CANTERBURY DISTRICT HEALTH BOARD

statement of intent

Healthy Canterbury "longer, healthier, more independent lives"

2010-2013

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Presented in 2010 (6 July) to the House of Representatives
Pursuant to Section 149 of the Crown Entities Act 2004

Produced by the
Canterbury DHB
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About the Statement of Intent

DHBs were created on 1 January 2001 under the New Zealand Public Health and Disability Act 2000 (NZPHD Act) and are categorised as Crown Entities under the Crown Entities Act 2004. As such, all DHBs are required to produce a Statement of Intent to meet the requirements of both these Acts – the NZPHD Act (section 42 and section 39(8)) and the Crown Entities Act 2004 (section 139(1)).

The Statement of Intent sets out the DHB's objectives and goals against its established strategic priorities and national expectations and describes to Parliament and to the general public what the DHB intends to achieve in 2010/11 in terms of improving the health and well being of its community. The document also contains non-financial and financial forecast information for the subsequent two out-years 2011/12 and 2012/13.

Due to the wide range and volume of health and disability services provided across the health system this document provides a grouped output class view rather than a list of each and every specific service the DHB funds or provides. The performance measures used in this document are focused on those disease and service areas agreed as priorities for the region and those areas signalled as priorities by the Minister of Health and Government.

The Statement of Intent, as a public accountability document, is used at the end of the year by auditors working on behalf of the Office of the Auditor-General to compare the DHB's planned performance with the actual performance delivered which is then reported in our Annual Report.

OUR VISION TĀ MĀTOU MATAKITE	**OUR VALUES** Ā MĀTOU UARA	**OUR WAY OF WORKING** KĀ HUARI MAHI
To promote, enhance and facilitate the health and wellbeing of the people of Canterbury. Ki te whakapakari, whakamaanawa me te whakahaere i te hauora mo te orakapai o kā tākata o te rohe o Waitaha.	Care and respect for others. Manaaki me te kotua i etahi atu. Integrity in all we do. Hapai i a mātou mahi katoa i ruka i te pono. Responsibility for outcomes. Kaiwhakarite i kā hua.	Be people and community focused. Arotahi atu ki kā tākata meka. Demonstrate innovation. Whakaatu whakaaro hihiko. Engage with stakeholders. Tu atu ki ka uru.

Executive Summary

We are pleased to present our Statement of Intent for 2010-2013. This document reflects our vision '*to promote, enhance and facilitate the health and wellbeing of the people of Canterbury*', and our commitment to meeting the objectives of the NZ Health Strategy and the expectations of the Minister of Health by delivering on performance targets and service and financial commitments.

Population growth, the increasing burden of long-term (chronic) conditions, the current fiscal environment and the ageing of our population are combining to place significant pressure on our capacity to deliver services, particularly more specialised services and those used predominately by our older population groups. If we make no change to the way we fund or deliver services, population growth and demand projections indicate that by 2020 – just to stand still – Canterbury will need an additional hospital the size of Christchurch Hospital, 2,000 additional rest home beds and a 20% increase in the number of Canterbury GPs.

Knowing these challenges lie ahead, we have embarked on a collaborative journey with clinical leaders, stakeholders and consumers and agreed on a 'whole of system' approach to a sustainable future. Acting on our collaborative vision, we are transforming the way we work, developing alternative models of care, reconfiguring traditional models and redesigning patient pathways to better manage acute demand and the increasing burden of long-term conditions. Through this transformation we will build the capacity required to meet the future needs of our community and improve health outcomes for our population.

Reflecting both what we have learnt over the past two years and the priorities of a new Government, there are changes in emphasis throughout this document. There is more of a focus on putting the patient at the centre so that '*the right person receives the right care and support, from the right provider, at the right time and in the right place*'.

The development of joint pathways across primary and secondary services has been prioritised to improve the patient journey and reduce duplication and delay across the whole of the health system. Clinical quality is also a key focus and improves the flow of patients through our services. This approach is founded on the recognised principles of 'lean thinking' and the basis that delays in patient care at any stage of the patient journey create risk and provide poorer health outcomes, in addition to higher costs. Our shared decision making, achieved through partnerships between clinical leaders and management, will ensure that strategic and operational decisions are as effective as possible.

For the 2010/11 year we will focus our outputs around early childhood and adolescence, where establishing healthy foundations gives people more chance of improved health outcomes, rather than dealing with people 'at risk' later in life. This means providing support for parents who need it, reducing risk behaviours and establishing environments and patterns of behaviour where the healthy choice is the easy choice.

We will also focus on our older population groups, who deserve certainty as they get older, and we will support the independence of older people to give them every opportunity to participate in their communities and remain well, and in their own homes, for as long as possible.

For the rest of our population, we will promote positive change and improved management of long-term conditions, and we will work to improve service delivery. We will provide more flexibility in terms of service models and develop innovative ways of assisting more people, within our current resources. In meeting the expectations of our Government, we will work to reduce waiting times and provide services in more convenient locations by providing access to diagnostics and specialist services in the community and in primary care, without the need for a hospital appointment.

In this document we set out the associated impacts we expect to make over the next three years and have set targets in our forecast Statement of Service Performance to enable evaluation of our performance over the 2010/11 year. Further detail on the specific actions and activity we have planned can be found in our District Annual Plan, which has been written alongside this document and can be found on our website www.cdhb.govt.nz.

Alister James, Chairman

Date: 30 June 2010

Peter Ballantyne, Board Member

Date: 30 June 2010

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1. Introducing the Canterbury DHB – Our Role and Purpose

The Canterbury DHB is the second largest by population of the twenty-one DHBs established in 2000 under the New Zealand Public Health and Disability Act (NZPHD Act), and the largest by geographical area. Our region extends from Kekerengu in the North, to Rangitata in the South and Arthurs Pass in the West and comprises the six Territorial Local Authorities of Kaikoura, Hurunui, Waimakariri, Christchurch City, Selwyn and Ashburton.

We collaborate with other health and disability organisations, stakeholders and our community to decide what health and disability services are needed and how to best use the funding we receive from Government to improve, promote and protect the health and wellbeing of our population.

Through this collaboration, we ensure that services are well coordinated and cover the full continuum of care, with the patient at the centre. These collaborative partnerships also allow us to share resources and reduce duplication, variation and waste across the whole of the health system to achieve the best health outcomes for our community.

As the Canterbury DHB we will:

- ***Plan*** the strategic direction for health and disability services in Canterbury, in partnership with clinical leaders, stakeholders and our community and in consultation with other DHBs and service providers;
- ***Fund*** the majority of health services provided in Canterbury, through relationship and service contracts with other health and disability service providers;
- ***Provide*** hospital and specialist services primarily for the population of Canterbury but also for people referred from other DHBs where more specialised or higher level services are not available; and
- ***Promote,*** protect and improve our population's health and wellbeing through health promotion, health education and the provision of evidence-based public health initiatives.

In addition to these responsibilities, we are the largest employer in the South Island, with over 8,000 staff employed across our fourteen hospitals and numerous community bases. There are also a similar number of people employed in delivering health and disability services through the rest of the Canterbury health system, funded either directly or indirectly by the Canterbury DHB.

1.1 Organisational Structure

We have an established governance and organisational structure, based on the requirements of the NZPHD Act, through which the DHB functions. Appendix 2 outlines the objectives of a DHB from the NZPHD Act and Appendix 3 provides an organisational chart of the Canterbury DHB.

Governance - the Management of the DHB

The Board assumes the Governance role and is responsible to the Minister of Health for the overall performance and management of the DHB. Its core responsibilities are to set the strategic direction for the DHB and to develop policy that is consistent with Government objectives and improves health outcomes for our population.

The Board also ensures compliance with legal and accountability requirements and maintains relationships with the Minister of Health, Parliament and the Canterbury community. Seven Board members are elected by the Canterbury community and four are appointed by the Minister of Health.

Three statutory (mandatory) advisory committees and three non-statutory committees have been established to assist the Board to meet its responsibilities. The membership of these committees is comprised of a mix of Board members and community representatives who meet regularly throughout the year. It includes both clinical and Māori members who contribute clinical and cultural experience and understanding to decision making. As part of the Canterbury DHB's commitment to shared decision making, front-line staff and clinical leaders also regularly present to the Board and Committees to provide a working perspective and technical advice to members.[1]

While responsibility for the DHB's overall performance rests with the Board, operational and management matters have been delegated to the Chief Executive. The Chief Executive is supported by an Executive Management Team, which includes General Managers of Planning and Funding, Community and Public Health, Finance, Communications, Human Resources and Corporate Services, along with the Executive Director of Māori and Pacific Health, the Chief Medical

[1] *There are currently two Māori members on the Board and three practicing clinical members as well as five clinical members on the Board's Hospital Advisory Committee and four clinical members on the Community and Public Health and Disability Advisory Committee.*

Officer, the Director of Allied Health and the Executive Director of Nursing, who provide cultural and clinical leadership, input into Board and Committee decision making and oversight of patient safety and quality.

Planning and Funding Health and Disability Services

The Planning and Funding Division of the DHB is responsible to the Chief Executive for planning and funding health and disability services in Canterbury and determining how best to invest the funding we receive from Government to meet the health needs of our population.

The core responsibilities of the Planning and Funding Division are:

- Assessing our population's current and future health needs;
- Determining the best mix and range of services to be purchased;
- Building partnerships with service providers, Government agencies and other DHBs;
- Engaging with our stakeholders and community through participatory consultation;
- Leading the development of new service plans and strategies in health priority areas;
- Prioritising and implementing national health and disability policies and strategies in relation to local need;
- Undertaking and managing contractual agreements with service providers; and
- Monitoring, auditing and evaluating service delivery.

Through our Planning and Funding Division, we enter into service agreements or arrangements with the organisations or individuals who can best provide the health and disability services required to meet the needs of our population, achieve the objectives of the DHB and enhance efficiencies across the whole of the health system. This includes an internal service-level agreement with our Hospital and Specialist Services Division and over 1,400 service-level agreements with external providers.

Providing Health and Disability Services

As well as being responsible for planning and funding the health and disability services that will be delivered in Canterbury, we also provide a significant share of those services as the '*owner*' of hospital and specialist services.

These services are provided through our Hospital and Specialist Services Division, which consists of six service divisions: Medical and Surgical Services, Mental Health Services, Rural Health Services, Women's and Children's Services, Older Persons' Health and Rehabilitation Services, and Hospital Support and Laboratory Services. (Refer to Appendix 4 for an overview of the hospital and specialist services provided.)

Our fourteen hospitals are also managed by the Hospital and Specialist Services Division, and while the majority of hospital and specialist services are provided from these hospitals, some specialist services are delivered from community bases or through outreach clinics. A significant proportion of our specialist mental health services are provided in community settings.

Because of the size of the Canterbury DHB, we provide an extensive range of higher level hospital and specialist services. While our responsibility is primarily for the population of Canterbury, many of our services are also provided to people referred from other DHBs where more specialised or higher level services are not available. We are the major tertiary provider in the South Island and have established a formal arrangement with the West Coast DHB for closer clinical collaboration and service provision.

Some of the services we provide on a regional basis include: brain injury rehabilitation; pain management; eating disorder services; child and youth inpatient mental health services; forensic services; fetal medicine; gynaecology oncology services; cervical cytology services; paediatric neurology and respiratory services; endocrine and diabetes services for children; paediatric surgery; neonatal transport and retrieval services; haematology/oncology services, cardiothoracic services, gastroenterology, respiratory medicine, neurosurgery, plastic surgery and ophthalmology services.

We also provide services on a national or semi-national basis, where we are the only provider, or one of only two providers in the country, including endocrinology services, spinal services, paediatric oncology and laboratory services, including providing specialist referral laboratory services for all of the South Island and lower half of the North Island, national Gynaecology Cytology Training and being the national Measles Laboratory and the tertiary hub for Labnet.[2]

[2] *Labnet is an alliance of public sector pathology laboratories who work together to benefit from common systems and economies of scale and currently includes: the Canterbury DHB, Taranaki DHB, Hawkes Bay DHB and Nelson Marlborough DHB.*

Other DHBs who refer people to Canterbury are responsible for meeting the costs of the services provided to their population, referred to as 'inter-district' services or Inter-District Flows (IDFs). Likewise, for those few services that cannot be provided in Canterbury, we have funding arrangements in place enabling Canterbury residents to travel outside the region. We also deliver against service delivery contracts with external funders, such as the Accident Compensation Corporation (ACC). We closely monitor IDFs and ACC volumes to ensure our ability to provide for our own population is not adversely affected by demand from outside the region.

Promoting Community Health and Wellbeing

Good health is also determined by many factors, or social determinants of health, which sit outside of the traditional health system (e.g. education, housing and income). Our partnerships with other agencies – including local and regional councils, Mental Health Commission, Child Youth and Family, Police, Housing NZ, the Ministries of Education and Social Development and ACC – are therefore vital in creating and supporting social and physical environments that prevent illness and reduce the risk of ill health.

Our Community and Public Health Division provides regional public and population health services on behalf of the Canterbury, West Coast and South Canterbury DHBs, and covers the largest geographic area of any public health service in the country. We also share Healthy Eating, Healthy Action (HEHA) resources between Canterbury and the West Coast with joint service development management in place.

Through our Community and Public Health Division and our HEHA contracts we support collaborative ventures and initiatives that focus on the reduction of behavioural and environmental risk factors to reduce long-term conditions and injury. This includes improving nutrition, increasing physical activity and reducing tobacco smoking, alcohol consumption and other risk behaviours. Working collaboratively to provide 'safe' social and physical environments for our younger populations is also a focus, and strategies to reduce inequalities in health outcomes prioritise work in areas of high need, such as education settings, workplaces and Māori and Pacific communities.

Our Community and Public Health Division also delivers population and public health services and supports the development of healthy and safe physical and social environments, with a focus on making 'the healthy choice the easy choice' through healthy housing, smokefree environments and encouraging physical activity. This Division also leads collaboration on safeguarding water quality, biosecurity (protecting people from disease-carrying insects and other pests) and the control of communicable diseases and emergency planning to ensure preparedness for a natural or biological emergency.

1.2 Our Shared Decision Making Approach

While responsibility for the DHB's overall performance, operation and management rests with the Board and Chief Executive, both ensure that their strategic and operational decisions are fully informed, with appropriate support at all levels of the decision making process including the following formal committee structures.

Clinical Governance

A commitment to quality and patient safety places responsibility on the DHB to have effective mechanisms in place for planning, monitoring and managing the quality of clinical care provided. Our Clinical Board is a multidisciplinary clinical forum, whose 26 members represent the primary, secondary and community sectors.

The Clinical Board oversees the DHB's clinical activity, provides advice to the Chief Executive on clinical issues and takes a proactive role in setting clinical policy and standards and encouraging best practice and innovation. Members support and influence the DHB's vision and values and play an important clinical leadership role, leading by example to raise the standard of patient care.

Clinical input into decision making is further facilitated by a model of shared management and clinician leadership at all levels within the DHB. This model is replicated across the whole of the Canterbury health system, with a framework of primary/secondary clinical leadership driving the transformation needed to improve the delivery of health services and to ensure change is sustainable long-term.

Māori Participation in Decision Making

We engage informally at many levels with Māori providers and community groups to facilitate genuine participation in the planning and delivery of health and disability services, particularly as they affect Canterbury's Māori population. The Board also has a formal Memorandum of Understanding with Manawhenua Ki Waitaha (representing the seven Ngāi Tahu Rūnanga*)* as a further step to enhance Māori participation in decision making.

Our Māori Health Plan, approved in 2008, commits us to establishing formal relationships with other Māori representative groups. We continue to explore mechanisms to facilitate these formal relationships and greater participation of Māori at an executive and governance level, as a pathway to shared decision making.

Consumer and Community Input

We also have links with a number of consumer and community reference groups, advisory groups and working parties. Their advice and input assists in developing DHB plans and strategies to improve the delivery of health and disability services and to reduce inequalities in health status within our population.

Our Consumer Council provides input into decision making as a permanent advisory group for the Chief Executive and supports a partnership model that provides a strong and viable voice for the community and consumers in health service planning and service delivery. The Council consists of 15 representatives nominated by consumers and consumer lobby and advocacy groups and networks support each representative in their role and facilitate wider communication across the Canterbury community.

1.3 Clear Prioritisation and Decision Making Principles

Supported by the Clinical Board, Consumer Council and Executive Management Team, we have established a prioritisation framework and a set of prioritisation principles. Based on best practice and consistent with our strategic direction, these principles assist us in making decisions about which competing services or interventions to fund, with the limited resources available.

The prioritisation principles that guide our decision making are:

- ***Effectiveness:*** Services should be effective, producing more of the outcomes desired, such as a reduction in pain, maintenance of daily activity, greater independence and the prevention of premature death.
- ***Equity:*** Services should reduce significant inequalities in the health and independence of our population.
- ***Value for Money:*** Our population should receive the greatest possible value (in terms of effectiveness and equity) from public spending on health and disability services.
- ***Whānau Ora:*** Services should have a positive impact on the holistic health and wellbeing of the person and their family and whānau. This has particular significance for Māori, but relevance for all cultures.
- ***Acceptability:*** Services should be consistent with community values. Consideration will be given as to whether consumers or the community have had involvement in the development of the service.
- ***Ability to Implement:*** Our ability to implement the service is carefully considered, including the impact on the whole system, workforce considerations and any risk and change management requirements.

Because the health sector is continually evolving with changes in health need, clinical practice and technology, the decision to develop or implement new services requires robust review. The prioritisation principles are also applied when we review existing health investments and provide the opportunity to reallocate funding, on the basis of evidence, to services that are more effective in improving health outcomes and reducing inequalities.

We do not see these prioritisation principles as the only criteria in the decision making process; however, starting with a base of analysis against the principles improves the quality of decision making.

In the coming year we will develop new approaches that better support our partnerships and treat the Canterbury health system as one system. At the core of the new approach is a decision making process that makes clear which decisions remain the role of the Government or its agent (the Canterbury DHB), and which decisions should be devolved to clinicians and providers (and ultimately be made at the clinician/patient interface).

In summary, the DHB retains the right to define '*what is to be funded*' and the '*outcomes*' that need to be achieved with public funds. The balancing side of the decision making process is to move as many decisions as possible into the hands of clinicians or providers by devolving the determination of '*how*' the required outcomes should be achieved. Clinicians and providers in the front line of health care provision are in the best position to improve technical efficiency (doing things the right way for the patient) and thereby releasing resources to increase overall productivity across the system.

1.4 Unleashing Our Health System

We believe that to build a clinically and financially sustainable Canterbury Health System we cannot focus on just cutting costs and implementing small line-by-line detailed savings programmes. Instead, we have invested our energy into working together as a whole system to make sure that we do the right thing for the right person in the right place at the right time, using the right workforce and resources.

To achieve this, we have removed the artificial barriers to clinically appropriate patient flow created by traditional organisational structures, funding mechanisms and contracts. We have focused on building capability and capacity through integrated teamwork based on what is best for the patient and what is best for the system as a whole.

The reorientation of our health system around the patient has major implications for service design, professional roles, technology, information management and infrastructure design. Our vision is one health system oriented around a primary point of continuity for the patient. This direction is consistent with international research, evidence and experience. It also meets the clear expectations of the Minister of Health for DHBs to provide '*better, sooner, more convenient health care'* for their populations.

At a Board level, we have focused on allocating resources to the right activity for our populations (*buying the right things*) and releasing our clinical workforce to take a lead in establishing the best way of delivering services (*doing things the right way*). The consequence of our transformational focus has been a significant increase in productivity, as evidenced by our reductions in waiting times, increases in direct care time on wards, increases in virtual activity (such as First Specialist Assessment), increased access to services across the community (such as spirometry, sleep assessments, and skin lesion removals) and $35 million worth of costs avoided through our whole of system approach to delivering more within the same resources.

Figure 1: Canterbury's Vision – One Health System (adapted from The King's Fund UK: www.kingsfund.org.uk)

2. Our Environment – Identifying the Challenges

This section provides background on the environment in which the Canterbury DHB operates. It outlines our population profile, identifies specific health issues for our population and provides a summary of the operating pressures that influence the choices we make.

2.1 Major Drivers: Demographics, Mortality and Risk Factors

2.1.1 Demographics

The Canterbury region is home to 510,915 people, representing 12% of the population of New Zealand and making Canterbury the second largest DHB in terms of population. The need for change is starkly apparent in the future demographic projections for the Canterbury population and the resulting impact of these demographic changes if we do nothing to alter our current approach to health service delivery.[3]

- There has been 10% growth in the total Canterbury population between the 2001 and 2006 Census, and our population is projected to grow a further 15% by 2021.
- Between 2001 and 2006 the total Canterbury population aged over 65 increased by 11%. The proportion of our population aged over 65 is projected to further increase from 13% in 2006 to 18% by 2021. Every day in Canterbury 13 people turn 65.
- The total Canterbury population aged over 85 increased by 21% over the same period, and the proportion of our population aged over 85 is projected to increase from 1.6% to 2.5% by 2021. 5 people turn 85 every day.
- The proportion of our older Māori population is also increasing significantly, and the proportion aged over 65 is projected to grow from 3.3% in 2006 to 6.5% by 2021.
- Our Asian population is proportionally our fastest growing demographic, and we will need to further consider the needs of this population, as well as the needs of other ethnic groups, in future planning;
- 12.5% of the Canterbury population live within more deprived areas, and while this is less than the national population, it is still associated with a number of significant inequalities.
- Much of our total population growth will occur within Christchurch City and the surrounding Waimakariri and Selwyn districts. However, the proportion of the population aged over 65 is higher in rural areas, with 15% of the population in Kaikoura and 16% of the population in Ashburton, aged over 65.

FIG 2: PROJECTED POPULATIONS BY AGE BAND
CDHB POPULATIONS 2010/11 VS 2021

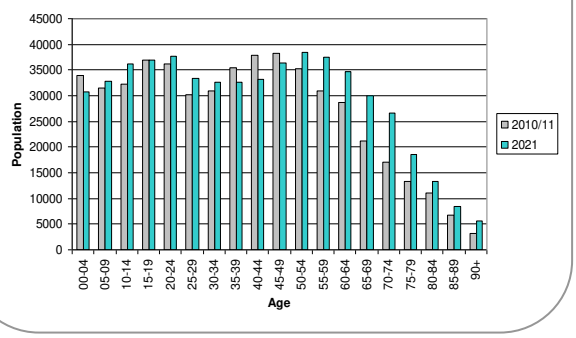
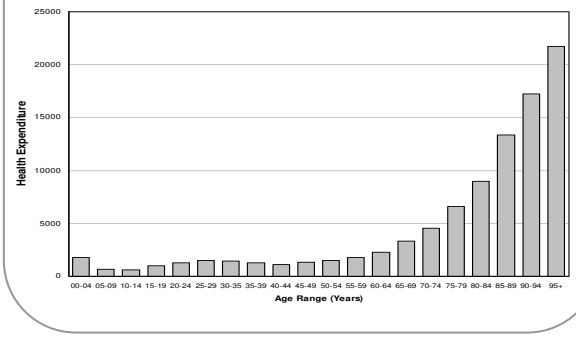


FIG 3: POPULATION HEALTH EXPENDITURE*
MEAN ANNUAL PER CAPITA HEALTH SPEND 2001



These demographics have a number of significant implications for the provision of health care services in Canterbury and across the wider South Island region, particularly the age, ethnicity and economic status of our population.

Age is a strong indicator of the need for health services. As we age we often have more complicated health needs and co-morbidities (multiple health conditions) than people in younger age groups and therefore consume more health resources. This is influenced by growing trends in a number of long-term conditions that become more common with

[3] *Data in this section based on 2001 Census and actual population projections from the 2006 Census information from Statistics NZ.*

** Ministry of Health, 2004. Population Ageing and Health Expenditure: New Zealand 2002-2051. Wellington: Ministry of Health.*

age including: heart disease, stroke, cancers, respiratory disease and dementia. Health expenditure, increases from an annual mean per person of $674 for the 5-9 age group, to $977 for 15-19 year olds, $1,292 for 35-39 year olds, $3,321 for those 65-69, $8,981 for 80-84 year olds and $21,738 for those aged 95+.[4] This is particularly relevant in Canterbury where the demand for services used predominately by our older population groups is growing at an even faster rate than the growth in our population and in rural areas where our populations are older.

Māori are also over-represented in terms of long-term conditions, which they develop at an earlier age than non-Māori. Māori have higher rates of preventable hospital admissions, and with a growing younger Māori population (54% under 25 compared to 34% of our total population), this will place additional demand on our child and youth services. Unless health inequalities are actively addressed, our growing Māori population will add to demand growth.

In Canterbury, socio-economically deprived people are hospitalised with potentially preventable conditions at almost twice the rate of those less deprived. A significantly higher proportion of Māori and Pacific people live in our more deprived areas. This is particularly relevant in that the larger proportions of our Māori and Pacific populations are under 25; therefore, more of our younger populations are living in areas of higher deprivation.

2.1.2 Key Health Trends - Mortality and Morbidity

Approximately 3,481 people die in Canterbury each year, and the top three causes of death are consistent with those at a national level.[5] Diseases of the circulatory system, including ischaemic heart disease and cerebrovascular diseases (e.g. heart attack and stroke), account for the majority of deaths in Canterbury (40%). Cancers are the second most common cause of death (28%), followed by diseases of the respiratory system, which include Chronic Obstructive Pulmonary Disease (COPD). Diabetes is an underlying causative factor in a significant proportion of people dying of circulatory diseases, as well as being the seventh highest cause of death in Canterbury, and therefore contributes significantly to mortality in Canterbury.

Long-term conditions, such as those associated with cardiovascular disease (CVD), cancer, respiratory disease and diabetes, are significantly affected by the age, ethnicity and deprivation of our population.

Hospital discharge rates can be used to estimate the presence or frequency of illness or disease (level of morbidity) within the population, and analysis of this data identifies a strong association between age and the rate of hospital discharge. Discharge rates for CVD and cancers are very low before 45 years of age, after which they increase dramatically, reaching a peak in the over 65 age range. A similar pattern is observed for diseases of the respiratory system, although an additional peak is apparent in the 0-4 age range.

Compared to national averages, our hospital discharge rates are lower for all ages and all conditions.[6] Although encouraging, the morbidity associated with these conditions still presents a significant burden on our health system. Many hospital admissions are considered 'avoidable hospitalisations' that could have been identified and treated earlier, thereby preventing the deterioration that resulted in hospital admission. Examples include angina, respiratory infections, asthma, complications of diabetes and vaccine-preventable diseases.

2.1.3 Health Behaviours and Risk Factors

While the negative health outcomes associated with poor health behaviours and risk factors represent a significant burden on the health system, they also present an opportunity to significantly improve the health and wellbeing of our population and to reduce health expenditure and the demand for more complex care. Social and economic factors, such as education, housing, and income, are now widely accepted as contributing greatly to a person's health. These determinants of health form the environment within which our population's health can be improved and health outcomes can be achieved.

Health behaviours and risk factors, such as a sedentary lifestyle, obesity, poor nutrition, hazardous drinking and tobacco smoking, are known to be significant contributors to poor health outcomes. Compared to the national average, Cantabrians have lower obesity levels, eat more fruit and vegetables and are less likely to be regular smokers. Despite this, we exercise slightly less regularly than the national average and almost a quarter of our population over the age of 15 are obese, with a body mass index (BMI) of 30.0 kg/m2 or more.[7]

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[4] ** Figures from 2001 year - Population Ageing and Health Expenditure: New Zealand 2002-2051. Wellington: Ministry of Health 2004.*

[5] *The data in this section is from Mortality Demographic Data 2006 NZ Health Information Service, 2009.*

[6] *The exception is neoplasms (cancers) in the 5-14 age range, where Canterbury rate is slightly higher than the national average.*

[7] *Obesity in New Zealand: How obesity is measured, Ministry of Health, 2009.*

Child and adolescent obesity has increased dramatically over recent years and is associated with several important chronic diseases such as diabetes, asthma and sleep apnoea, as well as social discrimination, poor self esteem and depression. More than 5,700 children in Canterbury were classified as obese in 2007/08.[8]

When it comes to alcohol, our population is as likely as other New Zealanders to drink in a hazardous manner (21% of both populations). However, this corresponds to over 103,000 people in Canterbury, constituting a major public health concern. Hazardous drinking has a wide range of adverse effects on health, including cirrhosis of the liver, pancreatitis, high blood pressure, haemorrhagic stroke, and a range of cancers. It also contributes to death and injury on the roads, suicide, assaults and domestic violence and some mental health disorders and sexual health problems. If consumed in a hazardous manner during pregnancy, alcohol can also lead to birth defects in infants, including foetal alcohol syndrome.

It is tobacco smoking however, that is the single most preventable cause of death. It is a major risk factor for cancer, cardiovascular disease (CVD), diabetes and respiratory disease. Tobacco also disproportionately impacts on Māori and Pacific people, and is seen as a substantial contributor to socio-economically based inequalities in health. Despite the prevalence of smoking amongst our population (18.3%) being lower than the national prevalence (19.9%), over 71,500 people in Canterbury were regular smokers in 2006.[9]

2.2 Operating Pressures

2.2.1 Demand Growth

As our population grows and the burden of long-term (chronic) conditions increases, so too does the demand for health services. Currently, demand for many of our services is growing at a faster rate than the growth in our population, particularly for those services used by our older population groups. Any increase in demand requires an increase in capacity, in terms of both infrastructure and workforce. Innovative solutions to address demand and make the best use of current resources have allowed us to increase capacity across most of our services. However, this demand growth is steady and significant, and the current economic climate dictates that new health dollars are limited.

In 2006/07, there were 95,946 inpatient and day case discharges from Canterbury DHB hospitals and 628,352 outpatient attendances. By the end of 2008/09, the corresponding number of discharges had increased to 101,074 and the number of attendances to 664,900. Not only do we need extra medical and surgical beds for those patients, but also the associated staffing and consumables. Assuming that we do nothing to change service delivery models, population forecasts indicate a 22% increase in medical and surgical demand by 2021.

Inpatient discharges for acute (urgent/emergency) services in Canterbury have also increased; 9% over the last four years. Acute demand is an area particularly driven by demographic changes and by the increase in long-term conditions and is reflected in increased demand in our Emergency Department (ED). Per head of population we have the third lowest ED presentations in the country, partially due to our general practice-run 24 hour services (including the 24 Hour Surgery which sees over 74,000 people every year). However, ED attendances have still increased 11% in the past four years. 79,317 people presented at the Christchurch Hospital ED last year and 64,885 in the first nine months of 2009/10.

Because acute services often take priority and use the same resources as elective (planned) services, any increase in acute demand puts at risk our ability to deliver elective services to our population. We delivered 1,740 additional elective services discharges in 2008/09, increasing from 11,500 in 2007/08 to 13,240. Nine months in to 2009/10, we have delivered 11,282 - well on track to deliver 14,369 discharges, a 1,129 increase on last year.[10] Our ability to continue to increase our electives delivery is of particular relevance, as we need to achieve compliance with national electives indicators and the national health target in order to maintain access to a number of significant funding streams that enable us to direct funding into other priority areas.

Population growth, the increasing burden of long-term conditions and the changing demographics of our population place similar demand pressures on primary and community services. Canterbury residents visit their General Practitioner (GP) on average 2.5 times a year, with people attending more regularly as they get older. Assuming current attendance patterns and models of care, we will need 20% more GPs by 2021 to meet the demands of population growth.

Demand pressure is also evident in the aged residential care sector. Compared to other DHBs, we already have the fifth highest utilisation of aged residential care services and a higher than national average utilisation of home-based support services (age-standardised per capita). In 2008/09, 8% of people over 65 received a residential care subsidy in

[8] *Obesity: Genetic, molecular and environmental aspects, Barness LA, Opitz JM, Gilbert-Barness E – A J of Med, Genet Part A 143A:3016-3034.*

[9] *Public Health Information Online, www.phionline.moh.govt.nz. (392005(15+ pop)*18.3%)*

[10] *These elective surgical discharges are aligned to the national health target definition and exclude elective cardiology and dental procedures.*

Canterbury (for rest home, long-stay hospital or dementia care). If we don't change current admission practices, future forecasts indicate that we will need to fund and staff an additional 2,000 residential care beds in Canterbury by 2021.[11]

This increased demand growth is spread across all of our service areas. Innovative solutions to address demand and make the best use of current resources have allowed us to increase capacity. However, as the following table demonstrates, this demand growth is steady and significant.

Volume Growth of Key Canterbury DHB Services – at all Canterbury DHB sites [12]

	2005/06	*2006/07*	*2007/08*	*2008/09*	*4 year variance*
New Out Patient Attendances	127,039	131,895	140,119	144,287	*14%*
Follow-up Out Patient Attendances	459,591	455,244	456,308	465,631	*1%*
Total Outpatient Attendances	617,513	628,352	650,364	664,900	*8%*
Day Case Discharges	27,894	32,412	31,267	34,566	*24%*
Inpatient Discharges Elective	8,404	8,600	8,888	9,061	*8%*
Inpatient Discharges Acute	52,903	54,934	55,682	57,447	*9%*
Main Theatre Visits	21,779	23,630	25,044	26,855	*23%*
Total Surgery Time minutes	1,312,710	1,415,050	1,493,721	1,586,712	*21%*
ED Attendances	71,278	71,946	73,691	79,317	*11%*
24 Hour Surgery Attendances	66,770	70,482	71,156	69,011	*3%*
GP Consults	1,116,122	1,200,298	1,227,925	1,229,962	*10%*

Demand for Regional Services

These local pressures are further intensified by the growing demand for the extensive range of specialist services that Canterbury provides on a regional basis. We currently provide a significant share of tertiary services in the South Island and a significant volume of higher level secondary care services.

Our ability to provide highly specialised and complex services to a growing number of people (and to intervene successfully at older ages) is a significant driver of this regional demand which will continue to grow in the future. This regional reliance and the viability of services in neighbouring DHBs are a risk for us. In the event of a service failure in another DHB, more people will be referred into our services. This will impact dramatically on our ability to provide for our own population. Coupled with local demand growth, our role as a regional provider of last resort is simply not sustainable.

Vulnerable service risks are being managed through active engagement with neighbouring DHBs, regional clinical health services planning and through sector-wide negotiations around IDF pricing. In the coming year formal arrangements will need to be put in place to carefully manage regional demand to ensure services are available for the wider South Island population while avoiding adverse effects on service delivery for our local population.

2.2.2 Workforce Pressures

Our ability to meet demand for services is also heavily reliant on having the right people, with the right skills, in the right place. As the greater proportion of our population reaches traditional retirement age, it presents us with concerns over the availability of sufficient workforce capacity to continue to meet predicted increases in demand for services. The impact of demographic changes is more significant in rural areas, where isolation makes recruitment more difficult and where the average age of our workforce is higher.

Pressures will have the greatest effect on clinical working models, as clinical staff make up 80% of our total workforce.

- The average age of our workforce is 44.7 years, slightly higher than the all-DHB average of 44.4 years.
- 10% of our workforce is over 60, compared to 7% three years ago, so our workforce is ageing rapidly.
- Workforce age is a more immediate challenge in rural areas, where the average age is 50.5 years and it is often difficult to attract people to more rural locations.

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[11] *Age Related Residential Care services are provided to individuals, usually over the age of 65, who have been assessed as being unable to care for themselves at home. It includes four levels of care: rest home, hospital, dementia (secure) resthome and psychogeriatric care and does not include services provided by retirement villages under license to occupy arrangements.*

[12] *Source: CDHB Measures Cube February 2010 – including SAP data, therefore all CDHB activity including ACC, SMH and OPH.*

- 40% of all our employees work in a permanent part-time capacity. Nursing staff make up 48% of all permanent part-time employees. This trend to part-time work is likely to increase as more of our workforce reaches traditional retirement age.
- Females are also more likely to work part-time than males, and 81% of our workforce is female, with 57% of all permanent female employees working in a part-time capacity.

This is a significant issue for the whole of the health sector. National and international competition for scarce workforce resources in some clinical specialties and nursing areas, coupled with a decreasing working age population, makes it increasingly difficult to recruit and retain health professionals. To address this, we are taking a strategic approach to planning and sourcing workforce across the whole of our health system.

We are fortunate that our staff turnover rates are relatively low; the average time spent in Canterbury DHB services is 9.2 years, compared to an average of 7.3 years across all DHBs. We will continue to strive to provide a rewarding and positive environment that supports the retention of our workforce, and to identify areas of improvement. However, as demand increases, workforce predictions emphasise the sense of urgency in transforming the way we work and developing alternative models of care to ensure we can continue to provide quality patient care in the future. If we do not address workforce challenges, we will simply not have enough clinical staff to provide services to our population.[13]

2.2.3 Fiscal Pressures

Sitting alongside the increased demand for services and our workforce challenges, are the fiscal pressures facing the health sector. Over the past ten years, an increasing share of national expenditure has been going into health. Government has given clear signals that it is looking to DHBs, and the whole of the health system, to rethink how we deliver improved health outcomes in more cost effective ways; while managing within a more moderate growth platform now and through the medium-to-long term.

Numerous factors contribute to the fiscal pressure on DHBs: the costs of meeting wage and salary increases; the demand for diagnostics, laboratory services and residential care services; rising prices of treatment-related costs such as pharmaceuticals, clinical supplies and new technology; and increased expectations from the Ministry of Health, our clinical staff and our community, particularly around the availability of new and more technically advanced (but more expensive) treatments.

We are already committed to a number of mechanisms and strategies to minimise cost growth and achieve financial sustainability. These include lean thinking processes, clinically led service transformations and regional collaboration with other DHBs to share resources and reduce waste and duplication. We also maintain a close focus on wage negotiations and employee management, given that salary and wage costs make up a major share of our total budget. However, many of these costs are growing faster than our funding levels. In several areas we spend relatively more than other DHBs, such as pharmaceuticals and aged residential care services. Our current levels of expenditure and delivery are not sustainable.

Over the next year, we will take a significant step in our commitment to our collaborative way of working and embrace a new decision making approach to service design and delivery across the Canterbury health system. Our new approach will engage all relevant clinical professional and provider groups in prioritisation and service management decision making. This is the logical consequence of cooperating in the development of patient pathways and working collectively to manage clinical and financial risk, and will create a number of opportunities to improve health outcomes and make technical efficiencies across the system.

[13] *Local DHB figures come from our Workforce Profile Report, as at 31 March 2008, with national figures from the DHBNZ Future Workforce Health Workforce Information Base Data Report as at June 2008.*

3. Our Strategic Objectives and Priorities – Meeting the Challenges

Our local direction and objectives were established through a health needs assessment and public prioritisation process undertaken to develop our District Strategic Plan in 2005/06 and have been built on by recent health services planning and visioning work which considered the transformation required to meet the needs of our population by 2020.

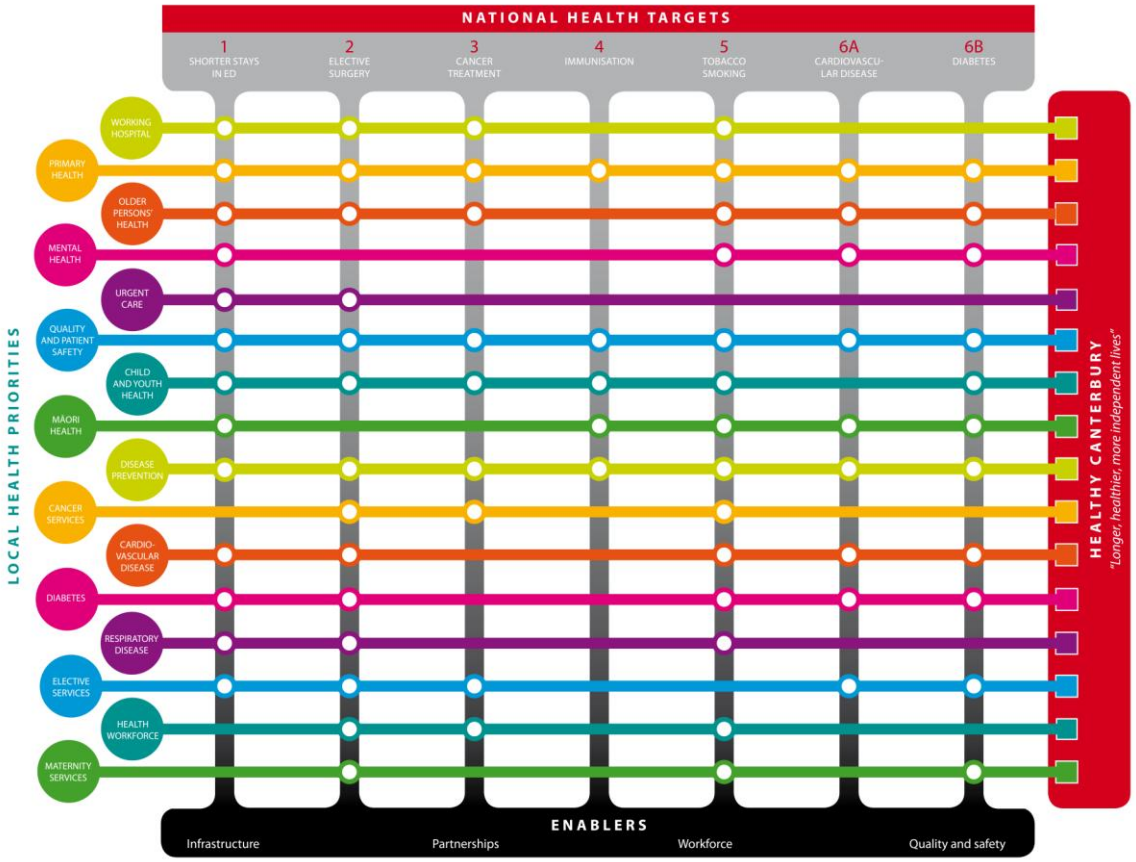
3.2 Canterbury DHB Health Gain Priorities

We will continue to be guided by our District Strategic Plan (adopted in 2006) and will pursue the overarching priorities and objective outlined in this Plan in order to meet the local needs of our population. The Strategic Plan sets out nine priority areas for improving health and reducing inequalities in Canterbury: Older Persons' Health, Child and Youth Health, Māori Health, Primary Care, Disease Prevention and the Management of Chronic Conditions, Cancer, Cardiovascular Disease, Diabetes and Respiratory Disease.

In line with the direction agreed in our District Strategic Plan we are focused on improving health outcomes for our population, reducing inequalities in health status and improving the delivery and effectiveness of services. Added to this is the imperative that any initiatives or programmes developed will enable the Canterbury health system to build the foundations essential to drive transformational change and improvements in our challenging environment.

Coupling local priorities with current national expectations, we have identified several for particular focus in 2010/11; areas we believe will provide us with the best opportunity to improve service delivery and health outcomes and to meet the immediate challenges we face in terms of increasing demand, cost pressures and Government expectations. These are: Making Our Hospitals Work, the Delivery of *Better, Sooner, More Convenient* Primary Care, Older Persons' Health Services, Mental Health Services, Urgent Care and Quality and Patient Safety. We have also identified three areas of additional focus to address specific Ministerial priorities: Elective Services Delivery, Workforce and Maternity Services.

Our strategic vision and our chosen priorities for 2010/11 fit well with the current national direction. The following diagram demonstrates the significant cross-over of local and national priorities and the alignment of our direction with achievement of the national health targets and the expectations of the Minister of Health.



3.3 Our Longer Term Vision

The Canterbury DHB acknowledged the challenge ahead and undertook a Health Services Planning programme to identifying the challenges and, through an extensive participatory engagement process with key stakeholders and consumers from across the Canterbury health system, agreed a consensus as to the way forward.

The focus is on the re-orientation of the health system around the needs of the person and working across traditional boundaries to achieve the best possible health outcomes. This focus on the patient and their journey is having major implications on service design, professional roles, technology, information management and infrastructure design.

We have already made significant changes to our models of care, the range and type of services provided and the location at which services are provided and are implementing three key strategic service shifts in line with our future direction:

- The development of services that support people to take increased responsibility for their health and a change of approach within existing services to support this;
- The development of primary and community services to support people in a community-based setting and to provide a point of ongoing continuity; and
- The freeing up of secondary care services and specialist resources to be responsive to episodic events, the growing complexity of cases and the provision of support and advice to primary care.

The implication is that in order to meet the future demand and the needs of our growing population, the health system will be oriented around a primary point of continuity for the patient, most likely based in the community with general practice. The predominant focus of hospitals and specialist services will be to provide an episodic responsive point of intervention or advice as part of a person's wider journey through the system.

To support primary and community services to safely provide more appropriate support to individuals and their families in community settings, we are enabling rapid diagnosis by enhancing general practice access to diagnostics, simplifying the transfer of care between settings, improving discharge planning and providing access to specialist advice without the need for a hospital appointment.

Population growth is increasing the demand for secondary care services, and as our population gets older, people are presenting with more complex health issues that require a higher level of intervention. By supporting the provision of less complex services in primary and community settings (through improving access to expert advice, diagnosis and treatment), we are freeing up our secondary care capacity to cope with growing and increasingly complex demand.

In achieving this service transformation, we are breaking down the traditional boundaries between providers, types of care and service delivery models. In the Canterbury context, these changes are being clinically led, supported by collaborative partnerships between the DHB and other provider organisations and health professionals.

This shift of less complex services out of hospital-based settings is a direction that is consistent with international research, evidence and experience. It also meets the clear expectations of the Minister of Health for DHBs to provide '*better, sooner, more convenient health care*' for their populations.

3.4 Our Model of Care

To supplement the agreed direction established during our health services planning process, we have developed a generic population model of care to ensure a consistent approach to understanding the full range of health needs over a person's lifetime and to redesign health care services accordingly.

This model is based on similar national and international approaches and supports a united health system, focused around patient services and quality clinical outcomes. The model does not represent a health plan for individual people, but a simplified way of co-ordinating all the different parts of the health system so that we get the best results from the resources available. We have a clear focus on provision of care over a person's lifetime, aiming to reduce the burden of long-term conditions as our population ages.

The model identifies a range of services (health promotion, protection and disease prevention, early intervention, management, complex treatment and support) that will be delivered by any number of providers on an individual or population-wide basis. It supports a flexible approach and can be applied to a specific group of people, a particular disease or condition or a type of service, and explicitly acknowledges the roles of other organisations, groups and individuals who have a key part to play in helping our population stay healthy.

Because the model is based on the patient journey, it is inherently more robust and sustainable longer-term. It is not reliant on any particular provider or organisation, but is centred on the patient's needs and what works for them.

Focusing on the person's journey, we start with health promotion and prevention and ask a series of questions:

- What do we need to do to keep people well in the community?
- What do we need to do to ensure early detection and early intervention?
- What do we need to do to better manage people in the community to avoid unnecessary hospital admissions and improve their quality of life?
- What do we need to do to ensure that when people do require specific interventions, such as hospital care, specialist advice or access to diagnostics, they are available in the right place, at the right time and are provided by the right people?
- What do we need to do to provide appropriate and restorative support services so that people can quickly return to their normal lifestyles and avoid further complications?
- What do we need to do to respect people dying with dignity, to listen to and meet their needs?

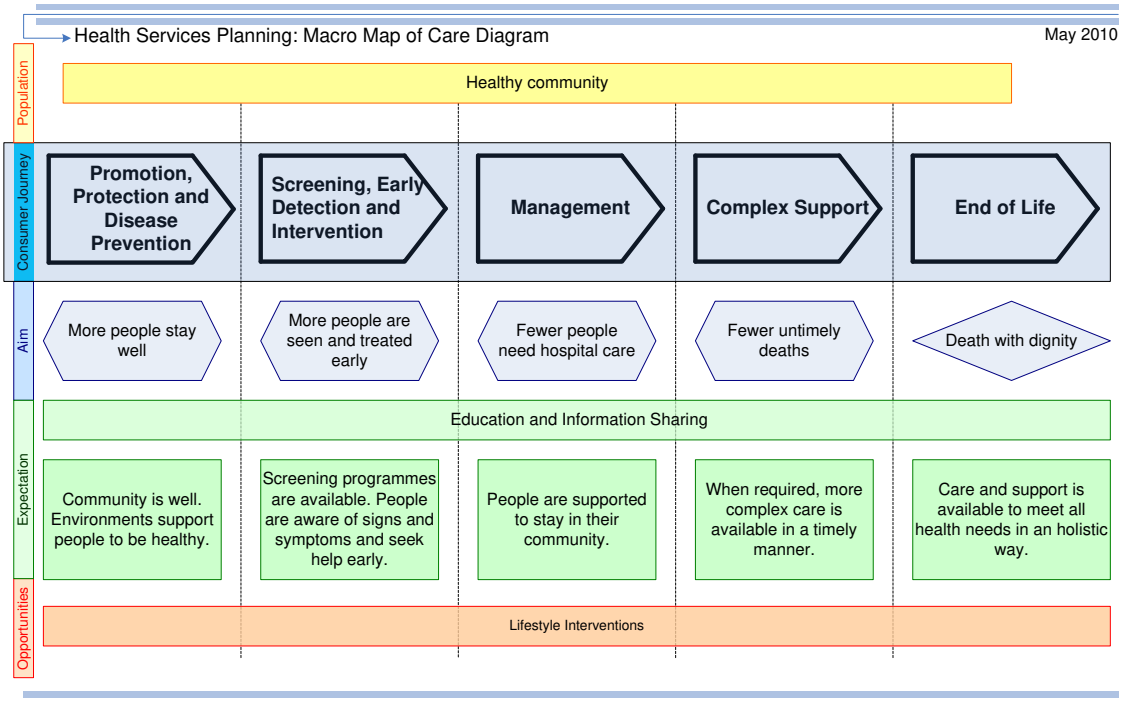


Figure 4: Canterbury DHB Population Model of Care

3.4 Bringing It All Together

Over the next few years we will continue to make the transformations needed to ensure we can meet the needs of our population and support an improved journey through the health system. The drivers for change, strategic service shifts and the model of care all suggest reorientation of the system to support a more patient-centred approach.

The following diagram illustrates groupings of our population getting progressively smaller in number as more intensive services are required. The upper left groupings represent the whole population in a given time period, including those who are healthy. The next layer represents those who have some health issues but tend to provide care for themselves, occasionally supported by health professionals. The next grouping is those who seek assistance from GPs, nurses and other primary and community providers to manage their health, while those who require more complex or hospital and specialist services are represented by the final bottom right grouping.

The diagram illustrates that only a small proportion of those who seek care require care at the more complex level. The size of the people also illustrates the relative cost of the treatment at those levels.

The smaller red arrow represents forces such as recent trends towards increased specialisation or over-reliance of people on professional help rather than self care. Our future direction and the strategic outcomes that we seek are represented by the larger blue arrow which runs counter to this with the aim of moving care (where appropriate):

- Away from complex and hospital and specialist level intervention to primary and community care through improved management of long-term conditions;
- Away from primary and community care to self care by empowering people to recognise symptoms and seek intervention early; and
- Towards having no-care requirements through improved individual and population-based prevention, such as health promotion, health protection, a reduction in risk factors and supportive environments that encourage healthier lifestyles.

We will achieve these strategic outcome goals through a focus on improving the patient journey through the system and implementing our model of care approach. We will focus activity in the coming year on the priority areas identified in our District Annual Plan and the priorities and expectations of the Minister and Ministry of Health.

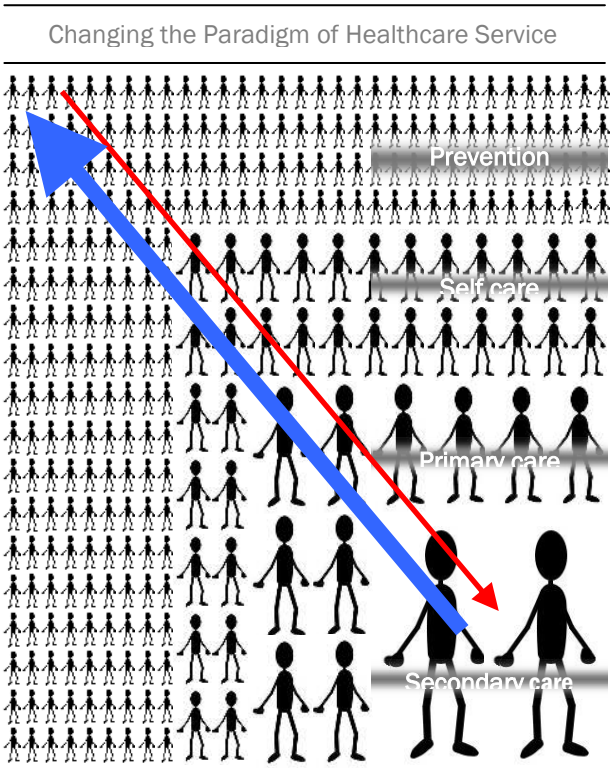


Figure 5: Outcomes We Seek – A Changing Paradigm of Healthcare Service Provision

4. Improving Outcomes for Our Population – What are we trying to Achieve?

This section presents an overview of how what we do and whom we influence creates positive change in health outcomes for our population. Our work improves the availability (access and equity) of services, as well as improving service quality and the timeliness of service delivery and enables people to make healthier choices and enhance the quality of their lives.

In line with the functions and responsibilities of a DHB, our vision is to improve, promote and protect the health and wellbeing of our population. In achieving our vision, we will deliver on the Ministry of Health's vision: *"All New Zealanders lead longer, healthier and more independent lives*".

The generic model of care we have developed is based on taking a consistent approach to delivering a full range of health services to meet our population's health needs over their lifetime. In achieving our vision, we are making three substantial and associated shifts in the way we work, and we aim to achieve three strategic goals in alignment with our planned service transformation.[14]

- The development of services that support people/whānau to take increased responsibility for their health, and a change of approach within existing services to reflect this.

  Strategic Goal 1: People take more responsibility for their health.

- The development of primary and community services to support people/whānau in a community-based setting and to provide a point of ongoing continuity in their health care.

  Strategic Goal 2: People are supported to stay well in their community.

- The freeing up of secondary care services and specialist resources to be responsive to episodic events, the growing complexity of cases and the provision of support and advice to primary and community services.

  Strategic Goal 3: People receive timely and appropriate complex care.

Sitting under these strategic goals, we have identified seven associated outcomes, by which we will measure our achievement. These outcome measures are long-term (5-10 years in the life of the health system) and as such, we are aiming for a measureable improvement over time rather than a fixed target. Over the medium-term, in our Forecast Statement of Service Performance, we have identified a set of related 'headline' impact measures for each output class and have set 3-year targets to measure the impact we are making over time.

The diagram on the following page shows the value chain of how the outputs we deliver (what we do) have an impact on the health our population and result in achievement of the long-term outcomes and priorities of the DHB and our Government.

[14] *These Strategic Goals are numbered for the purposes of this document only and the numbers have no other relevance.*

Government Goals	**All New Zealanders lead longer, healthier and more independent lives.**	
	Service delivery is better, sooner, more convenient.	The health system is adaptive, innovative, continually improving.

⇧ ⇧ ⇧

Canterbury DHB Strategic Goals	**Improve, Promote and Protect the Health and Wellbeing of the Canterbury Community**		
	People take greater responsibility for their health.	People are supported to stay well in their community.	People receive timely and appropriate complex care.

⇧ ⇧ ⇧

Outcomes	Reduced Smoking Rates.	Reduced Obesity Rates.	Fewer avoidable presentations to Emergency Departments.	Fewer acute admissions to hospital.	More people live well and in their own homes.	Fewer unplanned readmissions to hospital.	Improved clinical care and patient safety.

⇧ ⇧ ⇧

Output Classes	**Child and Youth Health Services**			**Adult Health Services**			**Older Person's Health Services**		
Impacts	Young people never smoke.	Children have good oral health.	Fewer avoidable hospital admissions	People have healthier diets.	People self manage long-term conditions.	People received prompt acute care in ED.	Fewer acute admissions to hospital.	Older people are supported in their community.	Fewer adverse events in hospital.
Outputs	Health Promotion, Protection and Disease Prevention Services		Screening, Early Detection and Intervention Services		Conditions Management Services		Complex Support Services		End of Life Services

⇧ ⇧ ⇧

Strategic Capability	Partnerships	Workforce	Quality and Patient Safety	Infrastructure

Strategic Goal 1. People Take Greater Responsibility For Their Health.

Expectation

Our population is well, with fewer chronic conditions. Our physical and social environment enables people to take more responsibility for their own health through improved education and support for self-modifying lifestyles and reducing risk behaviours. Screening programmes ensure people are aware of the signs and symptoms of ill health and seek help early.

Why is this Goal a Priority?

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and respiratory disease, which are major causes of poor health and morbidity and account for a significant number of presentations in primary care and admissions to hospital and specialist services. With an ageing population, the burden of long-term conditions will increase. The World Health Organisation (WHO) estimated that more than 70% of health care funds are being spent on long-term conditions.

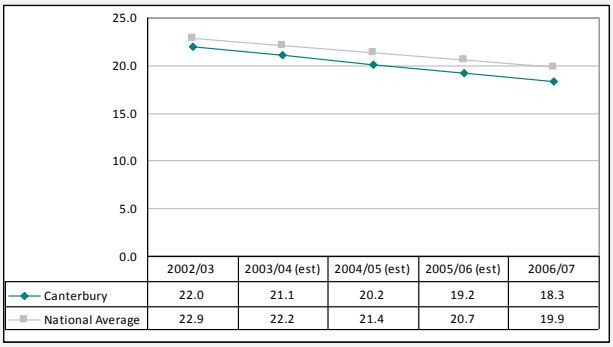
Supporting people to reduce their risk factors and to make healthy choices can make a real difference in enabling people to attain the highest possible quality of life and to avoid, delay or reduce the impact of long-term conditions. Tobacco smoking, inactivity, poor nutrition and rising obesity rates are major and common contributors to a number of the most prevalent long-term conditions in Canterbury and are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing.

Associated Outcome Measures - We will know we are succeeding when there is:[15]

A reduction in smoking rates for the Canterbury population.

- *Tobacco smoking kills an estimated 5,000 people in New Zealand every year, including deaths due to second-hand smoke exposure. Smoking is also a major contributor to preventable illness and long-term conditions. It is a major cause of lung and a variety of other cancers, as well as chronic obstructive pulmonary disease, heart disease and strokes.*
- *In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, resulting in less money being available for necessities such as nutrition, education and health. Supporting our population to say no to tobacco smoking is our foremost opportunity to target improvements in the health of populations with high need and to improve Māori health.*

Long-term Outcome Measure: The proportion of the Canterbury population who smoke (15 years+).

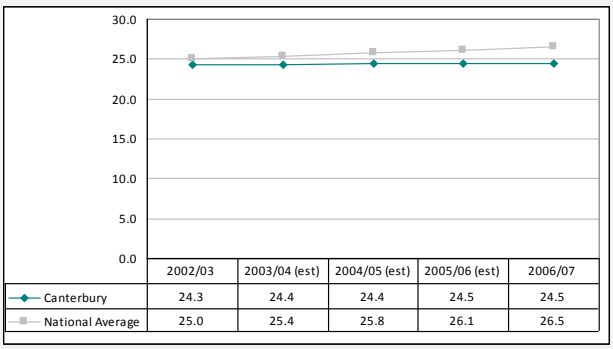


	2002/03	2003/04 (est)	2004/05 (est)	2005/06 (est)	2006/07
Canterbury	22.0	21.1	20.2	19.2	18.3
National Average	22.9	22.2	21.4	20.7	19.9

A reduction in obesity rates for the Canterbury population.[16]

- *Current trends indicate that by 2011, 29% of New Zealand's adult population will be obese. This has significant implications for rates of cardiovascular disease, diabetes, respiratory disease and some cancers, as well as poor psychosocial outcomes and reduced life expectancy.*
- *Supporting our population to maintain healthier body weight through improved nutrition and physical activity levels is fundamental to improving the health and wellbeing of our population and to the prevention of chronic conditions and disability at all ages.*

Long-term Outcome Measure: The proportion of the Canterbury population who are obese (15 years+).



	2002/03	2003/04 (est)	2004/05 (est)	2005/06 (est)	2006/07
Canterbury	24.3	24.4	24.4	24.5	24.5
National Average	25.0	25.4	25.8	26.1	26.5

[15] *The data for these two outcome measures comes from the national NZ Health Survey collected by the Ministry of Health every three years. The survey was undertaken in 2003/04 and 2006/07. Results from the 2009/10 survey are expected to be available in 2010/11.*

[16] *Obese is defined as having a Body Mass Index (BMI) of >30.0 or >32.0 for Māori or Pacific people.*

Strategic Goal 2. **People Are Supported to Stay Well in their Community.**

Expectation

People are supported to stay well and to remain in their own homes and communities, and fewer people need hospital level intervention. Primary and community services support people to recognise signs and symptoms and to seek help early and to better manage their illness or long-term conditions by providing a point of ongoing continuity.

Why is this Goal a Priority?

Canterbury is experiencing a growth in demand for acute (emergency or urgent) services that is faster than the growth in our population. There will be over 80,000 presentations at the Christchurch Hospital ED this year, with an equivalent number at Christchurch's 24 hour general practice service. Population growth and the increasing age of our population are driving much of this increased demand, along with demand for Aged Residential Care (ARC) services. We have the fifth highest age-standardised per-capita utilisation of ARC services and a higher than national average utilisation of home support services.

For most people, their GP is their first point of contact with health services. Primary care can deliver services faster and closer to home. It is also one of the most effective ways to prevent disease through early detection and screening, as well as through encouraging people to take responsibility for their own health. Primary care is also vital for the effective coordination of care across the continuum of care and for improving the management of care for people with long-term conditions.

A range of health professionals including midwives, community nurses, social workers, aged residential care providers, Maori health providers and pharmacists currently work in the community, often with the neediest families. These providers deliver services with positive benefits to those receiving them and have a prevention, early intervention perspective that links people with other services and community agencies and improves the management of long-term conditions.

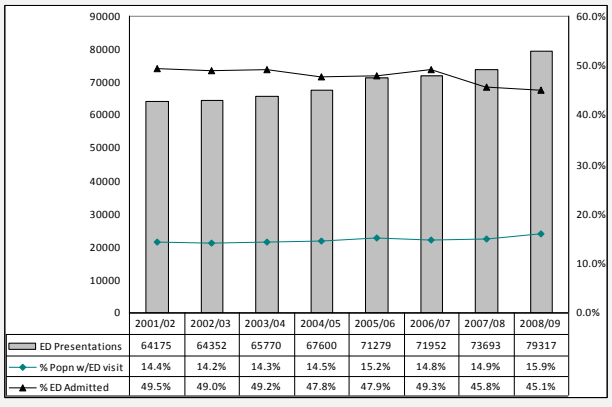
Studies show that countries with strong primary care systems have lower rates of death from heart disease, cancer and stroke and that they achieve better health outcomes for lower cost than those that focus on specialist or tertiary level care. Our ageing population will not only require strong primary care systems, but strong support services delivered in the community, including residential care, respite and responsive short-term and home-based support. If long-term conditions are managed effectively, we can prevent crises and deterioration and improve health outcomes. Providing flexible, responsive and needs-based care in the community will reduce the rate of hospital admissions, particularly acute and unplanned admissions, and will free up health resources, allowing them to be directed to other priority areas

Associated Outcome - We will know we are succeeding when there is:

A reduction in 'avoidable' presentation to hospital Emergency Departments (EDs).

- *Supporting people to manage their long-term conditions and seek appropriate intervention early will result in a reduction in the proportion of the population seeking urgent care or requiring acute admission to hospital.*
- *With increasing population growth, the number of people presenting to ED is increasing year on year - reducing current acute demand growth will be a challenge. Our first focus is on reducing the number of people presenting in lower triage levels (particularly 'self' and 'ambulance' referrals) who do not need hospital or specialist level intervention and could be better managed in more appropriate locations such as general practice.*
- *Improving access to alternative pathways of care will ensure people are being given the right treatment in the right place; improving health outcomes, reducing pressure on hospital resources and enabling investment in other priority areas.*

Long-Term Outcome Measure – The percentage of the population presenting at ED and the percentage who are admitted.



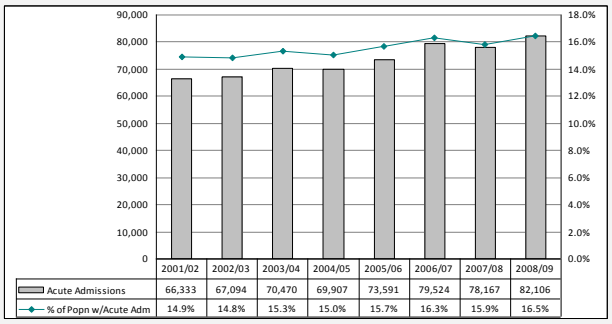
	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
ED Presentations	64175	64352	65770	67600	71279	71952	73693	79317
% Popn w/ED visit	14.4%	14.2%	14.3%	14.5%	15.2%	14.8%	14.9%	15.9%
% ED Admitted	49.5%	49.0%	49.2%	47.8%	47.9%	49.3%	45.8%	45.1%

Associated Outcome - We will know we are succeeding when there is:

A reduction in acute admissions to hospital for complications of long-term conditions.

- *The impact of long-term conditions in terms of quality of life and cost to the health system is significant. Early diagnosis and intervention and improved disease management provide major opportunities for improving health outcomes; particularly for Māori and Pacific people, who have disproportionately higher rates of many long-term conditions.*
- *Improving the management of long-term conditions will reduce acute admissions to hospital and specialist services and will enable the DHB to redirect resources and avoided costs into more effective prevention and early intervention services.*

Long-term Outcome Measure – The percentage of the population being admitted acutely to hospital.

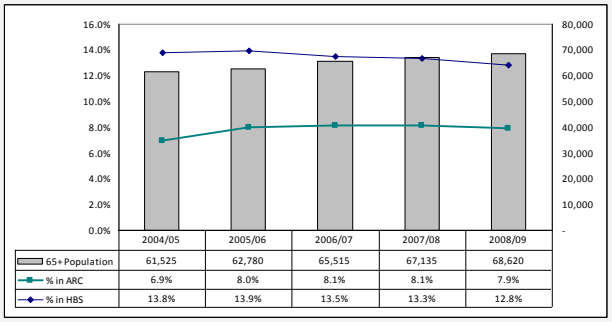


	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
Acute Admissions	66,333	67,094	70,470	69,907	73,591	79,524	78,167	82,106
% of Popn w/Acute Adm	14.9%	14.8%	15.3%	15.0%	15.7%	16.3%	15.9%	16.5%

An increase in the proportion of the population over 65 years supported to live well, in their own homes.

- *While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, Canterbury rates are above national averages. When people receive the adequate support for their needs to be managed, remaining in their own homes is considered to provide a much higher quality of life, as a result of staying active and positively connected to their communities.*
- *Living in ARC facilities can be associated with a more rapid functional decline than 'ageing in place'. It is also a more expensive option, and resources could be better spent providing appropriate levels of support to people in their own homes. The aim is to support older people to stay at home as long as possible rather than entering ARC facilities.*

Long-term Outcome Measure – The percentage of the population 65+ living in ARC and those receiving Home Based Support Services.



	2004/05	2005/06	2006/07	2007/08	2008/09
65+ Population	61,525	62,780	65,515	67,135	68,620
% in ARC	6.9%	8.0%	8.1%	8.1%	7.9%
% in HBS	13.8%	13.9%	13.5%	13.3%	12.8%

Strategic Goal 3. **People Receive Timely and Appropriate Complex Care.**

Expectation

Quality complex services are available in a timely manner. Secondary level hospital and specialist services meet people's complex and end of life health needs in a holistic way, are responsive to episodic events and support the provision of quality community-based care to reduced untimely deaths and improve health outcomes.

Why is this Goal a Priority?

Timely access to quality treatment improves health outcomes, and shorter waiting lists and wait times are indicative of a system matching capacity with demand, managing the flow of patients through its services and addressing the needs of its population.

Our Government is concerned that patients wait too long for hospital diagnostic tests, for cancer treatment and for elective surgery. The expectation around reducing waiting times, coupled with the current fiscal situation, means we need to develop innovative ways of assisting more people with limited resources.

This Strategic Outcome reflects the importance of ensuring that hospital and specialist services are sustainable and the DHB has the capacity to provide for the complex needs of our population now and into the future. Typically, an organisation's capacity is considered to be the means through which an outcome is achieved and not an outcome itself. However, as the major provider of tertiary level hospital and specialist services in the South Island, working within tight fiscal constraints and operating under increasing demand and workforce pressures, we have included the provision of timely and appropriate complex care as a Strategic Outcome.

Associated Outcome - We will know we are succeeding when there is:

A reduction in the rate of unplanned acute readmissions to hospital. ▪ *Unplanned acute readmission rates are a well-established measure of quality of care, efficiency and appropriateness of discharge for hospital patients. It is also particularly good as a quality counter-measure to balance improvements in productivity and reduce lengths of stay, at the same time as our population is ageing and people are presenting with more complex conditions.* ▪ *Improved patient-focused, clinically driven pathways will provide the flexibility for early intervention and planned readmission where clinically appropriate, and will support improvements in care across the whole continuum. Responsive intervention will also enable people, their families and caregivers to establish more stable lives.*	Long-term Outcome Measure – Unplanned Acute Readmission Rate. *NOTE: The intention is to use the national Ministry Indicator (OS8) which has been introduced for all DHBs from 2010/11. The data and definitions are currently being finalised between the Ministry and the DHB, and Canterbury will begin to report against this measure in 2010/11.*
An improvement in clinical quality and patient safety in hospital and specialist services. ▪ *Mortality rates are a well-established measure of clinical outcomes for hospital patients and are related to the safety and efficacy of treatment. Maintaining or improving our current mortality rate will demonstrate maintenance of clinical quality standards and is a good balance against productivity gains such as length of stay.* ▪ *We expect that the systemic changes we are making to the way care is offered to patients, such as changes intended to reduce the incidence of falls, pressure ulcers, pneumonia and hospital-acquired infections, will lead to a measurable change in patient mortality.*	Long-term Outcome Measure – 30 Day Mortality Rate. *NOTE: The intention is to use the national Ministry Indicator (OS9) which has been introduced for all DHBs from 2010/11. The data and definitions are currently being finalised between the Ministry and the DHB, and Canterbury will begin to report against this measure in 2010/11.*

5. Government Expectations – How Do We Contribute?

When planning investment and activity within the health sector, we must consider our contribution and role in the achievement of the vision and goals of the Ministry of Health and the expectations of our Minister.

In setting expectations for 2010/11, a clear signal has been given that the public health system must deliver better, sooner and more convenient health care by focusing on enhancing performance, increasing outputs, improving quality and effectively managing resources. There is also a strong focus on improving front line services and operating within existing resources and approved financial budgets.

The Minister of Health continues to support strengthened clinical leadership and constructive staff engagement, and expects to see improvements in hospital productivity, patient safety and quality.

The Minister's specific priorities for DHBs in 2010/11 are:

- Improved service delivery and reduced waiting times - increased elective surgery and first specialist assessments and reduced emergency department and cancer treatment waiting times.
- Implementation of the next steps in the Primary Health Care Strategy - closer integration of services across the care continuum to improve convenience for patients and reduce pressure on hospitals.
- Improved clinical leadership - strengthened clinical engagement throughout the health system.
- Regional cooperation - accelerated collaboration between neighbouring DHBs to maximise clinical and financial resources and evidence of real gains from this collaborative endeavour.
- More unified systems - working constructively with the National Health Board and Shared Services Board to ensure public health services are not reinventing the wheel 21 times.

To measure progress against national priorities, a set of national health targets has been established, with the anticipation that collaborative DHB focus will drive performance improvement across the sector.

While the health targets capture only a small part of what is necessary and important to our community's health, they do provide a focus for action and improved performance across a range of areas, from prevention and early intervention through to improved access to hospital and specialist services. There is also clear alignment between our priority areas (identified in our District Annual Plan) and the national health targets set by the Ministry of Health (refer to page 15 for a map of the alignment of local and national priorities). In this sense, achievement of the national health targets is a reflection of how well the health system is impacting on the lives of our population.[17]

We are committed to making continued progress towards achieving the national health targets, and our contribution is set out in the following two pages. The activity planned to deliver on these health targets is summarised in our Statement of Forecast Performance in this document and is presented in more detail in our District Annual Plan for 2010/11, which is available on our website www.cbhd.govt.nz.

[17] *Information regarding the Health Targets can be found on the Ministry's website www.moh.govt.nz.*

Shorter Stays in EDs

Government Expectation

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

Why is this target area important:

This target is reflective of a whole of system approach to managing acute demand, strong clinical leadership and a commitment to improving the quality of care for patients across the whole continuum.

ED length of stay is also seen by the Government as an important measure of the quality of acute care in our public hospitals. Long stays in ED are reflective of overcrowding, which can lead to compromised standards of privacy and dignity for patients and are linked to negative clinical outcomes for patients, such as increased mortality and longer inpatient lengths of stay. The target is also reflective of the flow of patients through the hospital and how well different departments interact.

Our contribution:

- 95% of people presenting at a Canterbury ED will be admitted, discharged or transferred within six hours.

Improved Access to Elective Surgery

Government Expectation

More New Zealanders have access to elective surgical services with an average of 4,000 additional discharges nationally every year.[18]

Why is this target area important:

The Government wants the public health system to deliver better, sooner, more convenient health care for all New Zealanders. In order to achieve this, the growth in elective surgical discharges must keep up with population growth. This in turn will increase access and achieve genuine reductions in waiting times for patients.

All patients also have the right to: clarity about whether they will receive publically funded treatment, timeliness in terms of those who are given a commitment to treatment receiving that treatment in a timely manner (a maximum of six months) and fairness in ensuing that prioritisation status is based on a patient's level of health need compared to other patients.

Our contribution:

- Canterbury will maintain compliance with all eight Elective Services Patient flow Indicators (ESPIs).
- 15,478 elective surgery discharges will be provided by the Canterbury DHB in 2010/11 – an additional 1,109 more than in the previous year.

Shorter Waits for Cancer Treatment

Government Expectation

All New Zealanders requiring cancer radiation oncology treatment receive it within four weeks of their first specialist assessment.[19]

Why is this target area important:

Cancer is the leading cause of death and a major cause of hospitalisation in New Zealand. Timely cancer treatment is important to improve outcomes and provide a better quality of life. The target measures one part of a patient's journey with cancer and provides an indicator of how well the system is working.

Māori and Pacific populations have proportionately higher cancer incidence compared to other populations. Providing support to improve access to treatment and ensure sufficient treatment capacity are both important factors in ensuring Māori and Pacific people have equitable outcomes.

Our contribution:

- 100% of people needing radiation oncology treatment will receive it within six weeks of the decision to treat having been made, by July 2010.
- 100% of people needing radiation oncology treatment will receive it within four weeks of the decision to treat having been made, by December 2010.

[18] *The national health target definition of elective surgery excludes dental and cardiology services.*

[19] *The national health target definition excludes Category D patients, whose treatment is scheduled to ensure effective sequence of radiation treatment with chemotherapy or other anti-cancer drugs.*

Increased Immunisation Rates

Government Expectation

95% of two years olds in New Zealand are fully vaccinated against vaccine preventable diseases by July 2012.

Why is this target area important:

Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides protection not only for individuals but for the whole population by reducing the incidence of diseases and preventing them from spreading to vulnerable people or population groups.

Population benefits only arise with high immunisation rates, and New Zealand's current rates are low by international standards and not sufficient to prevent or reduce the impact of preventable diseases such as measles or pertussis (whooping cough). Coverage for two year olds demonstrates whether children have received the full series of infant immunisations, when they are most vulnerable.

Our contribution:

- 85% of Canterbury two year olds fully vaccinated, by July 2010.
- 91% of Canterbury two year olds fully vaccinated, by July 2011.
- 90% of South Island two year olds fully vaccinated, by July 2011.

Better Help For Smokers to Quit

Government Expectation

95% of all smokers presenting to ED, day stay and other hospital services are provided with help and advice to quit by July 2012.

95% of patients attending primary care are provided with advice and help to quit by July 2013.

Why is this target area important:

Smoking kills an estimated 5,000 people in New Zealand every year, and smoking-related diseases are a significant cost to the health sector. Smoking is also a major contributor to inequalities in health and to a number of long-term conditions, including heart disease, cancers and respiratory disease.

Most smokers want to quit, and there are simple, effective interventions that can be routinely provided in both primary and secondary care. This target is designed to prompt health professionals to routinely ask about smoking status and provide smokers with brief advice and support to prompt quit attempts and quit success.

Our contribution:

- 80% of hospitalised smokers will be provided with advice and help to quit smoking, by July 2010.
- 90% of hospitalised smokers will be provided with advice and help to quit smoking, by July 2011.
- 80% of smokers attending primary care will be provided with advice and help to quit smoking, by July 2011.

Improved Diabetes and CVD Services

Government Expectation

People are supported to understand and identify the symptoms and risk of long-term conditions and to better manage their condition.[20]

Why is this target area important:

Long-term conditions comprise the major health burden for New Zealand now and in the foreseeable future. These conditions are the leading cause of morbidity and disproportionately affect Māori and Pacific people. As the population ages and lifestyles change, these conditions are likely to increase significantly.

Improving outcomes for people with diabetes and CVD will take a whole of system approach that encourages healthier lifestyles, supports early diagnosis, management plans and access to treatment. The targets measure one part of the journey and can provide an indication of how well long-term conditions are being identified and managed in primary care.

Our contribution:

- 73% of the eligible adult population in Canterbury will have their CVD risk assessed once every five years.
- 52% of the Canterbury population with diabetes will receive a free diabetes annual check.
- 79% of those receiving a free annual diabetes check will have good diabetes management (HbA1c>=8%).

[20] *The Diabetes and CVD service health target is an average of three target indicators, and there is no overall national goal.*

6. Forecast Statement of Service Performance 2010/11 – What Will We Deliver?

One of the functions of this Statement of Intent, and in particular this section, is to set out what services we will provide to our population in 2010/11. This section also defines the associated measures and targets with which we will evaluate our performance over the year.

We have chosen to reflect our activity across the life span of our population and have aggregated the services we deliver into three output classes: Child and Youth Health Services, Adult Health Services and Older People's Health Services. In definition terms:

- Child and Youth Health Services – services we provide for children 0-18 years of age, including maternity services which are focused on the health and wellbeing of the baby and setting foundations for a healthy future.
- Adult Health Services – services we provide for people 19-64 years of age.
- Older People's Health Services – services we provide for people 65 years of age and over.

We have chosen to aggregate our outputs in this way to demonstrate the responsibility we have for our population's health and wellbeing across the whole of their lifetime, while also demonstrating the specific needs of different age groups within our population.

Identifying appropriate measures of performance for the outputs under each output class is difficult. There are more activities and programmes being undertaken to influence the health of our population than can be reasonably addressed in one document. Consequently, the associated measures of performance we have chosen to use take into account current and prioritised health needs of the Canterbury population and reflect the interests and expectations of current Government. The areas of work we have chosen to measure are those that have the potential to make the greatest contribution to health and wellbeing in the shorter-term and build vital momentum that will contribute to sustained health improvements over the longer-term. They are also those most representative of the vast array of activities conducted or contracted by the Canterbury DHB.

To be effective, we must demonstrate that what we do has a positive impact on the health and wellbeing of our population. The performance measures we have chosen are a mixture of indicators of access, timeliness and quality, focused on our local and national priorities for the coming year.

In comparison to the previous years' Statements of Service Performance, there are a number of new performance measures and changes made where existing measures were not considered appropriate or where circumstance have changed. We have included the past years' performance (as baseline data) and the most recently available national averages to give context in terms of what we are trying to achieve and to enable evaluation of our performance at the end of the year. Unless otherwise indicated, national averages are based on Q3 2009/10 results.

The targets we have set are based on the growth of our population and the assumption that little increase in funding is available. Our focus is on the development of innovative service delivery models that enable us to treat more people from the same health resource, and performance targets tend to reflect the objective of maintaining performance against increasing population growth. The targets also reflect our commitment to reducing inequalities between population groups to meet our obligations under the NZPHD Act.

Achievement of the targets we have set requires the DHB to work across the whole health system to find better ways of working and developing collaborative models to sustain service delivery. We are reliant on partnerships across the health system to meet the objectives we have set, and we acknowledge the support and collaboration that allows us to achieve improved outcomes for our population.

Some of the measures are under development or relate to new services (ns) for which there is no actual service delivery (or baseline) from 2008/09. The aim is to reach national standards or a baseline target for the first full year of delivery. A number of the measures also relate to Canterbury specific services for which there is no national comparison or national average available.

More specific detail concerning the outputs of the DHB can be found in our District Annual Plan 2010/11.

Child and Youth Health Services

Why is this Output Class significant for the DHB?

Child and youth health is an important area of focus, and compared to other OEDC countries New Zealand has relatively poor health for this age group (relating primarily to a high degree of inequality). The health status of young people and expectant mothers is most strongly influenced by environmental determinants of health outside of the services the DHB provides. However, in Canterbury our focus is on influencing change that supports healthier environments, on ensuring our younger populations have a healthy start to life to set the foundation for their lifetime and on addressing the inequalities between population groups to improve overall population outcomes.

What impact do we want to make in the coming year?

- Young people reduce risk behaviours and adopt healthier lifestyles.
- Young people are healthier, aware of signs and symptoms of illness and seek help earlier.
- Children and young people are well, remain in their communities and need less hospital care.

Funding	$191,275M
Expenditure	$191,790M
Percentage of Total Spend	14.9%
Percentage of Total Population	26.4%

How will we show progress?

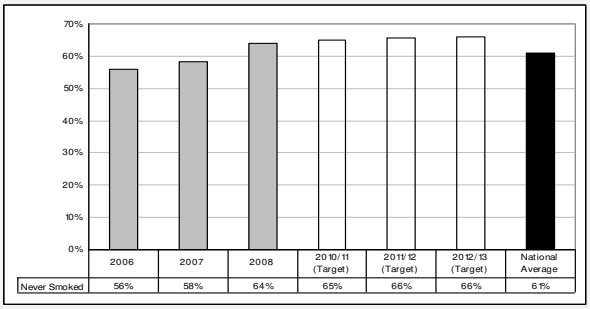
The quality and effectiveness of the services we fund and deliver will be measured using the following impact measures:

A reduction in the proportion of young people who take up tobacco smoking.

- *The highest prevalence of smoking is amongst young people, with approximately one in every four Canterbury teenagers 15-19 currently smoking.*
- *Reducing smoking prevalence is dependant on smoking cessation and on preventing young people from taking up smoking. Over 95% of smokers have started smoking by 18 years of age.*
- *A reduction in the uptake of smoking is a good proxy measure of successful engagement and a change in the social and environmental factors that influence risk behaviour.*

Data sourced from national annual Year 10 ASH Survey.

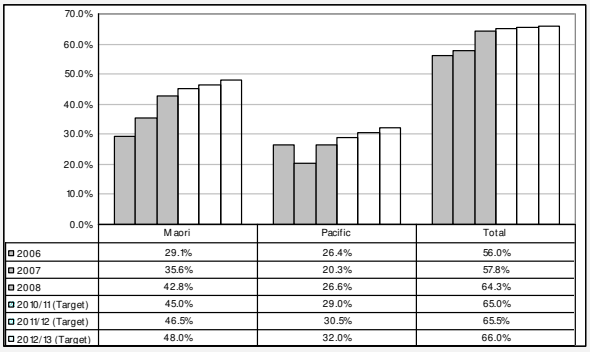
The proportion of 'never smokers' among Year 10 students.	Actual 08/09	Target 10/11	Target 11/12	Target 12/13
	64%	65%	65.5%	66%



An increase in the proportion of children who have good oral health.

- *Regular dental care has life-long benefits for improved health. While water fluoridation can significantly reduce tooth decay across all population groups, less than 5% of children in Canterbury have access to fluoridated water; therefore, prevention and education initiatives are essential to good oral health.*
- *Māori children are three times more likely to have decayed, missing or filled teeth, and improved oral health is a good proxy measure of equity of access to services and the effectiveness of mainstream services in targeting those most in need.*
- *Oral health outcomes are a good proxy measure of early contact with effective health promotion and prevention services and an indicator of reduced risk factors, such as poor diet, which has other benefits in terms of improved nutrition and healthier body weights.*

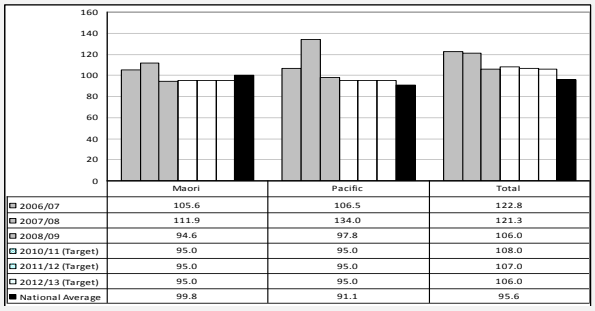
The proportion of children who are caries free (no holes of fillings) at age 5.		Actual 08/09	Target 10/11	Target 11/12	Target 12/13
	Māori	42.8%	45%	46.5%	48%
	Pacific	26.6%	29%	30.5%	32%
	Total	64.3%	65%	65.5%	66%



A reduction in the proportion of the population (aged 0-4) admitted to hospital with conditions considered 'avoidable' or 'preventable'.[21]

- *There are a number of admissions to hospital for conditions which are seen as preventable through appropriate early intervention and a reduction of risk factors. As such, these admissions provide an indication of the access and effectiveness of screening, early intervention and the continuum of care across the system.*
- *The rate of preventable hospitalisations in Canterbury is lower than the national rate, which is positive. However, it still represents a substantial and avoidable burden on our health system and highlights opportunities to better support people to seek intervention early and manage their long-term conditions. A reduction in these admissions will reflect better management and treatment of young people across the whole of the system.*

The ratio of actual to expected avoidable hospital admissions for our population aged 0-4.		Actual 08/09	Target 10/11	Target 11/12	Target 12/13
	Māori	94.6	<95	<95	<95
	Pacific	97.8	95	<95	<95
	Total	106	<108	<107	<106



[21] *Avoidable or 'Ambulatory Sensitive' hospital admissions are based on admissions for 26 conditions including: asthma, diabetes, angina and chest pain, vaccine-preventable diseases, dental conditions and gastroenteritis. The expected ambulatory sensitive admission rate is the age-group specific national average admission rate, and a ratio greater than 100 indicates performance worse than the national average. Results prior to 2009/10 were calculated using the previous definition of 37 conditions.*

What services will we provide?

To achieve our desired Outcomes we will focus on the following Outputs:

Health Promotion, Protection and Disease Prevention Services

Aim: More children and young people stay well

Service Description: The early years of life provide an important foundation for the development good health over a lifetime. The development of strong attachment to support services is protective against developing an array of health issues later in life, as a supportive environment positively influences the development of protective and risk factors that set up life-long health behaviours. These indicators measure engagement in supportive environments and resultant behavioural changes and therefore the quality of the services we are providing to influence change.

How will we measure our performance:	**Standard 2010/11**	Current National Average	Actual 2008/09
The percentage of schools engaged in the Health Promoting Schools (HPS) framework.[22]	Increase to 52%	-	48%
The proportion of schools engaged in the HPS framework that are 'priority' schools. [23]	At least 70%	-	73%
The number of eligible children (< 5) enrolled in school and community oral health services.	Increase to 20,300	-	19,516
The percentage of infants exclusively and fully breastfed at 6 weeks.	Increase to 68.5%	65%	68%
The proportion of compliant tobacco retailers identified from controlled purchase operations.	Increase to 90%	-	89%
The proportion of compliant alcohol retailers identified from controlled purchase operations.	Increase to 90%	-	86.9%

Screening, Early Detection and Intervention Services

Aim: Children and young people are seen and treated early.

Service Description: The early identification of health problems results in improved outcomes. Finding risks and problems before they compromise people's health is the key to protecting and restoring health. Engagement in health services increases access to screening and preventive services which may provide lifelong protection. The systematic identification of problems allows for early actions to ensure a healthy start to life.

How will we measure our performance:	**Standard 2010/11**	Current National Average	Actual 2008/09
The percentage of children and young people enrolled with a Primary Health Organisation.[24]	Maintain >95%	-	96.5%
The percentage of children (aged four) receiving B4 Schools Checks.[25]	Reach 60%	39%	18%
The percentage of children fully immunised at age two.	Increase to 91%	83%	86%
The proportion of eligible young women engaged in the HPV vaccination programme.[26]	Increase to 50%	36.5%	29.8%
The proportion of children enrolled in dental services, examined according to planned recall.	Increase to 90%	-	85%
The proportion of women meeting the clinical criteria, being offered longer post-natal stays.[27]	Reach 100%	-	ns

[22] *The HPS framework is an approach based on activities within the school setting that can impact on health; as such the definition also includes schools promoting Active Schools, National Health Foundation, Nutrition Fund and Fuelled 4 Schools.*

[23] *Priority schools are schools which are low decile, rural and/or have a high proportion of Māori and/or Pacific children.*

[24] *The national target for PHO enrolments is 95% and the aim is to continue to achieve a standard above this level in Canterbury.*

[25] *The B4 Schools Programme began in Canterbury in March 2009.*

[26] *The population engaged measures eligible young women who have received Dose 1. The national average based on the 'major' six DHBs.*

[27] *This is a new measure in response to national expectation introduced in July 2009; therefore baseline data prior to 2009/10 is not available.*

Conditions Management Services

Aim: Fewer children and young people need hospital care.

Service Description: For children and young people who develop on-going health problems, management of these conditions is vital. This requires timely access to interventions from health professionals who work in a supportive team role alongside the child/young person and his/her family to manage these health issues. General practice teams are key to providing and coordinating services for children and young people in the community rather than in a hospital environment.

How will we measure our performance:	**Standard 2010/11**	Current National Average	Actual 2008/09
The number of young people accessing mental health services in the community or through primary care (outside hospital specialist services).[28]	At least 226	-	226
The proportion of long-term mental health clients (0 -19) with current relapse prevention plans.	Increase to 95%	72%	75%

Complex Support Services

Aim: Less untimely deaths

Service Description: A small number of children will develop complex health problems. This group require timely access to health services which are both curative and help to manage the child's health problem.

How will we measure our performance:	**Standard 2010/11**	Current National Average	Actual 2008/09
Access rates to specialist mental health services for children and young people (<19).	Increase to 2%	1.9%	1.7%
The percentage of young people assessed, treated or discharged from ED in under six hours.[29]	Maintain >95%	-	98.5%
The percentage of young people provided with a First Specialist Assessment (FSA) for paediatric surgery within 6 months of referral.	Increase to 98.5%	98.5%	98.2%

[28] The DHB has recently begun to collect NHI level information from the NGO sector which will enable improved monitoring of mental health service delivery levels across the whole of the system; these services refer to those delivered in the community and primary care but not through hospital specialist mental health services to children and young people 0-19 years.

[29] This measure is based on the national health target of 95% and is based on a sub-set of the total population - young people 0-15 years of age. The aim is to maintain performance above the health target in Canterbury.

Adult Health Services

Why is this Output Class significant for the DHB?

The largest population group to which we provide services is adults. In Canterbury our focus is on supporting people to maintain good health and to recognise signs and symptoms and seek help early. Our population needs services closer to home and access to services without requiring a hospital appointment, but they also need to be assured that they will be able to access high quality complex care if required.

What impact do we want to make in the coming year?

- People reduce risk behaviours and adopt healthier lifestyles.
- People are healthier, aware of signs and symptoms of illness and seek help earlier.
- People are able to self manage their conditions and have access to quality care coordinated across a range of providers, reducing the need for hospital care.
- People have timely access to quality complex care, reducing untimely disability or death.

Funding	$567,511M
Expenditure	$566,021M
Percentage of Total Spend	44%
Percentage of Total Population	59.4%

How will we show progress?

The quality and effectiveness of the services we fund and deliver will be measured using the following impact measures:

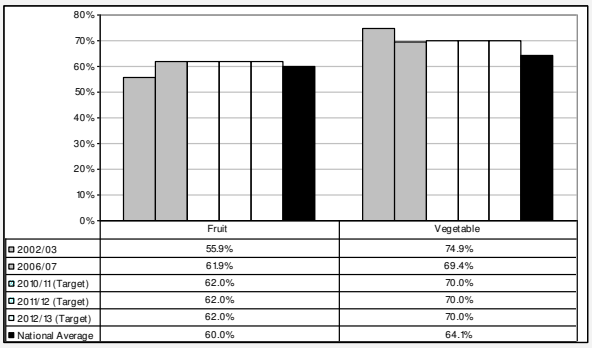
An increase in the proportion of the population who have healthier diets.

- *Good nutrition is fundamental to health and the prevention of disease and disability. Appropriate fruit and vegetable consumption helps to protect our population against obesity, CVD, diabetes and some common cancers and contributes to maintaining a healthy body weight.*
- *Nutrition-related risk factors (such as high cholesterol, high blood pressure, obesity and inadequate fruit and vegetable intake) jointly contribute to two out of every five deaths each year (approximately 11,000 deaths).*[30]

Data sourced from the national NZ Health Survey collected by the Ministry of Health every three years.

The proportion of the population (15+) having the recommended servings of fruit and vegetables.

	Actual 06/07	Target 10/11	Target 11/12	Target 12/13
Fruit 2+	61.9%	62%	>62%	>62%
Veg 3+	69.4%	70%	>70%	>70%



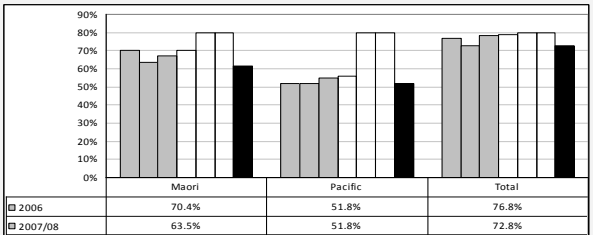
	Fruit	Vegetable
2002/03	55.9%	74.9%
2006/07	61.9%	69.4%
2010/11 (Target)	62.0%	70.0%
2011/12 (Target)	62.0%	70.0%
2012/13 (Target)	62.0%	70.0%
National Average	60.0%	64.1%

An increase in the proportion of people identified with diabetes who have improved management of their long-term conditions.

- *Diabetes is a significant cause of ill health and premature death, and prevalence is increasing at an estimated 4-5% a year. Improving the management of diabetes will reduce long-term avoidable complications which require hospital-level intervention, such as amputation, kidney failure and blindness, and will improve people's quality of life.*

The percentage of people with diabetes and satisfactory or better diabetes management (HbA1c<=8%).[31]

	Actual 08/09	Target 10/11	Target 11/12	Target 12/13
Māori	67.3%	70%	80%	80%
Pacific	54.9%	56%	80%	80%
Total	78.3%	79%	80%	80%



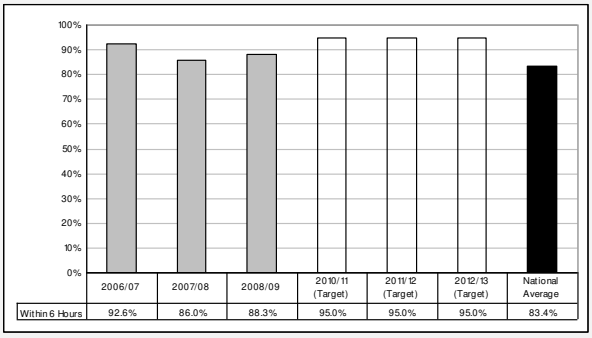
	Maori	Pacific	Total
2006	70.4%	51.8%	76.8%
2007/08	63.5%	51.8%	72.8%
2008/09	67.3%	54.9%	78.3%
2010/11 (Target)	70.0%	56.0%	79.0%
2011/12 (Target)	80.0%	80.0%	80.0%
2012/13 (Target)	80.0%	80.0%	80.0%
National Average	61.5%	52.0%	72.6%

An increase in the proportion of people who receive prompt acute care in the Emergency Department (ED).

- *Timely access to treatment improves health outcomes and is indicative of increased capacity and improvements in the flow of patients through our services. It also demonstrates a commitment to addressing the needs of our patients and valuing their time.*
- *Timely acute care in ED is also a proxy measure for how well the whole system is working together to support people to stay well and to provide timely and appropriate complex care through: management of acute demand in the community, improved capacity in ED and supported discharge into services in the community.*

The percentage of people (16-64) presenting to ED admitted, discharged or transferred within 6 hours.

Actual 08/09	Target 10/11	Target 11/12	Target 12/13
88.3%	95%	>95%	>95%



	2006/07	2007/08	2008/09	2010/11 (Target)	2011/12 (Target)	2012/13 (Target)	National Average
Within 6 Hours	92.6%	86.0%	88.3%	95.0%	95.0%	95.0%	83.4%

[30] *Nutrition and the burden of disease in New Zealand; 1997–2011, Niki Stefanogiannis Public Health Intelligence, MoH, NZ: May 2004.*

[31] *Previously diabetes data has been collected by calendar year. This was changed to financial year mid 2008, and the 2007/08 baseline is an estimate of the Canterbury DHB financial year performance provided by the Ministry of Health.*

What services will we provide?

To achieve our desired Outcomes we will focus on the following Outputs:

Health Promotion, Protection and Disease Prevention Services

Aim: People stay well

Service Description: Primary prevention (before a disease is present) remains the most cost effective approach for improving health outcomes from long term conditions. Influencing the greatest possible number of people with strategies to addressing behavioural and environmental risk factors will improve outcomes for adults.

How will we measure our performance:	**Standard 2010/11**	Current National Average	Actual 2008/09
The proportion of hospitalised smokers provided with help and advice to quit.[32]	Reach 90%	25%	ns
The proportion of smokers identified in primary care and provided with help/advice to quit.	Reach 80%	-	ns
The number of people enrolled in the Aukati Kaipaipa smoking cessation programme.	Increase to 200	-	182
The number of people enrolled in community-based Appetite for Life courses.	Increase to 540	-	504

Screening, Early Detection and Intervention Services

Aim: More people are seen and treated early.

Service Description: The early identification of health problems results in improved outcomes. Finding risks and problems before they compromise health is key to restoring health or slowing the progression of disease and maintaining functional capacity. Engagement in health services increases access to screening and early intervention services and leads to better outcomes for long-term conditions.

How will we measure our performance:	**Standard 2010/11**	Current National Average	Actual 2008/09
The percentage of the adult (20-64) population enrolled in a Primary Health Organisation.[33]	Maintain >95%	-	96.5%
The proportion of the eligible population (45-69) receiving breast screen examinations.[34]	Maintain >70%	58%	81%
The proportion of the eligible population (20-69) receiving cervical cancer screens.	Maintain >75%	75%	77%
The proportion of eligible population (35-79) having a fasting lipid/glucose test every 5 years.	Increase to 73%	74.5%	67.6%
The number of skin lesions (skin growths, including cancer) removed in primary care, without the need for a hospital appointment. [35]	Increase to 2,428	-	857

[32] *These smoking measures are national health targets, with the hospital programme beginning in the 2009 year and the primary care programme set to begin in 2010. Baseline data prior to the 2009/10 year is therefore not available.*

[33] *The national target for PHO enrolments across the country is 95%, and the aim is to continue to achieve above this level in Canterbury.*

[34] *The breast and cervical screening standards are based on national targets set for DHBs. Canterbury aims to continue to successfully deliver at a level above these national targets and the national average.*

[35] *The 2008/09 baseline data is for the last seven months of 2008/09, as data on subsidised procedures delivered in primary care was not collected prior to December 2008.Data includes subsidised skin lesion removals only.*

Conditions Management Services

Aim: Fewer people need hospital care.

Service Description: ***The management of long-term conditions is of primary importance, as this group of diseases places the greatest burden on health system resources. Maintaining and enabling access to primary care services is important for management of health problems in collaboration with the person and his/her family. Assessment and high quality management of long-term conditions in the community reduces the burden on hospitals and allows faster access to services.***

How will we measure our performance:	**Standard 2010/11**	Current National Average	Actual 2008/09
The proportion of the expected population with diabetes, receiving diabetes annual reviews.[36]	Increase to 52%	56%	38%
The number of integrated clinical pathways implemented across primary/secondary care.	Increase to 200	-	168
The number of spirometry tests delivered in the community.	Increase to 1,320	-	109
The number of level 4 sleep assessments delivered in the community.	Increase to 1,020	-	65
The number of urgent care episodes managed in primary care.[37]	Increase to 14,000	-	13,875
The number of people accessing mental health services in the community or through primary care (outside hospital specialist services).[38]	At least 968	-	968
The proportion of long-term mental health clients with current relapse prevention plans.	Increase to 95%	89%	93%

Complex Support Services

Aim: Less untimely deaths

Service Description: ***Complex health problems require timely access to assessment and treatment. Waiting for health services in some cases may result in poorer health outcomes; therefore access to both assessment and treatment must be timely both for acute and elective services. The quality of services also influences health outcomes, and as a system, improving errors is closely related to quality.***

How will we measure our performance:	**Standard 2010/11**	Current National Average	Actual 2008/09
Access rates for specialist mental health services for adults (20-64).	Increase to 2.5%	2.5%	2.1%
The number of elective surgical services discharges provided.[39]	Increase to 15,478	-	13,240
The proportion of people provided with a FSA within 6 months of referral (ESPI 2).[40]	Maintain >98.5%	98.7%	98.9%
The proportion of people given a commitment, who are treated within 6 months (ESPI 5).	Maintain >96%	97.2%	97.4%
The proportion of people provided with acute surgery within 24 hours.	Increase to 85%	-	80%
The percentage of elective and arranged surgery undertaken on a daycase basis (OS6).[41]	Increase to 60%	60%	48%
The proportion of people receiving elective or arranged surgery on the day of admission (OS7).	Increase to 90%	76%	73%
The proportion of people provided with radiation oncology treatment, within 6 weeks of the decision to treat.	Increase to 100%	97%	96%
The proportion of people provided with radiation oncology treatment, within 4 weeks	Increase to 100%	-	70%
The percentage of people referred to stroke rehabilitation services after an acute event.	At least 69%	-	69%
The percentage of people referred to cardiac rehabilitation services after an acute event.	At least 30%	-	27%
The number of pulmonary rehabilitation programmes provided in the community.	Increase to 12	-	ns

[36] *Previously diabetes data has been collected by calendar year – refer to footnote 31, page 35.*

[37] *Refers to general practice, ED and ambulance referred admission avoidable packages of care which allow people that would otherwise require a hospital admission to be treated in their own homes or community.*

[38] *The DHB has recently begun to collect NHI level information from the NGO sector; these services refer to those delivered in the community and primary care but not through hospital specialist mental health services to people aged 20 to 64 years.*

[39] *The elective surgical discharge volumes exclude elective cardiology and dental and are based on the national health target.*

[40] *The ESPIs measures are based on national targets, the aim being to deliver at a level above these national targets and the national average.*

[41] *The definitions for the OS6 and OS7 measures are based on national indicators of performance set for DHBs.*

Older People's Health Services

Why is this Output Class significant for the DHB?

Health system resources are increasingly used as we age. In Canterbury we are placing an increasing emphasis on providing services that will support people to manage long-term conditions and to live healthy lives in their own homes and communities, until higher level support is required. Our population also needs to be assured that they will be able to access high quality complex care if required and that services have a restorative focus to support them to regain and maintain their independence.

What impact do we want to make in the coming year?

- Older people are well and able to self manage their conditions, reducing the need for hospital care.
- Older people have access to quality coordinated care from a range of providers enabling them to remain independent and in their own homes and communities.
- Older people have timely access to quality complex care, reducing untimely disability or death.
- Older people have their end stage needs met in a holistic way that provides dignity and respect.

Funding	$526,462M
Expenditure	$527,436M
Percentage of Total Spend	41%
Percentage of Total Population	14.2%

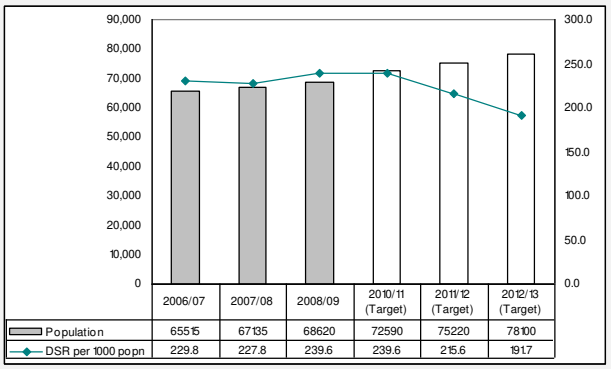
How will we show progress?

The quality and effectiveness of the services we fund and deliver will be measured using the following impact measures:

An increase in the proportion of people over 65 who are provided with appropriate levels of care and intervention to support their needs.

- *Appropriate support and care will allow 'ageing in place', maintaining a higher quality of life until ARC is functionally or clinically indicated.*
- *Unplanned acute admissions are a measure of older people being safe and well in their own homes and maintaining good health for longer. Effective primary and community service are important in keeping people well and avoiding hospital and early ARC admissions, through effective early intervention and medications management.*

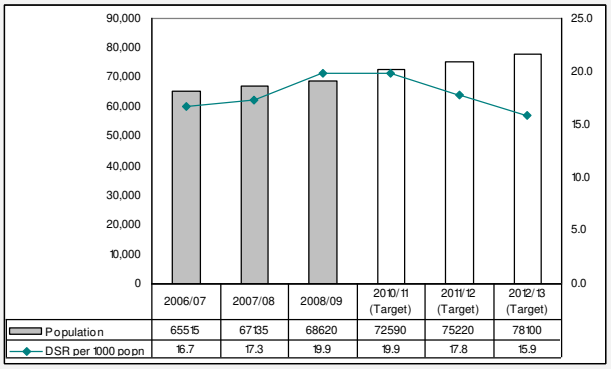
The proportion of the population over 65 having an unplanned acute admission.	Actual 08/09	Target 10/11	Target 11/12	Target 12/13
	239.6	239.6	215.6	191.7



An increase in the proportion of people over 65 who are supported to remain in their own homes and communities.

- *Around 1,000 older people are hospitalised annually as a result of injury due to accidental falls, and falls during a hospital stay make up the greatest proportion of the adverse incidents that occur for people aged over 65.*
- *The impact of falls can include death, prolonged hospital stay, loss of confidence, restriction of social activities, loss of independence and increased risk of institutional care.*

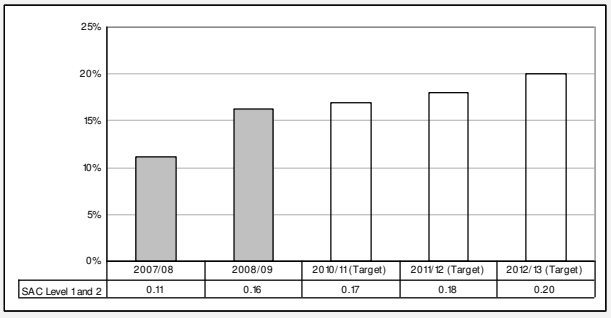
The proportion of the population over 65 being admitted to hospital as a result of a fall.	Actual 08/09	Target 10/11	Target 11/12	Target 12/13
	19.9	19.9	17.8	15.9



A reduction in serious incidents (adverse events) causing harm to patients in our Hospital and Specialist Services.

- *Adverse events in hospital, as well as causing avoidable harm to patients, also drive unnecessary costs for the DHB. Quality improvements in service delivery, systems and processes will improve patient safety and reduce the number of patient serious incidents causing injury - providing better outcomes for patients in our services.*

The rate of SAC 1&2 Incidents in our Hospital and Specialist Services for people 65+.[42]	Actual 08/09	Target 10/11	Target 11/12	Target 12/13
	0.16	0.17	0.18	0.20



[42] *The Severity Assessment Code (SAC) is a numerical score given to an incident, based on the consequence or outcome of the incident and the likelihood that it will recur. A matrix is used to stratify the actual and/or potential risk associated with the incident. Level 1 and 2 incidents are those with highest consequence and likelihood. The targets are set to increase the rate of reported falls, in line with the DHB policy of emphasising the responsibility of staff to report falls.*

What services will we provide?

To achieve our desired Outcomes we will focus on the following Outputs:

Screening, Early Detection and Intervention Services

Aim: Older people are seen and treated early.

Service Description: The early identification of health problems results in improved outcomes. Finding risks and problems rapidly is key to better recovery and maintaining functional capacity. Engagement in health services increases access to screening and preventive services.

How will we measure our performance:	Standard 2010/11	Current National Average	Actual 2008/09
The proportion of the population aged over 65 enrolled with Primary Health Organisations.[43]	Maintain >95%	-	97.6%
The number of flu vaccinations provided to people aged over 65.[44]	Increase to 51,000	-	48,911
The proportion of the total population aged over 65 having received a flu vaccination.	Increase to >75%	66%	74%

Conditions Management Services

Aim: Fewer older people need hospital care.

Service Description: The management of long-term conditions affects quality of life. Timely access to primary care is important for management of health problems in collaboration with the person and his/her family. Quality care requires a broad approach to managing a number of issues concurrently. Assessment and management allow older people to live fulfilling lives independently in the community.

How will we measure our performance:	Standard 2010/11	Current National Average	Actual 2008/09
The number of medication reviews provided for older people on multiple medications.[45]	Reach 250	-	ns
The number of older people supported through the integrated falls prevention services.[46]	Under development	-	ns
The number of post-discharge follow-ups provided in primary care for older people 65+.[47]	Reach 500	-	ns
The number of additional assessments provided for older people with complex needs.[48]	Additional 250	-	4,673

[43] *The national target for PHO enrolments across the country is 95%, and the aim is to continue to achieve above this level in Canterbury.*

[44] *This volume target is based on the number of vaccination required to achieve 75% coverage and assumes an enrolled population of 68,000.*

[45] *This measure refers to programmes which began in hospital settings in 2009 and primary settings in 2010; no baseline data prior to 2009/10.*

[46] *This measure refers to an integrated falls prevention service which is currently under development. The DHB aims to establish this service and collect utilisation data in the first year and set targets in the out-years.*

[47] *Post discharge follow-ups provided in primary care are a new service which will begin in 2009/10 as part of the implementation of Canterbury's Better, Sooner, More Convenient Primary Care Business Case.*

[48] *This measure refers to older people with complex needs who would benefit from an enhanced care management approach from general practice, pharmacy and other allied health and social services providers. Additional assessments are a new initiative which will begin in 2010/11.*

Complex Support Services

Aim: Fewer untimely deaths

Service Description: ***Complex health problems require timely access to assessment and treatment. Waiting for health services in some cases may result in poorer health outcomes and may compromise the ability to live independently; therefore access to both assessment and treatment must be timely both for acute and elective services. The quality of services also influences health outcomes, and as a system, improving errors is closely related to quality.***

How will we measure our performance:	**Standard 2010/11**	Current National Average	Actual 2008/09
The number of older people accessing supported discharge services after a hospital event.	Increase to 300	-	96
The number of people supported in their own homes with complex packages of care (L3-5).[49]	Additional 500	-	3,050
The proportion of people (65+) assessed, treated or discharged from ED in under six hours.	Increase to 95%	-	80.7%
The rate of SAC 1&2 Patient Falls in hospital for older people aged over 65.[50]	Reduce to <0.10	-	0.14

End of Life Services

Aim: Death with dignity.

Service Description: ***End of life services should preserve the dignity of the dying person and their family. The use of evidence-based pathways ensures this can be achieved. Access to services should not prevent people dying in their own home where they and their families choose to.***

How will we measure our performance:	**Standard 2010/11**	Current National Average	Actual 2008/09
The number of Aged Residential Care (ARC) facilities trained and providing the Liverpool Care Pathway option to residents.[51]	Reach 20 sites	-	ns
The number of people in ARC services being supported by the Liverpool Care Pathway.[52]	Under development	-	ns

[49] Packages of care (L3-5) refer to clients receiving an allocation of respite, carer support, day care or personal care services for greater than 3 hours a week. It is anticipated that with improved care management and service delivery older people with complex needs will be able to remain in their own homes for longer.

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

[51] The Liverpool Care Pathway is an international programme adopted nationally, and being run as a pilot programme in Canterbury from September 2009 to August 2011. The programme begins with training and is planned to run in 20 pilot sites

[52] The DHB intends to monitor and assess this pilot programme and set baselines and targets as the pilot evolves.

7. Financial Performance – Managing Our Financial Resources

7.1 Financial Outlook

The Canterbury DHB is forecasting funding/revenue, including non-Government-related revenue, to increase by approximately $54M for 2010/11. $35 million worth of costs will be avoided over the coming year through continued implementation of our whole of system approach to delivering more within the same resources. Deducting our projected deficit for 2009/10, estimated at $9M, leaves $45M for new expenditure in the coming year.

In preparing the forecast, the following key assumptions have been used.

- Early payment is retained.
- Normal operations will occur, without additional costs or disruptions associated with H1N1 or any other pandemic.
- There will be minimal impact from any revaluation of land and buildings occurring in 2009/10.[53]
- The impact of any legislative changes, sector reorganisation or funding devolvement will be cost neutral.
- We will receive fair prices for services provided for other DHBs and the Crown.
- Investment to meet increased demand is prioritised and approved by the Executive Management Team in line with Board's strategy. This will include any devolvement of additional mental health funding by the Ministry, as this funding may be at the expense of funds urgently required for investment in personal health or older peoples health.
- Employee cost increases for expired wage agreements are settled on fiscally sustainable terms, inclusive of step increases and the impact of accumulated leave revaluation.
- External provider increases will be within available funding received, after allowance for committed and uncontrollable funding, and will support the transformation of the Canterbury health system.
- Transformation processes and programmes to reduce duplication, variation and waste in the system are not delayed due to sector changes.

We intend to allocate this increase in funding/revenue as follows:

	$M (GST excl)
Net increase in funding/revenue (including non-base)	54.0
Less	
Deficit from 2009/10	(9.0)
Net available funding/revenue	45.0
Applied to:	
Committed Price Increases	4.3
Committed Investments in Services	6.4
Investments in Primary and Community-based services	26.1
Other cost and volume increases in Hosp Divs	8.2
Total Funds Applied 2010/11	45.0

7.2 Key Fiscal Challenges

The world-wide economic recession has resulted in the Government having fewer funds available for health spending. While the health sector continues to receive the largest share of Government's new funding, the whole of the health sector can expect to face significant financial challenges. In facing these challenges, we will be disciplined and will work in partnership with our clinical workforce and clinical leaders to ensure that funding and resource allocation decisions result in the highest possible healthcare return for our investment. Our major fiscal challenges include:

[53] *The last revaluation occurred in June 2006.*

- Population growth, the increasing burden of long-term conditions and the ageing of our population combining to increase demand for our health services. We will have to meet this increasing demand with limited funds.
- We compete in the international market for our clinical workforce, and workforce pressures are being experienced in some specialised clinical areas. Salary and wage expectations place additional pressure on our funding envelope. With the Government currently borrowing $250M per week to maintain existing level of expenditure, it is critical that employment award settlements be settled within a fiscally sustainable level for current and future years. Wages are our largest expense, and with automatic step (pay) increases already built into a large number of employment awards, even a small percentage increase will create significant fiscal pressure.
- We continue to be inadequately compensated for providing complex tertiary procedures. The national plan for adopting a role delineation model to fund tertiary procedures will further widen the gap between cost and funding. As Canterbury increasingly becomes the provider of last resort and new technology enables more complex services to be delivered, we need to close the gap between the cost and funding for complex tertiary procedures and better manage the introduction of new technology into the health sector.
- We have embarked on the transformation of services and activities that drive the majority of our expenditure by focusing on flow and ensuring that the right care and support are provided by the right provider, at the right time and in the right place. We are also focused on reducing variation, duplication and waste from across the system. It is critical that we remain focused and are not diverted away from current programmes, as this could result in delays in achieving the required transformation and place additional fiscal pressure on the DHB.

7.3 Action Plan for Dealing with Fiscal Challenges

The fiscal challenges facing the DHB are expected to continue in the year ahead and over the next five to six years. This means we require solutions that will stand the test of time, ensuring that Canterbury will have a good quality sustainable health system in the future. We have developed a strategic approach to enable us to achieve and maintain fiscal sustainability which includes the following:

- Transformation and Reduction in Variation, Duplication and Waste - Programmes for achieving this goal are vital to ensure the continued sustainability of our health services in the long term and not just for the coming year. We will ensure that our programmes are not diverted or delayed through robust project management, effective clinical leadership and proactively taking necessary corrective actions to ensure delivery of the programme targets.
- Partnerships and Collaboration - We will work in collaboration with other DHBs and health providers to share resources and reduce variation and duplication across the sector. We will work with the National Shared Services Establishment Board to ensure the effective use of health expenditure to deliver health services.
- Clinical Leadership - We will seek to maintain and enhance clinical input and leadership into our operational processes and decision making and to achieve quality and technical efficiencies across the system.
- Workforce Capacity - We will develop strategies to train, recruit and retain clinical staff in addition to ensuring that the right clinical care is provided by the most appropriate provider. We will also collaborate with other regional and tertiary DHBs in highly specialised clinical areas.
- Discipline - We will be disciplined to ensure that funding decisions result in the highest possible healthcare return, are developed in partnership with clinicians and provide the best value for investment.
- Doing the Basics Well - We will continue to build on our work to ensure that we understand our core business and deliver services effectively and efficiently, particularly around production planning, and will ensure that the DHB is fairly remunerated for services we provide.

7.4 Out-years Scenario

We expect funding increases for both 2011/12 and 2012/13 to be at the same rate as for 2010/11. We have also assumed that expenditure increases will be below funding increases received, on average, reflecting that some of the funding is for unavoidable commitments.

To cope with the pressures of changing demographics and workforce shortages, we will continue to transform our services and reduce variation, duplication and waste so that we are able to operate fiscally in a sustainable manner and can continue to provide a high performing, good quality health services.

7.5 Asset Planning and Sustainable Investment

Business Cases

We are planning to submit business cases for the redevelopment of Christchurch hospital and service facilities Stage 1 and the redevelopment of Older Person's Health hospital and service facilities.

We will also support the Canterbury Clinical Network's business case for Better, Sooner, More Convenient Care.

Capital Expenditure

We are about to embark on major hospital and service facilities redevelopment to support the transformation of our services. The first phase would see the DHB fully funding the capital expenditure without seeking financial support from the Government. The business cases for the new facilities will be developed and submitted during 2010/11. In order to achieve this, our ongoing new baseline capital expenditure budget will be set at $20M until completion of the facilities re-development programme.

There is significant capital expenditure already committed (e.g. boiler, electricity network infrastructure, linear accelerators) where the expenditure will be incurred in the 2010/11 financial year. We have estimated $5M is required to meet prior years' committed capital expenditure, giving a total 2010/11 budgeted capital expenditure budget of $25M. With a tight capital expenditure budget, we will continue to be disciplined and focus on the key priorities in determining our capital expenditure spending.

7.6 Debt and Equity

The Canterbury DHB has a $129,650M total loan facility with the Crown Health Funding Agency. The DHB's estimated total term debt is expected to be $75M as at June 2011. The DHB is also repaying $1.86M of equity as part of the agreed FRS-3 funding.

The Crown Health Financing Agency term liabilities are secured by a negative pledge. Without the Crown Health Financing Agency's prior written consent the DHB cannot perform the following actions:

- create any security over its assets, except in certain circumstances;
- lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee;
- make a substantial change in the nature or scope of its business as presently conducted, or undertake any business or activity unrelated to health; or
- dispose of any of its assets except disposals at full value in the ordinary course of business.

7.3.1 Disposal of Land

Disposal of significant surplus assets over the next three years could possibly include our former Christchurch Women's Hospital site (Colombo/Durham Street, Christchurch); however, a formal decision has yet to be made as to whether or not this land is 'surplus'. Due process will be undertaken with regard to any sale of the site. Our policy is that we will not dispose of any estate or interest in any land without having first obtained the consent of the responsible Minister and completed required public consultation.

7.3.2 Activities for which Compensation is Sought

No compensation is sought for activities sought by the Crown in accordance with Section 41(D) of the Public Finance Act.

7.3.3 Acquisition of Shares

Before we or any of our associates or subsidiaries subscribes for, purchases, or otherwise acquires shares in any company or other organisation, our Board will consult the responsible Minister/s and obtain their approval.

7.3.4 Accounting Policies

The accounting policies adopted are consistent with those in the prior year. For a full statement of accounting policies, refer to Appendix 6.

8. Forecast Statement of Financial Performance 2010-2013

8.1 Forecast Group Statement of Comprehensive Income

	2008/09 Actual $'000	2009/10 Forecast $'000	2010/11 Forecast $'000	2011/12 Forecast $'000	2012/13 Forecast $'000
Operating Revenue					
MoH Revenue	1,201,899	1,256,351	1,309,178	1,354,572	1,399,966
Patient Related Revenue	43,285	41,746	42,581	44,114	45,702
Other Revenue	33,667	21,966	22,225	20,826	21,448
Total Operating Revenue	1,278,851	1,320,063	1,373,984	1,419,512	1,467,116
Operating Expenditure					
Employee Costs	512,629	532,974	551,495	570,349	589,982
Treatment Related Costs	112,786	116,219	119,772	123,584	127,870
External Providers	494,885	509,553	535,427	554,702	574,671
IDFs	30,899	30,845	31,008	32,124	33,280
Non Treatment Related & Other Costs	72,424	70,117	68,627	71,098	73,658
Total Operating Expenditure	1,223,623	1,259,708	1,306,329	1,351,857	1,399,461
Result before Interest, Depn & Cap Chrge	55,228	60,355	67,655	67,655	67,655
Interest, Depreciation & Capital Charge					
Interest Expense	(4,698)	(5,090)	(5,090)	(5,090)	(5,090)
Depreciation	(45,100)	(45,265)	(45,265)	(45,265)	(45,265)
Capital Charge Expenditure	(17,791)	(19,000)	(17,300)	(17,300)	(17,300)
Total Interest, Depreciation & Capital Charge	(67,589)	(69,355)	(67,655)	(67,655)	(67,655)
Net Surplus/(Deficit)	**(12,361)**	**(9,000)**	-	-	-
Other Comprehensive Income					
Gains on Property Revaluations	-	-	-	-	-
Fair Value through other comprehensive income financial assets	-	-	-	-	-
Total Comprehensive Income	**(12,361)**	**(9,000)**	-	-	-

8.2 Forecast Group Statement of Financial Position

	30/06/09 Actual $'000	30/06/10 Forecast $'000	30/06/11 Forecast $'000	30/06/12 Forecast $'000	30/06/13 Forecast $'000
Public Equity					
Opening Equity	249,515	215,923	205,062	203,201	201,340
Revaluation	(19,802)				
Equity Repayment	(1,429)	(1,861)	(1,861)	(1,861)	(1,861)
Net Result for the period	(12,361)	(9,000)	-	-	-
Total Public Equity	**215,923**	**205,062**	**203,201**	**201,340**	**199,479**
Current Assets					
Cash & Bank (OD)	47,497	50,711	69,115	52,519	923
MoH Debtor	26,942	20,372	20,372	20,372	15,372
Other Debtors & Other Receivables	19,850	19,765	19,765	19,765	19,765
Prepayments	1,147	872	872	872	872
Stocks	9,641	9,641	9,641	9,641	9,641
Total Current Assets	105,077	101,361	119,765	103,169	46,573
Current Liabilities					
Creditors & Accruals	84,939	80,000	80,000	80,000	80,000
Capital charge payable	5,194	7,229	7,229	7,229	7,229
GST	4,998	5,770	5,770	5,770	5,770
Interest Accrual	821	800	800	800	800
Staff Entitlement	115,967	115,000	115,000	115,000	115,000
Total Current Liabilities	211,919	208,799	208,799	208,799	208,799
Working Capital	(106,842)	(107,438)	(89,034)	(105,630)	(162,226)
Investments	12,066	12,066	12,066	12,066	12,066
Restricted Assets - Trust Fund	12,483	12,483	12,483	12,483	12,483
Fixed Assets	395,324	385,059	364,794	379,529	434,264
Total Non Current Assets	419,873	409,608	389,343	404,078	458,813
Term Staff Entitlement	(9,625)	(9,625)	(9,625)	(9,625)	(9,625)
Trust Funds Liabilities	(12,483)	(12,483)	(12,483)	(12,483)	(12,483)
Term Loans	(75,000)	(75,000)	(75,000)	(75,000)	(75,000)
Total Non Current Liabilities	(97,108)	(97,108)	(97,108)	(97,108)	(97,108)
Net Assets	**215,923**	**205,062**	**203,201**	**201,340**	**199,479**

8.3 Forecast Group Statement of Changes in Equity

	30/06/09 Actual $'000	30/06/10 Forecast $'000	30/06/11 Forecast $'000	30/06/12 Forecast $'000	30/06/13 Forecast $'000
Total Equity at Beginning of the Period	249,515	215,923	205,062	203,201	201,340
Total Comprehensive Income	(12,361)	(9,000)	-	-	-
Amount recognised Directly in Equity					
Impairment of property	(19,802)				
Total Recognised Revenues and Expenses					
Other Movements					
Contribution back to Crown	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)
Contribution from Crown	432				
Total Public Equity	**215,923**	**205,062**	**203,201**	**201,340**	**199,479**

8.4 Forecast Group Statement of Cashflow

	2008/09 Actual $'000	2009/10 Forecast $'000	2010/11 Forecast $'000	2011/12 Forecast $'000	2012/13 Forecast $'000
Cashflows from Operating Activities					
Cash provided from:					
MOH Receipts	1,190,244	1,262,921	1,309,178	1,354,572	1,404,966
Other Receipts	61,099	60,256	61,265	61,399	63,609
	1,251,343	1,323,177	1,370,443	1,415,971	1,468,575
Cash applied to:					
Employee Costs	505,553	533,941	551,495	570,349	589,982
Supplies & Expenses	707,104	731,398	754,834	781,508	809,479
Capital Charge Payments	4,422	16,965	17,300	17,300	17,300
Finance Costs	19,826	5,111	5,090	5,090	5,090
Taxes Paid	772	(772)	-	-	-
	1,237,677	1,286,643	1,328,719	1,374,247	1,421,851
Net Cashflow from Operating Activities	**13,666**	**36,534**	**41,724**	**41,724**	**46,724**
Cashflows from Investing Activities					
Cash provided from:					
Sale of Assets	13,108				
Interest Received	5,544	3,541	3,541	3,541	3,541
	18,652	3,541	3,541	3,541	3,541
Cash applied to:					
Advance to JV/Trust Investments	2,896	-	-	-	-
Purchase of Assets	22,835	35,000	25,000	60,000	100,000
	25,731	35,000	25,000	60,000	100,000
Net Cashflow from Investing Activities	**(7,079)**	**(31,459)**	**(21,459)**	**(56,459)**	**(96,459)**
Cashflows from Financing Activities					
Cash provide from:					
Equity Injection	432				
Loans Raised	-	-	-	-	-
	432	-	-	-	-
Cash applied to:					
Loan Repayment					
Equity Repayment re FRS-3	1,861	1,861	1,861	1,861	1,861
	1,861	1,861	1,861	1,861	1,861
Net Cashflow from Financing Activities	**(1,429)**	**(1,861)**	**(1,861)**	**(1,861)**	**(1,861)**
Overall Increase/(Decrease) in Cash Held	5,158	3,214	18,404	(16,596)	(51,596)
Add Opening Cash Balance	42,339	47,497	50,711	69,115	52,519
Closing Cash Balance	**47,497**	**50,711**	**69,115**	**52,519**	**923**

8.5 Summary of Revenue and Expenses by Output Class

Consolidated	**2010/11 Forecast $'000**
Revenue	
0-19	191,275
20-64	567,511
65+	526,462
In house elimination*	88,735
Total Revenue	1,373,984
Expenditure	
0-19	191,790
20-64	566,021
65+	527,436
In house elimination*	88,735
Total Expenditure	1,373,984
Net Surplus/(Deficit)	0

** In house elimination includes items that are not part of core Vote Health funding, i.e. ACC contracts and subsidiary company operations*

8.6 Summary of Revenue and Expenses by Arm

Funding Arm

	2008/09 $'000	2009/10 $'000	2010/11 $'000	2011/12 $'000	2012/13 $'000
Revenue					
MoH revenue	1,156,695	1,211,630	1,264,929	1,308,618	1,352,439
Patient Related Revenue					
Other					
Total Revenue	1,156,695	1,211,630	1,264,929	1,308,618	1,352,439
Expenditure					
Personnel					
Depreciation					
Interest & Capital charge					
Other - Personal Health	825,808	869,797	911,418	943,074	974,466
Other - Mental Health	125,547	127,622	133,003	137,528	142,202
Other - Disability Support	204,132	215,022	217,592	225,000	232,651
Other - Public Health	1,989	907	1,068	1,104	1,142
Other - Maori Health	1,572	1,282	1,848	1,912	1,978
Other - Governance & Admin	311	-	-	-	-
Total Expenditure	1,159,359	1,214,630	1,264,929	1,308,618	1,352,439
Net Surplus/(Deficit)	**(2,664)**	**(3,000)**	-	-	-

Governance & Funder Admin

	2008/09 $'000	2009/10 $'000	2010/11 $'000	2011/12 $'000	2012/13 $'000
Revenue					
MoH revenue	329	418	420	420	420
Patient Related Revenue					
Other					
Total Revenue	329	418	420	420	420
Expenditure					
Personnel	3,426	3,210	3,216	3,216	3,216
Depreciation	60	36	36	36	36
Interest & Capital charge					
Other	(3,193)	(2,828)	(2,832)	(2,832)	(2,832)
Total Expenditure	293	418	420	420	420
Net Surplus/(Deficit)	**36**	-	-	-	-

Provider Arm

	2008/09 $'000	2009/10 $'000	2010/11 $'000	2011/12 $'000	2012/13 $'000
Revenue					
MoH revenue	678,450	718,535	742,323	767,777	793,906
Patient Related Revenue	43,285	41,746	42,581	44,114	45,702
Other	33,667	21,966	22,225	20,826	21,448
Total Revenue	755,402	782,247	807,129	832,717	861,056
Expenditure					
Personnel	509,203	529,764	548,279	567,133	586,766
Depreciation	45,040	45,229	45,229	45,229	45,229
Interest & Capital charge	22,489	24,090	22,390	22,390	22,390
Other	188,403	189,164	191,231	197,965	206,671
Total Expenditure	765,135	788,247	807,129	832,717	861,056
Net Surplus/(Deficit)	**(9,733)**	**(6,000)**	-	-	-

In House Elimination

	2008/09 $'000	2009/10 $'000	2010/11 $'000	2011/12 $'000	2012/13 $'000
Revenue					
MoH revenue	(633,575)	(674,232)	(698,494)	(722,243)	(746,799)
Patient Related Revenue					
Other					
Total Revenue	(633,575)	(674,232)	(698,494)	(722,243)	(746,799)
Expenditure					
Personnel					
Depreciation					
Interest & Capital charge					
Other	(633,575)	(674,232)	(698,494)	(722,243)	(746,799)
Total Expenditure	(633,575)	(674,232)	(698,494)	(722,243)	(746,799)
Net Surplus/(Deficit)	-	-	-	-	-

Consolidated

	2008/09 $'000	2009/10 $'000	2010/11 $'000	2011/12 $'000	2012/13 $'000
Revenue					
MoH revenue	1,201,899	1,256,351	1,309,178	1,354,572	1,399,966
Patient Related Revenue	43,285	41,746	42,581	44,114	45,702
Other	33,667	21,966	22,225	20,826	21,448
Total Revenue	1,278,851	1,320,063	1,373,984	1,419,512	1,467,116
Expenditure					
Personnel	512,629	532,974	551,495	570,349	589,982
Depreciation	45,100	45,265	45,265	45,265	45,265
Interest & Capital charge	22,489	24,090	22,390	22,390	22,390
Other	710,994	726,734	754,834	781,508	809,479
Total Expenditure	1,291,212	1,329,063	1,373,984	1,419,512	1,467,116
Net Surplus/(Deficit)	**(12,361)**	**(9,000)**	-	-	-

9. Our Organisational Capability

Having already outlined the challenges we face and the outcomes we seek for our population, the following section highlights the capability developments we will be focusing on in the coming year.

Capability is defined as "*what an organisation needs in terms of access to leadership, people, culture, relationships, processes and technology, physical assets and structures to efficiently deliver the outputs required to achieve its goals*".[54] We are committed to building organisational capability across the Canterbury Health System by improving clinical governance and leadership, provider relationships and inter-sector partnerships and collaboration. We also have an ongoing commitment to improving quality and patient safety, valuing our workforce and improving our infrastructure and information management.

9.1 Adjusting Capability to meet Changing Circumstances and Expectations

Clinical capability is facilitated and supported by the DHB's Chief Medical Officer, Executive Director of Nursing and Director of Allied Health, who provide clinical leadership and input into the decision making process at the highest level of our organisation. Clinical input into decision making is further facilitated by the DHB's Clinical Board and a model of shared management and clinician leadership at all levels within the DHB. This model is replicated across the whole of the Canterbury health system, with a framework of primary/secondary clinical leadership that helps to drive the transformation needed to improve the delivery of health services to meet the changing needs of our population and to ensure change is sustainable long-term.

We are also fortunate to have a well functioning Board whose members contribute a wide range of skills and expertise to their governance role. Governance capability is maintained through regular forums and training and is backed by the selection of a mix of experts, professionals and consumers on the Board's advisory committees. The role of the DHB's advisory councils in shared decision making also contributes to governance capability. These advisory councils include the Clinical Board, the Consumer Council and (through our Memorandum of Understanding) Manawhenua Ki Waitaha.

However, with funding constraints and increasing demand, our capability and capacity to deliver services and respond to changing expectations is stretched. To combat this, we are implementing alternative and innovative models of care, reconfiguring traditional service models and developing more robust prioritisation mechanisms. To achieve our long-term objectives and goals, we will determine the most appropriate and affordable mix of services to meet the needs of our population and to ensure that service investment is sustainable.

In building our capability to deliver more within current funding constraints, our aim is to create a Canterbury Health Service of joined up health services focused around the patient. The patient journey through the health system will be timely, seamless between providers and provide consistent quality to achieve the best possible outcomes. We will ensure that investment and workforce planning supports the delivery of patient-centred models of care and makes the best use of our available resources.

9.1.1 Collaboration and Partnerships – Working as a Whole Health System

We recognise that our goals and objectives will not be achieved through the services we provide alone, and our relationships with the organisations we fund need to be more than contractual relationships. These partnerships also allow us to share resources, combine effort and reduce duplication and variation across the health system, to achieve the best health outcomes for our population.

A number of existing partnerships already support patient-centred models of care and the provision of services across the full continuum of care. We will seek to enhance these partnerships over the coming year in order to improve the patient journey through the health system and ensure a seamless transition between services.

The six South Island DHBs have an agreed process for collective decision making to support collaborative health service planning. The framework provides direction for the type and level of service that will be required to best meet the needs of the South Island population, while allowing discussion and debate about how services can be configured and organised. Through our joint South Island Shared Services Agency, the South Island DHBs have commenced wider collaborative planning processes around elective services, mental health services, older persons' health services, cancer services and public health services. This regional planning will better support clinical networks, provide clear long-term signals around service planning and capital investment and improve the use of shared resources to increase service capacity and financial sustainability.

[54] *Guidance and Requirements for Crown Entities; preparing the 2005/06 Statement of Intent, www.crownentities.ssc.govt.nz.*

After a recent report into the future provision of health services by the West Coast DHB, we have also agreed to formalise some of our long-standing clinical partnership arrangements.[55] This collaboration is a natural progression from the long-standing links that we have with the West Coast, but formalising our partnership will allow us to better plan the assistance we provide, help to build a more appropriate workforce in both locations and improve patient safety, without having any detrimental affect on services provided to our own population.

Helping to drive regional planning and ensure the future sustainability of services are the many clinical networks that exist both regionally and nationally including: Southern Cancer Network, South Island Regional Mental Health Network, South Island Regional Health of Older Persons Network, National Cardiac Network, Paediatric Surgery, Paediatric Oncology, Paediatric Neurology and Neonatal Services Networks, Brain Injury Rehab Networks, Neurosurgeon Network and Anaesthesia Networks. We already recognise the importance of clinical leadership in the transformation of health services, and our future direction supports a strengthening of all clinical networks.

9.1.2 Quality and Patient Safety

The Canterbury DHB has a strong commitment to the provision of good quality health care services, and we seek to continuously improve quality and patient safety in our health services to improve outcomes for our population. Through the transformation of our services, we will provide an integrated Canterbury Health System that strongly encourages evidence-based clinical care and is responsive to consumer needs.

By supporting the initiatives taking place across the system that encourage the use of innovation and quality improvement to improve service delivery and patient outcomes, we can effectively respond to change. The opportunity exists to build our transformation momentum by supporting clinical leadership and engaging our workforce in these initiatives and in the development of patient pathways through the system. Improvements in quality will also provide a means for reducing variation in practice and duplication of effort and waste in the patient journey. Focusing on best practice and patient pathways will enable the DHB to make savings in terms of technical efficiencies and to make better use of our clinical workforce and limited resources.

A focus on the safe patient journey through the health system is also an effective mechanism for systematically identifying and managing problems and failures in the system and for informing the development of preventive strategies and the redesign of patient pathways to eliminate repeated harm. Improvements in the patient journey are a key focus for the DHB in the coming year, and activity over the next three years will align with our Quality Strategic Plan (2007-2010), which has five clear goals focused on improving patient safety and providing effective quality services.

The goals, and the priorities that sit beneath them, clearly demonstrate the importance of quality improvement across the whole of the system. The five Quality Strategic Plan goals are:[56]

- Continuous improvement in the safety of our services;
- Continuous improvement in our systems and processes;
- Continuous improvement in our practices;
- Continuous improvement in our relationships and partnerships; and
- Continuous improvement in the health of our community.

9.1.3 Workforce Development

Workforce development and strong organisational health is central to the DHB's ability to provide effective quality services and meet the ongoing and future challenges of improving our community's health. We seek to access the best possible talent available and unlock its full potential to support our strategic direction.

Workforce development activities over the next few years will include a number of key approaches to building and maintaining capability and capacity and engaging our workforce in the future direction, including:

- Establishing a leadership development model;
- Supporting an improved organisation/patient culture;
- Promoting employee engagement;
- Maintaining and supporting clinical retention;
- Implementing workforce systems and performance development tools;

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[55] *Analysis of options: Models of Care for West Coast District Health Board, by Law and Economic Consulting Group (LECG).*

[56] *The DHB's Quality Strategic Plan was developed within the context of the national document 'Improving Quality: A Systems Approach for the NZ Health and Disability Sector'. The Plan is available online at www.cdhb.govt.nz.*

- Improving workforce sourcing; and
- Supporting regional workforce initiatives.

We are also committed to being a 'good employer', and the statutory requirements of being a good employer are well embedded in our system. To meet requirements, we provide: good and safe working conditions; an equal employment opportunities programme; the impartial selection of suitably qualified persons for appointment; recognition within the workforce of the aspirations and needs of Māori, other ethnic or minority groups, women and people with disabilities; and training and skill enhancement of employees.

9.1.4 Information Systems and Infrastructure

The ability to provide a smooth patient journey through the health system also requires integrated information systems and the sharing of patient-focused information between primary and secondary providers. This information needs to be accurate, timely and available at the point of care to better inform clinical decision-making and improve health outcomes.

In order to deliver to clinical requirements, our information infrastructure requires continual updating. We work regionally and nationally to drive improvements and to ensure quality standards are met, taking a collective approach to implementing the Government's Health Information Strategy NZ (HIS-NZ). Alongside our commitment to the implementation of HIS-NZ, we have also established a local Information Services Strategic Plan (ISSP) which reinforces the objectives outlined in national strategies and involves working closely with stakeholders to implement solutions that satisfy local clinical and business requirements.

Information systems development over the next few years will include a number of key approaches to building and maintaining capability and capacity, including:

- Supporting the rollout of the Electronic Referral Management System (ERMS) and primary/secondary community communication systems;
- Providing an IT environment that supports clinical services by upgrading our Clinical Information System (Concerto), Laboratory Results Reporting (Éclair) and email (Exchange 2010) and replacing the Storage Area Network;
- Rolling out e-Referrals in secondary care facilities in line with the Canterbury Initiative programme;
- Implementing TestSafe South and capturing and reporting Canterbury laboratory results into one results repository;
- Establishing a Clinical Services Reference Group to provide clinical oversight for our Facilities Redesign project and clinical work streams to ensure there is broad engagement and facilities developed are appropriate for modern models of care and capture opportunities around co-location of services;
- Completing a business case for first stage development at Christchurch Hospital and a business case for the redevelopment of Health of Older Persons Services;
- Completing the concept design process by March 2011.

9.2 Associate and Subsidiary Companies

We also have two subsidiary companies, which as wholly owned subsidiaries, have their own Board of Directors (appointed by the DHB). Both subsidiary companies report to us, as their shareholder, on a regular basis.

- ***Brackenridge Estate Limited*** - Incorporated in 1998, Brackenridge Estate Limited provides residential care and respite services, together with day programmes for people with intellectual disability and high dependency needs. Brackenridge operates a range of houses on the Brackenridge site and in the community. Funding of Brackenridge comes from two sources: a contract directly with the Ministry of Health and contracts with the Ministry of Social Development. Brackenridge is currently working through a strategic planning process.
- ***Canterbury Laundry Service Limited*** **-** Canterbury Laundry Service Limited was incorporated as a company in February 1993. The Company acquired the laundry and linen supply operation from the former Canterbury Area Health Board; the shareholding was originally owned equally by the former Canterbury Health Limited and Healthlink South Limited. The Canterbury DHB now owns all shares and the land and buildings used by the Laundry Service (located at Sylvan Street in Christchurch). Plant and equipment, motor vehicles and the rental linen pool are now the major fixed assets of the Company. A rental is paid to us for the use of the land and buildings.

We are also a joint shareholder in the ***South Island Shared Services Agency Limited*** (SISSAL), which is wholly owned by the six South Island DHBs: Nelson Marlborough, West Coast, Southland, Otago, South Canterbury and Canterbury.

SISSAL is funded to provide services such as contract and provider management, audit, analysis, service development and project management. SISSAL has an annual budget of around $2.8m and produces its own Statement of Intent.

We are continually assessing the role and efficiency of our subsidiaries to ensure efficiency of our core services.

9.3 Accountability - Reporting to the Minister of Health

In accordance with Section 141 (1) (g) of the Crown Entities Act and the New Zealand Public Health and Disability Act, the DHB will consult with the Minister via the Ministry of Health in relation to the development of, or changes to, the District Strategic Plan, the District Annual Plan (and any significant capital investment or service change not covered in that Plan), and the disposal of land. The DHB also provides regular reporting to the Ministry of Health as outlined below.

Timetable of DHB Reporting	
Information Requests	Ad Hoc
Service Agreement Reporting	As per Service Contract Requirements
Waiting Times and ESPI Compliance Information	Monthly
Financial Reporting	Monthly
National Data Collections	Monthly
Risk Reporting	Quarterly
Health Target Reporting	Quarterly
Crown Funding Agreement Non-Financial Reporting	Quarterly
Indicators of DHB Performance Reporting	Quarterly
Hospital Benchmarking Information Reporting	Quarterly
Annual Report and Audited Statements	Annually

Alongside this reporting to the Minister and Ministry of Health, the Canterbury DHB provides monthly and quarterly performance monitoring against the mix of financial and non-financial indicators and targets set out in our District Annual Plan and Statement of Intent to our Board and its statutory committees at public meetings and makes this information available to the public on its website. We also support the Minister of Health's expectation that the public should be provided with better information on health system performance by publishing on our website and in local newspapers Canterbury's quarterly performance against the national health targets.

Over the coming year, we will actively work with the Ministry and the National Health Board to support performance indicators that provide positive incentives for change, recognise the different approaches of DHBs and demonstrate productivity and delivery across the whole of the health system, rather than just at hospital level to better support engagement with transformation and to eliminate possible financial risks associated with under-delivery.

We will continue to compare our performance against that of other DHBs to ensure we are providing our population with value for our investment and returning improved health outcomes. Quality benchmark reporting and standardised intervention rates are indications of performance, and we also monitor and assess the quality of services provided by our hospital and specialist services and external providers, through service agreements, reporting of adverse incidents, routine quality audits, consumer surveys, service reviews and issues-based audits.

9.3.1 Performance Improvement Actions

In 2010/11, DHBs are required to respond to the Government's request that all Crown entities develop performance improvement actions as part of 'Improving the Business of Government: Delivering Better, Smarter Public Services for Less". Performance Improvement Actions are intended to reflect key actions to improve efficiency, effectiveness, and alignment with the Governments priorities. Our Performance Improvement Actions are attached as an appendix to our District Annual Plan, to which they align, and to this document. (Refer Appendix 5.)

10. Appendices

- Appendix 1: Glossary of Terms.
- Appendix 2: Objectives of a DHB – New Zealand Public Health and Disability Act 2000.
- Appendix 3: Canterbury DHB Organisational Chart.
- Appendix 4: Hospital and Specialist Services Overview.
- Appendix 5: Performance Improvement Actions.
- Appendix 6: Statement of Accounting Policies.

References

Unless specifically stated, all Canterbury DHB documents referenced in this Statement of Intent are available on the Canterbury DHB website (www.cdhb.govt.nz).

All Ministry documents referenced in this Statement of Intent are available on the Ministry's website (www.moh.govt.nz).

The following two documents referenced in this Statement of Intent are available on the Treasury website (www.treasury.govt.nz):

- Crown Entities Act 2004; and
- Public Finance Act 1989.

10.1 Glossary of Terms.

GLOSSARY OF TERMS USED IN THIS DOCUMENT		
ACC	Accident Compensation Corporation	Crown Entity set up to provide comprehensive no-fault personal accident cover for New Zealanders.
	Acute Care	The provision of appropriate, timely, acceptable and effective management of conditions with sudden onset and rapid progression that require attention.
ASH	Ambulatory Sensitive Hospital Admissions	Hospitalisation or death due to causes which could have been avoided by preventive or therapeutic programme
	Capability	What the DHB needs (in terms of access to people, resources, systems, structures, culture and relationships), to efficiently deliver the outputs required to achieve its goals or those of Government.
COPD	Chronic Obstructive Pulmonary Disease	A progressive disease process that most commonly results from smoking. Chronic obstructive pulmonary disease is characterised by difficulty breathing, wheezing and a chronic cough.
	Crown Entities	A generic term for a diverse range of entities referred to in the Crown Entities Act 2004 (the Act which governs Crown Entities). Crown Entities are legally separate from the Crown and operate at arms length from the responsible or shareholding Minister and are included in the annual financial statements of the Government.
	Continuum of Care	Exists when a person can access responsive services matched to their level of need at any time throughout their illness or recovery.
CFA	Crown Funding Agreement	This is an agreement by the Crown to provide funding in return for the provision of, or arranging the provision of, specified services.
CVD	Cardiovascular Disease	Cardiovascular diseases affect the heart and circulatory system. They include ischaemic heart disease, rheumatic heart disease, cerebrovascular disease and other forms of vascular and heart disease.
DOSA	Day of Surgery Admission	DOSA is a patient who is admitted on the same day on which they are scheduled to have their elective surgery. The admission can be as either a day case or an inpatient.
	Determinants of Health	The range of personal, social, economic and environmental factors that determine the health status of individuals or populations.
DAP	District Annual Plan	This document sets out what the DHB intends to do over the year to advance the outcomes set out in the District Strategic Plan, the funding proposed for these outputs, the expected performance of the DHB provider arm and the expected capital investment and financial and performance forecasts.
DSP	District Strategic Plan	The DSP identifies how the DHB will fulfil its objectives and functions over the next five to ten years by: identifying the significant internal and external issues that impact on the DHB and affect its ability to fulfil its mandate and purpose, acknowledging societal outcomes and identifying appropriate system outcomes as they relate to population outcomes and outlining major planning and capability building
	Effectiveness	The extent to which objectives are being achieved. Effectiveness indicators relate outputs to impacts and to outcomes and can measure the steps along the way to achieving overall objectives or an outcome. Effectiveness indicators can also be used to test whether outputs have the characteristics required for achieving a desired objective or Government outcome.
ESPIs	Elective Services Patient flow Indicators	The ESPIs have been developed by the Ministry to assess whether or not DHBs are on the right track with the Government policies on elective services.
FSA	First Specialist Assessment	(Outpatients only) First time a patient is seen by a doctor for a consultation in that speciality, this does not include procedures, nurse or diagnostic appointments or pre-admission visits.
HbA1c	Haemoglobin A1c	The level of HbA1c reflects the average blood glucose level over the past 3 months. Also known as glycated haemoglobin.
HIS-NZ	Health Information Strategy–New Zealand	The Government's Health Information Strategy for all DHBs.
HNA	Health Needs Assessment	A process designed to establish the health requirements of a particular population
HEHA	Healthy Eating Healthy Action 'Strategy'	HEHA is the Ministry's strategic approach to improving nutrition, increasing physical activity and achieving healthy weight for all New Zealanders.
HSS	Hospital and Specialist Services	The Provider-arm Division of the Canterbury DHB.
	Impact	The contribution made to an outcome by a specified set of goods and services (outputs), or actions, or both. Normally describes results that are directly attributable to the activity of an agency (the DHB). Impact measures should be attributed to DHB outputs in a credible way and represent near-terms results expected from the goods and services (outputs) delivered. Impact measures can be measured after delivery, promoting timely decision and can reveal specific ways in which the DHB can remedy performance shortfalls.

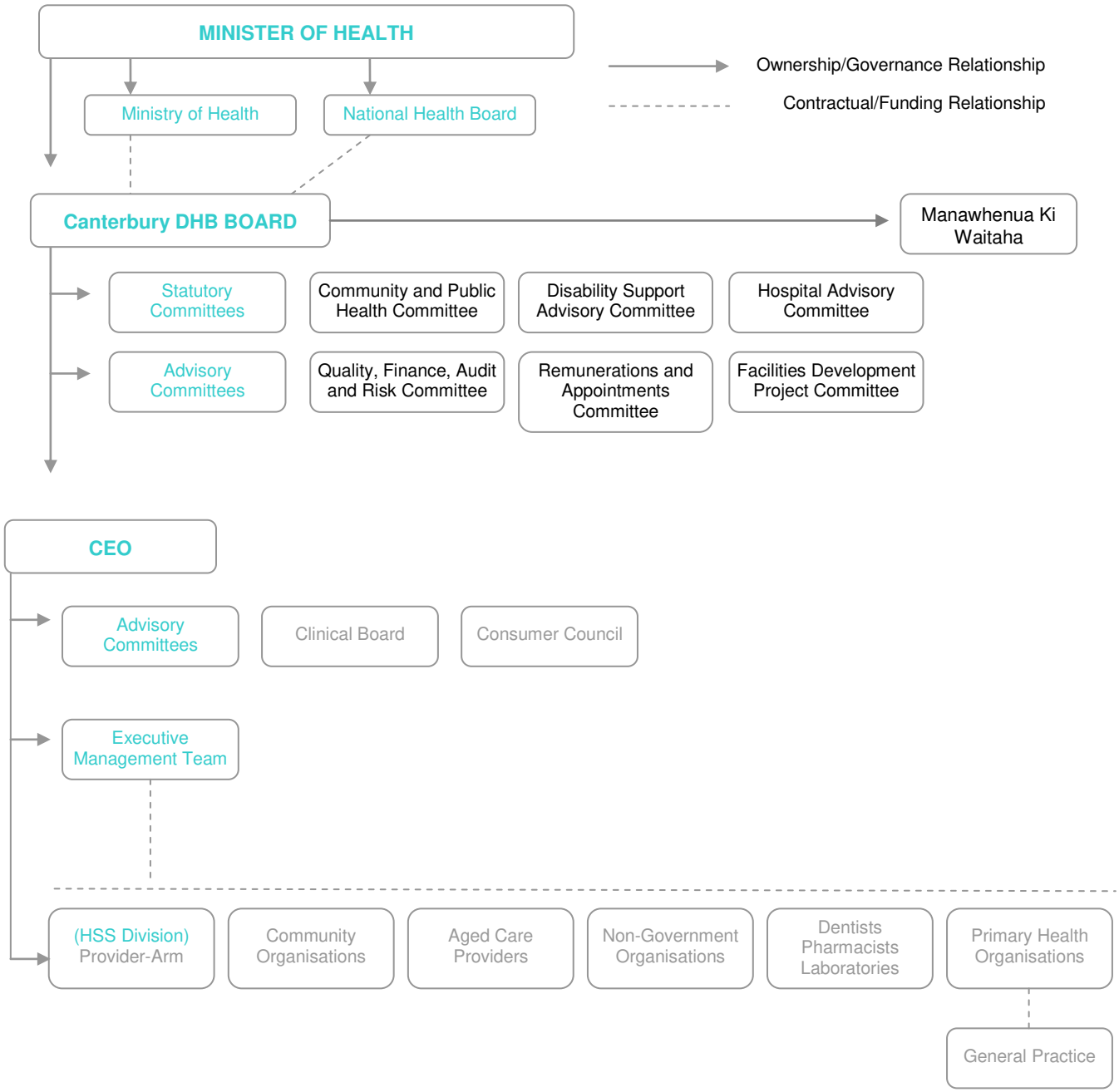
	Improving the Patient Journey	The Improving the Patient Journey Programme has been established by the DHB to encourage participants to positively influence the effectiveness and efficiency of the organisation and to improve patient outcomes. The overarching goals are to: reduce unnecessary waits and delays within the patient continuum of care and embed innovation tools, techniques and learning into services and other organisations. The involvement and leadership of frontline staff in the review of the system underpinning patient care is key to the success of the Programme.
ISSP	Information Services Strategic Plan	The Canterbury DHB's Plan for information services – in line with the national Health Information Strategy.
IDFs	Inter District Flows	An IDF is a service (output) provided by a DHB to a patient whose 'place of residence' falls under the region of another DHB. Under PBF each DHB is funded on the basis of its resident population therefore the DHB providing the IDF will recover the costs of that IDF from the DHB who was funded for that patient.
	Integration	'Combine into a whole' or 'complete by addition of parts'.
InterRAI	International Resident Assessment Instrument	Comprehensive geriatric assessment tool.
MoU	Memorandum of Understanding	An agreement of cooperation between organisations defining the roles and responsibilities of each organisation in relation to the other or others with respects to an issue over which the organisations have concurrent jurisdiction.
	Morbidity	Illness, sickness.
	Mortality	Death.
NHI	National Health Index	The NHI number is a unique identifier that is assigned to every person who uses health and disability support services in NZ. A person's NHI number is stored on the NHI along with that person's demographic details. The NHI and associated NHI numbers are used to help with the planning, co-ordination and provision of health and disability support services across NZ.
NGO	Non- Government Organisations	There are many ways of defining NGOs. In the context of the relationship between the Health and Disability NGOs and the Canterbury DHB, NGOs include independent community and iwi/Māori organisations operating on a not-for-profit basis, which bring a value to society that is distinct from both Government and the market. In reality this will mean that any profits are put back into the organisation, rather than distributed to shareholders.
OPF	Operational Performance Framework	The OPF is one of a set of documents known as the 'Policy Component of the DHB Planning Package' which sets out the accountabilities of DHBs. The OPF is endorsed by the Minister of Health and comprises the operational level accountabilities that all DHBs must comply with, given effect through the Crown Funding Agreements between the Minister and the DHB.
	Outcome	A state or condition of society, the economy or the environment and a change in that state or conditions. It normally describes the health status of an individual, group or population where a change in the health status is attributable or influenced by many different factors which may operate independently, and where attributing change to the individual activities of one agency is difficult.
	Output Class	An aggregation of outputs of a similar nature.
	Outputs	Final goods and services supplied or delivered to a third party outside of the DHB. Not to be confused with good and service produced entirely for consumption within the DHB (internal outputs or inputs).
PBF	Population Based Funding	Involves using a formula to allocate each DHB a fair share of the available resources so that each Board has an equal opportunity to meet the health and disability needs of its population.
	Primary Care	Primary Care means essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to, and a central function of, the country's health system, and is the first level of contact with the health system.
PHO	Primary Health Organisation	PHOs encompass the range of primary care and practitioners and are funded by DHBs to provide of a set of essential primary health care services to those people who are enrolled in that PHO.
	Public Health	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort. A collective effort to identify and address the unacceptable realities that result in preventable and avoidable health outcomes and it is the composite of efforts and activities that are carried out by people committed to these ends.
	Secondary Care	Specialist care that is typically provided in a hospital setting
SISSAL	South Island Shared Services Agency Ltd	SISSAL is an organisation funded by the South Island DHBs on an annual budget basis to provide consultancy and management services including contract and provider management, audit, strategy and service development, analysis, and project and change management.
	Tertiary Care	Very specialised care often only provided in a smaller number of locations
YTD	Year to Date	The 12 month period immediately prior to the date given.

10.2 Objectives of a DHB – New Zealand Public Health and Disability Act 2000.

Part 3: Section 22:

- To reduce health disparities by improving health outcomes for Māori and other population groups;
- To reduce, with a view to eliminating, health outcome disparities between various population groups, by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders;
- To improve, promote, and protect the health of people and communities;
- To improve integration of health services, especially primary and secondary health services;
- To promote effective care or support for those in need of personal health or disability support services;
- To promote the inclusion and participation in society and independence of people with disabilities;
- To exhibit a sense of social responsibility by having regard to the interests of people to whom we provide, or for whom we arranges the provision of services;
- To foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services;
- To uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations;
- To exhibit a sense of environmental responsibility by having regard to the environmental implications of our operations; and
- To be a good employer.

10.3 Canterbury DHB - Organisational Chart.



10.4 Hospital and Specialist Services Division - Overview of Services.

HOSPITAL SUPPORT AND LABORATORY SERVICES DIVISON

Covers support services such as: medical illustrations, specialist equipment maintenance, sterile supply and hospital maintenance. Hospital and Support Services also consists of patient and staff food services, cleaning services and travel and waste contracts. These Services also cover the provision of diagnostic services through Canterbury Health Laboratories for patients under the care of the Canterbury DHB and offers a testing service for GPs and private specialists. Canterbury Health Laboratories are utilised by more than 20 public and private laboratories throughout NZ that refer samples for more specialised testing and is recognised as an international referral centre.

MEDICAL AND SURGICAL SERVICES DIVISON

Covers medical services: general medicine, cardiology/lipid disorders, endocrinology/diabetes, respiratory, rheumatology/immunology, infectious diseases, oncology, gastroenterology, clinical haematology, neurology, renal, palliative, hyperbaric medicine and sexual health and surgical services: general surgery, vascular, ENT, ophthalmology, cardiothoracic, orthopaedics, neurosurgery, urology, plastic, maxillofacial and cardiothoracic surgeries and the services of the day surgery unit. Medical and Surgical Services also covers: emergency investigations, outpatients, anaesthesia, intensive care, radiology, nuclear medicine, clinical pharmacology, pharmacy, medical physics and allied health services. The Christchurch Hospital has a busy Emergency Department treating around 78,000 patients per annum.

MENTAL HEALTH SERVICES DIVISON

Covers adult acute services, specialty rehabilitation, long-term care and community services, child and youth inpatient and outpatient services, forensic services, alcohol and drug services and psychiatric services for adults with intellectual disabilities; including assessment treatment and rehabilitation. The Mental Health Service also provides specialist mental health services (including alcohol and drug services) through a number of outpatient, community-based and mobile teams throughout Canterbury. Regional beds and consultation liaison are also provided by the Forensic, Eating Disorders, Alcohol and Drug and Child Adolescent and Family Services. Rural Adult and CAF Mental Health Services are provided to Kaikoura and Ashburton through outreach clinics.

OLDER PERSONS SPECIALIST HEALTH AND REHABILITATION SERVICES DIVISON

Covers assessment, treatment, rehabilitation and psychiatric services for the elderly inpatient, outpatient and community; under 65 needs assessment service; generic geriatric outpatients; specialist osteoporosis clinics and specialist under 65 assessment and treatment services for disability funded clients. The Older persons' Health Specialist Service also operates a psychogeriatric day hospital. Inpatient and community stroke rehabilitation services are also provided by Older Persons' Health Specialist Services. Rehabilitation services (provided at Burwood Hospital) include spinal, brain injury, orthopaedic and chronic pain management services. The majority of CDHB elective orthopaedic surgery is undertaken at Burwood Hospital, as well as some general Plastics lists. The Burwood Procedure Unit provides a 'see and treat' service for skin lesions in conjunction with primary care.

ASHBURTON AND RURAL HEALTH SERVICES DIVISON

Covers a wide range of services provided in rural areas generally based out of Ashburton Hospital but also covering services provided by the smaller rural hospitals of Akaroa, Darfield, Ellesmere, Kaikoura, Oxford & Waikari. Services include: general medicine and surgery, palliative care, maternity services, gynaecology services, assessment treatment and rehabilitation services for the elderly and long-term care for the elderly including specialised dementia care, diagnostic services and meals on wheels. Also offered in Ashburton are rural community services: day care, district nursing, home support, and clinical nurse specialist outreach services including respiratory, cardiac, diabetes, wound care, urology, continence and stoma therapy. Within Ashburton the division also operates Tuarangi Home which provides hospital level care for the elderly in Ashburton and is introducing, in 2011, rest home dementia care for the elderly.

WOMEN AND CHILDREN'S HEALTH SERVICES DIVISON

Covers acute and elective gynaecology services, primary, secondary and tertiary obstetric services, neonatal intensive care services at Christchurch Women's Hospital, first trimester pregnancy terminations at Lyndhurst Hospital and primary maternity services at Lincoln Maternity, Rangiora Hospital and the Burwood Birthing Unit. This Service also covers children's health: general paediatrics, paediatric oncology, paediatric surgery, child protection services, cot death/paediatric disordered breathing, community paediatrics and paediatric therapy, public health nursing services and vision/hearing screening services. The Services' neonatal intensive care unit and staff are involved in world-leading research investigating improved care for pre-term babies and child health specialists provide a Paediatric Neurology, Oncology and Surgery Outreach Service to DHBs in the South Island and lower half of the North Island.

10.5 Canterbury DHB Performance Improvement Actions.

Benefits from Performance Improvement Actions are potentially realised in three ways: as direct financial benefits to the patients or health service agencies involved; as indirect financial benefits, in terms of avoided costs; and as health improvements for patients and populations.

The ability to improve performance is reliant on our single system approach to delivering health care within available funding and sector-wide strategies that aim to provide services in a timely manner in the most appropriate location.

By making health improvements the costs avoided are projected to be $35M.

Category	Actions	Deliverables	Costs Avoided
Improve Productivity and Quality.	Clinical Leadership	▪ Opportunities created for clinicians to provide leadership to 'make it better' through provision of clinical solutions to service delivery issues.	$35M
	Health Systems Integration	▪ Continued development of system-wide pathways disseminated via the HealthPathways website. ▪ Electronic referral management between primary and secondary care. ▪ Acute demand services to manage patients' health in the community. ▪ Leadership across the health system to provide integrated response to the ED health target. ▪ Development of single integrated service models.	
	Making Hospitals Work	▪ Quality production embedded to achieve planned throughput. ▪ Time released for caring. ▪ Reduction of variation, duplication and waste to improve service quality, increase capacity and deliver timely interventions.	
	Avoided Growth in Aged Residential Care	▪ Simplified assessment and case coordination to enable people to remain in their own homes. ▪ Improving the quality of community support to enable people to remain in their own homes. ▪ Restorative approach to manage complex cases in the community.	

10.6 Statement of Accounting Policies.

The prospective financial statements in this Statement of Intent for the year ended 30 June 2011 are prepared in accordance with Section 38 of the Public Finance Act 1989 and they comply with NZIFRS, as appropriate for public benefit entities. FRS-42 states that the (prospective) forecast statements for an upcoming financial year should be prepared using the same standards as the statements at the end of that financial year. The following information is provided in respect of this Statement of Intent:

(i) Cautionary Note

The Statement of Intent's financial information is prospective. Actual results are likely to vary from the information presented, and the variations may be material.

(ii) Nature of Prospective Information

The financial information presented consists of forecasts that have been prepared on the basis of best estimates and assumptions on future events that the Canterbury DHB expects to take place.

(iii) Assumptions

The main assumptions underlying the forecast are noted in Section 7 of the Statement of Intent.

REPORTING ENTITY AND STATUTORY BASE

Canterbury DHB ("CDHB") is a Health Board established by the New Zealand Public Health and Disability Act 2000. CDHB is a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. CDHB is a Reporting Entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, Public Finance Act 1989, and the Crown Entities Act 2004.

CDHB has designated itself and its subsidiaries, as public benefit entities, as defined under New Zealand International Accounting Standard 1 (NZ IAS 1).

CDHB's primary objective is to deliver health and disability services and mental health services in a variety of ways to the Canterbury community.

The consolidated financial statements of CDHB consists of CDHB, its subsidiaries, Canterbury Laundry Service Ltd (100% owned) and Brackenridge Estate Ltd (100% owned), and associate entity South Island Shared Service Agency Ltd (47% owned).

The CDHB will adopt the following accounting policies consistently during the year and apply these policies for the Annual Accounts.

BASIS OF PREPARATION

Statement of compliance

The consolidated financial statements have been prepared in accordance with the requirements of the NZ Public Health and Disability Act 2000 and Section 154 of the Crown Entity Act 2004, which includes the requirement to comply with NZ Generally Accepted Accounting Practice (NZ GAAP). In accordance with NZ GAAP, the consolidated financial statements comply with NZ equivalents to International Financial Reporting Standards (NZ IFRSs), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

Measurement basis

The financial statements are prepared on the historical cost basis except that the following assets and liabilities are stated at their fair value: derivative financial instruments (foreign exchange and interest rate swap contracts), financial instruments classified as available-for-sale, and land and buildings.

Non-current assets held for sale and disposal groups held for sale are stated at the lower of carrying amount and fair value.

Functional and presentation currency

The financial statements are presented in New Zealand dollars (NZD), rounded to the nearest thousand. The functional currency of CDHB is New Zealand dollars.

Changes in accounting policies

The accounting policies set out below have been applied consistently to all periods presented in these consolidated financial statements.

Standards, amendments and interpretations issued but not yet effective that have not been early adopted and which are relevant to Canterbury DHB include:

- NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The new standard also requires a single impairment method to be used, replacing the many different impairment methods in NZ IAS 39. The new standard is effective for reporting period beginning on or after 1 January 2013. Canterbury DHB has not yet assessed the impact of the new standard and expects it will not be early adopted.

Standards, amendments and interpretations issued and effective that have been adopted and which are relevant to Canterbury DHB include:

- NZ IAS 1 Presentation of Financial Statements (revised 2007) replaces NZ IAS 1 Presentation of Financial Statements (issued 2004) and is effective for reporting periods beginning on or after 1 January 2009. The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with the Crown in its capacity as "owner". The revised standard gives Canterbury DHB the option of presenting items of income and expense and components of other comprehensive income either in a single statement of comprehensive income with subtotals, or in two separate statements (a separate income statement followed by a statement of comprehensive income). Canterbury DHB intends to adopt this standard for the year ending 30 June 2010, and is yet to decide whether it will prepare a single statement of comprehensive income or a separate income statement followed by a statement of comprehensive income.
- NZ IAS 23 Borrowing Costs (revised 2007) replaces NZ IAS 23 Borrowing Costs (issued 2004) and is effective for reporting periods commencing on or after 1 January 2009. The revised standard requires all borrowing costs to be capitalised if they are directly attributable to the acquisition, construction or production of a qualifying asset. Canterbury DHB intends to adopt this standard for the year ending 30 June 2010 and has determined that the potential impact of the new standard to be minimal.

SIGNIFICANT ACCOUNTING POLICIES

Basis for Consolidation

The purchase method is used to prepare the consolidated financial statements, which involves adding together like items of assets, liabilities, equity, income and expenses on a line-by-line basis. All significant intra-group balances, transactions, income and expenses are eliminated on consolidation.

CDHB's investments in its subsidiaries are carried at cost in CDHB's own "parent entity" financial statements.

Subsidiaries

Subsidiaries are entities controlled by CDHB. Control exists when CDHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable or convertible are taken into account. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

CDHB measures the cost of a business combination as the aggregate of the fair values, at the date of exchange, of assets given, liabilities incurred or assumed, in exchange for control of subsidiary plus any costs directly attributable to the business combination.

Associates

Associates are those entities in which CDHB has significant influence, but not control, over the financial and operating policies.

The consolidated financial statements include CDHB's share of the total recognised gains and losses of associates on an equity accounted basis, from the date that significant influence commences until the date that significant influence ceases. When CDHB's share of losses exceeds its interest in an associate, CDHB's carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that CDHB has incurred legal or constructive obligations or made payments on behalf of an associate.

CDHB's investments in associates are carried at cost in CDHB's own "parent entity" financial statements.

Transactions eliminated on consolidation

Intra-group balances and any unrealised gains and losses or income and expenses arising from intra-group transactions, are eliminated in preparing the consolidated financial statements. Unrealised gains arising from transactions with associates are eliminated to the extent of CDHB's interest in the entity. Unrealised losses are eliminated in the same way as unrealised gains, but only to the extent that there is no evidence of impairment.

Foreign currency

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction.

Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the statement of financial performance.

Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at foreign exchange rates ruling at the dates the fair value was determined.

Budget figures

The budget figures are those approved by CDHB in its District Annual Plan and included in the Statement of Intent tabled in parliament. The budget figures have been prepared in accordance with NZ IFRSs, using accounting policies that are consistent with those adopted by CDHB for the preparation of these financial statements.

Property, plant and equipment

Classes of property, plant and equipment

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

- freehold land;

- freehold buildings and building fitout;
- leasehold building;
- plant, equipment and vehicles; and
- work in progress.

Owned assets

Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses.

Land, buildings and building fit-out are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of financial performance. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the statement of financial performance. Additions to land and buildings between valuations are recorded at cost.

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Fixed Assets Vested from the Hospital and Health Service

Under section 95(3) of the NZ Public Health and Disability Act 2000, the assets and liabilities of Canterbury Health Ltd were vested in CDHB on 1 January 2001. Accordingly, assets were transferred to CDHB at their net book values as recorded in the books of Canterbury Health Ltd. In effecting this transfer, CDHB has recognised the cost/valuation and accumulated depreciation amounts from the records of Canterbury Health Ltd. The vested assets will continue to be depreciated over their remaining useful lives.

Additions

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

Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value when control over the asset is obtained.

Subsequent costs

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

Disposal of Property, Plant and Equipment

Where an item of plant and equipment is disposed of, the gain or loss recognised in the statement of financial performance is calculated as the difference between the net sales price and the carrying amount of the asset.

When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to general funds.

Donated Assets

Donated assets are recorded at the best estimate of fair value and recognised as income. Donated assets are depreciated over their expected lives in accordance with rates established for other fixed assets.

Depreciation

Depreciation is charged to the statement of financial performance using the straight line method so as to write off the cost or valuation of fixed assets above $2,000 to their estimated residual value over their expected economic life. Assets below $2,000 are written off in the month of purchase. Land is not depreciated.

The estimated useful lives of major classes of assets and resulting rates are as follows:

Class of Asset	Years	Depreciation Rate
Freehold Buildings & Fitout	10 – 50	2 - 10%
Leasehold Building	3 – 20	5 - 33%
Plant, Equipment and Vehicles	3 – 12	8.3 - 33%

The residual value of assets is reassessed annually.

Work in progress is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

Intangible assets

Software development and acquisition

Expenditure on software development activities, whereby the new or substantially improved software and processes, is capitalised if the product or process is technically and operationally feasible and CDHB has sufficient resources to complete development. The expenditure capitalised includes the cost of materials, direct labour and an appropriate proportion of overheads. Other development expenditure is recognised in the statement of financial performance as an expense as incurred. Capitalised development expenditure is stated at cost less accumulated amortisation and impairment losses.

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

Amortisation

Amortisation is charged to the statement of financial performance on a straight-line basis over the estimated useful lives of intangible assets with finite lives. Such intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

Type of asset	Estimated life	Amortisation rate
Software	2 years	50%

Investments

Financial assets held for trading are classified as current assets and are stated at fair value, with any resultant gain or loss recognised in the statement of financial performance.

Other financial assets held are classified as being available-for-sale and are stated at fair value, with any resultant gain or loss being recognised directly in equity, except for impairment losses and foreign exchange gains and losses. When these investments are derecognised, the cumulative gain or loss previously recognised directly in equity is recognised in the statement of financial performance. Where these investments are interest-bearing, interest calculated using the effective interest method is recognised in the statement of financial performance.

Financial assets classified as held for trading or available-for-sale are recognised/derecognised on the date the CDHB commits to purchase/sell the investments.

Trade and other receivables

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

Inventories

Inventories held for distribution, or consumption in the provision of services, that are not issued on a commercial basis are measured at cost (calculated using the weighted average cost method) adjusted when applicable for any loss of service potential. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

Other inventories are stated at cost (calculated using the weighted average method).

Cash and cash equivalents

Cash and cash equivalents comprises cash balances, call deposits and deposits with a maturity of no more than three months from the date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows, but are shown within borrowings in current liabilities in the statement of financial position.

Impairment

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

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

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

When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in the statement of financial performance even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the statement of financial performance is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in the statement of financial performance.

The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration are not discounted.

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. The value in use is the depreciated replacement cost for an asset where the future economic benefits or service potential of the asset are not primarily dependent on asset's ability to generate net cash inflows and where CDHB would, if deprived of the asset, replace its remaining future economic benefits or service potential.

The reversal of an impairment loss on a revalued asset is credited to the revaluation reserve. However, to the extent that an impairment loss for that class of asset was previously recognised in the statement of financial performance, a reversal of the impairment loss is also recognised in the statement of financial performance.

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

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

Restricted assets and liabilities

Donations and bequests received with restrictive conditions are treated as liability until the specific terms from which the funds were derived are fulfilled. Until the conditions attached have been fulfilled, the assets received are treated as restricted assets.

Borrowings

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

Employee benefits

Defined contribution plans

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

Defined benefit plans

CDHB makes contributions to the DBP Contributors Scheme (the scheme), which is a multi-employer defined benefit scheme.

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

Long service leave, sabbatical leave, retirement gratuities and sick leave

CDHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The discount rate is the market yield on relevant NZ government bonds at the year end date. CDHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates. Sick leave amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date to the extent CDHB anticipates it will be used by staff to cover those future absences.

Annual leave, conference leave and medical education leave

Annual leave, conference leave and medical education leave are short-term obligations and are measured at undiscounted nominal values based on accrued entitlements at current rates for pay.

Provisions

A provision is recognised when CDHB has a present legal or constructive obligation as a result of a past event, and it is probable that expenditures will be required to settle the obligation. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability.

ACC Partnership Programme

CDHB belongs to the ACC Partnership Programme whereby the CDHB accepts the management and financial responsibility for employee work related illnesses and accidents. Under the programme the CDHB is liable for all its claims costs for a period of five years up to a specified maximum. At the end of the five year period, the CDHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to the reporting date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Trade and other payables

Trade and other payables are initially measured at fair value and subsequently stated at amortised cost using the effective interest rate.

Derivative financial instruments

CDHB uses foreign exchange and interest rate swaps contracts to hedge its exposure to foreign exchange and interest rate risks arising from operational and financing activities. The CDHB does not hold these financial instruments for trading purposes and has not adopted hedge accounting.

Derivative financial instruments are recognised initially at fair value. Subsequent to initial recognition, derivative financial instruments are remeasured to fair value at each balance date. The gain or loss on remeasured to fair value is recognised immediately in the statement of financial performance.

Income tax

CDHB is a crown entity under the NZ Public Health and Disability Act 2000 and is exempt from income tax under section CW38 of the Income Tax Act 2007.

Goods and services tax

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Revenue

Revenue is measured at the fair value of consideration received or receivable.

Revenue relating to service contracts

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

Services rendered

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

Interest income

Interest income is recognised using the effective interest method. Interest income on an impaired financial asset is recognised using the original effective interest rate.

Operating lease payments

Payments made under operating leases are recognised in the statement of financial performance on a straight-line basis over the term of the lease. Lease incentives received are recognised in the statement of financial performance over the lease term as an integral part of the total lease expense.

Non-current assets held for sale

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of non-current assets held for sale are recognised in the statement of financial performance.

Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-current assets held for sale (including those that are part of disposal group) are not depreciated or amortised while they are classified as held for sale.

Borrowing costs

Borrowing costs are recognised as an expense in the period in which they are incurred.

Critical judgements in applying CDHB's accounting policies

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

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year are discussed below:

Property, plant and equipment useful lives and residual value

At each balance date CDHB reviews the useful lives and residual values of its property, plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires CDHB to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by CDHB, and expected disposal proceeds from the future sale of the assets.

An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in the statement of financial performance, and carrying amount of the asset in the statement of financial position. CDHB minimises the risk of this estimation uncertainty by:

- Physical inspection of assets;
- Asset replacement programmes;
- Review of second hand market prices for similar assets; and
- Analysis of prior asset sales.

CDHB has not made significant changes to past assumptions concerning useful lives and residual values, other than a reduction in the useful lives of certain buildings for which CDHB has recognised an impairment to their carrying amounts.

Retirement and long service leave

The present value of the retirement and long service leave obligations depend on a number of factors that are determined on an actuarial basis using a number of assumptions. Two key assumptions used in calculating this liability include the discount rate and the salary inflation factor. Any change in these assumptions will impact on the carrying amount of the liability.

Leases classification

Determining whether a lease agreement is a finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to CDHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

CDHB has exercised its judgement on the appropriate classification of its leases and, has determined all lease arrangements are operating leases.

Non-government grants

CDHB must exercise judgement when recognising grant income to determine if conditions of the grant contract have been satisfied. This judgement will be based on the facts and circumstances that are evident for each grant contract.

A DAY IN THE LIFE OF THE CANTERBURY DHB

On an average Canterbury day: 3,370 people are seen in general practice; 230 people present at the Christchurch ED; 42 people have elective surgery; $359,453 is spent on pharmaceuticals; $66,176 worth of laboratory tests are completed; 134 people 65+ have a free flu vaccination; 205 children have a dental check; 41 young women have HPV vaccinations; 99 women have a cervical smear; 27 people have a free diabetes check; 56 adolescents access free dental services; 413 people have an Outpatient appointment and 1,418 people have a follow-up appointment; 7 cases of infectious diseases are notified; 523 Meals on Wheels are delivered; $79,203 is spent on Home Based Support Services; and 18 babies are born.