowly from 2001-2003 but the inpatient waiting list more than doubled over the same period. Data on this measure are unreliable, however.

Māori Health Status and Needs

6.3% of the Otago DHB population is Māori – 9% less than New Zealand as a whole. Statistics on Māori health status, needs, disease prevalence, and access must be cautiously interpreted because of the small numbers of Māori in the region (and therefore a lack of precision in estimates).

With the above caution, Māori in the Otago DHB region are more likely than others in the region to live in areas of relatively high deprivation, to earn less than \$5000, to live in crowded households, and to have no educational qualifications but the Otago DHB profile for Māori in all these areas is better than in other parts of the South Island and for New Zealand as a whole.

Māori in Otago smoke 38% more than Europeans but show more interest in being physically active (59% vs 54%).

The marked ethnic disparities in national hearing failure rates at 5 years are not evident in Otago.

Disease Prevalence in Māori

Cardiovascular Disease

Māori males in Otago have lower cardiovascular disease prevalence but a cardiovascular disease mortality rate that is significantly higher than the national rate, suggesting under-diagnosis of early disease.

AMI mortality rates (per 100,000) for Māori in Otago are higher than for non-Māori (male 88 vs 81; female 44 vs 41) but lower than AMI mortality rates for Māori in the South Island (male 110, female 60) and New Zealand (male 129, female 87).

Diabetes

In 2003 the Ministry of Health estimated there were 398 Māori with diabetes in Otago (8.2% of all Otago people with diabetes and 0.2% of the total Otago population). Diabetes prevalence in the Māori population is expected to increase more rapidly than in the non-Māori population.

Māori are under-represented in hospital discharges for diabetes – probably because of misclassification of ethnicity as well as true under-representation. In 1999, diabetes accounted for 6.4% of all Māori adult admissions in Otago and Southland, vs 1.4% of non-Māori admissions.

Māori uptake of free diabetes checks is also much lower than uptake by non-Māori (18% of estimated cases in 2001, 29% in 2002, and 24% in 2003).

Among those receiving free diabetes checks, more Māori than non-Māori have poor glycaemic control (52% with poor control in 2001 vs 28% for all people having diabetes checks; 49% with poor control in 2002 vs 27%; 41% with poor control in 2003 vs 27%).

Among those receiving free diabetes checks, more Māori than non-Māori smoke (30% in 2001, 24% in 2002, 22% in 2003 vs 13%, 11%, and 13% overall).

Among those receiving free diabetes checks, fewer Māori have retinal screening checks (77% in 2001, 79% in 2002, and 85% in 2003 vs 83%, 82%, and 83% overall).

These results suggest that in Otago Māori with diabetes have poorer health than others with diabetes but that free checks are contributing to important improvements in their health.

Cancer

Māori males in Otago have higher cancer mortality rates than their South Island and national counterparts.

Māori women in Otago have a lower prevalence of cancer than nationally.

Māori males in Otago have a significantly higher lung cancer registration rate than Māori males in the South Island and New Zealand.

Māori females in Otago have higher lung cancer mortality but lower lung cancer hospitalisation rates than the national average.

Māori females in Otago have a much lower breast cancer registration rate than non- Māori females. Data about breast cancer screening among Māori women are conflicting.

Asthma

From 1988/89 to 2002/03 asthma admission rates for Otago Māori children (0-14 years) were lower than the New Zealand Māori average.

19% of all Otago Māori child hospital admissions (1-4 years) in 1999 were for asthma, compared to 6% for non- Māori children.

Suicide and Self-Harm

Māori have higher suicide rates than non- Māori (13.4 deaths per 100,000 vs 11.2 for non-Māori).

Māori access to Health and Disability Services

The prevalence of Māori accessing Māori health providers is similar for Māori males in Otago to their New Zealand counterparts, but lower for Māori females.

In Otago, Māori obtain prescriptions and access pharmacies at a lower rate than their non-Māori and national counterparts.

Māori in Otago and the rest of the South Island tend to have poorer access to hospital services than Māori nationally. However, there has been a steady improvement since 1997/98 in access to elective services for Māori compared with non-Māori.

Mental health service needs for Māori are not known but the Mental Health Commission suggests that the access target for Māori should be 6%, double that for the general population. From 2001-2003 the percent of Māori accessing mental health services in Otago was 3.6%, 3.5%, and 3.8.

OUR KEY GOALS, STRATEGIES AND SUPPORTING INITIATIVES

Goal 1: Reduce Inequalities in Health	
Strategies:	
1.1 Improve the health of Māori, Pacific Peoples and others at risk to being at least as good as other NZers.	
Initiatives	
1.1	Models for Primary Care Practices. As part of our Otago Primary Care Strategic Plan, we want to provide primary care providers with best practice models to encourage more economical, multi-provider team-based practices capable of delivering a broader range of services to their community, consistent with the objectives of the NZ Primary Care Strategy. This should enable people to gain better access to services across the DHB and improve health outcomes.
1.2	General Practitioners with Special Interest (GPSI). As part of our Otago Primary Care Strategic Plan, the DHB has started co-operative programmes with the five Otago PHOs, their GP members, and the IPA to develop GPSIs to allow patients better access to certain treatment that is currently being delivered by secondary care but can be delivered through PHOs. The development of GYPSIs will enhance primary care’s range of services, improves people’s access to such services, and reduce the demand on certain secondary services.
1.3	Community for Mental Health. This is the project to implement of the recommendations from Review of Mental Health Services with wide community and stakeholder consultation.
1.4	Realignment of Mental Health Services to Achieve Equity of Access. This is one of the key strategies.
1.5	Encourage Collaboration Between all Sectors of the Community to Address Māori Health and Disability Needs. To achieve this we will implement our Māori Health and Disability Strategic Plan which is one of main strategies to reduce inequalities.
1.6	Support Māori to Develop Local Solutions and Delivery Models for the Otago Māori Community. To achieve this we will implement our Māori Health and Disability Strategic Plan which is one of our main strategies to reduce inequalities.
1.7	Otago Disability Strategic Plan. We will refine and further develop our Disability Strategic Plan towards implementing the NZ Disability Strategy.
1.8	Aging in Place. We will develop an Otago Older Person’s Health Strategic Plan to enhance the aged care sector’s ability to allow older people to age in place, while at the same time rationalise our funding for aged care against the current level of services.

Goal 2: Promote and Enhance Independence	
Strategies: 2.1 Disability. 2.2 Mental Health. 2.3 Older People. 3.1 Promote Healthy Lifestyles	
Initiatives	
2.1	Promote Healthy Choices. People have choices about their health and lifestyle. We will continue to promote healthy choice in the community, workplaces and schools through the (HEHA) Implementation Plan: 2004-2010, and other local initiatives.
2.2	Strengthen our Relationship with our Neighbors and Key Stakeholders. There are neighbouring DHBs and key stakeholders who provide services and facilities that impact on the communities' health and lifestyles. We will work closely with them to help shape their plans in order that they allow people to lead healthy lifestyles and be independent.
2.3	Otago Workforce Strategic Plan. We will develop an Otago Workforce Strategic Plan to provide sufficient numbers of trained staff across the range of health services to promote healthy life styles and to prevent, detect and treat chronic diseases and cancers.
2.4	Public Health Through Primary Care. As part of our Otago Primary Care Strategic Plan , we will encourage primary care to take a population based approach to promoting healthy lifestyles and independence.
2.5	Otago Māori Health and Disability Strategic Plan. We will implement our Māori Health and Disability Strategic Plan which, amongst other things, aims to promote healthy lifestyles and independence.
2.6	Foster and Support Research. Research into the causes of poor health is vital and we will continue to foster and support such research work.

Goal 3: Reduce the Incidence and Impacts of Chronic Disease and Cancer	
Strategies: 3.1 Promote Healthy Lifestyles. 3.2 Management of Chronic Disease and Cancer. 3.3 Target People to get 'right care, in right place at time'.	
Initiatives	
3.1	Chronic Care Management. We will establish chronic diseases management programmes for the most prevalent diseases in Otago, initially concentrating on CVD, COPD, and diabetes.
3.2	NZ Cancer Control Strategy. We will implement the NZ Cancer Control Strategy.
3.3	Public Health Through Primary Care. As part of our Otago Primary Care Strategic Plan , we will encourage primary care to take a population based approach to preventing, detecting and treating chronic diseases.
3.4	Integration of Care. Effective integration between primary and secondary services is vital to successfully preventing, detecting and treating chronic diseases. We will continue to find opportunities to improve integration.
3.5	Otago Māori Health and Disability Strategic Plan. We will implement our Māori Health and Disability Strategic Plan which, amongst other things, targets chronic disease.

3.6	Otago Workforce Strategic Plan. We will develop an Otago Workforce Strategic Plan to provide sufficient numbers of trained staff across the range of health services to prevent, detect and treat chronic diseases.
3.7	Otago Nursing Strategic Plan. We will establish a nursing strategic plan to develop nursing across the continuum of care regardless of their practice setting. This will enhance the roles of nursing to thereby providing better access to certain services and in particular certain chronic disease and cancer management programmes.
3.8	Foster and Support Research. Research into the causes and treatment of chronic disease and cancer is vital and we will continue to foster and support such research work.

Goal 4: Maintain and Enhance our Capability to Deliver Quality Health Services	
Strategies:	
4.1 Primary Care Development. 4.2 Collaboration. 4.3 Build the Strategic Capability of our Workforce. 4.4 Improve Effectiveness and Efficiency of Health Service	
Initiatives	
4.1	Access to Services. We will strive to maintain Otago's current level of access to services.
4.2	Otago Primary Care Strategic Plan. We will develop a Primary Care Strategic Plan to set the DHB's desired direction for primary care, and work closely with primary care towards it.
4.3	Model for Delivery of Medical, Accident, Urgent and Emergency Services in Dunedin City. As part of our Otago Primary Care Strategic Plan , we will develop a model of care that will ensure that inappropriate ED attendances are instead referred to primary care.
4.4	GP After-Hours Services. We will develop local solutions across Otago to address the issues around GP after-hours services.
4.5	Embed Successful Acute Demand Management Programmes. We will continue the current programmes to a point where, if proved to be successful, they can be embedded into the community health/primary care environment.
4.6	Management of Demand Driven Services. We will develop strategies to manage provider arm and community demand driven services starting with laboratory services, and pharmaceutical prescribing and dispensing. The overall objective is to secure long-term cost effective sustainable services.
4.7	Otago Workforce Strategic Plan. We will develop a Workforce Strategic Plan to provide for our anticipated staffing requirements.
4.8	Otago Māori Health and Disability Strategic Plan. We will implement our Māori Health and Disability Strategic Plan which, amongst other things, enhances cultural appropriateness of services and develops a Māori workforce.
4.9	Efficiency Improvement Strategies. We will continue to pursue opportunities for innovations to help reduce expenditure, and improve service delivery and patient outcomes.
4.10	Master Services and Site Plan. We will improve the alignment of our Dunedin hospitals' services to the facilities that we own.

4.11	Collaborative, Regional, Shared Clinical and Support Services with Southland DHB. We will work closely with SDHB to develop regional clinical services and to share certain administrative support services. This will improve better access on a regional basis to certain specialist services.
4.12	Strengthen our Relationship with Our Partners. We will consolidate and strengthen our relationship with our partners to enhance our collective roles as a teaching and research institutions as well as service providers of primary, secondary and tertiary health services.
4.13	Otago Older Person's Health Strategic Plan. We will develop this strategic plan and through it we will set out how we will meet the challenge of delivering the Government's Health of Older People Strategy, and at the same time living within our means.
4.14	Innovative Technological Solutions. We will continue to use information and telecommunication technology to enhance patient outcomes and reduce unnecessary costs.

OUR MEDIUM TERM OUTCOME MEASURES AND BROAD TARGETS

Goal 1: Reduce Inequalities in Health
Strategies: 1.1 Improve the health of Māori, Pacific Peoples and others at risk.
Measures ≈ Improvement in the capacity of providers to deliver services to Māori and Pacific People. ≈ Increase in enrolments of the Otago population in a PHO to 98%. ≈ Increase (numbers) of Māori accessing primary care services to average national levels. ≈ Reduction in mortality rates of Māori men from cardiovascular disease. ≈ Increase in uptake by Māori and Pacific People receiving free diabetes checks. ≈ Better data on Māori and Pacific People's access to all health services.
Targets 1. <u>Otago Māori Health and Disability Strategic Plan</u> . Plan in place by 2005/06. 2. <u>Models for Primary Care Practices</u> . Integrated Medical Centres™ established in Dunedin, North Otago, Central Otago and West Otago by 2009/10.

Goal 2: Promote and Enhance Independence
Strategies: 2.1 Disability. 2.2 Mental Health. 2.3 Older People.
Measures ≈ Provision of services, by all DHB funded and contracted providers, which are appropriate to people with disabilities. ≈ 'Community for Mental' Health fully implemented. ≈ A vibrant aged care sector where older people are care for in the most appropriate settings.
Targets 1. <u>Otago Disability Strategic Plan</u> . Plan in place by 2006/07. 2. <u>Community for Mental Health</u> . Key recommendations implemented by 2009/10. 3. <u>Otago Health of Older People Strategic Plan</u> . Plan in place by 2006/07.

Goal 3: Reduce the Incidence and Impacts of Chronic Disease and Cancer
Strategies: 3.1 Promote Healthy Lifestyles. 3.2 Management of Chronic Disease and Cancer. 3.3 Target People to get 'right care, in right place at time'.
Measures ≈ Increase in the proportion of non-sugar drinks availability in schools. ≈ Increase in the uptake of schools enrolled in HEHA. ≈ Increase in the number of intersectoral projects and joint ventures that enhance healthy living. ≈ Increase in the proportion of adults who undertake physical activity. ≈ Increase in the number of workplaces that are smokefree. ≈ Increase in access to structured programmes to reduce the impact of disease ≈ Reduction in the impact and incidence of CVD, COPD and diabetes ≈ Maintain current access to cancer services
Targets 1. <u>Public Health Through Primary Care</u> . All PHOs with established health promotion plans implemented by 2007/08. 2. <u>Chronic Care Management</u> . Chronic disease management programmes for CVD, COPD, and diabetes established by 2007/8.

Goal 4: Maintain and Enhance our Capability to Deliver Quality Health Services

Strategies:

**4.1 Primary Care Development. 4.2 Collaboration. 4.3 Build the Strategic Capability of our Workforce.
4.4 Improve Effectiveness and Efficiency of Health Service**

Measures

- ≈ Level and access to services remains at 2005 levels or better.
- ≈ Reduction in presentations at ED.
- ≈ Workable GP after-hours services established throughout Otago.
- ≈ A realignment of Dunedin based DHBs services across its facilities.
- ≈ Service provision and funding within our resources in accordance with our funding path to equity.

Targets

1. Model for Delivery of Medical, Accident, Urgent and Emergency Services in Dunedin City. A new model of care, which will ensure that inappropriate ED attendances are instead referred to primary care, in place by 2006/7.
2. GP After-Hours Services. Working models established across Otago by 2007/08.
3. Management of Demand Driven Services. New models for laboratory services, and pharmaceutical prescribing and dispensing established by 2007/08.
4. Otago Primary Care Strategic Plan. Otago Primary Care Strategic Plan established by 2005/06.
5. Otago Māori Health and Disability Strategic Plan. Māori Health and Disability Strategic Plan established by 2005/06.
6. Otago Older Person's Health Strategic Plan. Otago Older Person's Health Strategic Plan established by 2005/06.
7. Otago Workforce Strategic Plan. Workforce Strategic Plan established by 2005/06.
8. Collaborative, Regional, Shared Clinical and Support Services with Southland DHB. Effective regional clinical services and to share certain administrative support services established by 2007/08.

SUMMARY FORECAST STATEMENTS OF FINANCIAL PERFORMANCE